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From the Editor's Desk

JMA Activities Relating to National Health

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This paper identifies the most important of the various issues currently facing the Japan Medical Association (JMA) and provides a summary of the main points of each issue. I hope that this will be helpful to the members of overseas health organizations in better understanding the kinds of problems occurring in the health field in Japan and what efforts the JMA is taking to resolve each of these.

Legacy of the Koizumi Administration

Beginning in 2001 and lasting some five years, the Koizumi Administration came to a close at the end of 2006. Although born against a background of overwhelming support from the general public, at the end of the day I believe the Koizumi Administration legacy to the next generation was a heavy burden. A typical example of this is the more than a quadrillion yen in national and regional accumulative long-term debt. In the first place, I believe that when the Administration first came to power it was thought imperative to somehow halt the ever-increasing deficit. However, with its enthusiasm for reforming basic fiscal revenue and expenditure, I cannot help but feel that the Administration attempted to rebuild Japan's economy with excessive haste, with the result that reforms lopsidedly focused on the reduction of social security benefits.

Role of the National Government in Social Welfare, Social Security, and Public Health

Article 11 of the Constitution of Japan states that "the people shall not be prevented from enjoying any of the fundamental human rights", and Article 25 speaks of the people's right to life and the State's responsibility to provide social security. The article's first paragraph states that "All people shall have the right to maintain the minimum standards of wholesome and cultured living" and Paragraph 2 clearly states the important duty of the State to "in all spheres of life...use its endeavors for the promotion and extension of social welfare and security, and of public health."

In other words, the Constitution of Japan stipulates that the State must fulfill its responsibilities with regard to social welfare, social security, and public health. The JMA is a core organization involved in these issues and as such is vigilantly aware that government handling of these issues must not stray from the Constitution's stipulations.

In contrast, in the current social climate I sense a lack of serious and consistent principles in approaching social welfare and social security policies, even and especially amongst government officials. Japan has already established a health insurance system that provides high-level and functional medical care with only a small burden on the public, and in that sense the medical care is regarded as the core of Japan's social security system. It is precisely the maintenance and expansion of this health care system that I believe is the duty of the State stated in the Constitution of Japan.

Future Predictions for Health Expenses

The Japanese Government has made much of how explosively expenses for health care, the core of Japan's social security system, are increasing. However, investigations by the Japan Medical Association Research Institute (JMARI) or the JMA think tank show that this is far from being so. Medical care fees have been overhauled and reduced three times—in 2002, 2004, and 2006, and health care continues to be provided at these

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reduced fees. Predicting future medical expenses based on this pattern, the research results show that medical expenses in the future are unlikely to reach an unmanageable figure; expenses will not reach the semi-threatening high figures that the Ministry of Health, Labour and Welfare is claiming. However, the role of the JMA does not end with our simply saying "these are the figures"; we are now at the stage where the JMA must propose an appropriate system for providing health care based on these figures, and clearly state how health care in Japan should be supported in the future.

Promotional Activities of the JMA

The JMA conducted a questionnaire of the presidents and vice presidents of local medical associations to ascertain what they believed the most important role of the JMA to be. The results showed that the greatest demand was for "the JMA to clearly and properly explain our health care activities to the public"; we were told that the JMA should provide accountability—something that I am always saying myself. In other words, we have to boost our promotional activities. Other questionnaire responses included "should secure funding for health care", "should promote the disclosure of medical information", and "should secure health care human resources", indicating that an overwhelming number of respondents were of the opinion that advertising activities required strengthening.

Accordingly, the JMA is currently beginning a campaign to advertise the direction of the new path the JMA has embarked upon.

Regional Databases

It is necessary for the JMA to create a detailed health database for each region, and it is vital that we recognize the importance of this. The JMARI has been delegated this task, and the JMA intends to use the database in formulating, proposing, and then implementing health care policies that are acceptable to JMA members. The basic principles regarding these policies are that they maintain public security and safety, and so the JMA intends to propose new health care policies along these lines.

Strategies

Another important JMA task is the creation of strategies for the implementation of health care policies. Firstly we must continue to explain our position to the general public by strengthening our promotional activities as mentioned above. Secondly we must explain our position to those involved in national administration around the country and those in central administrative positions. Thirdly we must explain our position to the relevant administrative agencies and ministries, such as the Ministry of Health, Labour and Welfare; Ministry of Education, Culture, Sports, Science and Technology; Ministry of Economy, Trade and Industry; the Cabinet; and the Ministry of Finance.

I do not know how councils reporting directly to the Cabinet—such as the Council on Fiscal and Economic Policy and the Council on Promotion of Regulatory Reform and Privatization—have been functioning since the Abe Administration came to power, but I believe the first step in the JMA's strategy should be to first of all explain our health policies in forums such as these.

Effectiveness (Organizational Power)

To realize these strategies, the JMA must of course first of all achieve the necessary degree of effectiveness. It is this effectiveness, this ability to realize these policies, that is precisely the power of the JMA as an organization, and so it is necessary that we cultivate this power. Of course, it is, I believe, important that the JMA makes efforts to attract the membership of as many doctors as possible. It is therefore necessary for us to make repeated efforts to induce in the younger generation of doctors a desire and willingness to join the JMA. Here the question is what are the merits of joining the JMA, and I believe the answer is that together we are working to develop and implement the health care policies of the JMA.

Accordingly, it is imperative that we strive to listen to the opinions of doctors in regional areas and various positions—particularly hospital doctors, female doctors, residents, and medical students—and explain the policies and activities of the JMA so that each may become aware of the enormous significance of joining the JMA.

Regarding the merits of membership, there are of course the benefits of welfare schemes for doctors such as the JMA Pension Plan and Professional Liability Insurance Program which aim to accomplish community health care, but I believe the most important task for us is to work together to create health care policies and explain to young doctors and female doctors that this is how a future vision of worthwhile health care is created.

We hope to create a pattern in which doctors say, "OK! If that's what the association is trying to do, I'd like to join" and they join the JMA for this reason. This is precisely the power of the JMA, as well as its effectiveness. In order to realize these policies, not only the activities of our think tank, but also the cultivation of power such as I have just mentioned is imperative.

Lobbying Activities

Another important issue is that there can be "no health policy without lobbying activities, and no medical care without health policy". What we provide to society based on our medical discipline and ethics is health care. Considered in this way, how health care is provided to the general public becomes a matter for health policy. Important are approaches to the establishment, explanation, and implementation of health care policies. Lobbying activities are necessary for health care activities to be implemented. The JMA is an academic organization and by no means are its main activities political. However, the purpose of these academic activities is to pass their results back to society and contribute to the improvement of the general public's welfare. Accordingly, the JMA must conduct its activities within this broad philosophy.

Efforts Regarding Young Doctors, Hospital Doctors, and Female Doctors

Around the year 2025, the postwar baby-boomers will have reached old age, and many are expected to become ill. Looking at papers that have calculated the number of doctors necessary to provide health care for this great number of patients, there is expected to be a huge shortage of doctors if matters continue as they are. Health delivery systems for isolated and remote areas or islands that even now are inadequate may well collapse if the current situation continues.

Under such circumstances, there may be doctors completing their two-year clinical training who, when considering their future options, decide that they would like to experience medical practice in remote or isolated areas or islands. If this is the case, it will be necessary for public administration to take a central role in the creation of systems that meet these desires in each region. It will also be necessary to construct systems that can effectively evaluate such doctors in the medical facilities where they work. I believe that only the JMA has the capacity to realize such a system.

In future, the national government is gradually transferring authority over various aspects of the health care system to local government bodies. At that point, it will be an important period for determining what policies local medical associations propose and how they interact with local government bodies. The JMA intends to continue to work eagerly in the future to address the uneven distribution of doctors and trends concerning young doctors. Moreover, we hope to talk with people with influence over administrative authorities and local government bodies as well as people involved in national administration. The most important issue within this process is what kind of structure is best for hospital doctors and female doctors.

Issues Affected by Article 21 of the Medical Practitioners Law

The JMA is making particular efforts in certain activities that enable doctors to carry out medical treatment with peace of mind. Firstly, in the case of extremely high-risk, high-difficulty treatments, there is the possibility that unforeseen accidents will occur. In 2006, an obstetrician at a regional hospital was suddenly arrested more than a year after the operation in question on charges of professional negligence resulting in death and violation of Article 21 of the Medical Practitioners Law (failure to report an unusual death). The police intervened and arrested the doctor.

If this kind of thing is going to happen, I believe the shock to doctors in high-risk medical fields will be enormous; they are sure to be truly grieved as doctors that the health care they provide is not valued. Even worse, such factors could significantly influence young doctors when they are deciding their field of specialization.

With regard to application of Article 21 of the Medical Practitioners Law, one change that we hope to make is to establish a structure in which efforts of doctors are more rewarded.

No-fault Compensation Program

Another issue that the JMA is currently considering is the introduction of a program of no-fault compensation to protect doctors who provide extremely difficult medical treatments. In the course of medical treatment various problems naturally occur. In pregnancy and childbirth, for example, through no fault of the doctor and no fault of the pregnant woman, cerebral paralysis of the fetus occurs during the course of pregnancy or childbirth in a certain percentage of cases. Despite this fact, the doctor caring for such a mother and child feels tremendous responsibility, of course, and the situation is extremely difficult for both the parents and the child. The JMA is working to implement a system of no-fault compensation to support people in situation such as this.

Nurse Shortage

One urgent issue is the shortage of nurses. Medical institutions operate in accordance with various nursing standards, but the situation is becoming problematic. This is also a result of the government trying to implement changes far too quickly and so now even university hospitals are scrambling to assemble adequate nursing staff. However, there needs to be thorough discussion of such questions as what comprises a truly good nursing system and what kind of nursing system should university and large hospitals provide with a system for the provision of community health care. Of course, deciding that lots more nurses need to be trained is meaningless if there are few young people interested in becoming nurses. Even with such social issues, the JMA hopes to train many more people who are willing to make a difference in medical workplaces where safety and trust are required and will continue to make moves in that direction.

Hospital Beds

Another issue is a government plan to reorganize hospital beds that are allocated for long-term hospital care. The Ministry of Health, Labour and Welfare has announced it aims to reduce the current 380,000 hospital beds for medical/nursing care to a final figure of 150,000 by the end of 2011, discontinuing use of some 130,000 beds for nursing care and a further 100,000 beds for medical care.

This is far too unexpected—an item that was not even mentioned in the 3rd Long-Term Care Insurance Action Plan suddenly leaped up. The executive board members of JMA in charge of nursing care are leading the JMA's response, and it is time for us to seriously consider the repercussions of this decision and with the Central Social Insurance Medical Council and the relevant Ministry of Health, Labour and Welfare bureau discuss ways to ensure that medical institutions are not seriously damaged in this plan, and more importantly, to ensure that people occupying hospital beds are not forced to leave hospital, becoming so-called "nursing care refugees" or "medical care refugees".

A New National Health Care System and Health Care for the Future

Lastly, the JMA is considering such what shape a new national health care system and health care for the future should take. Under the present system, special functioning hospitals are at the apex in a hierarchical health delivery system with other hospitals and clinics providing primary and secondary health care. However, this is not what I myself have in mind.

We have become used to health care within the health insurance system and health institutions that waits for patients, health care in which the patient enters the health institution, presents their health insurance card, and are asked "What seems to be the trouble?" In the future, however, the conventional method of providing health care will be insufficient for ensuring that elderly people remain healthy and live longer, in other words, extending healthy life expectancy.

The doctors who take a central role in health care in the future will need to provide health care outside of institutions rather than "waiting" health care provided within health institutions. This should mean the beginning of home health care, and various community-based health care activities which will lead to a new phase of health care of the commnities.

Community health care is gradually changing,

and I believe that universities will undergo tremendous changes in the future. When young doctors have completed their two years in the new clinical training system and think, "Now, at last, I want to work in this field of medicine," it is vital that the universities have systems that will properly accept and embrace these doctors. There will also be young doctors who wish to try their hand at health care in remote areas. The JMA aims to create a system that warmly supports and values such doctors and gives them promise for the future.

The Health Care System in Japan: Current situation and future perspectives[*1]

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Yoichi HOZUMI[*2]

Today I would like to give a general overview of health care in Japan. I will also touch upon an issue of health care as an investment, which is a main theme of this scientific session.

Postwar Development

Approximately 60 years ago, Japan had just begun postwar reconstruction. Food was inadequate and nutritional and hygienic conditions for the general public were extremely bad. The incidence of infectious and other diseases was high in both urban and rural areas, and life expectancy in 1947 was 50 for Japanese men and 54 for women. Health care in these circumstances was completely inadequate.

Japan lost approximately 1.85 million people in the Second World War; most cities were razed and the national wealth lost. The postwar reconstruction of Japan's social security system proceeded with the establishment of a new National Constitution under the powerful supervision of the occupational forces GHQ. The new Japanese Constitution guaranteed fundamental human rights for citizens in Article 11 and based on this, guaranteed citizens' right to live in Article 25, establishing the State's social responsibility in Paragraph 2, which states that "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." Amidst the harsh conditions imposed by the devastation left by the war, Japan began to rebuild, and through the many efforts of its citizens the society's productive, economic, and educational conditions began to gradually and steadily improve.

Little by little, everyday living conditions also improved. The greatest issue for hygienic conditions was the supply of running water and maintenance of water quality. The improvement of these secured the supply of pure water for drinking and other domestic uses, enabling the supply and consumption of hygienic food and clean clothing. By 1956, Japan was no longer regarded as being "postwar", and the average life expectancy had grown to 63.6 for men and 67.75 for women. The country entered a period of economic expansion that saw business boom. Housing improved, and at the same time as the use of electrical appliances such as refrigerators, washing machines, and television sets became widespread, so too did the use of medical equipment such as X-ray, electrocardiographic, and endoscopic equipment spread rapidly amongst medical institutions, with medical technology also advancing rapidly. Throughout the country everyday living became hygienic and consideration to the environment improved with the installation of sewage systems and treatment of waste water, and these developments in particular contributed significantly to the enterprise of the people.

However, as industry expanded, atmospheric pollution was caused by smoke and other pollution was caused by industrial waste water; environmental pollution became a serious concern in some situations and efforts were made to rectify these. Against this background, health management measures to prevent over-consumption of salt and ensure the adequate consumption of protein were spreading at the same time that medical examinations became commonly carried

*1 This presentation was made at the Scientific Session on October 12, 2006 during the WMA General Assembly, Pilanesberg 2006, held in Sun City, South Africa.

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out as a means of preventing diseases. Group examinations were held for stomach cancer and businesses implemented health check-ups for their employees. Consequently, the early diagnosis of frequently occurring diseases and preventative examinations expanded on a national scale, producing highly significant results. Thus since about 30 years ago, people's nutrition has improved and the incidence of infectious diseases has decreased; in 2002 the average life expectancy for men was 78, and for women was 85, making Japan the world's top country for longevity.

Features of Nature and Industry

Japan is an island nation with little flat land; 90% of the country is forest-covered mountains. Not only is Japan a volcanic country that faces the constant threat of massive and epicentral earthquakes, but it also faces wind and water damage every typhoon season. Since plentiful rainfall is beneficial for tree growth, Japan has many fast-flowing rivers. Compared with continents, rivers flow only short distances from their wellsprings to the ocean. These plentiful, clear rivers play an important role, in rice cultivation, in hydroelectric power generation, and in many other functions in which water has been innovatively utilized. Japan cannot produce oil or natural gas as energy sources and its mineral resources are also small.

Consequently, national production in Japan tends towards importing raw materials from overseas, then manufacturing products using various original processing technologies; promotion of high intelligent added value in industrial production and high computerization, as well as industrial structuring in areas such as finance, distribution, and services is increasing more and more, invigorating the economy. Many innovations have been made to production methods for traditional rice, fruit, and vegetable crops; developments in production technology are not only used in domestic production but are also spread overseas, with the export of production technology now becoming an important industry that also contributes internationally. Deep-sea and coastal fishing are two other important industries; the development and promotion of innovative fish farming technology is becoming increasingly important as a means of securing resources. The international export of seafood is a small industry in Japan, but it also contributes greatly to the development and diffusion of technology. Since the industrial revolution, Japan's basic policy has been to enhance the education system; citizens make efforts to promote intelligent industry, understanding that we receive praise and great benefits from other countries through the development of science and technology and our contributions to the international community.

Health Insurance System in Japan

The development of transportation facilities in Japan has enabled many people and goods to be transported anywhere within the country within half a day, and information can be transmitted instantly throughout the country.

This was a huge leap forward for emergency and disaster medicine in Japan. With these development, from the 1950s onwards the basic components necessary for providing health care —hospitals, clinics, doctors, and nurses—all of which had been inadequate, gradually increased and health care in regional areas expanded. A health insurance system which operated independently for each health field continued to exist, but there continued to be a large number of people who had not paid their insurance. The Japan Medical Association recommended that the individual insurance systems be integrated and the entire system expanded. Eventually, in 1961, the total health insurance was expanded and a universal health care system available to all citizens was introduced. Through the process of establishing this system, medical fields were classified broadly into four groups.

All citizens were required to join one of four insurance plans depending on their occupation and position: government-managed health insurance administered by medium and small businesses; association-managed health insurance administered by the majority of large businesses; National Health Insurance administered by local government authorities; and National Health Cooperative Insurance, also administered by the same kind of businesses on a local level. The establishment of this system enabled citizens to receive health care equally and fairly anywhere in Japan, at any time and for whatever reason, for a minimal self-payment and without having to undergo screening simply by showing their

insurance card to prove they were insured. Under this system, the medical institution providing treatment receives the portion of payment covered by public funds under a reimbursement system known as a fee-for-service system. The system operates smoothly due to the efficient functioning of medical fee payment fund that carefully checks the details of medical treatment.

Improvement of medical institution facilities and the implementation of this medical insurance system have enabled huge advances in regional health care systems and provided the tremendous benefit of care being available equally and fairly to all citizens.

Because of differences in the history of their establishment and composition of member businesses and organizations, each of the heath insurance plans has difference insurance rates. The government-managed health insurance plan is the largest in scale and imposes public benefits in addition to the insurance burden on employers and members.

Against this background the Japan Medical Association has, as a pillar supporting the health care of citizens, has proactively promoted the establishment and maintenance of this system, and with the cooperation of medical institution nationwide, the National Health System has made a huge contribution to the health system in Japan.

With the development of the economy and industry in Japan I have already outlined, the emergency medicine infrastructure and treatment of chronic illness improved through the continued improvement of hygienic conditions, better nutrition, and the creation of infrastructure for the universal and fair provision of health care.

Health Care Statistics

In 2000 and 2004, the World Health Organization named Japan as a country with one of the highest longevity rates in the world, recognizing the excellence of Japan's health system. Japan ranks Number 1 in the world in a comparison of heath achievement; in 2002 longevity was again the highest in the world, with the average life expectancy for men being 78.4 and for women 85.3; and Japan also has one of the lowest infant mortality rates in the world. Japan's excellent National Health Insurance system is the most effective health insurance system of all the developed countries. Since the 1970s, Japan's GNP has skyrocketed. With citizens' growing health consciousness and medical care awareness as well as improvements in medicine and medical technology, the total cost of medical treatment in Japan is gradually growing and management of the health insurance system has been revised repeatedly.

Since 1980, the total fertility rate has dropped below 2.0 for a variety of reasons, and in 2005 dropped to a marked low of 1.25. In a world rapidly ageing, Japan has hurtled fastest into an aging society with fewer children.

As I have explained, medical expenses in Japan are not high compared with other developed countries. Total health expenses are 7.9% of GDP, a low rank of 17 amongst the developing countries. However, in 2000 Japan established a national Long-term Care Insurance system, administered on a municipal basis, aimed at elderly citizens requiring nursing care as a means of lightening the continuously increasing cost of health care for the elderly. The degree of nursing care required is determined through screening and nursing care services appropriate for the elderly person's needs are provided.

Health Care as an Investment

Here I would like to touch on the theme of this symposium—health care as an investment.

Considering the population dynamics of Japan, despite the difficulty of boosting the productive-age population, it could be possible to secure a potential working population by improving the health of senior citizens. Increased numbers of elderly people capable of working would be an enormous opportunity, creating fresh consumer activity and invigorating the economy. In other words, proactive health care to restore, maintain, or increase health—such as avoiding the risk of disease occurring through preventative medicine and the promotion of social rehabilitation and independence through early diagnosis and treatment—has ample potential to increase the heath investment of each individual, thereby increasing the population of potential workers, bringing about an increase in productivity, GDP, and revenue from tax, and thus more stable employment and fresh economic activity. Furthermore, health care is a labor-intensive industry, and so a stable supply of workers for medical institutions will facilitate more stable health care. Moreover, the

construction of the necessary medical facilities could also create a wave effect in the economy. In this way, there are certainly investment aspects in health care, and it is vital that this is recognized widely by members of the general public. The JMA is currently seeking the understanding of the government headed by Prime Minister Abe, newly formed in September this year, of the necessity of promoting basic policies such as this.

JMA's Health Reform Policies and Future Perspectives

The JMA is proactively pursuing the following items as comprehensive and central policies for health reform, including the views just mentioned.

1. Create a society able to truly rejoice at longevity through enhanced health care and welfare for the elderly.
2. Create a society where one can give birth with peace of mind through the expansion of obstetrical care and maternal and child health.
3. Create a society where children can thrive and grow healthily through enhanced pediatric care and school health.
4. Create a society where people can work healthily and enthusiastically through enhanced industrial health and workers' compensation insurance.
5. Create a society with as little occurrence of disease as possible through the promotion of and lifestyle disease countermeasures and anti-smoking campaigns.
6. Create a society able to provide high quality medical care for those who are sick through the guarantee and enhancement of community health care and health insurance.
7. Create a society that provides an excellent health care system through the enhancement of community heath care centered on primary care doctors and the promotion of cooperation between health services.
8. Create a society able to put medical advances into practice in health care through the establishment of lifetime education and a medical specialist system.

Finally, with regard to approaches to government agencies regarding issues such as these, the JMA is campaigning to prevent corruption of the medical care system, including financially motivated proposals for medical system reform, mainly through petitions and the endorsement of Diet members who represent the position of the JMA in the government.

The JMA intends to continue to promote the construction of a foundation for community health care, working with the general public to formulate and propose strategies for realizing the establishment of a health care framework that people trust, in order to create a durable social insurance system that safeguards the heath and welfare of Japan's citizens.

The WMA officers and the speakers. Dr. Hozumi, the author is third left.

Doctors' Efforts toward Appropriate Medical Waste Management in Japan*1

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Satoshi IMAMURA*2

Good afternoon, ladies and gentlemen. It is my great pleasure to have the opportunity to speak to you at this conference. My name is Dr. Satoshi Imamura from the Japan Medical Association (JMA). Today, I would like to talk to you about "Doctors' efforts toward appropriate medical waste management".

Before talking about medical waste, let me first introduce our organization (Slide 2). The JMA, is an organization for physicians in Japan. The number of members is about 165,000, which accounts for 60% of the total number of physicians in Japan.

The Threat of Medical Waste and Doctors' Responsibility

I would like to consider the issue of medical waste (Slide 3). You may be wondering, "Why should doctors be concerned about medical waste?" My answer to you would be that as doctors we should be concerned about medical waste because medical waste can cause disease, which we have a duty to prevent. As you know, medical waste can pose a threat to both human health and the environment.

Needles represent a significant threat to health caused by medical waste. Data shows that a considerable number of cases of HIV, and Hepatitis B and C are caused by needles. In other words, if medical waste is handled appropriately, such cases of these diseases could be prevented. As for the environmental threat, inappropriate treatment of waste can cause environmental pollution, such as dioxins. Though this is not only caused by doctors, as waste generators we have a responsibility to treat waste appropriately.

This responsibility extends from when the waste is first generated, such as in waste segregation at the medical institution, to the end, the final disposal of waste (Slide 4).

You may be surprised to know that, even if our waste is illegally disposed of by contracted waste company, we, as the generators of the waste, may still have a responsibility to recover it if they fail to perform their task responsibly.

Proper Disposal of Medical Waste

Regarding the fulfillment of our responsibility to properly dispose of medical waste, let me introduce for you the efforts by Japanese doctors' to treat medical waste appropriately, both in the hospital and outside of the hospital.

The first point relates to how to identify infectious waste in the hospital (Slide 5). We have made guidelines for the identification of infectious waste, in cooperation with the government and the waste treatment industry.

This flowchart is the summary of the identification process (Slide 6). As you can see, there are three steps to the flowchart, and if the target waste satisfies any one of the criteria, the waste is to be considered and treated as infectious waste.

After identification, the waste should be discarded separately as shown in Slide 7. Usually we use several disposal boxes to conduct thorough control of waste segregation.

Slide 8 shows another example. In this case, three boxes have been used, for needles, injections and other matter.

Let me also introduce to you the legal criteria concerning containers (Slide 9). Containers should

*1 This presentation was made at the Asia 3R Conference hosted by the Ministry of the Environment of Japan, held at the Mita Conference Hall in Tokyo on October 30th through November 1st, 2006, and partially revised for this publication.

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be strong enough so as not to be penetrable. On each container, a bio-hazard mark is used to let everyone know that the box contains hazardous waste (Slide 10). This seal comes in three different colors according to the different type of waste. From color of the box, then, anybody can tell what should be disposed of in it.

Also, each hospital should appoint a medical waste supervisor (Slide 11). In many cases, the hospital director holds this post. Medical waste supervisors are responsible for medical waste management and planning, and for raising awareness among staff. Under the Waste Management Law, only those who have enough medical knowledge are entitled to become the supervisor.

Of course, medical waste should also be properly treated after it is transferred outside of the hospital (Slide 12). Our responsibility also covers this waste treatment. Because of the generation of dioxins and difficulty in treatment inside the hospital, medical waste should be treated outside of the hospital under consignment contracts with waste disposal companies.

The procedures are divided into transportation, intermediate treatment and final treatment. If negligence and inappropriate treatment such as illegal dumping are detected in the actions of the waste disposal company under the contract, the burden of cost to restore the environment to its original state is incurred by the waste generator.

Ensuring this does not occur requires the use of waste management slips, which I will talk about in a moment, as well as visiting the waste disposal facilities. The best but most difficult way to solve the problem is to appropriately select the waste disposal companies to be engaged.

To manage waste outside of the hospital, the law requires the use of waste management slips. An example of these slips is shown in Slide 13. One unit contains a set of seven slips. Simply speaking, as you see this chart, a set of slips is always transmitted with wastes. Each slip should be returned to the medical facility after completing each step of the waste treatment. Therefore, if we do not get all the slips, we can suspect a possibility of the inappropriate treatment or loss of the waste.

Another effort being made by doctors consists of visiting and checking waste treatment facilities (Slide 14). By visiting the facilities themselves, we can understand how our waste is being treated outside of the hospital.

JMA's Activities toward Appropriate Medical Waste Management

Finally, I would like to discuss how the JMA's activities relate to this issue (Slide 15).

Lecturers, who include doctors, government officials, and members of the waste management industry talk about the environmentally sound management of medical waste (Slide 16). In addition, from 2006, the JMA will be organizing seminars to train medical waste supervisors

Another example of the activities of local medical associations is the coordination between hospitals and waste disposal companies (Slide 17). For small clinics, it is difficult to find and select an appropriate waste disposal company by themselves. Therefore, the local medical association should help small clinics by building networks and providing information about waste disposal companies.

In addition, the JMA is developing new technology aimed at the proper treatment of waste (Slide 18). An example of this is the IC chip tracing system. This system is illustrated in the top center photo of Slide 18. By attaching the IC chip to a waste container as shown in the top right-hand picture of Slide 18, the exact place where the medical waste was produced can be traceable throughout the treatment process. This system is actually already being used in the Tokyo area.

In spite of these efforts however, unfortunately, illegal dumping of medical waste still often occurs, to avoid the costs of treatment. In Slide 19, you can see injection cylinders in the soil, which have been dumped. Most of the illegal dumping is reported as being done by irresponsible waste disposal companies.

The JMA is working in cooperation with national and local governments against illegal dumping (Slide 20). In Japan, industries and the government have established a fund to support the work of local governments to recover sites where illegal dumping has occurred, and the JMA contributes part of this fund. We think this represents an important contribution to society.

Conclusion

In this presentation, I have briefly explained the efforts being made to treat medical waste in

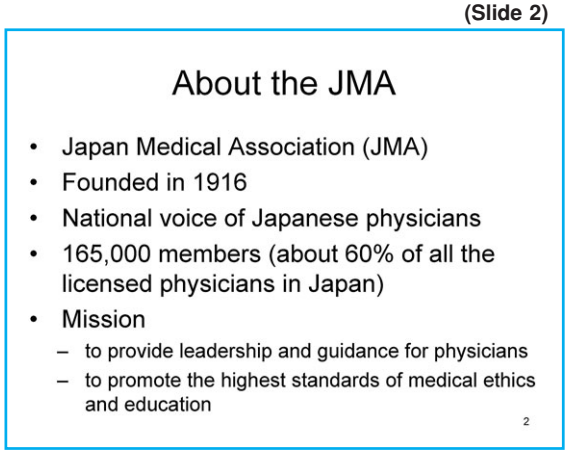
Japan. As the final message of my presentation, I would like to emphasize four points (Slide 21). First, please keep in mind that medical waste can cause serious adverse effects to human health and to the environment. In addition, from our experience, medical wastes will increase as industrialization progresses. Therefore, it is essential to build an appropriate treatment system for medical waste. The JMA would like to continue to share our experiences with the countries of Asia. There is a lot that doctors can do, and we should do it. Thank you for you attention.

Acknowledgement

Some pictures in the presentation were contributed by Ministry of the Environment of Japan and Japan Industrial Waste Technology Center.

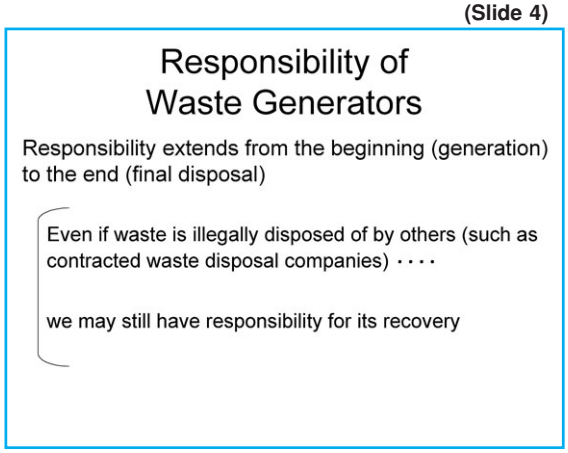
(Slide 1)

(Slide 2)



(Slide 3)

(Slide 4)



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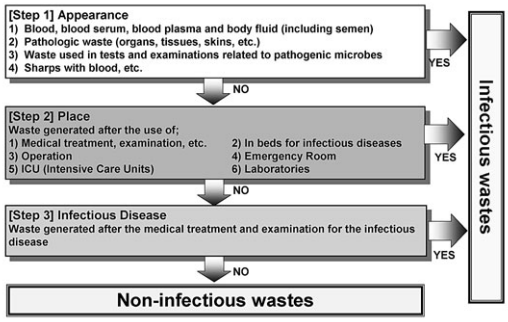
Doctors' Activities

- I. Waste management in the hospital
  1. Identification
  2. Segregation
  3. Container
  4. Bio-hazard Mark
  5. Medical Waste Supervisors
- II. Waste management out of the hospital
  6. Slips used for Waste Management
  7. Visiting Waste Treatment Facility

(Slide 6)

1. Identification



(Slide 7)

2. Segregation

Sharps | Plastics (compatible) | Glass bottles

(Slide 8)

Segregation (Laboratory Wastes)

(Slide 9)

3. Containers

- For Sharps (Needles, surgical knife)
  - Made of metal or plastic
  - Made of an anti-penetrable container
- For Solids
  - Double-use of plastic bags
- For Liquid and Sludge
  - Uses an anti-leak container (prevent liquid from leaking)

(Slide 10)

4. Bio-hazard Mark

Used on containers with a special color, so the type of waste can be easily distinguished

- **Red : for Liquid or Sludge waste**
- **Orange : for Solid waste**
- **Yellow : for Sharps waste**

(Slide 11)

5. Medical Waste Supervisor

- Each Facility should appoint a medical waste supervisor
- Responsibilities include;
  - Managing medical waste in the facility
  - Improving awareness among staff
  - Developing "Waste Management Plans"
- Qualification

  Degrees in medicine, pharmacy, public health, hygienology or veterinary science

  (Medical Doctors, Dental Doctors, Pharmacists, Veterinarians, Health Nurses, Midwives, Nurses, Clinical/Health Laboratory Technicians and Dental Hygienists)

(Slide 12)

II. Waste management outside of the hospital

Removal

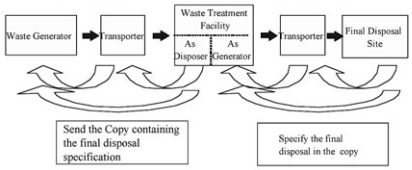
Treatment

Transportation

12

(Slide 13)

6. Waste Management Slips



(Slide 14)

7. Visiting Facilities

(Slide 15)

JMA's Activities

8. Promotion of the appropriate treatment of medical waste (ex. seminars)
9. Selection of the most appropriate disposal company
10. Making a Social Contribution to prevent Illegal Dumping
11. Pursuing Technology Developments, such as IC Chips

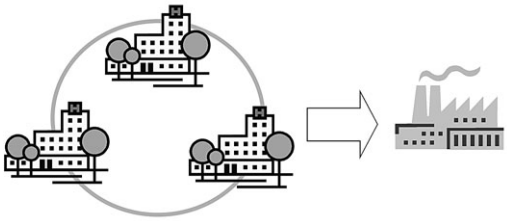
(Slide 16)

8. Seminars

(Slide 17)

9. Coordination between hospitals & waste disposal companies

- Local Medical Associations should play a key role
- Build Networks for small clinics



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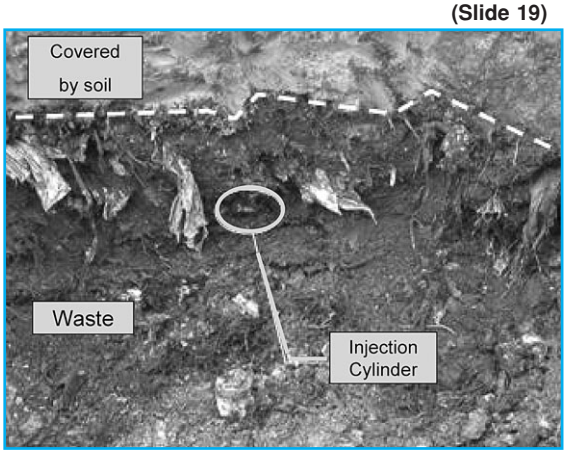
10. Technology Development such as IC Chips.

(Slide 19)



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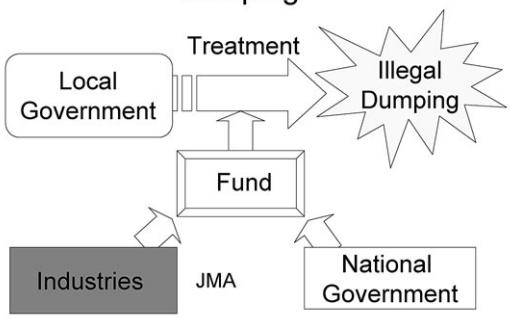
11. Social Contribution against illegal dumping



(Slide 21)

Take-Home Messages

- Medical waste causes serious adverse effects to human health and the environment
- History shows that medical waste increases in accordance with industrialization
- An appropriate system for the treatment of medical waste is essential
- Doctors can and should play a key role

(Slide 22)

Thank you!

Regarding the WMA Resolution on North Korean Nuclear Testing

JMAJ 50(2): 136, 2007

Tatsuo KUROYANAGI*1

October 2006

WMA RESOLUTION ON NORTH KOREAN NUCLEAR TESTING

RECALLING the WMA Declaration on Nuclear Weapons that was adopted at the WMA General Assembly in Ottawa, Canada, in October 1998;

The WMA:

1) Denounces the North Korean nuclear testing conducted against the heightened global vigilance on nuclear testing and arsenal;
2) Calls for the immediate abandonment of the testing of nuclear weapons; and
3) Requests all member associations to urge their governments on the adverse health consequences of nuclear weapons.

On October 10, 2006, the JMA delegation to the WMA General Assembly, Pilanesberg, South Africa (Leader: Dr. Yoichi Hozumi) were greeted on their arrival in South Africa with the news that North Korea had gone ahead with its underground nuclear test. The delegation immediately contacted Tokyo, where it was the middle of the night, and received the instructions of Dr. Yoshihito Karasawa, JMA President in Tokyo to present an urgent proposal to the WMA General Assembly that the WMA pass a resolution against North Korea's nuclear testing.

Accordingly, the resolution was drafted on October 11 and the wording adjusted in collaboration with the WMA secretariat, then put before the WMA Council Meeting as an emergency motion on October 13. The motion was supported by the medical associations of many countries, including the United States, and was accepted as a General Assembly resolution proposal with the unanimous approval of the entire WMA Council.

On October 14 the resolution was presented to the General Assembly as proposed by the JMA as a WMA Council motion. As representative of the WMA Council, Dr. Masami Ishii, Executive Board Member of the JMA, explained the background behind the decision to present the resolution. The resolution was unanimously passed with the enthusiastic support of all General Assembly participants.

The content of Dr. Ishii's statement when the resolution was being presented is as follows.

"On October 10th, 2006, North Korea announced that on October 9th the country had conducted underground nuclear testing in defiance of the heightened global vigilance on nuclear testing and nuclear arsenal;

The JMA is the representative organization of medical professionals in Japan, which is the only country to have experienced the destruction of atomic bombs in the cities of Hiroshima and Nagasaki and the radioactive exposure from nuclear testing suffered by Japanese fishermen at Bikini Atoll;

Moreover, the members of the JMA have treated the pain and suffering of the victims of the devastating effects of the atomic bombs and are living witnesses to the radioactive destruction wrecked on the environment;

Because of these experiences, the JMA has continuously called for the abolition of all nuclear testing and nuclear weapons, which directly threaten the very survival of mankind;

The JMA officially denounced the North Korean nuclear testing at a press conference on October 11th, 2006;

For these reasons, the JMA urges that the proposed "WMA Resolution on North Korean Nuclear Testing" be adopted by the WMA General Assembly."

*1 Legal Advisor, Japan Medical Association, Tokyo, Japan (jmaintl@po.med.or.jp).

42nd CMAAO Mid-Term Council Meeting: COUNTRY REPORTS

Grand Copthorne Waterfront Hotel, Singapore
November 25, 2006

Held from Fri. November 24 to Sun. 26, 2006 in Singapore, the 42nd CMAAO (Confederation of Medical Associations in Asia and Oceania) Mid-Term Council Meeting was attended by a total of some 50 representatives of 13 medical associations (12 existing member associations and Sri Lanka, whose membership has been newly approved). The CMAAO has a current membership of 17 associations in all.

At this mid-term council meeting, Dr. Masami Ishii, Executive Board Member of the JMA, was newly appointed as CMAAO Secretary-General, and it was unanimously agreed by all the attending medical associations that the activities of the CMAAO should from now on be published in the JMA Journal.

The CMAAO holds General Assembly meetings every two years and mid-term council meetings in between. Each member medical association presents a country report on its main activities over the previous year. The following are the country reports presented by the 13 attending medical associations on November 25.

CMAAO Meeting

CAMBODIAN MEDICAL ASSOCIATION

Sau Sok KHONN*1

Background

The Cambodian Medical Association (CMA) was created in 1994. In 1995, at the request of the Ministry of Health, the CMA participated in drafting the sub decree of a Code of Medical Ethics. The CMA has played an active role in promoting the establishment by Royal Decree in the year 2000 of the medical board. The CMA is also active in involving its leadership in discussions with the Ministry of Health in order to develop laws to regulate medical practice. The passing of legislation for compulsory registration of doctors provides a critical opportunity to review the role of CMA in relation to that of the Medical Board and Medical Council, and more generally to the advancement of quality care in Cambodia. Additionally, the CMA plays a more active role in continuing medical education, registration and licensing and issues relating to advocacy for quality of care.

CMA does have some successful activities, such as periodical, occasional symposia for members and an annual convention. However, in the current climate the CMA now has opportunities to develop its role in the setting of professional standards, the implementation of peer support and ethics, and in the definition of its input into medical registration and its consequences.

CMA was accepted as a membership of the Medical Association for the South East Asian Nations (MASEAN) in 1999. Moreover, CMA achieved a remarkable success in organizing the 10th MASEAN Conference in Cambodia, 2001. Also CMA became a membership of the Confederation of Medical Association in Asia and Oceania (CMAAO) in September 2005.

CMA Membership: As at October 2006, the total membership of the Cambodian Medical Association is 1,286. This represents 32.12% of all registered medical doctors in Cambodia.

CMA Council in 2004–2006, –May 2007

CMA always organizes an Annual Convention (AC). The purposes are: 1) to report annual activities, 2) to develop action plan, and 3) to elect new members of the CMA Council (every two-year). As plan, AC is organized in 2006 including election of 8th CMA Council members, but AC is postponed due to the time constraint. Thus the 7th CMA Council members extend their assignments till next year.

Twenty-four members of the association to stand the 7th Council as follow:

Steering committee	
Prof. Sau Sok Khonn	President
Prof. Kong Kimsan	Member
Prof. Mom Chot	Member
Executive Committee	
Prof. Sea Huong	Director
Prof. Touch Sareth	1st Vice-Director
Prof. Seang Tharith	2nd Vice-Director
Dr. Saint Saly	Secretary General
Dr. Kim Chhuong	1st Deputy Secretary General
Dr. Chou Rady	2nd Deputy Secretary General
Dr. Hu Bun Kim	Treasurer
Dr. Ly Sim Cheng	1st Assistant Treasurer
Dr. Iv Chhun Ros	2nd Assistant Treasurer
Sub-committees	
Scientific Sub-committee	
Dr. Kaing Sor	Chief
Dr. Pheav Piseth	Deputy-chief
Dr. Srey Sopha	Member
National and International Relation Sub-committee	
Dr. Nguon Peng	Chief
Dr. Dok Chanly	Deputy-chief
Dr. Chhim Youth Samphy	Member

*1 President, Cambodian Medical Association, Phnom Penh, Cambodia (cma@online.com.kh).

Social and Humanitarian Sub-committee

Dr. Say Sengly	Chief
Dr. Ouch Dina	Deputy-chief
Dr. Mao Nisay	Member

Medical Ethics and Professionalism Sub-committee

Dr. Huy Kim Heng	Chief
Dr. Chang Keng	Deputy-chief
Dr. Keuth Sok Mavy	Member

Main Activities of the CMA for the Year 2004–2007

- 6th Cambodian National Day of Medicine and Pharmacy: In collaboration with Cambodia Pharmacy Association (CPA), CMA organized the National Day of Medicine and Pharmacy on 11–12 August 2004 in Phnom Penh. Theme of the National Day was "Medical Ethics and Professionalism". Seven hundred participants from both CMA and CPA attended that event.
- 7th CMA Mid-Term Council Meeting: The 7th CMA Mid-Term Council Meeting held on Friday of June 24, 2005 in Phnom Penh, Cambodia. Objectives of the meeting were to draw conclusions, recommendations and lessons learned of the participants from 24 provinces/cities. According to the recommendation of the Annual Convention of CMA, the meeting revised the CMA Regulation and planning for next year.
- CMA Council organizes a monthly meeting for monitoring the CMA activities. In the last two years, 20 meetings were done to follow-up the CMA activities and discuss on how to improve the activities.
- As a partnership with the Ministry of Health (MOH), CMA has been strongly involving in monitoring and evaluating the mains activities of MOH; and developing the strategic plans such as the involvement of the project of Public and Private Mix for Tuberculosis Control by DOTS Strategy (PPM-DOTS) in the Urban Area, Malaria Program, HIV/AIDS Program, Mother and Child Health Program, Public medical colleges and medical university, Planning for Health Insurance and Equity Fund for the pilot areas, and developing all aspects of the Health Regulation etc.
- 7th Cambodian National Day of Medicine and Pharmacy: In collaboration with Cambodia Pharmacy Association (CPA), CMA organized the National Day of Medicine and Pharmacy on 10–11 August 2006 in Phnom Penh. The title and principle theme of this year's event was "Cambodia Health Towards Globalization in the New Millennium". Seven hundred participants from both CMA and CPA attended that event.

Relationships

- Attending the 6th International Conference "Setting Limits to Healthcare: the time is Now" on 12–13 February 2004 at the St. Francis International Center for Healthcare Ethics, USA (Prof. Sau Sok Khonn).
- Attending the International Conference on Herbal and Traditional Eastern Medicine: An alternative and Integrative Medicine to be held on 30–31 March 2004 in Macau, China (Prof. Sau Sok Khonn/Dr. Saint Saly).
- Attending 11th MASEARN Conference, 28–31 July 2004 in Bali, Indonesia (Prof. Sau Sok Khonn/Prof. Seang Tharith/Dr. Touch Sareth/Dr. Saint Saly).
- Attending the 24th CMAAO Congress & 41st Council Meeting, 9–11 September 2005, in Seoul, Korea (Prof. Sau Sok Khonn/Dr. Saint Saly).
- Attending 11th MASEARN Mid-Term Council Meeting, 16–18 November 2005, in Bangkok, Thailand (Prof. Sau Sok Khonn/Prof. Seang Tharith/Dr. Touch Sareth/Dr. Saint Saly).
- Attending 1st World Medical Association Asian-Pacific Regional Conference, 10–11 September 2006, in Tokyo, Japan (Prof. Sau Sok Khonn/Dr. Chi Meng Hea).

42nd CMAAO Mid-Term Council Meeting

24-26 November 2006

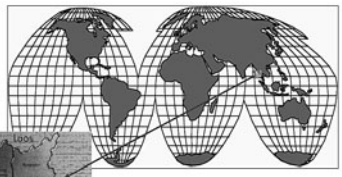
Grand Copthorne Waterfront Hotel, Singapore

CAMBODIA MEDICAL ASSOCIATION

COUNTRY REPORT

Background of Cambodia

-Area: 181,035 sq Km
-Border: Thailand, Lao and Vietnam
-Population: 13,809,532 (2004)



-More than 80% live in rural area and are farmers
-Average family size: 5.4
-National language: Khmer
-Adult literacy rate: 69%
-National religion: Buddhism
-Common food: rice, fishes and vegetables

Background of CMA

- CMA was created in 1994.

- CMA became a membership of the Medical Association for the South East Asian Nations (MASEAN) in 1999. Moreover, CMA achieved a remarkable success to organize the 10th MASEAN Conference in Cambodia, 2001.

- CMA became a membership of the Confederation of Medical Association in Asia and Oceania (CMAAO) in September 2005 in Korea.

- As at October 2006, the total membership of the Cambodia Medical Association is 1,286. This represents 32.12% of all registered medical doctors in Cambodia

Background of CMA

CMA plays a roles as partnership with the Ministry of Health:

1) in developing a Code of Medical Ethics and Laws to regulate medical practice,

2) in continuing medical education (basic and specialist), registration and licensing and issues relating to advocacy for quality of care

3) in developing/implementing/monitoring a new strategic health care system and primary health care approach etc.

Background of Health Care System

Before the reform(1995)

- 4 Levels: Central, Province, District & Commune
- Based on administrative criteria
- **Facilities:**
  - Central MoH, Centers and Institutions
  - 8 National Hospitals
  - 23 Provincial Hospitals
  - 164 District Hospitals
  - 1267 Commune clinics

After the reform(1996+)

- New Health System (3 Levels): Central, Province, Operational District (OD)
- Based on population & geography : **Health Coverage Plan** 73 ODs
- **Planned Facilities:**
  - Central MoH, Centers and Institutions
  - 8 National Hospitals
  - 23 Provincial Referral Hospitals
  - 44 District Referral Hospitals
  - 946 Health Centers

Members of 7th Cambodia Medical Association Council

At the last Annual Convention of the Cambodia Medical Association Council held on Friday, 14th May 2004, the following members of the association were elected to stand the 7th Council for the year 2004-2006 as following:

1. Steering Committee
2. Executive Committee
3. Sub-committees

Main activities of the CMA for the year 2004-2006

1- 6th National Day of Medicine and Pharmacy, 11-12 August 2004, Cambodia. Theme "Medical Ethics and Professionalism" (700 participants).

2- 7th CMA Mid-Term Council Meeting, 24 June 2005, Cambodia.

3- CMA Council Monthly Meeting

Main activities of the CMA for the year 2004-2006

4- A partnership with the Ministry of Health (MOH), CMA plays a roles in the Communicable Disease Control, MCH, Public medical colleges and University, Planning for Health Insurance and Equity Fund for the pilot areas, and developing all aspects of the Health Regulation etc.

5- 7th National Day of Medicine and Pharmacy, 10-11 August 2006, Cambodia. The title and principle theme of this year' s event was "Cambodia Health Towards Globalization in the New Millennium" (700 participants).

International Relationship (2004-2006)

1- Attending the 6th International Conference "Setting Limits to Healthcare: the time is Now" on 12-13 February 2004 at the St. Francis International Center for Healthcare Ethics, USA (Professor Sau Sok Khonn).

2- Attending the International Conference on Herbal and Traditional Eastern Medicine: An alternative and Integrative Medicine to be held on 30-31 March 2004 in Macau, China (Professor Sau Sok Khonn/Dr. Saint Saly).

International Relationship (2004-2006)

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4- Attending the 24th CMAAO Congress & 41st Council Meeting, 9-11 September 2005, in Seoul, Korea (Professor Sau Sok Khonn/Dr. Saint Saly).

International Relationship (2004-2006)

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6- Attending 1st World Medical Association Asian Pacific Regional Conference, 10-11 September 2006, in Tokyo, Japan (Professor Sau Sok Khonn/Dr. Chi Meng Hea)

HONG KONG MEDICAL ASSOCIATION

CHAN Yee-shing Alvin*1

With the conjoint effort of members, partners, staff and council members, Hong Kong Medical Association has made significant progress in the path of betterment for the medical and healthcare service of Hong Kong for the year 2005–2006. Our Association continues to play an important role in promoting and supporting continuous medical education. Forums and seminars have been organized by our Association alone or in conjunction with the other organizations. These educational programmes covered a broad spectrum of topics. We are still vigilant of infectious diseases that may affect every one of us. Open forums on Influenza Pandemic Preparedness for Healthcare Workers were organized in different Districts. We established close collaboration with Centre for Health Protection and Hospital Authority for control and prevention of communicable diseases. We promoted vaccination for influenza and promulgated guidelines on the use of Tamiflu to the public and healthcare professionals. Certificate Course on Advances in Chronic Disease Management and Exercise Prescription were successfully carried out at our Association's Central Premises and United Christian Hospital respectively. Structured CME seminars were continued with Kwong Wah Hospital, Queen Elizabeth Hospital and Hong Kong Sanatorium and Hospitals. A new online CME website was launched at the end of last year. Apart from educational programmes for doctors, HKMA Community Network has liaised with other allied health professionals and provided educational programmes to the patients.

The Patient Complaints Mediation Committee, set up in June 2005, had its first mediation held in one afternoon in January 2006. The mediator was one of the qualified mediators from the Hong Kong Mediation Centre, and the co-mediator was one of HKMA's Council Members. In the end, the patient and the doctor reached an agreement, and a settlement was made—the doctor having to pay the complainant HK$2,500. The settlement was supported by Medical Protection Society (MPS).

We promoted the use of serving chopsticks and spoons to the public. We have raised our concern on air pollution in Hong Kong, influenza prevention and control, health care reform, tobacco control, depression detection and suicide prevention, casualties at Marathon, unregistered vaccine and the importance of good dispensing practice. A "Good Dispensing Practice Manual" was published and promulgated to members. We also organized skills upgrading scheme to upgrade the knowledge and skills of healthcare personnel who works in private clinics. To ensure a free impartial private practice environment and to protect the interest of our profession, we are concerned with the proposal of establishing a new statutory Primary Care Registry and the revision of Medical Registration Ordinance.

To protect the interest of patients and the public, we are concerned with the lack of monitoring and regulation of medical procedures delivered by unregistered non-medical personnel and profit-making Health Maintenance Organizations (HMOs). We came up with a list of suggestions on how to regulate the HMOs and submitted them to the working group under the Department of Health which looked into the regulation. Correspondence were exchanged with the Administration and the Health Services Panel of the Legislative Council. Meetings were held with the Government and representatives from the Insurance Industry. The effort is continuing.

We continued our cultural and charity activities. The HKMA Orchestra and HKMA Choir continued to practise regularly and perform annually for charity. The HKMA No.1 Band was established last year as well to enrich the cultural manifestation of our colleagues, and we started establishing our own charitable fund. To assist in organ donation, we raised fund for the Organ

*1 Council Member, Hong Kong Medical Association, Hong Kong (yvonnel@hkma.org).

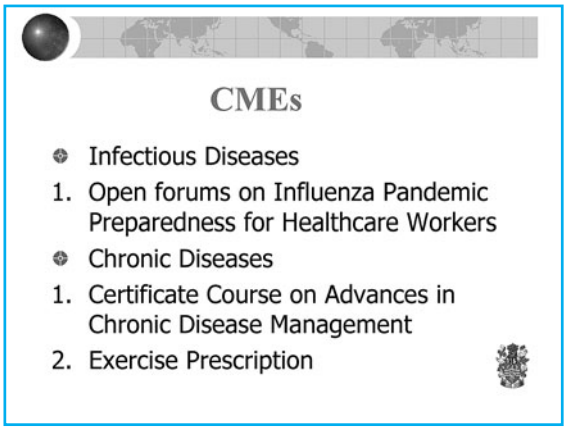
Donation Register. We have formed a sizable database for people who are willing to donate their organs. We are also willing to share this database with those who need it.

Twelve Council Meetings were held last year. Members were invited to attend our council meetings. We participated in the 41st CMAAO Council Meeting held at Seoul, Korea in September 2005. We also attended the 56th World Medical Assembly held in Chile in October 2005 and the 56th WHO Conference in Noumea, New-Caledonia in September 2005. We continued academic exchange with Chinese Medical Association. The Seventh Beijing and Hong Kong Medical Exchange Meeting focusing on "AIDS & Sexual Health" was successfully held in Beijing last year. Our president was invited to act as Regional Advisor for Royal College of Physicians of Ireland. We have published 12 monthly HKMA News and 12 monthly CME Bulletins. We continued publishing the bimonthly Hong Kong Medical Journal jointly with Hong Kong Academy of Medicine.

Meetings have been arranged with guests before our council meetings. Opinions and views on different topics relating to medical practice in Hong Kong were exchanged at the meetings. We also completed the Doctors' Fee Survey, the Information Technology Survey and four other opinion surveys. Apart from auto-reply system, we continued our collaboration with Hospital Authority and started the Public-Private Interface—Electronic Patient Record Sharing Pilot Project (PPI-ePR).

Our Association has been actively involved in promoting healthy life style to the public. We are in full support of banning smoking in closed environment. Apart from promoting exercise to the public, we have organized and co-organized sports activities for our members. These included family hiking, Joint Professional Football Cup, Public Hospital Football Cup and Joint Professional Golf Tournament etc. Sports night was one of the most successful events to applaud the contribution of our sportsmen in organizing and participating in these activities.

There are seven elected representatives of HKMA in The Medical Council of Hong Kong. This is the self-governing statutory body that regulates the profession in Hong Kong. It consists of 28 members of which 14 were government-appointed, including 4 lay members. There are also representatives in each committee like Ethics Committee, Education & Accreditation Committee, Health Committee, Licentiate Committee, Credentials Sub-Committee of the Licentiate Committee, Exemption Sub-Committee of the Licentiate Committee, Review Sub-Committee of the Licentiate Committee, and Preliminary Investigation Committee of the Medical Council.



- Structured CMEs
1. Kwong Wah Hospital
2. Queen Elizabeth Hospital
3. Hong Kong Sanatorium and Hospitals
- New Online CME Website
- Community Network CMEs

The Patient Complaints Mediation Committee (PCMC)

- had its first mediation held in one afternoon in January 2006.
- mediator was one of the qualified mediators from the Hong Kong Mediation Centre, and the co-mediator was one of HKMA's Council Members.
- In the end, the patient and the doctor reached an agreement, and a settlement was made – the doctor having to pay the complainant HK$2,500.
- The settlement was supported by Medical Protection Society (MPS)

Public Education

- influenza prevention and control - promoted vaccination for influenza and promulgated guidelines on the use of Tamiflu to the public and healthcare professionals
- promoted the use of serving chopsticks and spoons
- air pollution
- health care reform
- anti-smoking
- depression detection and suicide prevention
- casualties at Marathon

Risk Management

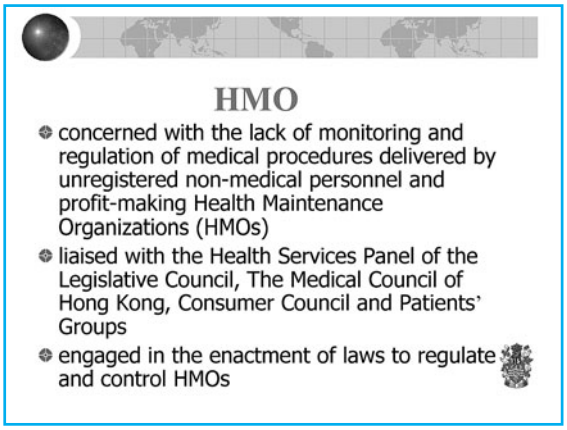
- "Good Dispensing Practice Manual"
- organized skills upgrading scheme to upgrade the knowledge and skills of healthcare personnel who works in private clinics.

Primary Care Registry

- established a "Primary Care Doctors Registry"

MRO Reform

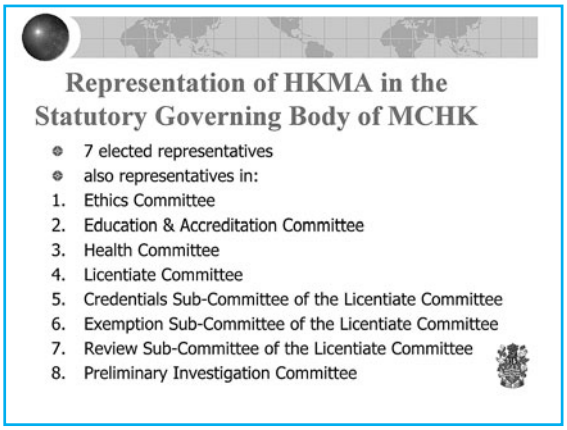
- engaged in the revision of Medical Registration Ordinance and reform of the Medical Council of Hong Kong


HMO
concerned with the lack of monitoring and regulation of medical procedures delivered by unregistered non-medical personnel and profit-making Health Maintenance Organizations (HMOs)
liaised with the Health Services Panel of the Legislative Council, The Medical Council of Hong Kong, Consumer Council and Patients' Groups
engaged in the enactment of laws to regulate and control HMOs


Cultural & Sports Activities
HKMA Orchestra
HKMA Choir
HKMA No.1 Band
Organ Donation Register
Sports
1. Family hiking
2. Joint Professional Football Cup
3. Public Hospital Football Cup
4. Joint Professional Golf Tournament
5. Sports Night


General
Council Meetings
41st CMAAO Council Meeting held at Seoul, Korea in September 2005
56th World Medical Assembly held in Chile in October 2005
56th WHO Conference in Noumea, New-Caledonia in September 2005
The Seventh Beijing and Hong Kong Medical Exchange Meeting focusing on "AIDS & Sexual Health" was successfully held in Beijing last year
12 monthly HKMA News
12 monthly CME Bulletins
bimonthly Hong Kong Medical Journal


Surveys
Doctors' Fee Survey
Information Technology Survey
Renaming the Faculty of Medicine of the University of Hong Kong
Link Management
Chief Executive Election
Primary Care Registry


Representation of HKMA in the Statutory Governing Body of MCHK
7 elected representatives
also representatives in:
1. Ethics Committee
2. Education & Accreditation Committee
3. Health Committee
4. Licentiate Committee
5. Credentials Sub-Committee of the Licentiate Committee
6. Exemption Sub-Committee of the Licentiate Committee
7. Review Sub-Committee of the Licentiate Committee
8. Preliminary Investigation Committee


END
~ Thank You! ~

INDONESIAN MEDICAL ASSOCIATION

Ihsan OETAMA*1

Since the last CMAAO Meeting in Seoul, September 9–11, 2005, the activities of the Indonesian Medical Association, among others are:

National

- Conducting monthly press conferences regarding IMA's concern for health problems that arises and became actual topics.
- IMA now becomes an active body in health screening and medical check-up for candidates participating in elections, be it in provinces or districts, as well as for central government.
- Holding National Workshops to restructure the system of Continuing Medical Education/Continuing Professional Development in line with the implementation of the new Law of Medical Practice.
- Actively socializing the new Law of Medical Practice, since enacted October 2004.
- Assisting the government and the society to enhance sanitation environment to control DHF spreading in Jakarta, October 2004.
- Proactive in handling/facing tsunami disaster through special effort to lead some non government association or other professional association. The government recognizes the IMA effort through MOU between IMA and MoH in which the government gives authority to IMA to coordinate medical personnel support placed at Aceh during the emergency phase, between December 2004 and April 2005.
- During the Yogya earthquake, and immediately followed by the Pangandaran tsunami, the IMA helped coordinate medical and personnel support by several volunteer foreign medical associations. Among others, The Korean Medical Association was never absent in helping Indonesia, through the IMA, wherever there is a natural disaster happening.
- Holding a National Workshop about The Family Medicine Concept in The New National Health System, February 2005.
- National Workshop to build the same perception about the profession standard definition related to medical law definition and its implementation, June 2005.
- Conducted a study to anticipate the new certification, regulation, advocate system in the new medical law, September 2005.
- Serial workshops to make a concept of medical education system for primary care, October 2005
- Working together with the Indonesian Veterinary Association to deal with the Avian Influenza outbreak.
- Holding the IMA Midterm Meeting in Jakarta, December 2005, prior to the IMA Congress, which will be held in Semarang, Central Java, November 29–December 2.

International

- To face the coming globalization, the IMA has formed a team to join the Indonesian government for talks with the World Trade Organization. The team actively were joined at regional and international event. As a team of Indonesian Delegation, the IMA team participated in WTO meeting in Geneva, and also in Health Sector Working Group in CCS (Coordinating Committee on Service) that periodically every three months conduct a meeting in Asean countries, since 2004.
- The Singapore Tourism Board, in which were included members of the Singapore Medical Association, paid IMA a visit to seek possibilities of working together to provide good health care, if needed, for people from both countries, when they are visiting as tourists.
- One of Indonesia's distinguished physician was selected to be included in the World Medical Association's Caring Physician of the World publication.
- Attended the Masean Council Meeting In Bangkok, November 2005, where the Standing Committee for Medical Education in Asean

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Countries were formed.
- Attended the 1st World Medical Association Asia Pacific Regional Meeting in Tokyo, September 2006.
- Attended the Masean Congress in Kuala Lumpur, November 9–11, 2006, where the Masean Presidency were handed over from Indonesia to Malaysia.

JAPAN MEDICAL ASSOCIATION

Kazuo IWASA*1

Of the international activities in which the Japan Medical Association has participated this past year, I would particularly like to report on the 1st WMA Asian-Pacific Regional Conference which was hosted jointly by the WMA and JMA in Tokyo on September 10 and 11.

Today I would like to briefly present an overview of the significance and achievements of this conference.

The conference was organized jointly by the WMA and JMA supported by the Pfizer Foundation Initiative. The main theme, proposed by the JMA, was "Disaster Preparedness and Response to Infectious Diseases."

The conference was attended by approximately 50 representatives of national medical associations in the Asian-Pacific region, mainly from CMAAO and MASEAN, and lively discussions were observed. Opening the conference was a keynote speech by Dr. Shigeru Omi, Regional Director of the WHO Regional Office for the Western Pacific, who spoke in detail about the situation at the time of the SARS outbreak and responses to it. One of Japan's leading seismologists spoke about mechanisms for the occurrence of earthquakes and tsunami. The topics dealt with were on a broad rage of issues including the acute phase following a disaster, the risk management of infectious diseases and the activities of a rescue team from the Korean Medical Association in the areas devastated in the Indian Ocean Tsunami. For medical specialists, the conference proved to be deeply significant and meaningful.

Both earthquakes and tsunami are unpredictable. The possibility of their occurring is high in the Asian-Pacific region and tremendous damage is anticipated. There is an urgent need for us physicians to work together across national boundaries to minimize the spread of damage, disaster, and infection. Human lives are equally valuable, regardless of nationality, race, politics, religion, or disparities in wealth.

As long ago as 460 BC, Hippocrates swore an oath that is now the basic philosophy of all medical profession. As one who had been granted the ability to practice medicine, Hippocrates swore to serve humanity throughout his entire life.

As medical profession, it is our duty to treat our colleagues as brothers and sisters and treat our patients equally without regard to race, religion, nationality, or social position. We must act and work in cooperation in accordance with the Declaration of Geneva (1948), which was created based on the philosophy of Hippocrates.

To coincide with this timely conference, the JMA also independently held a special public lecture open to the general public and rescue and disaster prevention organizers for regions throughout Japan on the same theme and the same day as the conference. It was attended by approximately 700 people.

This regional conference was the first of its kind in the Asian region, and I am certain that all the participants fully understood the significance of this event. As one of the hosts of this conference, the JMA also published a full-page article on the conference in the International Herald Tribune of October 7. For your reference I have brought a copy of the newspaper with me if you would care to see the article.

In future, the JMA intends to further strengthen its cooperative framework through the exchange of information, particularly with the CMAAO and WMA, providing forums for the discussion of serious problems such as those discussed at the conference and fulfilling our responsibilities as medical profession.

That concludes my introduction of one of the recent activities of the JMA.

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42nd CMAAO Mid-Term Council Meeting
24th -26th November 2006
Grand Copthorne Waterfront Hotel
Singapore

Country Report

Kazuo Iwasa, MD
Vice-Chair, World Medical Association
Vice-President, Japan Medical Association

1st WMA Asian-Pacific Regional Conference held in Tokyo on September 10 and 11, 2006

Discussion at the Regional Conference

Press Interview after the Conference

All attendees

JMA Public Lecture held in the JMA Auditorium in Tokyo on September 10, 2006

About 700 people attended the Lecture.

The Japan Medical Association

KOREAN MEDICAL ASSOCIATION

Dong Chun SHIN*1

Healthcare Policy Issues in Korea

Government's plan for reducing medical fee

The Korean government announced its plan for reducing medical fees in May this year, featuring transfer of medicine registration system to be covered by National Health Insurance (NHI) from negative system to positive system. Currently, all medicines including those newly-invented in Korea are automatically eligible for NHI registration except for some medicines designated as non-benefit items by the Government (negative system). When a positive system is introduced, only "cost-effective (pharmaco-economic)" medicine on the basis of clinical efficiency and safety will remain on the registration list. This brings forth controversy and confusion in the medical field and each association concerned such as the Korea Pharmaceutical Manufacturers Association and the Korean Pharmaceutical Association (KPA) have taken different stances. Pharmaceutical manufacturers take a strong opposition to this plan, arguing that it is too early to carry out the plan under the circumstances where standards to assess pharmaco-economic level of a medicine are not established and there is a lack in qualified manpower and data for assessment. It will also place additional burden on the manufacturers to outsource research for the assessment, which would eventually lead to the decreased invention of new medicines, according to the manufacturers.

Meanwhile, the KPA agrees with the Government on the necessity of a positive system based on the grounds that it will solve the problem of drug inventory caused by frequent changes in doctor's prescriptions.

The KMA requested that the Korean government take a careful approach, as the plan might harm physician's autonomy in prescription and limit patient's right to the best treatment.

This issue has been drawn into a even more controversial whirlpool linked with other separate issues such as the scandal about manipulating bio-equivalency test results, bilateral talks for a Free Trade Agreement between Korea and the US and so on. Nevertheless, the government sticks to its stance of implementing this plan within this year. The KMA will continue to keep a close eye on its proceeding and make efforts for establishing reasonable and fair standards of pharmaco-economic assessment.

Launch of Resident's Labor Union

The first physician's labor union came into existence in Korea. The Korea Intern Resident Association had submitted an application to establish the Resident's Labor Union and finally got the green light from the Ministry of Labor in July. Resident's Labor Union aims to achieve better training conditions for interns and residents in hospitals. As a labor union, it has a legal right to engage in labor actions including strikes.

Decline of Obstetrics & Gynecology

Like many other countries, Korea is suffering significantly from the dwindling birth rate. The all-time-low birth rate of Korea (1.02 baby per woman) began to take a toll on medical field, especially on Ob & Gyn part. In the past, Ob & Gyn enjoyed the highest popularity among physicians in training in terms of specialty selection but now it is on the brink of falling down into "specialties in need of support for fostering". Medical trainees who apply for "specialties in need of support for fostering" will receive training subsidy as a way to promote relatively unpopular specialties suffering from lack of trainees.

Free provision of essential vaccinations

The National Assembly passed the bill to provide essential vaccinations for all infants under age six

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

in all clinics. This bill will come into effect from next year on. However this bill refers to increase in tobacco tax as its financial resources, so it will face some financial problems if the increase in tobacco isn't followed.

Pressure to price down Iressa

The Government made a decision to lower the price of Iressa in response to the strong request of the NGO, "Health Network". "Health Network" is asserting that the price of Iressa is too expensive while its clinical efficiency has not been fully proven. The manufacturer of Iressa apposed to the decision and filed a lawsuit against the Government, saying the decision infringes upon the company's legal rights.

KMA's Public Affairs

Community Activities

The KMA has actively taken part in public health promotion and in other activities to come closer to the public. With the launch of the new executive board on May 2006, led by the President Dong Ik Jhang, serving the community will continuously be placed high on its agenda. As a part of these efforts, the Public Health Committee was organized as a special committee in June. It has nine sub-specialty committees under its umbrella. Sub-specialty committees have been organized by top experts in their respective fields including allergy/atopy, food safety, cancer, metabolic syndrome, environment, anti-tobacco committee and so forth. They are taking the lead in producing guidelines for both physicians and patients against certain diseases. It also has the mission of delivering the most reliable information to the public in the event of controversy such as outbreak of mass food-poisoning in schools, where people often get confused with an overflow of different views. The committee also aims to summit recommendations to the Government in its policy making process for better operation of national health system as a way of delivering voices from the forefront of healthcare.

Medical Aid Activities abroad

With the help of Indonesian Medical Association, the KMA sent the Korean Emergency Medical Aid Team (KEMAT) to Indonesia on June 1, 2006, just five days after the quake hit Indonesia. This was the second joint relief activity of the two associations following to the joint activity for the injured in Tsunami disaster in January 2005. The team was composed of 1 orthopedic surgeon, 1 cardiovascular surgeon, 2 general surgeons, 1 GP, 4 nurses, 4 administrative staff, 2 reporters and 3 interpreters and they set their base camp at the Happyland Hospital in Yogyakarta. This hospital is run by a Korean businessman and his Indonesian wife who is a medical doctor. The KEMAT divided its team members into three units, one providing medical cares at the base camp and the others mobilizing into remote areas, where hands of medical professionals have not yet reached out. The KEMAT treated approximately 600 patients (150 patients a day on average) for four days.

Other than this emergency medical aid activities, the KMA accomplished "Humanity medical march along the Silk Road" in collaboration with the Busan metropolitan government and provided primary healthcare to people in Kazakhstan, Kyrgyzstan, Vladivostok and the autonomous district of Urumiqi, where access to healthcare is limited.

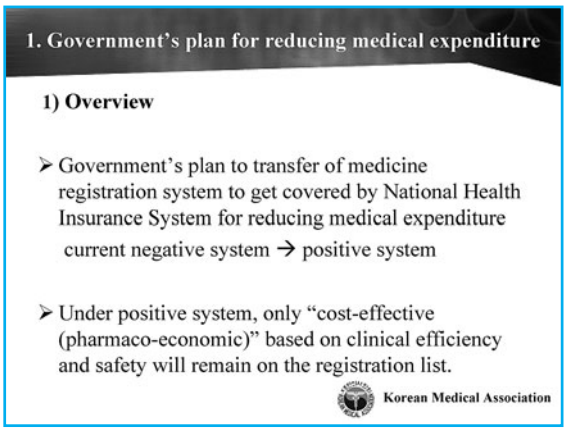
Gearing up for 2008 WMA General Assembly

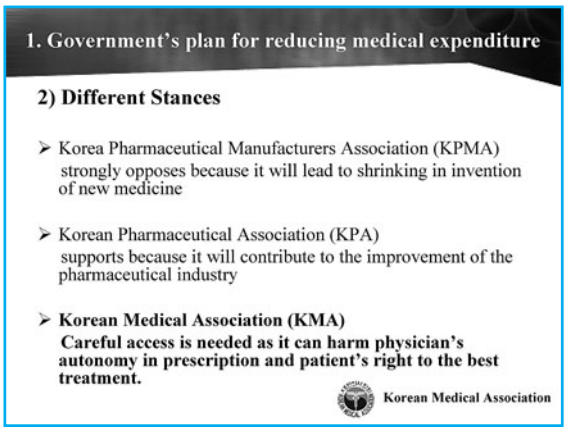
The KMA has been approved as the hosting NMA of 2008 World Medical Association (WMA) General Assembly in 2004 WMA Tokyo General Assembly. With the assembly only two years away, KMA launched the organizing committee in September to get down to preparation on details. The committee is spearheaded by Dr. T.J. Moon, the Honorary President of KMA and Dr. D.I. Jhang, the President of KMA and consists of members reflecting diversified voices of medical field including Korean Medical Women's Association and Korean Academy of Medical Sciences. The diversity in committee members will lead the Assembly to a success both in public promotion and academic achievement. The committee is now pooling their wisdom to select the theme for the scientific session of the assembly and plans to submit the draft to the next WMA Council Meeting in Berlin in May 2007. The date of the 2008 WMA General Assembly has been decided to be October 15–18, 2008 at the 2006 General Assembly held in South Africa last month.

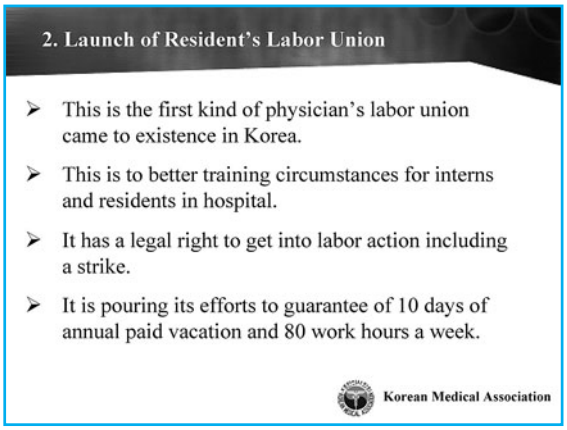
Bridges to the successful centennial anniversary

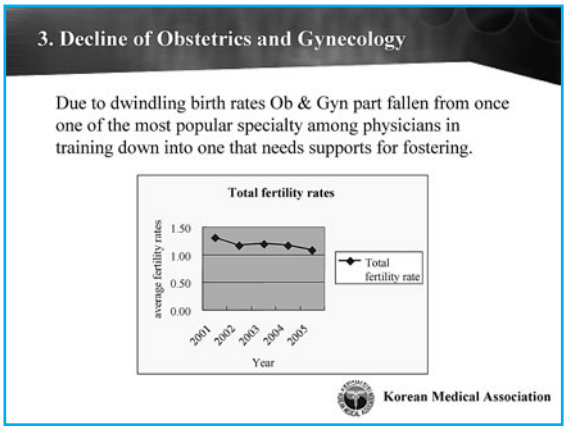
The KMA hosted various events in the framework of promoting the celebration of KMA's centennial anniversary in 2008. At a charity fashion

show held in January, 50 women physicians from various generation volunteered to be models of the show and won applause from audience and the media. In August, a special symposium was held in memory of the National Independence Day (August 15), which traces the lives of three physicians who devoted themselves to Korea's independence movement. This symposium is the first of its kind and considered to have contributed to the vitalization of the field of physician history. In addition, the KMA is preparing a full-blown scientific program to highlight the rapid improvement of medical technologies and infrastructures in Korea for the last century.









4. Free provision of essential vaccinations

- National Assembly in Korea passed the bill to provide essential vaccinations for all infants under age six in all clinics.
- Tobacco tax as its financial resources

Korean Medical Association

5. Pressure to price down Iressa

- The Governments decided to lower the price of "Iresssa" nevertheless of strong opposition from the manufacturer.
- The NGO "Health Network" asserts that Iressa has been priced too high, while its clinical efficiency has not been fully proven.
- The manufacturer of Iressa filed a lawsuit against this decision but lost it.

Korean Medical Association

Part 2.

KMA's Public Affairs

Korean Medical Association

1. Community Activities

- Establishment of National Health Committee, KMA, consisting of nine sub-specialty committee in cancer, food safety, metabolic syndrome, anti-tobacco and so forth.
- Holding of various public hearings and symposia on prevention of child-abuse, protection of environment, effects of endocrine disruptor and so on.

Korean Medical Association

1. Community Activities

Performance urging collect of no-more-used medicine at homes (June, 2006)

Korean Medical Association

2. Medical Aid Activities Abroad

1) Emergency Medical Aid Team to Yogyakarta, Indonesia

- Dispatch of emergency medical aid team to earthquake- hit areas of Yogyakarta on June 1, 2006.
- Provision of medical treatment to about 600 patients for four days in cooperation of Indonesian Medical Association

Korean Medical Association

2. Medical Aid Activities

2) Humanity Medical March along the Silk Road

Provision of primary healthcare to people in Kazakhstan, Kyrgyzstan, Vladivostok and the autonomous district of Urumiqi for about a month.

Korean Medical Association

3. Gearing up for 2008 WMA General Assembly

1) Establishment of Organizing Committee

The committee was established in September to prepare for the successful WMA General Assembly in 2008. It consists of members reflecting diversified voices of medical field including Korean Women's Association and Korean Academy of Medical Sciences, etc. for successful preparation.

2) Dates approved

The dates of 2008 WMA General Assembly have been decid ed as October 15~18, 2008.

Korean Medical Association

4. Bridges to the successful centennial anniversary

1) Charity Fashion Show (January 2006)

50 women doctors volunteered to participate as models to the show and won applause from audience and the media.

Korean Medical Association

4. Bridges to the successful centennial anniversary

2) Symposium on Physician Patriots (August 2006)

The symposium was held in commemoration of the 61st National Independence Day (August 15) and traced lives of physicians who devoted themselves to independence movement.

Korean Medical Association

Thank you.

Korean Medical Association

MACAU MEDICAL ASSOCIATION

Nai Chi CHAN*1

COUNTRY REPORT

DR. NAI CHI CHAN
DIRECTOR OF THE MACAU ASSOCIATION OF MEDICAL PRACTITIONERS
PRESIDENT OF THE MACAU SOCIETY OF HEMATOLOGY AND ONCOLOGY

RESTRUCTURE OF THE BOARD OF OUR ASSOCIATION

- Our Association has restructured our Board in order to get the reform of our Association
- Our Association would like to host the next year meeting of CMAAO in Macau

JOINING THE REFORM OF MEDICAL SYSTEM IN MACAU

- Our Association actively join the reform of medical system in Macau
- Our Association has made a lot of strategic recommendations for the local reform of medical system

PROMOTION OF THE CONTINUING MEDICAL EDUCATION

- Our Association has actively promoted the local continuing medical education in order to improve our quality medical services
- The representatives of our Association have attended the academic meetings in Beijing, Hong Kong, and Taiwan
- Our Association together with the Chinese University of Hong Kong establishes the Diploma Course of Family Medicine in Macau

CONTRIBUTION TO OUR SOCIETY

- Our Association invited the famous professor Chung Nam Shan, who is an expert in respiratory medicine in Mainland China to give us an academic talk concerning the bird flu

END

THANK YOU

*1 Director, Macau Association of Medical Practitioners. President, Macau Society of Hematology and Oncology, Macau (drj@macau.ctm.net).

MALAYSIAN MEDICAL ASSOCIATION

P. VYTHILINGAM*1

Objectives of the Malaysian Medical Association

- To promote and maintain the honour and interest of the profession of Medicine in all its branches and in every one of its segments and help to sustain the professional standards of medical ethics.
- To serve as a vehicle of the integrated voice of the whole profession and all or each of its segments both in relation to its own special problems and in relation to educating and directing public opinion on the problems of public health as affecting the community at large.
- To participate in the conduct of medical education, as may be as appropriate.
- To promote social, cultural and charitable activities in building a united Malaysian nation.

Council, Executive Committee, Sections, Societies, Committees and Representatives of the Malaysian Medical Association

The MMA Council consists of the following key office-bearers who are also members of the Executive Committee; as well as 19 branch representatives from the 13 states in Malaysia.

President
Datuk Dr. Teoh Siang Chin
Immediate Past President
Datuk Dr. N. Arumugam
President-Elect
Dato' Dr. Khoo Kah Lin
Honorary General Secretary
Dr. Mary Suma Cardosa
Honorary General Treasurer
Dr. P. Vythilingam
Honorary Deputy Secretary
Dr. Kuljit Singh
Honorary Deputy Secretary
Dr. George Fernandez
Chairman, Private Practitioners' Society (PPS)
Dato' Dr N.K.S. Tharmaseelan
Chairman, Section Concerning House Officers, Medical Officers & Specialists (SCHOMOS)
Dr. S. Vasan

We have two Sections in our Association; namely, the Section Concerning House Officers, Medical Officers & Specialists (SCHOMOS) and the Private Practitioners' Section (PPS).

There are six Societies—Public Health Society, Society of Sports Medicine, Society of Occupational and Environmental Medicine, Ophthalmological Society, MMA Physicians for the Prevention of Nuclear War and Society of MMA Medical Students.

We also have 30 Committees and MMA is represented in 33 external bodies—government and non-governmental organizations (NGOs).

Membership

As at 31st December 2005, the total membership of the Malaysian Medical Association stands at 12,030 (excluding students of 3,614), out of which 3,798 members are classified as 'Archives'. Thus, the MMA represents only 52.10% (8,232 benefits members), when compared to 15,800 registered medical practitioners in the country.

As of September 2006, the MMA membership stands at 13,601.

Liaison with Government Agencies

Ministry of Health

The MMA had attended various meetings with the Ministry of Health during the 2005/2006 term. Some of the significant meetings are as follows.

Section Concerning HouseOfficers, Medical Officers and Specialists' (SCHOMOS) Issues

On 16th December 2005, the SCHOMOS ExCo was invited to meet the Chief Secretary of the Ministry of Health, Dato' Dr. Hj Mohd Nasir b.

*1 Honorary General Treasurer, Malaysian Medical Association, Kuala Lumpur, Malaysia (mma@tm.net.my).

Ashraf and among the issues discussed were job vacancies—availability and allocation, promotion for Specialist Medical Officers, implementation of CPD Committee, full paying patient and the national health financing scheme, the Ministry of Health paid attention towards disabled doctors or those suffering from chronic illnesses, the problems of Medical Officers who pursued external degree programs such as FRCS, MRCP and MRCOG, allocation of allowance for Overseas Professional Medicine Conference, doctors who had served for at least 10 years in the Ministry of Health to be provided with medical facilities for themselves and their family when they retire or resign from the government and finally, allowance for Public Health Officers when the country is hit by infectious disease problem.

Private Practitioners' Section (PPS) issues

A meeting was held between the MMA and the Economic Planning Unit (EPU) on the Foreign Medical Examination of Foreign Workers (FOMEMA) on 11 August 2005. Among the main issues discussed were financial issues, general issues such as verification of foreign workers, payment, standard operating procedures, quota and untrue statements as well as operations, e.g. GPs—group practice and in-house clinics and x-ray facilities and Radiologists.

Liaison with Non-Governmental Organizations

MMA-Direct Access Affinity Programme

Direct Access was first conceived in 1995 as a division of Southern

Bank Berhad and is Malaysia's first 24-hour true direct banking service provider, meeting customers' needs for an effective and convenient alternative banking in place of conventional branch banking. As the country's premier direct bank, Direct Access offers a complete and extensive range of personal banking products and services such as current account, savings account, fixed deposit, overdraft facilities, personal loans, home mortgages and credit cards via remote channels such as telephone, fax, mail, ATM and PC.

Soon after Direct Access's establishment, the MMA entered into an affinity programme with the financial organization. With this programme, the MMA members enjoyed preferential bank rates for most of the 1990s, albeit these privileges are now also offered by other banks, which offer similar banking facilities, including "free" credit cards.

Group multiple benefits scheme

This scheme was launched in the year 2002 and is underwritten by Great Eastern Life Assurance (M) Bhd. The scheme offers a very comprehensive protection with attractive premium refund at retirement. The scheme is open to all MMA members, their spouses and children and provides coverage against death, disabilities and also 36 critical illnesses. The special features of the scheme is that same level of premium for all ages, the premium of this scheme is much cheaper than an individual policy in the market, members can participate in this scheme until the age of 65 and double the amount of coverage if death or disabilities are due to accidental causes. The members can terminate the policy at anytime and the minimum guaranteed surrender value is 35% of the total premiums contributed.

Other insurance packages

There are also other insurance packages specially tailored for the members of the MMA such as the special clinic insurance package covering all the clinic insurance needs under one policy, motor insurance scheme and doctors personal protector insurance scheme (personal accident policy).

Professional Indemnity Insurance

Medical protection society

MMA had several fruitful meetings with the MPS representatives during the year 2005. One of the highlights of these meetings was the signing of the MoU on 21st March 2005. The MoU was revised to provide for a fixed rate of commission across the board for each member.

On 26th September 2006, the MMA in collaboration with MPS launched the MMA Professional Medical Indemnity Insurance scheme for Medical Officers. This is to create awareness of clinical risk management as well as encourage these officers to practice with medical indemnity cover. This package brings a convenient solution to assist the transition from medical students to medical officers. As a member of the MMA, this professional association looks after their welfare and has various working committees on specific professional issues. We want to ensure that the development of a doctor's career is based on strong foundations of knowledge and awareness of patient safety.

The main benefit of the plan is that it is applic-

able across all disciplines and all kinds of hospital or primary care practice. If there is a problem, all the medical officer need to do is to dial the MPS helpline for advice. Together with Direct Access of the Southern Bank Group, the MMA membership will afford them a pre-approved free-for-life credit card to simplify payments.

Malaysian medical indemnity insurance

AON Insurance Brokers (M) Sdn Bhd took over the management of this scheme on 26th January 2001. The membership count at the time of take over was only 700 members.

AON Insurance Brokers had carried out a series of advertisements in our in-house publication, the Berita MMA, MMA Annual Reports and MMA Branches souvenir programme books. Road shows had also been conducted in the States of Penang, Kedah, Malacca and Kelantan. They had been able to increase the membership count to 2,300 as of 31st December 2005 with a premium base of around RM3 million.

International Affairs

Medical Associations of South East Asian Nations (MASEAN)

The 11th MASEAN Mid-Term Council Meeting was held on 16th to 18th November 2005 at the Chalerm Prabarani Building, Medical Association of Thailand, Bangkok.

The MMA was represented by the Immediate Past President, Honorary General Secretary and two of the Honorary Deputy Secretaries.

Two papers were presented—country report and a paper on "The Medical Role in Massive Disaster".

Confederation of Medical Associations in Asia and Oceania (CMAAO)

The 24th CMAAO Congress and the 41st Council Meeting was held on 9th to 11th September 2005 at the JW Marriott Hotel in Seoul, Korea. It was hosted by the Korean Medical Association.

The MMA was represented by the President and the Honorary General Treasurer. Two papers were presented—country report and a paper on the status of "National Health Financing Scheme in Malaysia".

Two important events took place—the installation of the 27th President of CMAAO, Dr. Jae Jung Kim from Korea and secondly, the 7th Taro Takemi Memorial Oration was delivered by Dr. Tai Yoon Moon. The topic was on "Progress and Problems of Health Insurance Program in Korea".

World Medical Association (WMA)

The 56th WMA General Assembly was held on 12th–15th December 2005 at the Hyatt Regency Hotel, Santiago, Chile.

The MMA was represented by the President and the Immediate Past President.

Datuk Dr. N. Arumugam, Immediate Past President was elected as the President-Elect of the WMA after defeating nominees from Hungary and Belgium over two rounds of close voting by delegates from the national medical associations. He assumed his post of President of the WMA at the recently held WMA General Assembly in Sun City, South Africa on 13th October 2006.

The publication "Caring Physicians of the World" was the central theme during Dr. Yank Coble's term as President from 2004–2005. The MMA nominated Dato' Dr. T.P. Devaraj as an inspirational role model for Malaysia and he was one of the 65 physicians selected from 55 members countries of the WMA (which has 84 national medical associations as its members) and featured in this book.

MMA Aid and Study Mission to Sri Lanka

This mission was organized by the MMA and the School of Medicine, University Malaysia Sabah and supported by the Hospital Mesra Padang, Sabah Medical Centre, Wong Kwok Group and the Sabah Psychiatry Welfare Body.

The world's most powerful earthquake in more than 40 years struck deep under the Indian Ocean on 26th December 2004, triggering massive tsunamis that obliterated cities, seaside communities and holiday resorts, killing tens of thousands of people in a dozen countries.

The objective of the mission was to provide aid—24 boxes of clothes, medicines and toys. Secondly, to conduct a study and finally, it was a fact finding mission to learn about the community and NGO interventions.

The location was the coastal belt of Vadamarachi in the Jaffna Peninsula, Mullaitivu in Vanni and Batticola (Ampara). The team coordinator was the current President of MMA.

Some of the activities during this period which were implemented by the taskforce were to create awareness and providing education, needs assessment to determine the developing long-term

consequences of the disaster, to promote access to existing services, to ensure quality of psychological interventions provided, community work, additional training on specialized topics, to coordinate plans and networking as well as to create awareness on the needs of special groups.

Seminars Conducted by the MMA

Ethics Day 2005

This event was organized by the Ethics Committee of the MMA and it was commemorated on 2nd October 2005. The aim of the celebration was to ensure that the ethics and its practice remained in the forefront of the association's activities. As essay competition was held for the medical students from all the local universities, both private and public. The title of the essay competition was: "Current Ethical Dilemmas—Problems and Solutions".

This year, the Ethics Day was on 18th September 2006 and in conjunction with this Day, again an essay competition had been organized but this time round it is for the medical students as well as doctors.

8th Scientific Conference for General Practitioners

This conference was organized by the MMA Penang Branch and was held from 16th to 18th September 2005 at the City Bayview Hotel, Penang. The target groups were doctors in primary care and a total of 200 participants registered for this conference. The areas covered included psychiatry, diabetes mellitus and obesity, hypertension, obstetrics & gynaecology, neurology, surgical procedures and CPR.

This conference has been conducted annually since 1998. This year, the conference was held on 8th–10th September 2006.

4th National Adolescent Health Symposium

This symposium was organized by the Adolescent Health Committee of the MMA and co-organized by the Ministry of Health, Sabah State Health Department, Federation of Family Planning Associations, Malaysia, Hospital Mesra, Sabah and the Malaysian Paediatric Association.

It was held on 18th and 19th March 2006 with the theme "Adolescent Health the Way Forward". The main objective was to bring together all stakeholders of adolescent health to discuss issues related to adolescent health. It also aimed to increase and improve awareness among health care providers, parents and youths on the importance of adolescent health in Malaysia.

The Society on Occupational Medicine (SOEM) Annual Seminar Medical Emergency Preparedness in Industry

This seminar was organized by the SOEM in collaboration with the Ministry of Health and Department of Occupational Safety and Health (DOSH). It was held on 4th March 2006.

Among the topics presented were Medical Emergency Preparedness in Industry, Role of Occupational Health Professionals in Medical Emergency Preparedness, Industry Medical Emergency Preparedness—are we ready?

Second Regional Conference on Occupational Health (RCOH)

This conference was held on 7th to 9th April 2006.

The target group were Occupational Health Physicians, Occupational Health Doctors, Medical Practitioners/Specialists, Allied Health Care Professionals (Nurses, Medical Assistants, Health Inspectors, etc), medical students, Industrial Hygienists, Safety Health Officers and Human Resource Personnel.

'Health and Flying' Seminar

This event was organized by the SOEM and the Royal Malaysian Air Force (RMAF).

It was held on 25th February 2006 and among the topics presented were on Introduction to Aviation Medicine, Aviation Physiology and Psychology, Medication and Flying, Medical Evacuation and Certifying Passengers Fitness for Air Travel.

MMA SCHOMOS Workshop on Empowerment of the Medical Profession in the New Millennium

This Workshop was organized by SCHOMOS MMA. It was held on 5th to 7th January 2006.

This workshop marked a milestone in the MMA's continual efforts to address the quality of care in the public health care sector. Fifty doctors representing all the States and specialties was invited to address issues of access and equity for the patients in the public sector.

The objective of the workshop was to retain skilled and development of motivated doctors

in the Ministry of Health. The maintenance of high standards and improving quality health care depends on structured career development and improving satisfaction. The doctors examined in detail our national health care system against the background of regional and global trends. The discussions were very analytical of the factors that contribute to the retention of the valuable and experienced doctors.

The MMA presented the final working paper of the recommendations of the workshop to the Honorable Minister of Health Malaysia on 19th January 2006.

14th International Union Against Sexually Transmitted Infections (IUSTI) Asia-Pacific Conference

This international conference was held on 27th to 30th July 2006 in Kuala Lumpur. It was hosted jointly by the Academy of Family Physicians of Malaysia and the MMA in collaboration with the Ministry of Health, Malaysia.

In line with the theme "STI : Challenges and Strategies", the programme highlighted the control of sexually transmitted infections (STI) including HIV/AIDS, with special reference to regional cultural practices and economic constraints. Besides the scientific presentations on recent advancements, there were also workshops and interactive sessions of interest to physicians in both hospital and private practice, public health experts and other healthcare professionals, as well as members of organizations concerned with the impact of STI/HIV on the society.

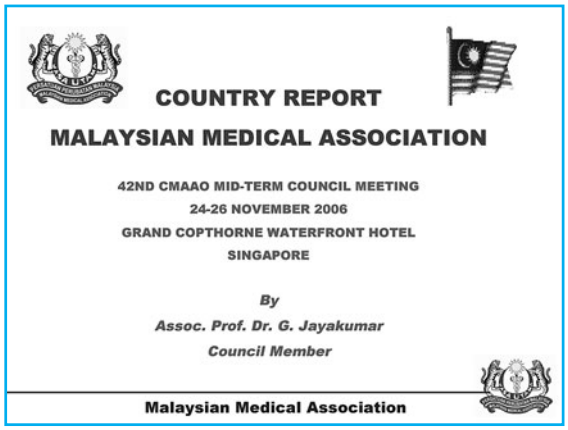
About 250 participants attended this conference.

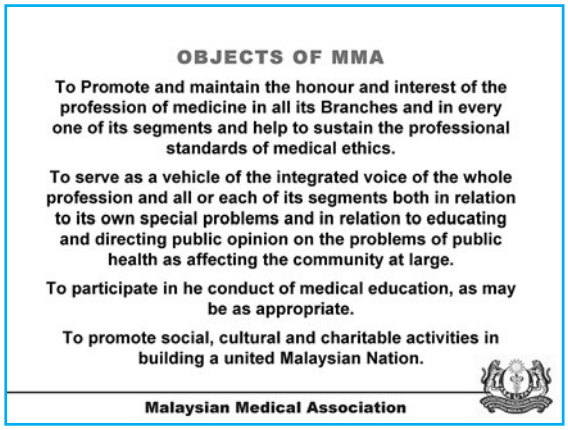
Conclusion

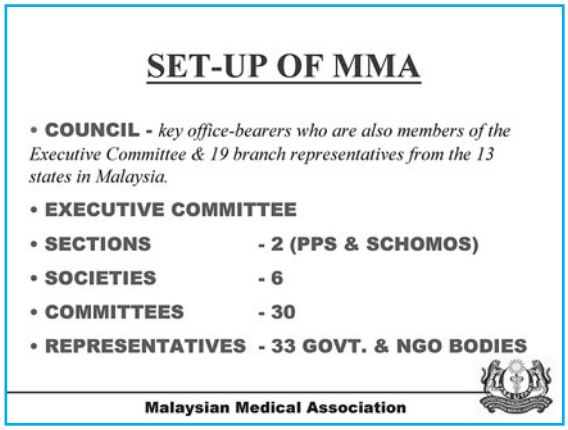
Overall, it was yet another active year for the 46th MMA Council especially the key office-bearers who had many meetings to attend with the Ministry of Health and other external organizations to help solve problems faced by the profession.

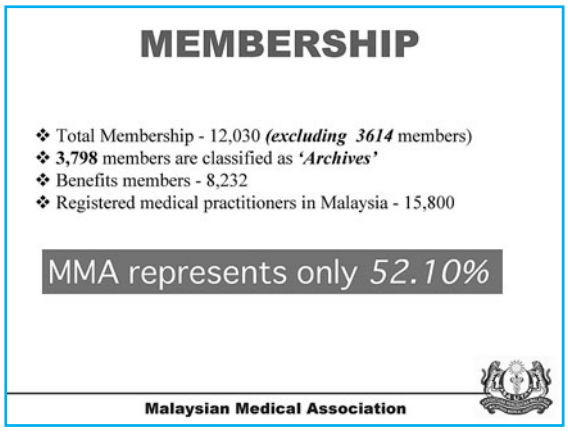
The Committees, Societies and Branches of the MMA were equally active participating in the various activities, meetings and courses which benefits the community at large.

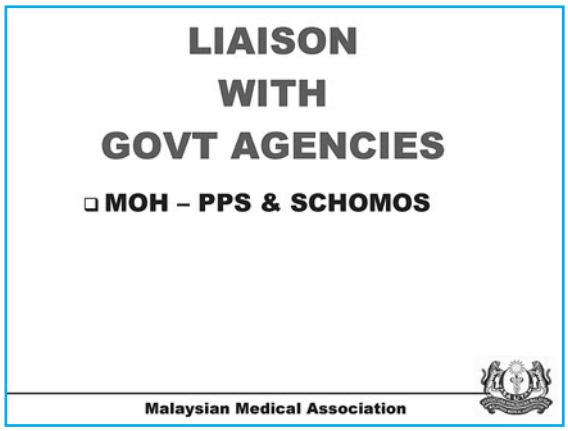
The Sections of the MMA were also busy having meetings with the various external organizations to resolve problems faced by their respective members. The Branches continued diligently with their activities, especially CPD and community activities. The main focus by Branches was to recruit more new members and some Branches had done very well in this recruitment drive.

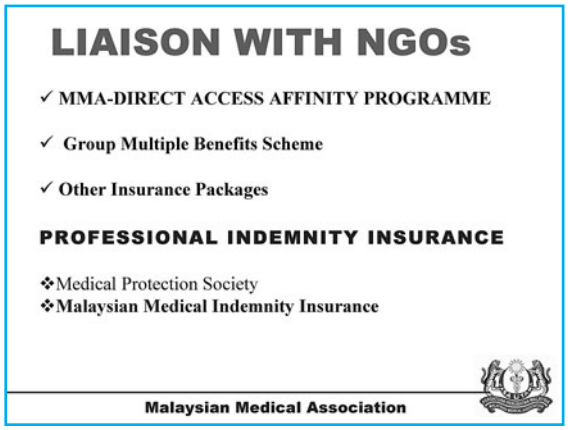



OBJECTS OF MMA
To Promote and maintain the honour and interest of the profession of medicine in all its Branches and in every one of its segments and help to sustain the professional standards of medical ethics.
To serve as a vehicle of the integrated voice of the whole profession and all or each of its segments both in relation to its own special problems and in relation to educating and directing public opinion on the problems of public health as affecting the community at large.
To participate in he conduct of medical education, as may be as appropriate.
To promote social, cultural and charitable activities in building a united Malaysian Nation.
Malaysian Medical Association


SET-UP OF MMA
• COUNCIL - key office-bearers who are also members of the Executive Committee & 19 branch representatives from the 13 states in Malaysia.
• EXECUTIVE COMMITTEE
• SECTIONS - 2 (PPS & SCHOMOS)
• SOCIETIES - 6
• COMMITTEES - 30
• REPRESENTATIVES - 33 GOVT. & NGO BODIES
Malaysian Medical Association


MEMBERSHIP
❖ Total Membership - 12,030 (excluding 3614 members)
❖ 3,798 members are classified as 'Archives'
❖ Benefits members - 8,232
❖ Registered medical practitioners in Malaysia - 15,800
MMA represents only 52.10%
Malaysian Medical Association


LIAISON WITH GOVT AGENCIES
❑ MOH – PPS & SCHOMOS
Malaysian Medical Association


LIAISON WITH NGOs
✓ MMA-DIRECT ACCESS AFFINITY PROGRAMME
✓ Group Multiple Benefits Scheme
✓ Other Insurance Packages
PROFESSIONAL INDEMNITY INSURANCE
❖Medical Protection Society
❖Malaysian Medical Indemnity Insurance
Malaysian Medical Association


INTERNATIONAL AFFAIRS
➢ MEDICAL ASSOCIATIONS OF SOUTH EAST ASIAN NATIONS (MASEAN)
➢ CONFEDERATION OF MEDICAL ASSOCIATIONS IN ASIA AND OCEANIA (CMAAO)
➢ WORLD MEDICAL ASSOCIATION (WMA)
➢ MMA AID AND STUDY MISSION TO SRI LANKA
Malaysian Medical Association

SEMINARS CONDUCTED

- ETHICS DAY 2005
- 8TH SCIENTIFIC CONFERENCE FOR GENERAL PRACTITIONERS
- 4TH NATIONAL ADOLESCENT HEALTH SYMPOSIUM
- THE SOCIETY ON OCCUPATIONAL MEDICINE (SOEM)ANNUAL SEMINAR MEDICAL EMERGENCY PREPAREDNESS IN INDUSTRY

Malaysian Medical Association

- SECOND REGIONAL CONFERENCE ON OCCUPATIONAL HEALTH (RCOH)
- HEALTH AND FLYING' SEMINAR MMA SCHOMOS WORKSHOP ON EMPOWERMENT OF THE MEDICAL PROFESSION IN THE NEW MILLENNIUM
- 14TH INTERNATIONAL UNION AGAINST SEXUALLYTRANSMITTED INFECTIONS (IUSTI) ASIA-PACIFIC CONFERENCE

Malaysian Medical Association

Terima Kasih!

(THANK YOU!)

Malaysian Medical Association

NEW ZEALAND MEDICAL ASSOCIATION

Ross BOSWELL*[1]

New Zealand's health sector has been radically transformed over the past decade and a half. Successive governments with different perspectives and ideologies have made huge structural changes. The current Labour-led Government, headed by Prime Minister Helen Clark, is now one year into its third three-year term, and is in a phase of consolidation rather than implementing new initiatives.

Over the past 15 years democratically-elected regional hospital boards have operated, been abolished and replaced by commercial companies, and then re-introduced. New Zealand now has 21 District Health Boards (DHBs) which are responsible for providing government-funded health care for the population in their region. DHBs focus on planning and delivering health services, running hospitals, overseeing primary health care services and delivering some public health programmes.

Adequacy of funding at District Health Board level is a continuing concern, with some running continual deficits and/or cutting services to meet budget constraints. Earlier this year the Government decreed that no-one must be on a public waiting list for specialist assessment or surgery for more than six months. The outcome? Thousands of New Zealanders have been removed from waiting lists and referred back to their General Practitioners, to widespread outrage in the community and medical profession.

Care in the private secondary health sector is available to those with health insurance or the means to pay. More than 50% of elective surgery takes place in the private sector, as funding restraints and restricted waiting lists mean only the most urgent cases get priority in public hospitals.

A major issue which came to a head in 2006 has been the reviews of laboratory services being carried out by DHBs. Individual DHBs around New Zealand have been reviewing and, in some cases, making changes to their contractual arrangements for laboratory services. In the most serious case, three of New Zealand largest's DHBs (in Auckland) rejected their well-established highly-respected laboratory provider in favour of a start-up company with no staff, premises or equipment. This decision is currently being challenged in court. Since September 2004 the NZMA has been warning of the outcomes of the lack of a national policy framework for DHB laboratory reviews, and has called on the Minister of Health to urgently address this issue.

Medical registration in New Zealand is controlled by the Health Practitioners Competence Assurance Act 2003, which brought together all registered health practitioners (such as doctors, nurses, dentists, midwives and physiotherapists) under the same registration, competency and disciplinary procedures. The Act has the primary aim of protecting the public. Of great concern to the NZMA is the fact that although the Act permits regulations to be made which would allow for elected members to the Medical Council of New Zealand (MCNZ), to date, the Minister of Health has not done so. For the MCNZ to work effectively it must have the respect and confidence of the profession, and that will not happen while there are no directly elected members.

The medical workforce in New Zealand continues to be under extreme stress. The high fees and resulting debt levels incurred by medical students in training lead to many newly-qualified New Zealand doctors seeking higher-paid positions overseas. Campaigning by the NZMA, along with the New Zealand Medical Students' Association, has resulted in the Government agreeing to reduce the student debt burden (including the debt of medical students/junior doctors). Many of New Zealand's practising doctors trained elsewhere in the world—currently one-third are from overseas countries.

Doctor shortages in some regions and notably in rural areas continue to place extra demands

*1 Chairman, New Zealand Medical Association, Wellington, New Zealand (nzma@nzma.org.nz).

on the profession. Specialities such as obstetrics, psychiatry and general practice are particularly short. After a report from the Health Workforce Advisory Committee, the Government has established a Workforce Taskforce to advise of solutions to workforce problems. This taskforce is currently examining the issue of medical education and models of medical training.

Six years ago the Government released its Primary Health Care Strategy, based on capitated funding to general practices which enrol their patients as members of a Primary Health Organisation (PHO). This was the biggest shake-up of the primary health sector for half a century. PHOs receive public funding through District Health Boards. The Government has progressively rolled out increased funding to more age groups, until now just the 25–44 year olds do not receive any public subsidy.

The New Zealand Medical Association supported the broad proposals of the Primary Health Care Strategy as having the potential to improve the health of New Zealanders and their access to primary health services. We have fought hard to retain the principle that GPs be able to set their own fees, and charge a co-payment if necessary (as the government funding does not cover the entire cost of visiting a GP). However, inroads have been made into this basic principle, often because some GPs have themselves abdicated this right in order to receive extra funding.

The NZMA has been involved with changes to maternity care this year. The Ministry of Health has proposed changes to the way maternity services are delivered, many of which the NZMA has rejected as unworkable. While New Zealand has a world-class maternity system, problems still exist, particularly in rural and provincial areas and with shortages of practitioners.

The NZMA continues to publish the New Zealand Medical Journal, which has been online only since 2002. The NZMJ is the premier scientific medical journal for the profession in New Zealand, and continues to publish well regarded research on a wide variety of medical topics.

The NZMA provides the Code of Ethics for the profession in New Zealand, and will be reviewing its Code next year.

The NZMA works closely with the NZ Medical Students' Association, recognizing that students are the future of the profession. The NZMA also has a Doctors-in-Training Council, which represents the interests of junior doctors and medical student members.

Other NZMA initiatives include:

- Around 50 submissions on a wide variety of issues, including organ donation, smokefree environments, obesity, epidemic preparedness, and direct-to-consumer advertising of prescription medicines.
- Promoting the message that people shouldn't take Benzylpiperazine-based party pills.
- Adopting a policy on obesity, a growing issue which can lead to serious health problems.
- Adopting a policy on alcohol use, which will be used to inform NZMA's work regarding the impact of alcohol on individuals and society.
- Issuing a resource—"Beginners guide to industrial action" in light of a planned junior doctor strike.

Government public health initiatives in the past year include:

- The majority of the under-20 population have been immunized against meningococcal disease type B. The vaccine has been specially developed for New Zealand conditions and is administered through general practices and schools.
- Planning has taken place for the possibility of a bird flu pandemic. The NZMA has written its own resource about pandemic planning aimed at doctors who employ staff.
- The Government launched a $67 million healthy lifestyles package for young New Zealanders, which aims to help young people improve their nutrition and be more active.

It has been another busy and challenging year for the NZMA. We place a high value on advocacy for the health of the population and support for professional conditions. Continuing liaison with health sector policy makers, representation on consultative bodies, preparation of submissions on health-related legislation and advocacy about the introduction of new initiatives continue to keep members actively engaged in improving health care for all New Zealanders. We continue to work closely with other medical organisations both within the country and at an international level.

PHILIPPINE MEDICAL ASSOCIATION

Jose Asa SABILI*1

COUNTRY REPORT

CMAAO

PHILIPPINE MEDICAL ASSOCIATION

By :

Jose Asa Sabili, M.D.

President 2006 - 2008

Philippine Medical Association

- Founded : 1903
- Member : World Medical Association
- Co Founder : MASEAN
  CMAAO
- Secretariat : PMA Bldg, North Avenue, Q.C., Phil.
- Website : www.pma.com.ph
- Email : medical@pma.com.ph
- Total Membership as of May 31, 2006 – 55,307
- Composed of :
  117 component chapter societies
  8 specialty divisions
  56 subspecialties
  35 affiliates

PHILIPPINE MEDICAL ASSOCIATION

VISION

- To have fellowship of physician united in a common goal of acquiring the highest levels of medical knowledge & skills through continuing medical education and research
- To promote healing ministration of the physicians in the delivery of health **care of patients**

OBJECTIVES & MISSIONS :

- Bring together and unite the entire medical profession
- Elevate the standard of medical practice
- Protect the legitimate rights & privileges of the Filipino physicians

PHILIPPINE MEDICAL ASSOCIATION

THEME :

" Makabayang Manggagamot, Dangal ng Lahing Pilipino "

(Patriotic Doctors, Pride of Filipino Nation)

HIGHLIGHTS OF PMA OFFICERS ACCOMPLISHMENTS :

For a more relevant PMA

- Granting of amnesty to reactivate inactive members
- Increase in death benefits for P 20,000.00 to P 25,000.00
- Increase in legal aid for P 16,000.00 to P 20,000.00
- Construction of 2-storey building Doctor's Inn & Hotel to provide additional rooms for members
- Address common concerns of members with PHIC, HMO regarding increase of professional fees
- Passage of a Joint Resolution in Congress on Patients Rights & Obligations as substitute for Medical Malpractice Bills
- Full support to the Breastfeeding Program of the government but opposed the Breastfeeding Bill with penal provision in House of Congress
- Full support to the effort of the government to lower the price of medicine but opposed the bill in House of Congress which penalize and criminalize dispensing act of medical practitioner

- Full lobby for the passage of the bill for Integration of the Philippine Medical Association and revision of Medical Act of 1959
- Worked & lobbied for full implementation of Magna Carta of Health Workers of 1991which was long overdue
- Worked for the implementation of payment of Hazard Pay for health workers
- Signed Memorandum of Agreement with DOH, BFAD, KBP, ADBOARD, PITAHC to curb misleading advertisements on herbal preparation and health treatment modalities
- Signed MOA with PNRC and major TV stations ABS CBN and GMA on disaster, calamity management and medical missions
- Represented the Association and participated in various international meetings like WMA, MASEAN and CMAAO.

FOR STRONGER PMA

- Held Leadership & Orientation Seminar for all component officers with emphasis on Theme Excellence & Strategic Planning
- Held Regional Assemblies for the entire 17 Regions to keep members abreast with the development
- Revitalized programs for continuing medical education for members

*1 President, Philippine Medical Association, Manila, Philippines (medical@pma.com.ph).

•Quarterly News Letter Journal and Full computerization of general membership
•Reactivation of all Commissions and Committees
•Improved accounting and auditing procedures at the secretariat
•Appointment of a full time executive director to assist all officers and monitor continuity and implementation of program
•Professionalized secretariat staff and upgraded salaries of personnel
•Held simultaneous Program of National Medicine Week Celebration on 4th week of September with uniform daily activities ranging from Preservation of Environment Day, Heart, Skin, Eye Saving, Senior Citizen, Mother and Child Day & Lay Fora for treatment and prevention of disease
•Successful Holding of Annual Convention, 103rd Foundation Day Celebration, Search for Singing Doctor, The Outstanding Physician in Community Service Award, Honoring of Senior Physicians and Halloween Party
•Peaceful PMA National Election with Yours truly, the youngest elected PMA President running unopposed for 2 terms, first in the history of PMA.

Maraming Salamat Po
Sa Inyong Pakikinig
(Thank you for listening)

Mabuhay ang PMA !
Mabuhay ang CMAAO !
I LOVE YOU ALL !!!

SINGAPORE MEDICAL ASSOCIATION

Raymond CHUA Swee Boon*1

COUNTRY REPORT

Presented by

Dr CHUA Swee Boon Raymond
Honorary Secretary
Singapore Medical Association

Developments

Singapore Medical Association

Membership

- As at 30 September 2005, total membership of the Singapore Medical Association stood at **4,824.**
- This represents **70%** of all 6,906 registered practitioners in Singapore.

47th SMA Council 2006/7

President	Dr WONG Chiang Yin
1st Vice President	Dr CHONG Yeh Woei
2nd Vice President	Dr TOH Choon Lai
Honorary Secretary	Dr Raymond Chua Swee Boon
Honorary Treasurer	Dr YUE Wai Mun
Honorary Asst Secretary	Dr WONG Tien Hua
Honorary Asst Treasurer	Dr LEE Yik Voon

Members

Dr CHIAM Yih Hsing John	Dr CHIN Jing Jih
Dr LEE Pheng Soon	Dr OH Jen Jen
Dr SOH Wah Ngee	Dr TAN Sze Wee
Dr TOH Han Chong	Dr YEO Sow Nam

Conventions & Seminars

12th SMA House Office Seminar

- Held on 29 April 2006.
- Attended by more than 100 graduating House Officers.
- Talks included "Morning Ward Rounds", "Changes", "What Makes a Good House Officer", "Night Duty" & "Medical Indemnity".

Conventions & Seminars

37th SMA National Medical Convention

- 19 August 2006. Attended by 160 participants.
- Theme: "Managed Healthcare".
- Presenters dealt with the different aspects of managed care in Singapore: history, perspectives on economic considerations, processing of payment, professional and ethical issues, & future of managed care in Singapore.
- There was also a report on dialogues with HMOs, and a preliminary presentation of the results from the SMA 2006 Survey on Managed Care in Singapore.

*1 Honorary Secretary, Singapore Medical Association, Singapore (sma@sma.org.sg).

Conventions & Seminars

SMA Lecture 2006

- 14 October 2006.
- Theme: "Professionalism in the Age of Computerised Medical Records"
- SMA Lecturer 2006: Professor Bernard Lo.

Conventions & Seminars

10th SMA Annual Ethics Convention

- 14 & 15 November 2005
- Professional Practice:
  - Advance Medical Directive Act Made Easy for Physicians
  - Ethical Challenges in Medical Tourism
  - Issuing Medical Certificates – Dos and Don'ts
  - A Medical Practitioner's Obligations under the Medicines Act
- Challenges of Consent & Confidentiality Requirements in a Globalised & Digitised Healthcare Environment

Ethics & Professionalism

AST Course on Medical Ethics, Professionalism & Health Law

- Compulsory requirement for exit certification from specialist training.
- Equip trainees with necessary communication skills & working knowledge of clinical ethics & local health statutes.
- Help trainees develop more systematic & professional approach to common ethical & medico-legal issues in Singapore.

Publications & Reports

Monthly/Bimonthly Publications

- Singapore Medical Journal
- SMA News
- Sensory *(bimonthly)*

Other Publications

- SMA Doctors Directory 2006/7
- SMA Guideline on Fees 4th Edition

Developments

Singapore

Healthcare Cost

Medisave for Chronic Disease Management Programme

- Initiative by Singapore's Ministry of Health to improve care for chronic diseases, starting with diabetes (from 1 Oct 2006), hypertension, lipid disorders & stroke (from 1 Jan 2007).
- About 1 million Singaporeans suffer from one of the above 4 chronic diseases.
- Medisave can now be used to help pay part of outpatient cost.
- Other chronic diseases will be considered in time.

Healthcare Cost

Medisave for Chronic Disease Management Programme *(cont.)*

- Educational tool-kits & support materials have also been developed to help doctors explain to their patients more effectively.
- Patients will receive education folders containing information on chronic diseases, booklets for recording vital clinical indicators to aid self-monitoring, & answers to FAQs.
- Helpline for public to call in with their queries, & website listing all participating clinics.

Medical Response

Flu Pandemic Response Plan

- Ongoing efforts by Ministry of Health & related agencies' to sharpen operational readiness & capabilities for handling a flu pandemic.
- Large-scale 2-day emergency exercise held on 21 & 22 July 2006, with over 1,000 personnel from Ministry of Health, Ministry of Education, & home-front agencies such as Civil Aviation Authority of Singapore, Immigration & Checkpoint Authority.
- Scenario:
  Simulated escalation of flu pandemic in Singapore.

Medical Response

Flu Pandemic Response Plan *(cont.)*

- Based on management of imported cases, procedures for contact tracing, implementation of infection control protocols at immigration checkpoints & healthcare institutions.
- Exercise also tested procedures for triage, registration & temperature screening of visitors at hospitals & polyclinics, isolation of suspected cases, treatment & transfer of patients.
- Foreign observers from Asia-Pacific region such as Hong Kong, Australia & Malaysia invited to exercise to share experiences & benefit from cross-learning.

Medical Manpower

Recognition of Foreign Medical Schools

- Number of recognised foreign medical schools increased from 71 to 100.
- Additional 20 schools from Canada, India, Israel, Japan, South Korea, Spain & USA.
- More doctors & clinician-scientists needed to support expansion of clinical & research activities in light of continuing advances in medicine, ageing population, & development of biomedical research in Singapore.

TAIWAN MEDICAL ASSOCIATION

Nan-Her WU*1

Promoting Medical Ethics Aggressively

"Medical care without boarders, human rights without ethnics." Patient rights and medical ethics have become key issues internationally in the 21st century along with the changing in the awareness of human rights, patient-physician relationship and medical technology. Physician's ethical responsibility is not limited to serve the community or country, it has become a global health issue.

WMA came up with the resolution to add medical ethics to the curriculum for medical students based on the WFME resolution in 1999. WMA also published its first medical ethics auxiliary material—Medical Ethics Manual in 2005.

In response to WMA's long term promotion on the central value of medical ethics, TMA acquired the authority to translate the Medical Ethics Manual into Chinese version and launched its published on the National Doctor's Day in November of 2005 in Taiwan. One copy had been distributed to every physician in the nation in order to promote the professional "disease curing" technique to "human-being caring" level. Taiwan is one of the few pilot countries who had done this with the hope to foster selfless-minded physicians, to provide priceless medical services to patients, to fulfill the duties as a member of the world health community and to put patients-first as the true value in the daily practice. This is also the most updated central value of medical care that the WMA has proposed in the 21st century.

Health Care System in Taiwan

Since the implementation of national health insurance system in 1995, the survey shows that more than 70% of people in Taiwan are satisfied with its remarkable medical care for all, eliminating medical care access and care for the minors. The Health Affairs Journal and ABC News both reported the achievement of Taiwan health insurance system in 2003. Many other countries have taken Taiwan's health care system as a model system. Up to July of 2005, 21 countries came to Taiwan to discover the secret of our national health insurance system, including the United States, Belgium, Canada, France, Germany...etc.

Health care expenditure in Taiwan accounted for 6.3% of GDP in 2003, compare to an average of 8% in other OECD countries and 14% in the United States. The health care expenditure per person was US$819, US$5,569 and US$2,306 in Taiwan, the United States and OECD countries respectively in 2003. This is an obvious evidence that the health care professionals provide high quality health care services with very low payment. However, the health care system has faced a constructional unbalance between the insurance premium and medical payment since July of 1998 and the financial insufficiency has reached NT$ 58 billion. By using the global budget system, this financial burden has been shifted to the health care industry. For example, the BNHI retrieved 30% of medical payment it made to health care institutions in 2004 and 2005. This has serious impact on health care institutions' operation.

The purpose of national health insurance system is to provide quality health services and to promote people's health. Taiwan Medical Association will focus on the advocacy of the health insurance system reform, establishing a premium adjusting mechanism, avoiding health care resource consuming and increasing service quality to create a comprehensive and holistic health care environment.

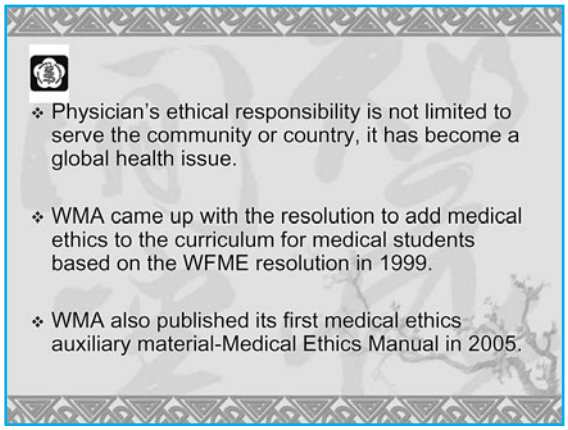
Donating US$50,000 to Assist the Establishment of WMA African Regional Office

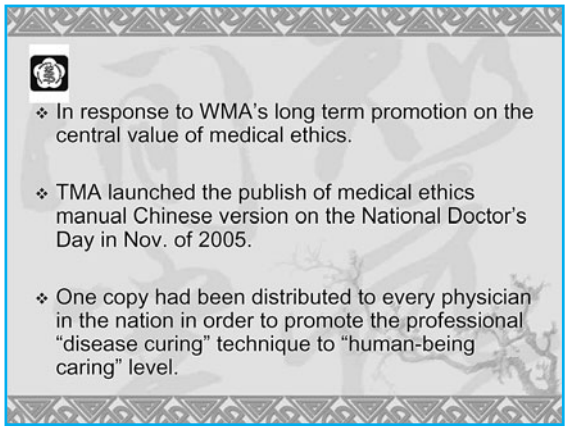
WMA has devoted itself to the establishment of

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

reference libraries in different regions in order to assist country members to monitor and prevent communicable diseases periodically. Besides, it also provides help to its member countries to identify those viruses and bacteria that are still unknown in recent years in order to prevent the outbreak of new epidemics.

In response to the call from WMA, TMA donated US$50,000 to the South African Medical Association to help with the establishment of a new office in African region which is to address on the prevention and treatment of AIDS/HIV, tuberculosis, malaria, cholera, Avian Flu...etc. to fulfill our duties as a member of the global health society and to carry out the spirit of medical care cross boarders. We are willing to provide necessary manpower support on the project and to share Taiwan's successful experience and accomplishment in Public Health.





- Taiwan is one of the few pilot countries who had done this with the hope to:
  - foster selfless-minded physicians
  - provide priceless medical services to patients
  - fulfill the duties as a member of the world health community
  - put patients-first as the true value in the daily practice

Health Care System in Taiwan

- Since the implementation of national health insurance system in 1995, the survey shows that more than 70% of people in Taiwan are satisfied with its remarkable
  - medical care for all
  - eliminating medical care access
  - care for the minors

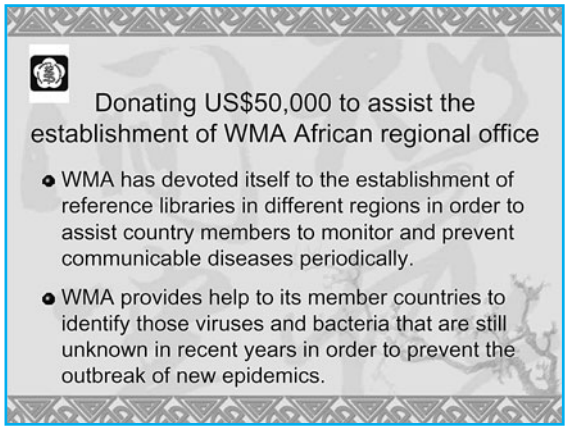
- The Health Affairs Journal and ABC News both reported the achievement of Taiwan health insurance system in 2003.
- Many other countries have taken Taiwan's health care system as a model system.
- Up to July of 2005, 21 countries came to Taiwan to discover the secret of our national health insurance system.

- Health care expenditure in Taiwan accounted for 6.3% of GDP in 2003.
  - 8% in other OECD countries
  - 14% in the United States
- Health care expenditure/per person:
  - Taiwan-US$819
  - USA-US$5569
  - OECD-US$2306

- The health care professionals provide high quality health care services with very low payment.
- The health care system has faced a constructional unbalance between the insurance premium and medical payment since July of 1998.
- The financial insufficiency has reached NT$58 billion(≒US$1.76billion).

- By using the global budget system, this financial burden has been shifted to the health care industry.
  - the BNHI retrieved 30% of medical payment it made to health care institutions in 2004 and 2005.
  - this has serious impact on health care institutions' operation.
- The purpose of national health insurance system is to:
  - provide quality health services.
  - promote people's health.


Taiwan Medical Association will focus on the advocacy of:
health insurance system reform.
establishing a premium adjusting mechanism.
avoiding health care resource consuming.
increasing service quality.
Create a comprehensive and holistic health care environment.


Donating US$50,000 to assist the establishment of WMA African regional office
WMA has devoted itself to the establishment of reference libraries in different regions in order to assist country members to monitor and prevent communicable diseases periodically.
WMA provides help to its member countries to identify those viruses and bacteria that are still unknown in recent years in order to prevent the outbreak of new epidemics.


In response to the call from WMA, TMA donated US$50,000 to the South African Medical Association to help with the establishment of a new office in African region:
to address on the prevention and treatment of:
AIDS/HIV
Tuberculosis
Malaria
Cholera
Avian Flu


to fulfill our duties as a member of the global health society.
to carry out the spirit of medical care cross boarders.
TMA is willing to:
provide necessary manpower support on the project.
Share Taiwan's successful experience and accomplishment in public Health.

THE MEDICAL ASSOCIATION OF THAILAND

Wonchat SUBHACHATURAS*1

The Administrative Committee is composed of 34 Council members. In which generally have a monthly meeting and set up 15 sub committees to work in different function.

Office Bearers and Councilors of MAT 2006–2007

President
Air Vice Marshal Dr. Apichart Koysuklo
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President of Royal Colleges of Physicians
President of Royal Colleges of Anesthesiologists
President of Royal Colleges of Obstetricians & Gynaecologists
President of Royal Colleges of Pediatricians
President of Royal Colleges of Ophthalmologists
President of Royal Colleges of Pathologists
President of Royal Colleges of Radiologists
President of Royal Colleges of Otolaryngologists
President of Royal Colleges of Psychiatrists
President of Royal Colleges Orthopaedic Surgeons
President of Royal Colleges Physiatrists
President of College of Family Physicians
President of Women Medical Association

Membership:

As at September 2005, The Total membership of the Medical Association of Thailand (MAT) at 17,168 This represented 60% of all registered practitioners in Thailand.

The Activities in the years 2005–2006 are as follows.

Activities to continue medical education and research in the medical area

- Organize Scientific Meeting twice a year
  - At Bangkok in January 29th, 2006
  - Provincial Scientific meeting and general assembly usually we organized in October every year. This year, we organized at Chiang-Rai Province on October 5–7, 2006.
- Providing five Scholarships. for Thai Physician who work outside Bangkok to extend their studies aboard for three months. One scholarship for one to two years research study.
- Providing Research grant for Thai doctors whose research project is accepted by the Committee. This year we have five awardees.
- Organize special lecture to continue Medical Education for members two times in April and June 2005.

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Medical ethics activities

- Publication of two new books "Ethics in the Medicine" and "Medical Ethic: Collecting cases in five years published in Thai and English editions for local and international distribution.
- Special Lecture for doctors in Private Hospital.
- Special Lecture in topic of Ethic for Medical student.
- Continue publish column about medical ethics in the Journal of Medical Association.

The activities of supporting and servicing to members of the association

- Publish Publication of the Journal of Medical Association of Thailand, distributed monthly to all member of the Association and major Library.
- Up-date and review the member registration.
- Serve and accommodate the member in using medical club house.
- Publish Publication of the newsletter of the Medical Association of Thailand, distributed to all members monthly.
- Set up the project to help the members who have legal problems from their medical practice over 24 hours.
- Organize the "Post Congress Tour" for 150 members to observe public health in Brunei during 18–22 October, 2006.

International activities

- 26–27 May, 2006; attended "Singapore Medical Association Annual Dinner 2006", at Regent Hotel, Singapore.
- 1–4 June, 2006; attended 46th Annual General Meeting of Malaysian Medical Association, Bay view Beach Resort, Penang.
- 25–29 June, 2006; attended "BMA's 2006 Annual Representative Meeting" in Belfast. 30 June, 2006 attended "Improving Health in the developing world at BMA House, London, UK.
- 10–11 September, 2006 attended "1st World Medical Association Asian Pacific Regional", Four Seasons Hotel, Tokyo, Japan.
- 10–15 October, 2006; attend "57th General Assembly of WMA" Sun City, South Africa
- 10–12 September, 2005; Medical Association of South East Asia Nations (MASEAN)—12th MASEAN Conference, Awana Genting Highlands Golf & Country Resort, Malaysia.
- Confederation of Medical Association in Asia and Oceania (CMAAO)—The 42nd Mid-term Council Meeting, Grand Copthorne Waterfront Hotel, Singapore.

National activities

- Founded the Committee of doctors composed of three Parties. Ministry of Public Health, The Medical Association of Thailand, Medical Council, for supporting each others.
- Take part in The Council of Scientific and Technological Associations of Thailand as one of association member.

Special activities

- Publication of three books in Thai.
  - His Majesty the King and Medicine in Thailand.
  - King's Mother and Medicine.
  - The Crown Price and his support in Medicine.
- Organized "The Medical Association of Thailand Healthy Family Walk-Run" on 26 June, 2005.
- Organized Charity Golf Tournament for Winning His Royal Highness Crown Prince Maha Vajiralongkorn Cup. on 27 June, 2005.
- Support Thai Culture by many projects from Subcommittee for Thai Art and Culture.
- Donate B30 Million and two statues of Lord Buddha to the King of Thailand on September 29, 2006.

Future plan in 2006–2007

Four major areas will be strengthened

- Improving the efficiency of connection of MAT to public and other related organizations both locally and internationally.
- Supporting protection of Medical Profession as well as Medical ethics through Medical students and site visits.
- Supporting Medical education, trainings and researches
- Magnifying the services to member through education, social, public understanding and legal supports.

SRI LANKA MEDICAL ASSOCIATION

Suriyakanthie AMARASEKERA F.R.C.A*1

The Sri Lanka Medical Association (SLMA) is the premier professional association in Sri Lanka, which brings together medical practitioners of all grades and all branches of medicine. The SLMA is the oldest medical organization in Australasia and South East Asia, with a proud history dating from 1887. At its inception it was called the Ceylon Branch of the British Medical Association. In 1951 it evolved into the Ceylon Medical Association and in 1972, when Sri Lanka became a Republic, the name was changed to Sri Lanka Medical Association.

The office of the SLMA is situated at "Wijerama House" on Wijerama Mawata Colombo 7, a beautiful Victorian building, named after Dr. E.M. Wijerama, a distinguished past president of the SLMA who donated his residence to the association.

At present the total membership of the SLMA is 2,216 which is rather disappointing, considering that there are approximately 20,000 registered medical practitioners in Sri Lanka today.

The Annual Scientific Sessions are held in March every year and provides a forum for the members to present their research and further their professional and academic development. The 119th ASS were held from the 22nd to 25th March 2006 and was attended by 449 Delegates. The Chief Guest at the Sessions was Dame Diedrie Hine, the President of the BMA and there were 33 Foreign and 45 Local Guest speakers. The program included 16 Symposia, 6 Plenary and 10 Guest Lectures, 3 Workshops and 2 Orations. There were also 47 Free Papers and 36 Poster Presentations of original research done by our members.

The lower key "Foundation Sessions" are scheduled to be held from 16th to 18th November. The program will consist mainly of Symposia with four Guest Lectures and two Orations

In addition to these, the educational program of the association includes Monthly Clinical meetings and Guest Lectures held in Colombo, and Quarterly Regional Meetings held in provinces outside Colombo.

The Association functions through its Expert Committees

- Communicable Diseases
- Drugs
- Ethics
- Ethical Review
- Food and Nutraceuticals
- Getting Research into Practice
- Health Care Waste Management
- Health management
- Media
- Medical Education
- National Health Policy
- Non Communicable Diseases
- Prevention of Motor Traffic Accidents
- Snake Bite
- Tobacco Alcohol and Substance Abuse
- Tsunami Disaster Relief
- Women's Health

The SLMA has taken the responsibility of formulating National Guidelines on various important topics. These committees have formulated several such Guidelines namely Management of Lipid Disorders, Communication Skills and Counselling Skills, Management of Asthma, Code of Practice for Assisted Reproductive Technologies, Advocacy Document for prevention of Type II Diabetes, and Management of Snake Bite.

I would like to high light some of the noteworthy activities of the Expert Committees in the past year.

Communicable Diseases Committee

Communicable Diseases Committee has conducted Seminars on Avian Influenza, HIV/AIDS and Varicella.

Three Seminars on Tuberculosis have been held, in Colombo, in Matara in the Southern Province and Chilaw in the North Western Province, in

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collaboration with the National Program on Tuberculosis and Control of Chest Diseases, to sensitize medical staff of General and Base Hospitals.

A booklet on Congenital Syphilis has been printed and distributed to all primary health care institutions and is available on demand to any health care personnel.

Committee on Drugs

A booklet on Antibiotic Guidelines to advise medical specialists, grade medical officers and family physicians on the appropriate use of antimicrobial agents is being prepared.

The Committee is also involved in developing a National Medicinal Drugs Policy in collaboration with the Ministry of Health and the WHO.

Continuing Professional Development Committee

Having successfully launched a pilot project in two Districts outside Colombo, the committee plans to conduct this program island wide. Steps are being taken to raise the necessary funds from the Ministry of Health & WHO.

Ethics Committee

Ethical issues such as unethical broadcast drug advertising, broadcast publicity by doctors, prevention of medical negligence, inadequate time spent on consultation, and updating the SLMA Declaration of Health which spells out the patients rights were taken up for discussion and disseminated to the membership by the monthly News Letter.

Health Care Waste Management

This committee has been successful in urging the government to implement the National Health Care Waste Policy that had been drawn up in 2001.

Health Management

A Consultation on "Balancing the requirement and supply of Doctors" was conducted with the collaboration of the WHO. The proceedings are now in print and will act as a policy document for the Ministry of Health.

A Career guidance Seminar for young doctors was conducted with participation by Specialist Colleges and Associations.

National Health Policy

Though there have been several health policy documents, strategic frameworks, task force documents and master plans, there has been a failure of implementation of accepted policies in a systematic manner and poor monitoring of progress. Further, the SLMA recognises the fact that the health needs of a nation are in a continuous state of flux and needs frequent evaluation and reprioritization of policies and action as was demonstrated in the Tsunami disaster.

This committee has drawn up a Document in which the main thrust is on Equity of distribution of health care, inclusive of vulnerable groups, Internally Displaced Persons, and Victims of Disaster, Investing more on preventive services, Enhancement of primary care leading to a national scheme of general practice and referral system, combating malnutrition, and efficient management of human and financial resources. The document contains General Directional Policies from which Operational Policies should flow and it has been presented to the Ministry of Health and all the Political Party Leaders.

Media

High quality Medical Journalism is being encouraged by awarding the "Excellence in Health Journalism" prizes to the best selected article in Sinhala, Tamil and English, the three languages used in Sri Lanka. A Seminar was also held for skills development in Health Science Communication and Career Guidance Seminar for prospective Health and Science Journalists.

Medical Education

A CME Bulletin is published bimonthly and distributed free of charge. The articles are presented in the distant education format, and provides a useful update for primary care physicians and general practitioners. Readers who return answers to the MCQ's in the CME Bulletin are entitled to certificate of CME participation.

A Training of Trainers programme in Counselling Skills is being planned. It is intended to produce a DVD of ideal counselling sessions, to be given to trainers who in turn will use them to train other doctors in their respective institutions.

Non Communicable Diseases

The committee has published an advocacy document for the prevention of Type II Diabetes in Sri Lanka.

There are an estimated 1M diabetics and

another 1M with pre diabetes in Sri Lanka and this figure is expected to double by 2025. In order to battle this pandemic a Diabetic Task Force has been set up The main activity of this committee has been to increase the public awareness of diabetes and prevention of diabetes and cardiovascular disease amongst school children and the youth of our country, through a series of Workshops, Seminars, Radio and TV programs and using the printed media, posters stickers, and slogans. The Health Education Bureau and the National Institute of Education have been, involved to institute curriculum changes in schools and universities. The activities will culminate with the "Diabetic Walk" which is scheduled for the 19th of November at which children from 25 schools in Colombo, University students, medically related professional organizations, diabetic patients from the diabetic association of Sri Lanka and members of the public are expected to participate.

Prevention of Motor Traffic Accidents

Efforts are being continued to legislate the wearing of seat belts. Implementation of fixing reflectors in bicycle pedals and use of luminous paint or stickers to mark elevated areas and obstacles has been done in various parts of the country in collaboration with the Police Department and the Department of Motor Traffic.

Snake Bite

The Guidelines in management of Snake bite have been made available in a CD.

Tobacco, Alcohol and Substance Abuse

Prevention of smoking has been promoted in the School Science day program throughout the island with the collaboration of the Ministry of Health and the Sri Lanka Association for the Advancement of Science.

Tsunami Disaster Relief

The generous donation of the CMAAO has enabled the SLMA to launch a joint CMAAO/ SLMA Scholarship scheme for children who have lost one or both parents in the Tsunami disaster of 26th December 2004. We hope to use the interest generated by investing the donation to generate sufficient funds to award 25 children a sum of Rs. 2,000/—monthly till they complete their education or leave school If funds permit we hope to give an extra sum of money to purchase school books, uniforms and shoes at the beginning of each year.

Women's Health

A seminar on Domestic Violence was held in the course of this year. The journal of the SLMA the *Ceylon Medical Journal* is published quarterly by Elsevier. It has the distinction of being the only Indexed Journal published in Sri Lanka. In keeping with the requirements laid down by the International Committee of Medical Journal Editors, the SLMA is in the process of setting up a Sri Lanka Clinical Trials Registry.

The SLMA has also launched a web site www.slma.lk opening our doors to the world.

Academic Activities

- Annual Scientific Sessions - March
- Foundation Sessions - November
- Monthly Clinical Meetings
- Quarterly Regional Meetings
- Guest Lectures

Expert Committees

- Communicable Diseases
- Drugs
- Ethics
- Ethical Review
- Food
- Nutraceuticals
- Getting research into practice
- Health Care Waste Management
- Health Management

Expert Committees (cont'd)

- Media
- Medical Education
- National Health Policy
- Non Communicable Diseases
- Prevention of Motor Traffic Accidents
- Snake Bites
- Tobacco, Alcohol and Substance Abuse
- Tsunami Disaster Relief
- Women's Health

Guidelines

Guidelines Produced in the Current Year

- Guidelines in Management of Lipid Disorders in Sri Lanka
- Communication Skills and Counselling Skills for Doctors
- SLMA Guidelines on the Management of Asthma (Pocket Edition)
- SLMA Guidelines on the Management of Asthma

Guidelines Produced in the Current Year (cont'd)

- A Provisional Code of Practice for Assisted Reproductive Technologies
- Advocacy Document for the Prevention of Type II Diabetes in Sri Lanka
- Revised Guidelines for the Management of Snake Bite in Hospital

Communicable Diseases Committee

- Seminars on
  - Avian Influenza
  - HIV AIDS
  - Varicella
  - Tuberculosis
- Booklet Congenital Syphilis

Committee on Drugs

- In the process of preparing
  - Antibiotic Guidelines
  - National Medicinal Drugs Policy

CPD Committee

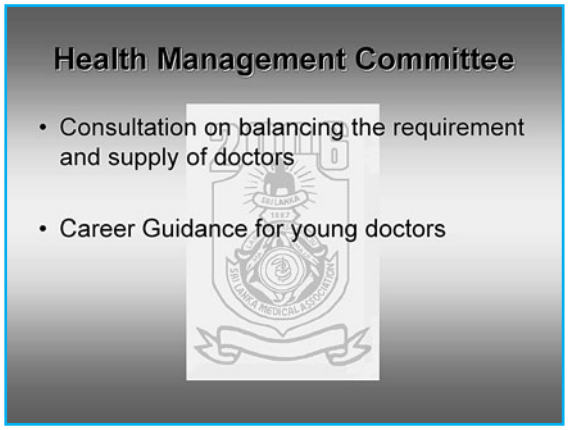
- Completed two pilot projects
- Planning to launch an island-wide programme

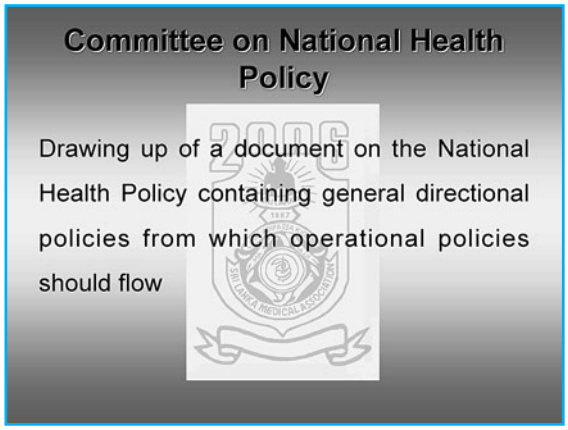
Ethics Committee

- Subjects discussed this year
  - Unethical broadcast drug advertising
  - Broadcast publicity by doctors
  - Prevention of medical negligence
  - Inadequate time spent on consultation
  - Updating the SLMA Declaration of Health

Health Care Waste Management Committee

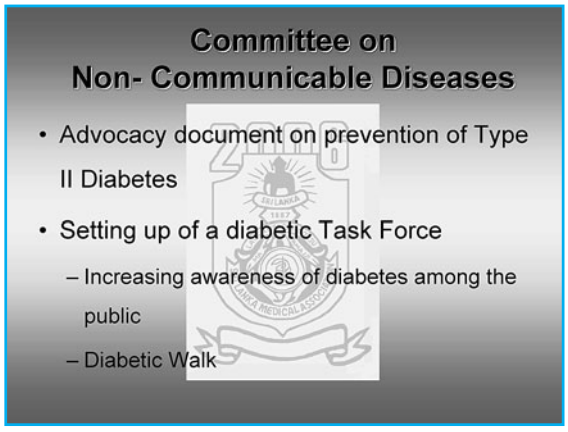
Implementation of the National Health Care Waste Policy of 2001


Health Management Committee
• Consultation on balancing the requirement and supply of doctors
• Career Guidance for young doctors

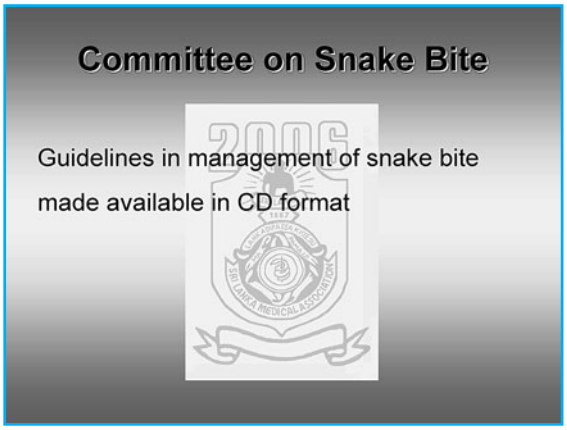

Committee on National Health Policy
Drawing up of a document on the National Health Policy containing general directional policies from which operational policies should flow


Media Committee
• Awarding prizes for excellence in Health Journalism
• Conducted seminar on Health Science Communication and Career Guidance for prospective Health Science Journalists

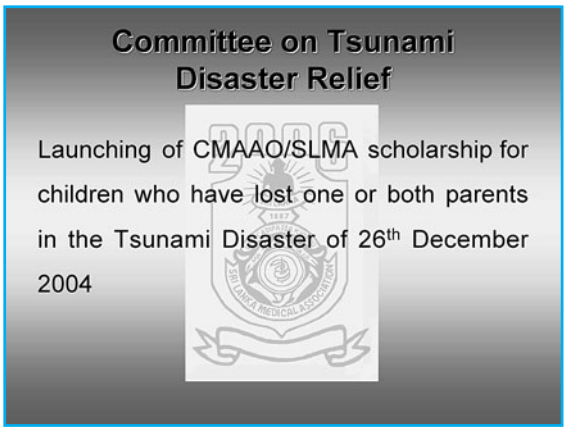

Medical Education Committee
• Publication of bi-monthly CME Bulletin
• Training of trainers in Counselling Skills


Committee on Non- Communicable Diseases
• Advocacy document on prevention of Type II Diabetes
• Setting up of a diabetic Task Force
– Increasing awareness of diabetes among the public
– Diabetic Walk


Committee on Prevention of Motor Traffic Accidents
• Efforts to legislate wearing of seat belts
• Fixing reflectors on bicycle pedals
• Luminous paint/stickers to mark obstacles on the road


Committee on Snake Bite
Guidelines in management of snake bite made available in CD format


Committee on Tobacco, Alcohol and Substance Abuse
School Science Day Programme to prevent smoking


Committee on Tsunami Disaster Relief
Launching of CMAAO/SLMA scholarship for children who have lost one or both parents in the Tsunami Disaster of 26th December 2004


• Ceylon Medical Journal
• SLMA Website - www.slma.lk


Thank You

Differences between Japan and the U.S. in Test and Treatment Strategies in Pediatrics

JMAJ 50(2): 184–186, 2007

Takashi IGARASHI*1

Abstract

The differences between Japan and the U.S. regarding the treatment strategies in pediatrics are discussed. In Japan, serum CRP measurement is considered an important screening test for serious bacterial infection and evaluating the effectiveness of treatment, antibiotics are used frequently for bacterial gastrointestinal infection, and theophylline is administered often to children with bronchitis or bronchial asthma. Theophylline is also given to children with asthmatoid bronchitis. On the other hand, these tests and therapies are not frequntly used in the U.S. These are preferred in Japan based on the physicians' experience and wishful thinking.

Key words Pediatrics in Japan and the U.S., CRP, Antibiotics, Bacterial gastrointestinal infection, Theophylline

Introduction

Each country has a distinct style in the practice of health care and medical sciences reflecting the tradition of the country. Japan has come through more than 130 years since the introduction of Western medicine and experienced strong influence of the U.S. medicine after the World War II. Despite this fact, there are several important differences between Japan and the U.S. in the test and treatment policies regarding the clinical findings and diseases in children.

The Use of Serum CRP

The first difference is the inclination of Japanese pediatricians toward the use of serum CRP (C-reactive protein) measurement in estimating the cause and evaluating the severity of infections.[1] CRP was first recognized as the protein produced in the liver binded to and precipitated pneumoccal C-polysaccharide.

While CRP has various physiological functions, it is generally understood as a marker for inflammatory response. I am not going to argue against this understanding, but more exactly, it should be considered as a protein that is called to action as a result of tissue damage. When tissue damage brings cells into direct contact with blood, the nuclei and DNA in such cells are quickly opsonized and processed in the reticuloendothelial system. Many Japanese physicians measure serum CRP as a marker for inflammatory response without recognizing the meaning of the important biological roles of CRP.

On the other hand, physicians in the U.S. do not measure CRP as frequently as in Japan. There are several reasons discouraging the measurement of CRP in patients with infection. Even in the case of bacterial infection, serum CRP is not elevated much in the early stage of infection. A patient with high fever due to bacterial brain abscess does not show elevated serum CRP because the presence of the blood-brain barrier prevents the transmission of the CRP production stimulus to the liver. Serum CRP may be elevated even in the case of viral infection, because EB virus, adeno-

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virus, and some other viruses cause tissue damage. Hence, serum CRP by itself is not a definitive means for discriminating bacterial infection from viral infection. Because of these reasons, American physicians use blood cultures more frequently than Japanese physicians when serious bacterial infection is suspected, in particular when the focus of infection is not identified. This attitude of American physicians seems to reflect their philosophy of placing more emphasis on evidence. Recently, serum CRP is measured in the U.S. for research purposes. For example, obesity is considered a condition involving chronic inflammation, and this theory is supported by the small increase in blood CRP in obese persons.

The Use of Antibiotics for Bacterial Gastroenteritis

The second peculiarity of Japanese practice is the use of antibiotics for bacterial gastroenteritis.

All physicians in Japan and in the U.S. know that enterohemorrhagic *E. coli* such as O157:H7 is the causative agent of bacterial gastroenteritis occurring frequently in the period from June to September. When a child is presented with diarrhea followed by bloody stool in summer, Japanese physicians use an antibiotic therapy typically with fosfomycin after a stool culture is done. A report from Japan demonstrated that the use of fosfomycin within 3 days after the onset of diarrhea was effective for the prevention of hemolytic uremic syndrome (HUS) secondary to enterohemorrhagic *E. coli* infection in a study comparing the groups with and without the use of fosfomycin. However, American physicians do not use antibiotics except for severe cases. To begin with, fosfomycin is not commercially available in the U.S. It should be noted that even in Japan, antibiotics are not given to patients with gastroenteritis, if *Salmonella* is considered to be the causative bacteria.

It is generally believed in the U.S. that there is no evidence that the use of antibiotics improves the course of bacterial gastroenteritis. On the final day of the international conference on verotoxin-producing *E. coli* (VTEC) in Washington DC, 1999, bacteriologists and pediatricians form Japan and the U.S. held a one-day conference sponsored by the Ministry of Health and Welfare. This conference only underscored the disagreement of opinions concerning the use of antibiotics. Bacteriologists from Japan alone argued for the usefulness of antibiotics. The report of the effectiveness of early fosfomycin therapy has not been a subject of serious consideration in the U.S., because it was not a controlled study.

Furthermore, the common opinion of pediatricians in the U.S. is represented by the report from Seattle[2] claiming that the use of antibiotics increases the risk of HUS. Although the result of this study was statistically significant and should be respected, it should be interpreted with caution because the study might have been biased by two facts: the patients who received antibiotics were much fewer than those who did not and the HUS occurrence rate was much higher than that in Japan. We need to see some more evidence before concluding that antibiotics are detrimental, but experience in Japan has also shown that the early use of antibiotics cannot always prevent severe HUS. When Verotoxin has been absorbed from the small intestines before the onset of diarrhea in VTEC infection, it is impossible to prevent encephalopathy and nephropathy by the early use of highly bactericidal antibiotics.

The Use of Theophylline for Bronchitis and Bronchial Asthma

The third point is the use of theophylline for bronchitis and bronchial asthma.[3]

Formerly in the U.S., the round-the-clock (RTC) therapy with theophylline was used commonly for the prevention of acute bronchial asthma in children, but this therapy is rarely used at the present. Theophylline is also going out of use for the treatment of acute bronchial asthma. This change reflects the facts that the effectiveness of inhaled steroids for the prevention of acute bronchial asthma was proved, several new drugs for the treatment of acute bronchial asthma were developed, and the risk of theophylline intoxication has become widely known to people. As a result, the convenient kit for the bedside measurement of blood theophylline is no longer produced in the U.S. In the U.S., relatively inexpensive theophylline is regarded as an antiasthmatic drug for developing countries.

In Japan, the 2005 version of the guidelines for the treatment of bronchial asthma ("Japanese Pediatric Guideline for the Treatment and Management of Asthma 2005" [JPGL 2005]) was published by the Japanese Society of Pediatric Allergy and

Clinical Immunology. The new version advises increased caution regarding the use of theophylline for the treatment of acute bronchial asthma. However, theophylline is still used in Japan, often on an outpatient basis, not only for bronchial asthma but also for bronchiolitis, bronchitis, and asthmatoid bronchitis in children.

The margin between the therapeutic range and the toxic range of theophylline is small, and theophylline intoxication may occur unless the blood level is monitored. There also have been cases of younger children developing so-called theophylline-associated convulsions, in which serious convulsions take place even when the blood level is lower than the toxic range. Convulsions due to theophylline intoxication and convulsions associated with the nontoxic blood levels of theophylline are often refractory, responding poorly to anticonvulsants and persisting for a long time. Such convulsions frequently leave aftereffects such as central nervous system (CNS) damages.

Recently, there have been an increasing number of lawsuits in Japan concerning the cases in which high blood levels of theophylline caused convulsions and CNS aftereffects. In most cases, the disputes have been settled through reconciliation. Japanese pediatricians should recognize the fact that the court often acknowledges the fault on the side of medical providers.

The decreased rate of theophylline metabolism during fever may cause the elevation of the blood level to reach the toxic range. To prevent CNS damages due to theophylline intoxication and those due to theophylline-associated encephalopathy, pediatricians should basically avoid the use of theophylline for bronchiolitis, bronchitis, and asthmatoid bronchitis in children under the age of 5. If theophylline must be prescribed, parents should be fully informed about potential side effects of theophylline and consent should be obtained. Revision of the current indications for theophylline is also needed regarding the fact that they include asthmatoid bronchitis.

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Overview of the Aizuwakamatsu Medical Association

JMAJ 50(2): 187–189, 2007

Yuzo TAKAYA*1

Aizuwakamatsu City is in the Aizu region, the western part of Fukushima Prefecture. The city is renowned for its Tsurugajo Castle, besieged during the Boshin Civil War in 1868. To the east of the city are magnificent Bandai Mountain and Inawashiro Lake, the birthplace of the outstanding medical scientist, Hideyo Noguchi. The natural beauty of the Urabandai area is also noteworthy. The city abounds with cultural assets, such as the historically important remains of Enichiji Temple founded by the great priest, Tokuichi, and Shojoji Temple housing invaluable Buddhist statues.

"You must not do what you must not do" has long been the spirit of Aizu, which strictly governed the acts of young clansmen attending the Nisshinkan school. Adhering to this spirit, Masayoshi Ito (1913–1994), a statesman from this area, refused to take office as prime minister, when he considered the governing party's reform policy as useless as "changing the cover of a book without changing the content." The climate and culture of the Aizu region as glimpsed here has had considerable influence over the origin and development of the Aizuwakamatsu Medical Association.

Establishment of the Medical Association

Like most local medical associations in Japan, the Aizuwakamatsu Medical Association was first established on April 4, 1906 under the Medical Practitioners Law (Law No. 47). Its antecedent, called the Ekiyuukai, had been formed by doctors in Aizuwakamatsu in 1886. The doctors held monthly or semimonthly meetings for continuing medical education. Although the Ekiyuukai was a voluntary organization, it served as a body to decide the activities of the association.

Following the promulgation of the new constitution of Japan, the Aizuwakamatsu Medical Association was reorganized as a corporate body on November 1, 1947 in concert with other medical associations in Japan.

Aizu Is Closely United

There are four local medical associations in the Aizu area: Aizuwakamatsu, Kitakata, Ryonuma-gun, and Minamiaizu-gun. A liaison council combining these medical associations was set up within this author's generation. The council meets whenever needed to discuss whatever topics necessary. Respecting the opinions of neighboring medical associations, the council unifies their opinions and communicates them to the prefectural medical association to facilitate the exchange of information.

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Hospital-Clinic, Clinic-Clinic, and Hospital-Hospital Collaboration

In Aizuwakamatsu City, there are two hospitals with more than 1,000 beds, a prefectural hospital with 401 beds, and a private hospital with 435 beds (including a psychiatric ward). The age of competition among hospitals has ended, and each hospital is now offering its own distinctive features, striving to strengthen cooperation with clinics to encourage referrals from clinics to hospitals and from hospitals to clinics.

The driving force behind this movement is provided by the presence of Hatsukakai, a group of doctors from all parts of Aizu which was formed in January 1983 under the motto of "No academic cliques, no seniority. All that counts is personality and specialty." Starting from a membership of eight doctors, this group gradually attracted more and more doctors, not only general practitioners but also department chiefs and managers of hospitals. Today, 22 years after its establishment, it has as many as 136 members. We are confident that the relationship among directly acquainted members has been effective in removing much of the hesitation in writing referral letters. The monthly meeting of general practitioners and hospital doctors, consisting of lectures and presentations followed by a reception, has helped the development of hospital-clinic, clinic-clinic, and hospital-hospital collaboration. This group has been instrumental in implementing model projects for hospital-clinic collaboration, the family doctor system, and regional health care collaboration promoted by the Japan Medical Association. Every member of the medical associations in Aizu is directly experiencing the importance of hospital-clinic collaboration and its role in the enrichment of community health care.

The School Doctor and Preschool Doctor Committee

In former days, the assignment of school doctors was hereditary in the sense that each position was handed down from the predecessor to the successor, but a committee now appoints school doctors impartially, and the new system has won the confidence of members.

Meetings of school doctors and nurse teachers and seminars for preschool doctors and preschool teachers are held annually. With the participation of schoolmasters, dentists, and pharmacists, these activities are contributing to the improvement of the health of children and students. The seminars of preschool doctors and preschool teachers are held to address common problems such as infection control measures (e.g., when students with infection should refrain from attending school and when they may return to school). Because of this, a large proportion of preschool teachers attend these meetings, and we have had to limit the number of participants from each preschool.

Holiday and Nighttime Emergency Medical Services

The shortage of pediatricians is a serious problem nationwide. An emergency child patient taken to the emergency room of a large hospital is not likely to be treated by a specialist pediatrician. Although citizens need specialist pediatricians, this need is hard to satisfy. Furthermore, the concentration of pediatricians in university hospitals is aggravating the shortage of pediatricians especially at clinics. Those working in hospitals are fatigued from overwork.

The Aizuwakamatsu Medical Association has reorganized holiday and nighttime emergency medical services to include pediatrics, in addition to internal medicine and surgery, so that three groups of doctors are available on holidays, although the number of doctors is still insufficient. Nighttime emergency centers are staffed with pediatricians on holidays (Sundays and public holidays) and with doctors trained in pediatrics on weekdays. Two years from the introduction of this system, the number of pediatric patients is increasing steadily, reflecting the growing awareness among citizens.

Promotion of Maternal and Child Health

We have been making efforts to improve social services and negotiating with relevant authorities to make changes in response to the needs of citizens, such as the in-kind payment of medical benefits for infants, the raising of the age limit to six, and the direct payment of the Lump Sum Birth Allowance from the municipal government to hospitals. While wide-area standardization of

individual (as opposed to mass) vaccination has not been implemented on a prefectural basis, we are calling for the cooperation of municipalities to achieve standardization, at least in the Aizu region.

Publication of the Journal of the Aizuwakamatsu Medical Association

The Journal of the Aizuwakamatsu Medical Association has been issued since April 1965. As of 2006, 500 journal numbers have been issued without any interruption. Under the motto of "Written by all, read by all" the journal has been published by the joint efforts of the four medical associations, and the monthly editorial meetings provide wonderful opportunities for interaction.

The Aizu Society of Medicine

The Aizu Society of Medicine evolved from a study group formed by members of medical associations in the Aizu region. The first lecture meeting in 1933 was held to commemorate Dr. Hideyo Noguchi, who passed on a few years before. Since then, a lecture meeting inviting two distinguished speakers from various fields has been held every year, and is attended by a large audience, of not only practitioners and hospital doctors but also dentists, pharmacists, and nurses.

Conclusion

The most serious problem at present is related to prefectural hospitals, which have become independent corporations under Local Public Enterprise Law and have a tremendous cumulative deficit. They must be revived through the process of closing down and consolidation, and finding a way to survive in the regional community as general hospitals. All members of the Aizuwakamatsu Medical Association are working together toward the enrichment and development of regional health care, striving to be doctors who are loved, trusted, and respected by citizens.

Perinatal Care in Crisis: Action required now

JMAJ 50(2): 190–192, 2007

Isamu ISHIWATA*1

A marked decline in the number of perinatal (birth) care facilities nationwide is creating anxiety amongst local residents and becoming a social issue in Japan. The Japanese government has set the goal of assuring safe and comfortable pregnancy and birth as an aim of its "Healthy Parents and Children 21" campaign. With the rapid decrease in the number of perinatal facilities, however, this government aim is far from being realized, creating anxiety amongst citizens and casting a dark shadow over national efforts to reverse the declining birthrate.

Perinatal medicine is facing a critical situation, but the severity of the crisis varies from region to region. This is not a problem that can be resolved by the Japan Association of Obstetricians & Gynecologists alone, but must be addressed comprehensively in all medical fields in conjunction with emergency medical care.

Together with the Ibaraki Association of Obstetricians & Gynecologists and the Ibaraki Pediatricians' Association, the Ibaraki Medical Association not only senses impending crisis with the current situation threatening the collapse of perinatal care, but also is working to encourage the government to implement reform.

Ibaraki Medical Association Efforts Regarding Perinatal Care

1. Twice-yearly meetings held with the Ibaraki Prefectural Government Health and Welfare Department for open and frank exchange of opinions.
2. Realization in 1983 of the perinatal care regionalization concept (the improvement of regional medical care through the classification of medical institutions from primary to tertiary according to function and the establishment of inter-institution cooperation and networks based on the classification)
3. Submission of a proposal for the creation of an extensive system of cooperation between government bodies, across administrative district boundaries (2001)
4. Establishment of a "Study Group on Comprehensively Improving the Perinatal Care System" within the Ibaraki Prefectural Government Health and Welfare Department (in 2003, attended by the President of the Ibaraki Association of Obstetricians & Gynecologists)
5. Establishment of the "Ibaraki Prefecture Perinatal Care Council" within the Ibaraki Prefectural Government Health and Welfare Department (in 2005, attended by the Vice-President of the Ibaraki Medical Association and the President of the Ibaraki Association of Obstetricians & Gynecologists)
6. Submission of a proposal regarding the issue of nurses performing vaginal examinations (2003)
7. Survey of actual conditions for medical institutions providing obstetrics and gynecological

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care (2005)
8. Explanation of the critical situation facing perinatal care to the Ibaraki Prefecture Press Club (2005)
9. Submission of petitions to the Governor of Ibaraki Prefecture requesting the creation of an environment enabling certain nurses to perform vaginal examinations, conduct of a survey of the midwife shortage, increasing the number of trained midwives, and securing of perinatal (birth) facilities in the north of the prefecture (there were only two such facilities in the broad northern region which comprises one-third of the prefecture's area) (2005)
10. Informal meeting held with Ibaraki Prefecture's Assembly members responsible for welfare (2005)
11. The Governor decided that in 2006 the capacity of prefectural midwife training facilities would be increased to 15 students (7 mature students) and would be further raised to 20 in 2007.

Current Situation in Ibaraki Prefecture

Over the past 10 years and in particular in the past 3 years, Ibaraki Prefecture has experienced a marked drop in the number of perinatal (birth) facilities. Compared with a 2.8% decrease in the birthrate in the 10 years between 1995 (27,517 births) to 2004 (26,751 births), there has been a decrease of 22% in the number of perinatal facilities (97 to 76) over the same period—a much higher figure than the national attrition rate.

1. The average age of obstetricians/gynecologists in general practice is over 64 years old and, with their successors avoiding specialization in obstetrics/gynecology, they have little choice but to eventually close their practices.
2. Twice, in 2002 and 2004, following notification issued by the Nursing Division, Health Policy Bureau, Ministry of Health and Welfare (prohibition of vaginal examinations by nurses under the direction of doctors at medical care institutions), birth services at perinatal (birth) care facilities with insufficient midwives on staff were withdrawn.
3. With the withdrawal of obstetricians gynecologists in postgraduate clinical training from university-affiliated hospitals, one after the other medical care facilities have had to close down birth services. The number of hospitals providing birth services has declined (37 hospitals in Ibaraki Prefecture providing birth services in 1995; by 2004 the figure had dropped to 32. In 2005 another 4 and in 2006 another 2 hospitals planned to ceased birth services).
4. In 30 years, the overall number of doctors has increased by 196% but the number of obstetricians/gynecologists has fallen to 82%.
5. Looking at where midwives are employed in Ibaraki Prefecture, 219 work in the obstetrics/gynecology departments of hospitals and 70 work at birth clinics. Of the Ibaraki-trained midwives who graduated in the three years from 2001 to 2003, 24 found employment at hospitals within Ibaraki Prefecture, 20 found employment at hospitals in other prefectures, and none found employment at clinics. Clearly, if nothing continues to be done about the issue of nurses performing vaginal examinations, the situation will become very grave indeed.

The Ministry of Health, Labour and Welfare "Committee to Consider the Health Nurse, Midwife, and Nurse Law with the Aim of Assuring Medical Safety" (attended by the President of the Ibaraki Association of Obstetricians & Gynecologists) debated "The Duties of Nurses in Obstetrics", but no resolution was reached on whether or not to lift the ban on nurses performing partial vaginal examinations (measurement of cervical dilation and/or engagement of baby's head), and it was decided to continue to investigate this issue.

Future Efforts

What we need to do right now is work from the standpoint of local residents to create as quickly as possible an environment that enables women in regional areas to give birth safely and without anxiety in their own communities. This means, at the very least, ensuring that the number of perinatal (birth) facilities does not decrease further at the prefectural level. To enable this, it is imperative that government approval be given to a system of nurse cooperation in pelvic examinations under the guidance and responsibility of doctors (experienced nurses performing measurements of cervical dilation and/or engagement of baby's head) at perinatal (birth) facilities where there is a shortage of midwives, at least until sufficient midwife numbers can be secured.

With regard to improvement of the perinatal

medical care system, the Ibaraki Medical Association as a whole is working to encourage the government to implement changes. In order to secure a supply of doctors in regional areas, it is imperative that (1) regional quotas be established in medical school examinations (already established in such medical schools as Sapporo Med. Univ., Shiga Univ. of Med. Science, Wakayama Med. College, Fukushima Med. College, Saga Med. School, and Shinshu Univ., School of Med.); (2) a scholarship system be introduced for medical students aiming to specialize in the fields in which there is already a shortage of doctors that is expected to continue in the future—obstetrics/gynecology, pediatrics, and anesthesiology; and (3) places at midwife training facilities be increased and mature student quotas be established.

Moreover, it is vital that Ibaraki prefecture residents understand the issues facing obstetrical/gynecological care. To ensure the happiness of the residents of our prefecture, the Ibaraki Medical Association intends to focus on activities from the standpoint of residents, and on being an open, familiar presence from which residents feel they can seek advice. In the past, we have held numerous public forums, and in 2004 this Association took the initiative in establishing with other medical care-related organizations the Ibaraki Council for the Promotion of Medical Care with that aim of protecting and preserving medical care. On December 13, 2005 a public forum was held as part of the "Ibaraki Citizen's Meeting to Protect the Universal Health Insurance System: Right Now, Your Life Expectancy is about to be Shortened".

The number of perinatal (birth) care facilities has not declined because of a reduction in the number of hospitals but because a decrease in the number of obstetricians and gynecologists and an absolute shortage of midwives has forced such facilities to close. The number of obstetricians and gynecologists has not decreased because the number of births has decreased; if working conditions were improved, medical fees commensurate with work assured, an environment created in which trouble would rarely occur (such as introduction of a no-fault compensation program), and young doctors shown in concrete terms the appeal of obstetrics/gynecology, then the number of obstetricians and gynecologists is sure to increase. Efforts by medical associations to encourage the government to implement reforms will become more and more important in future. Today, amidst resident's anxiety and dissatisfaction with perinatal care as it stands, the Ibaraki Medical Association intends to strive to explain to residents the current situation facing perinatal medicine and gain their understanding as well as to work together with residents towards improvement.

Message from the American Medical Association

JMAJ 50(2): 193–194, 2007

William G. PLESTED III*1

It is an honor and a distinct privilege to write some of my thoughts for your consideration.

The profession of medicine is truly the first global profession. Bacteria and viruses respect no national boundaries. Epidemics do not require passports. And treatments that are effective in Osaka, Japan, are equally effective in Omaha, Nebraska.

Today, there are two socio-economic tsunamis common to both our professional lives and our profession's future. I'm talking about demographic and technologic forces that are bearing down on both Japan and the United States. And both are products of our past successes.

The fact that life expectancy for your 127.5 million residents is 81.25 and for our 300 million is 77.8 years underscores the fact that we are all living longer. The fact that the worldwide life expectancy is but 64.77 years points up the successes our profession has bestowed on our respective nations.

Medicine in both countries has brought more years of life. But medicine in both countries has brought more life to years, not only keeping people alive but giving them previously unheard of good health.

Free from the ravages of old age, our senior citizens have a literal second chance to enjoy family and friends, to travel, to engage in all manner of activities their grandparents never knew, had they lived that long.

The twin economic miracles in both our countries means your average resident's share of Gross Domestic Product is $33,100 (US) and ours, $43,500—again an economic statistic without historic precedent. The worldwide average is $10,000. Our economic success, in turn, means our neighbors have more funds with which to purchase a healthy lifestyle—not only medical care when needed but also the foodstuffs, vitamins and other economic goods and services that produce health living.

From a public policy point of view, all of this good news is a mixed blessing. Gallons of ink and tons of newsprint have been expended in public discussion over the "graying" of society.

The debate centers on a totally private system of health care versus a totally public one. This, to me, is a false dichotomy, faulty logic which is an "either-or" approach when, in reality, the successful model appears to be "both." The American Medical Association continues to work toward making public-private partnership become a more and more effective solution.

Health insurance is a case in point. Federal resources pay 45% of the U.S. healthcare bill. Private insurance picks up the rest. Most recently, we are working out a public-private solution to the problems of uninsured Americans, looking at ways of making insurance affordable for those with the means to buy their own coverage, and ways of providing government funds to those without the means.

And, as is true in Japan as well as the United States, too many citizens each day make unhealthy lifestyle choices that add up to enormous costs to society at large. A survey of estimates of the health care costs, lost wages, lost productivity, lost investment and other societal costs provides this grim picture:

Violence in America drains $300 billion from the economy each year;
Drug and alcohol abuse, $246 billion;
Traffic accidents, $150 billion;
Work-related accidents, $171 billion;
Tobacco, $202 billion;
Obesity, $102 billion.

And, there are no estimates readily available for teen pregnancy, sexually transmitted disease and suicides, though intuitively one understands

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there are significant costs involved.

Now, these estimates come from a variety of sources using a variety of methods to calculate the amounts. Neither the AMA nor I can vouch for their accuracy or validity. But the enormity of the issue is obvious even before factoring in the heartbreak and disruption of countless lives.

I would be interested in learning if comparable estimates are available in Japan. I suspect the relative enormity of the problems are as great for you as they are for us in America.

The problems we wrestle with the United States are, I believe, common to every country in the 21st century.

Add to these problems the threats of terrorism, of pandemics and of severe weather and natural disasters and we have to conclude the globe is small but the common problems, enormous.

In the past, physicians in Japan and the United States have forged incalculable numbers of links, of shared professional concerns and solutions. It is even more vital in the 21st century that we reinforce those bonds, look for new and more productive public-private solutions and extend the breadth and depth of research.

We need to do so not so much from professional interest, though that would be reason enough. Rather, we need to do so for our patients, the men, women and children who look to us for healing, for health, for hope.

I, for one, look forward to closer, richer, deeper collaboration in the days to come.

Medical Cooperation with Indonesia

The following is a Congratulatory Message delivered by Dr. Masami Ishii, Executive Board Member of the Japan Medical Association and Secretary General of CMAAO on the Opening and Endowment Ceremony of the Banguntapan 3rd Health Center, Yogyakarata, Indonesia on March 10, 2007. This health center was financially supported by the JMA.

Banguntapan 3rd Health Center, Yogyakarata, Indonesia

Greetings

Distinguished guests, ladies and gentlemen,

On behalf of the Japan Medical Association, it is an honor for me to say a few words on the occasion of the Opening and Endowment Ceremony for the Banguntapan 3rd Health Center.

Let me begin by offering my deepest sympathies for the victims of the Central Java Earthquake that occurred in May 2006 as well as expressing my deepest condolences to the families and friends of those who were lost. I would also like to express my heartfelt respect and admiration for all those who were able to make such strong efforts towards recovery after experiencing such devastation.

Directly following the Central Java Earthquake last year, the Japan Medical Association began to collect donations and quite a lot of donations were received from local medical associations throughout Japan. Of the total amount collected, 36.6 million yen, or about 300 thousand US dollars was provided to support the activities of AMDA (Association of Medical Doctors of Asia) and this Health Center was constructed based on this donation.

Japan is one of the most earthquake-prone countries in the world. Most notably, more than 6,000 lives were lost in the Great Hanshin-Awaji Earthquake of 1995, and all the members of JMA had been driven to extend their utmost efforts from its humanitarian standpoint to help the victims damaged by the Java Central Earthquake. As an academic organization, we believe one mission of the Japan Medical Association is to contribute to the advancement of medicine, and in particular that we should strive to improve health care irrespective of national boundaries or race, which is stated in the Declaration of Geneva of the World Medical Association. The construction of this Health Center with the cooperation of the AMDA reflects this philosophy of the JMA as well as the enthusiasm of the local people here.

This center is exchanging hands today, and it is my great hope that it will be used to great effect. We have asked the Indonesian Medical Association to provide technical advice as required, as we would be grateful for support to enable the stable operation of the center.

I hope from my heart that the construction of this Health Center will lead to further improvement and promotion of health of the people in Indonesia. I also strongly believe that our cooperative activities devoted to the establishment of this center will ensure much deeper friendship between our two nations in the future.

Thank you very much.

From the Editor's Desk

Visiting Indonesia

I visited Indonesia in early March of this year. As seen on page 195, the JMA made a financial donation to Indonesia to assist in the country's recovery from the tsunami it suffered in 2006. The money was collected from JMA members. Using this donation, the JMA built a health center near Yogyakarta on Java Island through the AMDA (Association of Medical Doctors in Asia) in early March of this year.

During this visit I met with Dr. Idris and Dr. Oetama, President and International Director, respectively, of the Indonesian Medical Association (IMA) as well as officers of the Health Ministry. It was also agreed between the IMA and JMA that the IMA would provide technical assistance for the activities of the health center. The JMA highly appreciates this offer of cooperation.

During my stay in Indonesia, I also heard about a "lotus land" which is said to exist somewhere in Indonesia, with moderate temperatures all the year round and an abundance of all kinds of foods including rice, fruits and vegetables. A fascinating country!

My overall impression was that the first step toward raising the basic level of healthcare in Indonesia as a whole is the effective use of abundant natural resources. I hope that the joint efforts of the Indonesian Medical Association and other health related public organizations will contribute to the further development of Indonesia.

Discussion at the office of the Indonesian Medical Association. From Left: President Idris and Dr. Oetama of the IMA. From right: Dr. Ishii, JMA and Dr. Suganami, Director of AMDA.

Appreciation of the JMA Journal

On the occasion of the publication of the JMA Journal Vol.50 No.1, which features the 1st WMA Asian-Pacific Regional Conference held in Tokyo on September, 2007, I received congratulatory letters from Dr. Yank Coble, Chair of Caring Physicians of the World Initiative, and Dr. Otmar Kloiber, Secretary General of the WMA, expressing their appreciation for the efforts of the JMA in supplying Japanese and overseas physicians with their own high-class journal for 50 years and producing an excellent proceedings of the WMA meeting, and also saying that this journal volume will serve as a very high standard for the future.

It is a great honor for me to receive such words of encouragement. To improve the contents of this journal, I always welcome the frank opinions from our readers.

Publication of a Japanese version of the "Medical Ethics Manual" of the WMA

The manual of the WMA was published in 2005 and has been translated into 12 languages. The JMA has also made efforts to publish a Japanese version which will soon be ready for distribution to all JMA members—around 160,000 in total. This version will be also presented to all the medical students in Japan. The publication of this manual is sure to be highly appreciated because it presents a kind of global standard for medical ethics with which healthcare professionals can learn how to cope with any problems which may arise in daily clinical settings.

The 27th Medical Congress of Japan

The Japanese Association of Medical Sciences held its General Congress in Osaka in early April of this year. More than 25,000 participants registered for this congress and the total number of attendees at the event reached about 200,000. During the congress period, the Korean Medical Association delegation visited this big meeting to gain information about its organizational and logistical aspects. The JMA officers and KMA delegation exchanged opinions about health problems and enjoyed the cherry blossoms in full bloom.

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