

Changes in Measures against Infectious Diseases in Japan and Proposals for the Future

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Abstract: The new Infectious Diseases Control Law was implemented in April 1999 to thoroughly revamp measures against infectious diseases in Japan. The enactment of this law represents the final stage of transition from the previous system, which was characterized by legislation pertaining to individual infectious diseases, to a system based on a unified, comprehensive law for the control of these diseases. As a result of these changes, measures against infectious diseases in Japan are now governed by five laws: the Infectious Diseases Control Law, Tuberculosis Prevention Law, Rabies Prevention Law, Preventive Vaccination Law, and Quarantine Law. Under the Infectious Diseases Control Law, infectious diseases stipulated as subject to administrative management are classified as Type I (hospitalization in principle), Type II (hospitalization depending on the degree of infectiousness), Type III (restrictions on work), and Type IV (surveillance alone). The designation “infectious disease surveillance” pertains to a group of 44 diseases that require a survey with a complete count to be taken and a group of 28 diseases amenable to fixed-point survey. In addition, a computer-based system has been established to provide information on the current status of 72 infectious diseases in Japan.

Key words: Emerging and re-emerging infectious diseases; Law; Human rights; Medical care system; Surveillance

Introduction

From the 1960s to 1970s, the focus of concern regarding health issues shifted from infectious diseases to chronic diseases like cancer and cir-

culatory disease, similar to the trend in various other parts of the world, particularly the developed countries.¹⁾ In Japan, cholera, a classic, representative infectious disease, decreased markedly because of improved hygiene and

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advances in medicine and medical treatment. Currently, only several dozen people contract cholera annually, and there are very few deaths from this disease in Japan.²⁾ Whereas tuberculosis had ranked first among the causes of death in Japan until 1950, the number of patients and number of deaths declined sharply after it was surpassed by cerebrovascular disease the following year. Emerging infectious diseases, such as AIDS and Ebola hemorrhagic fever, and re-emerging infectious diseases, such as drug-resistant tuberculosis and malaria, have been encountered recently.³⁾ In terms of the quality of measures being taken against infectious diseases, questions have arisen as to how the public welfare system should function while maintaining a commitment to fairness, human dignity, and individual rights.

Laws concerning Measures against Infectious Diseases and Related Problems in Japan

1. One hundred years of the Communicable Diseases Prevention Law

The starting point for infectious disease control in modern Japan was the Communicable Diseases Prevention Law enacted in 1897.⁴⁾ This law was promulgated by the Meiji Government after Japan's former Constitution was ratified in 1889. This law was the first to stipulate measures against infectious diseases in statutory form. It contained certain regulations that were in conflict with basic human rights as understood today, such that compulsory hospitalization was possible simply when ordered by a municipal mayor. The eight infectious diseases covered at the time of the law's implementation had all occurred in the form of repeated large or small epidemics and included cholera, dysentery, typhoid, variola, epidemic typhus, scarlet fever, diphtheria, and plague. Municipal governments were responsible for implementing control measures, and elements of social defense were prominent in regulations concerning the specific implementation of mea-

asures. It was natural to attempt to protect citizens from the threat of infectious diseases by means of this law in the late 1800s, when the number of cholera patients sometimes exceeded 100,000 per year.

The Communicable Diseases Prevention Law remained in effect for a very long period, playing a central regulatory role in the control of infectious diseases in Japan. Its basic framework was maintained even after the current Japanese constitution was established in 1946, after the end of World War II.

2. Law on measures of disease control and health care services

Infectious disease control in Japan has been developed on the basis of laws that focus on particular infectious diseases (e.g., the Venereal Disease Prevention Law and Tuberculosis Control Law) and laws on comprehensive measures designed for particular health care services, e.g., the Preventive Vaccination Law and the Quarantine Law (Table 1). Because at the time of their enactment these laws were aimed at disease- and service-based measures and reflected the current levels of public health, medicine, and medical treatment, as well as the general climate of human rights, there was no coordination among them. In addition, critics pointed out that infectious diseases designated by law might be perceived as dangerous diseases, and might therefore lead to discrimination and prejudice against those with such diseases.⁵⁾

3. Change in measures against infectious diseases in Japan

In July 1996, the outbreak of enterohemorrhagic *Escherichia coli* O157 infection occurred in Sakai, Osaka, infecting several thousand people.⁶⁾ About the same time, a movement to amend the Communicable Diseases Prevention Law with the aim of providing new measures to counter infectious diseases reached fruition, and the Japanese government began to take action.

Table 1 Major Historical Japanese Laws Related to Measures against Infectious Diseases Leading to the Enactment of the Infectious Diseases Control Law

<i>Laws focusing on measures against a particular infectious disease</i>	
• Communicable Diseases Prevention Law	(enacted in 1897, abolished in 1999)
• Trachoma Prevention Law	(enacted in 1919, abolished in 1983)
• Parasitosis Prevention Law	(enacted in 1931, abolished in 1994)
• Venereal Disease Prevention Law	(enacted in 1948, abolished in 1999)
• Tuberculosis Control Law	(enacted in 1951)
• Leprosy Prevention Law	(enacted in 1953, abolished in 1996)
• Law concerning Prevention of Acquired Immune Deficiency Syndrome	(enacted in 1989, abolished in 1999)
<i>Law focusing on measures against sensitivity</i>	
• Preventive Vaccination Law	(enacted in 1948)
<i>Law focusing on prevention of invasion of infectious diseases from outside the country</i>	
• Quarantine Law	(enacted in 1951)

Note: The Rabies Prevention Law (enacted in 1950) has a complex nature involving the above three categories.

Initially, the Ministry of Health and Welfare (currently the Ministry of Health, Labor, and Welfare) set up a subcommittee to review fundamental issues within the Council on Public Health, an advisory body to the Minister concerning general public health measures. The subcommittee consisted of representatives from the fields of experimental medicine, clinical medicine, law, and journalism. The subcommittee published an interim report in June 1997, and submitted its final report, entitled "Measures against infectious diseases in the modern era," to the Council on Public Health in December of the same year.⁷⁾ In addition, after discussion by the Council on Public Health, a bill on the Law concerning Prevention of Infectious Diseases and Medical Care for Patients Suffering from Infectious Diseases (Infectious Diseases Control Law) that sought to annul three of the existing laws, i.e., the Communicable Diseases Prevention Law, the Law concerning Prevention of Acquired Immune Deficiency Syndrome (the so-called AIDS Prevention Law), and the Venereal Disease Prevention Law, was placed before the National Diet in March 1997. After the addition of various amendments, the law was enacted in September 1998 and took effect in April 1999.⁸⁾

New Measures against Infectious Diseases

1. Background of the enactment of the Infectious Diseases Control Law

The presence of emerging and/or re-emerging infectious diseases was not the only factor underlying the enactment of the Infectious Diseases Control Law.⁹⁾ Improvements in hygiene represented by a better sewer system and people's expanded awareness of health brought about a sharp decline in the incidence of water-borne infections. On the other hand, concentration of the population in large cities and tightly insulated houses equipped with air conditioners heightened the risk of air-borne and droplet infections. Another issue was the high incidence of food-mediated infections as well as the increasing scale and spread of such epidemics, which results from joint operations in the areas of food processing and distribution.¹⁰⁾ Another important concern is the frequent use and abuse of antibiotics, causing the emergence of drug-resistant bacteria. Yet another factor in public demand was seeking for better human rights for patients, consistent with the current general trend in society, plus fairness and transparency of administration. Further, with the advent of mass air travel,

Table 2 Classification of Infectious Diseases in Japan

	Nature	Chief measures and actions
Infectious Diseases-Type I	Infectious diseases that carry extremely high risk from a comprehensive point of view including infectiousness and severity of symptoms when contracted	<ul style="list-style-type: none"> • Hospitalization in principle • Measures upon things such as sterilization • In exceptional cases, measures on buildings or for restricting transit • Every physician who has diagnosed the patient is obligated to report
Infectious Diseases-Type II	Infectious diseases that carry high risk from a comprehensive point of view including the infectiousness and severity of symptoms when contracted	<ul style="list-style-type: none"> • Hospitalization according to conditions including presence/absence of pathogen and symptoms • Measures upon things such as sterilization • Every physician who has diagnosed the patient is obligated to report
Infectious Diseases-Type III	Infectious diseases that do not carry particularly high risk from a comprehensive point of view including infectiousness and severity of symptoms when contracted, but that could cause massive outbreak in particular occupational categories	<ul style="list-style-type: none"> • Restrictions on particular occupations • Measures affecting sterilization, etc. • Every physician who has diagnosed the patient is obligated to report
Infectious Diseases-Type IV	[Amenable to complete-count survey] Infectious disease of Type I, II, or III that does not carry particular risk but needs to be observed for occurrence, and whose incidence is relatively low	<ul style="list-style-type: none"> • Every physician who has diagnosed the patient is obligated to report
	[Amenable to fixed-point survey] Infectious disease of Type I, II, or III that does not carry particular risk but needs to be observed for occurrence, and whose incidence is relatively high	<ul style="list-style-type: none"> • Medical institutions in various parts of the country assigned to perform fixed-point surveys should report the case upon diagnosis

more than 16,000,000 Japanese go abroad each year. Air travelers are able to return to Japan from almost anywhere on earth within less than 30 hours, creating the problem of infected individuals entering the country during the incubation period of disease.¹¹⁾

2. Classification of infectious diseases

The primary purpose of the current reconsideration of measures against infectious diseases is to amend the fundamental law on which control measures have been formulated. However, the supposition that measures to control a number of infectious diseases which are diverse in their epidemiological or clinical aspects can be dealt by a single law has been challenged. In response, classification of infectious diseases has been attempted. First, all infectious diseases that necessitate control measures to be taken by the Government were

listed and assessed in terms of infectiousness, route of infection, seriousness of symptoms and conditions, and presence/absence of therapeutic or prophylactic methods. On the basis of the results of this assessment, infectious diseases were classified into four types, from the aspects of the propriety of (1) hospitalization, (2) restrictions on working, and (3) surveillance (Tables 2 and 3). “Infected individuals” (patients in a broad sense) include suspected patients, symptomatic pathogen carriers (patients), and asymptomatic pathogen carriers. These groups often require different actions. To cope with this situation, differences in policies for handling patients were introduced according to the type of infectious disease (Table 4). Infectious Diseases-Type IV were further divided into a group subject to complete-count survey and a group designated for fixed-point survey.

Table 3 Classified Infectious Diseases

	Classified infectious diseases	
Infectious Diseases-Type I	<ul style="list-style-type: none"> • Ebola hemorrhagic fever • Crimea-Congo hemorrhagic fever • Plague • Marburg disease • Lassa fever 	
Infectious Diseases-Type II	<ul style="list-style-type: none"> • Cholera • Bacterial dysentery • Typhoid • Paratyphoid • Acute poliomyelitis • Diphtheria 	
Infectious Disease-Type III	<ul style="list-style-type: none"> • Infectious disease caused by intestinal hemorrhagic <i>Escherichia coli</i> 	
Infectious Diseases-Type IV	[Amenable to complete-count survey]	
	<ul style="list-style-type: none"> • Amebic dysentery • Viral hepatitis • Echinococcosis • Yellow fever • Parrot disease • Relapsing fever • Q fever • Rabies • Cryptosporidiosis • Creutzfeldt-Jakob disease • Fulminant hemolytic streptococcal infection • Acquired immunodeficiency syndrome (AIDS) • Coccidioidomycosis • Giardiasis • Hemorrhagic fever with renal syndrome • Meningococcal meningitis • Congenital rubella syndrome 	<ul style="list-style-type: none"> • Anthrax • Trombiculosis • Dengue fever • Japanese spotted fever • Japanese encephalitis • Infant botulism • Syphilis • Tetanus • Infectious disease caused by vancomycin-resistant enterococcus • Hantavirus pulmonary syndrome • B virus disease • Brucellosis • Epidemic typhus • Malaria • Lyme disease • Legionellosis
	[Amenable to fixed-point survey]	
	<ul style="list-style-type: none"> • Pharyngoconjunctival fever • Influenza • Pharyngitis caused by hemorrhagic streptococcus group A • Infectious gastroenteritis • Acute hemorrhagic conjunctivitis • Acute encephalitis • Chlamydial pneumonia • Bacterial meningitis • Varicella • Chlamydia-caused infectious disease of sexual organ • Herpesvirus-caused infectious disease of sexual organ • Adult measles • Condyloma acuminatum • Hand, foot, and mouth disease 	<ul style="list-style-type: none"> • Erythema infectiosum • Exanthema subitum • Pertussis • Rubella • Infectious disease caused by penicillin-resistant pneumococcus • Herpangina • Mycoplasma pneumonia • Measles (excluding adult cases) • Aseptic meningitis • Infectious disease caused by methicillin-resistant staphylococcus aureus (MRSA) • Drug-resistant pseudomonas aeruginosa infection • Epidemic keratoconjunctivitis • Epidemic parotitis • Gonococcal infection

Table 4 Hospitalization or Restrictions on Work by Legal Mandate According to the Presence/Absence of the Pathogen and Symptoms of Infectious Disease

		Mandated hospitalization	Mandated restrictions on work
Infectious Diseases-Type I	Suspected patients	○	○
	Symptomatic pathogen carriers	○	○
	Asymptomatic pathogen carriers	○	○
Infectious Diseases-Type II	Suspected patients	△*	×
	Symptomatic pathogen carriers	○	○
	Asymptomatic pathogen carriers	×	○
Infectious Diseases-Type III	Suspected patients	×	×
	Symptomatic pathogen carriers	×	○
	Asymptomatic pathogen carriers	×	○
Infectious Diseases-Type IV	Suspected patients	×	×
	Symptomatic pathogen carriers	×	×
	Asymptomatic pathogen carriers	×	×

*Cholera, Bacterial dysentery, Typhoid, and Paratyphoid are amenable to hospitalization by legal mandate, whereas acute Poliomyelitis and Diphtheria are not.

The concept of these four types and the assignment of each infectious disease to a category are unique to Japan, and are open to critical comments from other countries. In supplementary Article 2 of the Infectious Diseases Control Law, it is stipulated that review of the classification of infectious diseases should be repeated every 5 years, in addition to an overall review of the law 5 years after its implementation. Discussion among health professionals is therefore important.

It is possible that new infectious diseases (pathogens) may develop or that existing infectious diseases (pathogens) may undergo changes in infectiousness, pathogenicity, and drug sensitivity. In that case, rapid action, even if provisional, must be taken to prevent the infection from spreading. Therefore, endorsement of the necessary formalities should be provided for by law. Two systems are incorporated in the Infectious Diseases Control Law for this purpose.

(1) Under the new infectious diseases control system, the government can designate a new infectious disease as such and take legal action on its own authority when it is necessary to implement rapid prevention of the spread of infection, even if the pathogen has not been identified. Since this system is executed by government ordinance rather than law, it should be applied under extremely limited conditions. The diseases subject to the ordinance are those restricted to the same or higher levels of infectiousness and seriousness as those of Infectious Diseases-Type I.

(2) Through the designated infectious disease system, the government designates an existing infectious disease as one that requires different control measures from those specified for the current classification of the disease because of altered pathogenicity owing to mutation or for other reasons (such as when a Type IV infectious disease observed for its epidemic trend becomes virulent enough to

require hospitalization by law). The government is allowed to implement necessary measures within a one-year time period.

A new infectious disease is construed as a designated infectious disease after the pathogen has been identified.¹²⁾

3. Restructuring of the medical care system

Under the Communicable Diseases Prevention Law, municipal governments have prepared about 10,000 beds nationwide (as of 1996) for legally mandated hospitalization of patients with infectious diseases in order to deal with the 13 diseases subject to the law.¹³⁾ However, in recent years, the number of new patients with these diseases are about 1,500 annually,¹⁴⁾ and most of the 10,000 beds for infectious diseases are left unused.

In order to restructure the medical care system for patients with infectious diseases under the current Infectious Diseases Control Law, medical care is divided into the following four groups, with three of them assigned to designated medical institutions and one assigned to general medical institutions, according to the type of infectious disease.

(1) Designated medical institutions for specified infectious diseases (about two institutions [about four beds] designated by the Minister of Health, Labor and Welfare) are in charge of the hospitalization of patients with any new infectious disease that is so designated when it is new in humans with its pathogen being unknown and when it is judged to be as dangerous as or more dangerous than Infectious Diseases-Type I.

(2) Class-1 medical institutions for infectious diseases (designated by prefectural governors, one institution per prefecture, about 100 beds) are in charge of hospitalization of patients with Infectious Diseases-Type I.

(3) Class-2 medical institutions for infectious diseases (designated by prefectural governors, few institutions per prefecture, about 2,800 beds) are in charge of hospitalization of patients with Infectious Diseases-Type II.

(4) Infectious Diseases-Types III and IV are dealt with by general medical institutions.¹⁵⁾

This three-tiered designation of medical institutions is not only aimed at segregating the medical treatment of Infectious Diseases-Type I and II but is also expected to serve as a base for training those who will assume responsibility for implementing measures against infectious diseases throughout the country in the 21st century and for the accumulation of knowledge and experience.

4. Considerations regarding the human rights of patients with infectious disease

A patient with a designated infectious disease may receive medical treatment based on the type of infectious disease and the kind of restrictions placed on behavior, for example, mandated hospitalization or restrictions on work. If the prefectural health administration requests legally mandated hospitalization, it is mandatory that proper formalities regarding hospitalization is taken on behalf of the patient, to avoid arbitrary actions by the administrative authority. This is important because such hospitalization may be tantamount to physical restraint in some situations.

The Infectious Diseases Control Law prescribes regulations for securing stepwise formalities based on the spirit and content of the International Covenants on Human Rights (rule B).¹⁶⁾ Prefectural governments are obligated to recommend hospitalization in writing to patients with Infectious Diseases-Type I or II who are judged to require hospitalization. Compulsory hospitalization by legal mandate is permitted only when the patient does not follow this recommendation. If a patient's admission is legally mandated under recommendation or compulsory admission, the hospital stay is restricted to within 72 hours. If a longer hospital stay is necessary, it requires the approval of a third-party council on the review of infectious diseases (composed of members from both the medical and legal communities).

If further prolongation of the hospital stay is

necessary, approval of the council is required by law for each 10 days of extension. If a claim is submitted by a patient who has been hospitalized under legal mandate for more than 30 days, the Minister of Health, Labor and Welfare is obligated to examine the need for such hospitalization and to notify the patient of the assessment. Medical expenses required for hospitalization under legal mandate in cases of Infectious Diseases-Type I or II are to be borne by the national and prefectural governments, excluding those reimbursed by social insurance. Medical care for patients with Infectious Diseases-Type III and IV, which are not amenable to hospitalization by legal mandate, are to be provided according to contract between the patient and the medical institution, in the same manner as in usual medical care.

Some have criticized this procedure of hospitalization by legal mandate as being too slow for the treatment of, for example, typhoid, while others are of the opinion that cautious, deliberate action needs to be taken. Implementation of this system in the future should be considered on the basis of the actual circumstances.

5. Strengthening of measures against infectious diseases of animal origin

Legal measures against human infectious diseases of animal origin have been limited to those against rabies in dogs through the Rabies Prevention Law.¹⁷⁾ The Infectious Diseases Control Law provides for animal quarantine and animal surveillance as control measures against infectious diseases of animal origin. The animals and infectious diseases amenable to such quarantine and surveillance are to be designated by government ordinance. In the first stage of control measures against infectious diseases of animal origin, the monkey has been designated the subject, with Ebola hemorrhagic fever and Marburg disease the targeted infectious diseases. Meanwhile, the target of the Rabies Prevention Law has been extended to raccoons, cats, skunks, and foxes in addition to dogs, and import quarantine and domestic

animal surveillance have been enhanced.

Further considerations based on the current, actual situation in which a wide variety of animals are being imported to Japan as pets are necessary in order to determine whether the subject animals and infectious diseases for quarantine should be extended under the Infectious Disease Control Law.

6. Strengthening the quarantine system

The former quarantine system in Japan targeted three diseases, cholera, plague, and yellow fever, on the basis of the quarantine law in compliance with International Health Regulation (IHR).¹⁸⁾ The quarantine law was revised at the same time as the enactment of the Infectious Diseases Control Law to cover Ebola hemorrhagic fever, Marburg disease, Lassa fever, and Crimean-Congo hemorrhagic fever, in addition to the above three diseases.

Further, the increase in air travel has heightened the risk that infected people would enter Japan during the latent or incubation period of a disease, making quarantine at ports of entry not sufficiently effective. Therefore, regulations aimed at enlisting and expanding the cooperation of quarantine stations and organizations aimed at preventing epidemics, such as health centers, were written into the revised quarantine law. In January 2000, a German tourist who returned to Frankfurt from West Africa developed Lassa fever. Three Japanese passengers were on the same flight as the German patient. The quarantine station followed these Japanese passengers in cooperation with public health centers and the National Institute of Infectious Diseases, and determined that they had not been infected with Lassa virus.

The revised quarantine law includes regulations to confer on quarantine stations the status of health center for travelers who enter and exit the country, i.e., the provision for those embarking from Japan for consultation and information about the characteristics, routes, and prevention of infectious diseases prevalent in various regions in the world. As a result of

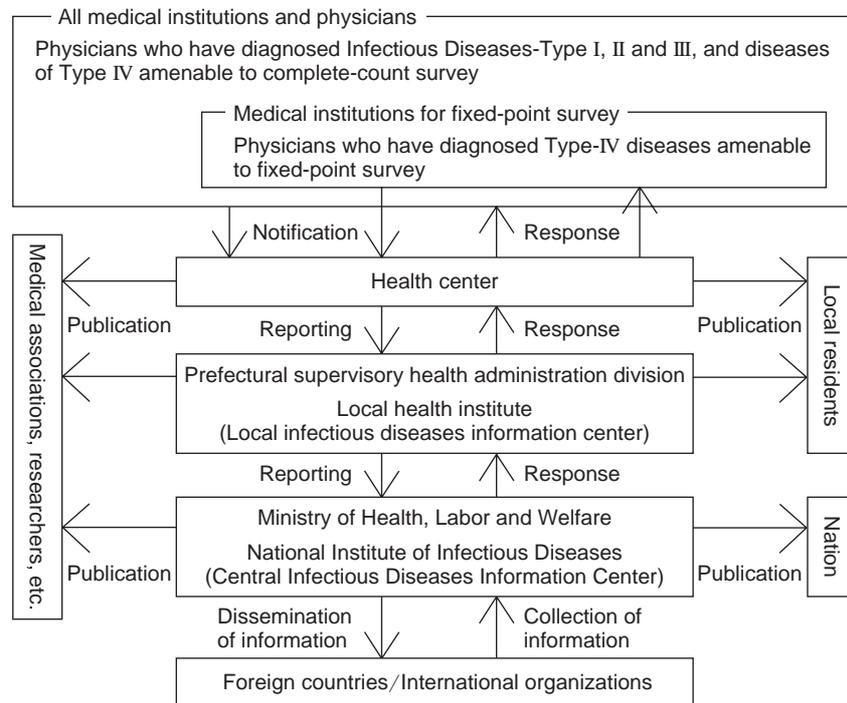


Fig. 1 Infectious diseases surveillance system

these regulations, quarantine stations no longer function simply to check people entering the country.

7. Development of advance measure-based administration

The aspects of both risk management and crisis control are important in providing measures against infectious diseases. Advance measure-based administrative policies including the preparation of manuals that specify control measures for possible cases on the assumption that epidemic outbreaks may occur, rather than devising countermeasures after infections have occurred, are necessary in ordinary times. For this purpose, the Infectious Diseases Control Law places the national government under obligation to publish the basic principles for measures against infectious diseases,¹⁹⁾ and each prefectural government under obligation to map out prevention plans, which are specific manuals of measures against infectious diseases that conform to the actual circumstances

of the region.

Future Considerations and Direction of Measures against Infectious Diseases

1. Improvement of the surveillance of infectious disease

According to the Infectious Diseases Control Law, a national surveillance system is to investigate the trends of occurrence of all 72 diseases assigned to the category Infectious Diseases-Type I (5 diseases), Type II (6 diseases), Type III (1 disease), and Type IV (60 diseases).

This law prescribes that every physician who has made a diagnosis of Infectious Disease-Type I, II, or III, and the 33 diseases of Type IV amenable to the complete-count survey should notify the regional health center. In addition, for the 28 diseases of Type IV amenable to the fixed-point survey [distinguishing measles in adults (18 years or older) from that in younger patients], physicians who have made a diag-

nosis in designated institutions for fixed-point survey should provide information to the health center on a weekly (or monthly for some diseases) basis.

This information will be sent from the health center to the prefectural supervisory health administration division and then to the Ministry of Health, Labor and Welfare. Cases will be totaled and analyzed by the National Institute of Infectious Diseases. Results are then published on the Internet at <<http://idsc.nih.go.jp>>, a site maintained by the National Institute of Infectious Diseases, in the form of the Infectious Diseases Weekly Report (IDWR) (Fig. 1). The data are also available in printed form since November 2000.

Although the infectious diseases surveillance system in Japan has expanded considerably, various issues remain to be discussed and solved. The need for additions to or deletions from the list of 60 diseases included in Infectious Diseases-Type IV and for shifting between the complete-count survey and fixed-point survey should be reanalyzed in 2004, i.e., five years after the implementation of the Infectious Diseases Control Law, when the overall classification of infectious diseases is to be reconsidered. All information collected should be returned to the public in such a way that all citizens can make use of it. Surveillance data should not be monopolized, but should be open to the public, not in the usual form of summaries, but as a database from which personal data are excluded, so that it can be utilized by public health professionals and clinicians engaged in research activities, community health activities, and clinical practice.

2. Provision of appropriate, high-quality medical care

Medical care for infectious diseases has had a history of isolation because of the misunderstanding that it is different from ordinary medical care in terms of infectiousness and high mortality rates, assumptions that arose in the past when no established treatment was avail-

able. However, the medical care of infectious diseases should never be considered special. The Infectious Diseases Control Law provides, to the greatest extent possible, regulations aimed at uniting the medical care of infectious diseases with general medical care. Specifically, such regulations are related to the system of designated institutions for infectious diseases, abolition of limitations on the use of hospital beds for infectious disease, reduction of hospital beds to the minimum necessary number, and concomitant use of public funds and insurance for payment of medical expenses, among others. This is the time to evaluate whether the medical care of infectious diseases based on the new policy is well established in this country. In this regard, a great deal is expected from health professionals as well as the Ministry of Health, Labor and Welfare and the prefectural governments.

Conclusion

In April 1999, a new law based on new ideas regarding infectious disease control in Japan was implemented, replacing a system that had continued for more than 100 years. The new system retains the merits of the past system, while adapting effective control measures employed by other countries and by international organizations, to create an original system that is well suited to Japan's needs. It is important that elements of this system is exported from Japan to other parts of the world and that the contents of the system continue to be re-examined.

The threat of infectious diseases can create change beyond our imagination. There is always the risk that failure to take immediate, appropriate measures may jeopardize public health and bring about a threat to the entire human race.²⁰⁾ Japan must work constantly to improve its control measures and prepare for possible crises while, at the same time, respecting the human rights of patients and others.

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