

# International Health: Its local and global perspectives from Japan

## — Lessons from the 2011 Great East Japan Earthquake —\*1

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Global Health Committee of the Japan Medical Association

The Japan Medical Association (JMA)'s Global Health Committee was launched in 2008 to examine its past international activities and to consider its future perspective.

This report first reviews the progress in JMA's domestic and international activities in 2010–2011. It then discusses the 2011 Great East Japan Earthquake as the top priority issue. This is because the scale of the disaster was so devastating that the JMA's effort in response inevitably went beyond the domestic framework and expanded to the international stage. This report concludes with recommendations for the JMA's international activities in the future.

### Background

The JMA has been contributing both nationally and internationally by undertaking diverse initiatives that enhance medical ethics and improve public health. In Japan, the JMA promoted and improved community healthcare and universal health insurance coverage, which have contributed to the world longest average life expectancy. The JMA has also made global contributions through its membership of the World Medical Association (WMA) and the Confederation of Medical Associations in Asia and Oceania (CMAAO) and other international activities.

Today's globalization has made the world increasingly borderless, and in this environment the authority responsible for total healthcare of a nation should not be satisfied with its own domestic situations. Medical professionals in Japan face various international problems, such as medical tourism and the Trans-Pacific Strategic

Economic Partnership Agreement (TPP). A global perspective is essential to solve these problems and further develop healthcare in this nation.

Having global perspectives does not only mean learning from other advanced countries. As shown later, experts in international cooperation with good experiences in developing countries played an active part in the aftermath of the Great East Japan Earthquake on March 11, 2011. They were able to take very practical and prompt actions in disaster-stricken areas where the infrastructure was severely shattered. Their experiences in developing countries proved to be useful and effective in solving many health problems in the devastated areas.

Sending messages out from Japan to the international community is another important aspect of having a global perspective in order to enrich global activities. Not only Japan can greatly contribute to the world in the field of basic research achievements such as vaccine development, its excellent public healthcare services can have global significance to other National Medical Associations (NMAs). Sending out reports about Japanese excellent local healthcare activities to the world would enable international feedback, which will allow healthcare activities in local communities to become more universal. There is a close connection between the community health and global health.

### Global Health Activities in Japan

Under the subject of global health activities, two topics in particular recently gained attention: "task shifting" and TPP membership. "Task shift-

\*1 This article is based on a report compiled by the JMA's Global Health Committee in March 2012 (jmaintl@po.med.or.jp).

ing” in healthcare is the term given to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. This is a global health issue that Japan also currently faces. The TPP membership issue has attracted attention from the standpoint of public healthcare. Below, the topic of task shifting is extensively examined.

One reason that task shifting came to draw worldwide attention is the HIV/AIDS epidemic in Africa. The proportion of HIV-positive people reached nearly 20% in some African countries, and many health professionals themselves died of AIDS. Because of national damages, it became difficult for physicians alone to diagnosis and treat HIV-positive people in such countries.

This created a situation in which some areas of medical practices had to be entrusted to nurses and other health professionals. On one hand, the scope of practice of nurse practitioners in the US and Europe has been expanding. In these global trends, there have been calls for expansion of the duties of nurses and other health professionals in Japan, and task shifting is now one of the major focuses for discussion.

The JMA’s Global Health Committee held meetings to discuss this problem. Its representatives also participated in the CMAAO Ad-hoc Committee Meeting held on March 2–4, 2011, where representatives of the CMAAO and WMA gathered to discuss the issue of task shifting and sustainable development of medicine.

This CMAAO committee meeting first discussed the guidelines on task shifting issued by the World Health Organization (WHO) and WMA. Some shared opinions include: “All-too-easy task shifting could backfire rather than provide safe medical care to patients,” “Task shifting should be implemented only under special circumstances, such as when there is a serious lack of medical profession or an emergency situation,” “When task shifting is implemented, it should be regarded as a temporary measure taken with the purpose of concluding it in a short time.” Other emphasized ideas include: “Shifting should be limited to specified skill-related practices and should not extend to knowledge-intensive tasks such as diagnosis and prescription,” “Tasks should be shifted under the direction of physicians with the premise that patient safety and professional autonomy will be ensured.”

In light of these opinions, the ad-hoc com-

mittee drew up the CMAAO Tokyo Statement with eight recommendations, including: “task shifting approach should not be seen as the final solution to address medical workforce shortages,” “transferring of tasks should be restricted to skill-related practices and should not be extended to knowledge-intensive practices such as diagnosis and prescription,” and “governments should not view task shifting as a cost saving measure.”

Task shifting used to be an important issue in developing countries. The fact that it now holds important implications in Japan as well is worth noting. A similar situation may arise again in future, and having a global perspective will be essential in addressing such issues.

## Global Health Activities on the International Stage

The global health projects conducted by the JMA from 2010 to 2011 included activities relating to the WMA and CMAAO, Takemi Program at Harvard School of Public Health, and publication of JMA Journal (JMAJ). Below is an overview of these activities.

### WMA activities

Besides the Council Sessions and General Assemblies, the WMA uses its own networks to hold meetings on individual themes. To name a few, at two meetings, namely the Financial Crisis—Implications for Health Care seminar (Latvia, 2011) and the Expert Conference on Ethics of Placebo Control in Clinical Trials (Brazil, 2011), groups of experts achieved great success and contributed to the WMA’s policy. The JMA has actively participated in these individual meetings as well. The fact that the JMA has been deeply involved in discussions of globally important issues in healthcare is of great significance.

The WMA expressed a strong interest in Japan’s earthquake and tsunami disaster of 2011. In response, the JMA gave presentations about the disaster from the medical profession’s view point at the WMA meetings and contributed disaster-related articles to the World Medical Journal (WMJ), an official journal of the WMA.

### CMAAO activities

The JMA hosted the above-mentioned CMAAO Ad-hoc Committee Meeting on Task Shifting

in March 2011, to which major NMAs of CMAAO and some representatives from the WMA attended. The CMAAO Tokyo Statement on task shifting was adopted in this meeting, which was later adopted as a CMAAO Statement at the CMAAO General Assembly in Taiwan in November 2011.

The Articles and Bylaws of the CMAAO were also completely revised at the General Assembly in 2011. In this revision, it was decided that a mid-term council meeting held every other year be abolished and a General Assembly be held every year from 2013 in order to improve the contents of future CMAAO meetings and strengthen its voice in the WMA. Information on these CMAAO activities is circulated internationally through the JMAJ. CMAAO member NMAs are expecting the contents of JMAJ to further improve as a publication media that send out information about healthcare situation in the Asia-Oceania region and the activities of the CMAAO and its members.

#### **Takemi Program at Harvard School of Public Health**

The Takemi Program in the International Health at the Harvard School of Public Health (HSPH) was established by HSPH and JMA in 1983. Two Japanese physicians in 2010 and one in 2011 studied in the program. Many of the past Japanese Takemi fellows have been making tremendous efforts to contribute to the Japan's foreign policy development beyond the field of global health. The Takemi fellows, both old and new, are expected to play more active roles in the future health policy making both nationally and internationally. The year 2013 marks the program's 30th anniversary, and a special program is being planned.

#### **JMAJ's role to disseminate information to the international community**

The JMAJ was originally published by JMA as the Asian Medical Journal in 1958, it changed its title to the Japan Medical Association Journal (JMAJ) in 2001. At present, the JMAJ is distributed to medical researchers and medical-related organizations in about 110 countries worldwide. The articles are available for free on through the JMA's English website (<http://www.med.or.jp/english/>).

Articles published in the JMAJ in 2010

include diabetes countermeasures, global health activities, universal health insurance, global warming countermeasures in hospitals, and a review of worker's accident compensation insurance and compulsory automobile liability insurance in Japanese public medical insurance program. In 2011, the main topics were about the occupational physician system, the Japan Medical Association Team (JMAT) dispatched in the aftermath of the Great East Japan Earthquake, JMA's continuing medical education, and home medical waste. Summaries of the CMAAO ad-hoc committee meeting held in Japan in March 2011 was also published in the July/August 2011 issue. Furthermore, the records of CMAAO formal meeting held every year have been included as a special issue. Additionally, messages about experiences and lessons learned from the Great East Japan Earthquake have been authored by members of the JMA's Global Health Committee as a special series.

#### **JMA's Activities in the Great East Japan Earthquake: The global health perspective and strengthening of community healthcare**

The JMA's Global Health Committee held a series of discussions as outlined below about healthcare support for the Tohoku region, which was massively damaged by the Great East Japan Earthquake and the tsunami that it triggered.

#### **Great East Japan Earthquake and global health**

##### **Global health perspective in disaster response**

In this disaster, especially during the acute stage, information was scarce and local disaster response systems were down. This extraordinary situation taught us the importance of the "rules of assistance," which people experienced in international cooperation already knew and functioned better. There are four basic principles: (1) *assisting* does not mean *giving*; (2) response should be flexible based on needs; (3) the importance of respect for human dignity and trust building should be recognized; and (4) support your counterparts rather than doing what you want. Experiences in international cooperation, including practical aspects such as supply management and logistics, were of great help to cope with the post-disaster difficulties.

These experiences were also extremely beneficial when handling basic sanitary problems due to lack of water, non-functional toilets, and no electricity. This kind of situation is rarely experienced in Japan, but it is a daily experience in developing countries. When the community healthcare system came to a standstill, it taught the importance of constantly improving the basic factors in primary healthcare such as education of community residents and health professionals in peace times. There is also a need to sincerely study and look for the most effective way to utilize overseas assistance for the affected people in disaster areas so that we can be better prepared to cope with the future disasters.

There are several things to reconsider in the future. For example, Japanese government's medical relief teams for domestic and international disasters are relatively small teams composed mainly of physicians and nurses. Unlike experienced relief teams overseas, they are not equipped with a total relief system consisting of a field hospital and mobile laboratory that can substitute or supplement basic medical care. Although it will require considerable preparation, providing such total relief teams would be ideal in the event of severe disasters. When they are not readily available through domestic effort, facilitating cooperation with emergency teams from overseas is worth considering.

It was found that financial aid was the most effective form of overseas assistance for this disaster. In many cases, domestic relief funds could not meet the emergency needs in a timely manner. In contrast, financial aid from overseas medical relief organizations, which was without legal and administrative restrictions and required short procedures, was shown to be effective.

Lastly, incorporating the non-government relief channels closely linked with the government into the support network beforehand would be advisable in the future. This will help the networks formed through international cooperation and global health activities play an important role.

#### **Role of international NGOs in Japan**

Japan's international NGOs played a major role during the 1995 Great Hanshin Earthquake and during the 2011 Great East Japan Earthquake. They worked especially effectively during the first week after the disaster when the government organizations had difficulty functioning. One of

the major roles was to serve as an agent to gather both domestic and overseas volunteers. Their rich experience in overseas countries was proven effective when dealing with many unstable factors for both Japanese and non-Japanese volunteers to accept.

For example, the Association of Medical Doctors of Asia (AMDA), one of the Japanese international NGOs, formed teams of medical volunteers who offered their help individually and dispatched them to the disaster areas. The action principle for these medical teams who do not know each other was: "Do anything for disaster survivors except things that must not be done." Here, the "things that must not be done" included committing medical errors, causing trouble to disaster survivors, and refusing the proposals of others.

The AMDA accepted four international groups who can speak Japanese, namely from Indonesia, Malaysia, Thailand, and South Korea. International volunteers were accepted because the organization wanted them to actually experience the real situations locally and to change their sympathy-based assistance to respect-based assistance. More specifically, the AMDA wanted them to know why violence did not take place in the evacuation shelters and that the damage from the Fukushima nuclear power plant was limited to particular areas. This was also a countermeasure to control harmful rumors involving the nuclear plant accident.

Generally speaking, there are three purposes for overseas medical teams to go to the affected area during the disaster. They are: (1) to provide medical services to citizens of their own country living in the afflicted area; (2) to require for assistance which the affected country had provided the helping country; and (3) to offer diplomatic humanitarian assistance.

In principle, accepting medical teams from overseas should be handled by private sectors. The government, including the Ministry of Foreign Affairs, needs to deal with the problem of official responsibility. There is a limit to the government's response to the disaster-stricken areas since their capacity is already overloaded. Establishing a system for accepting overseas medical groups during a disaster with the cooperation of international NGOs and foreigners living in Japan is an urgent task to complete before another major disaster strikes Japan.

## Strengthening community healthcare by reflecting the disaster experiences

### JMA's three-layer structure and the JMAT's position

Medical associations in Japan have a three-layer structure in accordance with the administrative levels; the municipality levels, prefectural levels, and the national level (JMA). These associations work in close cooperation with each other, but they are legally independent from one another. Municipal and prefectural medical associations collaborate with their corresponding levels of governments respectively in order to improve community healthcare administration and disaster prevention measures, just as the JMA addresses issues with the national government.

From this perspective, we can see a few characteristics about the activities of the JMA. First is the existence of universal health insurance established in 1961. Municipal medical associations have been dedicated to various activities for the entire public throughout Japan, such as regular health checkups, school physicians, industrial physicians, nursing care insurance, and emergency medicine. Prefectural medical associations have continued to provide them with support in the management area. Prefectural medical associations are playing indispensable roles in the activities such as disaster medicine agreements related to the Civil Protection Law. At the national level, the JMA has been responsible for the medical administration and policies. With individual medical associations in this three-layer structure, which are all an independent organization, the JMA has provided community-based healthcare covering the whole nation by working together with municipal medical associations. This features the activities of the medical associations in Japan.

This three-layer structure effectively worked in the field of disaster medicine in the past. Under the Civil Protection Law, the JMA was involved in disaster medicine services in the Aum Shinrikyo terrorist attacks, the Tokai nuclear accident, and the earthquake and tsunami in Indonesia. During the Noto Peninsula Earthquake and the Chuetsu Offshore Earthquake in Japan, the JMA dispatched the Disaster Medical Assistance Team (DMAT) to assist the local medical associations of the affected areas under the government leadership. But during the Great East Japan Earthquake, JMA established its own

relief teams, the JMAT, to collaborate with the DMAT in disaster medicine.

The healthcare, disaster prevention, transportation, and other basic conditions in the affected areas differ locally. Sharing information is essential in order for medical teams to coordinate their activities, which accordingly requires a chain of command. Municipal medical associations that thoroughly know the local conditions should be in charge, and the prefectural medical associations and the JMA should fully support them.

### DMAT and JMAT

The DMAT, each consisting of one physician, two nurses, and one coordinator, is a medical team that is dispatched immediately after the disaster by the government request. It was launched in Tokyo in 2004 based on the lessons from the Great Hanshin Earthquake in 1995. Each team is specifically trained in acute disaster medicine to respond to the post-disaster needs during the hyper-acute stage (within the first 48 hours).

On the other hand, many people who escaped the damage of the hyper-acute stage have no choice but to live in evacuation shelters such as schools and community centers for a certain period of time. Those survivors include children, elderly, and people with diseases, and there is serious concern about suffering new diseases and worsening of health conditions due to the harsh environment of shelters. Thus, providing proper medical and health care in evacuation shelters is an important issue, especially since local medical facilities are often severely damaged and the means of transportation may become restricted in time of disaster.

The JMAT is a term for medical teams proposed by the JMA in March 2010. The JMAT is to engage in medical and healthcare activities during the acute and sub-acute stages following the DMAT withdrawal. Each JMAT team consists of a physician, two nurses, and a coordinator, and pharmacists may participate when needed. Teams are dispatched to the disaster areas typically for three days to one week to provide medical care as continuously as possible. Each team is to bring their own supplies, including medicines for patients and foods and beddings for their use, so that their assistance does not deplete the limited local resources.

The JMAT program during the Great East Japan Earthquake was covered by the damage insurance of the JMA. Many physicians and

healthcare personnel offered to help the disaster victims based on professional autonomy advocated in the WMA Declaration of Seoul. This was the Japan's largest disaster relief activities for the earthquake and tsunami victims. The intention of the JMAT activities is to support those who are responsible for community healthcare, who are also the disaster victims themselves. Generally, the DMAT and the Japanese Red Cross Society withdraw from the assigned areas as the healthcare systems in those areas recover. However, the JMAT supports the self-recovery activities of the local medical associations that provide community healthcare so that services would continue to be properly provided under the universal health insurance program. This also is a part of the JMA's advocacy, which emphasizes the importance of community healthcare.

**“Well prepared means no worries in time of need”**

One lesson learned from this disaster was that we cannot do what we were not prepared to do. Most disaster response manuals assume earthquake damages, not the kind of large-scale tsunami disaster. Responding to what had been already anticipated went well, however, the response to unexpected difficulties was extremely poor with all the post-disaster confusion. Nevertheless, a number of difficulties were overcome through the wisdom and extraordinary efforts of many people. These valuable experiences should be reflected in the preparation for future disasters, to make the disaster response and relief activities more timely and effective.

Local authorities throughout Japan, as well as health professionals, healthcare organizations, and related companies and industries that are expected to play an important role in disaster preparedness and response, should all reevaluate their disaster manuals—especially those facing the risk of major earthquakes and tsunami damage along the coastline. The disaster manuals should be revised to include more specific and practical guidelines to disaster response.

**Lessons from the disaster**

- 1) Need of simulations of large-scale mass disasters

Simulations must include a number of patients using different sizes and types of disasters, such as earthquake, fire, and wide-area

radiation exposure. At each stage of the post-disaster, most appropriate healthcare should be provided in accordance with the needs. In the 2011 disaster, there were relatively less needs for emergency surgery compared with the past disasters. Mental care should also be provided for the affected people in the sub-acute and long-term stages.

- 2) Patient transportation and material supply  
The patients on dialysis or with serious diabetes in the affected area often had to be transported to different facilities in the same area or to distant facilities to avoid aggravation. Multiple means of transport should be arranged, including air transport in case of emergency. This time, even the risk of starvation was real in some isolated areas. The media helicopters should also transport and deliver a minimum amount of food and drinking water when flying over the isolated areas.
- 3) Medical care for radiation exposure  
An independent medical care system should be created in the radiation-exposed areas. After the Fukushima nuclear accident, there was an urgent need to publicly disclose maps of the areas that needed to be evacuated. At the least, the information about the areas that should not have been evacuated should have been made available. In the areas with nuclear power plants, certain drugs must be always stored in case of emergency. Iodine tablets should always be available for distribution like Europe.
- 4) Cash support  
Compared to the Great Hanshin Earthquake of 1995, there was insufficient financial support to build emergency systems during this disaster. Many people had no cash, and credit card was no use in the affected areas. New emergency countermeasures may be in need. A digital verification of personal identification may be a good tool to handle medical records and provide healthcare services under the universal health insurance system. The best form of financial support were cash, with flexibility on how to use it (e.g. purchasing vehicles). About 0.8 to 1.8 billion yen (10 to 22.5 million USD<sup>\*2</sup>) of the JMA's funds were used. Taiwan including Taiwan Medical

\*2 Yen/US dollar exchange rate: 1 US\$=80 yen.

Association donated about 40 million yen (0.5 million USD) to the JMA as the restoration fund.

5) Prophylactic use of iodine

After the Fukushima Daiichi nuclear plant accident, reportedly there was a delay in prophylactic administration of iodine to children. Some overseas health professionals estimate that patients with radiation damage will emerge as early as 2012. This delay might have resulted from a poor sense of crisis about a nuclear accident. People living in the areas of possible radiation exposure should have been informed of the importance of taking iodine tablets a few hours before exposure. This incident revealed that people in Japan were living in a myth of nuclear safety based on thin evidence. Information about the geographical distribution of radiation exposure and its level should have been provided to the public, especially to the local people, and instructions should have been provided about the direction to evacuate to. Overseas experts estimate that the rates of leukemia and other diseases for children and adults will rise in three to five years. The delay in initial response and disclosure of important information had deepened the damage.

6) Fuel stock in hospitals

In-house power generation in hospitals require fuels, such as gasoline and heavy oil. The supply systems for fuels should have included air transport as well. Being able to maintain enough electricity and energy systems for a few days must be considered the minimum preparedness before the outside support can reach.

7) Need for coordinators

There is a need to train disaster relief coordinators. Coordinators who had just been trained in the Miyagi prefecture successfully played active roles. Establishing an organization that can respond to all kinds of crises, like the Federal Emergency Management Agency in the U.S., should also be considered in the future.

Listed below are additional issues we learned from the disaster relief activities.

8) Need for combined assistance between affected municipalities and non-affected prefectures to augment and complement local

staff and administrative system

- 9) Creating the emergency and disaster relief funds, which can be made available at the discretion of local governments of the disaster-stricken areas
- 10) Education and development of emergency response teams nationwide that can promptly lead disaster relief efforts
- 11) Identifying and registering the teams of various specialties that would become essential for disaster relief, and developing a mobilization system to dispatch them in time of disaster. (This requires having a prior agreement with research institutions, expert organizations, industry groups, and NPOs.)
- 12) Creating a permanent disaster information center that can centralize basic information during a disaster for intensive management and information sharing (e.g., information management planning, information and data standardization, establishment of disclosure rules for survey data, preparation of a communication system and the internet environment during a disaster, etc.).
- 13) Developing a system that can make effective use of external resources including business companies and volunteers in order to build a network of logistical support and coordinate disaster relief efforts
- 14) Reviewing basic knowledge about disaster medicine management and its dissemination to health professionals and related organizations. This includes enhancing teaching materials, training instructors, and expanding education and training opportunities.
- 15) Adding other specialists such as nutritionists to the JMAT members
- 16) Good utilization of local human resources

## Recommendations

### Community health and global health

Experiences in the Great East Japan Earthquake taught us that community health and global health are strongly correlated to each other—like the two sides of a coin. In particular, the JMAT's activities in disaster relief through the JMA network enabled the local medical associations nationwide to support the disaster areas. There are many lessons we can learn from this commendable achievement in the interest of global health.

For example, the JMA's expertise in the disaster relief activities can be shared with other countries that potentially face similar natural disasters to enrich their systems. If and when a large-scale disaster strikes and assistance from neighboring countries is needed, sharing information about the disaster support systems of each other will considerably help implement the much needed relief activities smoothly. This would be a great international contribution. Only the JMA, which actually played an active role in the relief activities to network and control total medical care in the aftermath of the disaster, can contribute in such manner. We do hope that the JMA will be actively involved in the development of disaster relief programs of other medical associations in Asia.

#### **Cooperation among the local and global experts**

The JMA's Global Health Committee, which consists of physicians who are actively involved in local healthcare and global health experts who work all over the world, engaged in lively discussions. Both groups provided specific comments on the topics of the disaster and task shifting. Recognizing that the community health and global health are closely related to one another not only during emergency but also in peace time, community health professionals should make efforts to learn from the world and disseminate their achievements to the world.

#### **Leadership in the global health programs**

The JMA has demonstrated strong leadership in the Takemi Program, the WMA, and the CMAAO from 2010 to 2011. Further efforts in these activities are greatly expected.

#### **JMA's Global Health Committee and Committee on Emergency and Disaster Medicine**

At least two JMA's committees were involved in the relief programs in the Great East Japan Earthquake, namely the Global Health Committee and the Committee on Emergency and Disaster Medicine. Although there were informal exchanges of opinions between the members of the two committees, there were no formal joint activities. In future, when appropriate it would be advisable to hold official joint committee meetings to address specific problems that both

committees can contribute.

#### **Applying what we learned**

The lessons from the Great East Japan Earthquake have already been stated above. Considering massive earthquakes which epicenters are predicted to be in or near major cities in the future, the JMA's disaster relief programs should fully take advantage of these lessons at each level of the three-layer structure.

#### **Enhancement of secretariat functions**

One important message from the disaster relief effort in the Great East Japan Earthquake is "Well prepared means no worries in time of need." We hope that the JMA will enhance its secretariat function, not only for natural disasters but also for challenging diverse global issues.

#### **Conclusion**

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The community healthcare and global healthcare are closely linked. We have learned that it is important to have a bi-directional point of view, the local activities seen from a global perspective and the global activities from a local perspective.

Protecting the health of community residents is an important and eternal mission of local medical associations. Both community healthcare professionals and global health specialists should actively learn from each other's efforts and send out information about their activities to the world. In reality, unfortunately, daily practice keeps them busy, and the close relationship between the community and global health often goes unnoticed.

However, this relationship does certainly exist. For example, the JMAT activities were not unique to the JMA and its prefectural and municipal medical associations; they were support activities to enhance the healthcare system in the disaster areas based on community healthcare practice, and therefore served as a fundamental power in the recovery of healthcare in the affected areas. In this sense, although it was created based on the Japan's community healthcare system, the JMAT program can be effective in other countries as well. The JMAT program is versatile and can serve as a basic model for an effective disaster relief program for medical associations in neighboring countries. This is also another example of a close relationship between



community and global healthcare.

Building an appropriate relationship between physicians and other health professionals is a challenge in community healthcare practice, and this challenge is not unique to Japan. Healthcare professionals in the world face the same problem, and they too are searching for a good solution. Studying the other countries' efforts should prove useful. It is true that the Japanese healthcare system differs from those in other countries. But trying to reach a solution only through our own endeavor may lead us to an insufficient result. In today's world, having global perspectives has become essential even for addressing domestic issues.

So, what is our basis to consider the current domestic and global problems? We have a synergy effect created by the close network of municipal and prefectural medical associations and the JMA, which has supported community healthcare thus far. What must not be forgotten is a fact that prefectural medical associations and JMA exist between local medical associations and the global level. The efforts of prefectural medical associations and the JMA to support and enhance community healthcare activities

will bring the local and global healthcare closer together. Hopefully, this perspective of the committee will be further reflected on the daily activities of the JMA.

Taking these into account, we should turn our attention to the fact that there are areas in the world that are less fortunate. Let us look back once again at the support received from overseas for the Great East Japan Earthquake. Financial support totaling hundreds of millions of yen was received from developed countries, which greatly contributed to the victims of the affected areas. We must never forget that the list of the countries that donated money to Japan also included the poorest countries of Africa with per capita gross national income of \$200 to \$300. They did all they could to support Japan because of the trust that has been built between these countries and Japan. What they showed us was their deep and heartfelt compassion, which transcend money. This disaster has taught us how precious mutual cooperation on a global scale is. We do hope that this spirit of mutual cooperation will continue to stay in Japan and enhance the level of local healthcare.

## Global Health Committee of the Japan Medical Association (2010–2011)

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