LECTURER PROFILE

Emiko Namihira gained her MA from Kyushu University (Japan) and PhD from The University of Texas at Austin (USA) in anthropology. About 40 years of Namihira’s career in teaching and research in anthropology has been experienced in four Japanese universities. She has been engaged in anthropological field work in many areas in Japan since 1964. Her specific themes of anthropology are medicine, and beliefs and customs relating to death.

DECIPHERING THE FRONTLINES OF MEDICINE

CHANGES IN JAPAN OVER THE PAST HALF CENTURY WITH REGARD TO THE DISEASE STRUCTURE, VIEW OF DISEASE AND TREATMENT AND THE EFFECT OF THESE CHANGES ON ASIA

Over the last 50 years the world of cultural anthropology has seen changes in both methods and research themes, but among the various changes one thing that has remained constant is the need for specific and detailed basic data, gained from observations on the ground, or from person-to-person interviews. Surveys that target small groups of subjects are still being undertaken, in a similar way to 50 years ago.

People may question whether it is possible to engage in a subject with such a grand title as ‘cultural anthropology’ from a focus on small groups of subjects. However, in the case of psychiatry, for example, case studies have provided the starting point for research and in actual fact the detailed study of individual patients has given rise to significant changes in psychiatric theory in the past. In the same way, given the fact that all humans possess culture and the things that can be understood and identified from that culture can have groundbreaking impacts on the theory of cultural anthropology, a starting point for research is always the collection of detailed data on small groups of subjects. Based on such a stance the question presents itself: what kinds of issues can we identify and address by surveying life and survival in Asia in the face of various diseases, including cancer?

I first began my study of cultural anthropology in 1964. My first subject for research was a small outlying island with a population of around 10 000 people. Although the island had a medical facility it was difficult to find a doctor who would stay there for long and unless people were afflicted by a truly life-threatening or acute illness, they tended not to go to the medical facility at all. As my research and study progressed the number of areas I surveyed grew and until 2006 I was engaged in full-fledged research. During the course of almost without me noticing, it became my own personal style to research places which faced particularly severe situations with regard to medical services and the medical environment.

From the viewpoint of medical anthropology medicine is a science, whereas medical care and treatment are extremely closely linked with society, economy and ideology. Ideology is something that is decided at a very fundamental level and governs how people live from the time they are born until they die. It is also the primary factor in deciding the shape a particular society takes.

From the late 1950s through to the 1960s Japan experienced a period of high economic growth, during which tax revenues increased, making it possible to subsidize the cost of public medical care expenses. Backed by strong economic growth,
standards of medical care improved and individual access to medical care was made easier. Another point to mention is that the ideology of medical care was backed by the introduction of a national health insurance system. This system decreed that no person or any human life should be determined based on how much money a person possessed. The catchphrase of the national health insurance system was ‘Money should not be allowed to let life hang in the balance.’ It was this concept that made not only the development of the national health insurance scheme possible, but also, under the ‘Plan for Remodeling the Archipelago,’ enabled the implementation of an initiatives to ensure that there were no communities without doctors and to construct a public burden system for high-cost medical treatment.

Although it is often said that we live in an unequal society, in the world of medical treatment an ideology is still alive that puts life and health before everything and is equal in nature. If there is any attempt to incorporate the slightest change that seems to create inequality in the medical care system, it causes outrage and opposition. For example, there was opposition to treatment only partially covered by insurance and when it was proposed that the medical system for elderly persons be split off into a separate entity this also caused a storm of opposition concerning discrimination against the aged. Although there are in actual fact more complex political and economic factors at work below the surface, the image that presents itself to the public is that life is inviolable and medical care must be absolutely equal and fair. It is this ideology that supports the current Japanese medical system.

Changes in the Disease Structure Brought About by Changes in People’s Views on Health and Developments in Treatment

In 1961 the Japanese national health insurance system was launched, marking the dawn of public health in Japan. However, at that time it was a reality that even if clinics and hospitals were established, there were many such facilities that did not have medical staff to run them. It was therefore the case that the situation in which many people did not have access to the benefits of medicine did not change overnight. One of the major targets set out in the ‘Plan for Remodeling the Archipelago,’ authored by Kakuei Tanaka, was to ensure that medical staff were present in every community throughout Japan and that medical schools would be developed in prefectures where they had not existed beforehand. Accordingly, medical schools and universities were established throughout Japan and the number of doctors increased accordingly. In 1964, the year in which I began my research, the benefits of Japan’s high-growth era were starting to become apparent and permeating through the country’s social systems. I felt this at the time because my research required me to visit rural agricultural, fishing and mountain villages and engage in detailed interviews. The sort of questions I asked were whether anyone in the family had felt that their life had been in danger due to disease; what they had done when faced with a life-threatening disease; if they remembered what diseases or conditions people in the family had died from; and what kind of nursing care they had received and who had provided it.

When you look at medical care through the spectrum of cultural anthropological methods, you are able to see the picture from above by examining the smallest details. It is perhaps a paradox, but you cannot see the bottom when you are looking down from above, but when looking from the bottom you can see up to the top. By asking what decisions people made when their lives were in danger and what methods they used to protect their lives, and whether these methods were successful or not, you are attempting to see these things against a historical backdrop to the greatest degree possible. For example, I have heard stories from within the same family, about when the grandfather’s life was in danger it was ultimately not possible to save his life, but at a later date when the grandmother’s life was in danger, an ambulance came and took her to have surgery, which cost $20,000 yen. By listening to these stories we can see how, over the course of 20 years, the medical system in Japan, or the medical economy, underwent significant changes.

What can we say about the future? While it is easy to believe that views on life and death, the value of life and perceptions of disease are all fixed, in actual fact they are constantly changing. In actual fact, when you look at the case of people living in small rural communities and hear the thoughts of people of different ages, you can see just how dramatically views on life and death are changing and how susceptible they are to change. There are a variety of factors that are all intertwined, and they affect each other in a systematic way. For example, the national health insurance system in Japan enabled any resident of an isolated mountain village to receive treatment without having to worry about money and also enabled these residents to select a medical institution where they receive the treatment. Although there are various complex factors that are all intertwined, they have come together to change people’s views of life and death and disease. Japan is one of the rare societies in which it is possible to decide whether or not to receive treatment without having to factor in economic concerns. We should bear in mind that a country with a population of 120 million that has a medical care system under which it is possible to receive advanced medical treatment without worrying about money is a very rare country indeed.

At the time when I started my research I was able to gain access to data from the 1910s onwards, which detailed the causes of death of people in Japan. Most of the older causes were given as ‘sudden death.’ Although many of the interviews I collected were based on vague memories and testimonies, when I presented these interviews to a doctor to peruse, the doctor guessed that many of the ‘sudden death’ cases where probably attributable to a variety of conditions, such as cerebrovascular disease, heart disease, digestive system disease or influenza, for example. However, very few of the causes of death were actually given a name. In the past it used to be the case that tuberculosis was so prevalent as to
be almost thought of as a national disease of Japan, but even tuberculosis was not mentioned very often as a cause of death in early records. The reason for this was that even as late as the 1980s there was a stigma attached to tuberculosis and the family of a person who had died from the disease tended not to mention it.

The first story I heard about a death from cancer was in 1976. It was in a village in which there were a number of households where family members had succumbed to tuberculosis and in 1974 a man and wife had both died of cancer, leading to stories about a family prone to cancer. Subsequently there were other deaths from cancer in the same village, which led people to think that cancer was not a disease that was passed on through families. Cancer had become a widespread disease, but until around 1990 there were few means of discovering and treating cancer in its early stages and it was said that life expectancy after a cancer diagnosis was between 6 months to a year. The case fatality rate for cancer was extremely high and people were dying even before starting treatment. The case today is rather different in that some people are still alive 10 years after diagnosis and others who may have been told they have 3 years left to live are still alive after 5 years, even in cases where cancer has returned. We hear many such stories today. We can, therefore, see that observing changes in the disease structure in Japan at the micro level—in small villages around the country—gives us the same picture as the results of various research and surveys.

At the same time we have also seen surprising changes in longevity and the physical status of Japanese people, which the national health insurance system has helped to bring about. This is an accomplishment that cannot be discussed merely in terms of per capita GDP or other similar indices. Although it is said that Japan is becoming an unequal society, the medical system remains resolutely equitable, as a result of which the Japanese people enjoy good health, long life and robust physical status.

Necessity for Social and Cultural Structures When Living with Cancer: Learning from Japan’s Past Experiences

When we talk about surviving cancer in Asia, one of the things that Japan can share with the other countries of Asia is the changes it has experienced over the last 50 years. Japan’s medical care system is robustly underpinned by an ideology that ‘Money should not be allowed to let life hang in the balance.’ This concept started in the early 20th century, when large companies created their own health insurance systems. In addition, there were also cases in Nagano and Iwate prefectures, where residents of small villages created health funds to ensure that no one in the village would be unable to receive treatment due to a lack of money. Although these funds did not last long, they were also early examples of a health insurance system.

In an example in Yamaguchi Prefecture, a landlord realized that one of the reasons that disputes over smallholdings arose was due to the fact that money was a factor in matters relating to life, death and illness. This landlord therefore decided to build a clinic that could be used free of charge by his tenant farmers and which would be funded from rents paid by the tenants. This initiative gradually spread to other landlord associations around the country and there were cases where other landlords built similar clinics on their land. These cases demonstrate that there was a motivation to engage in such welfare-related efforts in local areas from many years ago, and the people who had started this movement maintained their desire to see it spread further. After the war they engaged in further widespread activities and there is no mistaking that it is these activities that provided the basis for the establishment of the national health insurance system in Japan.

Therefore, Japan is able to demonstrate to other countries in Asia not merely the current situation for the national health insurance system, cancer prevention and cancer treatment, but also about how the system actually came about, including relevant case studies. The reason that Japan is able to provide such detailed knowledge about the creation of the system is because it was created over such a short period, and many of the persons who were instrumental in its creation are still alive to testify to the activities that took place. By focusing on Japan’s experiences concerning issues relating to cancer it should be possible for Japan to contribute to efforts to survive or live with cancer in other Asian countries. However, from the perspective of cultural anthropology this is also an issue where cultural differences cannot be overlooked. If you look at the case of the USA, President Obama was eventually able to be successful in systemizing a public medical insurance system, but in the process of creating and formalizing this system he faced a great deal of opposition. The reason that such opposition arose is due to there being a culture and ideology in the USA that is entirely different to that of Japan, where people are expected to take responsibility and make decisions themselves concerning the maintenance of their health, disease prevention, early discovery and early treatment.

In the case of Asia there are many differences among the various countries, with some having adopted a public medical insurance system and others having adopted voluntary or discretionary insurance systems, which are all different and require comparison. Having first compared the various systems that are in use, it will be necessary to acquire know-how about how the wealth created by future economic growth can be distributed most effectively to contribute to public health and happiness. Given the various differences among Asian countries, when talking about surviving cancer in Asia, I think it would be most effective for Japan to disclose all of its experiences. These would include the details of the current status of the medical care system, which Japan has achieved in a tremendously short timeframe, and would also cover all aspects of the ways in which Japan went about creating such a system, from its small piecemeal beginnings, through to the steady but sure efforts that led to the development of current treatment structures and the health insurance system.
CULTURAL MECHANISMS

If we look back on the data that still exist from the Edo period (17th–19th centuries), while the data do not cover a wide expanse of history and is instead limited to small groups, nonetheless it tells us a surprising story about equality of life even in those days.

In the time of Yoshimune Tokugawa, the eighth shogun of the Tokugawa era, it was decided to devise a method of surveying households that would be more precise and accurate than previous surveys. Once this new method of survey was implemented it was used to assess the number of poor and needy people in all areas of the country. Although very few records remain from these surveys, we are fortunate to have the records for an entire ‘buraku’ community (a class of people who were historically discriminated in Japan) from one of the outlying feudal domains of Japan. According to those records the oldest person surviving in the village was 76 years old, and there were also people in their 70s and 60s who were bedridden. The 76-year old resident was a male and it is recorded that he had also been bedridden for 6 years. The fact that an elderly person could survive in a bedridden state even in a community that was discriminated against in one of the less wealthy feudal domains of Japan, suggests that such cases would not have been unusual in other regions, although actual records for other areas no longer exist. However, on the other hand, it was also the case that cultural mechanisms were in place, whereby if prolonging the life of a sick person would put the livelihood and lives of other family members in jeopardy, the family would give up on caring for that person, or the person in question would also give up the struggle to live. The current expression of this cultural mechanism, which has endured through the years while undergoing various changes, is the ideology that ‘Money should not be allowed to let life hang in the balance.’

In contemporary Japan efforts are made to encourage people in the terminal stages of their lives to spend the time they have left at home, and also die at home. There are two aspects to this practice, the first being that it reduces medical expenses and the second being that it enables individuals and families to write their own stories about how they wish to live their final days. This relatively new way of approaching death in Japan has some truly wonderful and rare aspects. The number of clinics that deal with home-based medical care is increasing in communities and the doctors themselves are finding a sense of mission and satisfaction at being able to provide human-centered medical care. Although the costs associated from moving from a hospital-based position to establishing a clinic of your own are very high, the expenses for home-based medical care for people in terminal stages of their lives are fixed and as there is no need for aggressive medical intervention the overall costs are low and also ensure a fixed income for physicians. This is the system that has come to be established. This system also allows the wishes of the individual and their families to be respected about how they want to die. This can also be viewed as a cultural mechanism.

These and other aspects can be shared with other countries in Asia. In a sense, Japan itself is brimming with vast intellectual property that it has built up since the 1960s. In a time when it is being said that the Japanese have lost their self-confidence, we must not forget the tremendous achievement of having created a system that has resulted in a nation of 120 million people becoming the longest lived in the entire world, reaching an age that has never before been seen in human history. We need to look back and examine not just our own lives, but those of our parents and grandparents and talk about the experiences of the various generations. Simply by listening to and writing down our own individual family histories and histories relating to bodily health and disease, I believe that we will be able to recover from our loss of confidence as a nation.

DISCUSSION

Q: When you have visited communities to engage in research, have you ever felt that although the ideas and experiences you are hearing about may be localized or small in the larger scheme of things, they nonetheless have meaning, which has caused you trouble about how to categorize or prioritize the various concepts?

Namihira: I have not been plagued by such worries, which, I think, is the case with the power of academic learning. Cultural anthropology has a wealth of theories that have been built up over long years of research of various societies, concerning what factors affect human actions and decisions. It is a case of applying the theory to the stories that you hear and if you make a new discovery that does not fit with existing theories, you can create a matrix that includes the new discovery and perhaps find some commonalities by writing down the details you have heard to identify links with existing theory. As you look at such a matrix you gradually find links. By visualizing these links on paper they become very clear.

Q: Although people in Japan are living longer, young people today are careless about looking after themselves and some commit suicide. What are your thoughts about this?

Namihira: It is not only that the number of people committing suicide has increased; the fact that suicide has taken a firm hold in society is truly worrying. Not only in Japan, but in general cultural theory death is classified into various kinds, from good death, quite good death, normal death, bad death, to very bad death. In traditional Japanese culture suicide is the worst kind of death, given that life is not just your own, but something that is given to you, and by committing suicide you are not making full use of the life that has been granted you. The cultural view on suicide is that it debases the value of all life, when considering the all the values and benefits that life provides. I believe that in Japan perceptions are changing to a more selfish, self-centered existence, where your body and your life are yours and yours alone.

Q: Why do you think it is that the young people of today do not treat their bodies, children and the things they own with proper care?

Namihira: There are probably many factors, but I believe that one of them is a mistaken understanding of individualism. If you stress the right to self-determination and self-responsibility too much, the things you do yourself become your responsibility. Total individualism is something that I personally think tends to negate our innate human tendencies.

Conflict of interest statement

None declared.