

The Japan Medical Association and its Political Development

Takakazu YAMAGISHI¹

Even after Japan achieved a universal health insurance in 1961, the health care reform continued to cause heated political debate in Japanese politics. Among many political stakeholders, the Japan Medical Association has been seen playing a large role in shaping the path of health care policy. In particular, Takemi Taro, who served as the JMA's president for twenty-six years from 1957 to 1982, contributed in making the health care debate more visible.

Media and commentaries have given much attention to the JMA and its role in Japanese politics. While many of them are written on how the JMA plays role in specific events, or legislation, or how politics of the JMA presidential election took place, social science scholars have produced only limited studies which focus mainly on the JMA. William Steslicke is one of the major social scientists who produced a book specifically on the JMA in 1973. He demonstrated how powerful the JMA was in Japanese politics, but he was not able to do much to see the historical development of the JMA.²

This paper is to understand what has driven the development of the JMA since the Meiji Restoration and complement what Steslicke and others have studied about the JMA. It first describes how the government's health policy affected the formation and development of the JMA. Second, it illustrates the JMA's organizational structure and sees how the internal politics took place. Third, it shows the historical transformation of the JMA presidents. Lastly, it explains how the JMA's membership has changed and then discusses how it has affected the development of the JMA.

This paper is part of a larger project that studies on how health policy and its politics have evolved in Japan and emphasizes special attention to the relationship between the government and the JMA. This paper makes a contribution by looking into how the JMA's internal politics has taken place historically.

¹ The research was supported by the Grant-in-Aid for Scientific Research (C) (00454405), Japan Society for the Promotion of Science, Ministry of Education, Culture, Sports, Science and Technology and the Pache Research Subsidy I-A-2 for Academic Year 2014, Nanzan University.

² William E. Steslicke, *Doctors in Politics: The Political Life of the Japan Medical Association* (New York: Praeger Publishers, 1973).

1. The Government Policy and the Development of the JMA

Medical associations are believed to make medicine more professional and scientific. And stabilizing doctors' finance is very important for them to increase membership.³ The American Medical Association was established in 1847 to improve medical education and professionalize medicine.⁴ The founding fathers of the JMA had similar motive but it turned out to be in a different position with the central government from its American counterpart. This section overviews the history of the JMA until it was reorganized after World War II to adopt the basis of the current organizational structure.

One of the unique aspects in the formation of medical associations in Japan was that they were created to reduce the power of the Japanese traditional medicine, known as Kanpō, which had been authorized as the state medicine under the Tokugawa Shogunate. The first national medical association was formed as a result of the competition between the traditional medicine and the western medicine which the new Meiji government made serious efforts to promote. Whether western-style doctors liked it or not, the formation and development of medical associations in Japan were enmeshed in the government's health care policy.

When the Meiji government began its policy to westernize the Japanese society, economy and politics, health care policy became part of it. Kanpō was perceived as inefficient medicine to treat patients. Particularly, Kanpō did not work for those who needed surgical procedures like wounded soldiers.⁵ Moreover, because there was not an integrated medical educational system in the era of the Tokugawa Shogunate, many doctors had begun to practice after only a brief apprenticeship.

The Tokyo Medical Society was born in 1886 as the first genuine doctors' association. The creation of local medical associations spread to whole Japan. Although it initially included Kanpō doctors, the Society soon began to push the government to produce legislation for doctors, particularly private practitioners, who practiced western medicine.⁶ The creation of local medical association resulted into a movement that formed the national association.⁷ In 1906, the Great Japan Medical Association was founded. It was created for private practitioners, excluding those who were employed by public hospitals.

In 1923, the Great Japan Medical Association pressed the government to give it a legal status. For the government, the legalization of the national association would be useful to

³ Carol S. Weissert and William G. Wissert, *Governing Health: The Politics of Health Policy* (Baltimore: Johns Hopkins University Press, 2006), 139.

⁴ Martin Kaufman, *American Medical Education. The Formative Years, 1765–1910* (Westport, Connecticut: Greenwood Press, 1941), 127–30.

⁵ Kawakami Takeshi, *Gendai Nihon Iryōshi* [History of Modern Japanese Health] (Tokyo: Keisō shobō, 1965), 91.

⁶ Hidehiko Kasahara, *Nihon no iryō gyōsei: Sono Rekishi to Kadai* [Health Care Administration of Japan: Its History and Problems] (Tokyo: Keio University Press, 1999), 81; Akira Sugaya, *Nihon Iryō Seidoshi* [History of Japanese Medical Policy] (Tokyo: Hara shobō, 1976), 243–44.

⁷ Kawakami, *Gendai Nihon Iryōshi*, 242.

implement the Health Insurance Law that was passed in the Imperial Diet in 1922. For elite doctors in the JMA, it would help them increase the membership and gain the power over local medical associations and individual members. The JMA cooperated in the policy-making process of the HI and had power to decide on doctors' fees. While the government had a powerful tool to implement the new legislation, the JMA elites gained a venue to influence the government and control doctors' finance by dealing with the HI. But in the meantime, the government earned a leverage to influence the JMA.⁸

Through the venue which tied the government and the JMA, WWII gave more power to the government against the JMA. The JMA was absorbed into the Japanese government's activities to conduct the war. The JMA elites began to cooperate with the government by proposing a drastic reorganization. In January 1943, the JMA was reorganized to be a state organization.⁹ As the war deepened, the government began to take control over doctors' fees by giving the Ministry of Health and Welfare (MHW) the authority to make decision on fees of specific procedures and drugs.

The US-led occupation began after the war ended in August 1945. As part of its demilitarization and democratization policy, the occupation authority ordered that the JMA be dissolved and reorganized as a voluntary organization. However, in its reorganization process and under the occupation, the JMA faced a deadlock and could not take the power of setting the fees back from the government.¹⁰ On the other hand, GHQ's postwar purge of public officers did not impact much the MHW. GHQ actually used the MHW's strong bureaucratic power to help Japan recover from the wartime devastation and reformed the health insurance system.¹¹

In sum, from 1900s to 1940s, the JMA was born and got involved in the government's health insurance administration. The JMA had a similar motivation to its American counterpart. But because the Meiji government took a strong leadership in the westernization of medicine, the JMA played lesser role in reforming the medical education and it emphasized more on the financial aspect. Soon, the JMA was absorbed in the war mobilization policy and became state entity. Then, with its reorganization, the JMA was reorganized to be a voluntary association. As the JMA developed, the JMA elites consistently sought to centralize the power structure. They had to do so to compete with Kanpō doctors and improve the economic status of members. By dealing with the HI, they had a venue to influence the government, but at the same time, they were enmeshed in the government's health care policy. When WWII was advanced, through the venue, it was easier for the Japanese government to absorb the JMA into the totalitarian regime. Although the JMA was reorganized again into a voluntary organization after the war, its power structure did not change much. This is a clear contrast with the AMA, which grew slowly without much of the central government's intervention and blocked the government's efforts to introduce a universal health insurance system in the 1930s and during

⁸ Taku Nomura, *Nihon Ishikai* [The Japan Medical Association] (Tokyo: Chikusa Shobō, 1976), 34.

⁹ *Ibid.*, 46-47.

¹⁰ *Ibid.*, 56.

¹¹ For the health care reform, see Adam D. Sheingate and Takakazu Yamagishi, "Occupation Politics: American Interests and the Struggle over Health Insurance in Postwar Japan," *Social Science History* 30 no. 1 (Spring 2006): 137-64.

WWII.

2. Organizational Structure

The current organizational structure of the JMA is based on one it adopted in its reorganization after the war. In the process of making JMA's policy proposal, the House of Delegates takes the role of the decision-making body. As Chart 1 shows, the Board of Trustees and the Executive Board of Trustees, which mainly make policy proposals to the House of Delegates, are positioned under the House of Delegates. The Board of Trustees is composed of one president, vice presidents, board members, and executive board members. It also has many committees under the direction of board members and executive board members.

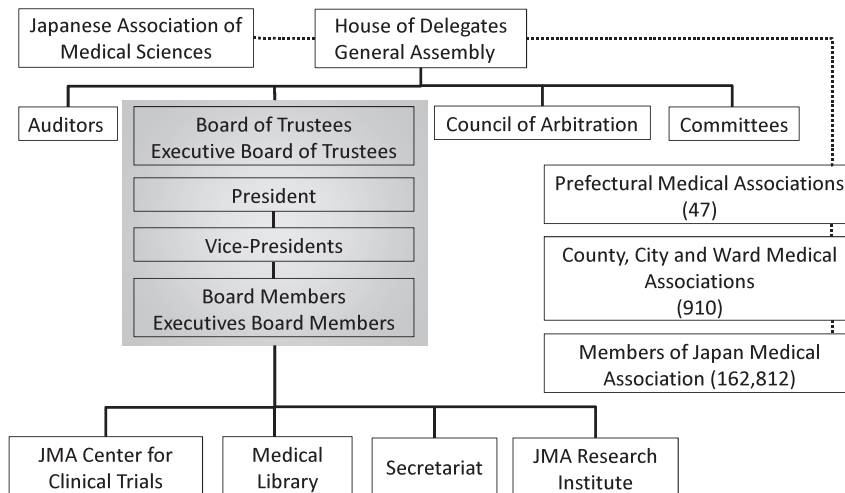


Chart 1 Organizational Chart of Japan Medical Association

Source: The Japan Medical Association, "Organization Chart of Japan Medical Association," http://www.med.or.jp/english/about_JMA/organization.html, accessed on April 24, 2015.

Among the many actors in the JMA, the most powerful person is the president. The JMA president has more power over the other actors within it than its American counterpart. Hajime Mizuno describes about the inter-politics of the JMA, "The president has a dominant power. In other words, the president can control the JMA's policy and have dominant administrative power. . . . If official positions are to be divided, one category is the president and the other category is others."¹² The president is in the position to control the agenda the JMA deals with.

In terms of the JMA's relationship with prefectural and local medical associations, it has a

¹² Hajime Mizuno, *Dare mo Kakanakatta Nihonishikai* [The Untold Story of the Japan Medical Association] (Tokyo: Sōshisha, 2003), 17.

large power base. Steslicke wrote in 1973, “Within the Association the level of interest and participation on the part of rank-and-file members tends to be fairly low. This means that a small, active minority of members, most of whom hold an elective or appointive office, are able to exercise considerable control over the management of the Association’s affairs and activities. It also means that this active minority is able to mobilize the relatively inactive majority at special times and for special purposes.¹³” This has not changed very much since then. This can be contrasted with the AMA that is based on more decentralized organizational structure and that local associations get involved more actively in the state-level health care policy-making process.

In sum, although there are many organizations and actors in the JMA, it has a large power against the prefectural and local associations. Among the JMA officials, the president cast a dominant power. This is largely related to the JMA’s history to centralize its power structure as it developed.

3. Presidents

The president has a large authority in the JMA’s decision-making process. This section reviews the characteristics of the successive presidents and then picked up two presidents who had significant influence on the JMA’s history. The history of the presidents demonstrates that the nature of the JMA leadership historically changed from more university-centered to private practitioner-centered.

Table 1 is the list of the JMA presidents in which some characteristic changes can be seen. First, as seen in their home medical association, most of them belonged to the Tokyo Medical Association. It shows that the Tokyo Medical Association has had leadership in the JMA. However, this trend changed recently; only one of the recent five presidents is from the Tokyo Medical Association. Second, the first nine presidents (Tamiya was the president twice in separate terms) experienced professorship at the university or college, and Kitazato Shibasaburo, Kitajima Taichi, Tamiya Takeo served as dean of medical school. In contrast, among the last eleven presidents, only one, Haranaka Katsuyuki, experienced professorship. All of them, including Haranaka, served as head of hospital and clinic. Third, four out of the last nine presidents once served as vice president, while two in the first ten presidents experienced it.

The contrast between the first nine presidents and last ten presidents demonstrates that before the end of the post-WWII reconstruction era, experiencing professorship was more an important factor to cast a large influence on the JMA than after that. In the latter period, however, serving as head of hospital or clinic and getting higher positions within the JMA became more important to become the president. It can be concluded that in the latter period, one has to have a better political skills to be on the top of the JMA than in the former period. Two presidents, who cast a large influence, reflect this characteristic change.

¹³ Steslicke, *Doctors in Politics*, 67.

Table 1 Presidents of the Japanese Medical Association

	Name	Home Medical Association	Previous Careers	Term
1	Kitazato Shibasaburo	Tokyo Medical Association	Dean of Keio University Medical School, Head of Kitazato Institute	1916–1931
2	Kitajima Taichi	Tokyo Medical Association	Dean of Keio University Medical School	1931–1943
3	Inada Ryokichi	N/A (appointed by the government)	Professor of Kyushu Imperial University and Tokyo Imperial University	1943–1946
4	Nakayama Toshihiko	Tokyo Medical Association	President of Tokyo Medical Association, Member of House of Peers	1946–1948
5	Takahashi Akira	Tokyo Medical Association	Professor of Tokyo Imperial University Medical School	1948–1950
6	Tamiya Takeo	Tokyo Medical Association	Dean of Tokyo Imperial University Medical School	1950
7	Taniguchi Yasaburo	Kumamoto Medical Association	President of Kumamoto Medical Association, Professor of Kumamoto Medical College, Member of House of Councilors	1950–1952
8	Tamiya Takeo	Tokyo Medical Association	Dean of Tokyo Imperial University Medical School	1952–1954
9	Kurosawa Junzo	Tokyo Medical Association	President of Tokyo Medical Association, Professor of Nippon Medical School, Head of Ogawa Ophthalmology Clinic	1954–1955
10	Obata Korekiyo	Tokyo Medical Association	President of Tokyo Medical Association, Head of Hamada Hospital	1955–1957
11	Takemi Taro	Tokyo Medical Association	Vice President of the JMA, Head of Takemi Clinic	1957–1982
12	Hanaoka Kenji	Nagano Medical Association	President of Nagano Medical Association, Head of Jikei Yoshida Hospital	1982–1984
13	Haneda Haruto	Tokyo Medical Association	President of Tokyo Medical Association, Head of Haneda Clinic	1984–1992
14	Murase Toshio	Tokyo Medical Association	Vice President of the JMA, Head of Murase Clinic	1992–1996
15	Tsuboi Eitaka	Fukushima Medical Association	Vice President of the JMA, Head of Tsuboi Hospital	1996–2004

	Name	Home Medical Association	Previous Careers	Term
16	Uematsu Haruo	Osaka Medical Association	President of Osaka Medical Association, Head of Muramatsu Clinic	2004–2006
17	Karasawa Yoshihito	Tokyo Medical Association	President of Tokyo Medical Association, Head of karamatsu Clinic	2006–2010
18	Haranaka Katsuyuki	Ibaraki Medical Association	President of Ibaraki Medical Association, Associate Professor of Tokyo University Medical School, Head of Kyojin Oohata Hospital	2010–2012
19	Yokokura Yoshitake	Fukuoka Medical Association	Vice President of the JMA, President of Fukuoka Medical Association, Head of Koei Yokokura Hospital	2012–

Source: The Japan Medical Association, “Journal of the Japan Medical Association,” Japan Knowledge, www.japanknowledge.com.

Among the JMA presidents, Kitazato Shibasaburo, the first president, should be the most important person for the JMA. The JMA would have not been formed in the way it did without him. He studied in Germany under the guidance of Robert Koch and became a world-famous researcher. He came back from Germany in 1892 and became the head of the Institute of Infectious Diseases that was a private organization created with financial support from Fukuzawa Yukichi and Moriyama Ichizaemon. Kitazato fought against the government’s intervention in turning the Institute into a national institution. Although it was eventually nationalized, Kitazato resigned with other staff members and founded the Kitazato Institute. He also played a great role in establishing the medical school of Keio University, a private university created by Fukuzawa. He believed in a practical branch of learning and had distant himself from the government.¹⁴

The second important president is Takemi Taro. Unlike many of his predecessors, before he became the president in 1957, he did not serve professorship. After he dropped out from research assistantship at Keio University, he worked at Rikagaku Kenkyūsho (Riken) which was established in 1917 as the first large-scale national science research institute. After that he became a solo-practitioner in Ginza. Through his personal connection owing to Riken, he began an active networking. He had a direct access to the center of politics through his marriage to the grandchild of Makino Nobuaki, son of Okubo Toshimichi and Lord Keeper of the Privy Seal. Through the marriage, Takemi also became a very close kin to Yoshida Shigeru who served as the Prime Minister for about seven years after the war. With his strong connection in politics, Takemi was asked to serve as vice president under Tamiya Takeo twice. After he became the president in 1957, Takemi fought against the government to ask for the

¹⁴ Ogawa Teizo, *Igaku no Rekishi* [History of Medicine] (Tokyo, Chuokoronsha, 1964), 199. Also see, The Kitasato Institute, “Kitasato Shibasaburo,” <http://www.kitasato.ac.jp/kinen-shitsu/about/index.html>, accessed on September 30, 2014.

freedom of doctors and increase of doctors' fees. He became well-known as "Kenka Taro" after his aggressive strategies, including his refusal to accept patients with health insurance programs. He served as the president much longer than the others for twenty-six years.¹⁵

In sum, the president has a dominant power in the JMA; however, the necessary conditions to be the president have changed. The Takemi's presidency seems to be a turning point in this transformation. After him, to be on the top of the JMA it became more important for one to have political skills to climb up the ladder within the JMA rather than being a professor or dean in medical schools. This transformation means that the JMA became, or at least began to be seen, more of the association of private practitioners, for private practitioners, and by private practitioners after the Takemi presidency.

4. Membership

Interest groups cannot exist without their membership. To maintain its membership, as Mancur Olson points out, interest groups must provide selective benefits which one can get only by becoming a member.¹⁶ However, it is difficult for medical associations to provide selective benefits to their members. What they mainly seek is the development of medicine, professionalization of health care workers, and the financial stability of doctors. All of them cannot be purely selective benefits for medical association members because non-members can receive them as well.

The JMA has suffered from the decline of membership. As Figure 1 shows, in 1947, 75.1% of doctors were JMA members, but the rate dropped to 68% in 1953. It got back to 74.5% in 1967, but the JMA faced gradual decline of membership after that and the rate was 57.7% in 2008. This decline reflects the decreasing trend of solo-practitioners on which the JMA rely its membership. As Figure 2 shows, solo-practitioners occupied 61% of all doctors. But the number declined to 40% in 1981 and 26% in 2008.

The transformation of its membership has given the JMA presidents harder time to take leadership in policy-making process of health care reform. The decline of members means that the JMA loses its financial and political power in election and the policy-making process. To increase the number of members, moreover, they have to reach doctor who are employed by hospitals. A symbolic way would be that the JMA makes an effort to raise the national health insurance fees for hospitals. However, it is very difficult for the JMA leaders to do it because, particularly in the recent fiscal austerity, benefiting hospitals results in hurting solo-practitioners. In fact, the percentage of the JMA members who are employed by hospitals has not increased, around twenty-five percent since 1955.¹⁷ The JMA has got into a very difficult

¹⁵ Shuichi Hido, "Itansha Takemi Taro [A Heretic Takemi Taro]," *Chuokoron* 79 no. 7 (July 1964): 246–258; Takakazu Yamagishi, "A Short Biography of Takemi Taro, the President of the Japan Medical Association," *Journal of the Nanzan Academic Society Social Sciences* 1 (January 2011): 49–56.

¹⁶ Mancur Olson, *The Logic of Collective Action* (Cambridge: Harvard University Press, 1965).

¹⁷ The data has been provided by the JMA.

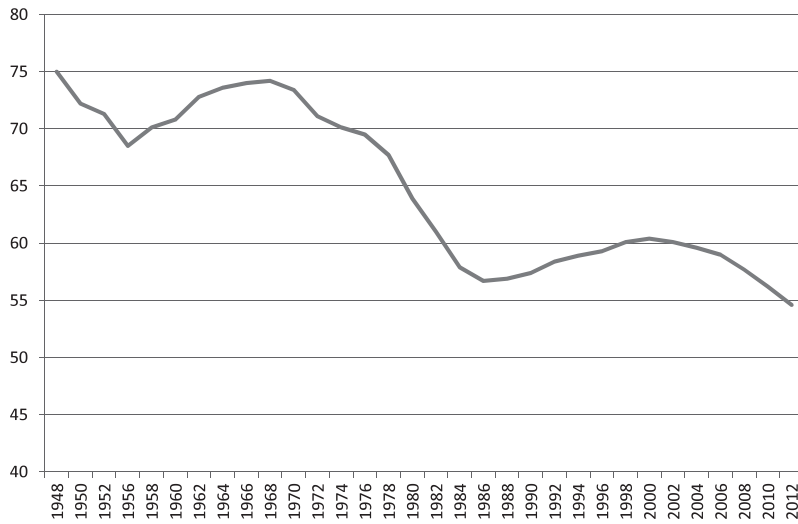


Figure 1 The JMA Membership (% of All Doctors)

Source: The Japan Medical Association

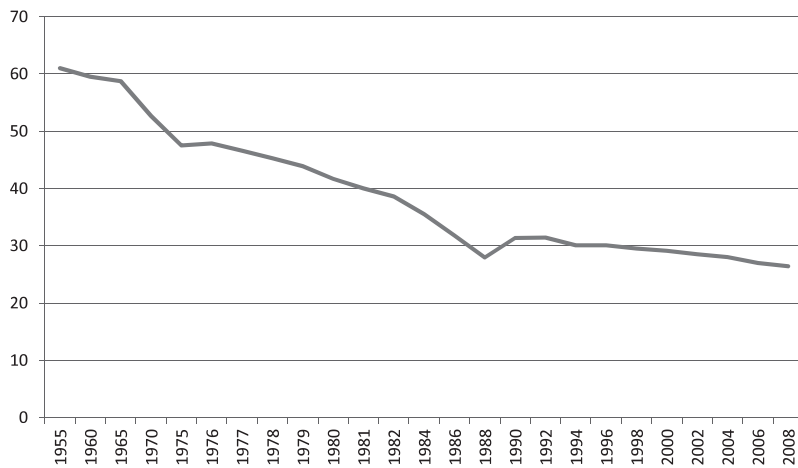


Figure 2 The Number of Solo-Practitioners (% of All Doctors)

Source: Portal Site of Official Statistics of Japan, "Ishi, Shikaishi, Yakuzaishi Chosa [Statistics of Doctors, Dentists, Pharmacists]," <http://www.e-stat.go.jp/SG1/estat/List.do?lid=000001060599>, accessed on February 2, 2015.

dilemma.

Conclusion

This paper demonstrates how JMA's internal politics took place by looking at its formation

and development, its organizational and political structure, and its membership. The way the JMA was established largely affected its subsequent development especially its power relationship with the government and its internal power structure.

With the powerful new Meiji government that took the leadership to westernize Japanese medicine, western-style doctors earned their legitimacy to form medical association to push for further westernization. After the government created the Health Insurance Law of 1922, the government saw the newly legalized JMA as a tool to implementing the law. WWII made the JMA a means for the government to make healthier soldiers and workers to win the war. After the war, the big “loser” in the health care policy-making process was the JMA. It was blamed for its wartime cooperation with the government. However, the MHW was almost intact during GHQ’s public official purge and maintained its strong authority to reform the health care policy. It was after Takemi became its president, the JMA began to be seen as a full-fledged interest group.

The JMA’s organizational structure had been consistently centralized. Kitazato played a dominant role in the formative period of the JMA. It could be attributed partly to his personality; however, it was largely because the JMA needed to deal with the strong central government. The JMA’s internal power structure remained centralized even after the reorganization process during the US -led occupation. The Takemi’s presidency tried to take stronger leadership to make the JMA politically stronger. But the membership began to decline and it has given instability to the JMA and made it harder to impact the debate of health care reform.

This paper is intended to contribute to the study which investigates on how the health policy has developed in Japan and how it affected the JMA. The first thing to advance this paper is to see more carefully how institutional and policy changes by the government affected the JMA. The second is to understand how the JMA interacted with other stakeholders in health care, such as nurses association, hospital associations, and pharmaceutical associations affected one another. The last is to analyze how internal politics has taken place after Takemi resigned in 1983.

The Japan Medical Association and its Political Development

Takakazu YAMAGISHI

Abstract

Although the JMA played a significant role in the history of health insurance policy in Japan, social scientists have produced only limited to study its historical development. This paper is to understand what has driven the development of the JMA since the Meiji Restoration and complement what the major existing works by William Steslicke and others. This paper is part of a larger project that studies on how health policy and its politics have evolved in Japan and emphasizes special attention to the relationship between the government and the JMA by looking into how the JMA's internal politics has taken place historically.