

*An Alternative Perspective to Battling The Bulge:
The Social and Legal Fallout of Japan’s Anti-Obesity
Legislation*

Barron T. Oda *

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PROLOGUE

There was a time in the world's history when physical peril was the greatest threat to man's existence. Those who reached what we now call "middle age" were considered lucky, wise, brave, skillful, and old. They somehow survived frightening tangles with beasts long extinct, healed from broken bones and torn flesh, braved thousands of freezing, dark nights and all the mysterious, unseen dangers it brought, weathered bouts of famine, and resisted succumbing to hunger, eventual malnutrition, and death. As man's understanding of the world around him increased, so did his chances of survival. Man worked with the elements within his reach. Fire was the first. The night would no longer hold the cold or danger it once did. Earth was next. Man learned to grow edible plants and harvest its fruits. Water followed. Irrigation meant that as much as man needed to feed, he could grow.

Civilization was born and one now became vulnerable to physical peril only when leaving its protection. People clustered together. Social exchange flourished. Ideas were formed. Law developed. Technology progressed. Famine still visited now and again, but in the grand picture it was a mere irritant compared to the newest, greatest threat to man's existence—contagious disease. Laws could protect citizens from each other but was powerless to this new threat. While reaching middle age became more common, those who attained it were still considered lucky. Unseen demons spirited infants away from their mothers with such regularity that a baby reaching his first birthday in good health became a milestone achievement. Scourges thought to have been wrought from the heavens swept through villages, towns, cities, bringing sores, fevers, decaying skin, and death to hundreds, thousands, millions, with each sweep.

Civilization and technology continued to progress over the centuries while contagious disease continued to claim an unfair share of children, picked off those in advanced age, and scavenged those it could from the adult ranks. Those from each generation who met this unseen bringer of illness and survived lived a bit better, a bit more abundantly, than the generation before. Through technology, man's understanding of the world around him increased again. The source of contagious disease—

tiny monsters too small to be seen with the naked eye—was discovered with the advent of the microscope. Medicine, the greatest technology of all, could now contain the greatest threat to man’s existence and extend life so that “middle age” truly became middle-age.

With contagious disease now contained, affluence spread in its place. Standards of living that were considered obscenely extravagant centuries ago were now commonplace in the developed world and famine had been virtually banished. However, a new threat to man’s existence emerged. Just as civilization borne contagious disease thousands of years ago, affluence birthed a new malady, and it too, distinguished “middle age”—chronic disease. Heart complications, risk of stroke, diabetes, and high blood pressure are the new smallpox and bubonic plague. Just as those diseases of the old days announced their appearance with boils and swelling in the armpits, this new disease’s signature is excessive body weight. It also has a fancy name—“metabolic syndrome” or, more commonly known as obesity. Just as the Black Death wiped out one-third of Europe’s population, this disease affects the same proportion of the most affluent population in the world—the United States.

Knowledge of the elements conquered physical peril. Medicine contained contagious disease. One country—ironically the least afflicted of all developed nations—thinks it has the answer to combat chronic disease brought on by obesity. Japan is using the law.

I. INTRODUCTION

This is a story, to be sure. It is a story of a nation facing a problem so novel and enormous that there is absolutely zero precedent on how to solve it. It is a story of a complex modern ailment deceptively simple in appearance. It is a story of doctors with little incentive to do more than the minimum required and the medical system that enables such conduct. And it is a story of ordinary people who have been shut out of the legal system and have few options for redress. This story has been told in bits and pieces before, mostly infused with hefty doses of humor, but it is a serious story and needs to be told in its entirety. The unseen character of this story is *Standards Concerning Implementation of Special Health Examinations and Special Public Health Guidance*, MINISTRY OF HEALTH, WELFARE, AND LABOR Order 159 (“MHWL Order 159” or “Metabo law”). The setting is Japan.

MHWL Order 159 took effect on April 1, 2008. It is more popularly known as the “Metabo” law and aims to reduce incidences of obesity among Japan’s middle age population. Announcement of this new law tickled the imagination of news media outlets worldwide and amused scores of readers. Newspapers ran stories about the new law under headlines infused with irony.¹ Puns abounded.² Fat jokes and tongue-in-

¹ A quick search on the internet will reveal numerous reports embedded with irony and bordering on satire. To illustrate one example, the Irish Times article with the

cheek references to the sport of Sumo wrestling peppered accounts of the legislation.³ Despite the obvious potential for humor, enactment of Japan's Metabo law seems to have struck a nerve—and it's not the funny bone. Comments posted by readers of internet articles that did not poke fun at the law instead raised "Big Brother" cries, accusing Japan of fascism, government-endorsed discrimination, and of being a nanny-state.⁴

Bits and pieces of this story were told in these manners for the next year. It wasn't until 2009 that it was finally told with the seriousness and dignity it deserves—from a scholarly perspective. That fall, Christin Lawler published a comment titled, "An International Perspective on Battling the Bulge: Japan's Anti-Obesity Legislation and its Potential Impact on Waistlines Around the World" in the *San Diego International Law Journal*.⁵ Lawler's thoughtful and provoking comment was an original attempt to (1) predict the effectiveness of the new law in reducing the occurrence of obesity and related diseases among the Japanese population, and (2) examine the potential of effecting similar legislation in the United States. Lawler came to the conclusion that whether Japan's Metabo law will ultimately serve its purpose of curbing the occurrence of obesity among the Japanese population, Japan will emerge as a world leader in addressing metabolic disorders. In Lawler's opinion, such

headline, "Japan Battles the Bulge With Mandatory Fat Checks" began with, "Once the butt of jokes, the sight of men sucking in their bellies just got a lot more serious in Japan, where the government has introduced mandatory 'fat checks' for the over-40s." David McNeill, *Japan Battles the Bulge with Mandatory Fat Checks*, IRISH TIMES, Mar. 27, 2008, at 12, available at 2008 WLNR 5789393.

² See *infra* p. 18 and note 73.

³ One such example: Web-based Neatorama.com, a site specializing in collecting eccentric pop-culture news, picked up an article from the Global Post titled, "Fat in Japan? You're Breaking the Law!" and, taking cues from a photo of a mural depicting two Sumo wrestlers in the original article, ran its own caption under a photo of a Sumo wrestler that read, "Before: Sumo Champion. Now: Scofflaw." Alex (no last name given), *Big In Japan? You're Breaking the Law!*, NEATORAMA, Nov. 12, 2009, available at <http://www.neatorama.com/2009/11/12/big-in-japan-youre-breaking-the-law/>; see also David Nakamura, *Fat In Japan? You're Breaking the Law*, GLOBAL POST, Nov. 10, 2009, available at <http://www.globalpost.com/dispatch/japan/091109/fat-japan-youre-breaking-the-law>.

⁴ Again, a quick search on the internet will produce many examples of such comments left by anonymous readers. A comment on David Nakamura's article, by Paul Hsieh, M.D., read in part, "Such nanny-state regulations are already present to a lesser degree in the United States . . . For our sakes, I hope we won't be 'turning Japanese.'" Paul Hsieh, *Fat In Japan? You're Breaking the Law*, <http://www.westandfirm.org/blog/2009/11/fat-in-japan-youre-breaking-law.html> (Nov. 10, 2009, 10:15 AM CST) (reviewing Nakamura, *supra* note 3).

⁵ Christin Lawler, *An International Perspective on Battling the Bulge: Japan's Anti-Obesity Legislation and its Potential Impact on Waistlines Around the World*, 11 SAN DIEGO INT'L L.J. 287 (2009).

legislation could benefit the U.S. population, but it would ultimately fail due to our individualistic culture and the structure of our healthcare system.⁶

Like all stories, there are different versions told from different perspectives. Some versions of this story—like those few newspaper articles and most web blurbs—are told mostly to entertain. Lawler’s comment seems to have been told to provoke thought and stimulate discussion on the topic. This version of the story will be told to educate, to shine light on social and legal problems in Japan that this law exposes and, in turn, causes. Because the version I will tell differs substantially from Lawler’s, I will point out along the way where Lawler and I diverge on our perspectives.⁷

Good stories have messages. Lawler’s—and it is a good story—seems to be that Japan has a “compelling need” for anti-obesity legislation.⁸ The message of this story is a bit different. The anti-obesity legislation, though noble in its official goal of reducing healthcare costs, is misguided in its application. With a true purpose of providing for the future solvency of a dying elderly healthcare system, the legislation solves little and may ultimately prove to be a liability for the burdens it imposes on citizens and their employers, and the potential harm it may bring. Rather, the “compelling need” rests with finding genuine solutions to fund a healthcare crisis rooted in a shrinking and graying population.

II. THE STORY

There is a king. He has been a kind ruler—gentle and fair, genuine and benevolent to his constituents. Nations all over the world hold the King in high esteem even though they sometimes have difficulty understanding his kingdom’s cultural ways. His kingdom has prospered under his watch and his constituents have little want for their basic needs. Most notably, the King has always taken care of them when they were ill and provided for their care in their old age. His kingdom is known

⁶ Lawler explains that:

Although the success of the new ‘Metabo’ legislation in decreasing Japanese obesity is uncertain at this point, it is clear the Japan will emerge as the world leader in the war on waistlines ahead of the United States. Despite the United States’ arguably greater need for anti-obesity intervention, the cultural and structural factors that serve to support the program in Japan are notably absent in the United States.

Id. at 316.

⁷ This essay only concerns itself with the first part of Lawler’s comment on the Metabo law. The second part of Lawler’s comment (on whether such legislation would be met with success in the United States) is not reached. The theme given here pertains only to the first part of her comment.

⁸ See Lawler, *supra* note 5, at 291.

worldwide for fostering values of peace and concord, and his constituents have the reputation of giving up their individual liberties for the good of the kingdom. However, the King has a problem. A very big problem. His constituents are rapidly getting older. Each generation is having fewer children than the one before. His kingdom is shrinking and graying. The King, being the kind ruler he is, is concerned with caring for his constituents' health as they advance into old age. They've been loyal to him their entire lives, they've made great contributions to his kingdom, they've paid their taxes without fail, and so they deserve to be taken care of. The King has a healthcare system set up so that all can receive care should they need it and it is funded with taxes. However, with each passing year, as more and more of his constituents retire, there are less and less workers to pay taxes while more and more people need care. The system is going bankrupt. In order to continue providing for his constituents, the King needs to generate more revenue to support the system but he can't since there are less people entering the workforce to pay taxes.

So the King thinks of a plan. He's been concerned for a while about his constituents' adoption of certain aspects of outside culture—one of them being a growing taste for foreign foods. He's noticed that some of his constituents have gained weight and he thinks it's because they're eating unhealthy foreign foods. He decides to impose a "fat tax." He issues a decree stating that all constituents age 40 through 74 must have their waistlines measured annually. If their waistline exceeds set guidelines, they must go to dietary counseling and their employers must pay a fine. The King plans to use the fines to pay for the healthcare system so the elderly can continue to be taken care of. The King thinks this is a great idea! By keeping his constituents trim, they'll stay healthier and need less medical care in the long run. Also, a little money is raised in the process. It's a win-win situation. His young and middle-aged constituents remain happy and healthy, and he can continue to provide for his elderly constituents as well—or so it seems. The King, despite his good intentions, has overlooked major areas in his plan that could turn into big issues. Upon hearing the King's decree, the King's advisor rushes to the King's throne. "Your Highness," the advisor says, "as your trusted advisor, I must inform you that there may be some complications with implementing your decree."

"How can that be?" the King replies. "It's a great plan. Everyone will become healthier because of it and I'll be able to provide for my loyal constituents in their old age. What could possibly go wrong?"

"Your noble intentions are not lost on me or your constituents, your Highness. However, there are four areas that may provide considerable difficulty."

The King ponders his advisor's words for a moment. He cannot imagine what could be of issue with his advisor. His brows furrow.

Curiosity starts to take hold. “Speak,” he commands. This is what the advisor conveys to his ruler.

First, the King does not quite understand obesity. He does not realize that obesity could be caused by things other than overeating. He is aware that there have always been large people in his kingdom—some were born that way—but he does not realize that obesity could be a symptom of an underlying disease or a side-effect of treating a disease.

“No problem,” the King says to his advisor, “I’ve built a great medical system to take care of it. Is that all?”

“It’s just the start, your Highness.” The advisor goes on.

Second, the King does not realize that the medical system he built isn’t properly equipped to handle obesity well or most other complex diseases, for that matter. The doctors are overworked, are not paid very well, and because of it, he has a lot of doctors in his kingdom who don’t take time to know their patients well or properly diagnose their ailments. They overmedicate their patients and rarely develop specialties. The King, understandably, does not want to hear any of this.

“Enough.”

“Please, your Highness. I do not like bringing this to your attention any more than you enjoy hearing it. But the fact is, I would not be doing my job or honoring your kingdom if I did not bring these unsavory realities to your attention.” The King’s advisor implores the King to allow him to continue. The King is adamant in his refusal at first, but realizes he himself would not be a just ruler if he chose to remain ignorant. Reluctantly, the King allows his advisor to go on.

Third, many people could be harmed by this decree. Overweight people may lose their jobs if they cannot lose weight because their employer will not want to be fined. Further, they may suffer embarrassment and ostracism because the King has labeled them as “fat.” Also, some constituents may be seriously hurt when they resort to extraordinary measures to lose weight. They may demand compensation from the King. For the first time in their conversation, the King smiles.

“Ha!” the King bellows triumphantly. “My loyal servant, there is no need to trouble yourself with such worries! Yes, some people may be hurt, some may suffer or endure hardship, but they will understand that this is for the good of all because it truly is. That is how it’s been in my kingdom. They will not seek redress. Besides, the court system I’ve set up will hardly allow it.”

“Please do not allow yourself to be lulled into an illusory sense of security, your Highness.”

“Lulled?” the King confusedly utters. “And what exactly ‘lulls’ me? Isn’t it true that it is indeed a rare occurrence when someone seeks redress in the courts, and even rarer for them to prevail?” He wonders what his advisor sees at the edge of the horizon that he can’t.

“It has been true for some time, your Highness, but things have

changed recently. I fear a storm may be on its way. Please let me explain.”

Finally, it is true that constituents have traditionally sought ways outside the courts to resolve conflict. However, it may not totally be because of the kingdom’s values of peace and concord. It may be because they have not had much choice in the past. But barriers to the courts that have traditionally stood high have been lowered in recent years. Trial times have been reduced. Lawyers, once scarce in this kingdom, have increased and now it is much easier to find one. More people are now seeking redress through the court system—lawsuits have been increasing each year.

The King is beside himself. “What should I do?”

The advisor does his best to comfort his King. “Your Highness, my duty is to advise you, however, I cannot tell you what to do for you are the ruler. You face some serious troubles. Your kingdom is graying and slowly withering. You need to do something, but perhaps this decree is not the best way. The law is meant to protect people, yes, but from others mostly. It should protect people from themselves only when they cannot do so themselves. Such a decree cannot be expected banish habits, nor should it interfere with personal choice when it does not cause imminent harm. Most importantly, such a decree should acknowledge and promote personal responsibility for one’s wellness—which this does not. Perhaps it would be best to learn more of what I had just told you, your Highness.”

With eyes cast to the floor, the King nods almost imperceptibly. “Such news is never received warmly. But you are correct. I should learn more. Please show me all you know so I may decide what to do next, my trusted servant.”

“To do so is my duty and my privilege,” the advisor replied.

III. THE KINGDOM

A. *Japanese Society and Demographics at a Glance*

With an estimated population of 127,176,000,⁹ Japan is “the second largest industrialized democracy in the world.”¹⁰ 21st Century Japan is a fascinating juxtaposition of modernity and tradition. The bright lights of Tokyo, Yokohama, and Osaka provide a surreal setting for traditional arts, dress, and cuisine found throughout these cities. Japan is a world leader in automotive and high technology industries yet retains an incredibly strong cultural grounding. This strong cultural identity exists

⁹ This was the estimated population for 2010. Ryuchi Kaneko et al., *Population Projections for Japan: 2006–2055 Outline of Results, Methods, and Assumptions*, 6 JAPANESE J. OF POPULATION 77, 84 (2008).

¹⁰ Aki Yoshikawa, Norihiko Shirouzu, & Matthew Holt, *How Does Japan Do It? Doctors and Hospitals in a Universal Health Care System*, 3 STAN. L. & POL’Y REV. 111, 111 (1991).

alongside a distinctive, original, vibrant youth-oriented subculture that is a global hotbed of fashion, art, and music duplicated nowhere else in the world.¹¹ Westerners harbor the gross misconception that Japan is a homogenous society.¹² While Japanese society does hold values of cohesiveness and, for lack of a better word, harmony,¹³ the reality is that it features just as much, if not more, complexity, depth, and innovation as any industrialized society. The overall youthful innovation and energy that is 21st Century Japan is juxtaposed with another reality—“Japan is now the oldest country in the world and getting older by the day.”¹⁴

Japan enjoys (or, depending on one’s perspective, has the burden of) one of the highest life expectancy rates of any nation.¹⁵ Lawler states that nearly one-fourth of Japan’s population will be age 65 or older in 2050. However, Japanese government sources project that figure will

¹¹ Harajuku, Tokyo, in particular, is a global fashion destination approaching the status of Paris and New York City. Japanese pop music, termed “J-Pop,” has a unique, distinctive sound; Japanese *anime* (animated film) and *manga* (graphic novels) have signature visual cues. In a rare instance of Japanese-American intercultural “exchange” going the other way, American youth are now emulating fashion styles pioneered by Harajuku and have embraced J-Pop music, while *anime* and *manga* are used untranslated to refer to those specific Japanese art forms catering to youth.

¹² Westerners frequently express and validate this misconception of homogeneity when they commonly refer to Japanese society as “the Japanese.” Bernstein and Fanning state, “Generalization about cultural tendencies of a country is always a risky project, and the hazards are especially great when the country is Japan.” Anita Bernstein & Paul Fanning, “*Weightier than a Mountain*”: *Duty, Hierarchy, and the Consumer in Japan*, 29 VAND. J. TRANSNAT’L L. 45, 48 (1996) (drawing from the following works: J. MARK RAMSEYER & FRANCES MCCALL ROSENBLUTH, *JAPAN’S POLITICAL MARKETPLACE 2-3* (1993) (describing misuses of “culture” in studies of Japan); Hiroshi Wagatsuma & Arthur Rosett, *The Implications of Apology: Law and Culture in Japan and the United States*, 20 LAW & SOC’Y REV. 461, 464 (1986) (noting that “all attempts to describe the factors contributing to cultural differences are reductionist.”)).

¹³ “The siren notion is often called Harmony, a mistranslation of the Japanese *wa*.” RAMSEYER & ROSENBLUTH, *supra* note 12.

¹⁴ LAURENCE J. KOTLIKOFF, *Avoiding a Fiscal/Demographic/Economic Debacle in Japan*, in *TACKLING JAPAN’S FISCAL CHALLENGES: STRATEGIES TO COPE WITH HIGH PUBLIC DEBT AND POPULATION AGING* 181 (Keimei Kaizuka & Anne O. Krueger eds., 2006).

¹⁵ Although it continues to remain above 82 years, Japan has gone from having the highest life expectancy rate in the world in 2006 to having the third highest life expectancy rate in 2009. Compare Lawler, *supra* note 5, at 296 (citing David A. Wise) (explaining that based on David A. Wise’s figures published in 2006 that “[t]he average life expectancy in Japan has reached eighty-two years—longer than the life expectancy in any other country.”), and CIA WORLD FACTBOOK, Country Comparison: Life Expectancy at Birth, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html> (last visited Nov. 11, 2010) [hereinafter *Country Comparison: Life Expectancy at Birth*] (listing Japan as having the third highest life expectancy in the world, at 82.12 years, as of 2009).

probably reach as high as thirty-nine percent.¹⁶ The extent and rapid progression of Japan's aging is difficult to fully comprehend. To put this incredible proportion into perspective, for every retiree currently living in Japan, there are three working-age citizens.¹⁷ By 2050, there will be four retirees per five working-age citizens. Japan is a "graying" nation, meaning that its birthrate has fallen below the replacement level.¹⁸ In other words, Japan's population is shrinking.¹⁹ One reason for Japan's high life expectancy is its healthcare system. Whether young and sturdy or old and gray, all Japanese citizens receive virtually unlimited access to healthcare through a universal health insurance system.

B. *A Brief Overview of Medical Coverage for All*

During the postwar years, Japan underwent explosive economic expansion wrought with inevitable growing pains falling disproportionately on urban citizens. "Problems such as a lack of proper housing, insufficient water supplies, inadequate sewage and garbage disposal, and a sharp rise in traffic accidents"²⁰ brought about by rapid economic growth endangered the welfare of the common urban dweller. Then came relief. 1961 was a watershed year for the health of Japanese

¹⁶ Relying on David A. Wise's figures, Lawler wrote, "[i]n 1990, nearly 13% of the Japanese population was age sixty-five years and older, but this proportion is expected to hit a whopping 23% by 2050." Lawler, *supra* note 5, at 296 (citing Wise, *infra* note 74, at 1) (projecting Japanese elderly population at 22.9% by 2050). However, Japan's NATIONAL INSTITUTE OF POPULATION AND SOCIAL SECURITY RESEARCH, based on the Japanese government's 2000 census, projects that by 2050, the proportion of its population aged 65 and older will be between 33.1% (low variant) and 39.0% (high variant). NATIONAL INSTITUTE OF POPULATION AND SOCIAL SECURITY RESEARCH, POPULATION PROJECTIONS FOR JAPAN: 2001-2050 1-3 (2002), <http://www.ipss.go.jp/pp-newest/e/ppfj02/ppfj02.pdf>. News sources have reported the high variant of these figures rather than David A. Wise's figures. See Blaine Harden, *Health Care in Japan: Low Cost, For Now*, WASHINGTON POST, Sept. 7, 2009 ("Japan already has the world's oldest population; by 2050, 40 percent will be 65 or older."). Additionally, the CIA WORLD FACTBOOK currently puts Japan's sixty-five and over population at an estimated 22.2%, just 0.7% shy of Wise's figures with a distance of forty more years to go. *Country Comparison: Life Expectancy at Birth*, *supra* note 15.

¹⁷ KOTLIKOFF, *supra* note 14, at 181.

¹⁸ Japan had an estimated 1.21 children born for every woman and its population had a negative growth rate of -0.191% in 2009. CIA WORLD FACTBOOK, East and Southeast Asia: Japan, <https://www.cia.gov/library/publications/the-world-factbook/geos/ja.html> (last visited Nov. 11, 2010) [hereinafter *East and Southeast Asia: Japan*].

¹⁹ In the past five years, Japan's population has already shrunk by an estimated 592,000. Kaneko et al., *supra* note 9. 2010 estimated population is 127,176,000 and is projected to decrease by 37,246,000 to 89,930,000 by 2055. *Id.* The percentage of elderly displays an inverse proportion to the population's movement, increasing from an estimated 23.1% in 2010 to 40.5% in 2055. *Id.*

²⁰ Yoshikawa, Shirouzu, & Holt, *supra* note 10, at 112.

citizens. That year, Japan established a nationwide public health insurance system controlled by the government.²¹ Although universal and mandatory, it is not entirely funded by the government. It is a “hybrid system”²² that survives on three streams of funding—government subsidies, health insurance premiums, and individual copayments.²³ The system covers the employed, self-employed, unemployed, and retired through three main plans. Though slightly different in construction, all three plans offer the same benefits—“uninhibited access to medical care, equity in care delivery, and cost-containment.”²⁴ These plans are the Employee’s Health Insurance (“EHI”), the National Health Insurance (“NHI”),²⁵ and the Health and Medical Services System for the Elderly.²⁶

The EHI is a plan for employed individuals and their dependents. Under this plan, workers pay four percent of their salary to an insurance provider selected by the employer and the employer provides matching contributions.²⁷ Under the NHI, government workers, the self-employed, and the unemployed pay \$1,600 per year for coverage.²⁸ The NHI places responsibility for care primarily on local governments.²⁹ Local governments also provide secondary care for children in their district.³⁰ Under both plans, copayments for office visits are negligible although copayment for drugs is thirty percent. Total cost for a doctor’s visit, including drugs, usually comes out to less than \$30.³¹

The Health and Medical Services System for the Elderly “provides health insurance for citizens aged seventy years and older (or bedridden

²¹ SATOSHI TANAKA & TOMOFUMI SONE, *GETTING SICK IN JAPAN: UNDERSTANDING THE JAPANESE HEALTH CARE SYSTEM* 38 (1996).

²² Blaine Harden, *Health Care in Japan: Low Cost, For Now*, WASHINGTON POST, Sept. 7, 2009, available at <http://www.washingtonpost.com/wp-dyn/content/article/2009/09/06/AR2009090601630.html?sid=ST2009102805439>.

²³ Yoshikawa, Shirouzu, & Holt, *supra* note 10, at 114.

²⁴ *Id.* at 111.

²⁵ TANAKA & SONE, *supra* note 21, at 38.

²⁶ This was a special plan implemented on February 1, 1983, by the Health and Medical Services Law for the Aged. KYOICHI SONODA, *HEALTH AND ILLNESS IN CHANGING JAPANESE SOCIETY* 52 (1988). This law was instituted to cope with special problems of the aged and placed primary responsibility for care upon local governments. *Id.*

²⁷ Under the EHI, the average Japanese employee pays \$1,931 in premiums. Premium payments are capped at \$6,000. Harden, *supra* note 22.

²⁸ *Id.*

²⁹ Lawler, *supra* note 5, at 292 (citing Yoshikawa, Shirouzu, & Holt, *supra* note 10, at 116).

³⁰ Harden, *supra* note 22.

³¹ *Id.*

citizens over the age of sixty-five).”³² This system stands to benefit from fines imposed on EHI and NHI providers through the Metabo law.³³ During the 1970’s, when Japan first began to realize the graying of its population, attention began to be focused on the special medical needs of the elderly.³⁴ Originally conceived as an all-encompassing, free system of healthcare for the elderly, changes were made and cost-sharing was introduced with the passage of the Health and Medical Services Law for the Aged in 1983.³⁵ Besides providing minimal relief of financial burden on the system, the rationale for introducing cost-sharing (through copayments and monthly fees) included (1) increasing the elderly population’s awareness of their own health, (2) allowing the elderly to bear some responsibility for their health, and (3) discouraging excessive medical treatment.³⁶ Costs to the elderly still remained very low and were meant more as a symbolic gesture than to provide meaningful support. Four years after the law’s passage, elderly citizens were paying the rough (2010) equivalent of eight dollars per month for medical coverage and four dollars per day for hospital stays.³⁷ This system is the most stressed of all three because of higher expenditures per insured, negligible revenue generated through premiums, and more people transferring into the system due to the graying of the population.

C. *A Looming Crisis Ahead*

The combination of a population that is both graying and shrinking will wreak financial devastation upon Japan’s healthcare system in the coming decades. In fact, it has already begun.³⁸ A graying population needs an increased amount of medical services. The working population pays for those services. The system works fine as long as the overall

³² Lawler, *supra* note 5, at 292 (citing Yoshikawa, Shirouzu, & Holt, *supra* note 10, at 116).

³³ For a discussion on how fines will be assessed and transferred to provide elderly health care, see *infra* p. 25 and note 85.

³⁴ “Until the 1970s the government and private businesses concentrated so much on first rebuilding the nation and later fueling the economic miracle that social concerns such as . . . attention to health and old-age relate issues were ignored.” LUCIEN ELLINGTON, *JAPAN: A GLOBAL STUDIES HANDBOOK* 61 (2002).

³⁵ SONODA, *supra* note 26, at 52.

³⁶ See generally *id.*

³⁷ The 1983 Health and Medical Services Law for the Aged was amended in 1987. New fees represented a 100% increase for monthly premiums and a 25% increase for hospitalization over the original rates. See SONODA, *supra* note 26, at 55.

³⁸ “By 1999, 85 percent of Japan’s 1,800 health-insurance societies had fallen into arrears, forcing them to take the radical step of halting payments for elderly policyholders because they simply could not afford to pay them.” ALEX KERR, *DOGS AND DEMONS: TALES FROM THE DARK SIDE OF JAPAN* 261 (2001).

population maintains or exceeds replacement level. A shrinking population will eventually reach an imbalance of services required of the graying population in proportion to revenue raised from the working population. The result is a deficit. An example familiar to Western readers will go far to fully illustrate the severe impact this coming crisis will have on Japan's healthcare system.

Japan's future healthcare crisis is analogous to America's current Social Security woes. The Social Security system projects a negative cash flow beginning in 2016 with funds depleted by 2037.³⁹ One of the main reasons is the population "bubble" of the "baby boom" generation (those born around 1943-1960). This population has paid into the system for the great majority of their working lives and they will soon reach the age where they will stop working.⁴⁰ As this portion of the American population creeps closer to retirement age, stress on the Social Security system will occur because citizens will switch from being contributors to the system to being beneficiaries.⁴¹ Following the baby boom generation

³⁹ A concise summary of Social Security's depletion illustrates the parallel between it and Japan's healthcare crisis:

Under current law, the cost of Social Security will soon begin to increase faster than the program's income because of the aging of the baby-boom generation, expected continuing low fertility (compared to the baby-boom period), and increasing life expectancy. Based on the Trustees' best estimate, program cost will exceed tax revenues starting in 2016 and throughout the remainder of the 75-year projection period. Social Security's combined trust funds are projected to allow full payment of scheduled benefits until they become exhausted in 2037.

THE BOARD OF TRUSTEES, FEDERAL OLD-AGE SURVIVORS INSURANCE AND DISABILITY INSURANCE TRUST FUNDS, THE 2009 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL OLD-AGE AND SURVIVORS INSURANCE AND FEDERAL DISABILITY INSURANCE TRUST FUNDS 19 (2009), *available at* <http://www.ssa.gov/OACT/TR/2009/trTOC.html>.

⁴⁰ Although early members of the baby-boom generation have already begun to switch from contributors to beneficiaries of the Social Security system, the real push will be felt in a couple of years. "From about 2012 to 2030, the cost rate rises rapidly because the retirement of the baby-boom generation will cause the number of beneficiaries to rise much faster than the labor force . . ." *Id.* at 46.

⁴¹ Stress on the Social Security system caused by contributors switching to beneficiaries and its anticipated magnitude is explained thus:

Social Security's cost rate is projected to rise rapidly from about 2012 through 2030 because *the retirement of the baby-boom generation will cause the number of beneficiaries to rise much faster than the labor force*. Thereafter, the cost rate is estimated to rise at a slower rate for about 5 years and then to remain fairly stable for the next 25 years. Continued reductions in death rates and maintaining birth rates at levels well below those from the baby-boom era and before will cause a continued increase in the average age . . . There were about 3.2 workers for every OASDI beneficiary in 2008. This ratio has been extremely

was the “birth dearth” generation (more popularly known as “Generation X”), which saw a decrease in children born.⁴² These children of the “birth dearth” generation are now of working age and are actively contributing to the Social Security system; however, their contributions are insufficient to provide for their parent’s generation while sustaining long-term solvency for their own because of the disproportionate amount of contributors in relation to beneficiaries.⁴³

Japan’s healthcare system features a strikingly similar pattern. Through their employers (in the EHI system) or directly (in the NHI system), young Japanese workers pay into the healthcare system and do not draw a disproportionate amount of medical services, resulting in a surplus.⁴⁴ Conversely, retired Japanese citizens no longer contribute to the healthcare system⁴⁵ yet draw a disproportionate amount of medical services, resulting in a deficit.⁴⁶

stable, remaining between 3.2 and 3.4 since 1974. However, *the baby-boom generation will have largely retired by 2030, and the ratio of workers to beneficiaries is projected to be only 2.2 at that time.*”

Id. at 10 (emphases added).

⁴² It’s hard to appreciate just how great of a disparity existed between the baby-boom and birth-dearth generations. At its peak in 1957, the fertility rate was 3.68 children per woman and remains the highest in the 20th century. *Id.* at 76. Contrasted with the birth-dearth generation, the fertility rate was 1.74, lower than the fertility rate during the Great Depression. *Id.* The fertility rate as of 2008 was 2.08. *Id.*

⁴³ How the disproportionality occurs is explained in the following:

The estimated OASDI cost rate is expected to rise rapidly between 2012 and 2030 primarily because the number of beneficiaries is expected to rise substantially more rapidly than the number of covered workers as the baby-boom generation retires. This occurs largely because of the swings in fertility rates over time. Because the baby-boom generation had low fertility rates relative to their parents, and those low fertility rates are expected to persist, the ratio of beneficiaries to workers is expected to rise rapidly, reaching a permanently higher level after the baby-boom generation retires.

Id. at 50-51.

⁴⁴ Although Japanese workers visit the doctor more frequently than average (14 times per year), they are simultaneously paying into the system through premiums and co-pays, and the system has been relatively sustainable since its inception after World War II. *See Harden, supra* note 22.

⁴⁵ As noted previously, contributions of the elderly are meant more symbolic in nature because it does not provide meaningful support. To borrow Alex Kerr’s analogy, premiums paid by the elderly are likened to “throwing water on a red-hot stone.” KERR, *supra* note 38, at 262 (who in turn borrowed the analogy from an unnamed “popular daily newspaper”).

⁴⁶ “More than one-third of the workers’ premiums are used to transfer wealth from the young, healthy and rich to the old, unhealthy and poor.” Harden, *supra* note 22.

The conclusion that can be drawn from these facts is that with each passing year, more and more people are drawing medical services than contributing revenue to fund those services. “An aging population translates into trouble for Japan’s . . . health-insurance plans, which must rely on a shrinking pond of productive workers to support an expanding lake of old and sick retirees.”⁴⁷ Any system functioning at this level would not be sustainable. Whether we’re talking about Japan’s healthcare system or using America’s Social Security system as an example, the basic principle remains the same: if the system had an equal amount of contributions as there were withdrawals of resources each year, and if the same amount of contributors entered each year as there were beneficiaries passing out of the system due to age or untimely death, resources in the system would remain at stable, sustainable levels and there would be no crisis.

The demand on Japan’s healthcare system in the middle of this century will be financially overwhelming. Lawler’s statement, “as Japan’s increasingly obese population continues to age, the costs associated with treating obesity and its affiliated diseases will skyrocket,” is only partially true. Japan has a massive healthcare crisis looming on the horizon and it is not rooted in obesity; it is due to Japan’s aging population. The issue is not about obesity; it is about the future solvency of Japan’s healthcare system. What Lawler fails to consider is that as its population continues to age, Japan’s medical costs will skyrocket regardless of the weight of its population—and already has.⁴⁸ If the status quo is maintained, collapse of the system is inevitable. Demand for medical care is expected to triple in the next 25 years.⁴⁹ There are two viable options to keep the healthcare system functioning. The first option is to raise premiums. One estimate projects premiums paid by workers will have to increase from its present level of four percent⁵⁰ to twenty-four percent of their salary.⁵¹ The other option is an infusion of fresh funds⁵²—hence, the Metabo law.

⁴⁷ KERR, *supra* note 38, at 261.

⁴⁸ “With population aging and advances in medical technology, continued increases in medical care costs are unavoidable.” SONODA, *supra* note 26, at 51. Note that this quote was published over two decades ago.

⁴⁹ Harden, *supra* note 22.

⁵⁰ The present average EHI employee premium is \$1,931. *See supra* note 27.

⁵¹ KERR, *supra* note 38, at 261.

⁵² “Medical insurance for the aged . . . was financed by contributions from other forms of medical insurance. How to finance benefits for aged persons has been the focal point of discussions on medical insurance.” Keimi Kaizuka, *Challenges in Creating a Cohesive System for Health Care, Pensions, and the Needs of the Elderly*, in TACKLING JAPAN’S FISCAL CHALLENGES: STRATEGIES TO COPE WITH HIGH PUBLIC DEBT AND POPULATION AGING 175 (Keimei Kaizuka & Anne O. Krueger eds., 2006). The Metabo law aims to generate funds by imposing fines on health plans under the EHI and NHI

IV. THE DECREE

A. *A Literal Explanation of the Metabo Law*

As of this writing, the Metabo law has not been translated into English. Scores of news articles worldwide and the only scholarly voice to weigh in on the topic have not cited to the actual law. The Metabo law that articles have been referring to is actually a set of guidelines called the *Standards Concerning Implementation of Special Health Examinations and Special Public Health Guidance*, MINISTRY OF HEALTH, WELFARE, AND LABOR Order 159, effective April 1, 2008.⁵³ These guidelines, in pertinent part, call for a maximum waist size of 33.5 inches (85 centimeters) for men and 35.4 inches (90 centimeters) for women⁵⁴ (For the sake of simplicity and in maintaining consistency with sources I have relied on, I will follow suit and continue to use the term “Metabo law.”). What gives these guidelines teeth is the *Law Concerning Health Protection of the Elderly*, Law 77 of 2008, art. 20 (last amended July 15, 2008). It is in this section that authorization is given to conduct mandatory annual examinations to all citizens aged 40 through 74.

Under the Metabo law—affecting approximately fifty-six million individuals—all citizens aged 40 through 74 must submit to a mandatory annual examination where their waistline is measured.⁵⁵ An annual examination has been available to Japanese citizens since at least the 1980s.⁵⁶ Annual examinations are “compartmentalized,” meaning, various tests not related to other examinations are given *à la carte*, as needed. X-rays, urinalyses,⁵⁷ blood pressure checks, anemia tests, liver function tests, and serum lipid tests⁵⁸ are among some of the tests that may be given at an annual examination. What the Metabo law does is it takes this annual examination, makes it mandatory for the aforementioned portion of the population, and adds another test—the waistline measurement. Men’s

which will then be allocated to elderly care. *See* discussion *infra* Part IV.C.

⁵³ Deepest gratitude is expressed to Keiko Okuhara, Librarian at the University of Hawai‘i William S. Richardson School of Law Library for procuring the actual law and related guidelines in untranslated form and to Mark Levin, Professor at the University of Hawai‘i William S. Richardson School of Law for extracting the necessary information to provide a citation.

⁵⁴ Some background on these guidelines: they were introduced as MHWL Order 157 on December 28, 2006. It was last amended on November 18, 2007 as MHWL Order 159. MHWL Order 159 went into effect April 1, 2008.

⁵⁵ *Anti-Metabolic Syndrome Scheme Needs Rethinking*, NIKKEI WEEKLY, May 12, 2008, available at 2008 WLNR 8937071; *see also* Nakamura, *supra* note 3.

⁵⁶ Relying on the publishing date of SONODA, *supra* note 26 and containing information from *infra* note 57.

⁵⁷ SONODA, *supra* note 26, at 52.

⁵⁸ TANAKA & SONE, *supra* note 21, at 61.

waistlines must not exceed 33.5 inches and women's waistlines must not exceed 35.4 inches, taken without clothing. Should one pass the exam, no further action occurs. If not, a "two-pronged attack"⁵⁹ follows.

B. *For Individuals: Dietary and Lifestyle Counseling*

For individuals who fail the waistline measurement test, the doctor considers the results of other tests given *à la carte* to determine the severity of *metabo*, or susceptibility to chronic diseases sharing a nexus with obesity.⁶⁰ Such tests may include blood pressure, fat analysis, and blood sugar and lipid levels.⁶¹ The combined results of those tests will give a doctor a better picture of an individual's overall susceptibility to chronic diseases. The doctor will put the individual into one of three categories, according to severity.⁶² Individuals in the highest category will be required to attend counseling sessions followed up over three months with phone calls and e-mail correspondence.⁶³ Those in the lowest category are presumed to be given the option of participating in "motivational support"⁶⁴ to lose weight. At no point in time are individuals fined for failing the waistline examination, though fines can be levied. Those fines fall on the individual's employer.

C. *Employers: A Funding Mechanism for Elderly Health Care*

The funding mechanism of the Metabo law operates under a theory of *respondeat superior*. While employees under the jurisdiction of the Metabo law must submit to annual examinations and participate in dietary counseling (if required) or make lifestyle changes, ultimate financial liability is placed on the employers.⁶⁵ Companies (under the EHI) and local governments (under the NHI) are required to ensure a minimum sixty-five percent participation rate with the annual waist examination.⁶⁶ The overall requirement is to cut the amount of the Japanese population categorized as *metabo* by twenty five percent⁶⁷ within seven years. If

⁵⁹ Lawler, *supra* note 5, at 292.

⁶⁰ Nakamura, *supra* note 3.

⁶¹ *Anti-Metabolic Syndrome Scheme Needs Rethinking*, *supra* note 55.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Govt [sic] to Actively Target Metabolic Syndrome*, DAILY YOMIMURI, Aug. 19, 2006, available at 2006 WLNR 14763605.

⁶⁵ Law Concerning Health Protection of the Elderly, Law No. 77 of 2008, art. 22, para. 6 (Japan).

⁶⁶ Norimitsu Onishi, *Japan, Seeking Trim Waists, Measures Millions*, N.Y. TIMES, June 13, 2008, available at <http://www.nytimes.com/2008/06/13/world/asia/13fat.html>.

⁶⁷ "To reach its goals of shrinking the overweight population by 10 percent over

either requirement is not met within five years,⁶⁸ fines up to ten percent of current payments could be levied,⁶⁹ which will go to fund elderly care.⁷⁰

D. *Who the Metabo Law Really Benefits.*

There is no question that chronic disease is now among the greatest health threats globally,⁷¹ and increased incidences of chronic disease have a tendency to follow obesity.⁷² Japan is no different in this respect from other developed nations; it has certainly experienced increases in certain chronic diseases along with the rest of the world.⁷³ But with an obesity

the next four years and 25 percent over the next seven years, the government will impose financial penalties on companies and local governments that fail to meet specific targets.” *Id.* “The plan calls for a 25 per cent cut in the ‘metabo’ ranks by 2011. . . .” McNeill, *supra* note 1.

⁶⁸ “Health insurance societies will be required to contribute more money to the new health insurance scheme for the elderly if they fail within five years to either raise the ratio of employees who take the tests or sufficiently reduce the number of those suffering from the syndrome.” *Anti-Metabolic Syndrome Scheme Needs Rethinking*, *supra* note 55.

⁶⁹ “Municipalities that fail to achieve implementation rates set by the government will face financial penalties. Depending on the case, a poorly performing municipality may face an increase of up to 10 percent in medical expenses for those 75 years and older.” *85% of Local Govts [sic] Offer Free Metabolic Syndrome Checks*, DAILY YOMIURI, May 13, 2008, available at 2008 WLNR 8940486.

⁷⁰ Any fines levied and collected are allocated to providing for elderly care plans. See Onishi, *supra* note 66.

⁷¹ Recognizing chronic disease as a global problem, the United Nations General Assembly recently passed a resolution to “convene a high-level meeting of the General Assembly in September 2011, with the participation of Heads of State and Government, on the prevention and control of non-communicable diseases.” Prevention and Control of Non-communicable Diseases, G.A. Res. 64/114, ¶ 21, U.N. Doc. A/RES/64/114 (Apr. 28, 2010). The resolution further acknowledged that despite a lack of data, chronic or non-communicable disease is also a problem in developing countries, *id.* at ¶ 19, and is considered a challenge to development, *id.* at ¶ 7 and ¶ 24. Also:

The world faces major health threats. The significant threats discussed in this session are the threat of lethal and rapidly spreading infectious diseases (a pandemic); the threat of prevalent and costly chronic diseases (particularly diabetes, which is greatly affected by obesity); and the aging of the world’s population due to longer life expectancy and lower birth rates.

Harvard Business School, The Global Health Summit (Oct. 13, 2008), <http://www.hbs.edu/centennial/businesssummit/healthcare/global-health-threats.html>.

⁷² “Obesity is a growing concern because it poses a higher risk and results in a higher incidence of health conditions such as diabetes, cardiovascular disease, stroke hypertension, osteoarthritis, and certain cancers than other risk factors.” LAWRENCE O. GOSTIN ET AL., *LAW, SCIENCE, AND MEDICINE* 603 (3d. ed. 2005).

⁷³ “Notably, the number of diabetics in Japan has doubled in the past 15 years to 8.2 million, and the government estimates that a further 10 million people may have

rate of only three percent, the slimmest in the world,⁷⁴ why the incredible push to lower it even more? Simply put, because Japan is also among the oldest in the world.⁷⁵

The Metabo law does not only seek to keep its population slim and trim.⁷⁶ In fact, one may confidently say that may just be as much a positive externality of the law as its purpose.⁷⁷ There is a rhythm to what Lawler termed the “two-pronged attack” of the Metabo law. Stiff requirements of compliance and achievement are backed by stiffer penalties on the employer side of the law. However, extremely lax, unenforceable requirements⁷⁸ are bestowed on the employee side, leading toward a biased application of the law that will make it hard for employers (under the EHI) and municipalities (under the NHI) to meet requirements of sixty-five percent compliance and twenty-five percent reduction in

warning signs for the disease.” *Policing the Dietary Do’s and Doughnuts*, U.S. NEWS & WORLD REP. 29, June 30, 2008. In addition, T. Kita describes that:

The prevalence of coronary disease is increasing in the Japanese population, although it remains lower than in the US and other Western populations. Nevertheless, the prevalence of lipid risk factors in younger Japanese people is now similar to that in the US population, and there has been a continuous increase in the frequency of diabetes in Japan.

T. Kita, *Coronary Heart Disease Risk in Japan—an East/West Divide?*, EUROPEAN HEART J. SUPP. 6 (Supplement A), A8–A11, A11 (2004).

⁷⁴ “Japan has the lowest obesity rate among OECD [Organization for Economic Cooperation and Development] countries (3 percent), while the United States has the highest (31 percent).” DAVID A. WISE, *Introduction*, in HEALTH CARE ISSUES IN THE UNITED STATES AND JAPAN 2 (David A. Wise & Naohiro Yashiro eds., 2006).

⁷⁵ With an average life expectancy of just over 82 years, Japan’s population qualifies it as the third oldest nation in the world. *Country Comparison: Life Expectancy at Birth*, *supra* note 15.

⁷⁶ “The so-called ‘metabo law’ hopes to save Japan money by reducing obesity-related health risks.” Rosemary Black, *Living Large in Japan is no Laughing Matter With New Government-Imposed Waistline Restrictions*, N.Y. DAILY NEWS, Nov. 18, 2009, available at http://www.nydailynews.com/lifestyle/health/2009/11/18/2009-11-18_living_large_in_japan_can_be_considered_against_the_law_and_result_in_mandatory_.html. “The new exam is part of a government effort to curb spiraling medical costs.” Patrick Rial & Kotaru Tsunetomi, *Japan’s Bulging Waistlines Trigger Flab Tests in Land of Sumo*, BLOOMBERG, Mar. 12, 2008, available at <http://www.bloomberg.com/apps/news?pid=20601109&sid=aTcgvBD7ty.0>.

⁷⁷ “The ministry also says that curbing widening waistlines will rein in a rapidly aging society’s ballooning health care costs, one of the most serious and politically delicate problems facing Japan today.” Onishi, *supra* note 66.

⁷⁸ “Extremely lax, unenforceable requirements” refer to submitting oneself to the annual waistline examination itself, not meeting the examination’s thresholds. Individuals aged 40-74 are required to take the examination; however, no enforcement mechanism exists to ensure that individuals actually comply.

obesity. The law requires all citizens between 40 and 74 to submit to the annual waistline exam, but no enforcement mechanism exists to compel individuals to actually comply. Further, for those who comply with the annual waistline examination, fail, and then subsequently do not comply with assigned dietary and lifestyle counseling, no penalty is levied. In effect, the law on the employee side is unenforceable.

“A controversial element of the program is the mandating of financial punishment for poor performers. Health insurance societies will be required to contribute more money to the new health insurance scheme for the elderly if they fail within five years to either raise the ratio of employees who take the tests or sufficiently reduce the number of those suffering from the syndrome.”⁷⁹ Employers face an uphill battle to maintain compliance with the law and yet they bear ultimate accountability for what is essentially beyond their control.⁸⁰ With no legal enforcement mechanism to ensure their employees do their part to submit to annual waistline examinations and follow through with prescribed improvement plans, employers will find it difficult to meet the mandated sixty-five percent compliance rate and twenty-five percent reduction in obesity. Already, “only sixty percent of adults currently attend annual check-ups.”⁸¹ To spur employee participation, employers have been offering benefits such as retreats, free health food,⁸² and discounted gym memberships.⁸³ This uphill battle employers face will likely make it easier for the government to impose fines—fines that will be funneled into the elderly health care system. The law is constructed in such a manner that, like a pinball machine where the ball always gravitates toward the flippers, is tilted to allow cash to flow from “the young, healthy and rich to the old, unhealthy and poor.”⁸⁴

Although there is logic in the rationale that a healthy younger

⁷⁹ *Anti-Metabolic Syndrome Needs Rethinking*, *supra* note 55.

⁸⁰ “That said, unions with low metabolic checkup rates and poor health improvement records will be penalized in the form of an extra financial burden under the new medical system for people age 75 and older.” *Metabolic Syndrome Sector Swells*, NIKKEI WEEKLY, June 9, 2008, available at 2008 WLNR 10870294. In her article, Lawler relies on “Japan’s cultural emphasis on harmony” to attempt to reconcile and bridge this apparent gap between employee responsibility and employer accountability in the Metabo law by saying, “[b]ecause of Japan’s unique emphasis on consensual lawmaking, the Japanese are generally more willing to obey and uphold laws once they have passed.” Lawler, *supra* note 5, at 299.

⁸¹ *Id.* at 302 (citing Mayumi Honda, *Government Set to Tackle Lifestyle Diseases*, DAILY YOMIURI, June 22, 2006 at 4, available at WLNR 14765084, and DAVID A. WISE, *supra* note 74, at 19).

⁸² *Policing the Dietary Do’s and Doughnuts*, *supra* note 73.

⁸³ Nakamura, *supra* note 3.

⁸⁴ Harden, *supra* note 22.

population eventually translates to a healthier elderly population requiring less medical care, the overall aim is not so much to slim down the already slimmest population in the industrialized world; it is to provide for the future solvency of the elderly healthcare system. For additional support of this, one needs to look no further than the letter of the law: it is part of the *Law Concerning Health Protection of the Elderly*.⁸⁵ The real beneficiaries are not the three percent of Japan's population considered obese so much as it is the scores of elderly Japanese endangered by a healthcare system going bankrupt.

V. VOICES OF OPPOSITION

A. *Criticism on Both Ends of the Law*

Without even leaving the letter of the law to enter into the broader medical, legal, and social fallout potentially arising out of its implementation, critics fault the law itself on both sides—the employee side and the employer side.

B. *The Employee Side*

Despite no formal enforcement mechanism to ensure their compliance, fifty-six million individuals are “required” to submit to the annual waistline examination and bear the brunt of slimming down, which, if they don't, their employers ultimately end up paying for it. The waistline examination itself is the focus of much criticism. First, there is the issue of *reference*. Waistlines of Japanese citizens have not been regularly measured in the past.⁸⁶ Consequently, there is no historical baseline of what the average waistline is or should be. The law relies on guidelines published by the International Diabetes Federation,⁸⁷ which itself has come under scrutiny—the waist-size guidelines have already been corrected once by the IDF⁸⁸ after initial publication and acceptance, bringing into question its validity. At best, the guidelines are too stringent

⁸⁵ Law Concerning Health Protection of the Elderly, Law No. 77 of 2008, art. 20.

⁸⁶ “Comparable figures for the Japanese are sketchy since waistlines have not been measured officially in the past. But private research on thousands of Japanese indicates that the average male waistline falls just below the new government limit.” Onishi, *supra* note 66.

⁸⁷ IDF Definition of the Metabolic Syndrome: Frequently Asked Questions, International Diabetes Federation, <http://www.idf.org/idf-definition-metabolic-syndrome-frequently-asked-questions> (last visited Nov. 11, 2010).

⁸⁸ “It is reasonable to establish the cut-off point of VFA at 100cm² as indicative of the risk of obesity-related disorders and a waist circumference of 85cm in men and 90cm in women approximates to this visceral fat mass.” Yuji Matsuzawa et al., *New Criteria for ‘Obesity Disease’ In Japan*, 66 CIRC. J. 987, 991 (2002). The IDF published waist measurements above as guidelines in 2005, which was later replaced with 90cm for men and 80cm for women. *Id.*

and have the potential to admit individuals not *metabo*,⁸⁹ thereby increasing costs unnecessarily (one estimate pegs the *metabo* price tag at the rough equivalent of \$150 to \$200 per person, per year)⁹⁰ and decreasing the potential for cost savings. At worst, critics assert the guidelines are arbitrary.⁹¹

Second, “critics point out that the standard of abdominal obesity used to select people with high risk [waistline measurement] is not based on scientific data.”⁹² The simplest supporting argument advanced is that the actual act of measurement itself allows for too much variation.⁹³ In a blind study of ten physicians measuring the waistlines of twenty individuals (ten male, ten female) variations of physician’s measurements of the same individual exceeded three inches.⁹⁴ Other arguments lead deep down the mysterious, dimly-lit halls of medicine (which will take us out of the scope of this article) with discussions on how to best account for ethnic physical traits and hereditary traits, such as height, hip width, and trunk-to-leg ratio,⁹⁵ as well as the best overall method for measuring

⁸⁹ Nigishi Hotta, director of Chubu Rosai Hospital in Nagoya, stated, “[m]ost people have an abdominal circumference of about 85 centimeters. So the criterion [85cm for men; 90 cm for women] will wrongly identify many healthy people as having the syndrome.” *Metabolic Syndrome Criteria ‘Too Strict’*, DAILY YOMIURI, Oct. 14, 2007, available at 2007 WLNR 20158492. Lawler came to the same conclusion: “Ogushi [Professor Yoichi Ogushi at the Tokai University School of Medicine] is certainly correct that the long-term costs associated with the ‘Metabo’ legislation will only increase as more patients are included.” Lawler, *supra* note 5, at 304.

⁹⁰ “The service costs about 15,000 yen to 20,000 yen per capita.” *Metabolic Syndrome Criteria ‘Too Strict’*, *supra* note 89.

⁹¹ “The plan calls for a 25 per cent cut in the ‘metabo’ ranks by 2011, despite criticism that the waist-size limit is arbitrary and will encourage size-ism in the workplace.” McNeill, *supra* note 1. See also *Metabolic Syndrome Criteria ‘Too Strict’*, *supra* note 89.

⁹² *Anti-Metabolic Syndrome Scheme Needs Rethinking*, *supra* note 55.

⁹³ “In fact, the waist circumference that defines metabolic syndrome among Japanese people varied so much between studies that the Internal Diabetes Federation’s (IDF’s) ethnicity-specific cut-off for Japanese people was changed from the original... to an alternative . . . in just two years.” Satoru Yamada, *Waist Circumference in Metabolic Syndrome*, 370 LANCET 1541 (North American ed. 2007) (internal citations omitted).

⁹⁴ *Id.* Variations among physicians measuring the same individual deviated as much as 7.8cm. *Id.*

⁹⁵ E.g., Erdembileg Anuurad et al., *The New BMI Criteria for Asians by the Regional Office for the Western Pacific Region of WHO are Suitable for Screening of Overweight to Prevent Metabolic Syndrome in Elder Japanese Workers*, 45 J. OCCUP. HEALTH 335, 341 (2003) (advancing an argument in support of the Body-Mass Index method of measuring obesity that “[t]hese higher body-fat deposits at low BMI levels in Asians can be partly explained by differences in the trunk-to-leg ratio [where Asians will generally have a longer torso and shorter legs than Caucasians].”). Such arguments are best left to the realm of medicine to examine, and additionally, are far from being settled. *But cf.* Charlotte Kragelund & Torbjorn Omaland, *A Farewell to Body-Mass Index?*, 366

obesity.⁹⁶ Such arguments are best left to the realm of medicine to sift through and sort out. What is relevant here is that the waistline measurement method of testing for obesity is controversial and has yet to be universally accepted as a favorable method in the medical field.

C. *The Employer Side*

In addition to employers potentially facing financial liability for noncompliance of their employees,⁹⁷ the biggest criticism of the law is that despite the heavy burden placed on employers, benefits to elderly Japanese citizens will not accrue until much later in the future,⁹⁸ if at all. Assuming Lawler's highly debatable and unsettled assertion of *wa* is correct,⁹⁹ it follows that Japanese employers would have no problem following through with the Metabo law. However, it takes an incredible leap of faith to put trust—and the company's bottom line—into a law that may not even pan out to achieve its goal of shoring up the elderly healthcare system.¹⁰⁰ From a strictly economic standpoint, employers are in a lose-lose situation that will end up costing them significant amounts of money.¹⁰¹ Employers are fined if enough employees do not comply with their portion of the Metabo law. In order to avoid being fined, employers are offering their employees incentives to shape up, which ends up costing money as well.¹⁰² Whether employers ultimately are able to

LANCET 1640 (2007) (advancing arguments against the use of the Body-Mass Index method of measuring obesity).

⁹⁶ *E.g.*, *Bloated Metabo Market May Have to Slim Down*, NIKKEI WEEKLY, Nov. 4, 2008, available at 2008 WLNR 21057789 (“CT scans measure the precise amount of internal fat, but they are too expensive for health checkups.”).

⁹⁷ See discussion *infra* Part IV.D.

⁹⁸ “The benefits of the anti-metabolic program—which policy promoters expect will take the form of reduced medical fees—are unlikely to appear before 2025, according to the Ministry of Health, Labor, and Welfare.” *Metabolic Syndrome Sector Swells*, *supra* note 80.

⁹⁹ See *supra* note 80, for a brief illustration on Lawler's reliance on the concept of *wa*.

¹⁰⁰ “Municipalities are also skeptical about whether the new metabolic checkup and consultation system will actually curtail future medical expenses.” *85% of Local Govts [sic] Offer Free Metabolic Syndrome Checks*, *supra* note 69.

¹⁰¹ One striking example:

NEC, Japan's largest maker of personal computers, said that if it failed to meet its targets, it could incur as much as \$19 million in penalties. The company has decided to nip metabo in the bud by starting to measure the waistlines of all its employees over 30 years old and by sponsoring metabo education days for the employees' families.

Onishi, *supra* note 66.

¹⁰² *E.g.*, in addition to sponsoring “metabo” education and implementing its own

avoid being subject to penalties under the Metabo law, significant financial expenditure because of the law is unavoidable nonetheless.

VI. THE COMPLEXITY OF OBESITY

A. *From Prehistoric Survival Mechanism to Modern Liability*

Put in its simplest form, “obesity results from the chronic consumption of energy (calories) in excess of that used by the body”¹⁰³ Rarely is obesity ever so simple, though. From a strictly physiological standpoint, the mechanisms that lead to obesity serve a vital function in human survival. “Evolution is mostly to blame. It has designed mankind to cope with deprivation, not plenty. People are perfectly tuned to store energy in good years to see them through lean ones. But when bad times never come, they are stuck with that energy, stored around their expanding bellies.”¹⁰⁴

Such a mechanism may very well be a driving reason behind a new study in Japan that found overweight people tend to live slightly longer.¹⁰⁵ However, in our affluent modern world where famine is scarce, that physiological mechanism is rendered obsolete and becomes a liability to the body instead of an asset, frequently resulting in increased susceptibility to chronic disease.

In today’s world, “the causes of obesity are both complex and multifaceted.”¹⁰⁶ While it is true that the Japanese population has embraced the worst of all offerings of the Western diet, namely fast food,¹⁰⁷ other variables may contribute to “a propensity for obesity”¹⁰⁸ in

waistline measurement program, Japanese personal computer maker NEC has reworked its employee cafeteria to offer a “healthy menu” at an undetermined cost. *See Policing the Dietary Do’s and Doughnuts*, *supra* note 73.

¹⁰³ Marion Nestle & Michael F. Jacobson, *Halting the Obesity Epidemic: A Public Health Policy Approach*, in LAWRENCE O. GOSTIN ET AL., *LAW, SCIENCE, AND MEDICINE* 605 (3d. ed. 2005).

¹⁰⁴ *The Shape of Things to Come*, THE ECONOMIST (U.K. Edition), Dec. 11, 2003, at 11.

¹⁰⁵ Authors of the study are careful to admit that the nexus between obesity and longevity is not fully understood, and go on to caution that environmental factors (such as increased resistance to contagious disease) and lifestyle choices (such as not smoking) may play a part in the surprising results. *Japanese Study Shows Overweight People Tend to Live Longest*, THE YOMIURI SHINBUN, June 18, 2009, available at <http://www.physorg.com/news164519566.html>.

¹⁰⁶ GOSTIN, *supra* note 72.

¹⁰⁷ According to Ellington:

The Japanese, who have the reputation of effectively borrowing from many other cultures, have certainly done so with food. One may find a large variety of Western and Asian cuisine in any Japanese city, and even small towns have a variety of American fast-food restaurants such as Baskin Robbins, Dunkin’ Donuts, McDonalds, and Wendy’s.

the three percent of Japan's affected population, such as environmental¹⁰⁹ and genetic¹¹⁰ factors.¹¹¹ Obesity is not only wrought by overindulgence in food; obesity is oftentimes the outward symptom of an underlying illness¹¹² and sometimes occurs as a side effect in the course of treatment of an unrelated illness.¹¹³

B. *A Singular Remedy for a Complex Malady*

It is important to remember that obesity is not necessarily a disease; it is a common risk factor of a buffet of chronic diseases.¹¹⁴ The

ELLINGTON, *supra* note 34, at 244.

¹⁰⁸ GOSTIN, *supra* note 72.

¹⁰⁹ Environmental factors are oft-overlooked yet potentially significant contributors to obesity:

Although the causes are uncertain, many contend that environmental changes are almost certainly responsible and focus overwhelmingly on food marketing practices and technology and on institution-driven reductions in physical activity (the 'Big Two'), eschewing the importance of other influences [commenting on how studies of obesity have primarily placed importance of diet and exercise while not giving sufficient attention to environmental factors].

S.W. Keith et al., *Putative Contributors to the Secular Increase in Obesity: Exploring the Roads Less Traveled*, 30 INT'L J. OF OBESITY 1585 (2006).

¹¹⁰ E.g., *Bloated Metabo Market May Have to Slim Down*, *supra* note 96 (“Experts have found some non-obese people lose adiponectin due to a genetic factor.”). Adiponectin is a hormone that is involved in the metabolic process. *Id.*

¹¹¹ Brief discussion is in order regarding socioeconomic factors contributing to obesity and its relevance to Japan. Socioeconomic factors are strongly thought to influence health and prevalence of obesity, especially in disadvantaged and minority groups. Because little cultural disparities are negligible and economic disparities are much less pronounced than in other developed countries, socioeconomic factors contribute little, if any, to obesity in Japan. *See generally*, Tony Iton, *Life and Death From Unnatural Causes: Health and Social Inequality in Alameda County*, Apr. 2008, on file with Alameda County Public Health Department, 1000 Broadway, Suite 500, Oakland, CA 94607, (510) 267-8020 (discussing generally, how income, employment, and housing affect physical activity and food choices). *See also* Prevention and Control of Non-communicable Diseases, *supra* note 71, at ¶ 6 (acknowledging that “risk factors have economic, social, gender, political, behavioral, and environmental determinants”).

¹¹² Some examples where obesity is a symptom of an underlying disease: insomnia, hormonal imbalances that affect lipid metabolism, mental illness and side-effects of medication used in treatment, and genetic predisposition. S.W. Keith et al., *supra* note 109, at 1585.

¹¹³ Obesity occurring as a side effect of treatment of an unrelated illness is especially relevant to Japan. Japanese patients are frequently overmedicated because of profit incentives to doctors and are normally not advised on potential side effects of medication. TANAKA & SONE, *supra* note 21, at 45.

¹¹⁴ “Obesity is a growing concern because it poses a higher risk and results in a

nature of obesity is also subjective and at times seemingly random, “many obese individuals do not have obesity-linked metabolic disorders and from the medical point of view do not necessarily need to reduce their weight. However, others, regardless of their BMI [Body-Mass Index, a ratio determining weight in relation to body dimensions], have obesity-associated metabolic diseases and need to lose weight immediately to improve their health.”¹¹⁵ Put more bluntly, “there are fat health food fanatics and skinny people who live on fast food.”¹¹⁶

The myriad causes of obesity are unpredictable and complex yet the *Metabo* law only proposes a simple and straightforward course of action consisting of dietary and lifestyle counseling.¹¹⁷ In simple cases where obesity is caused by the “chronic consumption of calories in excess of that used by the body,” the *Metabo* law’s process is highly likely to help individuals shed excessive pounds. However, when obesity is the result of some other malady hidden within the body, the law is ill-equipped to effectively remedy obesity. In other words, “[t]he result may be well-intentioned but ill-founded proposals for reducing obesity rates.”¹¹⁸ While the *Metabo* law and the healthcare system provide recourse in the form of medical treatment, and even encourages it, Japanese citizens afflicted with complex cases of *metabo* will likely find that obtaining proper, competent treatment is difficult at best.

VII. THE MEDICAL SYSTEM ‘THROUGH THE LOOKING-GLASS’

A. *Akin to ‘Alice in Wonderland’*

On its surface, the Japanese healthcare system seems like a dream. To see a doctor, no appointment is needed. Simply stop by and take a seat. Drop in as many times as needed, even if you’re only mildly ill. If drugs are your preferred method of recovery, physicians not only prescribe them freely, but dispense them as well.¹¹⁹ Should you become injured or fall violently ill, not to worry. With three times more hospitals per capita than the U.S.,¹²⁰ you can take your pick! The best part about all this first-

higher incidence of health conditions such as diabetes, cardiovascular disease, stroke hypertension, osteoarthritis, and certain cancers than other risk factors.” GOSTIN, *supra* note 72.

¹¹⁵ Matsuzawa et al., *supra* note 88, at 989.

¹¹⁶ Edward P. Richards III, *Is Obesity a Public Health Problem?*, in LAW, SCIENCE, AND MEDICINE 617 (3d ed. 2005).

¹¹⁷ *Govt [sic] to Actively Target Metabolic Syndrome*, *supra* note 64.

¹¹⁸ S.W. Keith et al., *supra* note 109.

¹¹⁹ “If a supermarket sells aspirin, a pharmacist must be present and have medical tools on hand—yet nowhere else in the developed world are physicians free to dispense drugs themselves, and as a result the Japanese use far more drugs, of dubious efficacy, than any other people on earth.” KERR, *supra* note 38, at 138.

class service is it costs next to nothing!

The reality of the system is entirely different. To see a doctor, no appointment is needed, but be prepared to, in the words of Japanese doctors Satoshi Tanaka and Tomofumi Sone, “wait for three hours for three minutes of impersonal consultation”¹²¹ with the doctor. Doctors routinely share patients’ medical information with their employers;¹²² yet they do not feel a duty to disclose potential side effects of medication prescribed to the patient or even say what the medication is for.¹²³ While

¹²⁰ Harden, *supra* note 22.

¹²¹ TANAKA & SONE, *supra* note 21, at 32.

¹²² This fact is not a flaw in the system; it is culturally-grounded. Drs. Tanaka and Sone explain:

The Japanese employer worries about and checks on the employee’s health in order for the employee to do her or his best for the long-term benefit of the company. In order to best help the employee, the employer feel [sic] justified in knowing the employee’s physical condition and may call the doctor with an inquiry . . . the employer-employee relationship in the Japanese society is based on paternalism and composed of superior-inferior relationships similar to those of the healthcare system.

Id. at 33-34.

¹²³ “Generally, medical care in Japan has been carried out in a paternalistic manner. The doctor ‘knows best’ and treats the patients accordingly. The patients are to follow the doctors without questioning. Doctors are used to giving only the minimum information necessary to patients and doing so without criticism.” *Id.* at 31. In what is the first Japanese Supreme Court case to acknowledge a physician’s duty of informed consent, the Court in [*Doe*] v. Ozu City remarked:

Generally speaking, the treatment doctor had a duty to inform to the patient or his legal representative about the contents of the planned treatment and the risks involved in the treatment . . . *When there are elements of uncertainty, the doctor does not have a duty to inform the representative or the patient concerning the patient’s present condition, expected improvement possibility, or prospects in the event of non-treatment. Nor did the doctor have the duty to inform regarding his grasp of the patient’s condition.*

[*Doe*] v. Ozu City, 1011 Hanji 54, 447 Hanta 78 (Sup. Ct., June 19, 1981) (emphasis added). Commenting on this case, author Yutaka Tejima wrote, “[a]s this case is not published on the official judgment record of the Japanese Supreme Court ‘Minshu,’ it may be possible to infer that the informed consent concept was not regarded as important at that time.” Yutaka Tejima, *Recent Developments in the Informed Consent Law in Japan*, 36 KOBE UNIV. L. REV. 45, 48 (2002). The prohibitive atmosphere shrouding informed consent in Japan is slowly clearing as more patients are becoming aware of their right to know and are demanding more information from their doctors ([*Doe*] v. Ozu City involved a suit from parents of a 10-year boy who died from a head injury against the city that administered the local hospital. As this case was never published and Tejima does not clarify the case name, “Doe” is inferred for the plaintiffs).

prescription medication is dealt out like candy at Halloween,¹²⁴ major operations such as surgeries are relatively rare and surgeons are frequently paid “under the table.”¹²⁵ Hospitals are abundant, yet beds are in short supply and so are specialists. Ambulances must frequently try multiple hospitals before finding one that has the room or the skill to admit their patient—in a recent news article, it took ambulance personnel fifty tries to find an admitting hospital.¹²⁶ What Westerners hear of the Japanese healthcare system and how the system really operates is so divergent that it seems to cross the boundary between reality and fiction. “Indeed, medicine [in Japan] is a statistical *Alice in Wonderland* where the numbers verge on comedy.”¹²⁷

B. *Dearth of Specialists, Overabundance of Generalists*

Dr. Toshihiko Oba began his medical career as an eye, nose, and throat specialist in a Japanese hospital.¹²⁸ For thirteen years, Dr. Oba worked 80-hour weeks at numerous hospitals for an annual salary of approximately \$100,000.¹²⁹ In 2004, he “made a career change common for Japanese doctors at the pinnacle of their careers”—he opened a general-practice clinic.¹³⁰ He now works closer to a 40-hour workweek with less stress and has increased his income “severalfold.”¹³¹ He treats an average of 150 patients per day, spending about three minutes with each.¹³²

Dr. Oba’s story is common to Japanese physicians. Overworked and underpaid as specialists in hospitals, doctors find the appeal of half the hours, half the stress, and double the income that comes with going into

¹²⁴ See *infra* p. 30 (discussing overmedication in Japan) and FELDMAN, *infra* note 141.

¹²⁵ Kerr explains that:

In the case of medical costs, Japan’s expenditures appear to be far below those of the United States—but that’s because published costs do not include the payments of ¥100,000–200,000 in plain white envelopes when they have surgery. There is no way to calculate how much under-the-table money boosts Japan’s national medical bill.

KERR, *supra* note 38, at 125.

¹²⁶ Takahiro Fukada, *Doctor Shortage Gives Patients Runaround*, JAPAN TIMES, Apr. 12, 2008, available at <http://search.japantimes.co.jp/cgi-bin/nn20080412f2.html>.

¹²⁷ KERR, *supra* note 38, at 125.

¹²⁸ Dr. Oba’s story ran in THE WASHINGTON POST on September 7, 2009. See Harden, *supra* note 22.

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

general practice hard to resist. Improved working conditions and income are just two reasons why generalists are in abundant supply and specialists are hard to come by in Japan. To Westerners, it seems counterintuitive that specialists would earn less than generalists. Westerners are used to the concept that investing in human capital, i.e., education, pays off in the way of increased compensation.¹³³ Needless to say, the structure of the Japanese healthcare system does not acknowledge investment in human capital the way western developed nations do.

With regard to the structure of the medical system, Japan's healthcare system is structured in a way that physicians are typically paid the same per patient regardless of the procedure being performed or the physician's qualifications in the area of treatment.¹³⁴ As such, there exists no financial incentive for a physician to pursue a specialized area of practice.¹³⁵ While not intentionally structured to do so,¹³⁶ the lack of

¹³³ See J. Mark Ramseyer, *The Mortality Effects of Cost Containment Under Universal Health Insurance: The Japanese Experience*, HARVARD JOHN M. OLIN DISCUSSION PAPER SERIES 619 (2008), available at http://lsr.nellco.org/harvard_olin/619.

¹³⁴ Ramseyer explains:

With low prices and subsidized demand, Japanese doctors have little incentive to invest in specialized skills. Skilled or no, they can fill their days at the same government-mandated prices. Yet they do have an incentive to build simple clinics and hospitals. Admit a patient to their private institution rather than the large public hospital, and they can bundle (what are effectively) high-priced hotel stays with quotidian medical services.

Id. at 2.

¹³⁵ J. Mark Ramseyer makes an excellent point about investment of human capital versus physical capital by Japanese physicians. See *id.* at 5. Investment in human capital, i.e., completing medical school, fulfilling residency requirements, then putting oneself through years of training to develop a specialty yields no substantial return. Conversely, investing in physical capital, i.e., doing the minimum necessary for a license then building a general practice clinic, yields enormous return. The net result is a proliferation of clinics offering superficial medical care, hospitals that lack no real skill or reputation for expertise in a particular field, and a medical profession characterized by doctors who have done just the minimum to attain membership. See *id.* at 6. Ramseyer states that of 19,000 Japan Medical Association members in Tokyo, barely 1,100 are board-certified. *Id.*

¹³⁶ The prevailing philosophy guiding the Japan's medical system is affordability through egalitarianism. This philosophy is responsible for the small differences in compensation among physicians despite specialization or expertise in a certain field. Yumiko Arai and Naoki Ikegami explain:

Overall, if egalitarian principles are to be upheld, then the health care system must be so structured that it remains affordable for the poor . . . Thus, more egalitarian systems tend to have low health expenditures, whereas the contrary holds true for the United States. However, a truly egalitarian system would lead to dissatisfaction among the powerful and rich. It is for this reason that there is private health insurance in the

financial incentive actually discourages physicians to develop a specialty. Conversely, the healthcare system indirectly encourages general practice. Dr. Oba's story illustrates this concept: because physicians' compensation is based not on skill or expertise in a particular field of medicine but on the amount of patients seen, the only way physicians can maximize their earning potential is to increase their volume of patients. The best way for a physician to increase volume is to start a general practice. When Dr. Oba's story ran in THE WASHINGTON POST on September 7, 2009,¹³⁷ Kansas newspaper HUTCH NEWS picked up the story that same day. Dr. Oba added to the story by posting a comment online. He wrote about using technology to increase his volume of patients. By wiring his clinic with computers and display monitors and using support staff, Dr. Oba is able to continue treating a high volume of patients without actually "seeing" them face-to-face.¹³⁸ One has to wonder about the quality of such "tele-diagnoses" and quick, cursory diagnoses in general—especially when it comes to complex cases of obesity.

C. Pill-Popping and Drug-Pushing

While the best way for a physician to increase his earnings is to go into general practice, it is not the only way. Doctors may also boost their income by prescribing drugs. "In the present health insurance system, the more patients a doctor treats, the more methods of treatment and *the more*

United Kingdom. In Japan, such a blatant system would be unpalatable. Instead, more affluent patients provide 'gifts', a long-standing point of grievance for patients, but which acts as a safety valve. This takes the form of monetary gifts to the attending doctor

Yumiko Arai & Naoki Ikegami, *Health Care Systems in Transition II. Japan, Part I. An Overview of the Japanese Health Care Systems*, 20 J. OF PUB. HEALTH MED. 29, 31 (1998).

¹³⁷ Harden, *supra* note 22.

¹³⁸ The entirety of Dr. Oba's comment is as follows:

9/9/2009 I am Dr. Oba in Tokyo: I am Dr. Oba who sees 150 patients a day in Tokyo. And I have studied the computer system for medical use. (I presented my machine at IBM Watson Res.6 years ago) To see over 100 patients is very rare even in Japan now. In the small clinic, 9 high-speed computers, 13 displays and 7 full-time healthcare workers like Chloe O'Brian "24" support me to see the patient. IT especially for (patient-doctor- healthcare workers) interface can make this system. - Toshihiko Oba, M.D., Ph.D.

Blaine Harden, *Two Sides to Japanese Health Care*, HUTCH NEWS, Sept. 7, 2009, available at <http://www.hutchnews.com/todaystop/health2009-09-07t21-16-47>. Note that the first instance of "see" is taken to mean "treat," the second instance is taken to literally mean "see," as in "face-to-face," and the third instance is taken to mean "treat."

medication a doctor prescribes, the more profit she / he makes."¹³⁹ Further, "payoffs from drug companies to doctors are commonplace, with the result that Japanese medical results have become a laughingstock in world medical journals."¹⁴⁰ As a result of drug-pushing by doctors, Japanese patients are among the most overmedicated in the world.¹⁴¹ The drug business is big business in Japan—the irony is that just as Japan isolated itself from the world during the Edo period, Japan's big pharmaceutical industry is isolated from the medical world. And although Japanese patients have access to drugs—so many drugs that they sometimes can't take them all¹⁴²—they lack access to common, proven medication used worldwide.¹⁴³ Author Alex Kerr comments that "Rather than use a foreign drug with proven value, the MHW [Ministry of Health and Welfare] encourages local firms to produce copycat medicines with little or no efficacy and sometimes with terrible side effects. These are known as zoro-yaku, "one after another medicines," because firms put them out one after another."¹⁴⁴

Japan's overprescribed climate spells trouble for individuals afflicted with complex cases of obesity. Weight gain is a common side effect with certain medications and unfortunately, due to Japan's

¹³⁹ TANAKA & SONE, *supra* note 21, at 45 (emphasis added).

¹⁴⁰ KERR, *supra* note 38, at 125.

¹⁴¹ "And in what may be the nation with the world's highest rate of prescribed and ingested medication, patients lack the right to know about the intended and unintended effects of what they are consuming." ERIC A. FELDMAN, *THE RITUAL OF RIGHTS IN JAPAN: LAW, SOCIETY, AND HEALTH POLICY* 46 (2000). It is my intention to cite directly to Eric A. Feldman because of a discrepancy in Lawler's comment. Although Lawler quotes Feldman the same, she cites to a different page (page 44) in her footnote (footnote 55).

¹⁴² Drs. Tanaka and Sone describe that:

According to a confidential report offered to the Ministry of Health and Welfare by the Chuikyo (Central Health Insurance Council), it was found that 89% of university hospitals and 45% of general hospitals prescribed excessive amounts of medications. A survey conducted by the Health Insurance League revealed that 16.7% of those who stated dissatisfaction with the present health care system noted *being unable to take all the medications prescribed by the doctor because of the large quantity*.

TANAKA & SONE, *supra* note 21, at 45 (internal citations omitted) (emphasis added).

¹⁴³ "A similar pattern afflicts medicine, where, in an effort to protect domestic pharmaceuticals, the Ministry of Health and Welfare refuses to approve foreign drugs. As a result, the Japanese are denied medicines that are in common use around the world for the treatment of arthritis, cancer, and numerous other ailments from headache to malaria." KERR, *supra* note 38, at 372.

¹⁴⁴ *Id.* at 373.

pharmaceutical structure, side effects of prescribed medications may not be known to the doctor.¹⁴⁵ Even if the doctor is aware of side effects, such information, due to limitations on their time with patients, will rarely be conveyed. In complex cases of obesity where obesity arises as a side effect out of treatment for an unrelated ailment, misdiagnosis is likely to occur as the culprit will be difficult to weed out of the patient's prescribed cocktail of pills—if the physician thinks to look there.

D. *Misdiagnoses and Missed Diagnoses*

The portrayal I've painted of Japan's healthcare system with regards to overmedication and the compensation structure of physicians is admittedly grim. I should mention at this time that Japan's healthcare system does function quite well in keeping most of the population healthy most of the time. With a large number of generalists, it especially excels with treatment of common everyday ailments. The existing system is highly likely to enjoy much success in treating those patients afflicted with simple cases of obesity where the cause is merely overeating and a lack of sufficient physical activity.

However, the dearth of specialists, overabundance of generalists, and the limited amount of time doctors spend with their patients¹⁴⁶ all converge to erect a barrier to treatment for those afflicted with complex cases of obesity. When obesity is not the disorder but the visible symptom of an underlying disorder, patients in need of specialized care may "fall through the cracks" of Japan's healthcare system.¹⁴⁷ In those cases of

¹⁴⁵ *E.g., id.* at 338 ("Basic research in Japan is understaffed, weakened by bureaucratic inertia, and limited by a lack of freely shared and reliable data.").

¹⁴⁶ Drs. Tanaka and Sone explain:

Even though people may understand that in three minutes the doctor is quite limited as to what she or he can do, a problem also exists in that Japanese doctors have become so accustomed to such a rushed, impersonal consultation that they are apt to consult with patients in the same way even when they do have enough time to explain and to give information as needed.

TANAKA & SONE, *supra* note 21, at 32.

¹⁴⁷ Ramseyer provides insight into how patients' specialized needs may go unmet:

As the proliferation of generalist clinics shapes the accumulation of medical experience, it necessarily shapes the care patients receive as well. Because it dissipates complex illnesses among nearly 100,000 small clinics, it sharply reduces the number of doctors and hospitals with any substantial experience in the more sophisticated modern procedures. Yet many of these procedures stand at the core of the modern assault on the pathologies that claim so many Americans and Japanese lives.

Ramseyer, *supra* note 133, at 10.

complex obesity where the patient requires the expertise of a specialist (such as an M.D., R.D., a cardiologist, or an endocrinologist), timely access to quality specialists needed for treatment of their underlying ailment may be unavailable, especially in non-urban areas. Even worse, a *misdiagnosis* often results in a *missed diagnosis*. If misdiagnosed by a generalist and treated according to that misdiagnosis, the afflicted patient may never have the opportunity to be treated by a specialist, thus being deprived of a proper diagnosis and proper treatment.

VIII. THE CONSTITUENTS' HURT

A. *The "Cash Cow"*

The real issue of the Metabo law is money. The official aim of the Metabo law is to save on future healthcare costs by preventing chronic disease by targeting a common risk factor—obesity. The real purpose, though, is to shore up a dying elderly healthcare plan bleeding red ink. Admittedly a cynical view, the government is banking on raising funds from three percent of its population (through that population's employers) to help support forty percent of its population by 2050. Doctors, generally, already receiving kickbacks from the pharmaceutical industry and poised to make even more with every prescription they write,¹⁴⁸ have a potential windfall waiting in the wings when the latest anti-*metabo* drugs hit the market. Supermarkets rejoice at the sight of empty shelves where health foods and herbal teas were once stocked. Companies not traditionally affiliated with health products aren't just dipping their toes in the water; they're jumping in headfirst.¹⁴⁹ And with sales of fitness equipment in high demand, stores welcome the Metabo law even more than free advertising. Japan's new obesity obsession has turned a large portion of the population into the nation's cash cow. Real money is being made¹⁵⁰ and everyone wants a grab at the udders. But who is tending to and looking out for the benign beast? Japanese consumers are "popping herbal pills and buying products touted for their metabo-fighting properties"¹⁵¹ in droves yet in discussing the Metabo law, news sources have just barely grazed the topic of consumer protection and potential human costs. Those costs may turn out to be very real and very high.

¹⁴⁸ See *supra* text accompanying note 139.

¹⁴⁹ Yamaha Motor Co. is now in the health food business with projected sales of 30 billion yen (\$315.7 million) in 2015. *Bloated Metabo Market May Have to Slim Down*, *supra* note 96.

¹⁵⁰ The *metabo* market is currently estimated to be "several trillion yen." *Id.*

¹⁵¹ Rosemary Black, *Living Large in Japan is No Laughing Matter With New Government-Imposed Waistline Measurements*, NEW YORK DAILY NEWS, Nov. 18, 2009, available at http://www.nydailynews.com/lifestyle/health/2009/11/18/2009-11-18_living_large_in_japan_can_be_considered_against_the_law_and_result_in_mandatory.html.

Should people become hurt because of the Metabo law, Japan could be opening itself up to liability on a massive scale.

B. *Injury to the Innocent*

Upon the advice of his doctor, a father of three begins a strenuous exercise regimen that results in considerable muscle and nerve damage. He is consequently unable to provide for his family. An older newlywed couple, fresh off their honeymoon and a few pounds heavier, go on a crash diet in an effort to lose weight quickly before their upcoming annual examinations. They both end up hospitalized for dehydration and malnutrition. A single working professional picks up a cheap set of exercise equipment on sale at the local store. Shoddily made, it falls apart and crushes her chest, resulting in death. A husky middle-aged bachelor is unable to slim down after numerous attempts and is subsequently discharged from his job because his weight resulted in fines for his employer. Despite looking for months, no one will hire him because of his weight. In addition to financial hardship, he suffers ostracism and ridicule because the government labels him as “fat.” Among many others, the preceding scenarios involve elements of malpractice, products liability, wrongful death, employment discrimination, and emotional distress claims; yet all scenarios can be traced back to one source: the Metabo law.

Admittedly, the “but-for” argument is usually weak on its own. But my purpose is not to analyze in detail every conceivable claim that could arise out of the Metabo law and the potential for foreseeability. Indeed, any claim tendered to the government in the form of a lawsuit is highly likely to fail and ultimate financial liability¹⁵² will likely fall on individuals and companies. My purpose is to illustrate what has already been happening in the wake of the Metabo law’s implementation, and what else may happen in the future.

C. *Pumped-up Sales From Questionable Claims and Cheap Wares*

The *metabo* market is gigantic. Over half of Japan’s population has been turned into potential consumers of health and weight loss products virtually overnight.¹⁵³ As a direct result of the Metabo law’s implementation, the drug market is currently experiencing explosive growth.¹⁵⁴ Sales of an herbal anti-obesity drug, projected to garner 400

¹⁵² See discussion *infra* Part X.B.

¹⁵³ Japan’s population is approximately 127 million. 56 million people—approximately 44% of the population—are already directly under the jurisdiction of the Metabo law and are “required” to submit to annual waistline examinations. Millions more younger people that are not yet under the jurisdiction of the Metabo law are taking active steps to avoid being labeled as “metabo” when they do reach age 40.

¹⁵⁴ “One area that is seeing immediate benefits is drugs for people seeking to avoid being diagnosed with metabolic syndrome in the first place,” according to an official of Mizuho Investors Securities Co.” *Metabolic Syndrome Sector Swells, supra*

million yen in sales when it was originally released in March 2006, skyrocketed more than tenfold two years later with an unbelievable 5.4 billion yen in sales.¹⁵⁵ The *tokuho* market—products in between food and drug products such as herbal supplements, teas, and tonics—have seen astronomical growth as well. This niche market has expanded from annual sales of 46 billion yen in 2001 to 230 billion yen in 2007¹⁵⁶—nearly a sixfold increase. As it does with the pharmaceutical industry, the Ministry of Health, Labor, and Welfare (“MHLW”) oversees the *tokuho* market and certifies certain *tokuho* products.¹⁵⁷ The same criticism falling on the MHLW’s management of the pharmaceutical industry regarding dubious efficacy of products¹⁵⁸ has also infected the *tokuho* market—as an example, bottled coffee that supposedly helps with management of body-fat levels has been certified by the MHLW as improving health.¹⁵⁹ Other products with similar certification are also very popular¹⁶⁰ with consumers looking for a quick way to become *metabo*-compliant. With such strong profit potential, stores have been clearing room to make sections dedicated to *metabo* products.

Products with questionable claims aren’t only limited to the drug and *tokuho* markets. They’re popping up all over the place to cash in on the *metabo* frenzy while it’s still hot. One of the more outrageous products to take advantage of those labeled as *metabo* is underwear from Wacoal Holdings Corp. The manufacturer claims their high performance underwear will help to burn off excessive body fat.¹⁶¹ At the rough equivalent of \$52 per pair, the underwear isn’t cheap. But sales are brisk—one department store reported moving as many as fifty pairs in a day.¹⁶² Even well-known manufacturers are jumping in to the *metabo* business¹⁶³ or catering their products to it, with some hawking products that may mar their hard-earned reputations. One such product from a reputable manufacturer exhibiting high bunk¹⁶⁴ potential is the *Joba* from

note 80.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Outwitting Metabolic Syndrome*, NIKKEI WEEKLY, June 16, 2008, available at 2008 WLNR 11357379.

¹⁵⁸ See generally, KERR, *supra* note 38, at 373.

¹⁵⁹ *Outwitting Metabolic Syndrome*, *supra* note 157.

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ See *supra* note 149 (describing Yamaha Motor Co.’s entry into the health food business).

¹⁶⁴ The term “bunk,” though dated and its general use fallen into obsolescence, is

Matsushita Electric Industrial Co.—better known as Panasonic. The *Joba* is an electronic exercise machine that mimics the motion of riding a horse.¹⁶⁵ Equipped with stirrups, the “rider” climbs on, powers up the machine, and holds on for a “workout” that claims to improve muscle tone in the legs and lower back while burning 200 calories per hour.¹⁶⁶ A review by THE WASHINGTON POST found the *Joba*’s purported benefits doubtful—the machine brought the reviewer “closer to motion sickness than improved fitness.”¹⁶⁷ At the equivalent of \$1,400,¹⁶⁸ it isn’t cheap and so sales of the *Joba*, along with all pricier products upwards of 100,000 yen, have been relatively stable compared to the tremendous sales growth of inexpensive counterparts.¹⁶⁹

The old adage goes, “you get what you pay for.” An alarming trend is the influx of cheap products seeking to grab a piece of the hot *metabo* market. “Consumers are flocking to inexpensive health products with a name for being effective.”¹⁷⁰ Some products, such as \$9 pedometers, exhibit virtually no potential for injury and are thus quite harmless. Others, such as inexpensive \$17 barbell sets¹⁷¹ of unknown quality, make those familiar with Japan’s products liability laws¹⁷² cringe at the thought of the high potential for injury, though not at the likelihood for financial liability of unscrupulous companies. Even publishers, which

entirely appropriate here for it refers to a thing that garners favorable public opinion yet fails to deliver on those expectations.

¹⁶⁵ See Panasonic Japan, *Joba*, <http://www.panasonic.jp/fitness> (last visited Nov. 11, 2010).

¹⁶⁶ John Briley, *A Core Workout—or Just Horsing Around?*, THE WASHINGTON POST, Oct. 10, 2006, available at <http://www.washingtonpost.com/wp-dyn/content/article/2006/10/06/AR2006100601241.html>.

¹⁶⁷ *Id.*

¹⁶⁸ Nakamura, *supra* note 3.

¹⁶⁹ “Consumers are flocking to inexpensive health products with a name for being effective Meanwhile, demand for pricey goods is roughly unchanged from last year . . . demand for exercise bikes and other fitness equipment with price tags of 100,000 yen and up remains flat.” *Outwitting Metabolic Syndrome*, *supra* note 157.

¹⁷⁰ *Id.*

¹⁷¹ “Pedometers selling for 1,000 yen to 3,000 yen (\$9-28), and lightweight dumbbells priced from 1,680 yen are examples of this trend.” *Id.*

¹⁷² A detailed analysis of Japan’s products liability laws is admittedly out of the scope of this article but deserves brief mention. Japan adopted strict liability in products liability cases through enactment of the Products Liability Law (*Seizobutsu Sekinin Ho*, Law no. 85 of 1994). Jason F. Cohen, *The Japanese Product Liability Law: Sending a Pro-Consumer Tsunami Through Japan’s Corporate and Judicial Worlds*, 21 *FORDHAM INT’L L.J.* 108, 110 n.15 (1997). Enacted on July 1, 1994, it went into effect July 1, 1995. *Id.* at 146. The law helped plaintiffs injured by defective products to seek redress in courts by lowering their burden of proof. *See Id.* at 162 n.392.

normally have a heightened awareness for prudent dissemination of information, are seeking to stick their hands into the proverbial cookie jar. Publishers are taking notice of those who lose weight and are buying their stories. “Toshio Okada, for example, gained national notoriety (and several book deals) after losing 110 pounds.”¹⁷³ Further, guidebooks on questionable *metabo* products such as *tokuho* are under consideration to be published,¹⁷⁴ while fad-diet books are runaway bestsellers.¹⁷⁵

D. *Extraordinary Measures*

Potential for harm does not stop with puffed claims of questionable supplements and cheap exercise equipment. In the previously illustrated example of the *Joba*, potential harm (to one’s checkbook at the very least) is present. In its lackluster review of that machine, writer John Briley commented, “You might not want to hear it, but for efficient, effective core exercise, we still endorse standard-bearing crunches, planks, bridges, push-ups and the like.”¹⁷⁶ That sentiment is felt throughout a good deal of Japan’s population. Many are resorting to good old-fashioned dieting and exercise—but some are taking it too far, resulting in extraordinary harm.

Lawler seemed to acknowledge this potential for extraordinary harm when she wrote, “If those diagnosed with metabolic syndrome resort to quick-fix medications or unhealthy binge diets, the program may ultimately raise healthcare costs.”¹⁷⁷ Though she grazed the subject, she did not follow up on it. She is partially correct; the potential for harm has already been realized. According to one news account, Japan has become an increasingly sedentary society in recent decades.¹⁷⁸ When individuals accustomed to sedentary lifestyles suddenly heed the siren call of exercise, overexertion is a likely outcome. The *metabo* bandwagon has already imperiled at least one rider in a published account. In 2007, “a 74-year old local government official in the rural Mie prefecture collapsed while jogging in an effort to cut his 100cm (39in) waist.”¹⁷⁹ Others have taken to combining strict diets with vigorous exercise. Miki Yabe, 39 years old,

¹⁷³ Lawler, *supra* note 5, at 297 (internal citation omitted).

¹⁷⁴ Mitsubishi UFJ research is considering publishing a book of *tokuho* products for use as a post-examination health guide. *Metabolic Syndrome Sector Swells*, *supra* note 80.

¹⁷⁵ In just six months, “Morning Banana Diet books published since March have sold over 730,000 copies” Michiko Toyama, *Japan Goes Bananas for a New Diet*, *TIME*, Oct. 17, 2008, available at <http://www.time.com/time/world/article/0,8599,1850454,00.html>.

¹⁷⁶ Briley, *supra* note 166.

¹⁷⁷ Lawler, *supra* note 5, at 303.

¹⁷⁸ See *Policing the Dietary Do’s and Doughnuts*, *supra* note 73.

¹⁷⁹ McNeill, *supra* note 1.

5 feet 3 inches tall and weighing 133 pounds, recently undertook a diet and exercise regimen consisting of daily running and swimming while eating nothing but cabbage soup¹⁸⁰ in an effort to pass her upcoming waistline examination. Still others resort to fad diets encouraged by bestselling books—the most popular one at this time being a “banana diet,” replacing last year’s *natto* (fermented soybean) diet.¹⁸¹ The most desperate individuals resort to nothing at all, literally. Fasting, although generally accepted as a dangerous way to lose weight, has become a method increasingly resorted to in the final days before one’s waistline examination.¹⁸²

E. *The Future: Overweight and Unemployed*

For reasons presumed to be beyond the scope of her comment, Lawler acknowledged in passing the potential for individual harm, but did not touch upon the very real danger of social harm to individuals labeled as *metabo*. This harm will come in the form of social rejection, isolation, and unemployment. It is a hushed, but persistent fear among Japanese workers. Because the structure of the Metabo law fines employers for employees’ failure to comply, employers may ultimately come to see the heftier portion of their workforce as a financial liability. Going beyond “the [Metabo law] penalty could even provide an incentive for employers to discriminate against overweight employees in promotions and pay hikes,”¹⁸³ the law could lead to ostracism. Toshio Mochizuki, director of the Medical Urban Clinic in Osaka and author of the recent book, *I’M METABO, SO WHAT!*, commented, “I’m worried that the overweight will start to be shunned at the workplace and these new rules will make no one want to hire them.”¹⁸⁴ Ultimately, one’s size may determine social status and limit career potential. Construction engineer and self-proclaimed “borderline tubby” Katsura Sigiura, 37, poignantly noted, “Fat people will be critici[z]ed by skinny people, old people by the young, and companies will refuse to hire overweight people.”¹⁸⁵

IX. THE KING’S COURT

A. *Litigation in the Context of Medical Malpractice*

The Metabo law potentially invites harm. Harm demands redress.

¹⁸⁰ Nakamura, *supra* note 3.

¹⁸¹ See Toyama, *supra* note 175.

¹⁸² See generally, Kaori Shoji, *Fasting is Hefty’s Secret Way of Escaping Metabo*, THE JAPAN TIMES, Apr. 8, 2008, available at <http://search.japantimes.co.jp/print/ed20080408ks.html>.

¹⁸³ *Anti-Metabolic Syndrome Needs Rethinking*, *supra* note 55.

¹⁸⁴ Rial & Tsunetomi, *supra* note 76.

¹⁸⁵ McNeill, *supra* note 1.

Redress typically involves the court. When harm may manifest itself not in a singular form, but a host of apparitions—in this case, malpractice, products liability, wrongful death, employment discrimination, emotional distress claims, and many others—is there one single best angle to adopt in order to approach discussion of the court? No, there is not. However, we may choose one that is (1) most pertinent to the cause that gives rise to the discussion, namely, the Metabo law; (2) has a developed history that illustrates the rich and relevant context of the social atmosphere; and (3) broadly represents and is capable of showing the challenges plaintiffs face in court. Medical malpractice fits this bill because (1) doctors, whether they agree with or acknowledge such responsibility, are the human connection between Japanese citizens submitting themselves to the waistline examination and the law that “requires” it; (2) the medical field illustrates relevant social contexts such as paternalism and “harmony” with regards to litigation; and (3) is notable for the near-insurmountable barriers plaintiffs face when pursuing a malpractice suit. For these reasons, discussion of “the King’s court” will progress in the context of medical malpractice.

B. *Doctor Knows Best*

It has traditionally been the case that “medicine in Japan has generally been practiced in a paternalistic manner, with patients following doctors’ orders with little or no explanation to or questions from the patients about their illnesses.”¹⁸⁶ However, that notion has been changing, albeit slowly, as more and more patients become learned of their right to informed consent and right to participate in the course of their treatment.¹⁸⁷ Lawler states with accuracy, “Although Americans grew increasingly intolerant of medical paternalism during the civil rights era, the Japanese have only recently, and perhaps tentatively, embraced the general legal concepts of access, accountability, and transparency in healthcare.”¹⁸⁸ When the subject of medical paternalism is brought up, a discussion on “Japan’s cultural emphasis on harmony”¹⁸⁹ seems hard to avoid. Such cultural norms would tend to explain the existence of medical paternalism in Japan—and even foster the continuance of it.

Historically, malpractice claims in Japan were extremely low,¹⁹⁰

¹⁸⁶ TANAKA & SONE, *supra* note 21, at 30.

¹⁸⁷ For a recap of the clearing atmosphere of medical paternalism and the growing awareness of patients’ rights, see *supra* note 123.

¹⁸⁸ Lawler, *supra* note 5, at 297.

¹⁸⁹ *Id.* at 299.

¹⁹⁰ Historical perspective: Japan had only 234 malpractice lawsuits brought to court in 1976. TANAKA & SONE, *supra* note 21, at 31. Eleven years later in 1987, that number still remained extremely low at 325 lawsuits. *Id.*

leading some to believe the assumption that in Japan, “doctor knows best” and low incidences of malpractice mean high quality doctors. However, Drs. Tanaka and Sone note:

[M]alpractice probably occurs frequently in Japan, but the number of cases brought to trial remains very low . . . Many Japanese still consider the cultural values of harmony and conciliation in the community as a whole much more important than their individual rights. The shortage of lawyers may be an additional reason for the low number of malpractice lawsuits in Japan.¹⁹¹

C. *Two Competing Theories*

Drs. Tanaka and Sone offer two competing theories for the low prevalence of medical malpractice lawsuits in Japan. On one hand, “the language of law is subordinate to the power of social integration, and leads people to forego lawsuits.”¹⁹² On the other, “Japan’s low litigation rates posits a more structural cause, namely that the elite have created barriers to inhibit access to the legal system and limit the extent to which courts can be a potent force of social change.”¹⁹³ Lawler’s discussion promotes the argument in favor of cultural values of social harmony and thus takes the stand of the former; however, the latter seems more rational when Japan’s recent legal changes are taken into consideration.

D. *A Lowering of the Guard*

Despite the historical “general tendency of the Japanese judiciary to defer to medical practice in matters of information disclosure,”¹⁹⁴ the legal atmosphere has changed in the fourteen years since Lawler’s source¹⁹⁵ was published. From 1992 to 2003, new medical malpractice claims have more than doubled.¹⁹⁶ Such drastic increases in new medical malpractice claims over a relatively short time period are inconsistent with a theory of emphasis on harmony discouraging lawsuits. Several recent changes in Japan’s legal atmosphere may explain this new trend, two of which are of particular importance in illustrating Japan’s changing legal attitudes to the deference given to medical professionals.

¹⁹¹ *Id.* at 30.

¹⁹² Eric A. Feldman, *Law, Society, and Medical Malpractice Litigation in Japan*, 8 WASH. U. GLOBAL STUD. L. REV. 257, 257 (2009).

¹⁹³ *Id.*

¹⁹⁴ Lawler, *supra* note 5, at 298.

¹⁹⁵ Lawler relied on Robert B. Leflar, *Informed Consent and Patients’ Rights in Japan*, 33 HOUS. L. REV. 1, 45 (1996).

¹⁹⁶ 371 new medical malpractice claims were filed in 1992; whereas 913 new medical malpractice claims were filed in 2006, representing a 146% increase. Feldman, *supra* note 192, at 260.

First, the number of licensed attorneys admitted to the bar has increased over fifty percent from 1990 to 2005.¹⁹⁷ This rise in attorneys follows the doubling of medical malpractice claims in the same period. Mere coincidence cannot explain this correlation—there is definitely a relationship between the two. An increased number of attorneys expand the *availability* of attorneys to accept cases—especially salient when a major barrier to pursuing medical malpractice claims was a shortage of qualified attorneys.

Second, access to courts has improved while the time it takes for a trial has been shortened considerably. Eric A. Feldman writes, “[s]everal of Japan’s most important courts—including the district courts in Tokyo, Osaka, Nagoya, and Chiba—have recently created ‘consolidation divisions’ (*shuchubu*) that specialize in malpractice claims.”¹⁹⁸ Benefits of having courts dedicated to malpractice cases include more experienced judges that are better informed about pertinent medical issues, better access to expert witnesses, and speedier trial times. With regard to trial times, the average plaintiff spent 16.3 fewer months in trial during 2006 than they would have in 1994.¹⁹⁹

One disincentive to pursuing a malpractice suit that remains is the prohibitive filing fees. Filing fees are determined by the amount of damages sought (which is a predictable amount as Japan allows no punitive damages). A \$1,000,000 suit commands a filing fee of approximately \$40,000—in addition to a lawyer’s retainer.²⁰⁰ For individuals of modest means, the filing fee remains a substantial barrier to pursuing a medical malpractice claim. By increasing the capacity of the legal system through admitting more attorneys to the bar and creating specialized medical malpractice courts, and by drastically shortening the length of time a medical malpractice trial takes from filing to judgment, the legal system seems to be moving away from a policy of giving medical practitioners great deference and toward a call for more accountability in the profession. As barriers to litigation are removed, more lawsuits are filed. This solid correlation calls into question Lawler’s opinion that Japanese patients “may be more willing to blindly accept a mandated diet

¹⁹⁷ In 1990, there were 13,800 licensed attorneys in Japan. *Id.* at 267. This number increased to 21,185 in 2005, representing a 53.5% increase. *Id.*

¹⁹⁸ *Id.* at 273.

¹⁹⁹ Trial times for medical malpractice cases have been seen as a barrier to pursuit of claims. Whereas civil cases in Japan take an average of 8–9 months, medical malpractice trials can take five times longer to conclude. Steps have been taken to streamline the trial process in recent years. In 1994, the average medical malpractice trial took 41.4 months (almost three and a half years). *See* Feldman, *supra* note 192, at 269, tbl.5. Trial times have fallen steadily through the years. In 2006, the average malpractice trial took 25.1 months, or just over two years. *Id.*

²⁰⁰ *Id.* at 265.

and exercise program than their American counterparts²⁰¹ and points to a deeper reason why Japanese patients have historically shied away from conflict with doctors.

X. THE ADVISOR'S PERSPECTIVE

A. *In Summary*

In the dawn of early man, physical peril—exposure to the elements, encounters with predators, and starvation—was his greatest threat. Understanding of and harnessing the elements conquered that threat. Contagious disease then emerged with the advent and spread of civilization. The greatest technology of all—medicine—contained it. In this affluent, modern world, chronic disease is man's newest and greatest threat. Japan is using the law to keep this threat in check.

But is the law Japan's best way to deal with this modern disease? Specifically, is the Metabo law the best way? To start, staving off chronic disease seems to be a concurrent, if not subordinate, goal of the law. First, Japan is already among the slimmest and healthiest of the world's developed nations. Second, deficiencies in Japan's medical system may be large enough to not make a significant difference in the prevalence of chronic disease in its population. Last, the structure of the law and its tilted enforcement mechanism points to a broader goal—to shore up a dying elderly healthcare system.

Further, in aiming to provide for the sustained future care of its elderly population while improving the health of the younger generation, the law actually puts its citizens in danger of harm in three ways. First, the Metabo law has created a new market for consumer goods. And manufacturers, in their attempts to grab a stake of that new market, release products of questionable efficacy and quality. Second, the law neither discourages nor prevents citizens from taking extraordinary—and dangerous—measures to lose weight before their examinations. Third, those unable to comply with the Metabo law may eventually be shunned by society and have severe limits placed on their livelihoods because of job loss and an inability to find new employment. When—yes, when²⁰²—individuals suffer harm, they will find access to the courts easier than in decades past.

Japan's legal system has undergone rapid change in the past two decades. These changes favor plaintiffs by improving access to the courts; however, much remains to be done in the legal system to ensure all plaintiffs, not just the wealthy, have equal access. Should citizens harmed because of the Metabo law seek redress through the legal system, their

²⁰¹ Lawler, *supra* note 5, at 298.

²⁰² McNeill, *supra* note 1.

prospect for holding the government liable is almost zero.

B. *Why the Japanese Government is Virtually Immune*

The Metabo law potentially exposes more than half of its population to physical and emotional harm, yet the Japanese government is unlikely to bear any financial responsibility should that potential for harm be realized. The reason is very simple and it is found in the letter of the law. Compliance is not mandatory. Compliance is urged, not compulsory. Technically, submitting oneself to the annual waistline examination may be considered voluntary because the individual is not subject to any penalty for avoidance. Even if one does participate in the examination and is deemed *metabo*, further participation in dietary and lifestyle counseling is compelled but again, is not mandatory. Thus, one who complies with the Metabo law does so of his own volition.²⁰³ And if one does so of his own volition—the Japanese government, technically speaking, is most likely free from blame if harm befalls the individual.

But just because the Japanese government is not legally liable does not absolve it of moral responsibility. An argument should be made that it is morally wrong for the government to draw a line and declare that anyone whose waistline is above it is officially considered fat²⁰⁴—especially when that line is disputed by learned physicians and even considered by some to be arbitrary.²⁰⁵ Alas, I concede that philosophers—with intimate knowledge of pragmatism, consequentialism, deontology, and utilitarianism ingrained in their creative minds and with Plato's *Republic* and Aristotle's *Politics* in their toolkits—would be best fitted to construct that argument. I may, however, offer some perspective regarding future revisions of the Metabo law²⁰⁶—if Japan decides to keep it.

C. *A Better Way—Personal Responsibility*

There is no question that Japan, with its shrinking and graying population, is facing a near-insurmountable problem and that disaster is almost certain if nothing is done. But is its present course—using the Metabo law in its current incarnation—the best solution? The world has

²⁰³ Of course, there are consequences (such as putting one's job at risk), but those consequences are social in nature and have a very tenuous to zero nexus with the law itself due to its structure.

²⁰⁴ Just as I have contributed to the scholarly discourse surrounding the Metabo law that Lawler started, it is my hope that in the future, another scholar will add to this discourse and visit this issue.

²⁰⁵ “The plan calls for a 25 per cent cut in the “metabo” ranks by 2011, *despite criticism that the waist-size limit is arbitrary and will encourage size-ism in the workplace.*” McNeill, *supra* note 1. *See also Anti-Metabolic Syndrome Scheme Needs Rethinking, supra* note 55.

²⁰⁶ The law is scheduled to be revised, although the date cannot be accurately determined because of conflicting information from sources. *See infra* note 213.

started to take notice of Japan's efforts, and not to poke fun at it, either. In America, of all places, where the storied "Cheeseburger Bill"²⁰⁷ almost became federal law, states are taking notice of how Japan's law will turn out. The state of Alabama has recently enacted its own "Metabo law," although its purpose differs significantly from Japan's. Effective January 2010,²⁰⁸ Alabama's law imposes a \$25 monthly health insurance fee for all state employees with a Body-Mass Index greater than 35 who refuse to shape up within a year.²⁰⁹ The purpose of Alabama's law is to encourage state employees to take personal responsibility for their health.²¹⁰ The fee structure makes them financially and thus personally responsible, unlike Japan's where the financial responsibility falls not on the employees, but on the employers who have less control.

In the landmark New York *Pelman v. McDonald's Corporation*²¹¹ case, Justice Sweet remarked, "Where should the line be drawn between an individual's own responsibility to take care of herself, and society's

²⁰⁷ In a nutshell, the purpose of the "Cheeseburger Bill" was to legally acknowledge that citizens have a personal responsibility to maintain their own health by preventing lawsuits alleging that food establishments should be held liable for would-be plaintiffs' chronic health problems because of selling foods with high caloric and fat content. *Personal Responsibility in Food Consumption Act*, H.R. 554, 109th Cong. (2005). It was introduced in the House of Representatives in 2004, passed, but failed a Senate vote. *Id.* It was reintroduced the following year with the same result. *Id.*

²⁰⁸ Matt Sloane, *Alabama to Link Premium Costs to Workers' Health*, CNNHEALTH.COM, Dec. 9, 2008, available at <http://www.cnn.com/2008/HEALTH/diet.fitness/09/19/alabama.obesity.insurance/index.html>.

²⁰⁹ Katie Hoffer, *Alabama's New Law to Tax the "Big People,"* ASSOCIATED CONTENT, Oct. 2, 2008, available at http://www.associatedcontent.com/article/1020228/alabamas_new_law_to_tax_the_big_people.html?cat=51. Promoted as the "Wellness Premium Discount Program" by the Alabama State Employees' Insurance Board, its discount structure is essentially a fee for those exhibiting obesity-related risk factors. Monthly state employee insurance premiums doubled from \$25 per month to \$50 per month in 2010. Upon submitting to a battery of tests, body-mass index included, the employee's health insurance premium is discounted \$25 to its original \$25 monthly rate for 2010. This applies to all employees who submit to the tests, regardless of obesity. Starting 2011, the discount will only apply to employees who clear these tests. The net result of Alabama's Wellness Discount Program is a \$25 premium increase for state employees who refuse to be tested for obesity-related risk factors and those who submitted themselves for tests in 2010, did not clear at least one of them, and did not improve by 2011. See "State of Alabama Wellness Premium Discount Program," available at <http://www.alseib.org/PDF/SEHIP/SEHIPWellnessPremiumDiscount.pdf>.

²¹⁰ *Id.*

²¹¹ *Pelman v. McDonald's Corporation*, 237 F.Supp.2d 512 (S.D.N.Y. 2003). Plaintiffs were regular patrons of McDonald's restaurants and sued McDonalds when their obesity led to chronic health problems at an early age. *Id.*

responsibility to ensure that others shield her?”²¹² To a lesser extent than Alabama, New York, or in the United States for that matter, Japan already recognizes the concept of holding its citizens personally responsible for their health through financial responsibility; hence, the introduction of copayments into the elderly healthcare system in 1983. If the *true purpose* of the Metabo law really is to increase citizens’ health rather than to fund the elderly healthcare system, future revisions could replace the current fines structure with one similar to Alabama’s. Rather than imposing fines on employers, Japan could look at fining individuals to encourage personal responsibility for one’s health. However, in doing so, the funding mechanism for the elderly healthcare system (fines levied on employers) will have to be destroyed.

Japan must make a choice if it plans on keeping its Metabo law—either revise it to emphasize citizens’ personal responsibility for their health so that it is truly a *Metabo* law (at the expense of losing the funding mechanism for the elderly healthcare system); or keep it as-is and in doing so, continue to discount personal responsibility in favor of maintaining the funding mechanism for the elderly healthcare system. This suggestion is based on the assumption that all else remains the same. Should Japan address problems with quality delivery of medical care and consumer protection, it could very well be possible that Japan may enjoy the best of both worlds—an overall healthier population and a small stream of funds to provide for the future sustainability of the elderly healthcare system. Ideally, this is the best outcome, however, it will require the most effort (in terms of restructuring the medical system, portions of the Ministry of Health, Welfare, and Labor, and massive consumer education about proper dieting, exercise, and related lifestyle products).

XI. THE END

This story has run its course. A nation with such an admirable, protective interest in the future welfare of its citizens has a looming crisis on its hands: how can it provide for the care of its elderly in the coming decades when its population is shrinking and growing older by the day, and the healthcare system designed to provide for its citizens in their advanced years is itself in danger of dying? It thinks of a plan. The answer is a law intended to discourage obesity of its citizens through fines levied upon their employers. Those funds will go to support the elderly healthcare system.

In putting this law into effect, the nation is ridiculed by news sources worldwide. The law’s noble but misguided intent is lost on them. Worse still, such reporting does not uncover the myriad issues that will prevent this law from achieving its true potential. Japan’s healthcare system, though not fundamentally flawed, is not adequately structured to

²¹² *Id.* at 516.

treat and resolve complex cases of obesity, though it is more than competent to remedy simple cases of it. Those who do try to lose weight may resort to extraordinary measures or use drugs, supplements, and exercise equipment that are of dubious efficacy or downright dangerous. For those obese citizens who cannot slim down, potential ostracism and employment discrimination await. Citizens may suffer harm. The law may be opening the nation as a whole to legal liability for that harm in unprecedented ways.

The harmed will most likely turn to the courts, which has traditionally served to deter conflict by presenting near-insurmountable barriers to plaintiffs. However, when the harmed seek redress in the courts this time, they will find an inviting atmosphere for plaintiffs not found in decades past. The nation may experience an explosion of litigation. The government of the nation itself need not worry, though, as the law is structured so that citizens' compliance with its directives is unenforceable and therefore, not mandatory. And although the potential explosion of litigation will likely be traced back to the law, the unenforceability of it will most likely spare the government from liability.

The nation did not have this potential fallout in mind when it put the law into effect. Yet it needs to be brought to the forefront, however unsavory it may be, so these negative externalities may be addressed in order for the law to function as intended.

There is no end to this story, at least not at the present moment. It will be written in the near future²¹³ when the Metabo law goes under review. At that time, the Japanese Parliament—the Diet—will choose to either write another chapter in this story, hopefully addressing present concerns with the law, or write the ending of it and find another way to resolve its looming crisis. There is no doubt that Japan has the interest of its citizens at heart, but whom? If changes are not made that will address the issues presented in this story, Japan must decide where its greater interests lie—in protecting the three percent of its population that are currently obese, or providing for the welfare of its projected forty percent of elderly citizens in 2050.

²¹³ The Metabo law is scheduled to be reviewed; however, current sources are in disagreement over the exact date. Dates range from “a couple of years” to 2011 and 2012. In the face of such uncertainty with the inability to independently verify the exact date of its revision, I must hesitate to commit to an exact date, and although insufficient, “in the near future” will have to suffice for the present.