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d. Security of latrine.
e. Sanitation security of living quarters.
f. Sanitation security with children relative to individual mode of sanitation associated with food and living.

g. Environment sanitation security associated with gutter cleaning, removing pools and grass bushes surrounding the living quarters.
h. Advisability of requesting the earlier stage medical consultation.

4. Number of pieces of Educational Literature prepared:

a. At the time of the outbreak of epidemics (dysentery, typhoid, paratyphus) Preventive Medicine Guide for com unities: 1,000 pcs
b. Communicable diseases prevention easy reference: 2,000 pcs
c. Synopsis on how to guide the family members with dysentery patients: 3,000 pcs
d. Let us kill flies: 3,000 pcs
e. Let us keep our hands clean: 2,000 pcs
f. Sanitary home vs unsanitary home: 2,000 pcs
g. Responsibility for getting immunization: 2,000 pcs
h. Diseases outbreak from contaminated water: 2,000 pcs
i. The use of streams thus spreading epidemics: 2,000 pcs
j. Let us stop the spreading of epidemics of digestive organs which are liable to be spread by use of the streams: 1,000 pcs
k. Let us get rid of parasitic diseases: 3,000 pcs
l. Let us love our eyes: 3,000 pcs.

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INSECT AND RODENT CONTROL

By Clinton W. Allen
Sanitary Engineer
Kanto Civil Affairs Region

The problem of insect and rodent control in Japan are extremely numerous. One can hardly glance about the towns and villages without seeing some ideal condition for the increase breeding of these pests rather than for conditions which prohibit their breeding. A few examples of these ideal conditions should be mentioned. The general type of Japanese household architecture gives rodents a place to live and breed close to what sources of food are available, in comparative safety. The floors, walls, overhead ceiling arrangements, together with thatch roofs make any rat proofing arrangements of existing homes entirely impossible. The raised floors with accumulations of household goods tucked away between the pillars give ample hiding places for rodents as well as roosting places for mosquitoes and other insects. The extremely crowded conditions of housing areas makes elimination within districts very difficult as there is always the reentrance of rodents from other adjoining districts. The few large streets are in some instances barriers for rodents, but many towns and villages do not have large streets, thus no barriers. The streams going through towns and villages are so often crossed by bridges that they too fail to keep rodents out of the areas. The insect population have much in their favor to aid them. The present sliding doors prevents screening to any satisfactory degree. The tatamis only aid the insects in being an excellent hiding place. The semi open drainage allows mosquitoes to breed at over increasing large numbers if frequent cleaning

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is not carried out. The methods of human waste disposal, storage and use, all aid in spreading and in increasing the fly population. The lack of bathing facilities in many areas is conducive to keeping people away from bathing frequently. The charges while often low are enough of a hindrance to prevent the lower income bracket people from bathing as often as desired. Thus louse infestations are common from this factor as well as the economic factor of not having sufficient money to buy more than a single complete set of clothing. These are a few of the factors which make insect and rodent control extremely difficult. To add to these factors one has to take into consideration 1. the rice producing factor for large bodies of stagnant water, 2. the ideal weather conditions, long mild spring, hot damp summer, and in many areas mild winters all tending to aid the increase of insects as well as rodents.

Regardless of the obstacles which meet the persons engaged in this work the present plans and methods of control can be carried out to a satisfactory degree taking into consideration the aforementioned facts. However, there seems to be many factors concerned with this type of program which according to what I have found true which come under one of the following classes. First is the problems of budget; secondly, the problems of administration; thirdly, the problems of coordination and last, the problems of education. The entire program in which we are interested center around these four major topics, which of these is most important cannot be settled for they are of equal value and without proper studying of the entire problem from all sides a good program cannot be carried out.

Rather than give actual technical advice on insect and rodent control I would rather point out the common mistakes of this program.

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The problems of budgets should be undertaken at as early a time as possible based on previous experience and information. While the Welfare Ministry tends to reduce the activities as the program continues, it is up to the local prefecture to plan according to local conditions. Wherein, an area that special problems exist the possible budget from the Welfare Ministry is too small. Wage scales are also too low for metropolitan districts; however, this is governed for the entire area of Japan and a wage scale for a largely rural prefecture is not suitable for a metropolitan area. It is entirely up to the prefecture health department to set standards of pay which are suitable. If a higher standard is necessary such additions must be met by the local government. The importance of making an adequate pay scale cannot be over emphasized. A low scale will attract only the poorest type of workers and will result in a corresponding low type of work. Therefore, to stick to the definite ratio of pay each from the national government, prefecture and local government often invites trouble in carrying out the program. The arrangement for getting the correct amount of personnel and finding that there is not sufficient money is often the case. There is a definite need of coordination of the program between personnel and material to be used. Having the full quota of sanitary teams with no equipment or insecticides is of no use whatsoever. Teams equipped with poor sprayers and small quantities of material not only waste the material but also waste the labor cost too. Too often the teams can use their meager supplies in a few hours in the morning and waste the rest of the day. Proper use of available materials according to the conditions often results in tremendous savings. For example, the use of 5 DDT residual in streams of running water does very little good. Too much emphasis is often times

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placed on putting large amounts where a much smaller amount would be sufficient. With all this in mind, it is realized that with the best that is available and with its proper use it is nearly impossible to do all that is necessary. It is self evident that the large amount of work to be done is generally too much for the budget available. Therefore, it becomes necessary to place emphasis on that part of the program that does the most good for the greatest numbers of people.

The problems of administration of this program are extremely difficult to carry out. The main reason for this is the fact that the actual control work is done by small groups of men without too much direct supervision by the persons in charge. It then becomes imperative that each team chief as well as each member realize the importance of his job and strive to do his best at all times. This spirit of doing a good job is difficult to promote within a group of temporary laborers. The realization of the great amount of good that can be done should be one of the major aims of those in charge of the work. Another important factor in correct administration is the placing of responsibility of an area's condition on a definite team chief. An area should be the responsibility of a team for the entire summer. This is for two reasons. First, to allow the team members to get acquainted with all existing conditions within an area and secondly, to get the team to shoulder the responsibility of proper control measures being continually carried out.

Basically many of the health departments and health center personnel believe the sanitary teams are primarily an emergency measure. This is often times due to the inadequate supervision of the teams in other than in emergency cases. Weeks will go by with little or no interest shown of

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the teams activities and then a case of a communicable disease such as typhus breakout in the area and a great deal of attenti n is paid to the teams. The disease outbreak is over and again the teams are forgotten. The entire program is like a fire station which rests between fire, displays a lot of activity when a fire starts, and goes back to the fire station only to wait for another fire to break out. This idea should be done away with as soon as possible and the idea of a continuous program of day by day preventive work should take its place.

The prefecture people have another definite problem to combat in the placing of responsibility for parts of the program on the health centers and on the local city and town personnel. The need of making these local governing units feel their own responsibilities is truly great. Altogether too often nothing is done because the local government says that the prefecture authorities have not told us to do that. The need of having the sense of responsibility and the desire to correct the faults becomes a major issue in this program when local condition play the important part.

The entire sanitation program is always involved in the work of other sections of the local government. The engineering sections are involved in proper drainage, ditch repair and maintenance, and in removal of accumulated sludge in drainage ditches. The scavenger section's work of proper and frequent removal of garbage, trash, and nightsoil plays a very important part in insect control. The prefecture information sections are vitally interested in aiding any publicity campaign that the sanitation section needs. Schools are always a part of a well planned sanitary environmental improvement plan. In other words there are many section which are part of your program and without th ir aid the amount

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of work done is much less of effective. This coordination of those sections is not carried on to any extent in most prefectures. Often times when police help is necessary to satisfactorily carry out a program, the police are not even informed much less asked to help.

In order to realize any permanent improvement it is often times necessary to aid another section to secure money for a project. If all that the Public Health Section does is to report a needed repair job or ditch construction very often it is forgotten if the same program was worked out with the proper sections the condition could have perhaps been overcome. There is no need to say that nothing can be done by your section and forget about it. Many sections are only too willing to aid your program, but not if you do not try.

The final idea of education in this sanitary environmental program cannot be over emphasized. However, it should be of two main groups. First, the education of the personnel working directly with the health departments and secondly, much larger group, the general public. The group of persons working directly with the program need a much broader and complete knowledge of the control of insects and rodents, they must know why, where, and what for concerning all the details, techniques, etc. so as to be able to answer correctly all these matters. After proper instruction to these person, especially, the sanitary inspectors, assistant sanitary inspectors and sanitary team members they in turn must become teachers of all persons in their areas. Instructions to groups of housewives, school children, shopowners, and food processing plant owners are all a necessary part of the program. No program can be built up entirely of instruction, but without instruction your programs will

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never get the results necessary. Many of the people in Japan do not yet know the facts concerning disease and insects, do not know how the fly carries disease and some even like to think that their homes harbor rats. Until the many ideas of sanitation become known by the majority of the people and are practiced by them there will be no true advancement of environmental sanitation. Therefore, frequent refresher courses for all concerned are necessary as well as lectures and instructional periods.

Finally all public health personnel connected with the environmental sanitation program must realize that this type of work requires constant inspection surveillance and instruction. If the people in your various sections spend the great majority of their time in the office, they can be said not to be coming out their job. Constant work in the areas rather in the offices is necessary. In closing I wish to stress once again, proper budgets, education, administration and coordination will bring about improvements if all are worked out together after a complete knowledge of existing conditions in your areas are known.

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SUBJECT: The Five-Year Tuberculosis Control Program for Hokkaido and Its Progress

BY : Kazumaro Igarashi, M.D.
Chief, Communicable Disease Control Section,
Hokkaido Prefectural Office

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I. Progress and spread of tuberculosis in Hokkaido
II. Bases of the Five-Year Tuberculosis Control Program for Hokkaido
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B. BGG inoculation
C. Detection of early tuberculosis patients by means of mass examination
D. Popularization of the surgical treatment of tuberculosis
E. Home visiting by public health nurses
IV. Conclusion

I. Progress and spread of tuberculosis in Hokkaido

The progress and spread of tuberculosis in Hokkaido differs somewhat from the average of Japan, as regards mortality(Charts 1 and 2). Before 1931 the mortality rate of tuberculosis for Hokkaido was less than the average of all Japan, however, from 1931, the turning point, the mortality rate increased gradually to rise above the average. From 1937 when Hokkaido attained the second highest rate, it has progressed rapidly on this Island. That is, from the beginning of World War II tuberculosis entered the "stadium incrementi". During the final phase of the war, 1944, the mortality rate reached 306 per 100,000 populatien, the "stadium acme," following which it decreased until in 1947 it was 216, a reduction of 30%. But it was still the highest rate in Japan. Now Hokkaido along with a few other prefectures forms an area of wide spread tuberculosis in the northern part of Japan. However, I invite attention to the fact that the trend appears to have reached the "stadium decrementi" (Charts 3/1-3 and 4). If Hokkaido had already become a well developed country, such a trend should continue in the future also. However, at present Hokkaido is in the process of expansion; increased development of commerce, industry and mining as well as progress in the cultural field is expected, so we are aware of the possibility that the tuberculosis mortality rate may rise again. It should be noted (Charts 4 and 5/1-10), that there is a difference in mortality rate between the urban and rural areas, as well as among the administrative districts. In the rural areas, in so far as the spread of tuberculosis (mortality rate) is concerned the trend seems to be towards a gradual increase from 1948. At the same time in the center of low-affected areas there exist widely affected cities, for example the newly-developed cities, Yubari, Iwanizawa, Kushiro etc. We note therefore an increase of tuberculosis and we can find too a close

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Next I will explain the actual work which we did in the first year of the tuberculosis control program aimed at accomplishing the above.

III. The first year of the Five-Year Tuberculosis Control Program in Hokkaido:

A. Extension of tuberculosis control:

1. A Tuberculosis Control Committee has been organized in Hokkaido as a consulting group to the public. Its members are authorities in various fields and consultation may be political, scientific, etc.

2. Since health centers and Sanatoria are the first line of the battle field in the war against tuberculosis, their enlargement and extension receive first priority.

a. Concerning the staff and equipment of the health centers, Dr. Nishino, has already mentioned in detail, so I will say only that the number of physicians, public health nurses, and other technicians has shown more increase.

b. Each health center is now equiped with a 500 mA or 300 mA capacity X-ray and one or two indirect X-ray machines (Chart 9).

c. Culture of tubercle bacilli is now possible in 13 places and next year 20 places will be added to this category (Chart 10).

d. Enlargement of tuberculosis treatment facilities with increase of bed capacity. In 1948 the number of tuberculosis beds (tuberculosis sanatoria, National Hospitals, Red Cross Hospitals plus the University Hospital) was 3,250. This equalled one-third of the number of tuberculosis deaths in a year and was far below even one-half of the minimum requirement. In regard to their distribution (Chart 11 and 12/1-2) the majority of them are situated in the southern part of Hokkaido with very few in the north and east. So our plan was to correct this inequality and to establish at least the minimum number of beds needed. That is, the Prefecture will establish 750 beds; we anticipate a total of at least 4,000 beds at the end of five years. Over this same period we expect new construction at the National level and actually this is being accomplished (Chart 13). Now, in the second year of the Program the total number of tuberculosis beds is greater than estimated. This is very fortunate for us. However, on the other hand one-half of the open tuberculosis cases are living under very crowded conditions (Chart 20), where in the same family there may be a child less than 10 years of age, so that more and more tuberculosis beds are needed. At the same time attempts at solution of the living situation form part of our overall Prefectural program.

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3. Organization of private tuberculosis control associations and promotion of their activities. Basic in the program of tuberculosis control is public health education. To accomplish this purpose, private organizations are very important. A Public Health Education and a Women's Tuberculosis Control Association of Tuberculosis Committee for each health center has been established (Chart 21) and some of them are now quite active. At the same time the activities of the Tuberculosis Prevention Association (a foundational jurdical person) is expected to bring about great progress in education aimed at tuberculosis prevention and control in the near future. But accurate knowledge of Hokkaido people concerning tuberculosis is still poor (Chart 22). For example, in certain areas 48.2% of the people do not know about BCG and 19.5% believe that tuberculosis is an hereditary disease. Surely more and more education is needed.

B. BCG innoculation. Such immunization is one of the principal points in the Five-Year Control Program, however, despite the cooperation of health centers, industry and private practitioners it is impossible to carry out a 100% complete program. We have made an estimate of what should be accomplished (Chart 15) and allocated BCG according to such a schedule. BCG is allocated not only for the people requiring immunization according to the provisions of the Preventive Vaccination Law but also certain people older than the stated age are included, since it can be shown (Charts 14/1-5) that primary infection is occuring in the older age groups as well as in the younger. For this reason we are handling the more aged groups in the same manner as the younger. And we strongly favor the removal of the maximum age limit in BCG immunization. Unfortunately in 1949 it was impossible to perform the BCG program; as outlined we had so many disappointments and discrepancies. We are now making plans for improvement in the performance of these activities.

C. Detection of early tuberculosis patients by means of mass examination. 80% of the factories and companies are able to carry on mass tuberculosis examinations by themselves (Chart 16), employees of the other 20" of the factories and companies along with the general public, students and government employees are cared for by the health centers. In the past one obvious weak point has been the long time required to notify the examinee of the results of examination. This situation is now being remedied and arragements are being made for giving advice on the necessary patient care at the same time.

D. Popularization of the surgical treatment of tuberculosis. It is very unfortunate that even if patients desire surgical treatment of their disease, very few physicians will carry out such procedures. According to our survey about 1,000 patients receive treatment with artificial pneumothorax during 1948 in hospitals and health centers (excluding sanatoria and national hospitals). In 1949 we hoped for five times that number however the actual figure (Charts 17 and 18) are much less than expected so we must encourage physicians more and more.

E. Home visiting by public health nurses. All tuberculosis patients discovered by mass examination or revealed by the physician's reporting form who will receive treatment in the home should be visited by a public health nurse. However, public health nurses working in health centers number about 150 with an additional 150 employed by cities, towns, village, factories and companies. This makes a total of 300 public health nurses and it is far from

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relationship between coal mining and subsequent progress of commerce and industry and tuberculosis. For this reason I want to say that the development of new areas should be paralleled by a tuberculosis control program. In summary tuberculosis in Hokkaido is now in the number one position of Japan. However, in general the trend in Hokkaido seems to have entered the "stadium decrementi", but a consideration of economic expansion may lead one to expect a rising rate again.

II. Bases of the Five-Year Tuberculosis Control Program for Hokkaido. In line with the above mentioned reasoning we in the Hokkaido Prefectural Office decided upon a five year control program for tuberculosis as an important part of the general development project, aiming at a 50% reduction in the mortality rate over that period. At the same time the Welfare Ministry presented to the Nation a five year program in July 1948. Most important are the decision as to the possibility of attaining such results and the choice of methods of first priority for reducing the mortality after 5 years. And at the same time we must consider how by employing the present day level of preventive medicine and medical treatment techniques as practiced in Japan we should work out a method for attaining our goal. It is possible if considered according to the following bases and accomplished in line with the subsequent plans.

The main points of reference are:

1. Report of No. 8 Sub-committee, Science Promoting Committee, relating to the results of BCG innoculation.

2. Vital statistics of Ishikawa Prefecture and Sapporo (Chart 7).

First I want to explain the bases of this plan and the figures used in calculation. The whole population of Hokkaido may be divided into tuberculin positive and tuberculin negative groups. Next there are figures for new cases, the calculated number of tuberculosis patients, and the number of deaths by tuberculosis. We expect that as this plan is developed more widely year by year, the morbidity and mortality rate will demonstrate a progressive decrease. My calculations are as follows (Chart 8/1-2):

1. Each year the "natural" reversal to tuberculin positive is 8-10%.

2. The morbidity of the BCG innoculated group is about one-fourth that of the non-BCG inoculated group. The mortality of the BCG inoculated group is about one-tenth that of the non-BCG inoculated group.

3. Morbidity of the non-BCG inoculated group is 18%.

4. Morbidity of the tuberculin positive group will be decreased from 0.4% to 0.3% as the program develops.

5. Fatality will be decreased from 10% to 8% by employing methods advocated by the program.

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CORRECTION

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ideal. The number of open tuberculosis cases alone not directly under the supervision of a physician is estimated at 7,700. Home visiting for them can not be of sufficient frequency nor completeness. Since the number of public health nurses is so inadequate (Chart 19), for a solution we must wait for more nurses prepared under the new system. The public in addition to being very familiar with this system is highly desireous of its being carried out; we are therefore anxious to see the expansion of education facilities with consequent increased availability of public health nurses.

In summary we can say that in so far as enlargement of facilities and examination for possible patients is concerned, the first year has progressed according to schedule. On the other hand the shortage of physicians and public health nurses, the inadequate supply of BCG, and the lack of knowledge concerning tuberculosis has hindered the progress of this program.

IV. In conclusion, this Five-Year Tuberculosis Control Program has been set up as one of the bases of Hokkaido's general development project. The accomplishment of this program is of the upmost importance. Every deficiency or weakness must be made up or corrected as soon as possible. Fortunately the Prefectural budget is rather adequate (Chart 23 and 24) and in addition to this the Central Government has given us most generous assistance. We ask your continued favor in the future as we endevor to solve our problems.

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Questions and Answers Handled at the South Japan Public Health Conference at Osaka. These are supplied for your information.

DISCUSSION

Additional material and discussions will be shown in the recorded procedure of the Kinki Civil Affairs Region records of the conference (four recorders recorded in shorthand discussions which often amounted to a separate speech).

A composite list of questions turned in by the evening of 24 February was given to General Sams who indicated he would lead the formal discussions on the afternoon of 25 February. He conferred with Dr. Miki, Ministry of Welfare, in preparation of answers and announced that the answers could be considered as coming from SCAP and the Ministry of Welfare. General Sams expressed pleasure at the type of questions asked.

Questions and answers according to grouping were as stated below:

BUDGETARY

1. Q. Can money allocated by subsidy from Ministry of Welfare be paid quicker so that prefectures can make firm plans, get materials and begin the particular program on time?

A. The payment of a subsidy from the National Government in accordance with the laws is usually on the basis that prefectures or autonomous agencies entitled thereto may be reimbursed up to a stated percentage of money involved in a plan provided the Ministry of Welfare has approved it. It behooves the prefecture to have well-prepared plans submitted earlier to the Ministry of Welfare so that early action can be taken and avoid delays due to clarification of technical details.

2. Q. Small towns and cities need financial assistance from prefecture and National Government. Is there a publication that summarizes what money is available and how it may be applied for?

A. There is no one publication that gives such information, but every law passed by the Diet authorizing subsidies is augmented by ministerial ordinances which set forth rather precise information as to the intention of the subsidy and the requirements for obtaining grants from it. Every prefectural public health department should have a complete file of these laws and ordinances and should be able to assist small cities and towns in finding the validity of their requests and in helping in the proper preparation of their application.

PAY FOR PROFESSIONAL STAFF

1. Q. Will the National Personnel Act mean that the professional staff in public health departments and enterprizes will receive better pay?

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A. The National Personnel Act is being pushed for all employees working for the government; the rate of pay will depend upon the degree of qualification required by each job and it is expected that professional staff in public health institutions will receive better pay that is in line with their qualifications.

2. Q. When may such benefits be expected?

A. Classification of jobs so as to establish job ratings is a tremendous task. It is expected that it will be completed in a few months.

3. Q. Is it legal and advisable for prefectures or cities to give supplemental pay to the professional staff so as to make a larger total income with a greater chance of attracting well-trained personnel?

A. It is legal and advisable for this to be done and will serve as a way of keeping a better trained staff in public health for the next several months. After the job classifications are approved and rated it should no longer be necessary for prefectures and cities to give supplemental pay to their professional staff.

PROFESSIONAL TRAINING

1. Q. Will more public health subject be included in the curriculum at universities for their medical courses?

A. Yes. A conference on medical school curricula is being held in the very near future and more subjects directly related to public health will be included in the revised courses. It is hoped that a few universities will give post-graduate training in public health courses and that some years later that one or two, or a few universities will have a complete post-graduate schedule of public health with a separate faculty.

2. Q. Can the medical licensure examination be given to interns before they work at a health center to get practical experience? At present, they spend their time at the health center studying books for the examination instead of seeing clinical patients.

A. No. The national law requires that a medical student complete his internship before he takes his examination for licensure, if he has passed the licensure examination, he is no longer an intern.

VETERINARY (FOOD)

1. Q. Does the food sanitation law apply to fish?

A. Yes.

2. Q. Does any instruction from the Ministry of Agriculture and Forestry overrule food sanitation law in so far as they pertain to handling of fish?

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A. No ministry of the National Government has authority to issue an instruction which overrules a national law or to nullify an instruction from a co-equal ministry, consequently, the answer is no.

3. Q. What sanitation law applies to the handling of fish being caught while the fishing boat is at sea?

A. Fishing boats operate under instructions from the Ministry of Agriculture and Forestry and catch fish in a way so that they will be acceptable as food items when they arrive in a port. They must meet criteria for quality, as a food and food sanitation laws apply when the fish arrive at port.

TUBERCULOSIS

1. Q. Why is streptomycin not given to health centers so early cases of tuberculosis can be treated there.

A. Answer is in two parts:

(a) Tuberculosis patients receiving streptomycin must be hospitalized. Streptomycin is not yet plentiful in Japan and as a controlled item is considered best used in hospitals in accordance with established criteria.

(b) At a later date when streptomycin may become plentiful in Japan, it may be made available for treatment of tuberculosis cases at home where bed rest can be simultaneously provided under supervision.

VENEREAL DISEASE

1. Q. Does the Ministry of Welfare have any national program for the control of prostitutes?

A. No.

2. Q. What is the opinion of higher authority as to the legality of anti-prostitution laws passed at a prefectural or city level?

A. The answer is rather involved. An anti-prostitution bill was considered by the National Diet where it never came to a vote. This is a negative way of handling the subject with the implication that the Diet thereby refuses to prohibit voluntary prostituion. A fine legal point therefore arises. In accordance with the local Autonomy Law, does such a negative action on the part of the Diet therefore prohibit local assemblies from taking positive action by passing local legislation and if such legislation is passed is it unconstitutional in view of the implied adverse action on the part of the Diet? Some local bodies have passed anti-prostitution laws. The answer may be obtained if someone enters suit against the arresting body under the local anti-prostitution law and the case should then be taken to the Supreme Court for a decision as to whether such a law is contrary to the provisions of the constitution based on interpretation of the legal points stated above.

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3. Q. Can penicillin be more generously supplied instead of mapharsen in treating venereal disease patients of a non-paying or a low-paying status?

A. This question is being considered, and it is expected that penicillin will be more generously supplied for the treatment of venereal patients. The present ministerial instruction for treatment of early suspects is bismuth and mapharsen, and this will be changed to the use of penicillin. This change should reach the prefecture through ministerial instruction within the next month or two.

4. Q. What is the attitude of higher authority on having prefectures issue cards to prostitutes showing that they have been given physical examinations?

A. Such cards are worthless and should not be given by a prefecture. A status of not being infected at the time of examinations may not be true fifteen minutes later.

Although this does not pertain to a specific question, I want to point out relation of military police activities in venereal disease control. SCAP has recently seen fit to issue instructions to all commanders of tactical troops saying that military police may accompany Japanese police to prevent soldiers from interfering with Japanese police if they are carrying out venereal disease law. Military police may also go into "off limits" establishments or accompany Japanese police to arrest occupation personnel that are violating occupation directives. The military police have no other function in this program so far as enforcement of the Japanese law is concerned.

By the above action SCAP has placed a great deal of confidence in the Japanese public health authorities to control venereal disease and to do effective contact tracing. It is up to you, the prefectural public health officers, to see to it that your actions are such as to merit the confidence that the Supreme Commander has indicated he has in you.

REPORTS

1. Q. Are all of the reports required by the National Government really necessary? We have too few clerks and we need our money for professional services.

A. Many times reports are required by law and other reports often remain in force for a long time after the condition upon which their inauguration was made has ceased to exist. It is a good practice to have an experienced committee review all reports required from lower echelons and to eliminate all reports no longer required. This review may be made every six months and it should be made at least once a year. Dr. Miki, when he returns to Tokyo, will set up such a committee to review reports and will eliminate all those felt to be no longer necessary.

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JURISDICTION

1. Q. By what authority can the prefectural health department direct the activities of public health employees such as sanitary teams which are paid by the city?

A. The answer to this is in several laws such as the health center laws, medical service laws and the autonomy laws. When the national government places responsibilities, they are placed upon the prefectural governor even though some cities have certain activities that they carry on quite independently. This concept in no way lessens the responsibility ultimately resting in governor of the prefecture, and if the separate governmental bodies such as a city fail in any way to accomplish what the law requires, the prefectural governor may take away those privileges which the city has failed to live up to. If a sanitary team in a city failed to accomplish what is considered necessary to meet the provisions of the law, the prefectural health officer should report that fact to the governor who would in turn instruct the mayor to have the sanitary team accomplish those things deemed necessary to meet the requirements of the law. If the mayor failed to accomplish this, the governor could then withdraw the privilege of the mayor of directing such an operation and the prefecture would take over.

2. Q. Is a city by reason if the Autonomy Law permitted to operate independently of the prefecture?

A. This question is very similar to the preceding question, and the answer is that the governor delegates certain responsibilities to the mayor; if measures are not properly executed to comply with laws, the delegated authority may be taken back by the prefecture governor so as to insure that the laws in his prefecture are properly executed. This was necessary in one of the northern prefectures recently when the governor had to take over operation of some health activities in the city for the prevention of disease.

3. Q. Where a town or village health department is "old-fashioned" does the health center district director have the authority to correct these "old-fashioned" departments.

A. It is a little hard to determine just what "old-fashioned" means, but it is assumed that it means inefficiency or inability to carry out public health measures required by law. If this is true, the health center director does have the authority to correct such deficient organizations. He should go to the mayor of the town or village and point out how laws are not being met with and what must be done. The health center law makes a health center director responsible for his district.

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SUBJECT: Public Health Administration in Hokkaido

BY : Mutsuo Nishino, M. D.
Director, Health Affairs Department
Hokkaido Prefectural Office

Due to the limitation of time I am unable to speak about the general subject of public health administration as it applies to all prefectures, so I will confine myself to such administration in Hokkaido.

I. Introduction.

Public health administrative policy in Hokkaido as in other prefectures is under the supervision of the Welfare Ministry. But taking into account the following three distinctive characteristics a unique plan of public health has been established for this area.

A. Hokkaido is located in the so-called subfrigid zone of the north with snowfall observed six months of every year.

B. Hokkaido occupies 21% of the total land surface of Japan, an area greater than all the six prefectures of Tohoku District plus Niigata Prefecture.

C. Hokkaido as an island colony dates back only to the beginning of the Meiji Era. Large numbers of people continue to immigrate year by year: adding to this the natural population increase plus repatriate families and one notes a rapidly expanding population.

To accomplish the general political administration of Hokkaido there are fourteen basic units, the subprefectures. However in the field of publid health administration health centers exist distinct from the subprefectures; under these health centers there are 15 cities, 73 towns and 190 villages with a total population of about 4,200,000.

II. General character of public health administration and budget.

A Health Affairs Department was created in Hokkaido in November 1946 with five Sections: Medical Affairs, Chronic Communicable Disease Control, Acute Communicable Disease Control, Public Health and Pharmaceutical Affairs. Following this innauguration the scope of public health activities expanded rapidly until reorganization of the Department had to be accomplished in order to cope with this increased responsibility. So in July 1949 the following five Sections emerged: Medical Affairs, Communicable Disease Control, Environmental Sanitation, Health Instruction and Pharmaceutical

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Affairs. Basically this reorganization eliminated Acute Communicable Disease Control as a distinct Section and created a Health Instruction Section aimed at assigning first priority to health education.

The basic units for the accomplishment of all public health activities are the 35 prefectural Health Centers plus their 20 branches and the three municipal centers. In addition there are a Prefectural Public Health Institute (Laboratory), Prefectural Foods Research Institute, the Prefectural Sapporo Medical University, and Prefectural Public Health Nursing School under the direct supervision of the Health Affairs Department. As for medical treatment facilities, eight hospitals, twenty clinics, four tuberculosis sanatoria, and six venereal disease hospitals (one for the treatment of prostitutes exclusively) are operated directly by the Department.

In the Department there are 2026 positions with 1641 individuals employed at the present time. Notable vacancies exist among health center physicians and other persons requiring technical training.

Next, in regard to budget it should be noted that money spent for the public's health differs from that put out for example in civil engineering projects because in general the public does not see such concrete results as a building or other structure. Therefore careful attention to the budget is necessary to assure wise spending in the face of a lack of local wealth and the National Government's long standing colonial attitude towards Hokkaido. As a consequence the level of culture and of public health lagged far behind during Hokkaido's past. However in recent years, with the advisory assistance of the Occupation Forces, the money appropriated for public health measures has been increased greatly. In the 1945 fiscal year the budget of the Health Affairs Department, including salaries, constituted 1.5% of the total Prefectural appropriations; in 1946, 2.0%; in 1947, 2.8%, in 1948, 3.4%. In the 1949 fiscal year the proportion of the total budget allocated to the Department constituted 6%. For 1950 the first request was for 8.0% of the total budget or ¥1,043,000,000. Our aim in order to accomplish public health activities smoothly is a minimum of 12%.

III. Characteristics of public health administration in Hokkaido.

A. The program of aid to communities without physicians.

As I mentioned above the area of Hokkaido is large, on the other hand the population is small, but 5% of all Japan. Population density is 51 per square kilometer, one-sixth of that of Honshu. The number of physicians in Hokkaido is 2324, one per 33.76 square kilometers or one per 1800 population as of October 1949. Compared with Honshu each physician covers an area 3.3 times as great in Hokkaido and is responsible for 1.7 times as many people. These figures indicate a real shortage and a real problem for us.

In the past the single institution for medical education, Hokkaido University, was not able to make up this deficit of physicians. A Prefectural Women's Medical College was in operation from 1947 but admitted its last freshmen class in 1947. Finally we have been able to establish a Prefectural

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Medical University and place it in operation from April of this year; this should aid greatly in reducing the existing shortage.

35% of the nurses in Hokkaido are the so-called "practical nurse" (minarai Kangofu). In compliance with the provisions of the new law these nurses must cease practicing with a resultant marked shortage of nurses in Hokkaido. Six A Class Nursing Schools and 18 B Class Schools have requested accreditation, a total of 575 graduates each year. During March permission was received from the Welfare Ministry for the opening of five of the six A Class Schools but for none of the B Class. With permission denied all B Class Schools, but 190 nurses will be graduated each year with consequent serious difficulty in performing medical service. We would like to secure immediate permission from the Welfare Ministry for the operation of these B Class Schools.

Hospitals number 208 with 12,322 beds; there are 1263 clinics with 3625 beds. As I mentioned before a general shortage of physicians exists aggravated by their concentration in cities. Five villages and 170 communities of more than 500 population are without doctors. In 1948, aiming at a solution to this problem, we outlined a Four Year Plan which included the establishment of thirty Prefectural Clinics. At the present twenty clinics are in operation and five more will be added during the 1950 fiscal year. Paralleling this program we have medical teams visiting 161 communities, serving a population of 160,000. Here in Hokkaido in the summer of 1948 we instituted hospital inspection under the supervision of Civil Affairs starting with the coal mine hospitals. From February 1949 we inspected other hospitals even prior to the receipt of the Welfare Ministry memorandum.

B. Expansion of the health centers.

As mentioned previously this large Island is divided into 38 public health administrative districts. As a result a health center district may be quite extensive. Adding to this the difficulty of communication, the operation of public health administration may indeed be quite a problem. For example, Bekkai Health Center District is larger than the whole of Kagawa Prefecture, and there are certain adjoining islands which are completely isolated from the mainland during the winter months. Therefore the general rule which states that there should be one health center per 100,000 population is not strictly applicable to Hokkaido. This year we innaugurated the Four Year Health Center Program intending to add 23 new centers to the 38 already existing. Not only in quantity but also in quality out health centers must differ from those of other Prefectures. That is, special construction is required for added warmth, for the prevention of freezing, and of damage from the deep snow not only in the main buildings but also in the attached living quarters. Tsubo for tsubo the cost is about twice that of prefectures in warmer areas. We therefore encounter greater difficulty in the construction of new buildings, in maintenance, and in the repair of snow damage. A standardized budget based on tsubo size creates a greater problem for us in comparison with other prefectures.

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Securing the staff for our health centers is not easy because of the difficult natural conditions, the reduced social life, and the poor living situation. This may be different from other prefectures. At the present time we have 23 full time directors and twelve additional full time physicians. As for living quarters, provision has been made for 31% of the subprefectural officials, 19% of the engineering officials, 13% of the labor office officials but only 6% of the health center officials are currently accomodated. This in itself explains away a good part of the shortage of health center personnel. It is believed that a Central Government subsidy is necessary for the construction of living quarters.

In regard to the physicians' salary several attempts have been made to secure increases from the Welfare Ministry without any basic solution to date. Therefore from August 1949 the Prefecture from its meager budget has been paying out a ¥5000 a month research fee as a temporizing measure. We are hopeful for a basic improvement from the Central Government level.

To compensate for the poor communication facilities each health center should have a powerful and sure means of transportation. In certain health center districts a single visit entirely within the area of jurisdiction for the purpose of a careful communicable disease survey, a public health nursing visit, or a simple inspection may require three days. At present 25 automobiles are available for traisportation and during the next fiscal year this number will be increased to 35. As noted above our transportation fee must necessarily be greater than that of other prefectures; we hope that the Welfare Ministry can readily understand this point.

III. Health Education.

There is a vast difference between the levels of health knowledge of the urban and rural population in Hokkaido. In the money appropriated for the work of our Department a decrease can be noted in the ratio of the budget for communicable disease control to that for health education. It indicates an increased awareness of the necessity for good health education especially in the rural areas. We employ a mobile health museum in addition to the usual exhibitions, and this museum has travelled over the entire Island. Through this museum we present educational material on tuberculosis, venereal disease, maternal and child health, nutrition, and the summer communicable diseases. A portion devoted to environmental sanitation is currently under construction. Each section costs between ¥400,000 to ¥500,000 which is a rough estimate of how highly we value its worth. A Prefectural Health Museum for Sapporo is presently being planned.

IV. Pharmaceutical Affairs.

More than one-half of all the area devoted to the cultivation of medicinal plants in Japan is located in Hokkaido. The future of this industry appears bright. In order to increase this production we secured 30 chobu of land with the assistance of the National Government and established

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a Prefectural farm for the cultivation of medicinal plants. On the other hand the money spent on the purchase of medicines in one year here in Hokkaido reaches about ¥3 billion, all of it being imported in its final form from other prefectures. Hokkaido has many natural resources, coal, marine, agricultural and forestry products, therefore it is necessary to establish a school of pharmacy or a pharmaceutical research laboratory. Our intent is to have a pharmaceutical college in the Hokkaido Prefectural Medical University; from this year out budget provides for the training of technicians in the field of pharmacy.

Hokkaido has established its own minimum standards in the assay of medicines, cosmetics, and sanitary products. Passing the assay entitles that product to bear the Prefectural certificate which is affixed to the label.

V. Tuberculosis control.

This is Hokkaido's number one public health activity and a Five Year Tuberculosis Control Program has been established and is currently in operation. Concerning this program Dr. Igarashi, Chief of the Communicable Disease Control Section will offer a brief explanation tomorrow.

VI. Improvement of environmental sanitation.

Many discrepancies exist among the laws and ordinances pertaining to food sanitation, insect and rodent control, environmental sanitation and water works; their weak points must be compensated for by vigorous health education. In line with noted improvements the incidence of communicable disease has demonstrated a marked decrease. Following is a good example of what I mean: The Horonai Coal Mine had been plagued by the outbreak of many intestinal diseases each year until 1949 when every member of this coal mine community participated in an insect and rodent control and general clean-up program. The results were excellent, not a single case of intestinal disease and no mosquitoes in the area. And by this example we may learn that it is cheaper to spend money for complete prevention than it is for partial control. Next, it may be noted that there are several separate fishing seasons in Hokkaido, e. g. the herring and atko mackerel in the spring. Such intensive fishing with large catches in a short period renders the maintenance of sanitary conditions difficult. It would be advantageous to extend the jurisdiction of the Food Sanitation Law to include the fishing vessels and seashore. Hokkaido possesses large marine and dairy product industries so it must carry on a complete inspection service and good leadership.

Hokkaido being blanketed with a deep snow for a six month stretch with the accumulation of mountains of ashes during this shut-in period, experiences a more difficult Spring clean-up program compared with other prefectures. April and May are given over to cleaning up with sanitary inspectors and teams working diligently. As for the water works, we are advocating the chlorination of drinking water and at the same time are

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offering instruction t technicians in the performance of bacteriological and chemical examinations. The greatest difficulty in the administration of the water works program stems from the absence of a single unified controlling law. We intend, therefore, to establish a Prefectural regulation which will extend even to the more simple water works.

VII. Health problems unique to the Cold Zone.

A. Rickets prevention and control program.

In 1949 an infant survey of 2276 children revealed the presence of 929 suspicious or proven cases of rickets; this equals 40.9% of those examined. The principle causes are attributable to the shortage of sunlight and the mode of living during the winter. In our prevention and control program early detection while the disease is still in its initial stages, and early treatment, along with improvement in living conditions and diet are considered most essential. At the same time we are teaching the public the value of liver oil in the prevention of disease.

B. Influence of acid soil and mist.

In Hokkaido there are many peat-bog, acid soil, and volcanic ash areas. Professor Inouye of the Hokkaido University is conducting research into these problems with the aid of the Prefecture.

The mist observed during the months of June, July and August hanging over the Pacific coastline bears a close relation to the rickets problem as well as to other infant health programs. The Health Affairs Department intends to carry out a survey of this problem also.

C. Housing problem in the Cold Zone.

A consideration of the health aspects of housing in this cold area has prompted a survey into the actual status of farm homes in eleven areas; 330 houses were investigated. A study of the best form of house construction, of eight different kinds of heating apparatus, of stoves, and of optimum arrangement of homes for the cold zone is currently being conducted. The results of this study will be made public and utilized as the basis for education as to the most suitable construction for dwellers in Hokkaido.

Another study concerning nutrition in the cold zone is being carried out under the leadership of the Prefectural Foods Research Institute with popularization of the results as soon as they are known.

This investigation into the effects of acid soil and study of housing in the cold zone were made known to the Japan Academy of Public Health in September 1949.

VIII. Communication between the Central Government and the prefectures.

Since Hokkaido is located at a great distance from the seat of the

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Central Government, communication and transportation are extremely difficult. Not a small amount of money is spent, time wasted, nor difficulty encountered for these reasons alone. We are desirous of a scientific policy adaptable to the local situation and would welcome your sage advice.

IX. Conclusion.

I have already talked about public health administration, budget, and Hokkaido's distinctive character which sets it apart from other prefectures. Due to the shortage of time I have cut my remarks pertaining to the population problem, however, I want to add a few words concerning this.

In concluding I wish to point out the extreme importance of the population program. To accommodate an expanding population in this country, Hokkaido must be cultivated. From the viewpoint of area as well as natural resources, this is the only possible solution. The Central Government, therefore, is sharing actively in the cultivation of land areas and the expansion of industries in Hokkaido, but little interest is being evidenced in its cultural development or a consideration of basic public health.

Important, too, is the Central Government's awareness of the geographical configuration of Japan with its great north-south extent and consequent modification of its rigid, uniform policy for warm Kyushu in the south and cold Hokkaido in the North.

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PRESENT SITUATION IN NATIONAL HEALTH AND POLICIES FOR THE FUTURE

By Dr. Y. Miki
Chief, Public Health Bureau, Ministry of Welfare

It is four years and a half since the war ended; it is true that time flies like an arrow. We can never thank General Sams and his staff and officials of the Civil Affairs Regions enough for their extensive guidance as to every aspect of public health in Japan.

Recently the General Headquarters decided that the policy of Japan's self-support should be pursued, and it becomes necessary for us to do things gradually in an autonomous way though we have been prone to depend upon PHW in our works.

Under these circumstances, I have a high regard to this timely plan of holding the meeting at which responsible men of both the Civil Affairs Regions and Japanese side, who are in charge of P.H. matters, assemble and have lectures and discussions to recognize the present situation of Japan's public health and, further, to make out future plans. I feel very grateful for being given the opportunity to express my opinion here at this meeting.

In the various activities of disease prevention, and health promotion in this country, a sign of promising future development was observed at the beginning of Showa era, about twenty years ago. But soon after that, with the outbreak of a series of wars which lasted long and ended in the termination of the Pacific War, not only these activities were greatly misled but also, the promising sprout of the future development withered away by the demand of the government at the time.

However, with the termination of the war, SCAP gave us under occupation an earnest guidance; a new public health movement on the principle of democracy has been rapidly developed and reinforced, and on the other hand a marvelous attainment has been done by the efforts made by you who have the direct responsibility for the local field activities.

In the case of infectious disease prevention, for instance, the contraction rate of the legally designated infectious diseases had been showing a gradually increasing tendency for a time since over ten years ago; especially, immediately before and after the end of the War, an unprecedented spread of epidemics resulted from the social turmoil at that time to endanger the national hygienic life, but with the proper directions as well as the effective release of DDT and other materials by the PHW authorities, the crisis was surmounted in a very short time. Furthermore, the number of infectious cases was drastically decreased to an extent never attained before in this country.

And yet, it is regretable that the total number and contraction rate of the legally designated infectious diseases decreased in a degree last year, as compared with those for the year before last, but, ~~that increase was~~ there was an increase accounted for by the increase of dysentery cases; other diseases generally showed a steady decrease.

We think that the prevention of infectious disease has come to a stage of stabilization, and we would like to make a new start this year in the field of this work.

For this purpose, I think, we must, from this year, improve our mode of epidemic prevention activities in which we were liable to adopt an allopathic method, and must develop our activities into a perpetual and premeditated epidemic prevention movement. In order to attain this aim, epidemics prevention works must closely be linked with rat and insect extermination works, and with hygienic observance over water mains and sewers. This combined work should be organically operated under a synthetic plan, and the result thus to be obtained will be enlarged by the active cooperation of examination and inspection institutions and of persons in charge of hygienic education. In this way I would like to push drastic measures.

As anticipated, production examinations of vaccines will realize its long-waited-for status, this will go a long way with the epidemic prevention works, above all, with the one against whooping-cough, which in Japan shows a death rate as high as over 15 times that of U.S.A. and with the one against diphtheria, which shows as high as over six times. I hope this will play an important role in decreasing the infant death rate of this country.

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As to tuberculosis, which is the first in the order of death causes in this country, of which a great concern was shown in the Diet of late, I regret very much that about 110,000 persons died during last year from this disease of which death rate was 13.6, over three to four times more of those of U.S.A. and England, though the above figures in this country showed a result of deceasing tendency up to last year. It goes without saying that stabilization of the national economy, elevation of livelihood standard, and establishment of social security system are essential as fundamental requirements for the improvement of this situation, but at the present time, those fundamental requirements will not be met in the near future and it is necessary for the present that a thoroughgoing dissemination about collective medical examination and health administration should be pursued. On the other hand, guidance of medical treatment should be carried out properly by increasing the accomodations for tuberculosis in-patients. At the same time, those who are under treatment at home must be given proper instructions by visiting doctors; guidance as to recuperation should also be given; thus the spread and recurrence of this disease should be prevented. The above-mentioned facilities and manpower directly relating to the prevention of tuberculosis are needed to be enlarged and strengthened, in line with this we are contemplating the revision of the Tuberculosis Prevention Law.

It can be pointed out that the prevention of venereal disease has come to be directed to people in general, instead of former emphasis upon prostitutes, and to obtain further attainment in this line of work, this year, we have in mind that the operation of V.D. hospitals and attached clinics to the health centers should be changed, and the strength of officials exclusively in charge of V.D. prevention at the health centers should be reinforced, and they should be technically trained to increase their ability of examining contacted persons and in dissemination of V.D. prevention.

I expect a big jump in the reinforcement of organization and personnel of the health center which is the core of various epidemic prevention activities this year. The plan under contemplation for 1950 fiscal year is: (1) to set up 15 new health centers; (2) to increase the number of A-class health centers (46 at present) to 150; (3) to raise 313 unclassed health centers to C-class; and (4) to increase 10,000 more persons (about 30% to the present number) in health centers. By this, I hope, the strength of the whole public health activities will be reinforced, and thus we will make more effort to realize the ideal of the health center.

Now, turning to environmental health, this item forms a defect in Japan's public health as was pointed out in the recommendation concerning social security: though we started this phase of activity under the guidance of GHQ, yet further energetic effort will have to be made hereafter. Water-mains, sewers, rats, insects, cleaning, as well as hygiene are the objects not only relating to epidemic prevention but also of the fundamental problem of the public health, and at the same time of the basis upon which people may enjoy a pleasant and cultured living. This item will occupy the largest portion in our future program of public health.

To conclude my speech, I should like to express my heartfelt thanks to General Sams and his staff and to the dignitaries from the Civil Affairs Regions for their valued suggestions in obtaining the epoch-making attainment of public health of today, and we earnestly solicit a continuance of their assistance.

And, now to the chiefs of the Health Divisions, I hope we will combine our effort in line with the policy of Japan's self-support to lessen, at least, the causes to trouble GHQ and the Civil Affairs Regions.

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this one!

WATER SUPPLY AND PUBLIC HEALTH IN JAPAN

Mr. Van K. Tharp, Sanitary Engineer,
Tohoku Civil Affairs Region

Less than 12% of the population of the combined Tohoku and Hokkaido Regions obtain their water supply from municipal or other forms of public water-works. I cannot speak for the rest of Japan, but I doubt if more than 16% of all the persons in Japan have access to such public water supply!

So far as I can determine, there has been no outbreak of enteric diseases traced to such public water supply in Tohoku or Hokkaido during the past three years. For earlier periods or for the rest of Japan, I am not qualified to speak. But again I doubt if any of the larger public water supplies can be blamed for such outbreaks anywhere in Japan in the past few years.

I can truthfully state that other sources of water supply have caused many outbreaks and several epidemics of enteric diseases in the past two or three years. Such outbreaks are becoming even more frequent!

At least 80% of the persons in Japan are obtaining water for domestic purposes from private dug wells; drainage and fire ditches; and even sink holes and paddy fields. Almost every month we hear of dysentery cases traced to these sources of water supply. Yet American sanitary engineers and Japanese health officials go merrily on . . . and . . . on . . . !

Inspecting well designed, well operated, and well staffed public water-works. They spend their time talking expansions and repairs that are economically unsound and impractical at the moment. They see a housewife dipping water from an irrigation ditch; they see a child washing dishes in the combination fire and drainage ditch and shrug their shoulders . . . . They make long range (perhaps 25 years) plans to expand the local waterworks. But they forget, or ignore, the present loud crying need of the Japanese housewife for WATER . . . GOOD WATER . . . NOW!!

Yes . . . I know . . . Subsidies for waterworks are out! But do we need subsidies to teach the farmer and villager that clear and running water is not necessarily good drinking water? We need the <u>will</u> and the driving power to educate!

We need to, perhaps, re-educate. In my earlier years in Japan, I cannot remember of once seeing a Japanese drink plain water. He always drank tea, or some other form of boiled water. Now I see Japanese drinking water from streams, ditches and wells every day. The tea drinking of Japan, and the Orient, had its start in the knowledge that water boiled and made into tea was safe to drink.

But there are other ways to make water safe, without the wishful thinking of expensive water plants. It has all been written in books and papers that we have all read at one time or another. There is no need to repeat it now. What we all need to do is stop, think, then go to work in the proper direction.

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Two prefectures in Tohoku, and several areas in Hokkaido, have taken the first step in the proper direction. They have started surveys and are compiling data on private wells and other miscellaneous sources of domestic water in their respective areas. They have determined the number of wells in the area, have made examinations, and have listed the wells as:

a. Producing potable water, safe for all domestic purposes.

b. Producing water which is potable most of the time but should be boiled or chlorinated before using "raw".

c. Producing water which is not safe - - and should not be used!

We hope that they will not stop with this first step, but will go on, and take measures to improve these sources which supply the vast majority of Japan's population with water.

I do not mean to insinuate that we should drop all work and activities in regard to the public or municipal waterworks. There is much to be done in that field. But let us be practical. Make programs for long range work within the economy of the individual location.

At the same time we can work for the coordination of the various government agencies responsible for designing, construction, operation, management, and finance of waterworks projects. At present we have the Welfare Ministry and Construction Ministry interested in city owned works with neither knowing just what the other is doing, nor agreeing upon standards. The Railroad and Mining Bureau are also interested in certain types of public water supply. Even Labor Standards officials are concerned at times, and establish their own standards.

Yes . . . . We have plenty of problems in water supply. But the most important problem of the moment is to improve the small, individual sources of water used by greatest number of persons in our respective areas. . . . The well . . . . The spring . . . The "ditch". We must teach the population why they must protect their water supply . . . . Why a safe water supply is necessary . . . . How an unsafe supply effects them PERSONALLY! We must teach them how to construct safe wells, how to maintain those wells, and protect them from future contamination . . . . .

These are the problems that most concern the majority of public health officers of Northern Japan today.

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c

Home Care of The Tuberculosis Patient

Sada Miura

The responsibility of the public health nurse who gives a nursing service to the tuberculosis patient in the home is very great because it is a family disease and a communicable disease. However, good tuberculosis nursing care for these patients is lacking in both quality and quantity. This is a subject which should be given much more study.

1. Before discussing the home care of the tuberculosis patient in the home and mentioning this care as it is given in Japan, I would like to briefly mention the functions of the public health nurse in a tuberculosis control program.

a. The nurse assists in finding patients and contacts and in securing medical examination and supervision for them.

Case finding is one of the most important functions of the public health nurse. When making home visits she should always ask if any members of the family have been exposed to the disease or if any of them have symptoms of tuberculosis. Public health nurses often learn of these symtpms or of some past exposure while the patient is talking so they should listen carefully and ask a few questions which will bring out this information.

They must encourage patients who have symptoms or who have been exposed to the disease to seek medical care by explaining the importance of early diagnosis and early treatment. Some of these patients are afraid and some are not afraid enough, so we must use methods of approach which will suit the situation.

b. The nurse assists in making epidemiological investigations.

The purpose of this investigation is to discover the source of the infection or other possible cases of the disease and to get an accurate history of the patient's illness on which the doctor can base a diagnosis.

c. To assist in securing reporting of all cases.

The reporting is not a responsibility of the nurse but she can help collect the necessary information for reporting of cases.

d. To give or arrange for necessary nursing care.

The nurse helps the family to plan for the patients nursing care. She teaches some nursing to the person who can best give this care to the patient. It is necessary to teach this nursing care and isolation technique to the attendant by actual demonstration. The nurse must also teach healthful living habits which are necessary for the patient and his family.

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The number of home visits which will be necessary in order to teach these things will depend upon:

The policy of the health center.
The stage of the disease.
Home conditions (intelligence of the family, economic ststus, emotional reaction to the disease)
Number and age of contacts.
Success of the nurse's teaching.

e. To help arrange for sanatorium care, post sanatorium care and rehabilitation of the patient.

The doctor has the responsibility of deciding where the patient should be treated but the nurse can give him information which will help him make a wise decision. She can describe to him the home environment, and the health of the other members of the family.

She helps plan this patient's care with his family when he returns from the sanatorium so that he will continue to follow the schedule recommended for him by the sanatorium physicians.

f. The nurse helps the patient and family maintain an emotional and social adjustment toward a long term communicable disease.

She must give the patient and his family a real understanding of tuberculosis to calm their fears and correct misunderstandings which they may have regarding the disease. She can help the family to understand the patients feelings and mental insecurity.

She helps them secure necessary help from social agencies to solve their social and economic problems.

g. The nurse helps to educate the public concerning unmet needs of the community for the prevention, control and cure of tuberculosis.

The nurse should explain to the public that it is desirable for the patient to enter a sanatorium to protect the family and the community and that the sanatoriums at present are very inadequate.

She should use every opportunity to teach individuals and groups about the disease so that they will establish general health habits which will protect them from tuberculosis.

h. The nurse assists in coordinating the services of clinics, sanatoria, private physicians, the health center and other related health and social agencies.

Tuberculosis as a long term communicable disease, cannot be effectively controlled without the close cooperation of all of these Community resources.

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A good working relationship between these agencies will prevent duplication of service and gaps in the service and will help to avoid confusion regarding instructions in the mind of the patient.

2. Home care of the Tuberculosis Patient

The tuberculosis patient who stays at home should always be under the supervision of a physician. The public health nurse interprets the doctors orders and gives and teaches nursing care to the patient and his family by visiting in the home. The first things she must consider when teaching this nursing care are isolation, rest and the mental and physical comfort of the patient.

a. Isolation unit set-up.

When setting up an isolation unit the nurses arrange the things which the patient needs in his daily life within a certain limited place and removes all things from that place which he does not need. The nurse can secure the family's understanding and cooperation by thoroughly explaining the reasons for the isolation of the patient.

It is desirable to have a separate room for the patient but if this is not possible the patient can be isolated by putting a screen or a curtain around the unit.

Some articles which should be in the isolation unit are:

1) Patient's toilet articles (bath basin, soap, comb, toothbrush and basin for rinsing mouth)
2) Bed pan and urinal
3) Bedside table.
4) Bottle for water and glass.
5) Paper tissues and paper bag.
6) Thermometer.
7) Dishes and tray
8) Rice steamer for sterilizing dishes.
9) Attendant's hand washing set-up. (Table, basin, soap and soap dish, pitcher for clean water.)
10) Bucket for liquid waste
11) Waste basket
12) Container for soiled linen.
13) Bell for calling attendant.
14) Attendant's apron
15) Towels
16) A few comfort devices such as air cushion, small pillows, foot support and back rest if they are needed.

b. Isolation technique

Putting the patient in a separate room means nothing if the patient,

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the family and the attendant do not keep certain techniques. Some of the most important of these are:

1) Proper handling and disposal of the patients sputum. The nose and mouth should be well covered with paper tissue when the patient coughs. He should expectorate into the paper tissue, put the soiled tissue into a paper bag and the bag should be burned at least once a day. Whenever possible, paper tissues should be used instead of sputum cups. It is difficult to empty and clean the sputum cup without contaminating the hands and it is difficult to safely dispose of sputum.

2) Dishes and equipment used by the patient. Dishes must be boiled or steamed for 10 minutes. Other equipment used by the patient must be disinfected by soaking it in a 2% solution of lysol for 30 minutes.

3) One member of the family should be designated to give all care to the patient and the other members of the family should stay out of the patient's room or unit.

4) Children should be kept strictly away from the patient's room.

5) The attendant should be taught to wash her hands before leaving the patient's room and to wear a gown or an apron when giving bedside care to the patient.

c. Providing rest for the patient.

1) The patient and family should have a clear understanding of rest.

2) Only a few visitors should be allowed to see the patient for short periods of time.

3) The patient should have good nursing care so that he does not have to exert himself beyond the limits of his physical condition.

4) He should have a comfortable bed.

5) He should be provided with reading material which will keep his mind occupied.

6) He should keep a regular daily schedule.

Example

6:30	Awaken patient and help him to brush his teeth and wash his hands and face.
7:00	Breakfast - then rest or read.
9:00	Bed bath. Make bed.
10:00	Nourishment.

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10:30 - 12:00	Rest or sleep
12:00	Lunch
1:00 - 3:00	Rest period.
3:00	Nourishment
3:00 - 5:30	A few visitors or reading or handwork
5:30 or 6:00	Supper
8:30	Brush teeth, wash hands, face and back, straighten bed.
9:00	Sleep

d. Comfort of the Patient.

1) The patient should have a comfortable bed, clean sheets and nightgown. Back rests, knee rolls, pillows and air cushions can be improvised from ordinary household articles and will contribute a great deal to the patient's comfort.

2) He should have good nursing care to keep his skin clean and in good condition.

3) He should have a pleasant, sunny room overlooking a pleasant view, if possible.

3. Some points which should be emphasized today in Japan.

a. It is only recently that public health nurses have started using visiting bags and actually giving and teaching nursing care. It is still not being done everyplace. Formerly the instruction given to the patient was vague and indefinite. Special emphasis should be placed on giving the patient definite instruction and teaching the procedure by demonstration.

b. The mental and physical comfort of the patient has not been stressed enough in Japan in the past. This is especially important for tuberculosis patients because many physical, emotional and social problems result from the disease.

c. The nurse must use every opportunity to teach health. She has many opportunities as she travels in her district to discuss health problems with patients, their families and groups of people in the community. She must learn what to teach, when to teach, and how to teach. If she knows this she can make her work much more effective.

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TUBERCULOSIS CONTROL IN HEALTH CENTER

Dr. Hikaru Yosano
Preventive Medicine Section, Tokyo

Tuberculosis control is the most important part of health center activities; the health center also plays the most important role in an entire tuberculosis control program.

The Welfare Ministry has already distributed "Manual of Health Center" in 1948 throughout Japan, under the strong recommendation and support of the PH & W Section, GHQ, SCAP. How to handle tuberculosis control works at the health center was described in detail. That article prepared by Dr. Knight and other staffs concerned, is very complete and needs no additional comment on it.

Therefore, I would like to discuss topics from another scope, especially from the practical side.

I. Discovery and Control of Tuberculin Positive Persons.

According to tuberculin test, we can identify tuberculin positive and negative. Among tuberculin positives, there are some numbers of tuberculosis patients, already immune healthy persons and also persons just after changed into positive.

Until recently, we discarded all positive, a x-ray negative group, as immune people from health center. However, it is wrong. Among them there are some who have just changed into positive, in other words, persons in incubation periods. Over 80% of patients involve tuberculosis during the two years after the tuberculin reaction becomes positive. So, it is most important the health center supervise and lead such groups. If a person recognizes that he becomes positive and follows health center directives, such as enough nutrition, sleep, rest, avoids heavy loadings, heavy work, regular and adequate living programs at least 2 years, he can escape very easily from becoming tuberculosis. If the health center carries out monthly tuberculin test against all tuberculin negatives in its district, it is very easy to pick up such persons, when they become positive. However, it is too idealistic.

So it is recommended to perform such monthly test at least against families of tuberculosis patients, and possibly persons who have many chances of exposure, such as middle school students, barbers, food handlers, etc.

Tuberculin reaction of such group is always very strongly positive due to high allergy. On the contrary, advanced tuberculosis cases show not so strong a reaction.

Therefore it is advisable that when the health center finds out persons who show strong reaction, such as big reddish reaction over 20 mm diameter, double reddish ring, haemorhage at center or water bulb, and no x-ray finding, give them diagnosis as possibly incubation cases and explain necessary information to them. Supervise at least 2 years.

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This is the earliest and one of the most fruitful methods of tuberculosis control program at the health center.

II. Immunization of BCG.

Today there are no questions about the effect of BCG. From now on persons under 30 years old who show tuberculin negative must receive BCG by the innoculation law.

According to the law, each city, town and village must carry out a regular mass innoculation campaign once a year under the direction of the health center. Usually towns and villages and even small cities hire no full-time medical officer, therefore actually innoculation business will be done by local private physicians. Therefore The health center must demonstrate and train them before the campaign how to handle BCG and other necessary notices.

Among persons who receive innoculations of BCG, some will show induration, pus, and ulcer at the site of innoculation, sometime one to two months after the innoculation. During the past, in various prefectures, many of them involved ulcer, and health authorities were criticized by the public. Main reason of ulcer is due to immunity against tuberculosis. Tuberculin reaction become positive 2 - 3 weeks after BCG innoculation and reverses to negative after 2 - 3 months. Allergy due to BCG is slight and discontinues soon. However I believe that the immunity itself remains at least 2 - 3 years.

Therefore if the person receive a second BCG innoculation after some time period, it usually involves induration or ulcer. Such ulcer is not so big and will be easily cured by application of mercurochrome solution, ultra-violet ray, and streptomycin.

In rural districts there are many people, at one time positive and who became negative. We call it reversion of tuberculin reactions. Reversion rate is very high in rural districts. In rural districts of Japan the reversion rate is around 10% per annum and 3 or 4% in large cities. Such reversed persons also tend to show ulcer by innoculation of BCT.

So the health officer must explain them correct information and tell them not to develop active tuberculosis by innoculation or from ulcer.

However, to avoid such misunderstanding of the public thorough disinfection of skin and change of the needle for each person is strongly advised. From this year on, plenty of BCG would be available, it was told. So don't be afraid of the loss of the vaccine in changing the needle.

Besides, the lawful annual innoculation program, the health center must innoculate BCG at clinic throughout the year. Any time, any person want to be immunized, the health center must open the window. Health center must immunize families of tuberculosis patients, and persons who have chance of exposure.

Each vial of BCG contains 120 doses, therfore for the benefit, it is desirable to open BCG innoculation day, every Monday or Tuesday, and make appointment with negatives of week before.

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III. Tuberculosis Clinic

The first priority of tuberculosis clinic is detection of early cases. Many early cases have a very slight sign, such as cough, mal-appetite, loss of body weight, tiredness, slight fever, etc. So, in the first place health center opens the clinic against any complaint. If he suffers from other disease, such as nephritis, heart disease, recommend him to visit a private doctor, and eliminate the patient. X-ray examination and blood sedimentation test must be done against all tuberculin positive. If a patient is suspicious, sputum examination is very important to do. Recommend to bring first morning sputum. There are many chances of finding out the germs. All family members must be checked for the tracing of source of infection and finding of family infection.

The health center clinic must classify patients due to the findings. Open cases should be sent to the tuberculosis sanatorium, but if patients remain at home, refer to the Nursing Section for home visit.

The clinic should supervise early cases throughout the course. If they are indication of pneumothorax, start immediately.

In this country, many tuberculosis patients remain at home. The clinic should repeat necessary health examinations until the case is arrested. If a patient has his home doctor, refer the findings to that doctor.

Recently some health centers gave them some kind of medica symptomatica to the tuberculosis patient. As the result, some patients came to the clinic 2 - 3 times a week to get the drug.

Prefectural government sometimes evaluates health center activities by person-day figure. So health center tried to increase number instead of patients. Such business must be strictly forbidden. Clinics must not give any drug and any medicine receipt to the patient.

Tuberculosis clinics are becoming more popular and visitors are increasing month after month. However, many nobdy persons have no chance to come due to office hours. Therefore, in Tokyo, 4 health centers operate so-called evening clinics and have obtained good results. Evening clinic is advisable especially to the urban health center.

IV. Mass Examination

A majority of early tuberculosis patients do not go to the clinic, unless some signs is involved they miss the chance of early treatment. Therefore health center should carry on mass examination especially against students, daily workers, and laborers with the close cooperation of schools and factories. If the location is not so far from the health center, call them to the health center. If not, temporary diagnostic clinic should be moved in that institution Portable x-ray equipment is provided in each health center now. All tuberculin positive must be x-rayed using 35 mm film. All suspicious cases must be re-examined at health center clinic.

One thing to be kept in your mind is pay much attention about absentees of examination. According to my experience, suspicious patients frequently try to escape from mass examination and avoid to be discovered.

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They are afraid too much of loosing their jobs. If you do not care about it, the whole program will be in vain. Therefore, all members must always be examined and absentees should be called to the health center for the checking.

In Tokyo, we opened several times the so-called road-side diagnostic clinic, at public places or parks and obtained good results. People on the road want to check their health and many receive examination. Every time we got lots of cases. Procedure is just the same as mass examination. The final examination for the necessary suspect is done at the health center clinic.

V. Home Visit

Public health nursing to the tuberculosis patient is very heavy part of the control program. A majority of tuberculosis patients remain at home in Japan, therefore home care is very important in this country. Public health nursing will be discussed in detail by responsible author, so I need not spend many words on it.

Today home visit is mostly done against patients who came to the clinic but not to the so-called private patients. Main reason is due to the lack of enough nurses, but also due to the lack of cooperation of private physicians.

However, at Nakano Health Center of Tokyo, Nurse visits not only clinic patients but also private patients. At Nakano, the local medical association understand correctly about the activity of public health nursing and nicely cooperate with the health center. If a private doctor finds out the case, report to the health center, and request that a nurse see a patient. Nurse refer with home doctor first and visit patient and work was done very smoothly. To get such cooperation of medical profession is the duty of the director.

VI. Health Education

Health education concerning tuberculosis is very necessary in this country. There is much misinformation and traditional custom in this country. So education of the public giving correct information is the primary job. The health center should continue endless campaigns of propaganda by means of pamphlets, posters, movies, talks, etc.

Secondary education is to the patients and their families. They want to know correct information, especially how to do at home. The health center must provide special information notes or pamphlets for the patients.

I talk very briefly and regret that I could not tell full scope of health center activities concerning tuberculosis control. Thank you.

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By Dr. I. Kumagai, Tuberculosis Research Institute, Sendai

ADMINISTRATION AND MANAGEMENT OF A TB HOSPITAL

Since I established a tuberculosis hospital, a welfare installation with research-institute attached, I shall use my own experiences to clarify my ideas on the Administration and Management of a tuberculosis hospital.

For about 30 years I have served as a professor of internal medicine in the University Hospital. During that period I was a director and therefore responsible for the management of the hospital. In the University Hospital of Japan each service is independent of the others, which makes examination or treatment of the same patient by more than one service very difficult. The situation is almost the same in all public and private hospitals, which pattern their organization on the University Hospital. The treatment of tuberculosis at present encompasses the fields of internal medicine, surgery, and other departments; and since it is difficult to separate these treatments, still retaining the necessary coordination, in an average hospital, as well as the fact that research facilities in the ordinary hospital are too limited to undertake the study of tuberculosis, I decided to set up a tuberculosis hospital and research-institute. In this hospital there is no division between surgery and medicine. At that time such a project could not expect a government subsidy, so around 1930 we began to plan various ways of financing the venture. Finally we succeeded in getting donations from a textile company and an insurance company for the establishment of the Tuberculosis Institute and Welfare Hospital.

Although the research-institute has since been transferred to the Educational Ministry, the hospital runs smoothly as an endowed foundation and is still self-supporting. A board of directors decides the policy of the management; actual enforcement is accomplished by the director. When I established the installation, many of my friends advised me to abandon my project since they felt it would inevitably go into debt; but the facts will show - it is running with a relatively small amount of difficulty and without financial troubles. This is proof that a tuberculosis hospital can be self-supporting, if the correct methods are used. We have 47 doctors, 2 pharmacists, 35 nurses, 6 interns and about 100 other personnel. The number of doctors is excessive, but it is because those interested in research are drawn to our facilities. The situation here is different than in the ordinary hospital.

How should patients be admitted to a tuberculosis hospital? If the Health Center is well developed they can refer tuberculosis patients to this hospital and the hospital, in turn, can accept them on the recommendation of the health center. I think all patients in the future should be admitted that way, but the present conditions of the country do not allow us to rely completely on this channel. We are running an out-patient clinic both as a source of new in-patients and as a health consultation clinic. Physical examinations are given the sick, those who feel something may be wrong with them, and groups of officials, teachers or any other person whose employment may require periodic examinations. These initial examinations are done by Dr. Ebina, Dr. Oka and myself. Two associate professors see these patients on their second visits. Three assistants conduct pneumothorax for an average of 70 - 100 out-patients daily. In theory no medicine is given except cod liver oil emulsion and symptomatic medication.

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All patients entering the hospital are first examined by this out-patients clinic and judged needy of hospitalization there - even those referred to the hospital by private doctors or other hospitals. Patients with serious cases or even mild but suspected primary infection capable of developing into tuberculosis are admitted to this hospital for research purposes. In ordinary hospitals, however, I think only those whom the treatment is expected to enable to recover should be admitted. As we have a shortage of tuberculosis beds in Japan, it is imperative that the maximum use be made of each one . . . even double fold the number of beds.

Some of the tuberculosis cases in Japan advance very fast. For instance, when he was examined it was just a slight finding. But in a couple of months he had a far advanced pulmonary tuberculosis. The way to find such rapidly advancing cases is in the x-ray and the sputum. If the picture shows very little but thinly-walled cavity and the picture is obscured by cloud-like shade, and the sputum smear shows positive, it is certain that the case will develop into the advanced stages in a short period. Such a case should be given priority of admission, thus checking the development. In cases of chronic patients whose lesion is limited to upper lobe with a cavity, i.e., a typical type of reinfected tuberculosis, surgery will be effective as a short-time cure. It is best to catch this type in its earliest stages, but if this is inconvenient it wouldn't matter too much if they waited for some time.

Also, it might be well to give priority to those cases which can be cured and closed only by rest and pneumothorax.

Of course physicians and surgeons should talk together in deciding when an operation is necessary. It is felt that a doctor well trained in internal examination is better qualified to conduct surgery. We are training such doctors in our hospital. When the surgery patient becomes free from tuberculosis bacilli in the culture and his sedimentation rate becomes normal, he may be discharged from the hospital and treated from the out-patient clinic.

Rest, as well as surgery, is an important treatment of tuberculosis. The patient should have the strictest observation and rest - this is as important as leaving the windows open all the time regardless of time and season.

What is most important for a tuberculosis case in Japan is diet. The fact that Japan has many more cases of tuberculosis and the development is more rapid than the average country may be attributed to the diet rather than the racial nature or any factor of dermal pigment. I once chanced upon information that General Sams had the same idea. For 20 years I have been emphasizing the improvement of diet as a means of lessening tuberculosis cases in Japan. What is essential to tuberculosis treatment is decrease in the rice intake and increase in the protein and fat intake. Now this idea, which I have been practising, has become so popular that some patients think of butter as an efficacious medicine for tuberculosis. But even now this practise is not being fully carried out. In our hospital the patient's diet contains 90 - 100 grams of protein (with more than 30% of animal protein), 80 - 100 grams of fat, 400 - 450 grams of carbohydrate, and total calorie is 3,000, the daily intake of an ordinary healthy American. In Japan, however, it is pretty hard to maintain this level, not only for economic reasons but because of the tastes of the people. In such a diet rice should be cut from 3 to 2 bowls per

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meal. Since the doctors and nurses in our hospital have had 20 years experience with the administration of this diet, the diet is administered fairly easily. However, in the beginning some patients from the rural areas found butter so difficult to eat that it had to be wrapped in waffers. When we adopted this diet 20 years ago, we saw a remarkable decrease both in the death rate (1/3) and in the haemorrhage rate (1/5). Also, before the institution of this diet, 1 or 2 patients got meningitis out of about 100 patients every 3 or 4 months; after the change, there have been no such cases. I think that if the people of Japan would try to improve their diets, the incidence of tuberculosis would decrease. From this viewpoint, I don't think the rice ration need be increased more than it is; and it is recommended to import more edible oils (such as coconut oil) instead of rice. Also, I think the livestock industry should be encouraged to give more meat and milk to the people.

Every day we number 10 - 30 or 50 - 60 new out-patients, and our old ones number from 80 - 90 or to a maximum of 150 - 160. In-patients number about 270 - 280. We are doing the following: Pneumothorax, phrenic nerve interruption, pneumoperitoneum, and if there is any indication, thoracoplasty, pneumolysis with filling plastic balls or paraffin into the extrapleural cavity, or pulmonary resection. In this case we examine the condition of mucous membrane of the trachea by means of bronchoscope before operation.

As examples, take 137 patients who were discharged from January to June 1948. By means of the aforementioned methods the following results were obtained:

50 or 36.5% were treated by minor surgery, such as pneumothorax phrenic nerve in corruption. 52 or 37.2% were treated with major surgery, such as thoracoplasty, filling with plastic balls or pulmonary resection. 30 patients or 22% were too serious for any therapy. Five patients or 3.6% were mild cases who needed only rest. As a whole 65% recovered and 34.3% became worse and died. The percentage of those who were open when admitted and became closed when discharged is 55%. The average hospitalization period is 7 months. Deaths numbered 61 in 1948 but dropped down to 44 in 1949. This year a greater drop is expected through the use of streptomycin, etc.

Measures are taken to safeguard the health of personnel, especially of nurses who come into direct contact with the patients, of the hospital. Regular examinations including x-ray, etc., are done twice a year, and BCG innoculation is given to the tuberculin negative. As a result, for 6 years there has been no tuberculosis death rate among nurses. The only death in that period was due to leukemia. This record may be compared to 1 - 2 tuberculosis deaths in 30 - 40 nurses every year when I was at the University Hospital.

I would really recommend to you health officers from each prefecture, that you establish at least one tuberculosis central hospital in a prefecture under such management as I have just described. Whether the hospital is run by the prefecture or private managers makes no difference. The important thing is to have a hospital where medicine and surgery can be coordinated; and where

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close li ison with local health centers may be maintained to make the hospital a veritable tuberculosis control center.

Or if this is impractical, a half of some other hospital could be used. This would not damage the economy of the hospital at all, but would probably serve in bringing better finance into the management.

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IMPORTANCE OF THE PRIVATE PRACTITIONERS IN THE TUBERCULOSIS CONTROL PROGRAM

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I have been a hospital physician these thirty years directly contacting various patients. Accordingly I stand on the same position as private practitioners treating patients in most cases from their first affection, always doing my best to find out as early as possible the source of their ailment. In my long clinical experience, I have confirmed a fact there exists a conventional trend or mental inclination common in patients of this country to feel uneasy about the diagnosis of any doctor they first consult. In nine cases out of ten, they are inclined to call at several physicians and place confidence in the doctor who diagnosed the case least seriously. In case all the physicians they consulted are of the same opinion in prescription, they prefer the doctor most trustworthy in general view. Even major hospitals with eminent doctors in lineup could never make all visiting patients rest on their clinical turnout. Thus it is usual for a patient to call at doors of several clinics to hear different medical advices, only piling up burdens in vain.

No exception to this rule was the case of health insurance-associated patients who formerly changed freely their consultants, most cases nee the better for it. Viewed from this point, the revised regulations for health insurance patients are regarded beneficial in that any patient must receive a sustained treatment with his "health insurance diagnosis card" filed with a specific consultant throughout the time of medical care.

Thus far I presented the general trend or inclination on the part of patients. But, on the other hand, practitioners, and hospital clinicians alike, should share the responsibility for causing the unstable stand on the side of patients. First of all, they should concentrate more efforts and sincerity in making a proper and pertinent diagnosis so as to be able to convince patients of the turnout. Utmost carefulness and circumspection should be paid in the examination. Today most patients want scientific method in their health examination. They want at least chest x-ray, blood test, tuberculin test, sputum microscopy, and scatoscopy. They know these methods are reliable in confirming the sign of physical affection. In this sense, all physicians must always be ready to apply scientific therapeutics on all patients to get them admit the turnout.

A few years ago, I received a call of some parents who accompanied with them their four children, aged 8, 6, 4, and one, to have them diagnosed as the elder three were in trouble with moist cough, fever and night-sweats. The examination through x-ray expressly confirmed that the three children were all affected with tuberculosis. I wondered how they should alike be affected in the same degree and wanted to trace the cause through inquiry into the health conditions of the family members. Informations made available included that the father suffered from occasional fits of coughing at that time after the lapse of two months since his recovery from acute pneumonia. It took untiring perseverance for me to persuade him finally to receive health examination, which proved that this father was the very source of the infection. I know all of you

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have a rich stock of experience similar to this case. This was an instance that a father unconsciously got his children infected with his own bacilli. Another example shows that a mother got her four our of five children to fall a victim of her chronic phthisis in eight years. In this case, the invalid mother was under care in an isolated room in the most circumspect consideration to avoid inter-contact with other members of the family.

I believe there still are too many cases in which tuberculosis patients are getting their family members to become the prey of their bacilli. Here dreadful are incubative patients of tuberculosis who are working with their comrades just in the same way with the carriers of law-controlled infectious diseases. More than ten years ago, Dr. Kumagai, Professor of Tohoku University, stressed that tuberculosis-affected school teachers were substantial spreaders of the bacilli little less than family sources. This warning led to a strict enforcement of teachers hygiene with successful fruit in the juvenile hygiene program. With such a living instance, it seems rather late that the Government put into force a law only the year before last enforcing a universal control of plants, firms and other working quarters from the viewpoint of hygiene. Though late in codification, the regulations are beneficial in view of it going a long way toward preventing working quarters from becoming incubators of tuberculosis.

We physicians in general must of course cooperate in this national program for the hygienic control of industrial as well as clerical workers. But I think practitioners in particular should rather lay focal stress on the prevention of tuberculosis from spreading through family contact, as they have more frequent chance of visiting home patients.

It is gratifying to observe that of late an increased number of health centers have been greatly contributing toward fructification of the public health program with the control of tuberculosis as one of their priority duties.

On our report of a tuberculosis case, the health center concerned dispatches in time its public health nurse to the patient with beneficial advices concerning the medical care, nutrition, mental rest and environmental considerations.

At the Sendai Central Health Center, the number of tuberculosis case visits is reported to amount monthly around 200. This periodical case-visit program is most acceptable in view of public hygiene, and I have appointed a nurse for the home-visiting care of tuberculosis patients, with cautions paid to avoid duplication over the health center's case-visit program.

Through intimate talks with family members of tuberculosis cases, we know that, aside from sincerest desire for the recuperation of patients, they most seriously fear the contamination of other healthy members, the very point we physicians most fear. How to prevent the tuberculosis infection through family contact? This is a problem of national importance not so easy to solve.

Some may bluntly argue that the issue can be settled by a compulsory hospitalization of tuberculosis patients. But, as things stand today, tuberculosis carriers are forced to work among healthy persons, as is often the case with family mainstays to eke out a minimum livelihood. The matter is out of the control of physicians, its final solution depending upon an intensive and powerful policy on national or social basis.

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The only and most effective role we physicians can play in this field is, I believe, to streamline the home-visit program of public health nurses with closer liaison kept with the health center. At the same time, we should not ignore the importance of health examination for all the family inmates of tuberculosis patients.

This is now included in the health center program, but I think there is much room for expansion.

All in all, we physicians or practitioners in general should pool our efforts for the consummation of the hygienic control of the families harboring tuberculosis patients.

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PUBLIC HEALTH RESPONSIBILITIES IN MEDICAL CARE AND HOSPITALIZATION

By Colonel H. G. Johnson
PH&W, SCAP

There are four parts to any good Public Health program, prevention of disease, care of the sick, welfare and social insurance, which provides a means for the ill to pay the costs of sickness. Medical care envisages both care in and out of hospitals, and the responsibility of providing good medical care cannot be relegated to regulation by law and ordinance alone. Physicians themselves carry the greater responsibility and the quality of the care furnished will depend upon the ethical understanding of their duty. This ethical approach plus an assumption of social responsibility are the determining factors. One should be able to assume that the educational training given an individual in preparing him to become a doctor would be such as to produce in him an awareness of responsibility, which could only result in a willingness to serve. But unfortunately in Japan, the consciousness of medical ethics and social responsibility is either lacking or lost sight of in the struggle of earning a living by many physicians [redacted]. It is this [redacted] group of doctors who are mostly employed in the operation of out-patient clinics and social insurance. While rules alone will not eliminate careless medical practice, they become necessary in order to provide minimum standards of service and conduct below which they cannot drop without the extraction of penalties. These standards are embodied in several Japanese laws, which will be referred to in this paper.

I call to your attention Law #201, Medical Practitioners Law. Article 19 states: "A medical practitioner shall not give medical treatment without examining the patient personally." This provision was incorporated into the law because it is not unusual for clinic doctors to refuse treatment or brush patients aside with a careless examination conducted in a brusque and disinterested manner. Clearly the intent of the law does not permit of such practice and the intent should not be lost sight of by officials, for this provision can be used by public health officers in improving medical practice, particularly in public clinics and government institutions.

Article 18 of the law will be briefly commented upon. It states as follows: "One shall not use the title of medical practitioner or attach the names liable to be confused with it unless he is a medical practitioner." This provision may be invoked in outlawing the many harmful quasi-medical practices now in vogue

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which are not authorized by law. Only four quasi-medical practices are permitted, those of moxacautery, judo-orthopedics, massage and acupuncture. These practices are regulated by the imposition of limitations in application and require for license, basic educational and technical training. Law #217 of 1947, known as "Law Governing the Business of Moxacautery, Judo-Orthopedics, Massage and Acupuncture" should be known to all public health officials.

The provisions of the Medical Practitioner Law referrable to practice of medicine in Japan seemingly has escaped the attention of certain members of the Occupation Forces. Article 17 stipulates that "One shall not be engaged in medical profession unless he is a duly licensed medical practitioner." Several cases have arisen where foreign national physicians unlicensed in Japan have been engaging in practice, claiming that local Occupation authorities have granted such permission. It should be remembered that only SCAP has authority to authorize licensure of foreign nationals in Japan. This authority has not been delgated to subordinate commanders. SCAP has seen fit to require that candidates for licensure shall meet the requirements set up in the Medical Practitioner Law. No authority, therefore, is invested in military commanders or Civil Affairs Teams to circumvent the law. The question also arises regarding repatriated Japanese physicians and dentists being issued licenses to practice medicine or dentistry in Japan. A large number of individuals licensed by territorial governors or consuls of former Japanese colonies to practice in areas in which they resided, do not meet the requirements of the Medical Practitioner or Dental Practitioner Laws. Special consideration, however, has been granted this group by an amendment to the Laws allowing two trials of preliminary type examination to determine qualification for licensure. Failure after the second attempt is final. A small number have already qualified but the large percentage have failed. This group is now clamoring for further privilege. The Ministry of Welfare does not support their request and considers further action undesirable. SCAP supports the Ministry of Welfare's stand, realizing that medical care cannot be of two qualities--one good and one bad. There is no place in any land for an unqualified professional man. The responsibility carried by physicians and dentists is so great that regulations leading to licensure cannot be subject to leniency or careless interpretation.

Allow me now to mention a habit of Japanese medical practice which adversely effects the quality of medical care available to the people, that of physicians

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selling drugs. This practice is so universal that it constitutes a public health problem. The custom has been present for so many years that it is accepted as usual by the practitioners and the people alike. Japanese doctors have not been and are not today paid properly for their medical knowledge. They receive most of their income from the sale of medicine to their patients. It is obvious that a busy practitioner devoting serious attention to diagnosis and advice cannot spend time compounding drugs in an improvised pharmacy attached to his office or clinic. The medicine he dispenses may or may not be the drug discriminating medical judgment might prescribe. It is more apt to be a drug readily available on his shelf. It cannot be denied that it is only in the well-stocked pharmacy that an adequate supply of drugs can be found in the fresh and potent state necessary. In the Medical Practitioner Law, Article 22, it is stated "in the event that a patient has asked for prescription instead of medicine, the medical practitioner shall not refuse it." This Article recognizes the harmfulness of the present practice but is not alone sufficient to break the long established custom. Re-education of the public and Japanese medical profession, the dental profession and the pharmacists as to the division of their respective responsibility is necessary and this should be begun now. Medical care will be greatly improved when the physicians of Japan recognize as fallacy their present custom and resort to writing their orders on prescriptions to pharmacists who are qualified by specialized training and technical skill in compounding and dispensing drugs.

But more harmful than the sale of drugs by doctors is the practice of pharmacists prescribing remedies for patients--of the two practices, this is the dangerous one and illegal as well. Prescribing medicine is the perogative of the physician and outside the jurisdiction of the pharmacist. Such practice is now prohibited by law and doctors, therefore, need have no fear that pharmacists will in any supplant them. In the new Pharmaceutical Law, pharmacists are not permitted to diagnose or prescribe medicine for disease. They can do no more than fill the doctors' prescriptions or sell a specific medicine if asked for by a customer, provided the sale of such is not prohibited by law.

I hope what has been said has stimulated your thinking far beyond the scope of the points raised and that the Medical Practitioner Law, the Dental Practitioner Law, the Dental Hygienist Law, the Law Governing Quasi-Medical Practices, and the Pharmaceutical Law will be carefully read and digested.

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Let us now pass on to hospitals. The hospital best indexes the quality of medical care available to a community and stamps as well the professional abilities of physicians. It is safe to say that a hospital carelessly operated, untidy, dreary and unclean, furnishes medical care of like caliber. In reverse, an institution found to be bright, orderly and spotlessly clean is likely to have attached to it, physicians who are professionally honest men, abreast of recent advances in medical science and aware of their social responsibility. This measuring stick is rarely wrong. In an endeavor to develop Japanese hospitals into institutions of the latter type, it became necessary to establish minimum standards and to write these into Law.

The Medical Service Law (Law #205) carries the minimum standards which apply equally to all hospitals, national, prefectural, municipal, college hospitals and private institutions. The purpose and intent of the law can be found in its first Article, quoted as follows: "In this law 'the hospital' means the place where medical practitioners or dentists give medical or dental practice to the public or to specific masses and which possesses the equivalents with the capacity for not less than 20 patients, and it shall be an institution organized and conducted primarily for the purpose of providing facilities where the sick and injured may be given scientific and ethical medical care."

May I direct your attention to specific articles of this law, which have general application leading to improvement of the present unsatisfactory condition of hospitals. Article 20 reads: "Hospitals, clinics and midwifery homes shall keep themselves clean, and construction and equipments of them shall be safe from the viewpoint of hygiene, prevention of fire and public peace." Article 24, leading to enforcement of this provision, empowers prefectural governors to take remedial steps to effect these ends, quote: "in case a hospital, a clinic or a midwifery home does not keep itself clean, or in case he considers the construction and equipment thereof to be against the provisions of Article 21 or Article 22 or the Ministerial Ordinance or to be harmful from the hygienical point of view or dangerous to public peace, to restrict or prohibit the use of the whole or a part of them for a fixed term or order the repair or reconstruction of them to the establisher." This is a powerful weapon, and cannot be interpreted as granting permission for enforcement but rather imposing upon governors a duty to maintain hospitals within

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their geographical boundaries in such a condition as to meet the minimum standards of the law.

Article 26 establishes the medical inspector system. In this article, prefectural governors are required to appoint hospital inspectors. These persons are drawn from individuals already in government service, preferably persons who have received special training in the Institute of Hospital Management. Hospitals are inspected and classified "A, B. C, and D", depending upon how well they qualify on the main points of management, personnel, buildings and equipment. The minimum standards of the Medical Service Law are the criteria for classification. It is believed that careful inspection and classification of hospitals will lead to improvement in service and the rapid attainment of higher standards of management.

Largely lacking in Japanese hospitals is the classification of patients according to diseases and frequently disregard of segregation of infectious disease cases. In Ministerial Ordinance implementing the Medical Service Law (Ordinance #50), prohibition is made to the treatment of infectious diseases or mental diseases in wards other than those set aside for that purpose. Proper enforcement of this Ordinance will immediately remedy the disturbing condition.

In the same connection, your attention is directed to that section of the Ordinance which requires disinfection of eating utensils, bedding and clothing used by patients with infectious diseases.

The control measures referred to are but a few of the standards laid down in the Medical Service Law and Ordinances. With a detailed knowledge of this law and an honest attempt made towards enforcement, Japanese hospitals can be rapidly improved.

To speed improvement in hospital management, a School of Hospital Administration was established to train as many people as possible in this neglected field. During 1949 the School graduated 299 persons, mostly directors and business managers of established hospitals. They were drawn from all parts of Japan. Applications for admission are again being received greatly in excess of the number which can be accommodated. All prefectural health departments have been furnished with entrance blanks, which when properly filled out may be forwarded to the School of Hospital Administration, First National Hospital, Tokyo, for selection. Unfortunately, many applicants will be required to await acceptance. Two courses of two months' duration are given each year and courses of one week

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duration, six times a year.

Many factors influence improvement in medical care. Stress on any one factor will accomplish little good and do no more than emphasize the fact. All the factors which make medical care and hospital conditons what they are today must be considered together and interwoven into the whole if permanent improvement is to result. The type of Japanese doctor desired must be considered and steps taken to provide medical education geared to produce medical men of this kind. No-one is satisfied with the Japanese physician developed in technical colleges (senmon gakko). Here abbreviated medical courses were given by didactic methods to young individuals possessing no more than a high school background. The medical educational reforms initiated by SCAP were designed to develop physicians qualified in clinical medicine and capable of understanding the broader aspects of public health. To what extent success is being reached in providing this type of doctor, no-one as yet knows but if passing National Examinations for licensure, largely clinical in nature, can be taken as a measure, certain success has been reached, for in 1948 50% of those competing were successful, whereas in 1949, 75% passed.

With the groundwork laid by the passage of laws leading to improvement in the quality of medical care, and the establishment of minimum standards for hospitals, the opening of a School of Hospital Administration and the development of a Model Hospital at the First National Hospital in Tokyo, it is hoped that the hospitals of Japan can be developed into institutions equal to those found in the United States and eventually may be able to meet the requirements laid down by the Council on Medical Education and Hospitals of the American Medical Association in its definition of a hospital: "An institution suitably located, constructed, organized, managed and personneled, to supply, scientifically, economically, efficiently and unhindered, all or any recognized part of the complex requirements for the prevention, diagnosis and treatment of physical, mental and the medical aspect of social ills; with functioning facilities for training new workers in the many special professional, technical and economic fields essential to the discharge of its proper functions; and with adequate contacts with physicians, other hospitals, medical schools and all accredited health agencies engaged in the better health program."

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STATUS OF THE BIOLOGICS PRODUCTION, ASSAY AND CONTROL PROGRAM

It has been fourteen months since it became necessary to stop the production and usage of biologic products as a result of the Kyoto incident. You will recall that a tremendous reassay program was initiated to include all biologic products on hand, regardless of where they were located; at the manufacturing laboratory or distributed to the various local agencies for use.

Concurrently with the initiation of the reassay program the Ministry of Welfare conducted an inspection of each laboratory manufacturing biologic products. The inspection of each laboratory included physical and technical facilities, personnel qualifications, financial condition, as well as an examination of the production capacity and quality of the products produced. As a result of this survey it was considered advisable, either for the best interests of the individual producer, or for the best interests of the biologics program, to allow only ten of the 46 licensed laboratories to reopen and to resume operations immediately. An additional 4 laboratories were requested to prove themselves capable of producing high quality products. They possessed good facilities, good personnel and were in good financial condition but there were no records upon which to base an evaluation of the quality of the product each laboratory had produced. Ironically, two of those ... laboratories, the Osaka Saikin, and the Meguro Institute, possessed what was probably the best physical plants in Japan at that time. Not all of the ten laboratories permitted to resume operations possessed good or adequate facilities for the production of biologic products; however, the quality record of these laboratories was very outstanding. Two excellent examples of this situation are the Kitasato Institute and Handoi Biseibitsu of Tokyo and Osaka, respectively.

Now: 22 labs 11 biological licensed issued

These ten laboratories were issued a total of 48 individual product licenses representing nine biologic products. At this time 20 manufacturing licenses representing about 70 product licenses are in process of issue or are under consideration.

Concurrent with the reassay program, it was necessary to plan for continued new production of biologics products. Fundamental regulations pertaining to the biologics program had to be rewritten. Minimum requirements for specific products had to be either written or rewritten and

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promulgated.

A complete set of four fundamental regulations upon which to base a sound, fundamental, and progressive biologics program have been promulgated. These are designed to reduce to a minimum and to eliminate as nearly as possible, reactions resulting from the use of biologics. They are intended to include every conceivable type of biologics product and to explain procedures to be followed for control purposes. These fundamental regulations are:

1. Ministry of Welfare Ordinance #8, "Regulations for the Control and Manufacture of Biologic Products" 21 February 1949.

2. GAKUHATSU #1990, "Guiding Principles for the Manufacture of Biologic Products" 24 December 1949.

3. GAKUHATSU #1991, "Labels, Circulars for Biologic Products" 24 December 1949.

4. YAKAHATSU $66, "License Procedure", 31 January 1950.

5. An explanatory notification GAKUHATSU #1510, "Grouping of Biologic Products," 27 August 1949, is also very important.

Specific minimum requirements for Typhoid-Paratyphoid Vaccine, BCG Vaccine (dried), Pertussis Vaccine, and the Sterility Test have been promulgated. Fifteen additional minimum requirements will be promulgated within the very near future.

In the early days of the present biologics program, many types of criticisms of the program were voiced by producers. These were natural and expected criticisms. Most producers have made a conscientious effort to cooperate and comply with the spirit of the program. The reward may be easily observed in the improved quality of product, the low failure rates of biologic products recently assayed and the absence of reports of reactions from the clinicians in the field.

Smallpox vaccine has shown the greatest individual product improvement and its example may be used to illustrate the progress which can be made. Official Ministry of Welfare figures indicate that in 1949 smallpox vaccine producers manufactured 92,970,950 human doses, and the National Institute of Health approved 77,092,180 human doses for use and rejected about 6 million doses. The balance of this material is either under assay

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or has not been submitted for assay. These figures become more significant when it is pointed out that about 85% of this material was produced and assayed during the period May to December. Clinicians report that about 98% takes are being obtained on primary vaccinations with this material, using a one site scarification technique for vaccination. This is an especially good record.

The same degree of progress has not been made with all other products; however, substantial improvement has been made and will undoubtedly continue to be made this coming year. The problem of shortage of biologics is very rapidly being overcome and is expected to entirely disappear in the near future. The quantities of typhoid, cholera, typhus, and smallpox vaccines needed for 1950 are assured. The quantity of diphtheria toxoid needed for fall immunizations is practically assured. High quality pertussis vaccine is now being produced in Japan. It is anticipated that sufficient quantities will be available in time for fall immunizations. There is no shortage of tuberculin. BCG vaccine production and assay has now reached a stable level and it is expected that sufficient material will have been released to enable completion of the first year's program by November 1950.

Although considerable progress has been made, much improvement remains to be accomplished. Continued emphasis will be placed on individual product improvement and rigid enforcement of all existing minimum requirements. Thus the emphasis shifts from a national level program to a problem at the local level. Modern methods for the production of high quality biologic products are being distributed to manufacturers. They should be continuously encouraged to place these methods in operation.

Manufacturers must be continuously encouraged to perform an assay of each lot of each product they produce. This assay should be done in complete conformance with the methods in use at the National Institute of Health and specified in official minimum requirements. The manufacturer can learn about his product only by assaying it himself.

The present inspection system needs to be enlarged and strengthened by more capable and better trained full-time inspectors in order that enforcement of all regulations may be assured.

One of the greatest handicaps of the biologics program has been the

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slowness of payment of manufacturers for the product which has been used by the various local agencies. Also, the period of time taken by local groups to complete an individual immunization program has been much too long. For example, the recent nationwide smallpox vaccination program required that every person in Japan be vaccinated at the earliest possible date. The program started in May 1949. In January 1950 about one half the population had been vaccinated but manufacturers had on hand roughly 35 million doses ready for immediate distribution. If manufacturers' funds are tied up for long periods of time on one or two products, all other vaccination programs, as well as the manufacturing laboratory, suffers.

Prefectural authorities must take steps to insure that immunization programs are completed as rapidly as product is made available and that manufacturing laboratories are paid promptly for the product supplied.

The National Institute of Health, Ministry of Welfare, and Public Health and Welfare Section, SCAP, stand ready to aid in the solution of any problems arising in the biologics program at any time. Do not hesitate to call on us.

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PUBLIC HEALTH LABORATORIES

For the information of all persons interested, it is considered that this is an excellent opportunity to explain the schema of Public Health Laboratory Orginzation which is being established for Japan by the Ministry of Welfare and Public Health and Welfare, GHQ, SCAP.

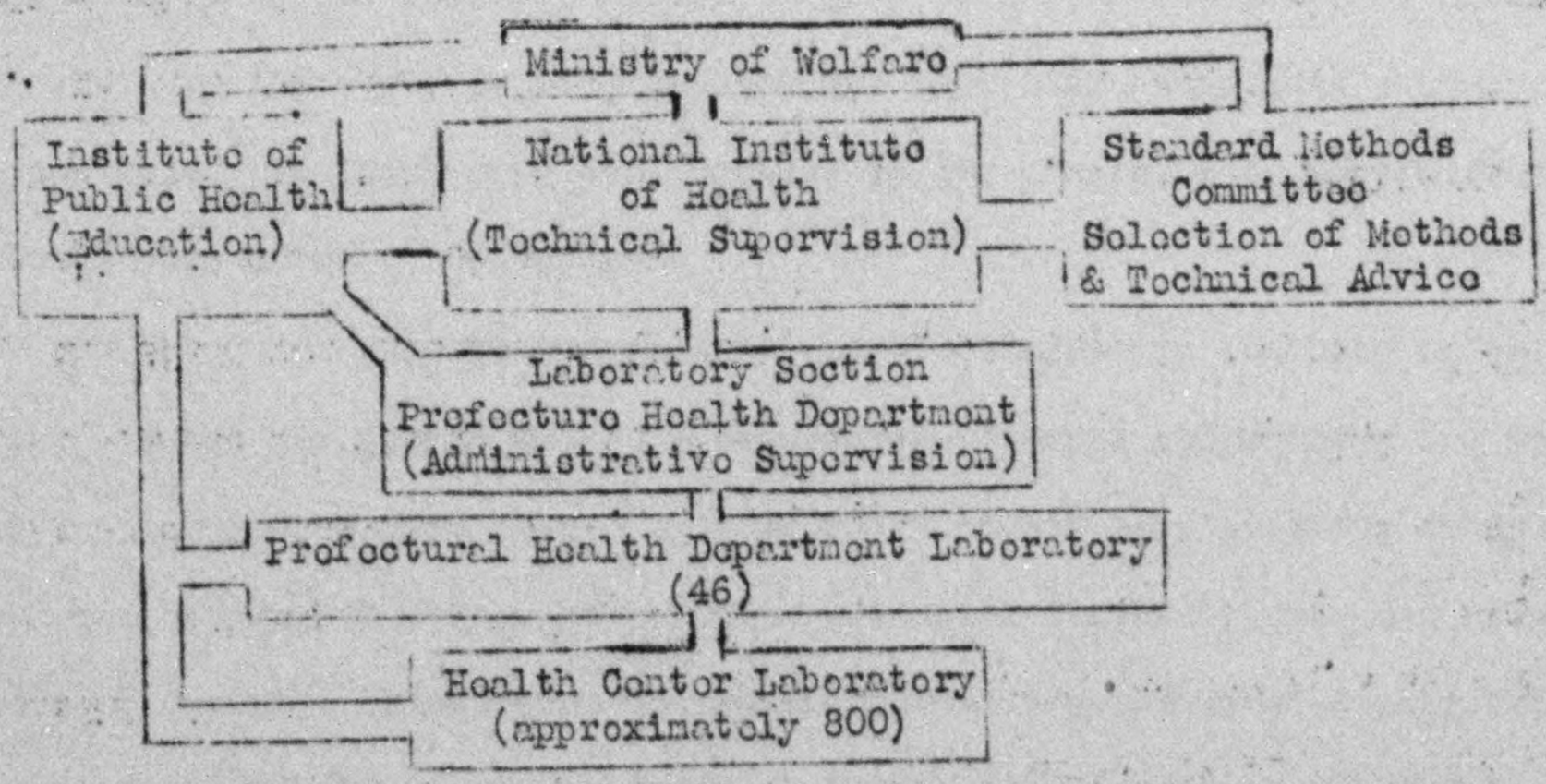
a. National diagnostic center and technical supervisory agency for all public health laboratory activity in Japan: The National Institute of Health.

b. National educational agency concerned with the training of all types of personnel for public health laboratories: The Institute of Public Health.

c. Advisory group for recommending methods and for aiding in the solution of other technical problems: Standard Methods Committee.

d. Regional Diagnostic center with responsibility for public health laboratory activity within each region: A prefectural health department laboratory in each prefecture.

e. Local diagnostic center offering direct service to the people: health center laboratory.



Since the termination of the war, great emphasis has been placed upon the training of health center laboratory personnel and upon the construction of health centers containing laboratories. Practically nothing has been done toward the organization of prefectural health department laboratories or for the training of prefectural health department laboratory personnel. Yet these laboratories are technically responsible for the laboratory work

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done by the health centers.

Prefectural health department laboratory personnel have been conducting training courses for health center personnel. There has not necessarily been correlation of this training between the various prefectures nor between a prefecture and the national level.

In order that further confusion may be eliminated from the public health laboratory program and in order to assist prefectures in the establishment of adequate prefecture health department laboratories, a training program for prefecture health department laboratory personnel has been planned and will be conducted this year. This training course will be based on the Standard Methods for Public Health Laboratories recently recommended and adopted by the Standard Methods Committee. This committee is composed of 40 of Japan's most capable scientists.

The actual training will be conducted at the Institute of Public Health Tokyo. You are requested to send one student from each prefecture to each general section of the training program. This is really an excellent opportunity for prefecture health department laboratory personnel. When this program has been completed, emphasis will again be placed upon the training of health center laboratory personnel. This emphasis will be in the form of training conducted at the Institute of Public Health and courses conducted by each prefecture health department laboratory for health center laboratory personnel within each prefecture.

A schedule of training courses for prefecture health department laboratory personnel, showing the period of time required for each course and the number of students to be accepted is given below.

Title of Course	Period of Training	No. of Students
Directors (survey course.)	1 May to 13 May	46
Bacteriology-Serology	15 May to 5 August	46
Chemical Examination of Food, drugs, water & milk	5 April to 3 June	25
" " " " " "	30 October to 23 December	25
Clinical Methods (Urine, blood, etc.,)	4 September to 28 October	30

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Separate Table

Outline of
Budget of General Account Related to
Health and Sanitation under the Jurisdiction of
the Ministry of Welfare
Fiscal Year 1950-51

¥2,762,117,000

The first is

Expenses concerning Minister's Secretariat ¥ 577,638,000

in which

Expenses for completion of health statistics business ¥ 274,750,000

is appropriated.

The second is

Expenses required for the counter-measures for public health and preventive sanitation ¥2,015,936,000

The main items thereof are as under: and the figures within brackets are grant amounts

1. Expenses of Ministry proper required for the nutritive improvement and guidances ¥ 347,000

2. Expenses required for nutritive surveys ¥ 30,785,000

3. Expenses required for the nutritionists' examination ¥ 234,000

4. Expenses of Ministry proper accompanying the management of health centers ¥ 1,979,000

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2. Expenses required for nutritive surveys
¥ 30,785,000

3. Expenses required for the nutritionists' examination
¥ 234,000

4. Expenses of Ministry proper accompanying the management of health centers
¥ 1,979,000

5. Subsidy for the expenses required for the management of 704 health centers and the foundation of 15 centers, both by prefectures, and the completion and expansion of 463 centers
¥ 806,535,000 (¥305,535,000)

6. Expenses of Ministry proper required for the strengthening of counter-measures for the control of tuberculosis.
¥ 20,936,000 (¥2,416,900)

7. Expenses for the subsidies for the expenses for the control of tuberculosis borne by prefectures, and to the expenses of tuberculosis sanatoria run by the municipal personnel for public welfare
¥ 78,564,000 (¥78,564,000)

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8. Expenses of Ministry proper required for the strengthening of the counter-measures for the control of communicable diseases
¥ 3,072,000

9. Expenses required for the subsidies for the prefectural and city, town and village expenses for the prevention on the basis of Infectious Disease Prevention Law, Leprosy Control Law, and Parasite Prevention Law, for the subsidies for the managing expenses of private leproseries, and for entrusting the preventive business of the prevention of communicable diseases from abroad to prefectures
¥ 452,645,000 (¥452,648,000)

10. Expenses of Ministry proper required for preventive counter-measures against venereal diseases
¥ 708,000

11. Expenses required for the subsidies for the prefectural preventive expenses, on the basis of Venereal Disease Control Law
¥ 157,588,000 (¥157,588,000)

12. Expenses of Ministry proper concerning the enforcement of Preventive Inoculation Law
¥ 222,000

13. Expenses for the subsidies for prefectural business expenses for inoculation, and the extra-ordinary expenses, on the basis of Preventive Inoculation Law
¥ 5,610,000 (¥ 5,610,000)

14. Expenses of Ministry proper required for the examinations, tests, researches and guidances for the prevention of diseases
¥ 1,613,000

15. Expenses of Ministry proper required for the management of quarantine stations
¥ 2,734,000

16. Expenses of Ministry proper for the planning of and guidance to the execution of extermination of rodent and insects
¥ 1,582,000

17. Expenses of Ministry proper required for the strengthening and expansion of sanitary engineering administration

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11. Expenses required for the [illegible] preventive expenses, on the basis of Venereal Disease Control Law

¥ 157,588,000 (¥157,588,000)

12. Expenses of Ministry proper concerning the enforcement of Preventive Inoculation Law

¥ 222,000

13. Expenses for the subsidies for prefectural business expenses for inoculation, and the extra-ordinary expenses, on the basis of Preventive Inoculation Law

¥ 5,610,000 (¥ 5,610,000)

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¥ 1,613,000

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¥ 2,734,000

16. Expenses of Ministry proper for the planning of and guidance to the execution of extermination of rodent and insects

¥ 1,582,000

17. Expenses of Ministry proper required for the strengthening and expansion of sanitary engineering administration

¥ 1,266,000

18. Expenses for the subsidies for the purpose of promoting the water-work and sewerage business carried out by cities, towns and villages.

¥ 3,153,000 (¥ 3,153,000)

19. Expenses of Ministry proper required for the enforcement of Food Stuff Sanitation Law

¥ 1,435,000

20. Expenses of Ministry proper required for the inspections and tests on foodstuff sanitation

¥ 4,518,000

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Expenses of Ministry proper required for the inspection of exported foodstuffs
¥ 2,062,000

Expenses required for the enforcement of Eugenic Protection Law
¥ 2,597,000 (¥ 1,538,700)

23. Expenses required for the expenses of Ministry proper and the subsidies to prefectures, accompanying the execution of hospital diet
¥ 555,000 (¥ 386,000)

24. Expenses for the subsidies for the expenses for prevention of hydrophobia carried out by prefectures on the basis of Domestic Animals' Infectious Disease Prevention L[illegible]
¥ 1,030,000 (¥ 1,030,000)

25. Expenses for the subsidies for the expenses defrayed by prefectures on the basis of Mental Hospital Law
¥ 101,093,000 (¥101,093,000)

26. Other expenses of Ministry proper for the prevention of encephalitis B, public health surveys and guidances, etc.
¥ 6,281,000

27. Expenses required for trainings by National Health of Public Health
¥ 41,434,000

28. Expenses required for National Institute of Nutrition
¥ 10,138,000

29. Expenses required for National Institute of Health
¥ 158,568,000

30. Expenses required for quarantine stations
¥ 111,431,000

31. Expenses required for resident epidemic prevention officer's offices
¥ 5,218,000

The 3rd is

Expenses concerning the counter-measures for medical affairs
¥5,852,368,000

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25. Expenses for the subsidies for the expenses defrayed by prefectures on the basis of Mental Hospital Law
¥ 101,093,000 (¥101,093,000)

26. Other expenses of Ministry proper for the prevention of encephalitis B, public health surveys and guidances, etc.
¥ 6,281,000

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28. Expenses required for National Institute of Nutrition
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29. Expenses required for National Institute of Health
¥ 158,568,000

30. Expenses required for quarantine stations
¥ 111,431,000

31. Expenses required for resident epidemic prevention officer's offices
¥ 5,218,000

The 3rd is

Expenses concerning the counter-measures for medical affairs
¥5,852,368,000

the main items of which are

1. Expenses of Ministry proper accompanying the enforcement of Medical Practitioners Law
¥ 1,857,000

2. Expenses for the execution of the medical practitioners' and dental practitioners preliminary state examination and the state examination
¥ 18,648,000

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3. Expenses of Ministry proper accompanying the operation of the dental treatment administration
¥ 1,954,000

4. Expenses of Ministry proper for the guidance to health-nurses, midwives and sick-nurses
¥ 7,288,000 (¥ 1,261,000)

5. Expenses of Ministry proper for the control and management of and the guidance to and supervision over national hospitals and sanatoria
¥ 926,341,000

6. Expenses for the short course on the management of national sanatorium and for the re-education of sick-nurses
¥ 2,323,000

7. Expenses for the completion of equipments of national sanatoria
¥ 182,854,000

8. Expenses for the investigations of the causes of deaths etc.
¥ 3,216,000 (¥ 3,203,000)

9. Expenses of Ministry proper for the medical surpervision business on the basis of Medical Treatment Law, and the subsidy to prefectures
¥ 2,621,000

10. Expenses required accompanying the execution of the A-class sick-nurses' state examination
¥ 5,101,000

11. Expenses for the purchase of the special medicine (promin)
¥ 95,000,000

12. Other expenses of Ministry proper for the medical administration
¥ 3,870,000

13. Expenses for national sanatoria
¥4,589,828,000

14. Expenses for medical affairs branch offices
¥ 11,463,000

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8. Expenses for the investigations of the causes of deaths etc.

¥ 3,216,000 (¥ 3,203,000)

9. Expenses of Ministry proper for the medical surpervision business on the basis of Medical Treatment Law, and the subsidy to prefectures

¥ 2,621,000

10. Expenses required accompanying the execution of the A-class sick-nurses' state examination

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11. Expenses for the purchase of the special medicine (promin)

¥ 95,000,000

12. Other expenses of Ministry proper for the medical administration

¥ 3,870,000

13. Expenses for national sanatoria

¥4,589,828,000

14. Expenses for medical affairs branch offices

¥ 11,463,000

The 4th are

Expenses for the counter-measures for pharmaceutical affairs

¥ 810,996,000

the main items of which are

1. Expenses of Ministry proper for the control over the dealers in medicament on the basis of Pharmaceutical Affairs Law, and the subsidies for the expenses of prefectural pharmaceutical supervisors

¥ 8,000,000 (¥ 1,656,000)

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2. Expenses accompanying the execution of the pharmacists' state examination
¥ 4,992,000

3. Expenses of Ministry proper for the security of production and distribution of medicament
¥ 5,943,000

4. Expenses of Ministry proper for the registration of medicament, toilet articles, etc.
¥ 2,321,000

5. Expenses of Ministry proper for the counter-measures for biological preparations, etc.
¥ 3,109,000

6. Expenses for the control over the narcotics and for the control and supervision over the growth of hemp
¥ 37,144,000 (¥ 2,113,800)

7. Expenses for the amendment of the pharmacopoeia with the intention for the just and proper purities and qualities of medicines
¥ 940,000

8. Expenses for the security of the supply of the special medicament (streptomycin, and vaccines against cholera, influenza, and erruptive ~~typhoid~~ typhus) ¥ 699,420,000

9. Expenses for the allotment of the designated materials for production required for the production of medicament
¥ 9,667,000

10. Expenses for the superintendence of the distribution of the precious metals for dental use
¥ 517,000

11. Other expenses of Ministry proper for the operation of pharmaceutical administration
¥ 4,577,000

12. Expenses for national hygienic laboratories
¥ 34,358,000

Beside these expenses, budget items concerning the Ministry of Welfare included in the local financial equalization grant of the general account under jurisdiction of the Prime Minister's Office are as follows:

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control and supervision over the growth of hemp
¥ 37,144,000 (¥ 2,113,800)

7. Expenses for the amendment of the pharmacopoeia with the intention for the just and proper purities and qualities of medicines
¥ 940,000

8. Expenses for the security of the supply of the special medicament (streptomycin, and vaccines against cholera, influenza, and erruptive ~~typhoid~~ TYPHUS
¥ 699,420,000

9. Expenses for the allotment of the designated materials for production required for the production of medicament
¥ 9,667,000

10. Expenses for the superintendence of the distribution of the precious metals for dental use
¥ 517,000

11. Other expenses of Ministry proper for the operation of pharmaceutical administration
¥ 4,577,000

12. Expenses for national hygienic laboratories
¥ 34,358,000

Beside these expenses, budget items concerning the Ministry of Welfare included in the local financial equalization grant of the general account under jurisdiction of the Prime Minister's Office are as follows:

1. Expenses for the control and supervision of raw hide the processing plant
¥ 3,048,000

2. Expenses for the infection disease control
¥ 2,500,000

3. Expenses for the subsidy to periodical preventive vaccination expenses
¥ 8,545,000

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4.	Expenses for the subsidy to the enforcement of rodent and insect control	¥ 591,716,000
5.	Expenses for the subsidy to tuberculosis prevention expenses	¥ 3,557,000
6.	Other expenses	¥1,514,010,000
	Total	¥2,123,384,000

This total amount plus: ¥638,733,000 for Local personnel subsidy that was counted in the expenses under Local Autonomy Agency will be

¥2,762,117,000

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Nursing Service

in the Field of Public Health.

I Basic Functions of Nursing Service in Public Health Field

A. Case finding.

In contacts made with patients in the clinic and their homes the public health nurse has opportunities of finding all types of public health problems.

B. Referral of cases.

Nurses are not qualified to diagnose conditions nor to prescribe treatment so she must always refer patients who have symptoms to physicians and dentists, therefore, if she does her work well the physicians practice should increase.

She refers patients who have social problems to medical social workers.

C. Follow up of cases

After treatment has been prescribed for the patient the nurse help the family to carry out the doctor's recommendations.

D. Bedside nursing.

The public health nurse does not have time to give all necessary nursing care to her patients but she is responsible for teaching some member of the family how to give it. She does this

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The public health nurse does not have time to give all necessary nursing care to her patients but she is responsible for teaching some member of the family how to give it. She does this by actually demonstrating the care and then by supervising the care given by the family.

All of these functions should be carried out on the basis of instruction or health education. In order to do this the public health must have a knowledge of the patient's emotional reactions as well as a knowledge of his physical condition.

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II Planning the Nursing Service

The public health nursing service must be planned according to the total public health program. It should be planned as a family health service and it should implement all of the medical services provided by the health center. When the prefectural health department public health programs are formulated the nursing service must be planned at the same time so that it will be well coordinated with the total program.

The above is also true of clinical nursing and the medical service and of midwifery and the maternal & child hygiene service. Both of these services contribute to the community's health and are a part of the total public health program.

III Nursing Education.

There is no doubt that nurses must be trained in a well organized educational institution and that additional training is needed by clinical nurses to work in the field of public health. However it is difficult to separate public health nursing from nursing in general and this we must seriously consider when we plan future nursing education.

The purpose of re-education or in-service training is to evaluate present policies and to teach new concepts so that our work keeps pace with the times and so that we continue to improve.

At present there are many nurses in hospitals and public health programs who lack special preparation for their work. For

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