Changes in the Remarks on Nanbyō (Intractable Diseases) in the National Diet

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Abstract

The Japanese word *nanbyō* (literally, "problem-disease") was formally defined in October 1972 with the publication of the Guidelines on Measures to Address Nanbyō by the Ministry of Health and Welfare. In this study, I analyzed how the word nanbyō was used in discussions in the National Diet in the years leading up to this publication. I specifically focused on three things: the diseases to which the term referred, all those who used the term, and the contexts in which the term was used. The analysis was processed on a computer using Higuchi's (2004) KH Coder, an open source program for quantitative analysis. Statements containing the term nanbyō were inputted into the KH Coder and yielded data such as frequency of references to nanbyō and the speakers of the statements. This analysis yielded two conclusions: first, nanbyō referred primarily to tuberculosis in the first phase of the discussions, and primarily to subacute myelo-optic neuropathy or Behçet's disease in the latter; second, the contexts in which legislators used the term differed from that of executive speakers.

Introduction

The Japanese word nanbyō (literally, "problem-disease[s]") is typically a catchall term for "intractable disease." However, the usage of the term has varied, with the referents and definitions depending on the person and time. Examples of such variations are found in the statements made in sessions of Japan's National Diet. On June 23, 1959, a Diet member described nanbyō as a disease "for which medical science currently offers no established therapy"

(32nd Diet Session, plenary meeting no. 2, June 23, 1959, Legislator Soma). Around a decade later, however, another member equated the term with "pollution-related disease" (55th Diet Session, special committee on industrial pollution countermeasures, no. 9, June 14, 1967, committee member Sakagawa).

According to Serizawa (1973), nanbyō entered the popular lexicon in 1963, in association with a campaign by patients with subacute myelo-optic neuropathy (SMON):

The term nanbyō had not been precisely defined by medical scientists or by healthcare professionals. Following an outbreak of SMON in the Warabi district of Toda, Saitama Prefecture, the treatment and rehabilitation of patients became a major public concern. In the autumn of 1963, SMON patients organized a civic group to put their concerns to national and local authorities. It was thanks to this campaign that the term entered widespread use (Serizawa, 1973, p.261).

Nanbyō received its first formal definition in October 1972, when the Ministry of Health and Welfare published the Guidelines on Measures to Address Nanbyō. This publication reflected the change in the usage of nanbyō. Originally, nanbyō was a generic illness-related term used in a number of contexts, but in the 1960s, it came to be associated in particular with the campaign to get government subsidies for SMON patients. Following this shift in usage, Diet members and civil servants began discussing the issue, using the word nanbyō to describe SMON. In response to the Diet discourse, the government announced a program to fund research on SMON and other nanbyō, as well as a program of welfare assistance for nanbyō patients. With the aim of funding such research and assistance, the ministry published the above-mentioned guidelines, thus providing the first formal definition of nanbyō. The guidelines specified eight nanbyō diseases that would receive government-funded research. The publication also specified that patients with one of four of the eight specified nanbyō diseases would be eligible to receive government assistance for medical costs.

Thus, following the above developments, the government formally recognized some of the referents of nanbyō that were in popular usage at the time. However, there is no literature on how people interpreted, described, and used the term in the national discourse in the above-mentioned period. A study by Eto (2005) offered a political analysis into how measures to address nanbyō came to take effect. Another study by Horiuchi (2006) provided

insights on the formation of welfare policies for nanbyō patients. However, no study has clarified the diseases to which nanbyō referred, or examined how legislators and civil servants used the term. It is essential to understand who used the term and how they used it in the national discourse leading up to the 1972 definition. This information can help us understand how the discourse culminated in the government finally recognizing nanbyō diseases as being eligible for publicly-funded research and medical subsidies.

1. Purpose

The purpose of this study is to analyze the usage of the term nanbyō (the diseases it referred to, who used the term, and in what contexts) before it was formally defined in the 1972 Guidelines on Measures to Address Nanbyō. To this end, I performed an analysis on the nanbyō-related oral and written statements that legislators, government officials, and others made in Diet sessions.

2. Method

To obtain data from the Diet record, nanbyō-related statements from among all the statements made between the Diet's first session (May 1947) and its 69th session (September 1972) were collected using the publicly accessible National Diet Library's online search service. After extracting the statements, I eliminated the orthographic variations among the words that occurred frequently. Examples of these words include *kaze* (common cold), rendered as 風邪 or カゼ, and *gan* (cancer), rendered as 癌 or ガン.

To gauge the contexts in which the statements featuring the word nanbyō were made, entire statements as recorded in the archives were used, instead of extracting only the sentences or phrases in which the word appeared. The documents that were analyzed encompassed the plenary sessions and committee meetings of both houses of the Diet.

In the analysis, each speaker was classified into one of three categories: legislative, executive, or other. "Legislative speaker" denotes a speaker who was a member of the upper or lower house of the Diet, but who was not a member of the executive category. "Executive speaker" denotes a speaker who was a member of the cabinet, a member of a government ministry or

agency, or another official tasked with explaining government policy. The term "other speakers" refers to an unsworn witness or other individual speaking before a Diet hearing.

I processed the analysis on a computer using Higuchi's (2004) KH Coder, an open source program for quantitative analysis. Statements containing the term nanbyō were inputted into the KH Coder and extracted data such as frequency of references to nanbyō and the speakers of the statements.

After calculating the trends in the frequencies of nanbyō statements, I broke this data down by legislative and executive speakers. There were minimal nanbyō statements among other speakers, so the frequency of these speakers were broken down collectively, rather than individually. In analyzing the contexts for the nanbyō statements, only those statements made by legislative and executive speakers in the second phase (1970–1972) were considered. As there were a large number of statements in this phase, the other two phases will be taken up later.

3. Results

3.1 Nanbyō Reference Frequency

As Figure 1 shows, the first reference in the Diet archives to nanbyō was made in 1948. The word appeared once that year. In subsequent years up to and including 1969, the frequency remained low, with the word appearing only one to six times each year. From 1970 onward, however, the frequency increased sharply. The word appeared 50 times in 1970 (a tenfold year-on-year increase), 120 times in 1971 (a 2.4 fold increase), 362 times in 1972 (a threefold increase). In view of this distribution, I grouped the data into two phases: the first (1948–1969) and second (1970–1972) phases.

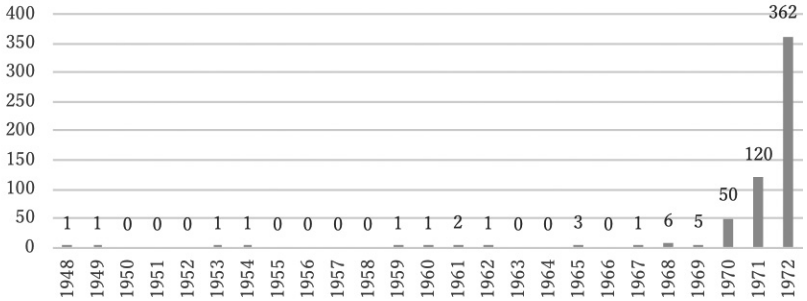

Fig. 1 Frequency of nanbyō references (number of times mentioned) by year

3.2 Diseases Referred to in Nanbyō Statements

Table 1 shows the frequencies for the diseases to which the speakers referred when they used the term nanbyō. As the table shows, in the first phase, the most frequent referent was tuberculosis (*kekkaku*), which accounted for 29 (48.3 percent) of the referents. Other referents in the first phase included cancer (*gan*), which was referred to six times (10.0 percent), and leprosy (*hansen-byō*), which was referred to five times (8.3 percent). In the second phase, there were two dominant referents, neither of which appeared in the first phase at all: SMON was the referent on 183 occasions (30.8 percent) and Behçet's disease (*beichetto*) on 127 occasions (21.3 percent). Referents from the first phase that appeared in the second phase as well were tuberculosis, cancer, leprosy, muscular dystrophy (*kin jisutorofī*), asthma (*zensoku*), epidemic (*densen-byō*), Minamata disease (*minamata-byō*), and the common cold.

Table 1—Diseases referred to in nanbyō statements (frequency)

First phase		Second phase	
Tuberculosis	29	SMON	183
Cancer	6	Behçet's disease	127
Leprosy	5	Cancer	90
Muscular dystrophy	4	Myasthenia	36
Asthma	4	Muscular dystrophy	24
Infectious disease	3	Kashin–Beck disease	12
Minamata disease	2	Minamata disease	12
Common cold	2	Tuberculosis	10
Whiplash	1	Autism	10
Filaria	1	"Adult disease" (i.e., lifestyle disease)	9
Gonorrhea	1	Yushō disease	7
Raynaud's phenomenon	1	Asthma	7
Pemphigus	1	Nephrotic syndrome	7
		Infectious disease	7
		Itai-itai disease	6
		Rheumatism	6
		Myositis	6
		Sarcoidosis	5
		Leprosy	5
		Mental illness	5
		Erythematosus	4
		Coralgil	3
		Renal failure	3
		Measles	2
		Stroke	2
		Leukemia	2
		Echinococcosis	1
		Common cold	1
		Hepatitis	1
		Arthritis	1
		Hemophilia	1

3.3 Who Made the Statements?

Table 2 shows the breakdown of statements by speaker categories in both phases. In the first phase, legislative speakers accounted for the largest share of the statements (70.8 percent), although the statements were few in number. In the second half, the total number of statements at 532, was 22 times higher than that in the first half.

The number of statements rose in the second half for each speaker category, but the legislative speakers' share of the statements declined by 18 percent. In contrast, the executive speakers' share doubled from 16.7 to 34.0 percent. The other speakers' share remained largely the same. Thus, the legislative speakers accounted for the largest shares in both phases, while the executive speakers doubled their share in the second phase.

Table 2—Nanbyō statements by speaker category

	Legislative speakers	Executive speakers	Other speakers	Total
First phase	17 (70.8)	4 (16.7)	3 (12.5)	24
Second phase	281 (52.8)	181 (34.0)	70 (13.2)	532
Total	298 (53.6)	185 (3.2)	73 (13.1)	556

Share (%) shown in parentheses

Table 3—Legislative speakers' nanbyō statements by party

First phase		Second phase	
Party	Frequency	Party	Frequency
Liberal Democrat	1 (5.9)	Komeito	84 (29.9)
Japan Socialist Party	11 (64.7)	Japan Socialist Party	148 (52.7)
Japan Communist Party	1 (5.9)	Liberal Democrat	17 (6.0)
Democratic Socialist Party	2 (11.8)	Japan Communist Party	31 (11.0)
Independent	2 (11.8)	Democratic Socialist Party	1 (0.4)

Share (%) shown in parentheses

Table 3 shows the breakdown of the legislative speakers' statements by party. In the first phase, the Japan Socialist Party accounted for the largest share (64.7 percent) with 11 statements. Members of other parties made statements too, but only once or twice. There were few statements overall. The Liberal Democratic Party (or its antecedent, the Liberal Party) dominated the Diet as the ruling party throughout the first phase. This might explain why 90 percent of the nanbyō statements came from opposition parties.

In the second phase, the Japan Socialist Party again accounted for the largest share (52.7 percent), with 148 statements. However, this share was 12 percent smaller than that in the first phase. This difference reflects a rise in the number of statements attributable to other parties. Komeito accounted for none of the statements in the first phase, but the party's members made

84 statements (29.9 percent) in the second phase, second only to the Japan Socialist Party. The Liberal Democratic Party had a roughly 6 percent share in both phases, but the ruling party accounted for 17 statements in the second phase as opposed to only one in the first phase.

Thus, in both phases, the Japan Socialist Party dominated both in terms of number and share of statements, and the opposition parties collectively accounted for 90 percent of the statements.

Table 4 shows the breakdown of the executive speakers' nanbyō statements. In both phases, most executive-speaker statements were attributable to the Minister for Health and Welfare and his civil servants. The Ministry of Health and Welfare eventually established a bureau for addressing nanbyō (the Bureau for Addressing Specified Diseases) in July 1972, just three months before the publication of the Guidelines on Measures to Address Nanbyō. The ministry had been tackling the nanbyō issue even before it had established a formal section dedicated to the issue, which may explain why it accounted for the vast majority of the statements in both phases.

In the first phase, there was one statement by a civil servant from the Ministry of Labor. This statement pertained to occupational diseases. In the second phase, there were four statements by civil servants from the Ministry of Finance. These statements concerned the budget for nanbyō.

Table 4—Executive speakers' nanbyō statements by party

	Minister of Health and Welfare	Civil servant in the Ministry of Health and Welfare	Civil servant in the Ministry of Finance	Civil servant in the Ministry of Labor
First phase	2 (50)	1 (25)	0 (0)	1 (25)
Second phase	83 (46)	94 (52)	4 (2)	0 (0)

Share (%) shown in parentheses

3.4 What were the Contexts for the Statements?

Table 5 shows the key phrases that appear in the statements in both phases. A key phrase exemplifies the category of text in which it appears. According to Higuchi (2014), a key phrase "has a very high probability of appearing in the relevant category of text relative to the text data as a whole." Table 5 shows the Jaccard similarity coefficients for the key phrases in both phases. As

Higuchi (2014, p.39) explained, "the Jaccard similarity coefficient is a value between 0 and 1, with a higher value indicating a stronger relationship."

Thus, a key phrase is one that pertains to a certain category of text more than it does with other categories and thus offers insight into the context behind the category of text. In the first phase, the key phrase with the highest Jaccard coefficient was "patient" (*kanja*) followed by "called" (*iu*), and "Japan." The second phase featured a different set of top-three key phrases: "think" (*omou*), "issue" (*mondai*), and nanbyō.

Table 5—Key phrases in each phase

First phase		Second phase	
Patient (s)	.077	Think	.169
Called	.062	Issue	.139
Japan	.051	Nanbyo	.111
Special account	.045	Medical care	.103
Tuberculosis	.044	Consider	.090
National sanatorium (a)	.044	Measure (s) (to address)	.081
Hospital	.040	Now	.080
Nursing	.040	Health insurance	.066
Severe	.037	Research	.066
Individual (s)	.033	Very	.063

The first phase had too few statements to enable a speaker category-specific analysis. However, this analysis was possible in the second phase, which featured many more statements by both legislative and executive speakers. Figure 2 shows a collocation network for legislative speakers, while Figure 3 shows the same for executive speakers.

According to Higuchi (2012), a collocation network is one in which a thicker line indicates a stronger collocation between the phrases (i.e., a greater likelihood that the phrases will appear together). In such a network, "importance lies in whether phrases are interconnected by lines; if two phrases are close to each other in the network but have no line connecting them, they do not strongly collocate" (Higuchi, 2014, p.158). A collocation between phrases can suggest the context.

Figure 2 shows the collocation network for legislative speakers, while Figure 3 shows the same for executive speakers. The figures indicate trends that are common to the statements of both legislative and executive speakers.

First, nanbyō strongly collocated with "measures (to address)" (*taisaku*), "issue" (*mondai*), "rare and unusual disease" (*kibyō*), and "Consider" (*kangaeru*). Second, "treatment/therapy" (*chiryō*) collocated with "research" (*kenkyū*), "SMON," and "cause(s)" (*genin*). On the other hand, some trends were specific to each speaker category. Among the legislative speakers, "issue" (*mondai*) collocated with "now" (*ima*). The statements by legislative speakers also featured some collocating phrases that did not feature among the executive speakers' statements; these were "health insurance" (*hoken*) "health" (*kenko*), and "nationals" (*kokumin*). Conversely, the statements by executive speakers featured some collocating phrases that did not feature among the legislative speakers' statements; these were "establishment" (*kakuritsu*), "diagnostic" (*shindan*), "criteria" (*kijun*), and "disease(s)" (*shikkan*).

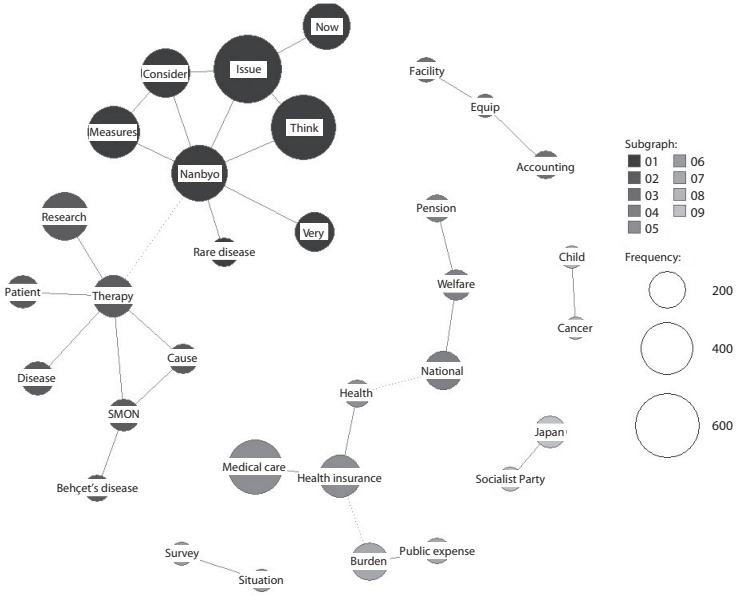

Fig. 2 Collocation network for legislative members' statements (second phase)

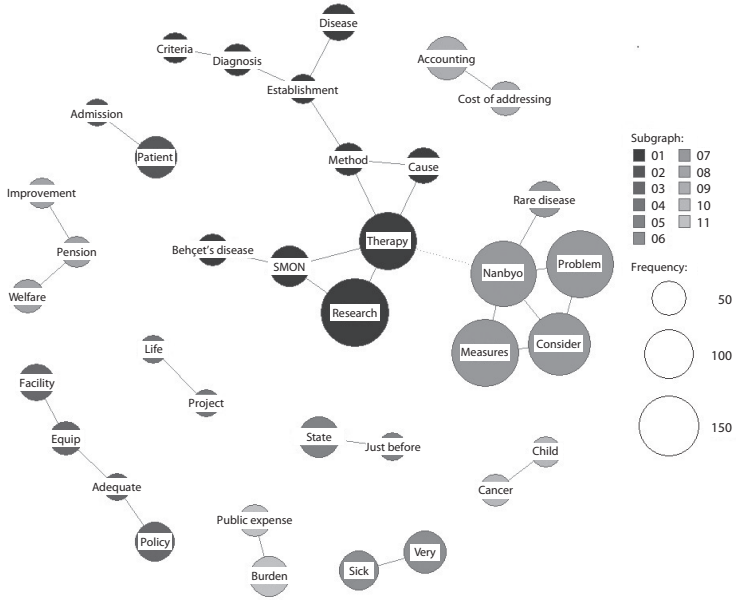

Fig. 3 Collocation network for executive members' statements (second phase)

4. Discussion

4.1 What is Nanbyō?

As Table 1 shows, in the first phase, nanbyō was most likely to refer to tuberculosis. This disease was the greatest cause of death in Japan between 1935 and 1950 (2017 population statistics published by Ministry of Health, Labour and Welfare). It was a top priority for the Japanese government in this period. In 1939, the government founded the Anti-Tuberculosis Association. In 1942, it started issuing BCG vaccines and in 1948, it toughened vaccination legislation. These measures coupled with postwar improvements in public hygiene resulted in a decline in the number of tuberculosis deaths in the 1950s. In 1951, tuberculosis fell from the first to the second greatest cause of death, having been displaced from the first position by cerebrovascular disease. By 1953, it dropped to fifth place.

To relate this historical trend to the analysis, tuberculosis collocated with nanbyō between 1954 and 1968, the time when the disease had fallen from second to fifth place among the major causes of death. I isolated the statements that featured the word tuberculosis but did not include nanbyō. These statements indicated that tuberculosis was mentioned as early as 1947, when it was still the deadliest disease in Japan. While tuberculosis remained the greatest killer, speakers mentioned the disease (in discussions about how to address it), but never described it as a nanbyō. The association between tuberculosis and nanbyō emerged once tuberculosis ceased to be the greatest killer.

These findings, coupled with the fact that tuberculosis was the main referent of nanbyō in the first phase (as shown in Table 1), suggest that describing tuberculosis as a nanbyō did not connote that tuberculosis was the deadliest disease. For the 15 years that tuberculosis remained the deadliest disease, the disease never collocated with nanbyō. Thus, during the first phase, nanbyō denoted a disease that was a common cause of death, rather than the top cause of death.

As Table 1 shows, whereas nanbyō had 13 referents in the first phase, it had as many as 31 in the second phase. Of these, 23 were exclusive to the latter. In the first phase, nanbyō denoted tuberculosis in about half of the cases. The situation in the second phase was completely different, since nanbyō denoted tuberculosis in only 1.7 percent of the cases.

The most frequent referent of nanbyō in the second phase was SMON. The first mention of SMON in the Diet records came up in 1967, during a meeting of the Committee on Social Affairs and Labor. A member of this government committee mentioned SMON as an example of a rare and unusual disease. From 1969, there was a dramatic increase in the use of the term, with Japan Socialist Party Diet member Kazutaka Ohashi and some government civil servants mentioning it regularly. Before 1969, the term had been mentioned only thrice, and on each occasion, it was mentioned during a meeting of the Committee on Social Affairs and Labor. In 1969, it was mentioned as many as 21 times, in each case by members of the Committee on Social Affairs and of other committees. These committee members frequently described SMON as a rare and unusual disease.

The first instance among the Diet statements where SMON is described as a nanbyō came in the second phase, in 1970. The speaker on that occasion was a minister (Fujio Uchida). Subsequently, a number of Diet members and government committee members mentioned SMON as a nanbyō-kibyō (a

"nanbyō / rare and unusual disease") along with Behçet's disease.

Thus, in the second phase, the predominant nanbyō referent was SMON, and nanbyō denoted a rare and unusual disease.

4.2 What were the Contexts in which the Statements were made?

In the first phase, few speakers mentioned nanbyō, and most of those who did were in the Japan Socialist Party (Tables 2 and 3). The first Diet member to mention the term was Shogetsu Tanaka, a member of this opposition party. Tanaka spoke about a study into the efficacy of acupuncture and anma massage in treating nanbyō. In the statement, he cited gonorrhea as an example of a nanbyō. As Table 1 shows, subsequent nanbyō statements referred to a range of other diseases, including leprosy and muscular dystrophy; but as discussed above, tuberculosis was the referent in most cases. The context for these statements on tuberculosis is evident from a number of key phrases in Table 5 (first phase)—namely, "national sanatorium(a)" (*kokuritsu ryoyojo*), "severe" (*jusho*), "tuberculosis," "patient(s)," and "nursing care" (*kango*). That is, the context concerned the "nursing care" of "patients" with "severe" "tuberculosis," a nanbyō requiring care at a "sanatorium."

Two other key phrases were "special account" (*tokubestu kaikei*) and "hospital" (*byōin*). These phrases were used in a 1968 Diet debate on whether to apply special accounting in national tuberculosis sanatoria. During this debate, legislators had highlighted an issue with special accounting in national hospitals, which did not willingly accept nanbyō. A minister and some civil servants used the two phrases while responding to the legislators' questions.

As discussed earlier, whereas tuberculosis was the dominant referent of nanbyō in the first phase, the situation was markedly different in the second phase, when the media ran stories on SMON, highlighting cases of numbness with no apparent cause. Against this backdrop, Komeito dubbed SMON, Behçet's disease, and other diseases with no known cause or treatment as "public diseases" (*shakai-byō*) and "nanbyō." The party also urged the government to provide welfare assistance to patients in addition to investing in research. However, the Health and Welfare Minister and his civil servants declined the request, citing the need to prioritize research spending. In response, Komeito members petitioned Prime Minister Eisaku Sato, proffering data that legislators had not previously presented. The petition convinced

Sato to signal a new policy direction, wherein he said:

> SMON causes great suffering to patients. We cannot help patients simply by lamenting their suffering or by noting its unknown cause. We must take active measures to address the situation. The Ministry of Health and Welfare should actively explore countermeasures in parallel with research; research and the measures should be explored as a separate matter from the research.
>
> (63rd Diet Session, Budget Committee, No. 18, March 30, 1970)

Before Sato's statement, the Minister of Health and Welfare together with his civil servants did not consider welfare subsidies (because they intended for research to be the priority). However, the Prime Minister's statement prompted a volte-face, and the ministry started considering welfare assistance in parallel to facilitating research. Emboldened by the statement, Komeito members pressed the minister and his civil servants to provide concrete measures for nanbyō, thus forcing them to respond. Thus, by the second phase, the context behind nanbyō had shifted from tuberculosis toward measures for addressing SMON and other nanbyō.

In the previous section, I discussed the flow of the discourse among all speakers in the second phase. In this section, I focus on the legislative speakers' statements.

As Figure 2 shows, the legislative speakers' statements prominently featured phrases that never appeared in the executive speakers' statements, including "health insurance," "health" (*iryo*), and "burden" (*futan*). These phrases reflect the discussions in the Diet about amending the health insurance system as a means of addressing SMON and other nanbyō. One legislator argued that the government should expand the scope of national health insurance to cover nanbyō (68th Diet Session, Committee on Social Affairs and Labor, No. 24, May 11, 1972; Legislator Kawamata). Another opposed this measure, arguing that the state should bear the entire burden of the costs associated with the nanbyō (68th Diet Session, Committee on Social Affairs and Labor, No. 27, May 18, 1972; Legislator Shimamoto). The topic of pensions came up during the debate, and one legislator discussed "welfare pensions" (*fukushi nenkin*; i.e., non-contributory pensions) in relation to nanbyō (I have underlined the key phrases):

What people want are stable prices, generous welfare, and an end to

recession. When it comes to the matter of welfare, as the Health and Welfare Minister and Labor Minister discussed earlier, people are interested in whether or not the government will raise welfare pensions by 100 yen—or by 200 yen. People are very interested in whether the government will raise them by 100 yen, to 1,100 yen, and whether the government will bear the 10,000 yen burden in medical costs that nanbyō patients currently pay each month (68th Diet Session, Committee on Social Affairs and Labor, No. 2, January 25, 1972; Legislator Kodaira).

Statements like the above were mostly from members of the Japan Socialist Party. Komeito members accounted for the second greatest share of such statements, despite them having made no nanbyō statements at all in the first phase.

Although Komeito had formed in 1961 (which falls in the first phase), the party's members did not speak about nanbyō in the first phase. In the second phase, a statement by a Komeito member (Yamada) had prompted Prime Minister Sato to announce that the government would pursue measures as a matter distinct from research. The statement marked the first of a spate of Komeito statements on nanbyō, indicating that the party had started taking an active interest in the matter. Komeito became interested in nanbyō countermeasures, according to Eto (2005), because of the presence of SMON patients in the members' constituencies coupled with the party's desire to shed its religious trappings. Eto's claim that the party made a calculated decision to focus on nanbyō measures is corroborated by the change in Komeito's nanbyō statements, as seen in Tables 3 and 4.

In the first phase, the Japan Socialist Party members (who accounted for most nanbyō statements in both phases) occasionally referred to national hospitals and specific diseases in their nanbyō statements. However, they neither mentioned nanbyō as a generic/collective term for multiple diseases nor petitioned the government for countermeasures, as the Komeito members did in the second phase. In the second phase, Yamada and other Komeito members started using nanbyō and "public diseases" as generic/collective terms and successfully petitioned the government for measures. The Japan Socialist Party then echoed this trend. When Komeito urged the government to take action against nanbyō, the Japan Socialist Party joined these calls and pressed the government to address nanbyō, such as SMON. These findings imply that the flow of the discourse leading up to the publication of the Guidelines on Measures to Address Nanbyō was as follows: After Komeito kickstarted

the discussion on measures for addressing nanbyō, the Japan Socialist Party started using the term nanbyō in a context that was different from that of the first phase, while continuing to account for the most nanbyō statements in the second phase as in the first.

Another notable finding is that the Japan Communist Party became the third contributor of nanbyō statements in the second phase, following the Japan Socialist Party and Komeito. In the first phase, only one Japan Communist Party member mentioned nanbyō. The statement concerned efforts to eradicate filariasis. In the second half, the Communists mentioned nanbyō as many 31 times (11.0 percent). In these statements, the members used the term not to refer to a specific disease but rather to denote a disease with no cure. Collectively, Komeito, the Japan Socialist Party, and the Japanese Communist Party accounted for 95 percent of nanbyō statements in the second phase, indicating that the opposition parties led the discourse that culminated in the Guidelines on Measures to Address Nanbyō. Thus, in the second phase, nanbyō was predominantly used by those members in opposition parties and in the context of promoting countermeasures for nanbyō, particularly SMON.

Executive speakers' statements in the second phase. In this section, I discuss the trends in the statements made by the executive speakers in the second phase. As the collocation network in Figure 3 shows, the executive speakers' statements include collocating terms that never featured among the legislative speakers' statements ("establish," "diagnosis [diagnostic]," "criteria," and "disease"). One possible reason for this difference is that whereas the legislative speakers were pressing the government to take action against nanbyō, the executive speakers focused more on researching nanbyō, establishing diagnostic criteria, establishing therapeutic strategies, and identifying underlying causes. During the second phase, the Ministry of Health and Welfare came under pressure to explore measures for nanbyō following the announcement of Prime Minister Sato that I cited earlier. Just before Sato made this statement, the Minister of Finance had stated that the Ministry of Health and Welfare was prioritizing research into underlying causes: "The Minister of Health and Welfare is working flat out to examine the cause and research other aspects of the issue. Once this work is done, it should then be possible to come up with measures." This statement implies that although nanbyō measures had become a pressing matter in the second phase, the Ministry of Health and Labor continued to prioritize research over the

countermeasures. The following statements by the Minister of Health and Labor underscored the ministry's focus on researching nanbyō and on establishing diagnostic criteria (The key phrases have been underlined):

With regards to the matter of nanbyō the member has raised, generally speaking, diagnosis is difficult in a great many cases. Unless and until we establish diagnostic criteria, we won't be able to identify and distinguish them from similar diseases (65th Diet Session, 4th Section of the Budget Committee, No. 2, March 24, 1971; Minister Uchida).

As part of measures for the elderly, some talk of establishing a project team to consider measures for addressing nanbyō. You are a doctor as is the head of public health, so you would surely understand how each of the diseases will have its own causes and pathology. Therefore, a project team may not be best for coming up with measures for the diseases. It would be better to have a research committee for each disease. As with SMON, a research team for each disease, with a set of experts and researchers, should explore the causes of the disease in question, as well as therapeutic strategies. These teams should also seek to establish the diagnostic criteria for the disease in question. This challenge is different in some respects to the challenge of addressing elderly issues. That's why our approach is to have independent, separate teams for each disease, as you know (65th Diet Session, 4th Section of the Budget Committee, No. 2, March 24, 1971; Minister Uchida).

During Diet deliberations, members repeatedly asked for updates about the progress in nanbyō measures. Although the executive speakers responded saying that progress was minimal, the Diet began discussing nanbyō measures in detail. Consequently, in the second phase, the government started examining nanbyō measures, and this development was accompanied by a sharp rise in government statements about the same. Having been unenthusiastic about engaging in the nanbyō matters theretofore, the government was now under pressure to do so. This sharp rise in government statements about nanbyō measures explains why executive speakers accounted for a much larger share of nanbyō statements in the second phase than they did in the first (see Table 2).

Thus, in the second phase, the nanbyō statements by executive speakers initially emphasized research, but the emphasis gradually shifted toward measures for addressing the issue.

5. Conclusion

5.1 What Diseases did Nanbyō Describe?

My analysis yielded the following conclusions. In the first phase, nanbyō typically referred to tuberculosis and connoted a disease that was prevalent, but was not the deadliest. In the second phase, the term primarily referred to SMON and connoted a rare and unusual disease.

5.2 Speakers

The breakdown by speaker category indicates that legislative speakers accounted for most nanbyō statements in both phases. The breakdown of legislative speakers' statements by party indicates that parties' engagement in the nanbyō issue depended on the phase. The Japan Socialist Party accounted for most statements in both phases, while in the second phase, there were also statements by legislators from the Komeito and the Japan Communist Party.

The statements by executive speakers were mostly from the Minister of Health and Welfare and his civil servants. Executive speakers referred to nanbyō twice as much in the second phase as they did in the first, suggesting that the second phase offered more opportunities for engaging in the issue.

5.3 What were the Contexts in which the Statements were made?

In the first half, legislators generally mentioned nanbyō in the context of treating tuberculosis patients in national sanatoria. In the second half, legislators mentioned the term in the context of measures for addressing SMON and other nanbyō. Executive speakers initially used the term in statements that emphasized how the government was prioritizing research into nanbyō. When pressed by legislators, however, these speakers began mentioning the term in statements that expressed a willingness to consider nanbyō measures.

5.4 Summary

With text analysis, I was able to investigate who used the term nanbyō and how they used it in the national discourse that eventually culminated in the government formally defining the term—a matter that has not been studied

before. Consequently, I could show the diseases to which the term referred, as well as how these diseases were described, in the course of this discourse.

Nanbyō was rarely mentioned in the Diet discussions between 1948 and 1970. In the few cases where it was, the speaker would typically be a legislative member, and the referent would usually be tuberculosis. The term was mentioned far more frequently from 1970 onward, wherein legislative members used it in discussions addressing SMON, Behçet's disease, and other nanbyō. During this phase, executive members initially mentioned nanbyō in the context of prioritizing efforts to establish diagnostic criteria. However, after legislative members steered the discussion toward measures for addressing nanbyō, the executive members' nanbyō statements shifted accordingly. Thus, I showed how the above contexts in which nanbyō featured in the above discourse, and how the discourse led to the publication of the Nanbyō Countermeasures Guidelines in October 1972.

However, in focusing on the speakers and contexts, I was unable to adequately investigate elements that do not appear in the text data, such as trends in policymaking or statements and actions that occurred outside of Diet discussions. Future research should build on the findings of this study and consider these other elements.

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