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Date 04 Oct 2002.
Abstract

This dissertation investigates the position that interest groups occupy in the decision-making process of the government of Japan from case studies in the area of health policy. Three important points are demonstrated. First, the medical associations have created strong interdependent linkages to the party in power and have obtained their policy preferences from within the party's decision-making organs. Second, the policy design process in Japan's leading political party, the Liberal Democratic Party, has left little room for the prime minister's initiatives in health care policy. The party has deconcentrated the policy approval process in various councils over which the prime minister has little or no influence. This stands in sharp contrast to the situation prevailing in most parliamentary systems. Third, the thesis demonstrates how the prime minister can, through the design of supra-partisan national councils for reforms, temporarily bypass the normal policymaking channels of the party and enhance its ability to carry out policy adaptation. Two such national councils are investigated: the Nakasone Provisional Council on Administrative Reform (1981-84) and the Hashimoto Administrative Reform Council (1997-98). The temporary national councils are investigated as institutions complementary to the normal policymaking channels of the ministerial and party committees. In the field of health care, the national councils have introduced policy options which had been rejected for years by the medical body and the party in power. The Hashimoto national council, in particular, introduced market-oriented policies that significantly altered Japan's health care system. Three policy areas are investigated: the introduction of principles of information disclosure through the provision of medical files, the creation of transparent price determination mechanisms, and the attempt at reforming the medical fee schedule. These policy changes are seen as a first step toward the introduction of market principles in Japan's service economy.
# Table of Contents

Abstract.......................................................................................................................... ii
Table of contents.............................................................................................................. iii
List of tables...................................................................................................................... vi
List of figures...................................................................................................................... vii
Acknowledgements.......................................................................................................... viii
Glossary of Japanese terms............................................................................................... ix

Chapter 1. Introduction..................................................................................................... 1
  Policymaking channels in Japan's parliamentarism......................................................... 4
  The institutional complementarity of national councils for reform.............................. 11
  Methodology and Précis of the Study.............................................................................. 16
  Note on sources............................................................................................................. 20

Chapter 2. Policy competition and government regulation:
  Between the constraints of adaptability and long-term commitment......................... 22
  The economics of state organization ........................................................................... 23
  Adaptability and commitments in government regulations........................................... 27
  Regulatory transactions and their political environment.............................................. 30
  The organization of the state....................................................................................... 32
  Policy competition mechanisms in conflictive regulatory transactions....................... 36
  Policy competition and incrementalism in American presidentialism........................ 41
  Executive leadership in French health care policy......................................................... 44
  Policy competition and regulatory adaptation in Japanese national councils............... 46
  Policy competition in Japan's national councils: An overview...................................... 50
  Conclusion.................................................................................................................... 52

Chapter 3. Interest groups in health care politics............................................................ 54
  Administrative controls and the rise of the Japan Medical Association....................... 54
  Influence of the Central Medical Council on health policies........................................ 60
  Interest groups and political contributions................................................................. 65
  Historical roots of interest group competition.............................................................. 75
  Conclusion..................................................................................................................... 80
Chapter 4. Containing regulatory adaptation in the 1970s:
The Liberal Democratic Party versus the Ministry of Finance

The entry of the Ministry of Finance in health care politics
Reviewing the Health care for the Elderly Law
First movement on reform: LDP veto
Second movement toward elderly health care reform:
Renewed LDP veto
Third movement on elderly health care reform:
Administrative objection and deliberation council's rejection
Fourth movement on elderly health care reform:
Administrative initiative and the role of deliberation councils
Conclusion

Chapter 5. National Council Decision-making in the 1980s:
Small government or the shifting of costs to Insurance Societies?

Brain trust decision-making and the Nakasone administration
Health care reforms under the Nakasone national council: An overview
Reforming the National Insurance:
Proposals to create the Retiree Health Care Insurance
The political imperative to increase workers' contributions to elderly care
Restoring government financial responsibility in welfare
Conclusion: The organizational strength of the national council

Chapter 6. Policy Competition in the 1990s:
Bureaucracies and policy experts in market-oriented reforms

The organizational strength of the Administrative Reform Council
The impact of the Administrative Reform Council
Origins of Hashimoto's reform policies
Economic planners in market-oriented health policies
Executive appeal for reform
The Ministry of Finance in health care reforms
Origins of reforms in the Ministry of Health and Welfare
Impetus from the Administrative Reform Council
Conclusion

Chapter 7. Reforming the medicine pricing system

Medicine prices determination mechanisms
Policy competition on medicine pricing systems
Attempt to re-institutionalize the decision-making process
Physicians-LDP decision-making
Reformist alliance and final outcome from the Central Medical Council
Conclusion
List of tables.

Table 1. Regulatory safeguards and the organization of political interests... 31

Table 2. Advantages and disadvantages of two types of public institutions of governance........................................ 35

Table 3. Political Interests in Health Care Regulations.................. 37

Table 4. Main decision-making bodies in health policy. Japan and Germany... 62

Table 5. Five main official contributors to the LDP. 1998................. 68

Table 6. Total political contributions from major health care related interest groups................................................. 69

Table 7. Targeted political contributions of the Japan Medical Association and the National Federation of Health Insurance Societies –1999-..................70

Table 8. Top ten contributions from the Japan Medical League to political organizations............................................ 71

Table 9. Factional strength and zoku members in six fields (1986)........ 73

Table 10. 1999-2000 Faction membership and Health care related LDP representatives.................................................. 74

Table 11. Employment transition in Japan 1960-1996........................... 144

Table 12. Employment development 1992-2010................................. 146

Table 13. Average number of medicines per prescription in three countries.......................................................... 163

Table 14. Drug costs in proportion to the total cost of healthcare in five economies (% 1993)........................................ 164

Table 15. Information disclosure regulations in selected countries........ 195

Table 16. Health care publicity regulation in four economies............ 200

Table 17. Policy commitments under the ministerial and the party committee structures........................................ 233

Table 18. Regulatory adaptation under national councils................. 236
List of Figures

Figure 1. Medical fees, yearly changes 1957-1996................................. 64

Figure 2. LDP Policy-making Game:
  Research Commissions Versus National Councils.......................... 247
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This research was made possible with the financial support of the Social Science Research Council of Canada and the British Columbia Center for International Education.
### Glossary of acronyms and Official Japanese / English translation

<table>
<thead>
<tr>
<th>Central National Insurance Council</th>
<th>Council on the national health insurance. <em>Kokuho Chuokai</em></th>
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<tr>
<td>Central Social Insurance Medical Council (Central Medical Council)</td>
<td><em>Chuikyo</em></td>
</tr>
<tr>
<td>Coalition Parties Health Insurance System Reform Committee</td>
<td><em>Chuo Shakai Hoken Iryo Kyogikai</em></td>
</tr>
<tr>
<td>Japan Dental Association JDA</td>
<td><em>Nihon Shika Ishikai</em></td>
</tr>
<tr>
<td>Japan Hospital Association JHA</td>
<td><em>Nihon Byoin-Kai</em></td>
</tr>
<tr>
<td>Japan Medical Association JMA</td>
<td><em>Nihon Ishikai</em></td>
</tr>
<tr>
<td>Japanese Nursing Association JNA</td>
<td><em>Nihon Kango Kyokai</em></td>
</tr>
<tr>
<td>Japan Pharmaceutical Association JPA</td>
<td><em>Nihon Yakuzai-shikai</em></td>
</tr>
<tr>
<td>Keidanren</td>
<td>The largest industry association</td>
</tr>
<tr>
<td>Keizai Doyukai</td>
<td>Japan Association of Corporate Executives</td>
</tr>
<tr>
<td>Komeito</td>
<td>Political party linked to the religious group <em>Soka Gakkai</em></td>
</tr>
<tr>
<td>[National] Federation of Health Insurance Societies Kenporen</td>
<td><em>Kenko hoken kumiai rengokai</em></td>
</tr>
<tr>
<td>Nikkeiren</td>
<td>Japan Federation of Employers’ Association (Merged to the Keidanren in 2001)</td>
</tr>
<tr>
<td>Provisional Commission on Administrative Reform Rincho</td>
<td>Nakasone Reform Council <em>Rinji Gyosei Chosa-Kai</em></td>
</tr>
<tr>
<td>Policy Affairs Research Commission (LDP) PARC</td>
<td><em>Seimu Chosakai</em></td>
</tr>
<tr>
<td>Research Commission on Fundamental Policies for Medical Care PARC on Medical Care</td>
<td><em>Iryo Kihon Mondai</em></td>
</tr>
<tr>
<td>New Frontier Party</td>
<td><em>Seimu Chosakai</em></td>
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<tr>
<td>Zoku</td>
<td>Sakigake</td>
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<tr>
<td>“Policy tribe”</td>
<td>Groups of Diet members In specialized areas.</td>
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Chapter 1

Introduction

Japan’s health care system has won international praise for ensuring universality at comparatively low costs.\(^1\) It has attracted, however, widespread domestic criticism for its lack of research promotion mechanisms, for encouraging physicians to rely on prescription drugs for profits and to over-treat patients, for protecting professionals from supervisory controls, and for its inability to solve problems of financial fraud in medical practices. Its health policies were criticized for lacking legislation on informed consent, for preventing patient access to second opinion and for limiting treatment choices. The list is long, this thesis shows, because legislative processes in the Liberal Democratic Party (LDP) have given backbenchers linked to the medical interests the key to lock regulatory changes in the safe havens of party committees.

Surprisingly, market-oriented reforms were introduced between the years 1995 and 2001. Informed consent was made a legal obligation in the delivery of care. Patients were granted the right to obtain second opinions and to freely consult their medical files. Physicians lost their ability to make profits from the prescription of drugs. Research promotion mechanisms were implemented in some areas of care. Health institutions obtained the freedom to publicize their services. Complaint windows were installed in hospitals and an independent organization to evaluate patients’ satisfaction was created.

Market values and transparency became principles in the determination of medicine prices. From the point of view of health care specialists and economic planners, these changes put an end to the parernalist relations entertained by physicians with their patients and represented the entry into an era of market-oriented services.

The introduction of market-oriented policies in health care services in Japan is a puzzle. The medical associations obtained most of their policy preferences since the 1960s because of their influence in the LDP committees on health care and in the ministerial advisory councils. Any attempt at altering the status quo by the prime minister would have met with severe criticism from the party and cost the leadership vital electoral and financial support from the medical associations. Most importantly, most prime ministers and government executive members have proven incapable of pushing major reforms through the Diet, particularly in health care, due to the role of the party commissions in the LDP. This is an aspect of Japan’s policymaking process which is not completely researched in the literature and deserves full attention. This thesis explains the surprising success in policy reform of two administrations in the creation of institutional mechanisms that suppressed the role of party commissions. The creation of supra-partisan national councils complemented the policymaking process and made change possible in a policy area where policy reform failures had become the norm. This “institutional complementarity” between the party commissions and the national councils challenges the wrong conception that policy change in any parliamentary system can simply be guided from the government executive. The thesis emphasizes the particularities of Japan’s brand of parliamentarism, where the decision-making authority of the prime minister is deconcentrated in a number of party commissions under LDP rule. Importantly, this statement implies that Japan’s
parliamentary system has been shaped by the almost uninterrupted rule of the LDP (in spite of the presence of a coalition government after 1993).

National councils played a crucial role in complementing the policymaking channels of the party. Rather than face the party, Prime Minister Hashimoto delegated the authority to design reform proposals to independent experts and administrative representatives in a supra-partisan national council. The introduction of market-oriented reforms was the result of an alliance between economic planners in the administrations of the Ministry of International Trade and Industry (MITI), the Ministry of Finance (MoF), and LDP Diet members linked to financial and commercial interests. Because the reforms were justified as economic policies to rejuvenate the service sectors, the Hashimoto administration centered decision-making authority within the newly created LDP Reform Headquarters, therefore bypassing the LDP committee on health care where the medical interests held influence over policy outcomes. The national council increased the impartiality of the decision-making process by integrating representatives from all parts of the government, independent experts, and industry representatives.

This thesis makes two important theoretical contributions. First, the thesis identifies a number of biases introduced in state governance due to the strong interdependency that tends to develop between regulators and interest groups in any political system. The organization of the Liberal Democratic Party in Japan has oriented policy decisions toward local and particularistic interests that have limited the ability of the prime minister to promote policies of national scope. Health care policies have been designed from within ministerial and party committees where the medical bodies have influenced outcomes and protected the status quo. The thesis refers to the ministerial
councils and party commissions as *vertical committees* that unite public regulators and private representatives in a single area of regulatory activity. The impact of the vertical committees on health policy is contrasted to the outcomes reached under policymaking institutions that promote *inter-administrative* policy competition in public forums gathering policy experts and interest groups. This double explanation offers a clearer explanation as to why policy reforms succeeded in a number of cases under the administrations of Nakasone and Hashimoto.

Second, whereas a number of economists see markets as the only solution to the biases of the state, this study shows that the organizational structure of the state itself can bring the public regulators' authority under control even without relying on the exogenous arrangements of markets. Inefficiencies arising from the legislative process can be solved from within the state by increasing the impartiality of the decision-making process. This is achieved in various economies through policy competition mechanisms that complement the vertical structure of legislative and ministerial committees. In this sense, the role of national councils in Japan is investigated as complementary to the vertical committee structure found in parties and ministries. These national councils are presented as playing a similar role to the policy competition mechanisms defined by the constitutional division of powers in the United States. A study of two supra-partisan councils, the Nakasone Provisional Commission on Administrative Reform (1981-84 and its Council on Administrative Reform after 1983) and the Hashimoto Administrative Reform Council (1996-1998), serves as a basis to demonstrate these claims. Rather than proceed generally,
the thesis investigates these processes in the conflictive area of health care policy.²

Section one in this chapter reviews the development of ideas related to policymaking in Japan. Section two identifies gaps in the literature on Japan’s parliamentary system and the relevance of health policy decision-making to understand the nature and impacts of linkages between interest groups and Diet members. Section three provides an overview of health care reforms under the two national councils.

*Policymaking channels in Japan’s parliamentarism*

Influenced by the classical writings of Gerschenkron on late industrialization, a substantial portion of the literature on Japan’s historical development identifies the concentration of authority at the level of the administration as the linchpin of its policymaking structure.³ Japanese politics has often been qualified by four words: decision-making from above. This section identifies how the rise of industry-related LDP Diet members since the 1970s has centered the party’s interests toward local issues, affecting the powers of the administration and deconcentrating the authority of the prime minister into numerous party committees.

The developmental state perspective offers a comprehensive way to understand

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Japan's policymaking structure concerning what has been referred to today as the 1940s system. The developmental state perspective is compatible with the conception that capitalist economies relying on government credit, such as France and Japan, require centralized decision-making organs to coordinate the different economic instruments and accomplish the sectoral shifts essential to pursue economic growth. Chalmers Johnson's analysis of the economic miracle in Japan particularly emphasizes the linkages between top bureaucracy and industry. In contrast to the view of the western state as a regulator of private interests, the developmental state approach presents the coordination of investments between private and public actors and the adoption of protective legislation in the Diet as two sides of a same coordinated outcome. Particularly supportive of this thesis is the fact that the Ministry of International Trade and Industry (MITI) remained capable of influencing the management of private industries through the rationing of highly sought after foreign currencies until 1964, and pursued its influence through economic roundtables ever since. Ultimately, for the developmental state perspective, politicians rubber stamp policies administratively designed.

5 John Zysman originally distinguishes between economies relying on capital markets, such as the United States, economies relying on credit dominated by financial institutions such as Germany, and credit-based economies where capital is administered by the state. John Zysman, Governments, Markets, and Growth: Financial Systems and the Politics of Industrial Change (Ithaca: Cornell University Press, 1983) 55.
Presenting a compatible story is Richard Samuel’s work “Rich Nation Strong Army,” itself a slogan of the Meiji period. The work depicts political authorities in Japan as having inherited from late industrialization a preoccupation with preserving the position of the domestic industry on international markets. Economic nationalism is equated to national security with the administration having coordinated its development efforts with the main industrial groups. In this perspective, the fostering of competition among domestic groups became a means to instill competitiveness in front of the world.

Unity of intent among public and private actors cannot necessarily be equated with a centralization of authority. This argument is defended in Kent E. Calder’s *Strategic Capitalism*, a convincing piece of criticism of the bureaucratic-led approach that points out the complexities of the 1940s system. Central to this competing story on late industrialization is the leadership role of private financial institutions in economic development. MITI’s administrative guidance primarily relied on financial incentives rather than direct regulations, ultimately depending on the conservative approval of the Ministry of Finance. Once firms acquired sufficient profits, the large and numerous private banks possessed autonomy in carrying out strategic investments in the consortiums they, in

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great parts, owned. Complementary to this thesis, it has been shown that industrial policy by MITI was mostly efficient with smaller firms in the 1970s.

A second criticism addressed to the tenants of the developmental state approach concerns the gradually more prominent role played by politicians in the postwar period. At political levels, leadership from politicians trained in the bureaucracy prevailed until the 1970s. Prime Ministers Ikeda and Sato (1960-63 and 1963-70) both emerged from elite institutions: the elementary school Yoshida, the high school Seidaikoko, and state universities, they respectively entered the Ministries of Finance and Railways (Transports) prior to joining the bureaucratic faction of the LDP. The common educational patterns of the elite favored the synergies between government planners, bankers, and industrial consortiums, but other channels of influence developed under LDP rule.

Muramatsu and Krauss emphasize the emergence of social movements throughout the 1970s as demands toward improvements in welfare services and environmental protection affected policy choices in the Diet, in what they refer to as patterned pluralism. The emergence of social movements did not completely inhibit the

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11 Such investments occurred n the fields of automobile or computers for example. Calder, Strategic Capitalism: 158-72.
role of the bureaucracy, the authors argue, and as long as industry associations and the
bureaucracy agreed, politicians would rarely attempt to intervene in bureaucratic decisions.
The bureaucracy also preserved the power to make top nominations.  

Important in understanding these coordination mechanisms at the level of the
administration is the National Administrative Organization Act of 1949 (Article 8, Section
1), which allowed the bureaus to enter into independent negotiations with social actors and
industry within deliberation councils (Shingikai). These bodies provided means for the
administrations to integrate ‘client’ groups’ opinion into their policy proposals, and carry
out their own agenda, as about half of Shingikai members represented administrative
interests.

As organized interests developed privileged linkages to the Liberal Democratic
Party, however, the ability of industry representatives to bend administrative decisions
through political appeals increased. The Ikeda administration repeatedly denied an
expansion of MITI’s authority through Special Measure Laws that would have legalized its

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14 Attempts in February 2002 by Foreign Affairs Minister Tanaka Makiko to nominate the personnel she had
selected as foreign ambassadors failed in front of bureaucratic opposition insisting on maintaining the
primacy of the seniority system. Similar accounts concerning the MoF are provided in Peter Hartcher, The
15 In the mid-1980s, bureaucrats made up 21 percent of the membership of these bodies, and former
bureaucrats 20 percent. Sone Yasunori and Al. Shingikai no kiso kenkyu: kino, taiyo ni tsuite no bunseki
[Research on advisory committees: An analysis of their functions and conditions] (Tokyo: Keio University,
1985).
16 Such appeals to politicians by interest groups in the United States are described as “fire alarms” in
Matthew D. McCubbins and Thomas Schwartz, “Congressional Oversight Overlooked; Police Patrols versus
17 Oyama Kosake, Gyosei Shido no Seiji Keizaigaku [The political economy of administrative guidance]
In health politics, the legislation allowing the Ministry of Health and Welfare to supervise and punish medical institutions for faulty behaviors was dismantled in 1961 at the request of the Japan Medical Association, and an attempt to reinstate the law failed in 1981. In the words of a member of the Ministry of Finance’s Financial Systems Council, “Shingikai are only a means for interest groups to obtain their policy choices from the administration.”18

To prevent potential interventions in their jurisdictional arenas, it is suggested that the administration had to design regulations that met the expectations of industry representatives and politicians.19 The party has thus acquired authority over the years, but who controls the party?

The influence of politicians in policymaking dynamics is enhanced by the decision-making institutions of the Liberal Democratic Party. According to the procedural rules of the LDP (Section 42, Article 2), the Party’s Policy Affairs Research Commissions (PARC or Seimuchosakai) must approve all policy initiatives prior to sending them to the Diet. The Policy Affairs Research Commissions are divided into twelve sections, but there is no limit on the number of special committees and research commissions that can be

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19 This is an argument of the constitutionalist approach on Japan’s decision-making, an approach however criticized for over-evaluating the influence of politicians over the bureaucracy. Mark J. Ramseyer and Frances McCall Rosenbluth, Japan’s Political Marketplace (Cambridge: Harvard University Press, 1993). Having authority over the design of regulations always granted the bureaucracy the right to refuse or at least negotiate with politicians, as argued by Gerald Curtis, The Logic of Japanese Politics (New York: Columbia University Press, 1999) 99.
created. The Commissions are the place where interest groups voice their demands. They are, in the words of Fukui Haruhiro, "the interest groups within the party."²⁰ In the field of health care, the Social Affairs Division and its Commission for Medical Care play a particularly important role in defending the medical interests. Who, then, controls the Policy Affairs Commissions?

The Policy Affairs Research Commissions are controlled by industry-related politicians who acquire expertise in specific policy areas and tend to protect the interests of the ministries and interest groups they represent.²¹ These industry-related groups of LDP politicians are referred to as "policy tribes" or zoku. Their emergence was encouraged by faction leaders in the LDP primarily as a means to gather financial resources by allying important social groups and industry associations. As Inoguchi and Iway explain, each zoku controls the party’s policy deliberation process in its sphere and can prevent leaders from adopting policies that do not meet their preferences.²² As the zoku tend to defend domestic and local issues, they contribute to a decline in the LDP’s overall executive leadership over national policies because the zoku’s power “allows it to help its ministry resist policy initiatives from outside its sphere --even when those policies that are supported by the leadership of its own party--."²³ The zoku do not refuse the party’s leadership altogether, but in case of conflict between the party’s executive and an administration or a powerful organized interest group, the zoku has the ability from within the Policy Affairs Research

²² Inoguchi and Iwai, Zoku-giin no Kenkyu: 279.
Commissions to block policy initiatives, including the ones from the executive. In the field of health care, the welfare-related group of Diet members has been closely linked to the medical associations, and has influenced the LDP from within its Commission for Medical Care. But who, then, controls the zoku?

Each zoku is under the leadership of prominent politicians, generally faction leaders, whose “influence in the policymaking process, both within the party and in front of the administration, is impressive.”\textsuperscript{24} Under such an organization, the prime minister must obtain the support of the prominent members of the party, the faction leaders and the zoku, to carry out his political agenda. Cooperation among faction leaders is crucial for the prime minister because the only organ above the PARC is the Party's General Conference (Somukai). How could executive leadership prevail over controversial policy issues in the field of health care?

The Hashimoto and the Nakasone national councils stroke a blow to one of the most influential zoku of the LDP, the welfare-related group of Diet members that holds control of the LDP Research Commission on Fundamental Policies for Medical Care (Iryo Kihon Mondai Chosakai). Contrary to the negotiations carried out in the party PARC which remain secret, the national councils made the legislative process publicly accountable. In both cases, the executive allied important administrative actors and committed the reputation of the party to the success of broad policy initiatives in the national council. Explaining how two LDP executives refocused the party toward national policy questions in health policies is the purpose of this thesis.

\textsuperscript{24} Inoguchi and Iwai, \textit{Zoku-giin no Kenkyu}: 155-56.
The institutional complementarity of national councils for reform

This thesis shows that a break with the status quo in health policies in the 1990s was achieved through the design of supra-partisan institutions of governance. The national councils limited the influence of the welfare-related Diet members and promoted regulatory adaptation. Why were such complex institutional mechanisms necessary to carry out regulatory adaptation?

Comparative theories on the institutions of governance of parliamentary systems emphasize their rapid execution of legislative orders by elected representatives bounded by party discipline.\textsuperscript{25} If this applied to Japan, the LDP executive could carry out regulatory adaptation “from above.” Japan’s parliamentarism would follow this principle were it not for the influence of zoku members in the Liberal Democratic Party, the lack of independent expertise and staffing at the prime minister’s office in spite of recent reforms, and the uncohesiveness of the party’s political platform. These factors have enhanced the influence of interest groups in the vertical committee structures of the party and the bureaucracy.

Synergies between private actors and the state were necessary to ensure strong regulatory commitments in all spheres of economic activity in the High Growth period (1960-75), including in the field of health care following the design of a universal compulsory insurance system in 1957 (implemented in 1961). These regulatory commitments became a

hurdle to policy adaptation once the economy matured. The period of slow economic growth that followed the Oil Shocks called for regulatory adaptations that the vertical ministerial and party committees made difficult.

In the field of health care, the vertical ministerial and party committees, the LDP PARC and the Central Medical Council of the MHW, ensured a close coordination between regulators and professionals but they posed a hurdle to regulatory change in a mature economy. The vertical committees were only superseded through the supra-partisan institutions of temporary national councils. In the history of Japan’s health care system, the vertical committees and the national councils played complementary roles; long-term regulatory commitments were guaranteed from within the vertical committees but periodical policy adaptations were conducted in the temporary national councils.

In health care regulations, the ministerial deliberation councils and the LDP Policy Affairs Commissions have guaranteed the professional autonomy of physicians and allowed a strong correspondence between policy design and policy implementation. These were important features of Japan’s public governance during the High Growth period. The influence of the Japan Medical Association has, however, encouraged an inexorable expansion of services while protecting low patient contributions in ways that—however beneficial from a social point of view—contributed to exhausting government financial resources after the Oil Shocks. Economic change called for the adaptation of health care regulations. This study analyses how the institutional mechanisms of the national councils counterbalanced the influence of the medical interest groups in the LDP and promoted a change in the relations between regulators and industry representatives once the economic
environment justified regulatory adaptation after the 1980s.

A focus on institutions may refer to norms and cultural understanding, or more precisely to the institutions of governance referring to the micro-mechanisms that determine how decisions are made.26 This study adopts the latter conception to investigate institutional processes that have allowed the executive in Japanese parliamentarism to bypass factional divisions in the LDP, limit the influence of zoku and organized interests, and carry out substantial adaptations in health care regulations after the mid-1980s. The Nakasone Commission on Administrative Reform (1981-84) and the Hashimoto Administrative Reform Council (held simultaneously with the Financial Reform Conference, 1996-98) sustained policy competition among numerous administrations and industry associations that granted the executive substantial authority to act amid factional opposition. Alliances between the LDP executive and administrative actors justified the creation of national councils through which supra-partisan policies prevailed over the sectoral interests of LDP backbenchers.

Nakasone broke away from factional politics by proposing an open policy competition process resting on the creation of a brains trust at the executive level and a national council (the Commission on Administrative Reform, 1981-1984). The Council superseded the normal deliberation channels of the Ministry of Health and Welfare and granted leadership to independent representatives of the financial world and the Ministry of

26 North alternatively defines institutions as “both informal constraints (sanctions, taboos, customs, traditions, and codes of conduct), and formal rules (constitutions, laws, property rights.)” Douglass C. North, Institutions, Institutional Change and Economic Performance (Cambridge: Cambridge University Press, 1990) 10.
Finance. This procedure created a consensus prior to consulting with organized interests and pushed LDP members into adopting a “council plan” composed of a package of legislative proposals rather than a single legislation. LDP welfare-related Diet members attempted to stop the reform process from within the Policy Affairs Research Commission as they mounted an impressive opposition to the prime minister. Public accountability and the public commitments made by the prime minister made it imperative for faction leaders to instill discipline among welfare-related Diet members. Members of the LDP PARC for Medical Care were threatened with expulsion if they were to further resist the consensus established in the national council. Under this process, controversial questions concerning the introduction of co-payments for health services could be dealt with within the span of a single session, a speed unseen in the history of Japanese health policies.

The second national council on reforms, the Hashimoto Administrative Reform Council (1996-1998), gave importance to regulatory adaptations in various fields, including welfare and health care services. This process granted the Economic Planning Agency the authority to carry out inter-ministerial negotiations on health care in which independent experts played a leading role, based on proposals forged by four administrations: the Ministry of Health and Welfare (MHW), the Ministry of Finance (MoF), the Ministry of International Trade and Industry (MITI).

The national council superseded the Party’s Policy Affairs Research Commission for Medical Care where Diet members related to medical interests were committed to the status quo. This was achieved through the creation of LDP Reform Headquarters, populated with politicians from the reformist wing of the Party (the commerce and finance-related Diet members) and nourished with bureaucratic ideas supportive of market-oriented
reforms. In front of the steep economic crisis affecting Japan in the 1990s, LDP members did not object to the creation of the Headquarters and the national council to quickly achieve financial reforms. Once the supra-partisan institutional structures were in place, the Hashimoto administration expanded the reform agenda to six other fields including health care. The national council pitted the protectors of the medical interests against party members allied to reformist administrations and commercial interests. Significantly, all the regulatory changes made possible under the national council had been repeatedly discarded since the 1970s.

The significance of the recent reforms lies in their introduction of competition mechanisms that formed a consensus between promoters of American style market rules in MITI and the softer preferences of the MHW administration. The legalization of informed consent, and the granting to patients the right to their medical files and second opinions in particular cancel the physicians' monopoly on medical decisions for their patients. The determination of medicine prices has been re-centered around independent experts in a way which promotes greater competition among pharmaceutical companies (here, again, pure market mechanisms have been avoided). With regard to the fee schedule, the council promoted the implementation of Diagnoses-Related Groups (DRG), already existing in the American Medicaid and Medicare systems since 1983. However, there have been widespread criticisms that DRG systems generally limit the physicians' freedom to decide on the most appropriate treatment, and after the national council, attention has practically shifted away from this issue.
Methodology and Précis of the Study

This thesis presents cases covering a fifty-year period of Japan's health policymaking from 1950 to 2001.\textsuperscript{27} It compares the policy commitments attained under the vertical committees of the LDP and the MHW until the 1980s to the policy adaptation achieved under the policy competition mechanisms of the national councils. The absence of policy competition in the vertical committees is contrasted to the policy outcomes attained under the competitive mechanisms of the national councils.

Chapter 2 relies on a cross-country comparisons to identify the impact of party committees versus policy competition mechanisms in health governance. The comparison emphasizes the role of national councils in France and Japan, versus the impact of the division of powers in American presidentialism. In the three cases, the committee structure is presented as a means to maintain regulatory commitments, whereas publicly accountable policy competition processes are presented as complementary institutions promoting regulatory adaptation. This comparison presents governance institutions as imperfect mechanisms, each introducing some form of bias. The chapter makes refutable hypotheses concerning the role of vertical committees in ensuring regulatory commitments versus the role of horizontal (inter-administrative) national councils in ensuring regulatory adaptation.

To comprehend the impact of national councils on the promotion of policy competition, control cases are provided in Chapters 3 and 4 which summarize policymaking dynamics during the 1960s and 1970s in Japan's health care policy. The main

bias identified in Japan's vertical committee structure is the strong influence interest groups obtained both within the LDP and the Ministry of Health and Welfare.

Chapter 3 provides an account as to how interdependency between politicians and the medical associations affected health policies until the 1980s. It shows that interdependency limited the possibility to adapt policies in spite of changes in the economic environment. The chapter particularly investigates the organization and influence of the main interest groups in health care politics: the Japan Medical Association (JMA), the Japan Dental Association (JDA), the Japan Pharmaceutical Association (JPA) and the Federation of Insurance Societies (Kenporen). The case studies indicate that the medical interest groups not only influenced the LDP but also held a decisive influence in the deliberation councils of the MHW. The medical associations obtained most of their policy preferences since the creation of the universal compulsory insurance system in 1957.

Chapter 4 accounts for the gradual influence of the Ministry of Finance (MoF) in welfare reforms after the Oil Shocks. The case studies indicate the inability of the MoF administration to achieve substantial changes in health care policies in the 1970s.

Chapter 5 investigates Nakasone's Commission on Administrative Reform. This national council signaled an important change in usual policymaking patterns in health care by instigating reforms through policy competition mechanisms in the 1980s. The Nakasone national council primarily dealt with the controversial introduction of patient co-payments in health care. The national council was successful in limiting the influence of interest groups in policymaking, although it failed to find a permanent solution to increasing health care costs and shuffled expenses onto the employees' Insurance Societies.
Chapter 6 exposes the mechanisms of reforms under the Hashimoto national council in the 1990s. The chapter emphasizes the involvement of the MITI administration in the promotion of market-oriented reforms and the inability of the administration to negotiate regulatory reforms on its own. The policy changes instigated under the Hashimoto national council are the focus of Chapters 7 to 9. Chapter 7 details the reform process that led to the introduction of market mechanisms in the determination of medicine prices. It explains how physicians lost their incentives to over-prescribe medicines as their ability to make profit from prescriptions vanished under the Reform Council. Chapter 8 identifies the important issue of informed consent and the provision of patient files as mechanisms of competition. The provision of patient files cancelled the physicians' monopoly over treatment choices by enabling patients to obtain second opinions. Chapter 9 is a case of policy failure concerning the attempt at reforming the fee schedule system. The case studies indicate how important the issue of the fee schedule is for the medical associations to maintain their membership, and how the medical associations have drowned reforms from within the committees of the MHW by demanding year-long researches on the validity of the new system. The case study qualifies the thesis' central contention about the role of the national councils by making clear that the councils increased the chances of reform but did not guarantee that policy change would occur.

Through a game-theoretical approach, the appendix explains why faction leaders have a greater tendency to follow executive initiatives and instill discipline to their faction members under national councils. Public commitments under national councils force a greater unity in the party that allows for policy adaptations whereas vertical committees tend to maintain the status quo and protect regulatory commitments. Since regulatory
commitments are necessary in the long-term but adaptations are periodically required, the two types of institutions play complementary roles.
Chapter 2

Policy competition and government regulation:
Between the constraints of adaptability and long-term commitments

Can the state cope with problems of opportunism and interdependency between decision-makers and organized interests? Or is the state doomed to suffer from its own social inclusiveness? This chapter makes the argument that widely recognized problems related to the influence of interest groups and the discretionary authority of public regulators may be particularly acute in the specialized (vertical) committees of legislative, ministerial or party structures. In contrast with the argument presenting states as essentially vertical organizations, however, the chapter shows that the organization of the state does include principles of policy competition in constitutional divisions of powers or suprapartisan national councils. Policy competition mechanisms, found in the organization of national councils in particular, are investigated as complementary institutions that solve problems of regulatory capture by increasing the public accountability of decision-makers and encouraging policy competitions between administrative actors and political parties. The central argument defended in this chapter is that national councils are particularly pertinent as complementary institutions in parliamentary systems where policymaking authority tends to be concentrated at the level of the parties. In American presidentialism, by contrast, the strong division of powers between the president and Congress creates

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1 In particular, Oliver E. Williamson analyses hierarchies in the public bureau as being suited for certain transactions. This section borrows from this perspective while adding that competition processes are also found in state institutions. Oliver E. Williamson, “Public and Private Bureaucracies: A Transaction Cost Economics Perspective,” *The Journal of Law, Economics, and Organization* 15.1 (2000): 306-42.
competitive dynamics that play an important rule in controlling the discretionary authority of the regulators.

The first section considers the problems that plague public institutions of governance. The second section considers how organized interests may affect policy outcomes. Third, while economists view markets as the most viable answer to state inefficiencies, this chapter investigates policy competition mechanisms in the state as a means to cope with problems of regulatory capture. Committee structures versus policy competition mechanisms in national councils are proposed as alternative organizational means to conduct policymaking. The last section compares the two institutional forms in the cases of Japan, France, and the United States. Rather than proceeding generally, the inquiry focuses on regulatory transactions in the contentious field of health care.

The economics of state organization

Three perspectives deriving from economic theories emphasize different kinds of inefficiencies affecting the public institutions of governance. The capture theory of regulation shows how specific interests are willing to devote resources and energy to have regulations, or policies more generally, that suit their needs. The interest group that is targeted by regulation is generally identified as the one generating opportunistic behaviors, information withholding, and possible regulatory capture. Regulatory capture refers to the control of the agenda and policies of an agency by the interests it is meant to regulate. It arises because of the interdependency that develops among administrators, politicians, and

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private actors, as governments specialize their activities and as the number of actors involved in decision-making circles is reduced to a minimum.³

Organization theory has similarly offered a means to look into the public bureau with an eye on the type of relations between interest groups and politicians that may affect agency design and efficiency. Terry Moe’s “politics of structural choice” offers an original view of the public administrator as an actor submitted to great uncertainties, where the politicians’ temporary hold of legislative power forces them to insulate their policy priorities within autonomous agencies that survive electoral cycles.⁴ In doing so, politicians depart from economic rationality in agency design. Whether adaptation of the public bureaus and their regulations is possible a posteriori is a question the theory leaves aside.⁵

Providing a compatible answer is Douglas North’s transaction costs politics perspective, showing that political networks are designed to meet the expectations of interest groups rather than the requirements of economic efficiency. Peculiar to politics are the power relations and biases that arise from the lack of communication between constituents and politicians and the presence of interest groups in the competition over state governance. These idiosyncrasies are summarized in three points. First, constituents do not know their interests sufficiently to properly voice them to their representatives. Second, this lack of contact between constituents and their representatives encourages pork barrel legislations. Finally, legislators lack the proper information to ensure that policies

administratively implemented meet their aims, and thus the public bureau is incapable of measuring itself against the more efficient markets. The possibility of capture is inherent to politics given that “institutions are not necessarily or even usually created to be socially efficient; rather, they, or at least the formal rules, are created to serve the interests of those with bargaining power to create new rules.” Common to the three perspectives is the idea that regulatory capture entails inefficiencies and costs, as the state defends particularistic interests that may impair the ability to design policies suited for changing economic conditions.

Ensuring timely adaptation of its regulatory framework, however, is not the only constraint imposed on public institutions of governance. The need to produce credible policy commitments also affects the organization of the public bureau. As a government cannot guarantee that a decision made will not later be reneged in the future, the ability to commit must be guaranteed through particular institutional settings in the state. Inefficiencies would prevail if discretionary decisions (the ones through which a regulator or decision-maker attempts to maximize its own self-interests) were to question previous commitments. This may particularly affect parliamentary systems, given that “there is only one supreme authority and that authority can overturn any restrictions.”

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and guarantee the credibility of its commitments through procedural arrangements at the level of the administration, or through judicial supervision.  

Central to both the perspective on regulatory capture and the emphasis on policy commitments is a concern for the possibility that discretionary decisions serve particularistic interests. Interdependency develops between political actors and organized interests because of their mutual interests for reasons that are obvious: Politicians want votes and money; interest groups want specific regulations. How these relations impact policymaking is empirically interesting; identifying the institutional mechanisms that may limit the influence of interdependency on policy outcomes is where the real puzzle lies.

The identification of constraints and inefficiencies in the state should not preempt the presumption of rationality in the ability of the state to cope with problems of interdependency. The next sections focus on regulatory transactions with an emphasis on the area of health care and compare two types of policymaking institutions. The first type is the (vertical) ministerial or legislative committees in which regulations are designed conjointly by administrators and interest groups. The second type is the open policy competition process that brings together politicians and regulators to propose and defend their policy preferences in open forums. The American constitutional division of powers creates competitive dynamics between the Congress and the presidency. Parliamentary constitutions, by contrast, entail a clearer concentration of authority at party levels which

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can be complemented by policy competition mechanisms based on the organization of national councils. France has created a number of national councils whose roles remain consultative, while Scandinavian countries have institutionalized the procedures formally. These processes played a significant role in solving problems of interdependency in Japan's parliamentary system. This analysis is particularly focused on the case of Japan, but opens a door to a comparison of political systems across constitutional differences by emphasizing the role of seemingly different policymaking procedures in reducing the impact of interdependency.

*Adaptability and commitments in government regulations*

This section starts by describing four areas of activity of the state and the type of relations entertained with interest groups in each sphere. The particularities of the regulatory transaction are disentangled separately.

Political scientists in the past have devoted their energy to understanding how policy types impact governance. Theodore Lowi, in particular, has distinguished between the forms of the public bureau in three models of the public agency. The political inquiry observes the changing organization of the public bureau according to two variables: the

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objective of the bureau, whether it is regulatory, redistributive, or distributive, and the type of interests each agency faces.\textsuperscript{12}

1. Distributive agencies (public works, research funding, university grants) do not specifically rely on centrally determined rules of conduct and can respond to political interests in a rather flexible, disaggregated manner. When costs for government programs are diffused to the general population, little opposition emerges toward distributive policies unless reductions in government spending turn budgeting into a zero-sum game between political actors.

2. Redistributive agencies (welfare programs, unemployment insurance) are characterized by a strong adherence to rules and internal hierarchy as they attempt to coherently apply central policies in local units. Their relationship with interest groups is relatively non-conflictive in the application of rules. Policy design may, on the other hand, become highly ideological and conflictive in certain polities where the public administration is seen as imposing a limit to market freedom.

3. Regulatory agencies (involved in the design of rules regarding the standardization of products, price controls, safety and health requirements, or specifications on market entry) are characterized by distinctive organizational features as they are the most rule-bound and "likely to have the most intense and unstable relationships with their larger political environment."\textsuperscript{13} Roger Noll defines the regulatory agency according to two characteristics. First, the agency attempts to alter the direction of an economic activity to

\textsuperscript{12} Noll and Owen make the compatible argument that groups are created more as a consequence of legislation than as an impetus for it. Roger G. Noll and Bruce C. Owen, Eds. The Political Economy of Deregulation: Interest Groups in the Regulatory Process (Washington and London: American Enterprise Institute for Public Policy Research, 1983) 52.
meet social expectations. Second, because private economic activities are protected constitutionally, the agency must satisfy procedural rules before it seeks to constrain market activities. In other words, the regulation must be justified by providing necessary safeguards that satisfy the social needs for security, accessibility, or the stability of an industry as a whole. As such, the regulation can be compared to a contractual arrangement between the state and the regulated industry that specifies a number of safeguards on market actors.

Noll identifies three types of regulations. The first one concerns standards of the production processes (emission-control methods, for instance). The second controls aspects of the market (prices, quality). The third controls market entries (competition, certifications, recognition of professional affiliations). The next section argues that differences in the behavior of organized interests can be identified among these three types.

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15 Explaining transaction costs theory is beyond the aim of this thesis, but the reader may see a similarity with some of the concepts. The aim here is to offer an analogy to the organization of the firm as an entity responding to variations in the number of safeguards which solve problems of bilateral dependency. To account for the particularities of the state and the role of organized interests, it is considered here in congruence with the literature on regulatory capture that safeguards entice problems of dependency, which can be solved through a re-organization of the state. Williamson considers the possibility that problems of efficiency can be solved by a re-organization of the firm between its unitary-form and multidivisional-form, as originally described by Alfred Chandler. As the author points out, “the organizational structure of the firm could also be an instrument for checking managerial discretion.” Oliver E. Williamson, *The Mechanisms of Governance* (Oxford: Oxford University Press, 1996) 59-60; 361-62.
Regulatory transactions and their political environment

If a particular interest group has influence on public administrators or politicians, it will direct its political actions to obtaining its preferences in the regulatory field that affects it the most. Toward which regulations will the group target its activity?

Some types of regulations involve more important safeguards than others. The remaining of this section argues that interest groups have a greater propensity to appeal to politicians for the regulations which involve more important safeguards. Three types of regulations, as identified above, are investigated. First, the regulation (call this Type A) may include standards of the production processes (emission-control methods, for instance) and service standards. In terms of health care regulations, the safeguards may specify the type of technology available, the type of medicines approved, the need to install complaint windows in hospital, or the ways supervisions on medical practices are carried out. Such regulations do not affect the fundamental interests of the medical bodies and insurers. In such a case, the preferences of the interest groups are as large as the safeguards are non-important for the industry.

Second, regulations may control aspects of the market (prices, quality) (call this regulations of Type B). This aspect involves regulations determining the costs of treatments or the costs of medicines in the field of health care. The safeguards that are included in regulations of this type are important to the extent that they serve to maintain accessibility to services or to control expenses of public services. The chances that organized interests appeal to administrators and politicians are heightened because the presence of industry and professional associations is justified by their ability to protect their members’ revenues and profits. The preferences of the industry and professional associations at this level are
limited. The propensity for interest groups to appeal to politicians or administrators to obtain their policy preferences is as high as these preferences are constrained.

A third type of regulation can be identified. This involves regulations that control market entries (competition, certifications, recognition of professional affiliations). (Call this form of regulation Type C.) Here also the contractual safeguards involved in the regulation are important. At such levels, professional organizations have limited preferences as they want to maintain control of the number of actors involved in their field of activity. Medical bodies want to preserve their independence, and want to have a direct say in the type of competition and the number of professionals involved in their sphere of activity. Regulations of Type C constrain the policy preferences of interest groups and bring about a high probability for political interference.

Table 1. Regulatory safeguards and the organization of political interests

<table>
<thead>
<tr>
<th>Type of regulation</th>
<th>Organized interests' set of Preferences</th>
<th>Propensity to appeal politically</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A –production processes-</td>
<td>Large</td>
<td>Low</td>
</tr>
<tr>
<td>Type B –price controls-</td>
<td>Limited</td>
<td>High</td>
</tr>
<tr>
<td>Type C –rules on competition-</td>
<td>Limited</td>
<td>High</td>
</tr>
</tbody>
</table>

Note: The three regulatory types are derived from Roger Noll, Ed. *Regulatory Policy and the Social Sciences*: 8-12

The three regulatory types can be distinguished according to three factors: 1) the importance of the contractual safeguard they include, 2) the extent to which the preferences of organized interests are limited, and 3) the propensity with which organized interests appeal to politicians or administrators to meet their policy preferences. Table 1 identifies a
potential relation between the type of safeguard included in the regulation and the propensity of organized interests to appeal to political actors. The significance of these relations is that even without adopting Lowi's assumption that some policy areas entice political interests to organize, the reduced set of preferences that goes along with a strengthening of regulatory safeguards affects the adaptability of the regulatory framework because the industry's preferences are constrained. (This does not imply an impossibility to carry out adaptation, simply that the probability to succeed will be diminished).

The size and strength of the interest groups are, in this framework, taken as exogenous variables rather than as consequences of the type of policy as in Lowi's model. The next section looks into policymaking institutions that cope with problems of interdependency in Japan, France, and the United States in comparative terms.

*The organization of the state*

Does the state adapt its governance structure according to the type of regulation and the propensity of interest groups to appeal politically? The main implication of this analysis concerns the type of public governance institution associated with each type of regulatory transaction. This section describes two different types of decision-making structures that affect the influence of interest groups and through which the state can determine the content of regulations.

The first one is the vertical committee structure situated either in the administration or attached to the legislature, such as Congressional Committees in the United States and the LDP Policy Affairs Research Commissions in Japan which review all legislations brought to the legislature. (These structures are referred to as vertical
committees due to their specialized nature and in contrast to the policy councils which bring competing administrations together, as investigated below.) In such vertical committees, interest groups may obtain their policy preferences by influencing related politicians to meet their expectations. If committees are non-accountable to the public, the regulation will tend to meet interest groups’ expectations. Vertical structures have the advantage of ensuring that clear regulatory commitments be maintained as long as the interest groups deem it necessary. They have the potential disadvantage of making regulatory adaptation difficult without the approval of the interest groups concerned, with potential consequences in terms of regulatory capture.

A regulatory transaction of Type A, where the regulation is mostly aimed at technical specifications, leaves organized interests latitude in defining their preferences. Correspondingly, the governance institution may assume a simple vertical form (as a regulatory agency or legislative committee), aimed at sharing the necessary technical information on product quality and standards with market actors. Majority decisions determine the regulatory outcome in congressional or parliamentary committees that the main legislative bodies rarely challenge, and similar roles are assigned to ministerial deliberation councils in Japan.

In order to carry out regulatory adaptation in areas where the preferences of the organized interests are limited, a second type of institution may be needed. That is, a public

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17 The Diet committees are not as powerful as the LDP Policy Affairs Research Commissions (PARC) under LDP governments, as shown in Appendix 1. For G. Curtis, “if there is anything comparable to the American congressional committee in the Japanese decision-making system, it is the division [LDP PARC] and not the Diet’s committee.” Gerald L. Curtis, The Japanese Way of Politics (New York: Columbia University Press, 1988) 113-116.
body where the number of actors is greater, where the public can scrutinize decisions, and where clearer policy competition mechanisms can be created becomes necessary. For Types B and Type C where regulatory safeguards provide price controls (in health care services or agricultural products for instance) or affect market size and competition (by controlling choices among providers or though publicity regulations for instance), interests groups possess limited policy preferences as any change in prices or variations in competition policy directly affect them. In such instances, legislative actors will be directly pressured to meet industry expectations, and designing rules in the vertical committee structure may alter the intent of the regulation.

In the case of the United States, the processes through which the Congress and the president negotiate policies through constitutionally determined checks and balances create important policy competition mechanisms among policymakers. Such imperfect mechanisms limit the ability of interest groups to target specific regulators and limit opportunistic behaviors on the part of the organized interests. In the case of a parliamentary system, the processes of policy competition are not designed constitutionally but may depend on the organization of publicly open national councils for reform. The design of open policy competition mechanisms may be necessary in parliamentary systems to ensure that regulatory capture does not ensue and that regulatory adaptation be carried out without interest groups affecting policy outcomes by controlling information or through opportunistic behaviors. This simple analysis makes clear that the state may adjust its policymaking processes in at least two ways, according to regulatory types.
Table 2. Advantages and disadvantages of two types of public institutions of governance

<table>
<thead>
<tr>
<th>Type of Regulation/safeguard</th>
<th>Committee structure</th>
<th>Policy Competition mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Legislative</td>
<td>- Constitutional division</td>
</tr>
<tr>
<td></td>
<td>committees</td>
<td>of powers</td>
</tr>
<tr>
<td></td>
<td>- Ministerial or</td>
<td>- National councils.</td>
</tr>
<tr>
<td></td>
<td>party commissions</td>
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</tbody>
</table>

**Type A: Low safeguard**

**Advantages:**
1) Ability to maintain regulatory commitments
2) High coordination with interest groups provides a stable environment conducive to investments

**Disadvantages:**
1) High costs
2) Unnecessarily complex

**Type B and C: High safeguards**

**Disadvantages:**
1) Possibility of regulatory capture
2) Tendency for interest groups to appeal politically to attain their policy preferences

**Advantages**
1) Ensurance of regulatory adaptation in conflictive areas
2) Public accountability limits opportunistic behaviors
3) Reduce opportunism

This analysis allows us to compare policymaking institutions in two types of constitutional systems, a parliamentary and a presidential one, as shown in Table 2. At this stage, the advantages and disadvantages identified for each policymaking structure represent hypotheses that will be verified throughout the case studies. Table 2 identifies the relations among the public institutions of governance, the type of regulation, and the types of institutions involved in the cases of Japan and the United States. The comparison indicates that institutions of governance that rest on mechanisms of policy competition are suited for certain types of regulations.

The advantage of this analysis is that it allows a comparison of political systems beyond their constitutional structures to identify how they cope with the problems of
regulatory adaptation. The remaining section of this chapter compares the size of the interest groups in American, and Japanese health care and the ways the two types of policymaking institutions have affected the regulatory outcome. The case of France is presented as a control case.

Policy competition mechanisms in conflictive regulatory transactions

A non-institutional factor that must be reckoned with in health policy adaptation is the presence of strong interdependencies between congressional committees and organized interests in the United States, and the links between the party(ies) in power and organized interests in Japan. The case of France is exposed as a control case to show that the lack of coordination among medical interests has granted the executive with sufficient authority to limit the role of national councils to purely consultative objectives.

Two variables explain the ability of organized interests to influence the design of regulatory and/or redistributive transactions. The first refers strictly to the unity of the political interests, as accounted for by the number of organizations representing the profession and their ability to coordinate political actions. The second is the inclusiveness of these political interests in decision-making institutions. Inclusiveness is particularly high if decision-making procedures render interest groups' participation compulsory, as in some

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18 Note that an analogy could be drawn with managerial practices of firms identified as the U-form (unitary) and the M-form (multidivisional) of the firm by Alfred E. Chandler. The M-form rests on a series of semi-autonomous divisions which create more effective oversight and controls as if an "internal market" existed. See Oliver E. Williamson, The Mechanisms of Governance: 361-2.
parliamentary democracies, or whenever physicians select their representatives, such as in the British Upper House and the Japanese Diet.\(^\text{19}\)

Table 3. Political Interests in Health Care Regulations

<table>
<thead>
<tr>
<th>Form of the State</th>
<th>Type and number of interest groups in health care and political activities</th>
<th>Political inclusiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States Presidential</td>
<td>115 professional associations. Occasional coordination of political actions. Physicians are represented in competing associations among which the American Medical Association (AMA) is the most organized.</td>
<td>Groups obtain representation at committee level negotiations. Presidential level negotiations may exclude any group. E.g., Clinton's 1993 proposal was designed with the ANA and excluded the AMA.</td>
</tr>
<tr>
<td>Japan Parliamentary</td>
<td>Five main professional associations. The Japan Medical Association is the main actor. The JMA coordinates its activities with the Dental, Pharmaceutical, Nurses, and Hospital Associations. The Insurance Societies (Kenporen), the National Insurance Council, and the MHW represent the insurers' side.</td>
<td>The JMA elects its own Diet representatives which participate in the LDP Research Commission for Fundamental Policies for Medical Care evaluating all policy proposals prior to Diet debates. Health care groups are formally participating in all consultations at the level of the MHW in its Central Medical Council.</td>
</tr>
<tr>
<td>France Semi-presidential</td>
<td>Less than 40% of professionals are represented in competing professional organizations. The Confédération des Syndicats Médicaux Français (CSMF) and the Fédération des Médecins de France (FMF) are the principal interlocutors of the government, but specialists retain affiliations with separate groups.</td>
<td>Ministerial authorities choose from among the medical bodies the ones to represent all physicians. Executive and ministerial leaderships render the national councils (such as the yearly Conférence de la Santé) consultative means to implement Cabinet policies.</td>
</tr>
</tbody>
</table>


\(^{19}\) For the British case; see Michael Moran, *Governing the health care state: a comparative study of the United Kingdom, The United States and Germany* (New York: Manchester University Press, 1999) 106.
Table 3 compares the cases of Japan, the United States, and France. Political interests are highly organized in the first two cases although medical associations differ in their degree of unity and their ability to enter policymaking institutions. In the United States, there were 115 recognized medical specialties organized under different groups in 1992. In Japan, by contrast, there is a single organization of physicians, the Japan Medical Association, a single association of hospitals, of dentists, and of nurses that play political roles. In France, medical bodies are organized under competing organizations with little or no coordination of their political actions.

The American Medical Association is the most organized health care related group in the United States with 2.3 million dollars in support of political activities in the 1991-92 electoral cycle distributed through its political arm, the American Medical Political Action Committee (AMPAC). This is comparable to the Japan Medical Association’s 3.0 million dollar budget in the 1995 political cycle redistributed through its political arm, the Medical League (Ishikai Renmei). Given the importance of factions in Japanese policymaking processes in the Liberal Democratic Party, the JMA targets a number of politicians from every faction to represent its positions. Faction leaders and ex-ministers of health are primarily targeted. In the American Congress, politicians are primarily targeted based on their influence in legislative committees.

The principal difference between the associations lies in the way they are represented in decision-making institutions. The AMA competes for access to the

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20 471 health care related groups, and 1,100 interest groups have a substantial stake in health care battles in the United States, according to Carol S. Weissert and William G. Weissert, Governing Health: The Politics of Health Policy (Baltimore and London: The Johns Hopkins University Press, 1996) 100.

21 Nihon Keizai Shimbun 7 June 2000. 4. Exchange rate at 110 yen per dollar.
legislature with the American College of Surgeons, the American College of Physicians, and the American Academy of Family Physicians, radiologists, and internists, who adopt conflicting policy preferences, as was the case during the 1993-94 health care debate. The five principal hospital associations are not united in their positions but may coordinate their strategies on a short-term basis (e.g., during the 1993 Clinton attempt at reform). Divisions among the associations imply that no single association can claim to speak for health care as a whole, giving the president the opportunity to negotiate with groups of his choice (e.g., President Clinton allied the Nurses Association). In front of major changes, however, the groups tend to adopt the status quo, and designing reforms is rendered a difficult enterprise for policymakers since a minority of senators can prevent legislation from coming to a vote.

In Japan, the JMA was the only officially authorized association with compulsory membership for physicians until 1947. No other physicians' association competes with the JMA in the political arena today, and the Pharmaceutical, Hospital, and Dental Associations coordinate their activities on important matters in the deliberation councils of the Ministry of Health and Welfare (MHW). Political inclusiveness is greater in Japan given the obligatory consultations between the Ministry of Health and Welfare (currently Health, Labor, and Welfare) and the medical associations in the deliberation councils. The JMA and the Hospital Associations tend to coordinate their position in the most important

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23 This is achieved primarily through the filibuster. More details are provided in Weissert and Weissert. *Governing Health*, esp. 19.
ministerial committees, particularly the Central Medical Council, where policies are designed and approved by interest groups.\textsuperscript{24}

In France, the medical associations are disaggregated, with less than 40% of physicians being members of an association in 1984.\textsuperscript{25} The Confédération des Syndicats Médicaux Français (CSMF) and the Fédération des Médecins de France (FMF) are the principal interlocutors of the government, but specialists retain affiliations with separate groups with little coordination.\textsuperscript{26} The groups are also divided according to ideological lines, with a number of unions supporting the integration of medical services in the state and other unions, such as the Syndicat de la médecine libérale (SML, Union of Liberal Medicine), defending free-pricing liberal practices. Negotiations with the medical body are carried out with the medical unions chosen by the government through an authorization process which leaves ample room for the cabinet to choose the interlocutor it deems fit.\textsuperscript{27}

The Ministry of Health plays a leadership role in price determination, as the medical body is not represented in the sickness funds that determine fees, although they are independently consulted in the yearly Conférence de la Santé since 1996. Health care regulations have been designed from above, making possible a clearer ideological orientation of the policies to correspond to the priorities of the executive.

\textsuperscript{24} Arioka Jiro, Senyo Iryo no Go-Ju Nen: Iryo Hoken Seido no Butai Ura [50 Years of Postwar Health care: behind the scene of the health care insurance system] (Tokyo: Nihon Isho Shinbo Sha, 1997).
\textsuperscript{25} Wilsford, David, Doctors and the state: 100.
\textsuperscript{26} The Confédération des Syndicats médicaux français is the largest organization, yet it represents only 8,9% of private practitioners. "La principale organisation médicale interpelle le gouvernement," Le Monde, 12 June 1997: 1.
\textsuperscript{27} According to the 1971 law on medical associations, representative groups are identified based on membership and financial criteria. Different groups are authorized depending on what method of calculation is used by the government. The Syndicat de la Médecine Libéral (SML) for instance was not deemed representative in 1992-93, but regained its label between 1993 and 1995. Patrick Hassenteufel, Les Médecins Face à l'État : Une comparaison européenne (Paris, Presses de Science Po. 1996) 170-1.
Policy competition and incrementalism in American presidentialism

In the United States, party committees played a central role in determining policy options until the creation of the primaries which separated the presidency from partisan politics. Combined to a constitutional division of powers dividing the veto on legislative proposals between the Congress and the president, the competition mechanisms that are at the center of the American policy process help solve problems of interdependency. This is an imperfect governance mechanism which does not eliminate the influence of major lobbies, yet reduces the ability of regulators and organized interests to design regulations that meet their own interests.

Before the New Deal, legislation in the United States had been formulated in consultation with congressional party leaders, and drafted by legislative staff. The Roosevelt administration defied the logic of the parties, selected a brain trust, and identified its main reform objectives through an Administrative Reform Committee composed of independent experts. These procedures allowed Roosevelt to cross party lines. In the end, “the measures that formed the backbone of the New Deal would never have been passed had the president followed customary political procedures.” 28 The creation of the primaries for the selection of presidential candidates further stripped parties of their political authority, isolating the presidency in the political arena but distancing it from the local patronage of party politics.

The presidency, kept in check as it is by congressional powers, possesses the

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ability to create strong policy competition dynamics that limit the extent to which local interests interfere with national policies. The main instrument of this policy competition is the presidential veto, which can only be reversed with two thirds of the House of Representatives.29 This is an imperfect governance instrument that favors adaptation of the regulatory environment in conflictive fields through a policy competition process.

In terms of health policy, however, the veto has been little used given that the boldest initiatives emerged from the presidency itself. Among the various attempts at increasing the scope of national health insurance benefits, the 1943 Wagner- Murray-Dingel bill which proposed a new program of national and hospitalization care was blocked by the Finance Committee, whereas any legislative action on the 1945 reviewed version of the bill promoted by Truman failed to reach Congress after four months of deliberations.30 Not only do congressional committees have the authority to review any legislative proposal, but since 1975 a shift in jurisdiction from the Ways and Means Committee to the Interstate and Foreign Commerce Committee over the Medicaid and Maternal and Child Health programs has embedded health regulation changes in a complex web of negotiations. In total, four congressional committees have direct jurisdiction over health care, and since 1974 committee recommendations could be reopened and changed on the floor of the House. A majority of bills are referred to the Commerce Committee and the Ways and Means

29 This tool became increasingly used after the New Deal: Truman used it more than 200 times during his presidency and required a bipartisan alliance to be overturned. The veto has been used to reverse the Taft-Hartley bill that was considered anti-labor. Fred I. Greenstein, “Nine Presidents in Search of a Modern Presidency.” In Greenstein, Fred. I., Leadership in the Modern Presidency (Cambridge, MA: Harvard University Press, 1988) 306.
Committee of the House of Representatives.\textsuperscript{31} The end result of such division of responsibilities is incrementalism.

The American government considered in a series of unsuccessful debates the possibility of establishing a compulsory insurance system in 1910 and during the New Deal. This appealed for the creation of a solid coordination of political activities between the American Medical Association and private insurer associations. Amid opposition from the AMA and private insurers, regulations in the 1960s were designed to cope with the potential lack of access to health care services for two well-identified groups only, the elderly and the poor, through Medicare and Medicaid.\textsuperscript{32} Political competition played an important role in reforming health care regulations at this point, whereas these competitive dynamics facilitated regulatory adjustments from a technical point of view until the 1980s.

With repeated failures to implement a universal national insurance system in the background, it is easy to miss the incremental policy process that has allowed federal intervention through cost control measures and supervisory activities. Legal controls over medical practices are more extensive in the United States than in Japan. Regulations gradually covered cost control mechanisms in a 1972 amendment to the Social Security Act implemented in 1975 despite the opposition of organized interests. The creation in 1972 of Professional Standard Review Organizations (which became the Quality Control Peer Review Organization Program in 1982) ensured that verifications on prices and billing

practices were gradually implemented. With the introduction of Diagnoses-Related Groups (DRG) in 1983, the state determined the remuneration of each medical therapy as a means to reduce health care costs. The ability to implement the DRG system with little conflict derives from it application to a limited segment of insured individuals (the ones which were part of Medicare and Medicaid).

Executive leadership in French health care policy

Contrary to the division of power which characterizes the American policymaking process in health care regulation, the French state is more monopolistic due to its semi-presidential features. Under the Constitution of the Fifth Republic, the cabinet sponsors all legislative projects which can even be approved without a parliamentary vote. The prime minister can assume a greater authority under governments of cohabitation characterized by the presence of a prime minister representing a different party than the elected president. Concentration of authority in the cabinet leaves little probability for policy capture by interest groups, but tends to promote ideological contents in policy choices.

The ideological divisions and the disunity of the medical body, coupled to the

34 House members can sponsor legislative “proposals” of lesser importance. Bypassing a parliamentary vote essentially amounts to a vote of confidence for the cabinet under Article 49.3 of the 1958 Constitution. The president plays a role in identifying national issues but lacks authority to design legislative proposals.
ability of the cabinet to choose its interlocutors, have made health policymaking a conflictive arena. Five national demonstrations of physicians took place between 1976 and 1991 in addition to a dozen of "administrative" strikes by private physicians.\(^{36}\) Since 1967, independent monitoring from the Ministry of Finance has introduced a means to control costs (with no input from parliament until 1996).

Contrary to universal health care systems in which medical professionals are included as salaried employees of the state, the system has allowed physicians to either follow a government-negotiated fee (sector 1), or charge higher fees directly to patients (sector 2).\(^{37}\) Physicians in sector 2 are reimbursed a portion of their fees from insurance and a portion directly from patients. This dual fee schedule system was introduced in 1982 as a reflection of the ideological divide among medical unions and the inability of the government to avoid public demonstrations of anger.

The relatively uncoordinated political actions of the medical associations have generally given the government the power to initiate reforms and determine budgets independently. National councils such as the 1996 Juppé initiative on health care have played a purely consultative role. The Juppé reform plan to reduce expenses provoked five more strikes in 1996. In spite of widespread opposition, the Socialist Government of Jospin went ahead with a delayed implementation of the Juppé reforms which capped yearly

\(^{35}\) Cohabitation may, however, play a greater role than was originally expected under the 1958 Constitution, as both President Mitterand and Chirac have had to face it for a number of years, from March 1986 to May 1988 and between 1993 and 1995 for the former, and since June 1997 for the latter.

\(^{36}\) These administrative strikes are accompanied by the closing of offices for a day. Paul Sorum, "Striking Against Managed Care: The Last Gasp of La Médecine Libérale?" *Journal of the American Medical Association*, 280.7 (19 Aug. 1998): 659-65.

\(^{37}\) Prices in sector 2 have been shown to be on average 45% higher than the ones in sector 1.
expenses and imposed fines for physicians who over-prescribed medicines.\(^{38}\)

As a means to cope with the disaggregation of the medical interest and a propensity to demonstrate, the government has created a national committee gathering professionals and government actors in a yearly conference, the *Conférence Nationale de la Santé*. De Tocqueville, who identified a propensity to associate as peculiar to democracy in America, would be most impressed by the composition of the *Conférence Nationale sur la Santé* in France today. The *Conférence* gathers 18 separate professional medical associations and 18 federations of public and private health care institutions, yet only a fraction of the number of associations in French health care. Importantly, the *Conférence* improves communication between the government and medical professionals by determining yearly budget caps in the new system according to ministerial planning of the *Secrétariat d'État à la Santé et à l'Action Sociale*.\(^{39}\)

**Policy competition and regulatory adaptation in Japanese national councils**

Under LDP governments in Japan, factions have promoted the specialization of Diet members in legislative areas. The welfare-related Diet members (the welfare-zoku) play a vital role in the decision-making process in the field of health care, as they control the LDP Research Commission for Fundamental Policies on Medical Care which approves legislative proposals prior to Diet debates. Commission members have an unlimited right to

\(^{38}\) The fines have since been cancelled by the *Conseil d'État* which judged them unconstitutional in 1998. The Juppé reform was introduced in 1996, and the government chose the most supportive Médecin Généraux de France (MGF) for interlocutor. “Santé et protection sociale des mesures Balladur à la réforme Juppé.” *Le Quotidien du Médecin* 6055 (1997) 4-5.

\(^{39}\) The budget is distributed regionally and private physicians are responsible for controlling expenses. “Groupes d’Intérêts Consultés dans le Haut Comité. De la Santé Publique.” *Le Quotidien du Médecin* 6979 (2001): 5.
speak in the meetings and decisions must be unanimous. This turns the LDP into a “mosaic of interests” which increases the interdependency between Diet members and specific social groups, as LDP members are generally limited to a participation in three commissions. The Research Commission for Medical Care provided the “entry point” through which interdependency between political interests and the LDP took root in the field of health care. In great part due to the lack of cohesion of the party’s platform, the definition of party policies through negotiations between factions, and the compulsory negotiations with industry associations carried out at administrative levels, organized interests have held influence over the policy process in the field of health care.

A second particularity of the LDP is that the party seeks reelection on general principles and policy priorities without defining a policy platform with party members. This is a rational option in one-party systems since the identification of specific policies may do more harm by creating cleavages that would help otherwise weak opposition parties. Japan’s Liberal Democratic Party defines policy options flexibly according to the will of the leaders of its principal factions. Such flexibility has allowed the LDP to shift its course of action rapidly, without losing control of the government. The administration of Tanaka Kakuei (1972-74), for example, arguably encouraged pork barrel politics and was brought down on corruption charges, but the LDP was reelected under an agenda which promoted stricter regulations on political contributions with the succeeding Miki administration (1974-76). The price to pay for policy flexibility is a relative absence of public input in policies defined by a deconcentrated party leadership, a condition that is conducive to

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40 This expression is from Inoguchi, Zoku-giin no Kenkyu: 103.
clearer interdependency with organized interests given the particular importance of the Policy Affairs Research Commissions.

Party discipline in the Diet hides subtle negotiation patterns within the LDP, as the party is divided between a mainstream group which controls the prime minister's position and a non-mainstream group that has opposed the selected prime minister. This can lead to divisions on controversial questions, with various legislations being discarded by the Policy Affairs Research Commissions before facing the Diet. Within the mainstream group, the size of the leading faction (the prime minister's faction by definition) is an important factor explaining the expediency of the legislative agenda. Tanaka Kakuei formed the richest and biggest faction in the history of the LDP in the early 1970s. He expressed the relation between the size of the leading faction and the expediency of the legislative agenda by arguing that the leading faction could control the Diet with only one eighth of its members. This condition would be met if half of the members of the mainstream factions were included in the prime minister's faction, if the majority factions represented half of the members of the party in power, and if the LDP controlled half of the membership of the Diet.

The reformist administrations of Nakasone (1981-88) did not rely on an important faction to carry out liberal and market-oriented regulatory adaptations upon entering the prime minister's office. The faction did not have sufficient members to elect Nakasone as LDP President as it counted with only 49 members in 1982, three under the required

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43 The Koizumi administration has failed in all of its policy reform initiatives since 2001 given the opposition of a stronger non-mainstream faction, the Hashimoto faction which counts on the support of 101 LDP members. Inoguchi and Iwai provide ten case studies on the in *Zoku-giin no kenkyu*: 213-57.
Nakasone was backed by the Tanaka faction to achieve his aims and was elected with 57 percent of the party vote, but he remained leader of the minority faction in the main factional alliance for his first years in power. His adoption of a controversial reform agenda “to get rid of the postwar system” increased the size of his faction but polarized the party.44 Hashimoto, by contrast, emerged as one of the most important members of a leading faction, and was elected with 77 percent of the party vote against one contender, Koizumi Junichiro. His adoption of an ambitious reform agenda gradually polarized party member, however, until his Upper House election rout forced his resignation after two years.45 Given the stance of the party on reform in both cases, how could important and controversial regulatory adaptations be carried out by the Nakasone and Hashimoto administrations?

Nakasone succeeded with important and controversial reform issues by limiting the influence of the LDP Policy Affairs Research Commissions. This was achieved through the design of a supra-partisan national council to create a consensus among faction leaders in the party. In the field of health care, a consensus among LDP faction leaders was created prior to consulting JMA-related politicians (the so-called welfare-zoku) in the Research Commission for Medical Care. Contrary to the secret arrangements of the Policy Affairs Commission, the national council included various social groups which made its policy commitment all the more credible. Public accountability made it difficult for faction leaders to defy proposals sponsored by the Party executive. For such a strategy to benefit the executive, relevant ministerial actors and policy experts designed policy options of the

45 Tsuchiya, Jiminto Habatsu koboshi: 107.
party and increased the possibility of moving away from the status quo.

Policy competition mechanisms similarly expanded the policy options of the LDP (the coalition of parties) under the Hashimoto administration. In the field of health care, the only legal requirement for deliberations is that sufficient consultations be carried out with health policy related groups. The Hashimoto national council redefined the meaning of “health policy-related” groups to financial planners and members of the commerce-zoku. The Hashimoto administration bypassed the welfare-zoku in PARC by creating supra-partisan policymaking institutions and delegating the administration to implement regulatory change through administrative guidelines. Taking advantage of the opposition between the LDP commerce-zoku and the welfare-zoku, the national council limited the direct influence of the medical associations in the so-called LDP Reform Headquarters.

**Policy competition in Japan’s national councils: An overview**

In Japan, the 1957 design of a compulsory national health insurance rested on a negotiated bargain between organized physicians and the administration of welfare. The negotiations were carried out until 1961 under threats from physicians that they would abandon the national system, unless guarantees were provided that professional autonomy would be protected and that physicians would assume a greater part in the main policymaking bodies of the MHW. The negotiated outcome gave physicians a prominent place in the administration of health care services from within the Central Medical Council of the Ministry of Health and Welfare. Physicians were guaranteed a strong commitment that any regulatory change would have to be negotiated administratively prior to facing the legislature. From their position of influence in the Central Medical Council, they acquired
the ability to boycott deliberations and block regulatory changes.

A web of 22 deliberation councils each with a consultative roles was attached to the MHW until the 2001 administrative reform, which reduced this number to eight councils including labor-related councils. The Central Social Insurance Medical Council (Chuo Shakai Hoken Iryo Kyogikai which is referred to as the Central Medical Council, Chuikyo) of the MHW has prime authority in health care policy. The regulatory framework may, in theory, be changed frequently by the Diet, but the participation and necessary consultation with interest groups in deliberation councils guarantees that contractual elements negotiated from the early days of the National Health Insurance (NHI) prevailed.

Although the MHW is not required by law to conduct consultations in the Central Medical Council, any change in procedure can be reversed by the party in power. Attempts by the MHW to provide negotiation authority to less politically charged councils have rarely succeeded. The MHW generally follows the will of the Liberal Democratic Party Research Commission for Medical Care. Under the Hashimoto national council, by contrast, the newly created Inter-Party Policy Coordination Council and the LDP Reform Headquarters superseded the vertical committee structure of the Party.

The Commission on Administrative Reform (1981-83) similarly provided a means to put a stop to program expansion and to catch up with the financial realities plaguing government finances. The national council welcomed the planning activities of the Ministry of Finance toward the compression of welfare expenses in policy areas where consultations with medical associations had failed for years. In 1984, a co-payment system for patients was introduced, and increases in physicians’ income were controlled. The influence of the national council was significant, yet temporary. After 1984, program expansion resumed.
with the shuffling of elderly health care expenses on the privately managed Insurance Societies and the creation of a retiree insurance.

The creation of supra-partisan consensus prior to carrying out consultation within the party did not inhibit the welfare-related Diet members (zoku) to voice their dissatisfaction in both national councils, but it led faction leaders to call for party discipline and threaten retaliation to their members in case of dissension. Public commitments and the involvement of commerce-related LDP members in the Reform Headquarters limited the role of the Medical Affairs Policy Affairs Research Commission. This analysis is formalized through a political game in the Appendix.

**Conclusion**

This chapter shows that interest groups' policy preferences are limited for certain regulatory transactions, the ones that affect the private competition and price determination mechanisms. Carrying out regulatory adaptation in these areas may become difficult given the limited preferences of the affected groups and the interdependency that may develop or exist with political actors. Specific institutional mechanisms of governance may be designed to cope with the problems of regulatory adaptation.

The American constitutional division of powers implies that unless the presidency and the Congress are united in their aims, policy adaptation in the field of health care remains defined by its incremental character. In the American system, incrementalism is the price to pay to limit interdependency in the partisan structure of party and Congressional committees. The presidential veto and the ability of congressional committees to stop legislative proposals create strong policy competition mechanisms that limit the possibility
of regulatory capture while protecting regulatory commitments and the status quo. Legislative difficulties justify the judicial interventionism characteristic of the United States in controlling and supervising the medical profession among other fields.

Democracy in Japan has been defined by the organization of the Liberal Democratic Party. No single individual actor possesses a formal veto power in its consultative democratic features which are characterized, instead, by a series of compulsory deliberation procedures between LDP factions, between parties in the post-1996 coalition government, and between organized interests and the administration. Policy adaptation is difficult to achieve within the regular committee structure that provides organized interests multiple points of entry. This has played a role in guaranteeing regulatory commitments amid political cycles and, in the field of health care, has ensured the professional freedom of physicians against bureaucratic interventions. The supra-partisan consultations of national councils complement the organization of policymaking at the party and ministerial levels by providing a structure of authority where executive leadership can ally ministerial actors. The public appeal of such councils in periods of financial constraints complements the regular committee structure by limiting the influence of interest groups and favoring policy adaptation.

Finally, the case of France shows a bias toward regulatory adaptations carried out from the executive office over which interest groups have little or no say, other than in the public outcry they regularly stir. The creation in 1996 of yearly national consultations on medical problems and the fee schedule is an attempt to reduce the executive bias in regulatory design.
Chapter 3
Interest groups in health care politics

The Japan Medical Association (JMA) gained influence over health policies in the main deliberation councils of the Ministry of Health and Welfare and in the Policy Affairs Research Commission on Fundamental Policies for Medical Care of the LDP after the universal health insurance system was created. This chapter identifies how interdependency between the medical interest groups, the Ministry of Health and Welfare, and political parties developed since the creation of the universal health insurance system in Japan. It identifies the position of the main interest groups, particularly the Japan Medical Association and the Federation of Insurance Societies, as they compete to attain their policy preferences.

Administrative controls and the rise of the Japan Medical Association

The small number of interest groups in Japanese health care politics partly derives from contingencies linked to late modernization. The Meiji government took forceful actions to advance the state of technological knowledge in all spheres of economic activities following the 1868 Renovation, and the promotion of modern medicine became a priority. The original aim of the new administration was to reduce the high proportion of traditional Chinese medicine specialists occupying 90 percent of the medical profession on the eve of the political transformation. Imports of Dutch medical materials and the creation of ten public medical schools and fifteen private schools remedied this situation during the following ten years, supported by a centralization of the management of the new medical services. The creation of the Japan Medical Association in 1906 and the Japan
Pharmaceutical Association a few years earlier (1893) were means for the central administration to promote swift changes toward modern practices.¹ The JMA expanded its local framework to national levels by 1911 and founded its political arm, the Japan Medical League (Ishikai Renmei) which remained relatively inactive until the postwar period.²

Centralization was further justified during World War II as the professional independence of physicians was circumscribed under the wartime guidelines of the Showa authorities to ensure the “unity between national objectives and physicians’ activities.”³ In 1942, four years after the creation of the Ministry of Health and Welfare (MHW), the Medical Association was recognized as the unique official organ for medical practitioners. Participation in the Association was made compulsory for certified practitioners unless they were directly affiliated to the army.

The Postwar Occupation did not significantly alter the organization of the medical associations. The General Headquarters of the American Occupation (GHQ) introduced electoral mechanisms for the selection of presidents, expelled “all physicians who previously had relations with the army,” and introduced voluntary membership. Its reforms stopped short of promoting a de-concentration of authority in the professional associations, which contrasted with its encouragement for free market practices in the delivery of care. Faced with a possible infiltration of communist members, the Medical Section of the GHQ opted to maintain unified medical groups under the Medical, the Dental, and the Pharmaceutical Associations.

¹ The Nippon Yakuzaiishi Kai (“Japan Pharmaceutical Association”) was renamed Nippon Yakuzaiishi Kyokai (“The Japan Pharmaceutical Association”) in 1949, after membership was made voluntary.
The departure of the GHQ brought about renewed interest in the centralization of health governance. Challenging the liberal arrangements that determined the offer of care until 1951, the Ministry of Health and Welfare defined clearer limits and controls over medical services. Prior to the creation of the universal national insurance system in 1957, the MHW had obtained the right to conduct supervision over medical institutions and to cancel any physician's right to practice in case of fraud or malpractice based on the 1953 Health Law. Physicians had to regularly reapply to the Ministry to renew their medical authorization. Price control mechanisms and limits in the number of patients assigned to each physician were introduced along with a strengthening of the insurance system to avoid further deficits that already affected the small to medium industry health insurance.4

Discontent among physicians and the possibility of a general strike were already high as Takemi Taro was elected president of the Medical Association in 1957. The Takemi presidency would mark a peak in the Association's political activities and direct confrontations with the welfare administration to guarantee professional freedom: "The conflict with the MHW did not occur because we expected to return to a free market in health care. We thought the creation of a universal medical insurance was the natural course of action. It occurred because under the insurance system planned by the administration, we [physicians] were simply losing our professional freedom."5

3 Arioka, Iryo no Go-ju Nen: 6-7.
4 This is the Employees' Health Insurance System, EHI [Seikan kenpo], which comprises today 1900 insurers including the society-managed insurance Kenporen (created in 1938) and preceded universal coverage.
The JMA repeatedly threatened to boycott the national insurance and quit the newly created system unless physicians were granted more freedom of action.\(^6\) The Association originally demanded the right to carry out treatments with little or no supervision from insurers or the administration and the elimination of numerical limits on patients assigned to physicians. The authority of the Medical Association in political circles was first symbolized by its ability to dissipate ministerial guidance over health care institutions. What the JMA demanded in reality was a say over any change in the insurance system and its price determination mechanisms as two MHW administrators reveal:

At that point in time [at the end of the 1950s], a lack of trust characterized the relations between the JMA and the Insurance Societies-MHW. Such relations prevailed for the duration of the Takemi presidency and after, for approximately thirty years. The JMA would oppose any proposed reform of health care laws, demand large increases in medical fees, repeatedly threaten to strike or to leave the Central Medical Council, and then quickly appeal to the Party and request political solutions. By defending the interests and the special rights of doctors, the unreasonable [irifujin: unfair or absurd] and anti-social [fushakaiteki] demands of the JMA were to greatly undermine [taihen komaraseta] the administration [of the MHW].\(^7\)

The LDP’s party history concurs in its section on health care:

The JMA was too political (...) Without consulting with the Minister of Health and Welfare it would bring all its requests directly to the Party and obtained what it wanted by ignoring the opinion of ministry administrators. Decisions regarding medical fees were all made according to such a practice.\(^8\)

But why would the Party listen? The Takemi presidency impacted health care policies by strengthening the Association’s political organization through its Medical

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\(^7\) Yoshihara and Wada, Iryo Seido Shi: 158. The last phrase reads “kangyo-i no rieki to tokken wo mamoru tame no Ishikai no rifuji na yokyû to hanshakaiteki kodo ha, koseisho wo taihen komaraseta.”
League. Prior to 1957, the Medical League would submit reports and requests to its affiliated politicians. Welfare-related Diet members would then freely discuss the proposals with the administrations, including the Finance administration, in relation to insurance payments. As Takemi explained, “until now, the JMA would make declarations, organize conferences and leave the issues with important politicians. Then our LDP representatives would leave it to the party to decide.”\(^9\) Given the lack of political staff in the Diet to carry out policy analyses, such practices left the administrative side to make final decisions.

The JMA developed interdependencies between the local offices of the Association and elected representatives. First, the JMA turned its organization into a vote-gathering support group for the LDP rather than a simple financial contributor to the party in power. For Takemi, “money might disappear somewhere, but the votes remain. Many organizations can give money, but they can’t necessarily deliver the vote.” Therefore, “our first impact was in the distant regions, where doctors directly visited patients to deliver care. At a minimum, a doctor could gather 200 votes. Possibly, one could deliver from 800 to 1000 votes. Each doctor could evaluate how many votes he could gather. Our aim was to turn the door-to-door doctor as a strength, having them appreciate and support political activities.” This strategy, in the words of the its president, “succeeded spectacularly.”\(^10\)

The interdependency between the JMA and the LDP was particularly rooted in the influence of Tanaka Kakuei in the two decades following the Occupation. Takemi Taro, as a native of Tanaka Kakuei’s Niigata Prefecture, financed the LDP candidate’s activities

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\(^10\) All quotes are from: Arioka, *Iryo no Go-ju Nen*: 149.
from the early days. Tanaka himself lacked the background that all postwar prime ministers until the 1970s possessed either in the top levels of the administration or the elite schools. He possessed, on the other hand, particular organizational skills that allowed him to create the biggest political faction the Liberal Democratic Party had known.\textsuperscript{11}

Tanaka never hid the importance of the financial links he created with interest groups. After his first electoral failure in Niigata, he declared to supporters that financial supports had been insufficient: “had you brought more we wouldn’t have failed.”\textsuperscript{12} His influence was already felt during the early 1960s within the party as he assumed the responsibility of chairing its Policy Affairs Research Commission (PARC). He climbed the party’s ladder to become the eleventh postwar prime minister between 1972 and 1974, before being indicted for fraud.

Partly due to the influence of the LDP Research Commission, the legal powers of the Ministry of Health and Welfare were gradually circumscribed after 1962. Rules concerning the registration and authorization of medical activities were made more flexible, and limits on the number of patients for each physician were cancelled. The supervisory guidance of the Ministry of Health remained diminished in size, and the administration lost its ability to punish fraudulent behaviors and had to rely on a more discreet notification of faulty behavior. The JMA never attained its objective of obtaining a veto on decisions regarding medical fees or to select the members of the administrative council who would

\textsuperscript{11} The competition between factions for capital date to their origins, but it has been argued that the LDP election for the party’s presidency in 1960 increased the linkages between the party and interest groups. During the election, Ikeda’s “bureaucratic faction” adopted the unconventional idea to choose a “party politician” [rather than one trained in the bureaucracy] to gather financial resources. This was Tanaka Kakuei who thus gained access to the more established factions of the LDP. Tsuji Kiyoaki and Hayashi Shigeru, \textit{Nihon Naikaku Shiroku-6 [History of Japanese Cabinets- Vol. 6]} (Tokyo: Dai-ichi Hoki Shuppan Sha, 1981) 10-12.
decide on matters related to the fee schedule. But the JMA was able to gain influence on the price determination process of the Central Medical Council primarily by appealing to the LDP and reforming the structure of the council, as described below. Already in 1960, Takemi had made his health care agenda clear to the LDP, stating that "if you can’t deliver, then we can’t deliver the vote."

**Influence of the Central Medical Council on health policies**

The influence of the JMA on price determination mechanisms and health policies was originally limited to its four members and the support of the Hospital Association in the 24-member Central Medical Council created in 1951. The Council is the most important body in the structure of the MHW. Its decision-making authority not only covers the fee schedule, but all policies that affect health care. The Council can reconsider any policy discussed in one of the other 22 deliberation councils (or the post-2001 eight councils). The MHW has the legal authority to redirect negotiations away from the Central Medical Council, although such attempts have failed given the JMA’s ability to appeal to the LDP. Negotiations between interest groups and the ministry take place under the Council, unless the executive creates a different body, such as a national council. In such a case, the Central Medical Council has to negotiate on policies decided “from above.” How

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12 *Records of the Medical Association*: 190.
13 These were Takemi’s demands as of 1957. *Records of the Medical Association*: 74 (on council representation) and 130 (on the veto power).
15 *Records of the Medical Association*: 82-3.
16 The Central Medical Council was divided into four groups: 1) insurers’ side (*Kenporen*, National Insurance, MH), 2) Physicians side (the JMA, the Dental and The Pharmaceutical Associations), 3) Industry side (labor unions and *Nikkeiren*), 4) Public members. Each group counted six members.
the Central Medical Council came to occupy such a prominent place will briefly be considered below.

Between 1927 and 1943, payments made to physicians were negotiated independently through the government employee insurance scheme, and in each Insurance Society. In 1943, the first negotiation of a "point system" centralized the payment method and the value of points, as decided by the Minister of Health and Welfare. The system did not prevail for more than one year, however, given the lack of capital that plagued Japan at the end of the Pacific War. An independent expert committee in which the physicians' side occupied a third of 33 positions was created in 1944. The influence of physicians was further reduced to a fourth of a 40 member committee in 1947, in a decision that completely crushed JMA opposition.

In 1961, the MHW administration proposed to reform the Central Medical Council by creating a five-member group to independently determine the fee schedule and reduce the influence of physicians to one member. This was "a very dangerous situation" for the JMA. This proposal not only failed, it ended up reinforcing the influence of the associations. First, the proposal turned rivalry among the Dental, Medical, and Pharmaceutical Associations to unity, creating what the groups referred to as the Sanshikai [Three Medical Specialists Group]. This alliance allowed a greater coordination of the associations' activities and put an end to their rivalry in the Central Medical Council. Second, the head of the LDP PARC, Tanaka Kakuei, created an "independent" evaluation

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17 Records of the Medical Association: 130.
18 The Pharmaceutical Association had always opposed the Medical Association because physicians had a tendency to fill prescriptions by themselves and keep the profits. This is explained in Steslicke, Doctors in Politics, 1973: 179.
committee with half of its members chosen by the Dental, Pharmaceutical and Medical Associations in 1961. The strategy was audacious, but left Takemi incredulous as he referred to Tanaka's idea as “only LDP talk” because “the bureaucrats never change, and even when the LDP makes promises, the bureaucrats check from behind.”

The new expert committee was never made to sit atop the Central Medical Council, but the latter was reformed the same year in a change that increased the influence of medical professionals to eight members among twenty. The professional associations did not possess the right to decide changes in the fee schedule, but could immediately stop negotiations by boycotting deliberations in the committee, as the JMA repeatedly did.

Table. 4 Main decision-making bodies in health policy, Japan and Germany

<table>
<thead>
<tr>
<th>Japan</th>
<th>Germany</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Central Medical Council: The physicians' side has 8 members, insurers 8, and independent experts 4 members. Negotiates point value in agreement with the Diet. Main policy body in health care.</td>
<td>1) Physicians' chambers: compulsory membership on a regional basis. In charge of licensure, ethical practices.</td>
</tr>
<tr>
<td>2) 22 advisory councils in the MHW (reduced to 8 including labor-related bodies in 2001)</td>
<td>2) (1933) Sickness funds: compulsory membership on a regional basis. Decides point value (capitation rate) by redistributing a capped budget, encourages limited billing. Supervises productivity, reduces the fees of physicians who exceed the regional average by 40 percent.</td>
</tr>
<tr>
<td>3) No cap on budget. Negotiations with LDP-MoF to determine the value of points in the fee schedule.</td>
<td>3) (1977) Concerted Action in Health Care: 68 members policy advisory board.</td>
</tr>
<tr>
<td>4) Supervision carried out by insurers with the assistance of the MHW. No direct contacts with patients by insurers are allowed.</td>
<td></td>
</tr>
</tbody>
</table>


19 The Insurance Societies would have boycotted the Central Medical Council if the expert group was not formed. The MHW named five independent “researchers” on medical fees in 1964 as a compromise [Iryo-hi Kihon Mondai Kenkyu-In] Arioka, Iryo no Go-ju Nen: 196-200. Yoshihara and Wada, Iryo Seido Shi: 250.

20 That is, eight members representing physicians, eight members representing insurers, and four independent experts (amid the original proposal for 8 independent experts and the JMA request for only one). This was passed amid the opposition of the insurers’ side and the MHW with the support of the LDP. Arioka, Iryo no Go-ju Nen: Esp. 185, 214 and 215-221.

21 The JMA called for all the physicians it represented (83% of all physicians at the time) to abandon their insurance affiliation until an increase in the fee schedule was granted in July 1971. Records of the Medical Association: 77-82. Arioka, Iryo no Go-ju Nen: 289-96. A whole chapter is devoted to JMA tactics between 1956 and 1972 in Yoshihara and Wada, Iryo Seido Shi: 238-60.
Self-governed medical bodies are a prominent feature of the health policy environment in Germany as well, but these offer no parallel to the concentration of authority of the Central Medical Council. Health policies are discussed in a 68 member advisory group that includes labor representatives. The fact that yearly caps on expenses are determined irrelative to the number of treatments encourages objectivity in the allocation of resources by sickness funds in the German case (Table 4).

Notwithstanding the position of medical professionals in the Central Medical Council, direct negotiations with the LDP in Japan played the main role in the creation of a privileged tax schedule in 1951 (considered in Chapter 9), the cancellation of strict ministerial supervision (1960), the cancellation on limits in the number of patient each physician can attend (1962), and an influence in the determination of the fee schedule, as the point value increased by 250 percent between 1963 and 1981. Figure 1 shows that the most important changes in the fee schedule occurred under the Tanaka administration, ending with the Suzuki/Nakasone Reform Council.

In 1974 alone, physicians were granted two successive raises in the value of medical services of 19 percent and 16 percent successively; in four years, medical payments increased by 50 percent.²² As the cancellation of limits on the number of patients assigned to physicians and the creation of free elderly health care (1973) also affected physicians’ income, the total increase in income of medical professionals cannot be inferred directly from the fee schedule. A more general indicator shows that over the period 1961 to 1981, whereas general household head wages increased by a factor of nine, pharmacists’

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income increased by a factor of eight, dentists’ income by a factor of ten, and physicians’ income increased by a factor of thirteen.  

Figure 1. Medical fee- yearly changes 1957/1996

Shiki | Ikeda | Saito | Tanaka | Miki | Suzuki | Nakasone | Kaifu

Government Cabinet

The month and year of implementation are shown above the columns. Source: MHW, 1999.

Interdependencies between the party in power and the JMA also played a role in reducing the importance of administrative supervision and guidance. Administrative supervision over medical institutions had been carried out since 1953; it imposed strict penalties including the revocation of medical insurance permits. In 1958 alone, 360 people were investigated, 86 insurance permits were revoked, 143 physicians received a warning concerning potentially fraudulent practices, and 97 remained under watch.  

The supervision was judged harsh and a limit to professional freedom. Revoking permits

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ultimately meant the end of a physician’s career as insurance payments had become the basis of their income since 1957. In 1959, two physicians committed suicide after seeing their permits revoked, and this ultimately united physicians and the LDP to reduce the scope of investigations and cancel penalties. The JMA originally proposed to amend the Medical Law concerning guidance to give prefectural Medical Associations the right to carry out investigations. JMA-affiliated politicians defended the Association’s right in the Diet, ultimately abolishing the harshest penalties in 1960. Current supervisions are carried out by the Insurance Societies without direct contacts with patients, whereas cases of fraud are ultimately reported to the MHW to be investigated. This always created a dilemma as insurers have never been able to directly verify if real treatments correspond with invoices, and this lack of information became one of the reasons for the harsh confrontations between the Japan Medical Association and the Insurance Societies.

**Interest groups and political contributions**

The National Federation of Health Insurance Societies, or Kenporen, comprises eighteen hundred insurance groups covering employees primarily in big companies. The Societies are responsible for the private management of the public insurance plan for these workers. The Societies possess no freedom to design their own insurance plans, contrary to private insurers in the United States. Their creation in 1938 was the achievement of an Interior Ministry that bypassed criticisms from the Medical Association, the Ministry of Finance, and the Ministry of Industry fearing that private management would limit

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professional freedom or pose a burden to government finance.\textsuperscript{25} Today the ministries recognize the tempering effect of private management on health care expenses.

The Kenporen possesses little direct political influence as it relies on the main industry association Keidanren (and Nikkeiren prior to its unification with the Keidanren in 2001) and labor associations to conduct negotiations with political leaders. Its main influence is with ministry officials who tend to adopt, as public insurers, similar policy positions.

The Japan Pharmaceutical Association (JPA) is the third professional association in importance after the Medical and the Dental Associations. The JPA represents approximately 50 percent of all pharmacists (90,000 members out of a total of 194,300 pharmacists), and remains smaller than the 240,000 members represented by the Medical Association.\textsuperscript{26} In total, professional associations are grouped under 24 denominations in Japan, as ophthalmologists, nurses, therapists, and a number of medical technologists are grouped under different denominations of relatively small size.\textsuperscript{27} The JPA and most professional associations remain relatively inactive politically.\textsuperscript{28}

The Japan Medical League (Ishikai Renmei, the political arm of the JMA) mostly competes with the Dental League (Nihon Kashi Renmei) in its financial support to the LDP.

\textsuperscript{25} Insurance Societies originally aimed at insuring farmers under 6140 groups in 1947. Yoshihara and Wada, Iryo Seido Shi: 66-80.
\textsuperscript{26} Pharmaceutical Affairs Bureau, Ministry of Health and Welfare, 1996.
\textsuperscript{27} These numbers do not include the regional sections of the associations and affiliated members. The JPA counts 47 regional sections, and 800 other affiliated local associations. In total 120 health care groups are involved in health care, including the associations in the field of traditional medicines. Japan Information Network, Directory of Health Care Associations, Tokyo 2001.
\textsuperscript{28} The Japan Pharmaceutical Manufacturers Association (JPMA) is grouped under the Federation of Pharmaceutical Manufacturers’ Associations of Japan which includes the JPMA, the Japan Direct-Selling Pharmaceutical Manufacturers Association, the Japan Home Drug Association, the Ethical Manufacturers Association, and the External Pharmaceutical Association as organizational members.
Other physician organizations, such as the College of Doctors (Nihon Igakukai) are included as organizational members of the JMA. It is becoming a cliché that the Medical Association “might not be capable of having a politician win an election, but could certainly have one lose it.” Some medical institutions are even reported as installing phone lines in their precincts for political incumbents such as former Prime Minister Hashimoto.29

The JMA has always been considered the main interest group in health care, even if its political power has declined in terms of its absolute representation of doctors over the last thirty years.30 Its membership accounted for 74-75 percent of physicians in 1967, and stabilized at 59.3 percent since 1996.31 The Association yet remains the most organized interest group linked to the MHW. Because the 1993 electoral reform created single-member districts, it is suggested that the influence of the local political arms of the Medical Association has increased over support groups and individual politicians. According to a Ministry of Finance official, “the personal links with various interest groups at local level make it difficult for politicians in single-member districts to clearly say ‘yes’ or ‘no,’” by contrast with the previous multi-member districts.32 The Ministry of Health, Labor, and

29 Interview. Health Care Specialist, University of Tokyo, Nov. 2001.
30 Note however that compulsory participation, which prevailed until the Occupation, was not a guarantee of influence for the JMA. Compulsory participation in Germany rather strengthens the supervisory authority of regional associations on billing and medical practices. Francis D. Powell and Albert F. Wessen. Eds., Health Care Systems in Transition: An International Perspective (London: Sage, 1999) 66-70.
32 Nihon Keizai Shim bun 7 June 2000, 4.
Welfare Handbook for the year 2001 also suggests that stronger links have been created between politicians and the JMA since the electoral reform.\textsuperscript{33}

Like the Kenporen, the JMA’s arguments are reflected in all the decisive deliberation councils, but the JMA combines this asset with strong links to the Liberal Democratic Party, and financial contributions on average ten times larger than the Insurance Societies. Individual membership fees for the JMA range from 24 thousand yen to 40 thousand yen varying with the electoral district, half of which is sent to the central office of the association.

Table 5. Five main official contributors to the LDP, 1998

<table>
<thead>
<tr>
<th>Association</th>
<th>Membership</th>
<th>Political Contribution (U.S. equivalent 110Y/$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan Dental League</td>
<td>63,000 members</td>
<td>425 million yen (3.86 million $)</td>
</tr>
<tr>
<td>Japan Medical League</td>
<td>75,000 members</td>
<td>305 million yen (2.77 million $)</td>
</tr>
<tr>
<td>Steel Industry League</td>
<td>32 companies</td>
<td>90 million yen (0.82 million $)</td>
</tr>
<tr>
<td>Automobile Industry League</td>
<td>13 companies</td>
<td>85 million yen (0.77 million $)</td>
</tr>
</tbody>
</table>


Supplementary contributions in electoral periods have been requested (in particular 20 thousand yen per member for the 2001 election.)\textsuperscript{34} The Japan Medical League brought 305 million yen to the central coffers of the LDP during 1998, and increased its


\textsuperscript{34} 10,000 Yen represent 90 US dollars at 110 Yen per Dollar. "Nichiren, tokubetsu choshū Yon-oku en" [Medical League special contribution of 400 million yen] Asahi Shimbun 7 Jun. 2001, 1.
contributions to 430 million yen for the July 2001 election (Table 5). This makes it the JMA the most important association to financially contribute to the LDP.  

Table 6 compares the contributions of the medical leagues with the *Kenporen*, the latter being comparatively insignificant. The table includes not only the direct contributions to political parties, but also the contributions to individual support groups. As the JMA privileges the latter form of contributions, its leads the Dental League in its total financial support to political parties.

Table 6. Total political contributions from major health care related interest groups
Million Yen (Million U.S. dollar at 110Y/$)

<table>
<thead>
<tr>
<th>Year</th>
<th>Dental League</th>
<th>Kenporen</th>
<th>Medical League</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>317 (2.88)</td>
<td>54 (0.49)</td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>425 (3.86)</td>
<td>78 (0.71)</td>
<td>710 (6.45)</td>
</tr>
<tr>
<td>1999</td>
<td>660 (6.00)</td>
<td>79 (0.72)</td>
<td>741 (6.74)</td>
</tr>
</tbody>
</table>

*Sources: Asahi Shimbun, 8 Sept 2000; Mainichi Shimbun 14 Sept. 2001*

The LDP is the first recipient of contributions from the associations. The LDP distributes funds either directly to welfare-related politicians or to politicians selected by faction leaders. Former prime minister and faction leader Hashimoto Ryutaro, for instance, does not officially appear to be as a major recipient of JMA contributions although he is the recognized leader of the health and welfare-related Diet members. The main reason for such an apparent incongruity is that funds were directed to faction members chosen by the faction leader, rather than being centrally managed. This method also explains why the

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35 Health care may not be the first sector in importance for the LDP however, as the separate contributions from construction companies reportedly play a more important role, but the unity of the medical interests makes the JMA comparatively more influential politically than individual construction companies.
leaders’ intra-factional redistribution of funds is officially kept low, to a mere 20 percent of total contributions to members, although in some regions the added contributions from the party and the faction account for a half of the district’s budget.\textsuperscript{36}

<table>
<thead>
<tr>
<th>Politician (Political post/ link to health care)</th>
<th>JMA contribution (1000 Yen)</th>
<th>Kenporen contribution (1000 Yen)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Takemi Keizo (LDP- Son of ex-president Takemi)</td>
<td>25000</td>
<td>—</td>
</tr>
<tr>
<td>Nakayama Taro (LDP- Former Physician)</td>
<td>21000</td>
<td>—</td>
</tr>
<tr>
<td>Watanabe Kozo (Indep. –Former MHW minister)</td>
<td>20000</td>
<td>2000</td>
</tr>
<tr>
<td>Mori Yoshiro (LDP-Former Prime Minister)</td>
<td>15000</td>
<td>—</td>
</tr>
<tr>
<td>Hata Tsutomu (Socialist- Ex-Prime minister)</td>
<td>13000</td>
<td>—</td>
</tr>
<tr>
<td>Muto Yoshibumi (LDP- tax committee)</td>
<td>10250</td>
<td>—</td>
</tr>
<tr>
<td>Kato Koichi (LDP - Ex-secretary general)</td>
<td>10000</td>
<td>3000</td>
</tr>
<tr>
<td>Koizumi Junichiro (LDP- Former MHW minister)</td>
<td>10000</td>
<td>2000</td>
</tr>
<tr>
<td>Kohno Yohei (LDP - Minister of Foreign Affairs)</td>
<td>10000</td>
<td>—</td>
</tr>
<tr>
<td>Murakami Masakuni (LDP -Upper House Leader)</td>
<td>10000</td>
<td>—</td>
</tr>
<tr>
<td>Jimi Shozaburo (LDP - Physician)</td>
<td>10000</td>
<td>—</td>
</tr>
<tr>
<td>Eto Golchi (LDP) (former Tax Com. Chair)</td>
<td>8000</td>
<td>2000</td>
</tr>
</tbody>
</table>


A major strategy of the JMA is to elect its own representatives or to select politicians to represent its political interests. The number of recipients of JMA contributions increased to 70 members in 2000, 90 percent who belong to the Liberal Democratic Party. The Association has particularly targeted ex-ministers of Health and Welfare, including Prime Minister Koizumi. The National Federation of Health Insurance Societies, Kenporen, targeted 29 politicians in 2000 but does not elect its own politicians as

\textsuperscript{36} On Hashimoto’s political contributions and JMA strategies, Sasaki Takeshi Ed. Daigishi To Kane [Diet Members and Money] (Tokyo: Asahi Shimbun, 1999) 36 and 114-115.
the JMA does. Table 7 shows the most important targeted contributions.

Table 8. Top ten contributions from the Japan Medical League to political organizations. Cumulative 1996-1999 (1996 figure when specified and U.S. Dollars 110Y/$).

<table>
<thead>
<tr>
<th>Financial division</th>
<th>Affiliated politician</th>
<th>Political party</th>
<th>Contribution (U.S. dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Keijin-kai</td>
<td>Takemi Keizo</td>
<td>LDP</td>
<td>80 million Y (0.73 million $)</td>
</tr>
<tr>
<td></td>
<td>Son of ex-JMA President</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Takemi.</td>
<td>JMA-affiliated</td>
<td></td>
</tr>
<tr>
<td>(2) Kin-mirai Seiji Kenkyu-Kai (Political Research Group)</td>
<td>Jimi Seizaburo</td>
<td>LDP</td>
<td>73 million Y -1996 alone- (0.66 million $)</td>
</tr>
<tr>
<td></td>
<td>Ex-physician</td>
<td>JMA-affiliated</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chair Med. PARC*</td>
<td></td>
</tr>
<tr>
<td>(3) -unspecified-</td>
<td>Miyazaki Hideki</td>
<td>LDP</td>
<td>50 million Y -1996 alone- (0.45 million $)</td>
</tr>
<tr>
<td></td>
<td>Ex-physician</td>
<td>JMA-affiliated</td>
<td></td>
</tr>
<tr>
<td>(4) Shakai Keikaku Kenkyu-kai (Social Planning Research Group)</td>
<td>Kato Koichi</td>
<td>LDP</td>
<td>30 million Y (0.27 million $)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LDP Secretary</td>
<td></td>
</tr>
<tr>
<td>(5) Shunpuikai</td>
<td>Mori Yoshiro</td>
<td>LDP</td>
<td>30 million Y (0.27 million $)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ex-prime minister</td>
<td></td>
</tr>
<tr>
<td>(6) Seiji Kokaku Kenkyu-Kai (Research Group on Politics)</td>
<td>Kohno Yohei</td>
<td>LDP</td>
<td>30 million Y (0.27 million $)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ex-vice p-m.</td>
<td></td>
</tr>
<tr>
<td>(7) Shinwa-Kai</td>
<td>Hata Tsutomu</td>
<td>Socialist</td>
<td>30 million Y (0.27 million $)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ex-prime minister</td>
<td></td>
</tr>
<tr>
<td>(8) Shin-Seiji Kenkyu-Kai (New Political Research Group)</td>
<td>Muto Kabun</td>
<td>LDP</td>
<td>26 million Y (0.24 million $)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LDP Tax PARC</td>
<td></td>
</tr>
<tr>
<td>(9) Seicho-Kai</td>
<td>Murakami Masakuni</td>
<td>LDP</td>
<td>26 million Y (0.24 million $)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>JMA-affiliated</td>
<td></td>
</tr>
<tr>
<td>(10) Kokusai Ishi Kokka (International Physicians Group)</td>
<td>Nakayama Taro</td>
<td>LDP</td>
<td>13 million Y -1996 only- (0.12 million $)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>JMA-affiliated</td>
<td>Med. PARC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Med. PARC</td>
<td></td>
</tr>
</tbody>
</table>


Table 8 identifies the ten highest financial divisions, recipients of JMA contributions, and their affiliated politicians. Most politicians rely on various financial divisions: Lower House member Ibuki Bunmei, officially affiliated to the JMA, relied on five different financial divisions; Takemi Keizo, son of ex-JMA President Takemi relied on six different groups. The 1995 revision to the Political Finance Law sought to limit direct
financial contributions to politicians to increase the role of the central party in collecting proceeds. The intent of the reform has been altered, however, as 5,736 different financial divisions (often identified as political research groups) have been created within the LDP as of 1999 to protect individual politicians and factions from the influence of the central party apparatus.\footnote{Sato, Seizaburo, and Tetsuya Matsuzaki, \textit{Jiminto seiken} [The LDP administration] (Tokyo: Chuo Koron Sha, 1986): 55-63. Tsuchiya, \textit{Jiminto Habatsu koboshi}: 63.}

The LDP Research Commission for Medical Care is formed of 45 members, 15 of whom are affiliated to the JMA or the JNA and seven are among the top 50 recipients of JMA contributions. Four leading members are prominent members of the LDP welfare-zoku, including the son of ex-JMA President, Takemi Keizo. Three members depend for only 20% of their electoral budget on private donations, but one member depends on private donations for 90% of its electoral budget, with an unidentified portion from the medical associations. Seven members among the twelve LDP representatives in the Lower House Health and Labor Committee (Kosei Rodo Iinkai), including its chairman, are officially sponsored by the JMA. Five members among the nine LDP representatives in the Upper House Welfare Committee (Kokumin Fukushi Iinkai), including its chairman, are also officially sponsored by the JMA and one is sponsored by the Nursing League.

Factions in the LDP also determine the composition of the Cabinet according to their proportional strength. Individual abilities in gathering financial resources are an important determinant of the position every politician holds within a faction.\footnote{Nikkei Shimbun 13 June 2000: 2.} This has
increased the interdependencies between politicians and interest groups. The influence of
the Medical Association can also be explained in terms of the grouping of politicians in
"policy tribe," referred to as zoku which affect the policy process by protecting their
industry's interests. Zoku members are distributed across factions.

Table 9. Factional strength and zoku members in six fields, 1986

<table>
<thead>
<tr>
<th>Ministerial affiliation</th>
<th>Tanaka Faction</th>
<th>Suzuki Faction</th>
<th>Fukuda Faction</th>
<th>Nakasone Faction</th>
<th>Kohno Faction</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoku members</td>
<td>17</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>33</td>
</tr>
<tr>
<td>Affiliated members</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>-</td>
<td>13</td>
</tr>
<tr>
<td>Industry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoku members</td>
<td>10</td>
<td>6</td>
<td>8</td>
<td>5</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>Affiliated members</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Finance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoku members</td>
<td>8</td>
<td>5</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>28</td>
</tr>
<tr>
<td>Affiliated members</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Agriculture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoku members</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Affiliated members</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Post-communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoku members</td>
<td>12</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>33</td>
</tr>
<tr>
<td>Affiliated members</td>
<td>4</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Health-welfare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoku members</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>27</td>
</tr>
<tr>
<td>Affiliated members</td>
<td>1</td>
<td>5</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Adapted from Sato, Seizaburo, and Tetsuya Matsuzaki, Jiminto seiken, [The LDP

Table 9 identifies the main industry-affiliated groups for 1986 and Table 10
estimates the position of the health-welfare zoku members since 1999, after important
factional transformations occurred.39

39 The relative distribution of zoku members among factions shown in these tables disconfirms the idea that
certain factions control particular areas of decision-making. This is because the PARC committees take
decision on the basis of unanimity rather than majority votes. In addition, an association like the JMA prefers
"investing" in different factions rather than gamble on a single horse. As Iwai and Inoguchi note, however,
some factions have developed preferential linkages: the Tanaka faction with the construction industry is the
Table 10: 1999-2000 Faction membership and health care related LDP representatives

<table>
<thead>
<tr>
<th></th>
<th>Yamasaki Faction</th>
<th>Obuchi/Hashimoto Faction</th>
<th>Mori Faction</th>
<th>Kato Faction</th>
<th>Eto/Kamei Faction (Shishikai)</th>
<th>Kohno Group</th>
<th>Independent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower House</td>
<td>28</td>
<td>55</td>
<td>42</td>
<td>50</td>
<td>40</td>
<td>16</td>
<td>19</td>
<td>250</td>
</tr>
<tr>
<td>Upper House</td>
<td>3</td>
<td>37</td>
<td>19</td>
<td>19</td>
<td>20</td>
<td>0</td>
<td>6</td>
<td>104</td>
</tr>
<tr>
<td>Health-Welfare related members</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>29</td>
</tr>
</tbody>
</table>

The Yamasaki Faction was formed in November 1998 from a division in the Nakasone Faction. The Obuchi/Hashimoto Faction directly succeeds the Tanaka Faction. The Mori Faction succeeds the previous Fukuda Faction. The Suzuki Faction divided into the Kato Faction (December 1998) and Kohno Group (January 1999). The Shishikai was created in March 1999 following a division in the ex-Fukuda and ex-Nakasone Factions.


The industry-affiliated Diet members are identified primarily according to the financial contributions they obtain and their position in industry-related decision-making bodies. The number of JMA-affiliated politicians is estimated to range between 10 and 20, whereas the number of health care-related Diet members ranges from between 20 and 100. With the health care debates becoming important aspects of the Hashimoto Financial Conference of 1996-1998 and the 1999-2000 Economy Strategy Council, however, the JMA gathered a record 200 LDP members in its December 1999 conference, “Diet members League on 21st Century Health Care,” presided by former LDP Prime Minister Takeshita. According to interviews with MHW officials, the zoku members can play

Note however that the Tanaka faction was unprecedented in its size and influence, and that Tanaka made his own fortune in construction during World War II. Iwai and Inoguchi. Zoku-giin no kenkyu: 150.

Numbers depend on whether the zoku is defined in terms of a) party membership in welfare related bodies (most inclusive measure), or b) the number of individuals influential in health care politics in each factions (most exclusive), or c) financial links with organized interests. The estimate here accounts for the main recipients of political contributions from health care related groups, and the main influential members in welfare politics (for example, Hashimoto Ryütaro does not appear as a main recipient of contributions, although his influence on health care policies is determinant).
various roles in supporting their industrial sector, including the exertion of pressures toward ministry officials to obtain approvals for certain medicines rather than others.41

**Historical roots of interest group competition**

The JMA and the Insurance Societies are situated at the opposite ends of the policy spectrum and compete as such for political access. From their inception in 1938, the Insurance Societies have provoked criticisms from the physicians’ side as the introduction of private management within the public insurance scheme inevitably called for constraints in expenses. These appeals for cost containment crystallized in the early 1960s as the *Kenporen* proposed to introduce patient co-payments and create evaluation mechanisms over health care institutions.42

The Medical Association made use of its rejuvenated political influence in the early 1960s to “save a health care insurance system on the verge of a breakdown, by unifying the insurance systems on a regional basis.” As MHW administrators recall, “the JMA proposal aimed at eliminating the Insurance Societies altogether” through the merging of all insurance systems.43 The confrontation between the interest groups reached unprecedented levels during the 1970s, as the *Kenporen* made public various cases of abuses by doctors and called for stronger administrative supervision over physicians.

At the other end of the spectrum, JMA President Takemi quixotically defended the idea that “all would be just fine if the Insurance Societies were turned into insurance fees

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collection groups,” eliminating at once their financial control on health care costs, and reducing their political role to lilliputian size. Directly voicing a preference for the “elimination of privately managed insurers,” JMA President Takemi applied political pressures with some success to the LDP against these “insurance bureaucrats” collaborating with a “totalitarian administration.”

In a memo released by the Tax Committee of the LDP, Medical Association President Takemi and Tax Committee Head Yamanaka jointly suggested that the workers’ Insurance Societies be turned into fee collection organizations without control over insurance. Ensuring that LDP members would not get cold feet during Diet deliberations, the Medical Association sent questionnaires to each party member to make their commitment clear. For the Kenporen, such a strategy amounted to asking politicians to pledge their uncompromising support to the JMA in a written form.

Interestingly, the government administration sided with the Insurance Societies, judging Takemi’s proposal as the epitome of the “irrational management” characterizing government insurance “having a wrong influence throughout the whole system.” As it

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42 The first proposal was gradually implemented until 1984. The second proposal was part of the MHW team directed by Insurance Bureau Yoshimura in 1983 and Miti’s health care strategy still in 2000. Yoshihara and Wada, Iryo Seido Shi: 188-98.
43 All quotes from Yoshihara and Wada, Iryo Seido Shi: 196.
45 The strategy was meant to please the Medical Association but the LDP policy platform remained unchanged. Secretary General Saito reiterated the party stance to increase the contributions of the Societies to public health care rather than eliminate them. Yamanaka’s memo is referred to in Kenporen, 1993: 186; the LDP policy plan was made public in a report called Iryoseisaku nikansuru kihonhoshin [Basic plan on health care policy], December 25, 1978. The quotes from JMA President Takemi are from a JMA-Memo of December 1978 referred to in Kenporen, 1993: 183.
47 The Shingikai criticized the government for seeking more revenues from private insurers while leaving intact the regional inequities in health care costs which did more to hurt the financial health of the public insurance. These debates are from the Social Insurance Deliberation Council, April 1972, transcribed in Kenporen, 1993: 182.
was discussed in the Diet, the proposal provoked the ire of the opposition who claimed it was the work of "secret negotiations" between the JMA and LDP executives. Insurance Bureau Chief Ishino considered the proposal to unify all insurance systems "a pillage of the Insurance Societies," and could only disapprove the second proposal to fund the public insurance with increased contributions from the private sector. The Ministry of Justice Legal System Bureau judged "irrational" that the Medical Law allowed the government to plunge into privately managed insurance scheme to fund the public system and requested an amendment to eliminate such possibility. The main industry associations all voiced their opposition, considering the proposal a reflection of "the fear LDP members have toward the Japan Medical Association when elections come, and of the shaky nature of the LDP."48 Kenporen President Iwakoshi, giving a lesson in democracy to LDP Research Committee Chairman Komoto argued that "the question of the financial contribution of private insurers to public health care should not be discussed in the ante-chambers of the Party, but through the public debates of the Diet."49 The LDP abandoned the proposal.

The LDP's retraction was considered an affront by the Medical Association: "The LDP is simply crushing its promise to reform the system, and leaves patients subject to the law of the jungle of LDP politics in which the population can no longer believe."50 The LDP Research Commission for Medical Care, headed by Nemoto Ryutaro and involving most Diet members linked to the Medical Association, resumed the process pledging to carry out the financial revision in a more gradual manner attracting less criticism.

49 Kenporen, 1993: 190.
50 These comments were made during the Iryo Kihon Mondai Kondankai [Roundtable on Medical Problems] of April 10, 1979.
By April 1979, the LDP Commission for Health Care Reform re-submitted a proposal to the Diet concerning the Insurance Societies, the government health care system, the health care cooperatives, and the workers health care systems. The proposal suggested that all proceeds from insurance be managed at the Agency for Social Insurance under a special account with government contributions jointly managed. Along with the document, the names of 66 supporting LDP Diet members were attached.

The proposal was greeted by the opposition in the Diet Committee on Social Security with the comment that “such a system would be counter to the fundamentals of the current organization [in which responsibilities are separated between private and public management], and shows the lack of responsibility of the government.” The Insurance Societies Kenporen reiterated that “the proposal welcomes the influence of specially selected pressure groups [the Medical Association] and is an outrage against the population.”\(^{51}\) Nikkeiren President Oki Bunpei declared that the proposal would “jeopardize the existence of the Insurance Societies altogether” and pledged to cancel any electoral support to reform supporters Nemoto Ryutaro, Ozawa Tatsuo, and all Diet members linked to them. It appeared as if other interest groups were gradually learning the harsh but efficient political tactics of Medical Association President Takemi.

The Kenporen went further in its opposition and, to the 72 party members supporting the proposal, it sent telegrams stating they would lose all support during the following elections as the LDP should not “blindly follow special interest group

Mounting the opposition pressure further, the Kenporen contacted all opposition members from the Komeito, the Socialist, and the Communist parties, asking for their cooperation in “obstructing reform.” Taking this opportunity to gather new important allies, the Socialist Party occupied deliberations in the Diet to oppose “a reform proposal which can only be qualified as the ‘psychological breakdown’ of the LDP.” LDP Secretary General Saito Kuniyoshi finally retracted a proposal that was “in no way a secret agreement with the Medical Association to compensate the loss of their preferential tax treatment” (an issue yet on his mind) as he assured his partners that “no one expects decisions to be taken at once.” The proposal was shuffled away to clear the way for the next elections.

The mounting pressure of all interest groups linked to health care isolated the Medical Association in the political arena. Sensing it was time to abandon ship, numerous LDP members who previously supported the reform agenda now called for its cancellation, and the party in power proposed an agenda focusing on other legislative priorities. JMA influence had met its limits in the Diet, but reliance on the LDP was expected to bring ulterior benefits, if not through indirect means. Insurance Bureau Chief Yoshimura later declared that the unification of the insurance systems was, in his view, “a brutal change” impossible to implement within five years.

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52 The labor unions Domei and Sohyo, during a joint conference pointed out that the LDP was ignoring their demand to increase supervision on medical practices, while listening to the JMA’s ideas on financial restructuration. The unions pledged that they would “not tolerate that the supporters of the current reform simply ignore our demands.” Seisaku suishin rodo kumiai kaigi, [Labor Unions Conference on the Pursuit of Reforms] May 24, 1979.

53 These comments are gathered from the Kenporen summary of the case. Kenporen, 1993: 198.

54 Quotes are from Arioka, Iryo no Go-ju Nen: 353. Kenporen, 1993: 188.

Conclusion

Contrary to the corporatist processes that characterize policymaking in the German health care system, decision-making authority in Japan is concentrated at the level of the Ministry of Health and Welfare, and particularly in its Central Medical Council. The participation of all interest groups in the Council promotes a structure of countervailing powers among the actors that the JMA has learned to bypass through direct negotiations with the party in power. Compulsory negotiations with interest groups did not impede the authority of the ministry until the creation of the universal insurance system. After 1957, the propensity for the JMA to appeal to the LDP and its Policy Affairs Research Commission for Medical Care increased. This interdependency between the JMA and the LDP sustained the professional autonomy of physicians in determining treatments and in billing practices with relatively little supervision.

Interdependency with the LDP did not afford the JMA sufficient leverage to eliminate the Insurance Societies. However, it is only due to an alliance between the insurers' side, labor unions, industry associations, and the opposition parties that the LDP was stopped from reforming the health care system along the lines requested by the JMA.
Chapter 4

Containing regulatory adaptation:
The Liberal Democratic Party versus the Ministry of Finance in 1970s health policy

The Ministry of Finance has tremendous authority over the creation of new programs as it approves all expenses for the government, and the administration assumed an important part in advocating expenses reduction in health care after the first Oil Shock.\(^1\) Tendencies toward budget control appeared early in Japan, partly due to the aging of the population and the unwillingness to increase taxes at levels encountered in Europe and Canada. As the Ministry of Finance challenged the LDP into introducing a co-payment for elderly patients, and as the Insurance Societies proposed principles to reform the fee schedule for physicians, however, pressure proved insufficient in challenging a status quo welcomed by the Liberal Democratic Party.

Politicians affiliated to the Medical Association and LDP executives not only cancelled administrative efforts toward a compression of expenses in health care, they encouraged further expansions of services with increased government contributions to health care budgets. The government supported a little over a tenth of health care expenses in 1955 but this proportion rose to a third by the end of the 1970s.\(^2\) Inversely, the portion of costs supported by individual patients decreased from a third of total medical expenses to a

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\(^1\) Since 2001, the Council on Economic and Fiscal Policy (Keizai Shimon Kaigi) attached to the prime minister’s office determines the outline of budgets, taking over some of the MoF’s responsibilities.

\(^2\) Insurance contributions are paid through employment contributions for employees, and paid separately from direct taxes for the general population in Japan. Insurance schemes covering the elderly, employees, professionals, and civil servants are public but separated. The Insurance Societies provide manage the employee insurance scheme primarily for professionals and companies with 5,000 employees or more. Individuals not covered under such schemes are immediately included in the National Health Insurance (NHI). Yoshihara and Wada, Iryo Seido Shi: 614.
tenth over the same period. The deficit affecting the National Health Insurance (NHI) reached 124 billion yen in 1977. The strong coordination mechanisms between regulators in the MHW, LDP politicians, and the medical interests, became an impediment to regulatory adaptation in the slow growth period that followed the Oil Shocks.

The entry of the Ministry of Finance in health care politics

A few months before the first Oil Shock, elderly patients were granted free health care services under the National Health Insurance. The 1973 revision of the Health Care Law similarly allowed increasing government contributions to family care to 70 percent of costs, whereas the previous system created in 1963 provided such contribution for the householder only. The changing economic conditions following the first Oil Shock marked Japan's entry into a period of slower growth. The implementation of free services for elderly patients seventy years old and above encouraged patients who previously made do without frequent visits to hospitals to take advantage of government generosity, inflating expenses to unexpected levels. During a two-year period, the individual cost of care for elderly patients rose from 3,400 yen a month to 5,300 yen in 1974, and further to 8,200 yen one year later. Costs for the elderly reached four times the cost of care for other age groups. The government insurance system also reported deficits between 1973 and 1975.

These financial constraints justified the entry of the Ministry of Finance in health care policies in the 1970s. The Financial Systems Council of the Ministry of Finance first requested a change in the provision of welfare services in 1975. In essence, the Financial Systems Council requested an increase in individual contributions to the NHI, the creation
of a separate insurance system for retired workers to reduce the burden on the NHI, and an increase in the amount of patient contributions to the costs of medical treatments. The MoF also recommended in its final report an extension of insurance provisions to small enterprises with five employees or fewer, as a means to reduce the burden on the national budget covering 45 percent of these costs. Relying on these recommendations, the MoF included in its financial budgeting for the year 1975 similar requests to the MHW.

Twice in six months the Financial Systems Deliberation Council renewed its request to the party in power. In its second attempt, in July 1975, the Council had submitted its report to Finance Minister Yohira Masayoshi recommending a ten percent increase in patient co-payment, and the creation of a medical insurance system for retired individuals. The Council’s report made the strong point that “welfare costs and social security related expenses occupy 50 percent of Treasury expenses and has reached a limit. Rationalization of health care costs must be done through the introduction of a higher patient co-payment.” The elimination of the deficit in the government health insurance had become a policy priority, and MHW Minister Watanabe Michio called on the councils in charge of welfare and insurance systems to consider the Ministry of Finance’s idea to create a special health care fee amounting to two percent of income from bonuses, as well as requests for increases in co-payment.

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6. The councils are, namely, the Social Insurance Deliberation Council and the Social Security Systems Deliberation Council. Employees normally receive bonuses twice on a yearly basis (July and December), which represent between 30 and 50 percent of annual income. A two percent hike was therefore significant.
Watanabe restated his determination to undertake reform, armed with the Social Insurance Deliberation Council’s approval for a reduction in expenses and an increase in patient co-payment. Diet discussions instead emphasized potential reductions of health insurance costs, and Senate discussions consumed time and jeopardized the proposals.

In December 1977, finally, a Special Diet Session was called, and the opposition, hoping to gather support for a Temporary Unemployment Measures Law, supported a ten percent co-payment fee upon treatment and a hospital entrance fee of 600 yen (rather than the 700 yen requested by the LDP), which was adopted. With elections coming up, other reform discussions dragged on and died out.

Succeeding MHW Minister Ozawa Tatsuo who was an important member of the LDP PARC on Medical Care, negotiated personally with JMA President Takemi prior to submitting a formal proposal to the Ministry of Health and Welfare. Negotiations on the medical fee schedule had been frozen for two years during the confrontations between Takemi and previous MHW Minister Watanabe, and the 1978 honorarium revision granted physicians a “compensatory” hike of 11.6 percent. Ozawa adopted policy initiatives that positioned him closer to the Medical Association. He suggested making equal the co-payment paid by employees and that paid by their family at a level of 30 percent for treatments outside hospitals. He made clear his intention to reform insurance coverage into three systems: an employee, a regional, and an elderly system. His strategy would unify the seven different employee insurance systems into a single one and revise the role of the Insurance Societies, one of the personal quests of President Takemi. The JMA agreed with

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8 Under this scheme the government would totally pay for hospital treatments.
Ozawa on equalizing fees among insurance schemes (increasing individual contributions to insurance costs) while reducing insurance costs for families. Deliberation Council members in the MHW took over the negotiations, suggesting that patients directly afford parts of the fees for medicines in hospitals to be repaid in a compensatory manner to protect low-income earners.

This broke the agreement between the LDP and the JMA. For Takemi, the fundamental problem was that the imposition of a ten percent co-payment for medicine failed to account for the varying costs of care, with some patients requiring more services than others. Further, the imposition of a co-payment forced clients to bring large amounts of money to hospitals and increased the workload of administrators. For these reasons, he argued, the co-payment ought to be supported by insurers. As Ozawa rushed to the JMA offices to obtain approval on his reform, Takemi scolded him: "The proposals do not amount to a fundamental reform, but to a total confusion; it's a loss that you can become minister without seeing this." To express their opposition to reform, JMA members had drug prescriptions filled outside of hospitals, contrary to the usual practice, for a period of one week. Through this scheme, the doctors relinquished parts of their profits on prescriptions and imposed further complications onto patients in order to make clear all the consequences of the proposed 'compensatory system'.

Discussions turned to confrontation between Minister Ozawa and President Takemi when the former brought to the Diet a MoF proposal to impose a 50 percent patient co-payment for medicines that partly reflected pressures from finance officials and partly

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expressed the minister's lack of patience.\textsuperscript{10} Again, this was breaking the previous agreement with the JMA, which immediately threatened to refuse prescriptions in hospitals. Shock waves in the LDP and the strong opposition of the Communist and Socialist parties in the Diet made deliberations impossible. Discussions were postponed. The Medical Association further declared it "illegal for government employees related to the Health and Welfare Ministry to enter JMA offices nationwide," pledged to cancel its one-sided support of the LDP, and carried out its threat to refuse prescriptions in hospitals.\textsuperscript{11} LDP members linked to the JMA cancelled negotiations in the party's Sub-committee on Medical Reform.

Financial reviews of health care had already been postponed twice under the Ohira administration, and the 1979 Diet session achieved no better results in spite of an alliance in the LDP between the Fukuda, Ohira, and Tanaka factions. Under appearances of strength, however, the postponement of reform discussions during the 1979 regular session was also the consequence of attempts by the LDP executive to consolidate its support from the JMA.\textsuperscript{12}

In the Diet, a four-party agreement to increase government and insurers' contributions to health care which proposed insurance contributions covering 100 percent of costs for workers and 80 percent for their families on hospital fees made its way, amid opposition from MHW administrators who judged such contributions superfluous in a period of financial constraints. Meant to please the JMA, the proposals instead invited

\textsuperscript{10} The introduction of a co-payment on medicine had been on the agenda previously, but Ozawa introduced his proposal to the Cabinet in May, and to the Lower House in June. Japan. Diet Reports. Lower House Social Labor Committee, 84\textsuperscript{th} Diet, 19\textsuperscript{th} Session (1 Jun. 1978).
\textsuperscript{11} This section is based on Arioka, Iryo no Go-ju Nen: 349-360.
\textsuperscript{12} The special Diet session called in December 1979 lasted only seven days, due to the complications brought by the wrangling over the choice of LDP president. The deliberations on health care were postponed three
criticisms on the ground that, in the end, increased insurance costs would be imposed on workers.

Following the double Lower and Upper Houses election of 1980, the first in Japan, and the creation of the Miki cabinet after the sudden death of Ohira, the second Minister of Health and Welfare to come from the Tanaka faction, Saito Kuniyoshi, agreed with the Medical Association to “protect patients and carry out reforms within the year.”¹³ By September, newspapers were filled with information on the abuse conducted in three Fuji hospitals, where a doctor without proper qualifications had falsified patient diagnoses to obtain financial compensation. Journalists documented numerous other cases of medical abuses, and Saito resigned after three months in office. Sonoda Nao assumed the position of Health and Welfare Minister only to face further controversy over medical mistreatments in hospitals. Action was now required. A new four-party agreement proposed a full contribution to workers’ care but 80 percent government contribution to family care for both in- and outpatients. It also reduced outpatient co-payment to 800 yen per visit and 500 yen a day for hospital treatments. Tensions eased after the proposal passed in November 1980, a speed unseen since 1978. The JMA re-allowed communications with MHW administrators.

times, partly as a result of the harsh debates surrounding a contract agreed to at bureaucratic levels to buy planes from the American company Lockheed.
¹³ The first was Noro Yamuichi, who served for only eight months from November 1979 to July 1980.
The process was not as quick when it concerned a review of the contributions of elderly patients to health care, although the public system was in deficit due to the increasing number of elderly patients. With the introduction of free elderly care in January 1973, the number of patients in hospitals quickly rose to the point where newspaper commentators argued that “hospital waiting rooms are turning into salons for elderly people,” drawing concerns in the Finance and Welfare ministries. By October 1973, the 78 billion yen prevision assigned as a yearly provision of elderly insurance costs became insufficient and the MHW administration revised its budget allocation with another 12 billion yen for elderly care for the two remaining months of the year. Although 4.7 percent of the population was over 70 years old by 1974, this portion represented 6.8 percent of the membership in the National Insurance, and only 3 percent of the salaried workers’ insurance. The budget portion from the NHI allocated to elderly care rose from 16 percent in 1973 to 24 percent by the end of 1974. Justified by those rising costs, municipalities in charge of administrating the National Health Insurance asked to revise the policy of providing free access to health care for the elderly.

By December 1974, the Central National Insurance Council (Kokuho Chuokai) held a conference for the Improvement of the National Health Care System, asking for a revision of the principles supporting insurance for the elderly. The conference elected a Research Committee on National Insurance Problems whose recommendation was to “create separate systems for health examinations, treatments, and home nursing, rather than
include all three aspects of health care into a single system." The Health Care Planning Roundtable directly affiliated to the Welfare Minister Tanaka Mazami also requested that patients contribute parts of the costs. This time, the reform process was instigated by the Ministry of Health and Welfare with MoF officials paying close attention.

The increase in costs was affecting the national treasury which shouldered two-thirds of the cost while the other third was divided equally between prefectural and municipal levels. Of concern for MoF officials also were agreements that the treasury would finance five percent of costs for prefectures and municipalities suffering from financial difficulties on top of the temporary subsidies (reaching 55 billion yen in 1975). Consequently, a few years after the introduction of the free service policy for elderly health care, MoF officials requested the introduction of patient co-payments. First, the Financial Systems Council urged the creation of a separate insurance system for retired individuals and the introduction of a co-payment scheme for elderly care. The proposal was integrated into budget proposals for 1976 with requests for a co-payment level equal to that of government insurance. Co-payment levels would thus reach 200 yen for treatments and 60 yen per day for hospital treatment.

MHW officials rejected this appeal on the basis that "increased fees reflect the great number of elderly patient suffering from illnesses, and introducing a patient share without further reform of the system is not a solution." The National Social Welfare

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15 Arioka, Iryo no Go-ju Nen: 350-60.
Cooperation Group also rejected the attempt at reform and organized “sit-in” protests in front of the Finance and Welfare bunkers in Kasumigaseki, the political district of Tokyo.

The Miki Cabinet decided to postpone the introduction of a co-payment for elderly patients while calling upon the Roundtable on Elderly Health care, directly attached to the Health and Welfare Minister, to report on the issue. Consultations would give the cabinet time to meet elections with a generous insurance program in place and provide a justification to slow down all requests from the Ministry of Finance. Meeting with the Senate Committee on Social Labor, then Minister of Welfare Hayagawa justified delays by the thorough investigations carried out under the Minister’s Roundtable which was evaluating future perspectives on the insurance system and investigating whether an independent elderly system was financially viable. Results were expected within two years.  

Financial difficulties irritated the patience of MoF officials who six months after their first request reiterated their proposals to introduce shared payment for elderly care. Fearing consequences in the coming general elections, the Miki cabinet and Welfare Minister Hayagawa intervened directly to postpone the issue. Even after the elections, the Fukuda Cabinet (December 1976), with Welfare Minister Watanabe Michio, agreed to maintain the free health care services for elderly patients.
Second movement toward elderly health care reform: 
Renewed LDP veto

By October 1977, the Roundtable on Elderly Health Care produced its report 
emphasizing the "need to reaffirm the comprehensive basis of the elderly health care 
system." Amid its technical jargon, the report made clear its opposition to the introduction 
of elderly patient co-payment without the creation of parallel systems to ensure appropriate 
nursing and home treatment services. The Roundtable further recommended a distribution 
of the financial burden of elderly care equally among the various insurance providers.

Minister Watanabe speaking to the Senate Committee on Labor cleared the way for reforms 
to be tackled by 1979, and MoF administrators postponed their budget review yet another 
year.

Within the confines of the MHW offices, however, the Elderly Insurance Bureau 
Chair Takenaka, when asked by the vice-minister whether he seriously envisaged reform, 
replied that "the minute a preparatory committee will be set up, we will have reached the 
point of no-return," then wondered whether he should go any further. Justifying such a 
comment was the opinion of numerous Diet members who considered free access as the 
symbol of a successful welfare state.

A preparatory committee on reform was however set up six months later, 
proposing to Minister Ozawa Tatsuo that the burden between the government, workers, and

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17 Detailed explanations are in Kenporen, 1993: 262-90.
the general population should be equalized.\footnote{This was the Rojin hoken iryo seido junbishitsu [Preparatory committee on elderly health care system] of December 1977.} For Takemi, such a division of the financial burden would amount to “sending old people to die in the mountain.” He replied with his own version of the proposal, suggesting to ease the burden on the government by creating a health care fund from revenues taken from workers 25 years of age and older as a means to cover the higher costs of care they will incur after the age of 40.\footnote{This was in August 1978. According to an unconfirmed legend, old people once went to die in the mountain to avoid being a burden on their family; this is referred to as “Uba sute yama”. This is suggested in Arioka, Iryo no Go-ju Nen: 367.} This fund would inevitably deal a blow to employee insurers, and the proposal was considered “only a diversion from the issue of the special tax treatment” being discussed at the time.\footnote{Over a period of one year, two proposals emerged from the LDP. The first, known as the Ozawa proposal, was made by the Welfare Minister prior to his leaving his office. He suggested to limit free treatments to elderly individuals over the age of seventy and distribute the costs in the following ratio: 45 percent to the state, 5 percent each for prefecture and municipal levels, 15 percent to employers, and a 30 percent surplus to taxpayers. High-income earners would be charged a certain fee upon treatments. This plan was scheduled for implementation by January 1980 after consultations with all related actors and consultation bodies. A second proposal was made in October 1979, as Hashimoto Ryutaro was in charge of the MHW and proposed to leave the system intact while distributing a third of the costs incurred by the elderly health care system through contributions from all other insurance systems. In fact, this position was close to demands made by the Medical Association, and it was reportedly a compromise reached with...}
Takemi as a means to appease the controversy that had surrounded the fallen tax privileges. Hashimoto always maintained his autonomy from the JMA, redistributing rather than accumulating the generous political donations, and submitted his proposal a few weeks before elections and his departure from office. He later suggested that his proposal was simply a means “to enlarge the options of the next cabinet.”

The position adopted by Hashimoto also reflected a departure from previous ideas defended in the MHW that could not reach any consensus among its own bureaus. Hesitations between proposals to create a completely new system for elderly people or adjust contributions between the various systems left the Minister in charge the chance to court organized interests.

The two proposals created confusion among health care decision-makers but allowed MoF administrators to readdress proposals they had kept shelved. Two months after the Hashimoto proposal was made public, the Financial Systems Council made public its Report on Rationalization of National Expenditures. In this report, it was made clear that “the annual expenditure on elderly care having exceeded 80 billion yen (two percent of the national budget), a revision of the individual contribution to insurance is necessary.”

Concerning the new insurance scheme being studied at the MHW, the report argued that “the creation of a new separate elderly system would cause expenditures to rise without limits.” 1979 budget previsions for the year 1980 thus accounted for the introduction of an increased patient co-payment, in itself a measure pleasing the privately managed Insurance

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21 Physicians were granted special tax treatments that the MoF wanted to cancel in the 1970s. The Kenporen opposed the creation of the workers’ fund, but Hashimoto also judged this proposal unrealistic. Kenporen, 1993: 268.

22 The report is summarized in Kenporen, 1993: 268. The two proposals were made in December 1978 and October 1979. See the Hashimoto declaration to the JMA in Shukan Shakai Hosho 1045 (Dec. 22, 1979): 14.

23 This position is made clear in Kenporen, 1993: 268-9.
Societies. In a repetition of events, the LDP Policy Affairs Council members intervened in the debate, arguing that the financial burden on patients would "act against the interest of the population." The reform was postponed.

*Third movement on elderly health care reform: Administrative objection and deliberation council's rejection*

Adding pressure toward reform was a report submitted by the Administrative Management Agency on an investigation carried out over the case of a 72-year-old patient sent to twelve different institutions to undergo various treatments. The investigation proved that abusive treatments had been performed, and the Agency argued for reform to ensure appropriate funding of health care as a means to guarantee the safety of patients. Responding to these pressures, MHW Minister Noro and Finance Minister Takeshita held a joint meeting meant to reach a compromise between their respective positions and claimed the system would be reformed in 1981. Deliberation councils would be formed to discuss the issue as quickly as possible.

The normal decision-making process would have brought the proposal for deliberation to the MHW councils. This was impossible. Welfare Minister Noro called on the Health Care System Deliberation Council to discuss reform, but his call included no specific proposal. The policy design process had been stopped from within the Ministry of Health and Welfare.

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24 Elderly care in 1980 represented 17.8% of total medical expenditures, a proportion which rose to 37.2% by 1999. See Yoshihara and Wada, *Iryo Seido Shi*: 612.


Reportedly, the head of the deliberation council, Ishihara Kenichi, had ironically argued that “no one can seriously carry out such a reform, nor have the intention to,” and the Chairman of the Council, Oko Uchi, losing patience made clear to the media that “the Ministry of Health brings us no proposal at all!”

Finance Minister Takeshita and Welfare Minister Noro reached a consensus with two basic points presented to the Elderly Health Care Council. These included the introduction of a co-payment for high-income earners and redistributed burdens among employers and the state. The members of the Council were still incapable of carrying out deliberations as “the Ministry only pointed out two areas of difficulties without identifying a priority order as to which area of the system we ought to deliberate on.”

Pressed by politicians, the vice-minister set up a Policy Department on Elderly Health Care to prepare the required reform proposal. This was, in a way, the “point of no return”.

The Ministry of Health and Welfare was finally ready to discuss its proposal by September 1980 in front of Council members. The proposal was similar to that proposed by the two ministers, based on a shared contribution toward elderly care to be taken from all existing insurance systems, prefectural and municipal levels, with a co-payment to be imposed on elderly patients with a high annual income. The proposal also contained the idea which had emerged in 1975 to create a new system to financially support medical prevention and rehabilitation for individuals above the age of forty.

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28 Kenporen, 1993: 270.

29 For the Kenporen, this proposal was the result of a rare occurrence of cooperation between the Ministry of Finance and the Ministry of Health and Welfare. Kenporen, 1993: 267-72.
At the time, the idea to reform and extend the system had already taken root among certain officials of the Ministry, in particular Yoshimura Kenichi. The 1980 proposal was also drawing from ideas which first appeared in 1978 to consolidate the system by dividing the burden of elderly care on the various systems. The proposal would again face opposition among administrative circles as it would further increase the financial burden on the state and the employers.

Drawing the most opposition, however, was the idea that annual income levels would be taken into account to impose minimal fees to certain elderly patients. The Elderly Club organized yet another sit-in in Kasumigaseki in an opposition movement supported by the JMA. Within the MHW as well, opposition toward the idea was building up as bureau chiefs argued that “at least in principle free access to services should be the justification of reforms.” The proposal was not presented as the Ministry’s idea, but rather as the “first proposal coming from the Policy Bureau.”

The Ministry of Finance also opposed the reform on the grounds that “it offer[ed] no solution to the inflating costs of care.” The Ministry of Home Affairs argued that “prevention and care are not the legal obligation of prefectures and municipalities,” and opposed any increase in regional contributions. JMA President Takemi kept outside of the debate due to his long hospitalization, nonetheless confirmed the group’s “total opposition” to the proposal and reiterated his conviction that “avoiding to cover the costs of elderly care denies the existence of the elderly.”

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30 Quotes are from Arioka, Iryo no Go-ju Nen: 369.
31 Quotes are from Kenporen, 1993: 271-3.
of the proposal to increase local contributions. The Kenporen more simply insisted on the need to create a system with shared patient contributions.\textsuperscript{33} The Social Security Council refused to pursue deliberations, given "the lack of concern for interest groups’ demands by the Ministry." The Council further decried the proposal for failing to consider whether municipalities were capable or not of assuming the increased burden, and whether the creation of further services would simply enlarge the gap between cities and the regions. The proposal was referred to as a "first trial."

\textit{Fourth movement on elderly health care reform: Administrative initiative and the role of deliberation councils}

In December 1980, the negotiation toward elderly care reform took a different turn within the deliberation councils. From its less politicized perspective, the Insurance System Deliberation Council argued for a proposal to increase services for home and preventive care, an idea that had originally appeared six years earlier during a conference of the Central Insurance Council.

The proposal, however, was difficult to implement under financial constraints, and Oko Uchi, Chairman of the Insurance System Council, gathered media representatives and made it clear that such a proposal would "disappear like an appetizer" in the hands of fiscal officials unless interest groups agreed to have the burden shared between patients and the government. The Ministry of Finance confirmed those fears, as "the creation of a parallel

system for elderly care would require policies that fairly distribute the financial burden." Receiving the proposal, Welfare Minister Sonoda Nao scheduled the potential change for 1982, with maintenance of the status quo on free health care access until then. Sonoda agreed with Finance Minister Watabe that the creation of a new system should rest on a more equal distribution of costs among insurers.

By February 1981, the backbone of the Elderly Health Care Law was set and ready to present for discussion at the LDP Policy Affairs Commission. The proposal would introduce patient contributions at level set though administrative decrees (rather than legal amendment) and was discussed in the new Elderly Health Insurance Deliberation Council. Sonoda called on two deliberation councils (the Social Insurance and the Insurance System Deliberation Councils) to discuss the project. The deliberations showed an agreement on the distribution of financial burden in a ratio of 20 percent for the government, 5 percent each for prefecture and municipal levels, and 70 percent to be assumed by employee insurers. This would greatly increase the financial burden of the employee insurers.

The Councils discarded the proposal to allow administrators to fix the amount of patient share through government decrees rather than through parliamentary approvals. Any delegation of authority to administrators in determining patient contribution would draw criticisms from all interest groups. Within the Social Insurance Council, MHW officials had to make clear the amount would reach “300 yen for first treatment and 100 for following treatments, with a daily contribution of 300 yen for hospital treatment.” Sonoda, responding to questions in the Diet, proposed that such a contribution would “solve the

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difficulties of the pay-per-treatment honorarium system [since patients would avoid unnecessary treatments], and ensure elderly patients would be treated with dignity.” Since the co-payments were determined as a fixed amount, however, it offered patients no clue as to the total cost of care but might discourage doctors from multiplying treatments. The rationale behind the reform effort, as made clear in the Diet, was to reduce the demand for care, particularly the demand from “elderly patients who in some cases went to five different care institutions in a single day.”

The LDP Social Affairs Division requested minor revisions. LDP PARC members were preoccupied by the “unlimited” payment of fees for patients who would incur great costs for lengthened hospitalization. The revised proposals it sent to MHW officials instead approved a limit of four months on monthly charges of 500 yen per treatment, and a daily 300 yen contribution upon hospital entry. The revised version was approved by the Policy Bureau of the MHW and the Cabinet. The law was sent to the Diet for approval just a few days before the closing of its regular session, and the reform was postponed until Nakasone’s Commission on Administrative Reform.

Conclusion

Significant in understanding Japan’s health policies in the 1970s is the importance the Ministry of Finance assumed in promoting fiscal restraints in welfare spending. The

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35 This section borrows from Kenporen, 1993: 279-84.
37 The Kenporen expressed its opposition to the revision in patient co-payments, but only as a means to impose pressure on politicians to consider a reform of the fee schedule. In a conference with regional cooperative societies in March 1981, the Insurance Societies made it clear that “we cannot support a review of co-payment levels while letting our demands to reform the medical fee schedule system being ignored.” Kenporen, 1993: 279-84.
conservative hand of the MoF administration limited the growth of welfare expenses. The Ministry of Finance, on the other hand, faced numerous hurdles in its attempts to reduce expenses (as a tax increase would be too controversial to consider) and instigate greater personal responsibility in assuming the costs of care.

During the 1970s, four groups of proposals designed in cooperation between MoF and MHW administrations were sent to the LDP. Only two revisions to increase patient copayment were adopted in the Diet. In all occasions, prominent politicians related to the medical associations reduced the scope of reforms and in two occasions the LDP PARC for Medical Care directly intervened to block the proposals. In all instances, the proposals were watered down and postponed. Government expenses in health care covered 11.6% of medical expenses in 1955, a proportion which rose to 30.4% in 1980.38

Japan is a parliamentary system with few constitutional veto points. This allows the LDP to center policymaking in its Policy Affairs Research Commissions where interest groups influence the preferences of the Party. Interdependency between the Liberal Democratic Party, the Japan Medical Association, and the MHW administration played a significant role in explaining the propensity to maintain the status quo amid numerous attempts by the Ministry of Finance to carry out regulatory adaptation. Since negotiations that are conducted in the LDP PARC are irregularly reported in the media, faction leaders and the party executive have little incentive to pursue reforms and depart from the preferences of the main medical associations.

38 Yoshihara and Wada, Iryo Seido Shi: 614.
Chapter 5

National Council Decision-making in the 1980s: Small government or the shifting of costs to Insurance Societies?

Upon being selected as president of the LDP in 1982, Nakasone did not control a sufficient portion of the vote in the LDP to promote controversial reforms. Nakasone’s faction counted 48 members, three below the minimum number required to become president of the party, and was elected with the support of Tanaka Kakuei. Upon assuming the presidency, however, Nakasone criticized his previous mentor who was being indicted for corruption and made his reform agenda clear. Nakasone managed to supersede factional politics in the Liberal Democratic Party with the broad public support he gathered and the use of non-partisan institutions of decision-making. Nakasone gave priority in the design of reforms to a brain trust, to the Provisional Commission on Administrative Reform [the Rincho, 1981-1983] and its Council on Administrative Reform created in 1983. Having the administration and industry association draft reforms, he was able to obtain the support of all faction leaders for the council’s plan, making it impossible for JMA-related politicians to confront him in the Policy Affairs Research Commission for Medical Care without facing expulsion.

*Brain trust decision-making and the Nakasone administration*

The use of brain trusts in politics has a history in Japan. The first brain trust was organized in 1932 under the Cabinet of Konoe Fumimaro following the advice of Nitobe Inazo. This Showa Research Group aimed at advising the executive on national policies and
as such it included socialist members, critics of the army as well as critics of the party system. The Group looked into constitutional reforms and ways to eliminate corruption among political parties, although some of its members were against the party system altogether. Its members were treated as diplomats sitting atop the national chamber, a fact that attracted criticisms as they were “welcomed by official cars and certainly too close to the prime minister’s office.” The Army eventually limited the influence of the brain trust, as popular participation in politics was constrained in 1938 to favor the “unification of the national polity.” Its members were replaced or brought to bow to military expansion until it was disbanded three years later.

The existence of the brain trust was well known to politicians and members of the elite in the postwar period. Prime Minister Ikeda designed the first Administrative Reform Council in 1961 but failed to rally the administration and abandoned his goals. Prime Minister Ohira, who had the reputation of being the most scholarly interested of the LDP leaders, created a similar consultation group in 1978 with the aim of “gathering opinions and information on the largest range of topics possible, so as to approach the policies of every ministry.” Two groups were created under Ohira. The first was the prime minister’s private council including representatives from the Ministries of Finance, International Trade and Industry, and Foreign Affairs. The second group, the Consultation Council, consisted of nine research groups gathering 176 specialists who covered all fields of

1 The Group held its first meeting in October with Goto, Konoe, Royama Masamichi, Tokyo University Professor Kawai Tōjirō, Ministry of Finance bureaucrat Ikawa Tadato, Ishigawa Shingo from the Navy, and Suzuki Sadakazu from the Army. Bix suggests that fascism referred strictly to Italy and was opposed to the extent that it questioned the authority of the emperor. Herbert Bix, Hirohito and the Making of Modern Japan (New York: Perennial, 2000): 255.

2 Tsuji and Hayashi, Nihon Naikaku Shiroku [History of Japanese Cabinets- Vol. 6]: 47.

3 Taro, Nakasone to ha nan datta noka: 97-108.
expertise from environmental concerns to health care. The Council achieved relatively little
given the sudden death of Ohira in 1980.

Prime Minister Nakasone surrounded the executive with experts of his own
choosing, mostly representatives of the business world and the bureaucracy (the Ministries
of Finance, International Trade and Industry, Health and Welfare, Transportation, and
Justice). Through weekly meetings, Nakasone attempted to center decision-making around
the executive, reversing the previous tendency to provide administrators with independence
in the design of the policy proposals discussed in the Diet. The brain trust also served as a
means for superseding factional politics and the LDP Policy Affairs Commissions. "LDP
politicians held the brain trust in distrust, as a top-down policymaking process ignoring the
position of elected officials in the legislative process." Among the experts close to
Nakasone were Gaikushuin University professor Koyama Kenichi, Tokyo University
professors Kumon Shumpei and Sato Saburo, and the actor Asari Keita.

A second particularity of the Nakasone administration was its reliance on a
national council for reform, the Second Provisional Commission on Administrative Reform
[Rinji Gyosei Chosa-Kai or Rincho] and the passage by the Diet of a vote creating its
Temporary Deliberative Council to Promote Administrative Reform in May 1983 [Rinji
Gyosei Kaikaku Suishin Shingikai] (both are referred to as "Reform Council" here). His
brain trust provided the linchpin of the Reform Council originally organized under the
Suzuki Cabinet in March 1981. Concerns about the accumulated debt among politicians
had taken root with the shift epitomized by the Suzuki cabinet in July 1980, under the
slogan "securing social fairness" [Kosei no kakuho], and in more practical terms in cabinet
discussions “on fiscal reconstruction to eliminate the accumulated debt from the 1960s” which announced changes in government priorities. The discovery of irregularities within public corporation management (financial irregularities involving the LDP and the president of Nippon Telephone) in 1981 gave the executive a chance to look into in-depth reforms. Nakasone Yasuhiro, then in charge of the Administrative Agency, assumed most of the challenge toward reforms through the national council. The Nakasone proposals to create the national council reinstated fiscal reconstruction as the main objective of the popular consultation in 1981, as government debt had reached levels of 3.7 percent of GNP in 1970, 5.8 percent in 1975 and a level of 28.7 percent in 1980.

Though Suzuki himself was closer to the left within the LDP, his clear emphasis on fiscal reconstruction guided his agenda toward the right as soon as more liberal minded groups within the administration speeded up the movement for reform. In essence, the difficulty of the Suzuki administration lay in the expansion of public expenses to nearly 35 percent of GNP during the 1970s and the need to think of government in terms of market efficiency, ultimately leading (under Nakasone) to privatization of government monopolies in trains and telecommunications. The pressure toward privatization and deregulation resulted from the commitment to avoid tax increases. The national council offered a means for the Suzuki administration to carry out fiscal reconstruction by elevating the objectives of reforms to a general review of governmental structures, expenses, and regulations. To

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4 Taro, Nakasone to ha nan datta noka. 110.
5 Quoted in Otake, Hideo, Jiyushugiteki kaikaku no jidai [The era of liberal reforms] (Tokyo, Chuo Koron Sha, 1994) 70.
6 Note however that the national debt reached a level of 74.5% of GNP in 2001, ten years after the collapse of the financial bubble.
centralize decisions in the party, Prime Minister Suzuki also established the Government - Liberal Democratic Party Administrative Reform Promotion Headquarters (Seifu - Jiyu Minshuto Gyosei Kaikaku Suishin Honbu).

The expectations regarding yet another deliberation body in a country where democracy seems synonymous with unlimited consultations were mitigated. The First Provisional Commission on Administrative Reform, created by Prime Minister Ikeda had achieved little, and when the various ministries were asked to join yet another council under Nakasone, the Ministry of Education in particular responded by sending retired individuals rather than influential and active administrators. As a result, the financial cuts reported in the first report from the Nakasone Council cancelled some financial priorities in education and reduced funding to private educational institutions.

Nakasone adopted the idea of a national council as a means to combine the influence of the bureaucracy and that of representatives of the financial world. Temporarily delegating authority was, interestingly, the surest means to concentrate power in the executive office. The national council gained influence because it reversed the tendency of previous investigative committees instigated by the executive that had primarily responded to policy proposals administratively designed. Significantly, a third of the members of the Nakasone Council were from the private financial sector. Their ability to disclose all information to the national media was significant in guaranteeing the impartiality of the procedure. The Chairman of the Council, Keidanren Chairman Doko Toshio, had a reputation that made him irreproachable for most politicians. He lived an ascetic life that appealed to the media as an example of the virtuous quality of the bushido tradition. For the
Keidanren, the lack of reform was similar to a general “suicide of Japan” caused by the ruin of the welfare government.⁸

The Second Commission and its Administrative Reform Council also counted on the support of the administration. The First Commission on Administrative Reform organized by Prime Minister Ikeda lacked the participation of the Ministry of Finance and faced the opposition from the administrations and the factions. Nakasone’s Council instead relied on proposals emerging from the MoF, supported and discussed by private financial specialists. The MoF obtained in return for its participation the assurance that government loan systems, budgetary processes, and difficulties related to its administration be kept outside of the procedures.⁹ Although its previous efforts had failed, the MoF projected as it had done successively over the years an increase in consumption taxes. The national council would become a platform from which the MoF voiced its policy priority under the authority of the executive. MoF administrators assumed the most important positions within the national council as they reduced the size of the Council’s Expert Committee from 120 members to a mere 20 members. The remaining 100 ministry participants gathered in a secondary and less important Advisory Committee.

Nakasone originally expected the Council to reach its conclusion within a year, possibly prior to the 1982 election. Members of the LDP who were gathered around Suzuki, however, were worried that Nakasone was concentrating power at the top and extended the process by asking for a series of three reports on reforms, enough to extend the process to the next elections. MoF administrators backed any extension of the process, as the first

⁸ Otake, Jiyushugiteki kaikaku no jidai: 80.
⁹ Otake, Jiyushugiteki kaikaku no jidai: 79.
report was already loaded with its proposal to impose a zero-ceiling budget for 1981. The Ministry of Finance had much larger aims, and achieving a tax reform in particular would require a well-trained body of specialists to face the LDP. Private industry representatives were gradually called in to give credit to tax reforms. As one member view the situation, "we [private industry representatives] were invited as advisors on how to reduce the size of the government, but are finally asked to help design the next budget."10

Faction leaders in the LDP accepted the proposal to impose a zero percent ceiling on increases in government expenses. The proposal nonetheless faced hardship from Diet members greatly relying on regional associations nourished by the state. Confronted to potential resignation from LDP members linked to the Ministry of Agriculture and its associations, the final resolution of the Diet reversed the executive position, and adopted a budget increase of one half percent from the previous year. When a ceiling on expenses was later imposed, budgets related to public corporations still remained at their previous level to the point where Suzuki concluded that all departments of the government were acting as to protect their own kingdom.11 This incapacity to easily adapt the ways and means of public management through direct taxation changes gradually brought privatization and deregulation as the means to cope with government management difficulties.12

10 Taro, Nakasone to ha nan datta noka: 133.
Health care reforms under the Nakasone national council: An overview

The national council promoted reforms in the health care system at two levels. First, it promoted the passing of the Elderly Health Care Law (discussed in Chapter 4) and the introduction of a co-payment scheme for elderly patients. The second policy outcome was to redistribute the burden of elderly care to employee insurance schemes and particularly to the Insurance Societies.\(^\text{13}\)

Despite the opposition from the LDP Policy Affairs Research Commission for Medical Care, the national council was unexpectedly efficient in carrying out reforms and implementing a 10 percent patient co-payment on health care fees for workers, a co-payment scheme for elderly patients, and a 20 percent co-payment system for patients under the NHI.\(^\text{14}\)

The first set of proposals provoked an impressive opposition from the JMA and LDP members. In particular, the JMA gathered the support of 168 LDP members within the 21st Century National Health Care Conference. Alliances between members of the Liberal Democratic Party and members of the opposition were planned to support the JMA position as “all the LDP members linked to the JMA or the Dental Association provided back-up on all fronts to oppose reforms.”\(^\text{15}\) Quick action followed when the Medical, the Dental and the Pharmaceutical Associations gathered in a “three Associations conference to prevent the destruction of the health care insurance system.”\(^\text{16}\) The gathering also reflected animosity

\(^{13}\) Otake in particular considers health care reforms as the most important success of the Council. I substantiate his conclusion, but argue that the inability to cover health care expense through a tax increase in the Council led Nakasone to shuffle health care expenses to the employee’s insurance scheme after 1986. Otake, Jiyushugiteki kaikaku no jidai: Chpt. 6.

\(^{14}\) Arioka, Iryo no Go-ju Nen: 390.


\(^{16}\) Arioka, Iryo no Go-ju Nen: 380.
toward the decision-making procedure from which interest groups had practically been
excluded, with the authority of the Central Medical Council superseded by the national
council.

In the LDP, Tanaka faction members were particularly clear in their opposition
against reforms, “whatever the MHW proposes.”17 The group further united the Dental and
Pharmaceutical Associations to request a unification of the various insurance systems in the
future, while the Kenporen a few days later opposed a policy that would “render the
administration of the system impossible to maintain.”18 The opposition to reform took an
even greater momentum, as the All-Japan Private Labor Union Cooperation Council (Zen
nihon minkan roku kyogikai) expressed discontent at the one-sidedness of reforms focused
exclusively on fiscal aspects of welfare.

Administrators from the MHW, fearing that reforms would suddenly halt,
commented that there was little to fear from the introduction of a co-payment system for
workers, as “the number of treatments with low financial support from the state is almost
the same between workers and their family,” the introduction of the co-payment system
would change little in the situation. This was meant to appease the fears of Diet members
on the consequences of reform, but the justification itself was obscure in its content, and the
comparisons it offered were statistically unconfirmed. Diet member linked to the JMA were
amused by its content and referred to it as “mathematical magic.”19

17 Arima, Kenko Kokkai NamiTakashi: 32.
18 On LDP negotiations with interest groups, see Shukan Shakai Hosho 1287 (16 Jul. 1984): 4 and 46.
19 Japan Medical Association, Koseisho PR ni okeru sugaku no majitsu [The mathematical magic of public
A more serious support for reform was a report sent to the Lower House Social Labor Committee emphasizing that co-payment and government contribution should be made equal regardless of the insurance scheme. “By the mid-1980s, all insurance systems should be equal in the co-payment level they require from patients, to be set at a 20 percent level.” The opposition in the Diet nonetheless cut it into pieces, claiming it was “strange to submit a report with no long-term vision on how such large scale reforms will affect health care.” The JMA similarly called reforms “a patchy work covering no more than the financial aspects of health care, and deceiving practitioners.”

Takemi who had been hospitalized resigned as President of the JMA in April 1981. Some of the strategies employed by the JMA’s new President Hata were unusual. At the personal request of President Hata who had experience in the Navy, all Diet members who had a similar experience (61 Diet members in total) were invited to participate in the activities of a “Navy Club” notwithstanding their affiliation in the Diet or in the factions of the LDP. The attempt was to influence Nakasone who also had experience in the Navy, and to ask all members of the Club to oppose health care reforms. Such an inter-factional gathering in the LDP was rare according to LDP Diet member Arima Genji who nonetheless agreed to participate in the event because “when a senpai [an elder] asks you for support, you cannot refuse.” JMA supporters could not fail. As a member of the opposition put it at the time, “never has any welfare reform passed within the span of a

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Within the span of a single Diet session, however, reforms passed. As Nakasone committed himself personally under the national council, in the words of a JMA-related LDP member, "if health care reform was not approved, Nakasone's reelection would have been impossible." Faction leader Ozawa Ichiro, who was close to the JMA and influential toward all JMA-related Diet members, met with Nakasone to discuss the possible conflict in waiting within the party. He returned to the Policy Affairs Commission for Medical Care and made clear that "anyone who would impede the next election would be thrown out [of the party]." For the JMA-related Diet members, it suddenly "became difficult to act."23

The co-payment approved in 1983 imposed on elderly patients a 400 yen contribution for out-patient treatment and 300 yen a day for hospital stays for patients (these rates were gradually increased to 1000 yen and 700 yen respectively by 1994). In 1983, the increase in elderly health care costs was 20.7 percent from the previous year level. After the introduction of the co-payment in 1984, elderly health care costs were reduced by 8.8 percent.24 Second, the national council introduced a 10 percent co-payment for workers under the Insurance Societies and 20 percent for patients under the National Insurance (the latter was gradually implemented until 1986).

The reform process, on the other hand, did not resolve the financial difficulties of the insurance programs in part because the LDP executive wanted to avoid controversies in

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22 This account is from Arima Genji, an LDP member linked to the defense zoku, whose participation in welfare policy resulted from the creation of the Old Navy Club counting 61 Diet members in 1982, and the participation of JMA President Hata. Arima, Kenko Kokkai NamiTakashi, 1984: 96.
23 All quotes are from Arima, Kenko Kokkai NamiTakashi: 20-29.
a council that publicly represented consensual policymaking. Pressures to adopt more aggressive changes were reflected in the Diet, with representatives of the Socialist Party taking the most radical stance against “a reform simply reflecting the power of the Medical Association in politics” as the physicians’ fee schedule was left intact.25

The national council focused on the priorities identified by the MoF, and as such it failed to confront some long-standing controversial issues. First, the national council avoided calls to reform the medical fee schedule. The Kenporen and labor unions had called for reform in the composition of the Central Medical Council to reduce the influence of physicians. The Komeito and the Socialist Party similarly requested a reform of the Central Medical Council if it were to take any important role in policy design.26 The Insurance Societies and the MHW administration had requested changes in the decision-making process concerning elderly health care, for which they wanted a new body, the Elderly Council, to be granted authority for determining co-payment levels, rather than the Central Medical Council which was influenced by the medical associations.

Rather, the Council achieved its financial aims without a tax increase by targeting the Insurance Societies with two measures. First, the Council created an insurance system for retired workers (ages 60 to 65) financed from the Insurance Societies and implemented in 1984. Second, increases in the financial contribution of the Insurance Societies to elderly health care were planned under the Council and concluded once the deliberations were over.

24 Yoshihara and Wada, Iryo Seido Shi: 340.
25 Declarations by representatives Watabe (SP) and Meguro (Komei). The former asked for a reform of the fee schedule system, an issue perpetually on the agenda, arguing that “In the back stages, the JMA and the LDP are totally transforming the contents of the reform.” Japan, Diet Records. Upper House Social Labor Committee, 96th Diet, 8th Session (13 Apr. 1982).
by doubling the contributions from the Societies to elderly care in 1986. The change had been discussed under the Nakasone Council and had provoked the opposition of industry associations and labor unions. In January 1984, the presidents of the economic associations Keidanren, Nikkeiren, Keizai Doyukai and the Japanese Manufacturing Industry Association, in a meeting with LDP executives, threatened to decline their support to the final council report if the party failed to put a brake on health care costs for the elderly. Directly meeting with the LDP, the Kenporen that was backed by the presidents of the main industry associations made it clear they considered future increases in contribution “as tricking the Insurance Societies with inflated expenses,” which it judged equivalent to “blaming workers for the government’s own mismanagement mistakes.”

Nakasone avoided controversial decisions under the Council but doubled the contributions to elderly health care from the privately managed Insurance Societies to avoid tax increases or welfare expense reduction in July 1986, once his reelection was guaranteed. The choice made by the administration targeted a limited group of insured workers to avoid redistributing the burden through taxes in a politically loaded decision. Ninety percent of the Insurance Societies faced deficits at the end of the 1990s. Each of these changes is described below.

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27 Kenporen notes on the January 20 and March 25, 1982 in Kenporen, 1993: 290. The comments are also in the report Roujinhokenhouni tsuite no ikensho [Opinion on the Elderly Law] from the Keizai Doyukai of the Kansai region and the Kansai Keizai Rengokai produced to the LDP in March 1982.

Reforming the National Insurance:
Proposals to create the Retiree Health Care Insurance

The national council relied on its popular support to implement reforms amid interest groups' preferences, and avoiding tax increases was an integral part of the public commitment of the executive. Maintaining services therefore implied that the burden of the privately funded Insurance Societies to national health care would be increased.

A main question dealt in the Nakasone Council was that of the National Insurance which occupied approximately five percent of the national budget. By the summer of 1981, the budget previsions of the government proposed that the central government would assume 40 percent of the expenses of the National Insurance, with a five percent share to be assumed by municipalities and prefectures. The Ministry of Home Affairs opposed the idea, and during a December meeting with Finance Minister Watanabe and Welfare Minister Morishita, it was decided that “the contribution of the municipalities and prefectures would not be increased in 1982,” but the government would study means to separate the burden fairly among authorities. The process drew longer with the creation in January 1982 of a Consultation Committee on the National Insurance introducing the idea that “a separate insurance scheme ought to be designed for retired individuals.”

The new system offered a way to reestablish the balance of costs by separating retired workers from the National Insurance. By having retired individuals join a different system, the government aimed at making patient burden lower than the one prevailing under the National Insurance. Behind the rhetorical argument also lay the aim, previously expressed when this idea originally appeared in 1943 in the Finance Bureau, to reduce central government welfare expenses.

The Insurance Bureau of the MHW had pointed out the obstacles facing the creation of a separate system solely for retired workers. Citing the example of the 1952 creation of the worker insurance system which was constantly under-financed except for its first two years, the Insurance Bureau concluded that the creation of a system for retired individuals would face even harsher difficulties.

By September 1982, however, the Nakasone Cabinet had committed itself to avoid tax increases and maintain the commitment to the National Health Insurance. It pressed the MHW into reconsidering its position. The proposal to create the insurance system for retired individuals and the reduction in treasury contribution to welfare that was part of Nakasone Council's commitments were both accepted by the LDP in December 1983. The Kenporen still argued that "the implementation of the insurance for retired individuals should be done in a step by step manner" and opposed the sudden changes decided by the government. The Nikkeiren, while agreeing with the percentile co-payment for workers argued that "conceptually we can understand the reason to create a system for retired individuals, but from the point of view of fiscal reconstruction, we oppose it." Interest groups were united in their criticism that the Ministry of Health and Welfare was "confused on reform" as it lacked a focus on how to preserve the quality of care, while simply following the leadership of Finance administrators.30

Another incentive toward reform was the expression of support from Hashimoto and Nakasone to the quixotic yet controversial JMA proposal to unify all insurance systems. The partners made repeated public announcements arguing that the LDP would

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30 Kenporen Annual Conference. 24 Feb. 1984. The JMA and labor unions expressed similar fears.
take charge of such important reform within the year. The threat was, in great parts, a means to limit the Insurance Societies’ criticisms against the creation of the retiree insurance.

The insurance system for retired workers was created in July 1984 after approbation in the Diet. The Insurance Societies and the state insurance for government workers assumed the greatest share of costs. The Insurance Societies gained in return the assurance that the Medical Association’s attempt to unify all insurance systems would be discarded and made its point that patients ought to assume a greater portion of costs. The final proposal made clear that the creation of an insurance scheme for retired individuals would be accompanied by further reductions in government contributions. This meant that increased contributions from the privately funded insurance systems would be requested.

The political imperative to increase workers’ contributions to elderly care

Under the system created in 1983, health care fees for elderly patients were partly paid by the Insurance Societies according to the percentage of elderly people they insured. The calculation system for the distribution of expenditures among insurers was based on a comparison between the number of elderly patients they insured and the total number of elderly per 1000 people. Insurers representing a below-average number of elderly patients would contribute a portion of expenses to the Social Insurance Medical Care Fee Payment Fund. This rather complex cost redistribution method offered, however, an easy means to shift the burden of care toward the Insurance Societies.

Insurers' contributions for 1990, for example, were based on a per capita proportion of elderly reaching 78 individuals per 1000 people. Each privately managed insurance society which represented a number of elderly patients below this average would cover a percentage of the difference by making payments to the central government. To reach fairness, an insurer with 30 elderly patients would therefore cover the difference for a percentage of the 48 patients (for a total equal to the national average of 78 for the year 1990) it would have covered were elderly patients equally distributed among the different insurance systems. This percentage was determined at 50 percent until 1986 (i.e., half the number of elderly patients an insurer would cover to reach the per-capita average, or 24 patients in the previous example). By 1990, this percentage was brought to 100 percent during a debate on the “fair distribution of the elderly burden, with Insurance Societies showing a deficit since then.

During the national council and until 1983, the executive of the LDP had promised that “after 1983, the rate of increase in contribution [from the private insurance associations] would be less than the percentage increase of elderly people in the population.” A secondary clause which specified that “the yearly increase in the fees supported by Insurance Societies may not exceed the yearly increase in the percentage of elderly people [65 years and above]” was integrated to the insurance law in 1983. In part because of this clause, the proportion of the fees supported by all insurers did not reach the

32 The Kenporen agreed to the creation of the insurance for retired individuals, but reiterated its total opposition to the unification of all insurance systems during its July 1984 Annual Conference. *Shukan Shakai Hosho* 1290 (16 Aug. 1984): 12-14.
33 In practice, future increases would be relative to the elderly population percentage increase (an average of 3 to 3.5%) based on the 1982 level of 78 billion yen in added contribution. At this rate, the Ministry of Health and Welfare estimated private contributions to reach 110 billion yen in 1985.
50 percent share targeted with the creation of the system in 1983. The agreement on a 50 percent share was questioned only one year later within the Elderly Insurance Deliberation Council, during the first review of the 1983 Law. In its October 1984 discussion, the advisory council became the center of a controversy as the representatives of the National Insurance and the Medical Association requested that insurers' contributions represent the totality of each insurer's medical expenditure for the elderly (that is, a 100 percent share rather than the 50 percent level agreed on in 1983). Insurance Societies requested the status quo while labor representatives requested an increase in individual co-payment to cope with increased costs.\(^{34}\)

In fact, the share of costs supported by all insurance systems versus the government contribution was gradually reduced from 47.2 percent in 1983 to 44.7 percent in 1985, making the burden proportionally heavier on the government.\(^{35}\) At the National Insurance, administrators asked for adjustments in May 1985 and for a redistribution of the burden toward Insurance Societies. Diet members representing the Medical Association and the National Insurance requested that insurers be responsible for a greater portion of elderly people's insurance, making the insurers' burden effectively 100 percent of the costs they would incur were they directly covering these costly patients. In May, during a Conference of the National Insurance, all prefectural subdivisions and related interest groups were gathered to discuss the financial crisis affecting the health care system, and once again requested that insurers assume the costs for 100 percent for elderly patients.

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\(^{34}\) Arioka, Jiro, *Iryo no Go-ju Nen*: 408-10.

\(^{35}\) Yoshihara and Wada, *Iryo Seido Shi*: 340. This was also discussed in the April 1985 roundtable "Chūkanshisetsu ni kansuru kondankai" organized by the Elderly Insurance Council.
The Insurance Societies refused any compromise given the creation of the retiree insurance scheme in 1984, the costs of which they covered entirely. For them, fairness had already been defined during the Reform Council with the privatization of welfare expenses. However, the financial difficulties incurred by the government were partly due to the lack of success of the new retiree insurance. In spite of the creation of the new insurance, numerous individuals decided to remain insured within the National Insurance rather than adopt the privately funded system created in October 1984. The total number of participants in the new insurance was four million people lower than the original estimates by the Ministry of Health and Welfare. Explaining this fact is a clause within the new insurance scheme stating that “workers pension will be limited to 20 years” for participants in the new system.36 Worried about possibly losing their pension in the long term, workers had an incentive to remain in the National Insurance. The final mistake was for MoF administrators to cut subsidies to the National Insurance after the creation of the new insurance scheme. These combined factors combined were making a review of the system necessary. In 1985, the contribution of the National Insurance to elderly care was double that of Insurance Societies, half of which came directly from the central government.

By July, the Elderly Health Care Council, in its first discussion report on the issue, viewed the current jump in costs as negatively affecting the whole system as the “proportion of participants in the new system drops every year.”37 It recommended that the portion of costs supported by insurers be brought to 100 percent, while stating the opposition of the Kenporen. Similarly, it emphasized the need to “study a further increase

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36 Details are in Yoshihara and Wada, *Iryo Seido Shi*: 340-46.
in individual co-payment” while stating the opposition of the Medical Association. Although it was given only a short time to consider the reform proposals, the deliberation council became a central stage for interest groups to confront their views with the administration. Debates were heated between natural enemies, with the JMA representative calling the lack of support from Insurance Societies “a reflection of egoism,” and the Kenporen insisting that “in the near future, the unstoppable rise in elderly health care costs will bring the Insurance Societies to their knees.”

Expressing his anger, the insurers’ representative accused ministry officials of wishing the death of the Societies. Five years after reforms, indeed, most Insurance Societies face deficits as explained below.

The Health and Welfare Ministry took its usual strategy by stepping into the middle of the two associations. It supported the 100 percent contribution level for Insurance Societies and supported a higher co-payment level for elderly patients. Its leadership was rather shaky at least in the phrasing of its convictions. Its report argued that the government “should study with prudent consideration to maintain necessary services an increase in co-payment without causing harm to the population.”

In a succession of events, the Kenporen called on media and labor unions in making this technical issue known to the wider public. Getting non-specialists’ attention on the nature of a mathematical formula to calculate the burden of care would, however, prove a gigantic task for the Kenporen and an easy way for politicians to escape a tax increase. By

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39 The Ministry’s position was for individual co-payments to be raised to 1000 yen a month for out-treatment, and hospital treatment to be brought to 500 yen a day without the previous one-month limit. Similarly, it recommended measures to increase participation in the retired insurance to 80% of retirees by 1986, and 100% by 1987.
shifting costs onto Insurance Societies, instead of adopting a tax increase, the government inflicted workers with the burden of the aging society. In practice, workers would be making contributions they would never recover after retirement.

The Insurance Societies along with representatives of four industry associations gathered with LDP executives in September 1985 to express their complete opposition to the Ministry proposal. Similarly, the Medical Association called on LDP members to cancel any further increase in co-payment by sending to its members a report calling the proposal “a blow ignoring the lives of elderly people.” The General Council of Trade Unions of Japan (Sohyo) sent to all its affiliated insurance associations a report asking them to oppose an increase in the proportion of elderly individuals they insure, and leave the proportion at 50 percent. The Kenporen, in a conference gathering 600 industry and labor representatives (and claiming a national representation of eight million members), prepared a petition calling for “the cancellation of the inappropriate fee increase.” The document was forwarded to the Finance and Welfare Ministries and all opposition parties, followed by a common declaration from five important labor associations. The Sohyo adopted a similar strategy asking all related companies to express their opposition and ask for a public commitment to assume the burden of elderly care.

40 The reasons expressed concerned the impossibility for Insurance Societies to meet the financial requirements, and the unfairness caused by the system. “Rokenseido no kanyusha hanbunritsu mondai ni taisuru yobo” [Requests concerning the distribution of patients in the elderly health care system]. Submitted to the LDP by the Association of Manufacturers Nihon Kogyokai, the industry associations Keidanren, Keizai Doyukai and the Nihon Keikokai. 11 Sept. 1985.

41 The Sohyo dissolved in 1987 to join the Japan Trade Union Confederation Rengo.

In spite of this opposition, the Nakasone Cabinet agreed to push the reform further by integrating the proposals into the 1986 budget. The pressure from the Ministry of Finance to reduce the government contribution to elderly care left little room for negotiation.\textsuperscript{43} The Insurance System and Elderly Health Care Councils supported reforms. The Insurance Systems Council was more critical. It stated that "the increase in individual co-payment is not a means to attain cost control" and requested that the needs of patients be taken into account by adopting a gradual implementation schedule. The councils also requested the creation of a home-nursing insurance to reduce the number of patients in medical institutions.\textsuperscript{44}

The MHW interpreted both reports as an acknowledgement of reform and asked for the cabinet to bring the matter to the Diet. In the meantime, Medical Association President Hata, in a meeting with Nakasone, urged the LDP to adopt a prudent stance on reforms affecting the costs of care, as "elderly health care reforms have impacts on elections," and particularly on the financial support offered by the JMA. The labor side also organized a show of strength calling for all unions to solidify their links to the opposition.\textsuperscript{45}

The Budget Committee's deliberations were also disturbed by four opposition parties requesting that state involvement in welfare be left untouched from previous levels. By April 1986, given the stance of all opposition parties, Diet deliberations were postponed. The quick dissolution of the special session of June allowed the LDP to avoid controversy on the eve of elections, and the issue was postponed until after the creation of

\textsuperscript{43} A copy of the MHW proposal submitted to the Councils in January 1986 is included in Yoshihara and Wada, \textit{Iryo Seido Shi}: 344-6. The quotes are from the same source.
\textsuperscript{44} This eventually became the Long-Term Insurance (Kaigo Hoken) created in the year 2000.
\textsuperscript{45} General Conference of the Sohyo, Domei, Churitsu Roren, Shinsanbetsu on March 26, 1986.
the third Nakasone government. The proposal Nakasone brought to the new session was unchanged from previous drafts. Secretary General Takeshita and various internal reports from the Social Labor Committee of the Lower House backed this position. The members of the latter Committee, nonetheless supporting the reform in principle, were concerned about its possible impact on the upcoming elections of 1987. Again, the promise to avoid a tax reform would justify the government into increasing the contributions from the Insurance Societies.

Facing the LDP refusal to immediately increase the taxation burden and threatened by the proposal to unify insurance schemes, the insurers’ side had little choice left during negotiations. Its last resort was to appeal for the Elderly Health Care Council favorable to its position to have its jurisdiction enlarged and decide on the issue. Taking away from the Central Medical Council its authority on matters relating to health care expenses would have required more than the insurers could afford. They would quickly have to abide by the principle—rather absent from American capitalism—that private groups must contribute to the burden of an aging community.

The LDP proposed an increase in the proportion of health care costs supported by insurers from its 1983 level of 50 percent, to 80 percent in 1986, 90 percent in 1987, and 100 percent in 1989. The heads of four of the major industry associations (the Keidanren, the Nihon Kogyokai, the Keizai Doyukai, and the Nikkeiren), insisted that Nakasone abandon changes opposed by a majority of industry associations. With budget concerns in mind, the prime minister sided with the opinion of the Central Insurance Council, for whom

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46 The JMA still supported its proposal to have the insurance schemes unified in December 1984. Shukan Shakai Hosho 1322 (Mar. 1985): 36-40.
“any further delay in reform will negatively affect the income of the state.”\textsuperscript{47} Although aiming for enactment by October, the LDP executive had to postpone procedures once more given the refusal of opposition parties to sit in the Diet for three days.

In the Upper House, the majority of the LDP was not as solid and this allowed opposition parties to press the government for a reduction in the patients’ share of health care expenses. The opposition attempted to escape a vote by posing hurdles to the debate, criticizing the proposal as “a means for the government to evade the responsibility of tax administration” which “under the false pretense of fairness, simply represents an attempt to reduce national expenses.”\textsuperscript{48}

Amid this opposition, the proposal was adopted with the somewhat ironical mention that “in the case that government support for Insurance Societies is not put into place, appropriate measures will be taken” a mysterious notice obviously meant to show a semblance of flexibility toward the opposition. The proposal was approved in both Houses by November 1986.

\textit{Restoring government financial responsibility in welfare}

Insurance Societies faced heavy financial burdens following the reform of the Elderly Health Care Law. Following the implementation of the measures, 20 percent of Insurance Societies were in deficit, as they supported 22.2 percent of elderly care expenses in 1988. The Insurance Societies submitted this information to the party in power in a report arguing “the destruction of Insurance Societies has become inevitable, unless a more

\textsuperscript{47} \textit{Shukan Shakai Hosho} 1322 (Mar. 1985): 37.
rational and fairer distribution of costs is found." They were still appealing to have the measures reversed.

Such an attempt was not beyond the scope of the previous reform. According to the Health Care Law, periodic reviews of the systems were to be carried out with a complete re-evaluation of the system to be completed by 1990. The priority for the Takeshita Cabinet in 1988 was the tax reform, however, and all other issues including the review of the Law were postponed. Takeshita's proposal to introduce an indirect tax was not counter to the aims of the Insurance Societies and the supporters of clearer state commitment to a welfare society. As the Mainichi newspaper pointed out, "the [Takeshita] proposals inevitably link the question of the tax system to the kind of welfare society we desire."50

The Elderly Insurance Council was not so receptive to the changes. It brushed aside various proposals to reform the distribution of costs and the fee schedule system. At the end of 1988, the industry associations led by the Nikkeiren and the Kenporen prompted the government more directly. The Kenporen in particular requested the creation of an indirect tax system to support elderly health care. Kenporen President Ariyoshi Shingo, during the Association's general conference of 1989, called for an increase in the public support for elderly health care to a level of 50 percent. These requests, supported by the Keidanren, the Keizai Doyukai and the Japanese Manufacturers' Association, were forwarded to the LDP executive.51 The insurers' proposal met with the expected demand

“to get rid of the private management of insurance by unifying the insurance system” from the JMA. The four main industry associations supported similar proposals to that of the insurers, however. They requested a change in the medical fee schedule system and supported a change in the patient co-payment system from a fixed amount to a percentile system indirectly informing patients of the total costs of care.

For the governing party which had suffered a blow during the summer elections of 1989, the possibility of facing further setbacks during the 1990 elections made Diet members call for prudence in starting what could become another roller-coaster political negotiation with interest groups. Avoiding discussions on reform, the burden on Insurance Societies was eased through temporary financial support rather than by an amendment to the Health Care Law. The time limit to review the elderly health care system was set as the end of 1989. From October 1988 to 1989, interest groups thus intensified their pressures on various ministry officials and urged reforms.

The MHW would refrain from taking a position contrary to the politicians’ will or to the Finance administration. Instead, it proceeded by creating a committee of experts with an independent voice and impartiality, whose recommendations would give the administration enough freedom in dealing with the LDP. This research group, contrary to the formal councils, also had the advantage for the administration of being non-binding in its suggestions, while its staff could be carefully selected. The MHW administration based its recommendation for budget revision partly on the research committee’s report, which argued for a balance in the burden supported by elderly people and the younger generation, as well as a balance in the distribution of patient co-payment between hospital treatments, out-patient treatments, and home services. The chair of the research group, Takenaka,
proposed that “it remains desirable to increase the personal financial responsibility of patients amid the opposition of Finance officials to a tax increase to support welfare.”\textsuperscript{52} The LDP unhesitantly shelved the report from the research group. At that point, with elections planned for February 1990, the LDP “did not wish to implement any policy affecting patient contributions,” as “even an increase in patient contribution by fifty yen would cost us seats.”\textsuperscript{53}

The absence of consensus between the Budget Bureau of the MoF and the LDP meant that the 100 percent level contribution to elderly care from the Insurance Societies would come into effect as planned by 1990. For the media, elections forced politicians to “postpone the bitter medicine.”\textsuperscript{54} The Lower House Committee on Welfare, evaluating the proposal, submitted its request to have the 50 percent government support extended to a yet-to-be-created home nursing system. It also supported the increase in elderly co-payment, as long as its implementation was carried gradually over a period of three years. More than a year after, in September 1991, the law had passed the Diet with little modification.

Conclusion: The organizational strength of the national council

The Reform Council played a vital role in ensuring swift decision-making for four reasons. First, the Council superseded all existing decision-making bodies for a temporary period. Deliberation councils were consulted on the ministerial proposals but their opinions were practically ignored. Concerning the introduction of patient co-payments, the Insurance

\textsuperscript{52} Kenporen, 1993: 463-67. 
System and Social Insurance Councils were called in after most decisions had already been taken, thus they deliberated less than a month. By February 1984, the Social Insurance Council considered “the consequences of the changes in the long-term as unclear” and handed a negative report to the MHW, calling for more public consultations to be conducted. The Insurance System Council similarly reported that the reforms offered no idea what the government planned in the long term, nor did it solve the long neglected review of the system “even if the current reforms are adopted.” Bypassing the reports, Ministry of Finance officials and the MHW administration argued that “basically, what the councils tell us is they acknowledge the changes.”

Second, the Council opened the door for ministerial proposals. Within the MHW, initiatives emerged from a group of young officials under the supervision of the Insurance Bureau Yoshimura who organized a study group on medical insurance policy. The group put forth the idea that unifying the insurance systems—as long requested by the JMA—was inappropriate, but that the government should study the idea that all citizens be given access to a health care cost contribution system. Concerning the question of medical abuses, the group requested more control on hospital care by creating a system through which each patient would be asked, at fixed intervals, whether he acknowledged the treatment received (a procedure which was in fact implemented in 2001). The group asked for the creation of specific guidelines from specialized groups on the means to recognize doctor’s expertise. Of these proposals, however, the national council focused uniquely on financial measures. In essence, the reform process remained in the control of the Ministry

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55 Arioka, Iryo no Go-ju Nen: 390.
of Finance imposing pressure toward diminished expenses, aimed at reducing its welfare budget by 69 billion yen.

Third, ways of silencing the opposition were easily found in the LDP. To limit the opposition of the Kenporen (which insisted on a co-payment greater than 10 percent to avoid being imposed a greater financial burden on elderly health care), Hashimoto, with the full knowledge of Prime Minister Nakasone announced to the three medical associations that the LDP "would take charge to unify the insurance systems right after the current Diet session." This invited the ire of the insurers' side formed by the Kenporen and the powerful industry associations Keidanren and Nikkeiren who reaffirmed their "total opposition to unifying the systems." Given the clear opposition of all administrative actors, who would have to design a completely new insurance system were the proposal to pass, the declaration was rather a threat, playing an important role in guaranteeing the creation of the retiree insurance. Ministry of Health and Welfare officials later destroyed this proposal after the insurance scheme was created. The Hashimoto announcement also saved the face of JMA President Hata who was repeatedly accused of being weak in confronting the LDP in the national council. Within the Medical Association, Hata was criticized for his lack of determination, and he later lost reelection in April 1984.

56 Campbell notes the importance of the research group in How Policies Change, 1993.
59 Hata was also criticized for having let a memo acknowledging his consent for the introduction of patient co-payments reach the LDP executives. Although he denied writing the memo, he was told "Hatasan wa jakugoshi da" [His back is weak; Hata lacks determination] Asahi Shimbun 7 Apr. 1984.
Representing the MHW to the Council, previous Insurance Bureau Chief Umemoto Junsei had played an important role in creating policy outlines for the LDP since the 1960s. He had assumed the position of vice-minister of the MHW, and later became vice-minister of the Environmental Agency. He had also assumed the position of Assistant to the Chief Cabinet Secretary and played a role in various councils of the MHW. About the Reform Council, he felt that it was "unsure whether legal reforms [could] be accomplished through the process."\(^{60}\) In fact, the Council did serve its purpose for the reduction of government expenses, but primarily because welfare costs were "privatized" in the process. With the increase in private contribution to elderly care and the creation of Retiree Insurance, the Insurance Societies contributed a much larger part to elderly. In 1982, 16.6 percent of elderly care expenses were covered by Insurance Societies, a portion jumping to 25.3 percent ten years after.\(^{61}\)

Reforms were justified with the argument that the Insurance Societies should keep on insuring the individuals who contributed to their funds during their working years. In reality, the creation of the Retiree Insurance scheme and the increased contribution to elderly health care imposed a greater burden to the Insurance Societies than what their fair share would call for. The double need to avoid a general tax increase and to avoid controversies during the Council made it imperative to "privatize" the burden of the aging society. LDP executives also failed to look into more controversial questions related to the fee schedule system and issues of supervision and over-treatments.

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\(^{60}\) Quoted in *Kenporen*, 1993: 467.

\(^{61}\) In comparison, the National Insurance contributed 40.1% of all elderly expenses in 1982, versus 34.2% in 1992. The remaining expenses were covered by the government employee insurance, the insurance cooperatives, and the separate insurance for ship crews. *Kenporen*, 1993: 332-3.
Fourth, the Council urged the LDP executive, and in particular Prime Minister Nakasone, to make a clear public commitment toward reform. The most important members of the LDP linked to the JMA, Hashimoto, Tanaka, and Ozawa, were regularly sent to negotiate with the JMA. In this process, the LDP executive went close to manipulating the support of the Medical Association. As JMA President Hata expressed, “before the [December 1983] election, the head of the LDP Policy Affairs Research Commission [PARC] Tanaka promised to cancel reforms, but when the election was over, the new PARC chairman rather said ‘I know nothing about it’ and turned his back on us.” Hashimoto later admitted that “the LDP broke its promise, and the fact that the JMA has created a support group for the Socialist Party is a warning that we must be careful.”

The public commitments Nakasone made during the national council are the main reason why policymaking was distanced from the influence of interest groups. In the party executive, Osawa defended the position of the JMA to “avoid confrontation and make sure the physicians don’t lean toward the opposition.” At that point, however, Nakasone’s reelection depended on his capacity to deliver on his public promises made during the national council. Nakasone’s decision was echoed to the welfare-related LDP members in the Policy Affairs Commission as Osawa supported the prime minister and warned zoku members that “a group which breaks a party decision will not be tolerated.”

62 Arima, Kenko Kokkai NamiTakashi: 68.
63 Arima, Kenko Kokkai NamiTakashi: 96.
64 All quotes are from Arima, Kenko Kokkai NamiTakashi: 133.
Party unity in the Diet was not jeopardized as the final vote approved reform in August 1984. The 10 percent co-payment for workers was implemented as a percentile contribution to health care fees. This satisfied the demands of Insurance Societies to indirectly provide patients with the exact information on the total cost of care as a means to increase controls over doctors.

The Council played an important role in temporarily limiting the influence of the medical bodies on health care policies. The JMA has been incapable of infiltrating the closed circles of decision-makers to strike deals prior to making any public commitments, as was previously the custom. While Takemi was always invited by MHW officials to join monthly discussions "to maintain harmony," as it was once justified, the new Medical Association President Hata was excluded from these semi-secret circles. Criticisms were now welcomed with the reply "it has already been decided." The JMA achieved little result as the national council forced harsher compromises onto organized interests while centering the decision-making authority on public announcements and changing the meaning of harmony to a more open policy process. The years of secret negotiations among politicians and interest groups so characteristic of the 1970s were replaced with straight public commitment for reforms.

The speed with which the Council made the implementation of reforms possible was a first in Japanese health care politics. Concerning the issue of patient co-payments, 

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65 Otake does not consider the issue of the Kenporen contribution to elderly care in his study and tends to be more positive about the policy outcomes of the Council: Otake, Jiyushugiteki kaikaku no jidai: 143.
Kenporen members thought it was "mysterious how quickly these proposals were implemented within the duration of a single Diet session.""^^66

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Chapter 6

Policy Competition in the 1990s: Bureaucracies and policy experts in market-oriented reforms

The creation of a seven-parties coalition government in June 1993 excluded the Liberal Democratic Party from the Cabinet for a total of eight months. This absence turned out to be cathartic for the LDP as reform-minded politicians were promoted to the forefront of the Party. Moderates such as Hashimoto Ryutaro and Ozawa Ichiro now defended the need for reform. The Hashimoto Coalition Cabinet taking office in January 1996 with a clear reform agenda in mind ended a three-years period during which the prime minister's position escaped LDP reach. What explains the numerous impacts that the Hashimoto Administrative Reform Council and its Financial Reform Conference had on deregulation and the design of market-oriented health care services?

This chapter explains the organizational strength of the national council in its ability to bypass the normal decision-making channels of the LDP by relying on inter-administrative talks to design reform proposals. The first sections explain the reasons for MITI's participation in the reform process, as well as the entry of the MoF in the design of health care policies. The last section identifies the modest responses of the Ministry of Health and Welfare to a majority of reform proposals until the coalition government endorsed the inter-administrative proposals. Although the Hashimoto national council created a strong consensus for reform, interest groups still held influence in the deliberation

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1 From June 1993 to April 1994 the LDP was excluded from the coalition governments successively formed under Hosokawa Morihiro and Hata Tsutomu. The LDP then joined a coalition with the Socialist Party and Sakigake lasting until the July 1998 election.
councils of the MHW and significantly altered the proposals prior to their implementation.

_The organizational strength of the Administrative Reform Council_

Prime Minister Hashimoto attracted attention in the media for his particular decision-making style. Prior cabinets relied on four ministry-delegated secretaries over whom the prime minister had little control, with a tendency to protect their jurisdictional turf or avoid the executive office altogether.² Hashimoto rather emphasized synergies with the administration. He physically merged the offices of the ministerial secretaries (from the Ministries of Finance, International Trade and Industry, Foreign Affairs, and of the National Police) with the offices of the Political Affairs Secretary and the prime minister in what became an extended executive.

This shift was more than symbolic in the way it affected relations with the LDP. Members of the prime minister's faction argued that: "Hashimoto relies on the leadership of the Ministry of International Trade and Industry, and he avoids contacts with members of his own faction. That is due to the influence of Hayashi and Eda."³ Hayashi Hirokazu and Eda Kenji were among the representatives from the Ministry of International Trade and Industry at the prime minister's office. They perceived the financial crisis as requiring administrative and financial reforms and particularly targeted the extensive powers of the Ministry of Finance. For Hashimoto, MITI was "the driving force behind the deregulation policies of the entire Japanese government."⁴

Rather than lean toward the LDP, executive-led policymaking called for the

² Interview with Eda Kenji, Political Affairs Secretary to Prime Minister Hashimoto. 24 Dec. 2001.
³ Sentaku Jul. 1997: 60. Also from MITI in the office of the prime minister was Isayama Takeshi.
creation of a national council to carry out a reform agenda in six phases: Administrative reform, government finance, the economic structure, the financial system, social welfare, and education. The Hashimoto administration adopted the broadest reform agenda the Kasumigaseki polity could imagine. This had some party members argue the head of the executive had more ambition than political sense ("Hashimoto ha seiji onchi da"). What was perceived as a Cabinet-Bureaucratic alliance lasted for two years under the Hashimoto administration, and the Obuchi administration maintained the cap on reforms until the year 2001 under the Economic Strategy Council.

The Hashimoto administration bypassed the LDP Social Section of the Political Affairs Research Commission on Fundamental Policies for Medical Care (Shakai Bukai-Iryo Kihon Mondai Chosakai), the Party committee where the medical bodies have their strongest allies. For the duration of the national council, relations between the executive and party members were delegated to the LDP Reform Headquarters [Jiminto Gyosei Kaikaku Suishin Honbu] headed by Muto Kabun. According to Muto who had previously been Minister of International Trade (1990), and Foreign Affairs (1993), the national council “of course listened to party members, but finally relied on the decisions made by the Reform Council.”

The selection of the LDP representatives to the national council and the LDP Reform Headquarters was targeted at reformists. In total, twenty LDP members related to

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the MoF and MITI administrations, the so-called finance and commerce zoku, occupied positions in the seventy member Headquarters. In this group, six were ex-MoF officials and three were ex-MITI officials. Obuchi Keizo, political ally to Hashimoto and his succeeding prime minister, sat in the council, as well as highly educated, bureaucratically experienced reform-minded politicians. Former Ministry of Finance official Ohara Ichizo had acquired expertise on the issue of the internationalization of the yen, and became Minister in Charge of the Reforms (Kaikaku Tanto Kokumu Daijin). Former Ministry of Finance official Aizawa Hideyuki played a similar role and later became chief financial regulator. Former MITI official Makino Takamori was named vice-chairman of the Reform Headquarters. Given the importance of the finance and commerce-zoku in the process, regulatory adaptation in health care was also discussed as part of the agenda of the Special Committee on Financial Structure Reforms in the Diet, rather than being monopolized by the Health and Welfare Committee.  

The various administrations reported to the LDP Reform Headquarters on proposals for deregulation they had considered in inter-ministerial talks. The inter-ministerial talks were conducted by the Economic Planning Agency which was in charge of six separate working groups in which administrators were asked to submit specific policy proposals to meet the objectives set by the Reform Council. The strategy allowed the executive office to control the reform agenda. 

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8 Some meetings of the finance committee were entirely devoted to health care. Japan. Diet Records. Lower House Special Committee on Financial Structure Reforms, 141st Diet, 5th Session (22 Oct. 1997).
The impact of the Administrative Reform Council

The first goal of the Hashimoto Administrative Reform Council was to strengthen the executive office. The policymaking process has been significantly altered since 2000 with the creation of independent budget and finance related organs to advise the prime minister. These shifts are not without parallels to the Roosevelt Administrative Council's promotion of policy evaluation committees at the executive level to increase the independence of the president from Congress and political parties. Similarities include the New Dealer's emphases on increased staffing at the executive level, the creation of consultation bodies on economic matters, and an increased role for the executive over administrative agencies. Within the LDP, however, the reforms were primarily justified as measures to increase the independence of politicians from the bureaucracy, rather than a means to distance the executive from the party. Symbolically, the Obuchi administration cancelled the right for high civil servants to answer questions in the Diet in 1998. These interesting institutional changes fall outside of the scope of the present inquiry, but point to the importance of the supra-partisan structure in carrying out adaptations.

In terms of the reforms affecting the Ministry of Posts and Telecommunications, the Financial Council aimed at privatizing banking and insurance services offered through post offices (which is a system originally organized to offer financial services on a countrywide basis in the early phases of development). The Council never obtained support

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10 In the Diet, only 13% of members were aware that the reforms were meant to “place the prime minister at the center of a cabinet-led government.” In the LDP, only 8.2% of members defined “political leadership” as referring to the authority of the cabinet and the prime minister to propose policies. Conference for a New Japan [Atarashii nihon wo tsukuru Kokumin Kaigi] Seiji Shudo ni kansuru Kokkaigi-in Anke-to [Survey of Diet Members on Political Leadership] 12 Oct. 2000.
from Ministry officials and zoku members in its efforts. Public support for privatization ran low and the efforts were abandoned. Hashimoto himself did not believe in the need to change the organization of the Ministry.¹¹

Financial reforms represented the core of the reform efforts, and a privileged area for the MITI representatives in the prime minister's office who were keen on denouncing the "dictate of budgeting procedures over ministerial programs."¹² The Council succeeded in making the Bank of Japan independent, and creating separate budgeting and financial supervisory agencies. From MITI's point of view, however, more was needed to eliminate the "supremacy of public financial controls over government policies" from a Ministry of Finance "dominating the administration, the government" and human resources in every ministry.¹³ To reduce this influence, MITI officials promoted a complete separation of the supervisory powers over public finance and private banking, adopted by the Council in 1998 and agreed upon by the coalition parties. In the coalition government, the Komeito originally promised, then cancelled its support. The Financial Planning Office was nonetheless eliminated, and supervisory powers moved to a Financial Agency. Because this Agency belongs to the Ministry of Finance, various commentators argue that reform there was, but only in appearances that reflect the influence of the MoF over LDP members.

¹² See Hashimoto's Political Secretary Eda Kenji's account of financial and administrative reform processes in Eda Kenji, Dare so Sei de Kaikaku wo Ushinai Noka [Why reforms fail?] (Tokyo: Shincho Sha, 1999).
Origins of Hashimoto’s reform policies

In the history of the Liberal Democratic Party, the use of administratively designed policy proposals had been a norm, and the Ikeda income-doubling plan certainly represents the paroxysm of such policy mechanism. The administration has been the main LDP policy think tank, preparing questions and answers for parliamentary sessions, answering questions for politicians in the Diet. Under the Hashimoto council, economic planning from the Ministry of International Trade and Industry and the Economic Planning Agency served as basis for discussions in inter-administrative talks organized by the Economic Planning Agency in which the voice of independent policy experts became prominent. As a MITI official pointed out: “The Second Hashimoto Cabinet informed the Ministerial Secretary that our Economic Reform Program was to become a central part of the Administrative Reform Council.”

The MITI administrators in the prime minister’s office, Hayashi Hirokazu and Eda Kenji, were not simple delegates for their ministry’s interests, however. They were fully supportive of an executive-led reform process and of an agenda that promoted deregulation in a spirit devoid of administrative controls. Promoting market-oriented policies and a departure from administrative controls from a bureaucratic standpoint would have become an oxymoron were it not for the presence of independent policy experts who played most of the role in promoting markets in the Planning Agency’s inter-administrative talks. The

\[13\] The Human Resource Section of the Administrative Agency is, according to Eda, a prime zone of influence of the Ministry of Finance. Eda, Dare so Sei de Kaikaku wo Ushinau Noka: 114-118.
\[14\] Report from Miti official Fujishima Yasuno. Waga Kuni no Keizai Kaisuryoku wo Shiji Shite Iku Tame no Wadai to Taiosaku [Responses to support our competitiveness] Presented to inter-ministerial deliberations on 15 Apr. 1997.
\[15\] Interview with Eda Kenji, Political Affairs Secretary to Prime Minister Hashimoto. 24 Dec. 2001.
two representatives of MITI in the prime minister's office did not even promote their ministry's attempt to merge the planning bureaus of the Economic Planning Agency with the new Ministry of Economy, Trade, and Industry (METI).

The administration of MITI still played a role in putting together groups of like-minded experts, aware of the Ministry's economic program that emphasized deregulation since 1990. Its attempt to negotiate a deregulation program directly with other administrations gave no result, however, as "MITI was all talk no action" when acting outside of the scope of the Council.\textsuperscript{16} MITI's economic program emphasized the need to proceed with regulatory adaptation in the service economy, but left for independent experts the responsibility to propose and promote changes in health care regulations. The participation of the same experts in the deliberation of every ministry ensured congruence between principles and policies. Sophia University Professor Yashiro Naohiro, in particular, was Chairman of the MITI Research Group on Health Care, Chairman of the MHW Research Group on Reforms, and a member of the EPA health Care Problem Working Group.

The predominant influence of financial reform under the Hashimoto Financial Reform Conference inevitably influenced the direction of reforms in health care.

\textsuperscript{16} The Miti Service Bureau had promoted deregulation in health care since 1985, but its influence was rather insignificant. In one case, the Bureau argued for faster approvals of foreign medical products —usually five years—to encourage technological developments, and was welcomed by the MHW with "deregulation" in the approval system by granting foreign companies "the right to submit requests by electronic means rather than hard formats." Interview with Eda Kenji, Political Affairs Secretary to Prime Minister Hashimoto. 24 Dec. 2001

Transparency and information disclosure were principles invariably applied to financial and health care markets. The term "big bang in health care" surfaced in 1996 during discussions in the Financial Structure Conference. The term certainly represented the high expectations of the council members as to what would be achieved. Public opinion was also responsive to the changes. A survey carried out under the initiative of Prime Minister Hashimoto showed a level of support as high as 65.9 percent for the introduction of market principles in health care. More general surveys conducted by industry associations showed patients arguing the previous system did not offer sufficient information on treatments.

In the MHW, administrators rather saw the reform process as a positive sign of change springing from domestic sources: "although foreign pressure had been the origins of deregulation ideas, demands from business associations and consumer associations to proceed with rule relaxation created a domestic dynamic toward change in matters of information disclosure."

What was unorthodox about MITI’s Industrial Structure Council’s economic program is that it made efficiency and employment creation in the offer of services a means to review the whole administration of the Japanese government, from the Ministry of Finance to the administration of health care. Every administration had to open its books, and answer questions designed by the Planning Agency, the LDP Reform Headquarters,

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and the Coalition Parties Reform Committee. The separate political and inter-administrative negotiations played complementary roles, as politicians gave administrators a mandate toward reforms, and the administrators silenced conservative minorities in the parties.

Economic planners in market-oriented health policies.

Interestingly, the 1990s saw economic planners become liberal economists. This section briefly considers the reasons that led an entity primarily known for its administrative guidance and concentration of authority, plan for deregulation and market competition after 1990. The changing conditions surrounding employment and the rise of the service economy are particularly emphasized as two factors that limited the role of MITI in the new economy.

The introduction of reforms is a consequence of policy shifts toward the promotion of third sector industries within MITI from 1990 because its traditional jurisdiction had been affected by economic changes. First, the increase in profits among Japanese consortiums distanced government administrative guidance from firms’ management given the reliance of MITI’s administrative guidance on financial and tax incentives rather than direct authorizations. The financial independence of big firms from MITI’s financial power gave them the freedom to accept or refuse research funds, or simply cooperate on the surface with the authority.

21 The argument that industries only give an appearance of cooperation is supported by Scott Callon, Divided Sun: MITI and the Breakdown of Japanese High-Tech Industrial Policy (Stanford: Stanford University Press,
Second, after the years 1975, MITI’s authority was affected by business delocalization, a phenomenon primarily recognized by the administration in 1990.22 The following decades were marked by important employment transitions that the MITI administration attempted to compensate by developing the service economy, and consider reforms in the regulatory environment of every administration.

Table 11. Employment transition in Japan 1960-1996 (thousand people)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td>5,180</td>
<td>6,190</td>
<td>7,630</td>
<td>8,740</td>
<td>11,950</td>
<td>13,890</td>
<td>15,420</td>
<td>15,980</td>
<td>308%</td>
</tr>
<tr>
<td>Commerc.</td>
<td>6,920</td>
<td>8,490</td>
<td>10,060</td>
<td>11,380</td>
<td>13,380</td>
<td>13,830</td>
<td>14,430</td>
<td>14,630</td>
<td>211%</td>
</tr>
<tr>
<td>Manufact.</td>
<td>9,550</td>
<td>11,690</td>
<td>13,680</td>
<td>13,240</td>
<td>13,970</td>
<td>14,540</td>
<td>14,960</td>
<td>14,450</td>
<td>151%</td>
</tr>
<tr>
<td>Agricult.</td>
<td>13,120</td>
<td>10,870</td>
<td>9,330</td>
<td>6,700</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Japan. Ministry of Labor, Rodoryoku Chosa [Inquiry on the labor force], 1994-96

The slow growth and decline in employment affecting first sector industries and manufacturing has been partly compensated by employment creation in services. By 1996, third sector industries guaranteed 62 percent of Japanese employment.23 Services provide employment for 25.8 percent of the Japanese active population, compared with 25.4 percent in the United States.24 Lowest employment provider among five wide categories in 1960, the service economy employs, after 1994, more people than any other sector, including the historically important fields of commerce and manufacturing.

24 These numbers also hide subtle social differences between the two economies, where legal and consulting services are relatively higher preoccupations in the United States (5.1 percent of labor) compared to Japan (1.5 percent of labor). Education stands at 3.4 percent in Japan versus 7.5 percent in the United States, and
The significance of these shifts transgresses the borders of government authority. The growth in services clashes with numerous regulations on service sector activities arguably inhibiting employment transitions to growing economic fields. Awareness of these difficulties became a central question for the Ministry of International Trade.25

Employment shifts are paralleled by fears in private sector industry associations that problems linked to aging and industry delocalization might provoke a sudden decline of employment in manufacturing. Industry delocalization must be answered, according to the main industry association, the Keidanren, by a gradual elimination of lifetime employment and seniority systems endangering competitiveness and posing hindrances to the creation of new growth fields.26 Similarly, MITI has become an ardent defender of deregulation to promote adaptation to economic trends. With the publication in 1994 of its "21st century industrial structure" and subsequent economic planning papers, the administration has made industry deregulation a policymaking priority.

From the point of view of the Ministry of International Trade, the relative decline of primary and secondary sectors industries, depicted in Table 12, threatens the economic significance of industries belonging to its exclusive jurisdictional authority. These trends create pressures on the administration to reform or be reformed, and to find new ways to increase its role in the future leading sectors of the economy; the service sectors. Overall,

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Table 12. Employment development 1992-2010 (previsions; thousand people)

<table>
<thead>
<tr>
<th>Industry</th>
<th>1992</th>
<th>2000</th>
<th>2010 previsions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Declining industries</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation-shipping</td>
<td>14,440</td>
<td>14,050</td>
<td>13,070</td>
</tr>
<tr>
<td>Mining-construction</td>
<td>6,810</td>
<td>7,510</td>
<td>5,900</td>
</tr>
<tr>
<td>Non-metal raw materials</td>
<td>1,570</td>
<td>1,490</td>
<td>1,460</td>
</tr>
<tr>
<td>Metallic materials</td>
<td>1,760</td>
<td>1,620</td>
<td>1,480</td>
</tr>
<tr>
<td>Machine tools</td>
<td>3,620</td>
<td>3,450</td>
<td>3,540</td>
</tr>
<tr>
<td>Other manufacturing</td>
<td>2,670</td>
<td>2,650</td>
<td>2,510</td>
</tr>
<tr>
<td>Others (First sector)</td>
<td>4,870</td>
<td>4,520</td>
<td>2,650</td>
</tr>
<tr>
<td><strong>Expanding industries</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance management</td>
<td>4,000</td>
<td>4,240</td>
<td>4,370</td>
</tr>
<tr>
<td>Education, medical services</td>
<td>8,020</td>
<td>8,930</td>
<td>9,390</td>
</tr>
<tr>
<td>Industry related services</td>
<td>3,870</td>
<td>6,200</td>
<td>8,940</td>
</tr>
<tr>
<td>Other services (trading etc.)</td>
<td>6,850</td>
<td>8,480</td>
<td>9,830</td>
</tr>
<tr>
<td>Electrical-electric apparels</td>
<td>2,530</td>
<td>2,610</td>
<td>2,550</td>
</tr>
<tr>
<td>Electricity- gas related</td>
<td>230</td>
<td>230</td>
<td>240</td>
</tr>
<tr>
<td>Water-sewage</td>
<td>420</td>
<td>450</td>
<td>490</td>
</tr>
</tbody>
</table>


Administrative actors had an interest to design their own plans to develop and sustain the service sectors. The service sector, however, cuts across numerous jurisdictional fields, from the Labor Ministry, the Ministry of Post and Telecommunication, to the Welfare Ministry. Each jurisdictional field has acquired regulatory specificity over the years, where the administrations of labor and welfare in particular have tended to tighten regulations as to allow for predictability rather than promoting market forces. The
regulatory authority of each ministry ranges from the design of policy orientation to the minutia of daily operations.

Debates within the Industrial Structure Council on its new industrial policy program were launched in 1990. The main points emphasized by the economic program were the elimination of the price gap between domestic and international markets (a problem related to the market for medicines in relation to the MHW). MITI defended this idea for various economic sectors to the Diet in 1996. From a consumer point of view, it urged the provision of proper information to consumers (later defined in terms of deregulation of publicity rules and access to medical files for patients). It asked for clarity in domestic price setting mechanisms, and the promotion of technological development in health care (in relation to price setting mechanisms for drugs and medical services). The program also promoted a revision of the health care and nursing systems to provide responses to problems linked to the aging of the population, as well as the development of services for the elderly. This last point met objectives already set by the MHW Golden Plan in 1989.

As an administrator within the Ministry of Health and Welfare view the situation, "the marketization of the world economy touched the administration of health care in Japan..."
with pressures toward deregulation.\textsuperscript{31} Closely linked to the original Hashimoto proposals, the Service Bureau of the Ministry of Trade argued that while after the war "the management of markets by the administration was appropriate," changes in the fiscal situation and the need to care for an aging population prompted the government to call for "the introduction of competitive market principles into health care."\textsuperscript{32}

Economic planners originally attempted to directly negotiate with competing administrations. MHW officials did consider various roads to reforming health care in January 1990, but the Ministry limited its inquiry to the enunciation of general goals (the improvement in service quality, free consumer choice, and publicity rules relaxation) with no practical measures as it would only "propose legal revisions to the extent that related groups approve of their content."\textsuperscript{33}

It is only in 1994 that the Diet approved inter-ministerial cooperation to meet the goals of economic planning.\textsuperscript{34} The promotion of services was not yet a central concern of the revitalization policy, and while the proposals were subsequently promoted by the Japan Productivity Center for Socio-economic Development (\textit{Shakai Keizai Seisansei Honbu}), an entity affiliated to MITI, the MHW remained skeptical of markets principles.\textsuperscript{35}

\begin{thebibliography}{99}
\bibitem{Kenporen} Kenporen, 1993, 596; Yoshihara and Wada, \textit{Iryo Seido Shi}: 383 and 404.
\bibitem{Yashiro} Yashiro, Naohiro, \textit{Kaikaku shido suru nihon no iryo sa-visu}: 4-5.
\bibitem{Comprehensive} This was adopted as the Comprehensive Economic Measures for the coordination of policies toward the creation of new industries. It was announced on 8 Feb. 1994.
\bibitem{Japan} The proposals it supported were essentially resting on "creation of more active nursing, and home services", "expansion of user's freedom and choice" and "the creation of incentives to improve efficiency in health care." Japan Productivity Center for Socio-economic Development, \textit{Fukushi Seisaku no Kakuritsu ni Mukete} [Toward the definition of welfare policies] 21 Aug. 1996. \textit{Shukan Shakai Hosho} 1902 (2 Sept. 1996): 20.
\end{thebibliography}
Between 1990 and 1997, the MITI administration urged reforms toward the introduction of market principles in a total of eight fields. "Aiming at the provision of efficient services involving private actors," the administration attempted anew "to introduce market mechanisms in health care."36 Lacking specific expertise to design detailed reforms, and necessitating support from related interest groups, the administration "consulted with all related consultation bodies to identify the main problems related to the administration and offer of health care services."37 Independent policy experts thus became central in the promotion of regulatory change in the MHW.

The ability of MITI to independently promote its economic program was practically nil, as it lacked the means to enforce its proposal. It is only under the national council that the EPA Working Group on Health Care urged and negotiated with the Ministry of Health and Welfare means to introduce market mechanisms and principles of competition after April 1996. In doing so, the MHW identified policy objectives that suited its administration and the proposals of independent policy experts. These proposals rested on the need to increase transparency and information on services, the need for transparent pricing mechanisms and greater competition among medical institutions.38 MITI's objectives were the same as the ones adopted by the EPA and a number of independent policy experts.39

39 Interview: MITI Health Care Research Committee, member. 20 Apr. 2001
The stance of economic planners became more reactive under the policy competition mechanisms instigated by the national council as independent experts took over. Rather than the fee-for-service system determining physicians' honorarium, MITI nonetheless supported the proposal studied in the MHW to introduce a diagnoses-related honorarium system as a means to increase transparency in health care, a proposal that was also backed by the Finance administration as a means to reduce expenses. This system, introduced experimentally in a group of ten hospitals as of 1990, would enable further control over quality and doctors' expertise, while eliminating frauds.

MITI’s White Paper on International Trade submitted to the Cabinet in May 2000 was also taken as an opportunity to stress the need for reform, by subtly introducing international comparisons on health care services. The White Paper particularly stressed the role of the American Professional Review Organizations in evaluating medical institutions according to their services and prices. “Efficient health care services are created elsewhere through the introduction of market principles. To achieve this, greater transparency, information disclosure, and the introduction of an evaluation mechanism for health care institutions are necessary [in Japan].”

Executive appeal for reform

The economic reform program gathered support in July 1995 as the Social Security System Deliberation Council attached to the Prime Minister’s office made clear its perceived need to restructure the welfare system. It requested the provision of choices among health care services and increases in the efficiency of services. The Social Security
Council went further than MITI in advising somewhat surprisingly that "profit-oriented services should be introduced as a means to increase the efficiency of services and respond to individual expectations." Economic planners had moderately supported a similar goal by requesting the offer of parallel health care services for which free-pricing mechanisms would apply and for which patients would assume all costs.

These principles did not find numerous supporters among health care personnel fearing that profit-making of health care would Americanize the system to the point where income would be key in the selection of patients, that costs would drastically increase in certain institutions, and that the needs of the general population would be neglected. The JMA was particularly adamant in arguing that hospitals would not be able to adjust to the changes, and that making sense of the excessive flow of publicity and information was a problem plaguing the American system.

The prime minister’s deliberation council further adopted the position that market principles should be introduced by making “contracts” the form of future relationships between clients and practitioners of health care. Whereas contractual arrangements were already agreed upon as part of the nursing insurance system for day care home helpers and elderly homes, the executive insisted on the extension of this principle to all welfare related services through private providers. This radical departure from administratively planned demand and offer was supported by 70 percent of individuals questioned as part of the

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42 See Yashiro, Naohiro, Kaikaku Shido Suru Nihon no Iryo Sa-visu: 114
43 These discussions are summarized in Shukan Shakai Hosho 2022 (25 Jan. 1999): 6-10.
secretariat's investigation. Again, the JMA warned that “although mixed services are allowed under the current system, expanding such mechanisms will simply increase the patients' burden.”

The Ministry of Finance in health care reforms

In a well-organized scheme, the Hashimoto Cabinet in 1996 increased the pressure toward reform by allying Finance administrators and the Financial Systems Council which requested the introduction of market principles as a means to increase efficiency in services. The Ministry of Finance argued for the introduction of market mechanisms in welfare, and contractual relationships as means to increase the efficiency of services.

Mandated by the Hashimoto administration to solve the financial difficulties of the government and particularly in the field of welfare and health care, the Financial Systems Council of the Ministry of Finance published its reform proposal in July 1996 to cover reforms in twelve fields. The report echoed the voice of the Industrial Structure Council in its recommending “a switch toward a system recognizing the responsibility of patients in choosing services.” Similarly, the Financial Systems Council recognized the need to integrate “incentives toward better quality care through the introduction of market competition” in medicine price determination, and doctors' honorarium as means to reduce welfare expenses. Its report pointed out that the health care system indirectly encouraged

44 Information Section of the Prime Minister' Office, Mutsu no Kaikaku ni Tsuite no Yushikisha Anke-to Chosa [Inquiry with specialists on the six reforms] Aug. 1997.
over-prescription of medicines and the “wrong use of financial resources.” The Ministry of Finance supported the introduction of a fee schedule system based on a fixed price for health care services, referred to as Diagnoses-Related Groups (DRG), or inclusive payment mechanisms. It recommended increasing the individual share of treatment costs as a means to foster patient responsibility toward service quality.

Finally, the MoF supported the idea to create more nursing and home services for patients “given the high costs related to hospital treatments.” Profit making was also supported with the argument that “administrative determination in the offer of services is not appropriate, and efficiency is reduced by the lack of market incentives.” The Hashimoto Administrative Reform Council called upon the MHW to conduct consultations on reform with the member of all consultation bodies.48 The national council became a means to achieve a reduction in a Health and Welfare budget already occupying 30 percent of the national budget.

*Origins of reforms in the Ministry of Health and Welfare*

The various appeals for reform from the opposition parties and the Hashimoto proposals spread both support and opposition within the Ministry of Health and Welfare. The Central Medical Council considered reforms in 1991 as it entertained the idea that patients ought to be made more responsible in choosing services, and supported the creation of evaluation mechanisms for hospitals and health care institutions. The committee stopped

short of supporting the introduction of market principles. As of February 1995, the Health Minister's private consultation body, the Roundtable on Information and Health Care Services, merely reconfirmed its acceptance of the national council's proposals on the need to improve the provision of services in the health care sector, yet proposing no specific measures to achieve these goals.

The MHW also counted with its reformist wing, spreading from the Yoshimura team active in the 1980s, which had already recommended patient evaluation of services. Yamaguchi Takehiko became one of the main supporters of reforms in the MHW after the Hashimoto Reform Council was established, as he argued that: “It becomes an urgent question to take position in debates on revisions of the medical insurance which currently faces deficit, as prescribed by the committee on financial structure reform.” Within the Ministry, Yamaguchi gathered deliberation councils to support this cause, without forging unity in the administration.

A research committee primarily formed of economists was organized at the instigation of the Social Protection Bureau Chief of the MHW in November 1997. Reflecting on the proposals of the national council, it recommended the creation of services based on market principles and individual choices. The MHW Minister aimed at bringing

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48 These were the Conference of Consultative Bodies Chairmen, the Consultation Table of Ministry Secretaries, the Medical Council, the Medical Insurance Council, the Elderly Welfare Council, and the Central Medical Council. *Shukan Shakai Hosho* 1899 (22 Jul. 1996): 12.


51 I thank John Campbell for pointing this out.

reform legislation to the Diet by 1999 but this was over-evaluating the capacity to create consensus among its numerous decision-making bodies.

The Social Welfare Reform Committee of the Central Social Welfare Council adopted a more prudent stance toward reform, vaguely stating the need to “ensure the relation” between clients and service providers; the need to “maintain [rather than create] high quality and efficient services”; and the need to “confirm [rather than increase] the clarity of procedures to make health care information accessible to the public.” The committee recommended the provision of clearer information on services to patients and the introduction private administrators in the management of elderly services. It proposed new principles in the design of health care, by placing individual satisfaction, rather than the equal offer of services to all, as the central principle for reforming health services. As it was an advisory forum composed of private individuals, however, it had little impact on the general direction of reforms within the MHW. Its proposals were to be discussed within the Central Social Welfare Council.

The aims of Prime Minister’s Hashimoto national council and related consultation bodies might have been too ambitious given the importance of physicians in all the main decision-making bodies of the Ministry of Health. The Central Social Welfare Council did not necessarily reject the need for “fundamental reform,” and instead of negating the aims of the market-oriented proposals, it simply called for “policies ensuring [within the current administratively managed system that is] the offer of efficient, high quality patient oriented

services." The Council recognized that postwar health care services made do without the opinion and desires of patients and that the offer of services had been determined administratively without the provision of choices to patients. The Council supported in principle the creation of a system "recognizing the right to choose to patients and the need to implement contractual relationships between patients and practitioners."  

*Impetus from the Administrative Reform Council*

Pressures from the Inter-party Committee on Health Care Reform and the LDP Reform Headquarters became necessary to give shape to specific proposals in the MHW. The MHW which had kept silent on the issue of the provision of patient files suddenly supported information disclosure after the Inter-party Committee produced its first report in June 1996. It proposed to rely more directly on markets for medicine price settings, and requested change in the medical honorarium system. Yamaguchi Takehiko became Insurance Bureau Chief in 1996 and in a first gathering with all sections chiefs related to the Bureau, emphasized the "need to proceed with reforms in 1997 given the deficit affecting all the medical insurance programs." The Bureau Chief further mandated the Medical Insurance Deliberation Council and the committee gathering all advisory councils' chairmen to proceed with reform proposals for a submission to the Diet by the end of 1997.

The provision of transparent information to patients occupied a central position in the revitalization strategy of the national council. The MHW which had taken a passive stance on the issue prior to July 1996 openly voiced its approval for the inter-party

55 Ibid, 42-3.
agreement supporting changes in publicity rules, the opening of patient files as means to give access to second opinion, and reduce the monopoly of physicians on information.\(^{57}\)

Within the Ministry, the Prime Minister Secretary for Health and Welfare, Itoh Masaharu, supported the position, arguing for the need to improve the quality of services for patients, a policy objective which depended on "informed consent" by patients.\(^{58}\)

Within the LDP, reforms were supported prudently under the leadership of the Reform Headquarters in consideration for the Medical Association having the most to lose from the introduction of market ideas. Health and Welfare Minister Koizumi who in other spheres was a well-known supporter of privatization, held for medical services a milder attitude. "Health care services are different from other economic activities. As they are part of the 'regulated economy,' demand and offer principles on which markets rest do not necessarily apply." He agreed, however, with the "need to introduce principles of competition to the extent possible."\(^{59}\)

**Conclusion**

The Hashimoto national council relied on similar strategies to the Nakasone council, with the creation of a supra-ministerial committee to carry out deliberations and decide the content of reforms without obstruction from party members and organized interests. This was achieved in two ways.

First, relations with party members were delegated to the LDP Reform

\(^{56}\) *Shukan Shakai Hosho* 1903 (9 Sept. 1996): 16.


\(^{58}\) These remarks were made during a reunion of the Japanese Medical Association, *21seiki no iryo taisei* [Symposium on the Health care System]. *Shukan Shakai Hosho* 1835 (17 Apr. 1995): 15.
Headquarters headed by Muto Kabun. LDP representatives to the Council represented the group of Diet members linked to the administrations of MITI and MoF, the so-called commerce and finance-related zoku members.

Second, the various administrations reported to the Headquarters and to the Inter-Party Reform Committee on proposals for deregulation they had considered in inter-ministerial talks. The inter-administrative negotiations were carried out according to principles defined by MITI, MoF, and independent economists, and policy options identified by the sectoral ministries such as the MHW. This process allowed the executive to determine the content of reforms in conjunction with the administrations.

As far as Hashimoto personally assumed the presidency of the Administrative Reform Council and the Financial Reform Conference, however, he became an easy target of criticism from welfare-related Diet members. The technical nature of most of the proposals made it difficult for the media to report on the council’s progress. This stood in contrast with the Nakasone strategy relying on a delegation of various posts to highly trained and respected personalities from the financial world to publicly phrase reforms and test public responses.60

Third, the Reform Council was organized amid the presence of a coalition government in which the Liberal Democratic Party shared power with the Socialist and Sakigake parties from June 1996, although both parties retired from the Cabinet in

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60 Hashimoto assumed the executive position “one of the most popular leader of Japan” with a support rate of 61% (Jan. 1996). The support rate suffered from the choice of convicted bribe-taker Koto Sato at the Administrative Agency (35.7% support rate in Sept. 1997). The support rate was only 28% as of April 1998 as corruption scandals hit the Ministry of Finance and the government stimulus package was negatively perceived. The technical nature of the Reform Council failed to increase popular trust in the government initiatives. Asahi Shimbun, 12 Mar. 1996; 17 Sept. 1997; 27 Apr. 1998.
November 1996 and left the coalition in April 1998. Under the coalition government, the newly created Inter-Party Policy Coordination Committee played an important role in promoting reforms in the Diet, particularly health care-related reforms, although it limited the extent of financial reforms and cancelled efforts at privatizing public financial services offered through the Ministry of Post and Telecommunications.

Under the Obuchi administration a new coalition government was formed with the Liberal Party in July 1998 with the participation of the Komeito after July 1999. The new coalition retreated on some of the compromises and as the executive office returned to its previous passivity (Obuchi was popular, yet referred to as the “cold pizza”), the LDP executive encouraged the administration to proceed with the implementation of reforms through administrative guidelines rather than legislative proposals, as the latter would require the approval of the LDP Policy Affairs Research Commission for Medical Care.
Chapter 7
Reforming the medicine pricing system

Until 1955, physicians were forbidden from directly providing drugs to patients or making any profits from the sale of medicines in Japan. The system was simplified in 1956 under an agreement between the JMA and the LDP, and allowed the dispensing of drugs by health care institutions in public or university hospitals and physicians in private clinics.\(^1\) The system was criticized by independent analysts, by MHW administrators and later by MITI reformists for encouraging physicians in dispensing numerous drugs to increase their revenues.

The physicians’ share of profits from prescriptions was reduced to a mere 2 percent in 2001, widening their policy preferences to a point where they practically stopped posing hurdles to regulatory changes in the determination of medicine prices. The Pharmaceutical Manufacturers Association which had the most to lose from the reform endlessly requested free markets, in vein, under the council, although the new price setting mechanisms adopted in 2001 are a means to promote competition among pharmaceutical firms.

*Medicine prices determination mechanisms*

Medicine prices are determined by the Ministry of Health and Welfare in Japan, under a pricing system originally established in 1950. This “bulk line” system originally set prices at a level corresponding to 90 percent of the highest production cost among all
providers for each medicine. It implied that pharmaceutical firms could influence prices by artificially producing smaller amounts of medicines at higher costs, allowing numerous small and comparatively inefficient producers to survive. MHW Minister Sonoda recognized the difficulty in 1981 as “various problems and price gaps emerge from the bulk line system,” and pledged to increase the transparency of the price determination process “as if only a glass or a vinyl surrounded the process.”

The centrally managed nature of this system allowed a certain bias from market prices. Important pharmaceutical companies often requested the creation of a free market pricing system as a means to increase their autonomy. In its yearly investigation on medicine prices, the MHW administration set the bulk line at 81 percent in 1983, and further reduced prices a second time in March 1984. The Ministry of Finance played an important role in urging the MHW to further reduce prices, and seven rounds of price reductions were carried out until April 1992. In total, medicine prices were reduced by 16 percent, decreasing physicians’ income by 6.1 percent. Public administrators never backed an approach that would eliminate small firms, but still had recognized a price bias in 1997 as “the price for highly traded medicines would have to be cut by 10 percent to remain closer to market prices.”

1 Yoshihara and Wada, Iryo Seido Shi: 152.
2 In other words, as various companies provide the same drug at a different production bulk costs, prices were determined by cutting a line at a level of 90% of the costliest provider. Hasegawa Hisashi, Iyakuhin: Sangyo no Showa Shakaishi. [Medicines: a social history of the industry since Showa] (Tokyo: Nihon Keizai Hyoron Sha, 1986) 75-6.
Price inflation was countered by replacing the bulk price with a volume-adjusted means in 1994, rendering price inflation impossible. The difference allowed between the market price and the price paid by insurers was referred to as the "reasonable zone" (R-haba), meant to account for administrative costs. This was an important change, eliminating the possibility for manufacturers to influence prices by reducing outputs. Administrative costs were originally set at 15 percent, but price differences between Japan and other industrialized economies remained high amid these corrective measures. Medicines were costlier in the United States than in Japan, but the overall price gap with all industrialized countries was evaluated at 23.1 percent in 1992, 19.6 percent in 1994, and 17.8 percent in 1996.7

Three reasons why expenses for drugs are high in Japan can be pointed out. First, pharmaceutical companies earn more profits for new drugs than generic drugs; they tend to produce and market the former more aggressively. Second, it is estimated that physicians fill approximately 70 percent of prescriptions themselves rather than relying on pharmacists.8 Physicians who dispense drugs have brand loyalty and rely less on low-cost brands. Generic drugs account for only 11 percent of total sales and are produced by small-scale manufacturers.9 Third, as patients did not share the costs of medications until the year 2000, they rarely questioned the physician's choice. In negotiations with economic planners in 1996, the Medical Association could only agree that: "Medical institutions have

8 The Japan Pharmaceutical Association estimated that only 30 percent prescriptions were filled by pharmacists as of 1998. Japan Pharmaceutical Manufacturers Association, Pharmaceutical Administration and Regulation in Japan Apr. 2001. 85.
a propensity to dispense high cost drugs to take advantage of the price gap between generic and brand products."\(^{10}\)

For the economic planners at MITI and the EPA, high medicine prices reflected a lack in the qualification of certain specialists who relied too heavily on drugs. This opinion was echoed in various health care councils in agreement that the medical fee schedule system should allow for the evaluation of doctors' skills and compensate specialists according to the type of treatment they carry out rather than the amount of drugs they prescribed.\(^{11}\) The average number of medicines per prescription was greater in Japan than in other economies (Table 13)

Table 13. Average number of medicines per prescription in three countries

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<tr>
<td>France</td>
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Second, MITI and other specialists pointed out the incentive to prescribe newer and more expensive medicines for doctors receiving a percentage of the total costs of sales. Increasing the transparency of medicine price determination mechanisms would further eliminate the possibility of collusion between interested actors, although direct contracting between medical institutions and pharmaceutical firms for the promotion of certain drugs


had been made illegal in 1992.\textsuperscript{12} The cost of medicines in proportion to the total cost of health care was significantly higher in Japan than in other OECD countries, including the United States, as shown in Table 14.

Table 14. Drug costs in proportion to the total cost of health care in five countries (% 1993)

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<th>Japan</th>
<th>France</th>
<th>Germany</th>
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<tr>
<td></td>
<td>29.5%</td>
<td>19.9%</td>
<td>17.1%</td>
<td>16.4%</td>
<td>11.3%</td>
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Third, economic planners argued that the introduction of market competition among brand names and pharmaceutical companies would reduce their dependence on government regulations to compete internationally and promote the consolidation of an industry that remained overly de-concentrated. Japan still counted 1400 pharmaceutical firms in 1998 compared with 800 firms in the larger health market of the United States.\textsuperscript{13} The de-concentrated nature of the industry eventually favored potential takeovers from international competitors once such investments were allowed in the early 1970s and the recession hit in the 1990s.\textsuperscript{14} At that point, consolidating the industry through heightened competition became a challenge for the inter-ministerial negotiations between economic planners and the healthcare administration. The pricing system became the means to inflict such a pressure by “creating medicine groups and determining prices so that competition

\textsuperscript{12} Yashiro, \textit{Kaikaku shido suru nihon no iryo sa-visu}: 86-9.
\textsuperscript{13} Japan Pharmaceutical Association, 1998.
\textsuperscript{14} As the Head of the Coalition Government Medical Insurance System Reform Committee [\textit{Yoto Iryo Hoken Seido Kaikaku Kyogikai}], Niwa Yuya, argued, “The Japanese pharmaceutical industry lags behind world makers. The source of the problem (...) is that product development is insufficient. Even if companies do not develop innovative medicines, our pricing system protects the profits of the industry.” \textit{Shukan Shakai Hosho} 1987 (11 Apr. 1998): 6-11
among brands ensues. The Ministry of Finance similarly promoted reforms to 
"eliminate the price gap, cancel the current price setting mechanisms and introduce market 
transactions." 

Policy competition on medicine pricing systems

During the years 1996-1999, four different policy proposals were submitted to 
induce competitiveness and price reductions. The coalition government based its 
recommendation on the report it gathered from the Planning Agency’s Economic Council 
under which negotiations between MoF, MITI, and the MHW and economists were carried 
out.

The three coalition parties requested that “market transactions be at the basis of the 
current system” while recommending studies and comparisons between the systems 
existing in other countries, such as the reference price system, the compensatory system, 
and market pricing systems. The support for “market principles” by the government 
certainly pleased the Kenporen and Industry Association Nikkeiren commonly supporting a 
reference pricing system.

Few months after this position was made public, the MHW produced its proposal 
to the coalition government. “The current pricing system is one of the reasons why health 
care costs are perpetually increasing: the system encourages the use of more expensive new

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15 Another innovation was included in the pricing system as of 1991 in the form of three types of premiums 
for innovation, usefulness, and market size. Conference of Insurance Bureaus, 9 January 1999. Quoted in 
17 MITI’s Policy Bureau also defended its argument to the Diet. Japan. Diet Records. Upper House Council 
medicines, it encourages physicians to prescribe in great quantities, the system also creates important price differences between medicines of similar value.”

It supported the introduction of a reference pricing system in which medicine would be grouped according to their nature and efficiency, with a single price fixed for every medicine within a group. Reference prices would be determined by free market exchanges, and discussed in ministerial committees. Reference prices would indicate the level at which insurers reimburse patients, with the latter assuming any costs above the indicated level. “The current proposal would eliminate the current price system, and based on the real market prices it would determine for each group of medicines the level at which insurers will offer compensation.”

For Insurance Bureau Chief Takamoto, this system offered the advantages of “clarity in the price determination mechanisms, and would encourage the provision of proper information to patients.”

This proposal gained the support of both MITI and the coalition government recommendation report.

The MHW was far from controlling the decision-making process, however, as proposals multiplied in the various discussion forums. Within the coalition itself, the Social Democratic Party (Shakai Minshuto) expressed criticisms. It argued that “prices should be determined in a system of public competition,” and produced a separate proposal. The new system, it argued, should be organized on formal market settings, with insurers and manufacturers agreeing among themselves on prices. The Social Democratic Party finally

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supported the coalition proposal, although it remained opposed to a Swedish-style Reference Pricing System which groups medicines according to their use, irrelevant of production prices. Its position remained closer to the existing “Bulk Line” system which accounted for production prices and was well established for over forty years. The “Bulk Line” system, it argued, could be palliated by making medicine prices public to counterbalance the lack of transparency of price setting ministerial committees in which manufacturers participated. The second coalition partner, Sakigake, was sympathetic to the proposed reform while emphasizing the need for more transparency. “The new system could allow another price gap to appear if the price determination process is not transparent. The efficiency of the new system would depend on a clear provision of information to interested parties.” 22

The JMA opposed the reform proposal. “There are risks that the market based price determination mechanisms would not indicate the appropriate prices at which insurers should reimburse patients.” 23 This, the Association argued, would force patients to assume an important part of costs or abandon the use of expensive medicines. The JMA rather proposed a system where insurers would negotiate prices with pharmaceutical companies within the established structure of the Central Medical Council. A fourth policy proposal emerged from the largest pharmaceutical companies which, predictably, supported free market principles.

23 Ibid, 14.
Attempt to re-institutionalize the decision-making process

At the same time MITI had completed its review of health care reform with the creation of a committee of experts, the MHW created a new deliberation council formed exclusively with experts taken from independent corporations, labor unions, professors, and only one member of the JMA. The MHW seemingly attached great importance to this new Medical Insurance and Welfare Council which, for the first time in the history of the Ministry, elected a chairwoman.\(^{24}\) In appearance, the MHW was trying to reduce the influence of interest groups in the reform process. The Insurance Bureau inevitably controlled the information provided to Council members. It asked for the members' opinion on the creation of a reference pricing system and requested proposals on the means through which groupings of drugs could be achieved.

The Head of the Insurance Planning Section of the MHW, Nakamura, aimed at presenting a proposal to the Diet by the end of March 1998 but the attempt failed. Bypassing the Central Medical Council prior to submitting a proposal the Diet would have forced politicians to intervene in the policymaking process and readjust the balance between the Ministry and interest groups, as it had done previously. The Insurance Bureau Chief insisted six months later on “the need to carry further consultations” in the Central Medical Council, an argument that MHW Minister Koizumi approved although he had personally pledged to reduce the influence of special interests in advisory councils.\(^{25}\)

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Deliberations were centered in the Central Medical Council after April 1998 and the discussions being carried out in the newly created Medical Insurance and Welfare Council became but a background noise. The report it submitted nonetheless deserves attention as it thoroughly investigated the various reform proposals. The Council strongly argued in favor of reference pricing, as "competition should be created among the various brands by grouping medicines." This would force pharmaceutical companies to distinguish themselves with new products and research rather than brand names and publicity. Patients, the committee argued, should contribute a portion of medicine costs as to promote competition among producers in terms of prices and quality. Finally, the government should fix medicine prices "with market principles in mind." The Council had four principles in mind; the promotion of research, the creation of evaluation mechanisms in health care, the introduction of percentile co-payments for patients to be informed on prices, and the provision of choices to consumers. Interestingly, these were the principles defended by the Industrial Structure Council since 1990, backed by the MoF, industry associations, the LDP commerce-related Diet members and the reformist wing of the MHW.

Among the four policy proposals existing on drug pricing, the independent experts committee favored reference pricing as it would allow price reduction while ensuring the trickling down of information to patients. Market pricing would run against the principles of equality central to the welfare system. Price negotiations between producers and physicians, as promoted by the Medical Association, would limit information disclosure and should be treated with "prudence" [i.e. should be rejected].

The expert committee could not, however, offer a unanimous voice on reforms. First, the grouping of drugs would, in the eyes of the JMA representative, impede the selection of the most appropriate medicine for any single patient. (A majority of participants nonetheless argued that a rational grouping of medicines “according to the use and efficiency of every drug” was possible.) Second, critics pointed out that “the implementation of a percentile co-payment for patients would not guarantee that cheaper medicines will be chosen.” In Germany, although price reduction had been attained the implementation of a similar grouping system, new medicines not included in reference groups had been highly priced and promoted by providers.

Regardless of the conclusions of the independent experts, moreover, debates started under a coalition government formed by the LDP, the Social Democratic Party, and the Sakigake, and final proposals were presented to a different coalition government. Within the new coalition, the Liberal Party was a strong supporter of reforms, but the previous pledge to carry out reforms taken under the Financial Structure Council was relaxed, and the LDP had more room to maneuver with interest groups.

**Physicians-LDP decision-making**

Once the Administrative Reform Council ended, Obuchi Keizo was elected Prime Minister and the LDP Policy Affairs Research Commission for Medical Care linked to the interests of the medical associations could resume its role in the policy process. This jeopardized the proposals of the national council and the reformist opposition made it clear in the Diet:

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27 Ibid, 43.
Hasn’t the LDP abandoned the public commitments it made in the Reform Council? The authority of the Cabinet is being put into question by Diet members and this is extremely worrisome. We were informed that the MHW was about to present its report to the LDP PARC for Medical Care of the Social Division [of the LDP] but was prevented from doing so by the Committee members.  

By April 1999, in what amounted to a tacit support for the Medical Association, the LDP declared no longer supporting any reform in particular. Officially, it considered equally potent the four existing proposals: The MHW reference-pricing compensation scheme, the JMA pricing system centered on the Central Medical Council, and the free market principles promoted by pharmaceuticals companies. In effect the LDP centered decision-making on the Central Medical Council. The JMA had already exposed its displeasure with the position of the previous coalition government whose “proposals utterly lacked clarity.”

The principles advocated by reformers nonetheless resisted criticisms. The JMA requested that a council formed by government and interest group representatives be in charge of determining prices “in a transparent process,” while ensuring the elimination of price gaps between generic and newly created medicines having similar use and efficiency. The Pharmaceutical Association inevitably rejected this unique pricing method, and requested “transparency” to be guaranteed through a more independent body.

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The LDP's retraction provoked the fury of industry association representatives: "zettai yurusarenai," "we will not allow the reform to be postponed."\textsuperscript{31} By means of its Committee on Drug Prices (Yakka senmon bōkai), the Central Medical Council also decided, by November 1999 and after practically three years of debates, "to consider again the arguments supporting each reform proposal."\textsuperscript{32} With this, the Central Medical Council reversed the previous support for reform from the Medical and Welfare Council in favor of a system with fixed reference prices.

In LDP consultations with interest groups, the JMA, arguably the "top batter", also backed down on its previous reform proposals, now supporting the status quo with prices determined in a volume-adjusted bulk line.\textsuperscript{33} Reforms would mostly focus on the implementation of transparent pricing mechanisms, and proper evaluation of the use and efficiency of medical products.

The Insurance Societies, backed by the Industry Association Nikkeiren, the Labor Union Rengo, and the National Insurance Council, reluctantly reopened the policy process by supporting a common position: "Do not postpone the implementation of reform beyond April 2000."\textsuperscript{34} The associations maintained their support for reference pricing, and would eventually make their point in the MHW. The Ministry had already been mandated by the Inter-party Reform Committee, and could make do without directly appealing to the LDP unless directly called by the party executive to put a halt to the reform process.

\textsuperscript{31} Shukan Shakai Hosho 2037 (17 May 1999): 40.
\textsuperscript{32} Shukan Shakai Hosho 2062 (15 Nov. 1999): 3.
\textsuperscript{33} Shukan Shakai Hosho 2038 (24 May 1999): 3.
\textsuperscript{34} Shukan Shakai Hosho 2037 (17 May 1999): 42.
Chances that the JMA influence the final outcome were still real at that point. The position of the Central Medical Council played the most in the balance, in part due to meetings between the LDP and JMA President Tsuboi. “Although my perception—that the deliberation process until now has been a loss of time and money—has not vanished, as a way to catch up on this delay proper policy proposals must be put forth [to the LDP].”

JMA President Tsuboi organized meetings with the MHW, the LDP Policy Affairs Research Commission for Medical Care and the Party’s Social Affairs Section. “Of course this is purely an informal procedure, and the proper rules of legislation according to the Party’s proposals will not change.”

The JMA naturally resented the meddling of the Industrial Structure Council, the Financial Structure Conference, or any “independent” opinion in reforming health care. The Association had time on its side, as it could lengthen the deliberation process to its guise from within the Central Medical Council, or in dealing directly with the LDP once the Financial Reform Conference was over. The JMA’s initiative to refer policy proposals directly to the LDP, according to its President, “came from our sense of fear in front of the loss of time suffered by a weakening MHW administration.” Interestingly, it was the JMA itself that had first disbanded the authority of the MHW in the 1960s, at a time when it still qualified as a “totalitarian administration” in the view of late President Takemi.

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36 Shukan Shakai Hosho 2060 (1 Nov. 1999): 27
37 Ibid, 27
38 This was the argument of JMA President Takemi in 1960, as quoted from Steslicke, Doctors in Politics: 109.
Reformist alliance and final outcome from the Central Medical Council

What established equilibrium in the policy process is an alliance between the MHW and four major proponents of reform at the time of the national council: the Kenporen, the industry association Nikkeiren, the labor union Rengo, and the National Insurance Central Committee (Koku Hoken Chuokai). In the end, the Hospital, Dental and Pharmaceutical Associations sided against the JMA in a meeting with LDP PARC members. In the Central Medical Council, the JMA was in minority and agreed that "the reform will group medicines according to their composition and use" in a way that parallels a reference pricing system. The main difference with a genuine reference pricing system was that every drug would be individually priced. By comparison, the German reference pricing system determines a single reimbursement price for all drugs in a therapeutic group and patients pay the difference between the reimbursed amount and the manufacturer's price.

Although the JMA has made clear its opposition to the LDP, it did not object to the principles of the reform concerning the elimination of price gaps, the creation of transparent pricing mechanisms and the adoption of measures to avoid shifts to newer and highly priced drugs. Profit making from prescriptions was being eliminated gradually until 2001 and the JMA did not possess any particular interest in setting medicine prices high. It

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40 The main difference with Reference Pricing is that the medicine groups and prices that were already established by the MHW (based on the composition, the use, the innovative character, and the efficiency of medicines) prevailed after 2001. Prices for older medicines are decided following the previously described "adjusted bulk-line" rather than pure market prices. Premiums for innovation are maintained. Market prices and the price of older medicines are to be taken into account for new medicines, as decided by independent experts. On the alliance between the organizations, and the JMA position: Shukan Shakai Hosho 2037 (17 Apr. 1999).
objected to having price setting mechanisms decided outside of the Central Medical Council, however, to avoid creating a precedent in the reduction of the authority of the Council on all matters related to health care policies, prices, and the value of the fee schedule. Price setting mechanisms would be determined by an independent “Medicine Prices Committee” to be organized under the jurisdiction of the Central Medical Council.

Medicine groups remained the favored alternative to palliate the bulk line system. The Drug Pricing Organization would “participate in medicine price settings by classifying products according to their efficiency, evaluation of basic prices, and innovative character.”\textsuperscript{41} It would also receive eventual complaints from pharmaceutical firms. These procedures would complement previous price setting arrangements based on negotiations between producers and the MHW. “Central Medical Council leadership” (\textit{Chuikyo Shugi}) would replace the previous “Administrative leadership” in price determination. As one JMA representative could argue, “doctors should not make profits from the selling of medicines.”\textsuperscript{42}

Complaints on the bias the Central Medical Council might introduce in price settings came from independent specialists members of the reform councils. “While the legal character of the proposed mechanism is well understood, there are doubts as to the strong participation of the buyer side [i.e. physicians] in the proposed structure.”\textsuperscript{43} Rather, it was proposed to consider the participation of various experts as consultants in the composition of the new committees. Similarly, the price setting mechanism for new

\textsuperscript{42} \textit{Shukan Shakai Hosho} 2065 (6 Dec. 1999): 51.
\textsuperscript{43} \textit{Shukan Shakai Hosho} 2065 (6 Dec. 1999): 42.
medicines would be framed on the previous system determining similarities with older drugs. The suggested reform would bring clarity in the process by testing the clinical efficiency of new products, and compare them with the price of existing drugs.

The reform brought clarity into the price setting mechanism with the setting up of two organizations in October 2000. The first, the Drug Pricing Organization (Yakka Santei Soshiki) would determine prices for medicines by following the MHW Policy Affairs Bureau’s classification of medicines in groups according to their use and discuss appropriate prices with pharmaceutical producers. This would replace the previous decision-making based on producers and administrators within the MHW. The organization would gather four times a year to discuss prices and its members were to be chosen from among specialists in medical affairs. The second organization, the Medical Products Organization [Hoken Iryo Zairyo Senmon Soshiki] would be in charge of discussing the level at which each group of medicine will be compensated by insurers. The members would meet once a month, from January 2001.44

Conclusion

Pricing mechanisms were reformed in 1994, as part of the MoF attempt to reduce drug prices and bring national prices with international levels. These changes made clear with the implementation of the volume-adjusted means gradually eliminated the possibility for doctors to earn profits from medicines, as the margin was reduced to a mere two percent in 2001. In part, MITI’s proposal to reduce national prices was already met by the Ministry of Finance in its 1994 reform. Inter-ministerial negotiations under the aegis of the Financial
Structure Council ensured, on the other hand, that transparent pricing mechanisms be established in committees formed of independent experts.

As of 1998, the LDP was retracting its previous commitment to establish a reference pricing system and getting closer to the position of the JMA arguing for a preservation of the previous system within the Central Medical Council. Since profits from prescriptions were practically eliminated, the Medical, Pharmaceutical and Dental Associations did not possess vital stakes in the issue. The question was mostly a matter, for the JMA, of protecting the jurisdiction of the Central Medical Council to avoid creating a precedent in the revision of the wide jurisdiction of the deliberation council. Avoiding reference pricing also eliminated the possibility that the MHLW limit the professional freedom of physicians by determining which medicines (the cheaper ones) are to be reimbursed by the insurers within each therapeutic group.

The JMA was not capable of stopping negotiations regarding the medicine pricing system, although it significantly altered the content of reforms to preserve both the jurisdiction of the Central Medical Council and the professional autonomy of physicians. In the LDP, only the executive could stop the reform process engaged by the MHW as mandated under the Hashimoto administration. Although the JMA had the influence to hinder reforms from within the LDP PARC for Medical Care, Prime Minister Obuchi was a political ally to Hashimoto and simply maintained the cap on regulatory adaptation.

Chapter 8

Information disclosure:
Patient right or mechanism of market competition?

By fostering information disclosure in the new system, we can ensure freedom, transparency and trust in the markets.

Hashimoto Ryutaro on financial market reforms

In order to ensure the quality of health care services, it is important to disclose medical information to offer choices to patients and ensure a relationship of trust with physicians.

Koizumi Junichiro on health care reforms

With the government’s attempt to offer solutions to the economic crisis in Japan, liberal principles trickled down from financial market reforms to health care services, with their technical prose spilling over the medical professionals. This chapter contends that while the access to medical files is considered a patient right in Europe and America, the issue took on a different signification in Japan, as it became a tool to reduce the physician’s monopoly over treatment choices and a means to create competition in health care services.

The weakness of the MHW administrative guidance and the lack of mechanisms of supervision on medical practices (through administrative or legal means) explain why health professionals have enjoyed a greater autonomy in Japan than in America and Europe. The provision of both information on costs and medical files were defended as a means to increase the ability of patients to evaluate the appropriateness of medical decisions. Access to medical files would make possible for patient to obtain second opinions on diagnoses and create a degree of competition among medical institutions. Previous attempts at

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tightening the independence of physicians were only partly met in 1983 with increased ministerial supervision and guidance. These imperfect mechanisms never provided a means to evaluate professional skills.

The Hashimoto Reform Council made the provision of clear information to increase patient choices a basis of its reform. Publicity rules also figured prominently in its proposals as a means to create competition among medical institutions. Similar arguments justified the legalization of contractual arrangements which are nowadays included as part of the Long-Term Insurance for home nursing (Kaigo Hoken), and the creation of evaluation mechanisms to inquire on patients' satisfaction toward health care institutions.

Four case studies are considered to tackle the importance of information disclosure in the ways it would affect health care services in Japan. The first is a little-known case of policy failure from the insurers' side, the Kenporen, which proposed to increase the public accountability of doctors by disclosing information on diagnoses and health care costs in 1978. The second and third cases consider the failed attempt by the MHW to strengthen its administrative guidance and the supervisory powers of the insurers over medical institutions in the 1980s. In spite of such failures, the provision of medical information to patients became a policy priority nineteen years later under a MITI-led research group. This makes a detailed description of the cases all the more relevant for understanding current reforms.

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**Historical sources of medical supervision**

Current debates on information disclosure and supervision on medical practices are affected by past confrontations plaguing the relationship between the Medical Association and the MHW. The same year the compulsory universal medical insurance was established in 1957 (with full implementation in 1961), a then powerful Ministry of Health and Welfare had made a proposal stating that “a medical institution refusing to submit itself to administrative supervision, or found guilty of fraud will see cancelled its authorization to administer care.”³ This was an intact copy of a proposal originating in 1927 when the first (non-universal) national insurance emerged in Japan. It was adopted many years later, in 1957, amid physicians’ opposition and little consultation in the Diet. The creation of the national insurance justified administrative controls toward cost containment and the supervision of doctors through stringent authorization procedures. As Takemi Taro assumed the presidency of the association the same year, he swore to “end administrative controls”; he was sustained by physicians already heated up and politically active.

In 1958 alone, 360 physicians were under investigation by the MHW. Physicians judged the central supervision a harsh means to create order in the ranks as the revocation of a permit amounted to ending the career of physicians practically depending on the national insurance for their income. In 1959, the JMA called for an amendment to the Medical Law and requested that city and prefecture level Medical Associations be put in charge of all investigations. As a result, the MHW lost its ability to revoke authorizations. It is in this climate that increased information concerning frauds re-launched the debates on information disclosure and supervision in the late 1970s.
Kenporen demands and media pressure on the MHW

In 1978 the climate surrounding the relationship between the Medical Association and the Insurance Societies was close to a state of war. JMA President Takemi had repeatedly asked the LDP to consider the unification of the insurance system as a means to simplify administrative tasks, but also as a means to eliminate the private management of insurance.

The Insurance Societies had also accumulated ammunition; they had gathered numerous files confirming that financial frauds had taken place in a number of medical institutions. During its 1978 national conference, the Kenporen first threatened to publicize cases "where treatment fees were charged even after a patient had passed away, or even in cases after patients had moved abroad for years." Refraining from immediately disclosing these cases to avoid traumas in LDP ranks, it was nonetheless made clear to various journalists that numerous cases of "fictive treatments" had been investigated. The Kenporen argued in a rather contemporary fashion for the defense of patient rights that:

[Under the current system] determining health care fees and the type of treatment for each patient is the entire responsibility of doctors. In practice, this means patients are unable to know the costs of treatments, and how insurance contributions are used. It is the right of patients to be informed of these costs.

This proposal was doomed to failure as it emerged in parallel to the elimination of the special tax treatment for doctors (which is considered in Chapter 9), a reform which had already made the LDP dependent on the Medical Association for generously bowing to the

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costly changes. As a result of this tax reform, Hashimoto Ryutaro had his hands tied as his first task as MHW Minister was “to reestablish the broken ties between the Ministry of Health and Welfare and the Medical Association” as he intended to meet with Takemi in his first days as minister.  

The JMA quickly replied to the Kenporen’s public affront. Making patients’ file public would, in the view of the JMA, jeopardize professional secrecy, and direct supervision by patients on costs would reduce their trust in doctors. What the JMA might have feared is a reversal of the unquestioned authority physicians have enjoyed and what has been referred to as the “paternalist relationship” they entertained with patients. As the Kenporen had launched an independent publicity campaign in various newspapers to encourage patients themselves to ask for details on treatment costs, the Health Insurance Bureau intervened in this debate which threatened to spill over into the Diet. Siding with the Medical Association in its argument that “prudence dictates us to spare doctors from measures which could create disbelief among the people,” all information disclosure would first have to be approved by its administration. In counterpart, the Insurance Bureau would take charge to increase surveillance on any institutions suspected of abuse. Guidance, rather than disclosure, would be the sealed format of an all too momentary peace between the

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7 As the Socialist Party argued in the Diet: “Because health care providers do not provide explanations to patients, and because the offer of information is limited, physicians have developed a paternalist relation with their patients” [Iryo teikyoshagawa ga aru shu no patanarizumu wo oshitsuketekuru.] Comments by Socialist Party Asahi Toshihiro. Japan. Diet Records. Health and Welfare Committee, 141st Diet, 5th Session (26 Nov. 1997). Similar comments were voiced by the MHW Social Protection Bureau Chief in Shukan Shakai Hosho 2009 (19 Nov. 1998): 7.
insurers and the JMA.

Kenporen President Iwakoshi defended his position; he would proceed with the publication of all cases of abuse without compromising the privacy of patients and provide information on treatment costs to patients.\(^9\) For the JMA, the insurers' initiative was contrary to the Medical Law prohibiting any direct contact between insurers and patients for investigative purposes. Backed by MHW Minister Hashimoto, the administration requested the usually docile Kenporen to back down on its threats to make cases of abuse public.

As no practical action was taken to increase supervision on medical practices, Kenporen President Iwakoshi, backed by four lawyers, released a number of investigated cases in December 1979. Among them, the case of a Tokyo resident deceased in July 1978 with hospital charges forwarded to the insurer for fictive treatments administered up to two months after his death. The case of a Tokyo resident who moved to Kumamoto in December 1977, with fictive treatments charged in a Tokyo practice until April 1978. In total nine cases were submitted to the media for fictive treatments charged to insurers for either real or "paper" patients. Three cases concerned individuals who had never received any care but on paper, and one case referred to a dentists' practice having over-charged in 30,000 occasions over a period of two years.\(^10\)

In response to criticisms in the Diet that the administration was neglecting to strengthen its supervisory measures, MHW Minister Noro made it clear that health care

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\(^9\) The Kenporen further argued it would carry investigations without trespassing its rights under Article 2 Section 2 of the Insurance Law. The Japanese Confederation of Labor Domei which included 2.2 million members in 1987 (at the time of its dissolution) supported the changes.

\(^10\) The cases are further detailed in Kenporen, 1993: 257-8.
fees would be made public by March 1979 to cope with abuses and to increase administrative supervision. Following on this pledge, the administration published a booklet in March 1979 gathering information on the finance of insurance systems and the individual costs of health care for the year 1978. These measures fell short of the insurers' expectations, even when in 1980 the decision was taken to inform workers of the monthly and yearly costs of health care which they had incurred the preceding year.

The responses were wise compromises between the Insurance Societies and the Medical Association. The Kenporen could no longer argue that information was not provided to patients, and the Medical Association remained protected from any direct patient inquiry on costs or service quality. The Kenporen abandoned the issue temporarily, instead pressing to increase patient co-payment as a percentile rate of the total cost of care. In essence, having patients assume a percentage of treatment costs amounted to the same result as informing them directly of the total cost of care.

The MHW would have had no hesitation in approving increased guidance and administrative investigations rather than information disclosure. Expecting patients to evaluate by themselves the quality or appropriateness of care was clearly not a burden a still paternalistic bureaucracy would leave individuals to assume. The administration attempted in 1981 to re-establish supervision and guidance over medical institutions by making obedience to any ministerial guidance compulsory--rather than the post-1961 simple acknowledgement of faulty behavior--backed with a potential loss of any institution's authorization to administer care. This was harshly criticized as "the final step

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11 Hashimoto Ryutaro was MHW Minister from Dec. 1978 to Nov. 1979. Noro took office under the Ohira Cabinet until Jul. 1980.
toward the bureaucratization of health care” by the JMA during discussions in the Social Insurance Deliberation Council.\textsuperscript{12} The information disclosure movement accumulated unprecedented energy on its own, however, with journalists investigating various cases of fraud. Media pressure would affect the relationship between physicians and the MHW.

\textit{MHW guidance and opposition to reform}

Numerous reports appeared in the media on abuses within health institutions in 1980, including three cases in the Fuji Women Hospital where a doctor without proper qualifications had administered care to patients. Discussions on how to increase supervision of doctors were launched. Welfare Minister Sonoda instigated a project team to “ensure ethical treatments and rebuild the trust of the population in the health care system.”\textsuperscript{13} Within the MHW, the team aimed at increasing supervision over health care institutions and centrally determining the number of beds within regional hospitals as a means to control the offer of services. The Medical Association, predictably, had always opposed any stricter supervision, instead calling for the maintenance of a self-regulatory environment in which it would deal itself with reported cases. Takemi had nonetheless agreed to implement some form of supervision on regional hospitals by centrally determining the offer of services as a cost control measure. Restraining the search for new funds in hospitals would arguably eliminate the temptation to overcharge insurers.

Proposals were sent to the legislature in March 1982. These included central controls over expenses in regional hospitals as a means to reduce spending on redundant

\textsuperscript{12} A summary of the discussion is included in \textit{Kenporen}, 1993: 572.
medical equipment. The proposal also included clauses to reinforce administrative guidance and extend the investigative powers of the MHW. These proposals were barely given appropriate discussion time within deliberation councils and could not be considered until the 1984 Diet session, where they were avoided again. Time, it seems, was required to water down the proposals a little further to avoid antagonizing the JMA.

With the doctors' side horrified by the prospect of guidance, what the LDP had in mind was a rather indirect control over the number of beds in every hospital as a means to determine the allocation of funds to every institution. This would protect the professional freedom of doctors, reduce expenses, and, according to the minister, the propensity to overcharge insurers. With the Third Nakasone Cabinet, the MHW had given its approval, and implementation became possible by 1986 (completed by 1990) in all prefectures. Obviously, the time span required to justify a response to financial frauds by controlling the number of beds was more than a few years. Debates, however sparse, lasted eight years in total. The issue was not to disappear so easily.

**Insurers supervision on medical institutions**

Supervision on doctor's treatment costs and billing practices imposed important constraints on the administration of the privately managed Insurance Societies. According to the *Kenporen*, financial predictions and budget allocations within the point-based honorarium system were frequently mistaken, imposing numerous administrative costs. Supervision created three practical difficulties. First, the verification occurred strictly

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12 Takemi had made a statement to this effect on January 16th 1980 to labor unions. Quotes from *Kenporen*, 1993: 281.
according to written materials related to treatments and diagnoses, with patients being kept outside of the process. Because insurers were prohibited to communicate directly with patients, supervision did not confirm whether appropriate treatments had been provided. Second, 4,000 supervisors across the country reviewed an average of 12,000 bills a month each. Because the number of receipts was too high and the number of points distributed to doctors exceeding 50 million a month, the process amounted to a "kamikaze investigation."\textsuperscript{14} Investigations were carried out in two forms: the first involved calculating the monthly cost of care per patient, and the second reviewing the total amount per institution. In both cases, costs above average were subjected to deeper investigations.

In 1983 again, the MHW proposed to step into the middle of insurers and patients as a means to fill the communication gap on treatments and costs through further guidance. The MHW, in fact, had little choice but to follow the request of insurers threatening once more to make numerous cases of abuse public. Through guidance, the MHW would intervene once cases of abuses were demonstrated and proceed with investigations of any suspected health care institution. Although the stricter law which allowed the Ministry to impose reforms and eventually close any faulty institution, had failed in the Diet, a 10 percent financial penalty remained for any financial delinquency. This rule applied to the 1979 case of the Seikakaisei dentist office having overcharged over 510 million yens in a year. It applied to the 1981 case of the Kinto medical institution and the 1982 case of the Sanro medical institution respectively for 230 and 25 million yen. Most cases of guidance

\textsuperscript{14} 1993 figures provided in Kenporen, 1993; 552.
were delegated at the municipal or at prefecture levels, but occasionally they resurfaced at the MHW.

Administrative guidance came to play an important role in supervising medical institutions given the particularities of the honorarium system in place. These administrative measures became necessary features of a system imposing tremendous pressures on insurers. Guidance might not have been sufficient in eliminating doctor abuses however. In 1987, a one-year investigation of 116 medical institutions found 63 of them guilty of fraud. In 1988, the Midori pharmaceutical company was found guilty of making false claims for the delivery of various medicines with the complicity of 596 medical institutions. The case totaled 800 million yen in false claims. Government investigations were limited to about one percent of all medical institutions and personnel; that is, 100 institutions and 1000 people out of 6,800 institutions and 10,000 people subject to some form of administrative guidance yearly.

Amid media pressure to limit fraud and increase patient awareness of health care costs, the JMA remained capable of arguing for self-regulation mostly by adopting political channels. Limited capabilities to implement controls prompted other administrative actors having an interest in developing health care from a market point of view to make their reform proposals known. The re-institutionalization of the decision-making process and an alliance between the LDP executive and MITI-MHW reformers forced important concessions on the part of the Medical Association by the year 2000.
Increasing patient control over health care through information disclosure

One of the main pillars of the proposals defended in the EPA inter-administrative talks and the inter-party agreement on health care reforms through the Hashimoto national council concerned information disclosure. Relying on the liberal argument that the functioning of markets depends on the proper provision of information to users, economic planners were backed in their request by Prime Minister Hashimoto.

MITI’s emphasis on placing consumers at the center of the offer of service and “providing all information” to patients still resounded fairly little in the MHW in 1990. The MHW had included proposals to improve the quality of services, create home services, provide information for clients to make clear choices among services, and liberalize publicity rules in a 1990 report. The MHW failed to follow suit on these pledges as organized interests in its deliberation councils ignored the proposals.

Under the national council, the EPA inter-administrative working group report defined the basic principles of reform, as “market mechanisms were to be integrated to the extent possible in health care,” while “transparency” would be ensured through information disclosure. Debates on information disclosure started anew between April 1996 and July...
1997 in the National Conference on National Health Care organized by the MHW, and the Financial Committee of the LDP.\(^{19}\)

The issue trickled down from the national council’s inter-administrative working group to the political parties. Interestingly, the coalition government originally justified health care reforms from discussions held in its Financial Structure Reform Committee.\(^{20}\) The Coalition Government Committee on Medical Insurance System Reform further responded to the insurers’ concerns that efficiency in health care was affected by the misuse of financial resources in some health institutions. For this purpose, it requested that patients be given a choice among health institutions and treatments, with the provision of all required information to do so including access to patient files (\textit{karute}). Committed to the national council and the coalition parties, the LDP Reform Headquarters and the Social Section of the LDP Policy Affairs Research Commission answered this call, as “trust must be the basis of the offer of care, and this requires progress in the provision of medical information, and transparency in processes.”\(^{21}\) Despite the complexity of the consultation process, all the parties were speaking of a common voice.

MHW administrators had participated in the inter-administrative discussions but only the coalition party agreement could ally its different bureaus under a common agenda in July 1997. “The MHW which had previously adopted a passive stance, now openly

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\(^{19}\) \textit{Shukan Shakai Hosho} 1944 (7 Jul. 1997): 42. This was also discussed in 1996-98 in the Diet. Diet Records. Upper House, 136\(^{th}\) Diet (7 Feb. 1996) and 142\(^{nd}\) Diet (30 Apr. 1998).


support[ed] the provision of medical information and costs to patients.” These proposals were included in the partial reform of the Medical Law submitted to the Diet and defended as the introduction of “informed consent” in July 1997. The most difficult task would be for the MHW to consult with interest groups from within its deliberation councils, particularly the Central Medical Council.

During the first stages of consensus building, interest groups occupied a lower position in the decision-making process monopolized by the prime minister’s conference and bureaucratic leadership. Private industries and the Kenporen were supportive of reforms from their inception. For the Japan Medical Association, the main difficulty with the disclosure of medical information was that “patients suffering from cancer or psychological problems would be negatively affected by access to their file,” although its president adopted a conciliatory approach, agreeing that “the provision of information to patients is currently insufficient and this does impact the efficiency of care.”

The JMA did not oppose principles of reforms that had made consensus among a majority of the members of the LDP, the coalition parties, and the administration. Although it claimed the reforms unnecessarily limited the physicians’ professional freedom, the Medical Association focused its energy on escaping legislation on the matter. This would

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22 The MHW proposals were further sent to the coalition parties for discussion. Shukan Shakai Hosho (1952) 25 Aug. 1997: 44-45.
23 The Medical Service Law was amended in 1997 to require pharmacists and physicians to properly inform patients and obtain their consent concerning medical treatments. This was a first step toward the disclosure of patient files.
25 In spite of a general agreement on the need to increase information disclosure, potential dangers for patients if files were to become public became one of the original reason for delays in deliberation. For the Chairman of the MHW discussion group, the “security problem related to the access of patient files over the internet was our main concern.” Quoted in Shukan Shakai Hosho 1942 (16 Jun. 1997): 12; 1947 (21 Jul. 1997): 12.
allow physicians to make decisions regarding what and how much information to provide. It would also prevent lawsuits against physicians for misinformation or for having failed to offer patients with all alternative treatments options.

Information disclosure would create two precedents in Japanese health care. First, it would give patient control over the type and frequency of treatments recommended by doctors. This was originally requested by the Kenporen in the 1970s as a means to create better controls over medical practices and a means to eliminate doctor abuses. Second, the measures would create a degree of competition among doctors, with every practitioner becoming accountable for their decisions and every patient enabled to judge according to their needs.

For the MITI research group on health care, information disclosure would imply three essential changes: access to patient files and evaluation by third parties on diagnoses and recommended treatments, access to honorarium sheets for patients to double-check the costs charged to insurers, and freedom in principle for all publicity related to health care. Ideally, the introduction of market principles through information disclosure would cause the doctors' monopoly over treatment types and costs to vanish. Combined with more liberal rules on publicity related to medical institutions, the reforms would be drawing a wedge into the strict regulations imposed on all medical information. These measures would transform a relationship in which physicians normally made decisions without informing patients of potential alternatives. To be effective, the changes require deeper behavioral modifications in the type of relationship physicians entertain with their patients.
Patient files: the influence of the Medical Association

After various postponements, the Medical Council of the MHW submitted a proposal to implement measures for the disclosure of information to patients in December 1998. The report was based on the LDP’s recommendations, made through its Medical System Reform Committee and submitted to the Health Care Policy Bureau; its members recommended implementation within the year. The report also echoed the economic planners’ concerns with the problem of “the aging population [which] makes it imperative to proceed with a change in our medical services from an emphasis on quantity to a concern for the quality of care.”26 The disclosure of patient files would, in principle, be directly granted to patients upon request. Informed consent would be guaranteed by the proper provision of health care related information directly from practitioners. The legal revision would make it a duty for doctors to open files and explain their contents to patients.

To the end, the JMA objected to having the Diet legislate on the issue of disclosure and insisted that “informed consent rests on the trust patients maintain toward physicians and this requires no legislation” or that “as practitioners can decide on their own when the provision of information and patient file is appropriate, legislating on the question is unnecessary.”27 Faced with pressures from various administrations, politicians, and most members of the Medical Council, the JMA had little choice but to accept the changes.

On a more technical level, the JMA insisted that “the files contain various abbreviations concerning sicknesses and treatments, some of which are in German, and we

doubt that patients can easily understand their content.” Despite such arguments, the Kameda medical clinic in Chiba had already computerized all patient files by 1995, making available to their 2000 daily patients, files and information on treatments. Computerized information being systematically organized, it rendered patient files readable with little help from practitioners. A second point of opposition between the MHW and the JMA concerned the impact of the reform on patient-doctors relations. For the JMA, the disclosure of all files related to tests, diagnoses, or even the interpretation of X-rays, would invite doubt in the mind of patients as to the credibility of professionals. Reforms might, in this sense, negatively affect treatments: “The main objective of the reform should be to improve the relationship of trust between patients and practitioners and increase the quality of care.”

Administrators took the different view that medicine being interpretative rather than purely scientific, maintaining the false idea that every practitioner’s diagnosis is equal in quality would be reinforcing an antiquated view of medicine. Were it demonstrated that the provision of medical information would negatively affect patients (in such cases as cancer or mental illnesses), access to information would be limited. The law would also ensure information is kept away from third parties.

The means through which these limitations were be implemented had important consequences. At stake was whether access would be immediately granted to patients, whether the Medical Association would retain the final say over disclosure, or whether a third party (a court of law) would be granted the right to review disputed cases. Table 15

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identifies how European countries and the United States have solved these issues.

Table 15. Information disclosure regulations in selected countries

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<thead>
<tr>
<th>United States</th>
<th>Europe (United Kingdom)</th>
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<tr>
<td>Courts specify that disclosure is a right for patient. How much information is disclosed depends on the state. A majority of states defines a “professional standard” for disclosure according to medical areas. Other states do not define standards. This allows a jury to decide how much information should be disclosed for patients to make medical decisions. Full disclosure is not required if disclosure was to interfere with treatments, although no doctor can completely avoid liability.</td>
<td>The EU adopted common standards for information disclosure in 1998 (Data Protection Act). Patients are entitled to see all information regarding physical or mental health recorded by a health professional. Information withholding may be decided by the health professional if disclosure would “cause harm (...) in the opinion of the holder of the record.” This opinion is almost impossible to challenge. In the UK, information is given, for a fee, after 21 days for information recorded in the past 40 days.</td>
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With the 1998 introduction of the Data Protection Act in Europe, physicians have final say on whether patient files ought to be disclosed. Avoiding legislation protects the autonomy of the medical body since challenging professional decisions becomes impossible. The American system allows for courts to challenge professional decisions even if a number of states identify a standard for information disclosure. The option requested by the JMA situated Japan with the group of European countries.

In June 1999, Central Medical Council members agreed that patient file disclosure required important adjustments in the ways diagnoses and medical information were recorded, as vocabulary had to be systematized and special guidelines distributed to all practitioners. In total, the committee predicted three years would be necessary prior to

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attempting to legislate on the matter as “the provision of information must be clear to the population for patients to be able to appropriately choose among all services offered.”\textsuperscript{31}

The JMA accepted the changes in January 2000 by producing its own proposal on information disclosure. It agreed with the fundamentals: “Upon requests, practitioners have a duty to offer all information to patients,” while adding that “the creation of a relationship of trust between doctors and patients requires that practitioners be granted authority over information disclosure.”\textsuperscript{32} In cases where patients remain unsatisfied, the JMA proposed the creation of a review board which “after inspection of the files, would submit to patients a summary of the file.” Further appeal would be granted to patients with the submission of a written demand to a “consultation window” to be installed in every municipality. Final say over the disclosure of the file would be reserved for the local Medical Association “Committee for the Offer of Medical Information.” By the year 2000 these “consultation windows” were set up in most hospitals, making in effect access to patient files possible.

Legislation on the issue remained controversial. With the practical steps taken to set up consultation windows in hospitals, and the general consensus that patient files were to be produced upon request, the LDP had no pressure to legislate quickly. MHW Minister Tsushima and Medical Policy Bureau Chief Ito commonly argued that a “legislation would be considered once the basic preparations on the means to standardize patient files were

\textsuperscript{31} Amid divisions in the committee, “further studies” were recommended. For the Health Policy Bureau of the MHW, these “these studies would only be conducted at the same time that preparations are carried out for doctors to record information in a systematic manner.” \textit{Shukan Shakai Hosho} 2034 (28 June 1999): 42.

completed." On March 1, 2001, the newly created Ministry of Health, Welfare, and Labor (MHWL) adopted its guideline for the disclosure of patient files. These give most patients direct access to their files, and in cases where disclosure would be judged detrimental, it requests patients to submit an application to the "complaint window." A number of institutions have made available patient files and billing information on the internet.  

Publicity rules

A second issue related to the provision of information in the creation of market oriented health services concerned publicity regulation. The national council recommended that all information necessary for patients to make an enlightened choice be made available through publicity. These measures were clearly supported by the "Deregulation" Committee [Kisei Kanwa Iinkai or literally "Rule Relaxation Committee"] affiliated to the prime minister and the Administrative Agency. The Deregulation Committee was a brainchild of MITI's Industrial Council and the administration played a role in negotiating changes since 1994, although its success was partial. The Committee could do little to push the balance toward reform, as it possessed little authority other than compiling what was approved in every ministry into an annual report. The Committee had been established in December 1994 as a means to eliminate various rules inhibiting the emergence of markets and its scope covered all ministries. Its effectiveness was evaluated in terms of the number of rules it eliminated or replaced, and in many cases ministry officials were capable of


34 In particular, the Miyazaki Prefecture Medical Association has cooperated with a local university in developing an internet system to provide medical records. Nikkei Shimbun. 17 Dec. 2001. 8.
finding minor clauses of laws to eliminate and protect appearances of deregulation. In the field of health care, publicity rules had been subjected to the committee’s revisions. Amid calls for “freedom in principle” from its early days, the only success it obtained was to allow hospital names and addresses to be publicized.

Other publicity about services, such as specialists’ names, experience, and the number of patients treated in the institution remained prohibited under the “liberalized” Medical Law. MHW officials “aimed at the implementation of a more liberal reform by the end of 1997.” Except for publicity deliberately making comparisons among institutions or making false claims about their services, “freedom in principle” would guide the new markets. The Central Medical Council approved reforms overall, making it a point in its 1998 discussion report that information provision was the means to increase efficiency in services, although the JMA was quick to denounce the moves toward markets as “nothing less than a blow by the legislative authority to our health care system, as the medical institutions will be incapable to adjust to the new environment.”

Publicity regarding the type of treatments (out-treatments or hospitalization) were allowed and the names of institutions could be publicized in 1997. Hospitals were allowed to advertise the type of facilities they offer as long as treatment information was not included in 1998. They could inform patients publicly on the number of practitioners and nurses they employed, the number of rooms, and the presence of certain technologies or types of consultation they offered. These were all counted separately as part of the

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35 Declaration by the Head of the MHW Policy Affairs Office in Shukan Shakai Hosho 1963 (10 Nov. 1997)
deregulation packages for these years.\textsuperscript{37}

One of the main criticisms directed at the Committee was that deregulation could not occur in an empty space. Part of the justification for changes were to come from Prime Minister Hashimoto's Financial Reform Committee. MITI supported freedom to publicize any services--while ensuring that false publicities or "miraculous" treatments be screened out--as a means to give patients a clear choice regarding the type of institution and the specialist they wanted. Information disclosure was to become part of the market principles as an instigation of more active health care services. For MITI's committee on health care reform, the principles underlying the Medical Law in its limitations concerning information disclosure amounted to managing health care services from above.\textsuperscript{38} These measures had been necessary during the postwar period as a means to ensure the provision of services to all without discrimination. With proper information disclosure, on the other hand, health care services could be revitalized to generate employment creation in the service economy.

Initially assuming a prudent attitude toward reform, the MHW clearly supported freedom in principle for advertisement in its 1999 statement of position. Publicity making clear comparisons between institutions, or making false claims or exaggerating facts, would be submitted to the review of the prefectural Medical Association and eliminated. In most cases, the content of publicity would be subjected to third parties (namely independent professionals), with the final decision left to the local Association.\textsuperscript{39} The Central Medical

\textsuperscript{37} A yearly report on rule relaxation was produced by the Administrative Agency, \textit{Kisei kanwa hakusho} [White Book on Rule Relaxation], yearly edition, 1997-99.
\textsuperscript{38} The committee's report was printed by Yashiro, \textit{Kaikaku shido suru nihon no iryo sa-visu}: 92-7.
Council similarly argued that "the government should rapidly proceed with the legalization of the measures to guarantee the patients' freedom of choice in the selection of care."[^40]

Table 16. Health care publicity regulation in four economies

<table>
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<tr>
<th>United States</th>
<th>France</th>
<th>Germany</th>
<th>Great Britain</th>
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<tr>
<td>Various changes according to states. Institution name, contact numbers, treatments offered, doctors' names are allowed. Special approval for fee disclosure, and doctors' educational background. Review by the Medical Association.</td>
<td>Publicity is prohibited in principle. Exceptional authorization granted for information contained on prescription forms (name, contact numbers, specialization, hours of operation).</td>
<td>Publicity is prohibited in principle, except for publicity showing the institution’s name, address, contact numbers, and hours of operation.</td>
<td>Guidance on publicity is done in accordance with the Council of Doctors. General hospitals are allowed to publicize services. Publicities offering comparisons between institutions are prohibited.</td>
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Source: Health Policy Research Center, Shogakoku no iryo seido ni kansuru kenkyu. [Medical Systems in the World], March 1997.

The reform proposal of the Medical Law submitted to the Diet in December 2000 included measures to increase the scope of publicity to all information normally found on medical files with all information being part of the newly created Organization for the Evaluation of Medical Institutions (Nihon iryo kino hyoka kiko) the professional history, age, and sex of physicians, the type of technology and treatments offered, and information on services offered by nurses. The Diet would also discuss whether information regarding the number of surgeries practiced could be made public.

Table 16 offers a comparison of the regulatory environment concerning health care

[^40]: Japan. Ministry of Health and Welfare, Central Medical Council, Iryo Seiko teikyo taiset no kaikaku ni
publicity in four countries. With the law that came into effect in April 2001, Japan’s regulatory environment is similar to that of the United States and Britain and more open than the French and German systems where publicity is forbidden in principle. As is the case in the United States and Britain, a review board will play an important role in screening contents. One can expect that the review board will provide a stricter environment in Japan than in the United States concerning the type of treatments offered in institutions, as profit-making is prohibited.

**Evaluation mechanisms**

In the early 1980s, Insurance Bureau Yoshimura had promoted evaluation mechanisms as a means to account for patient expectations in the delivery of care. The objective of this system would be to provide clients with the proper information on service types and quality so as to allow consumers to choose. The MHW did not seriously consider the implementation of evaluation mechanisms until the national council. Prompted by the Coalition Parties Health Insurance System Reform Committee in 1997, it now argued that “the creation of good quality and efficient services depends on third party evaluation of hospitals and medical institutions and, to the extent possible, on making this information as widely known as possible.” The implementation of the system has proceeded slowly however, and the current organization providing the evaluation of hospitals is criticized as providing purely technical information out of reach to patients. By 2001, patients in

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42 The coalition government proposal is found in *Shukan Shakai Hosho* 1953 (1 Sept. 1997): 16-21.
institutions for the elderly are provided with surveys to evaluate the quality of care, the results of which will be made public. The system is to be extended to every patient in the future.\textsuperscript{43}

\textit{Conclusion}

Informed consent being an internationally accepted right for patients, it may seem surprising that the Medical Association objected to the changes until it made public its own recommendations in 2000.\textsuperscript{44} The medical body, however, did not object to the principles of disclosure per se, but would not promote the changes until it was pressed by the national council because it feared patient intrusion into the number and types of treatment and potential legal side-effects of a legislation. The JMA wanted to avoid the implementation of a judicially supervised system that would make medical professionals liable. Given that supervision over professional billing practices is more limited in Japan than in America, or in Germany where professional associations have financial incentives to supervise colleagues, information disclosure changes the type of supervision affecting professionals while increasing choices for patients and creating a competition among physicians. This issue made it important for physicians to avoid as much as possible giving patients a direct access to their files. Without the influence of the national council, the constricted policy preferences of the JMA and the influence of professionals in the Central Medical Council of the MHW would have made regulatory change impossible. The fact that publicity rules

\textsuperscript{43} \textit{Nikkei Shimbun} 25 Jul. 2001. 1.
\textsuperscript{44} As of April 2000, deliberation council member interviewed still argued that the JMA would oppose reforms to the end. Interview, Administrative Agency. Deregulation Committee member. 20 Apr. 2001.
have also been adjusted to accommodate competition is consistent with the influence the national council had on medical professionals. Interestingly, the different interests of the MoF to control medical expenses and the economic planners' objective to promote competition in services converged toward principles of information disclosure that took on a different signification than the issue of patient rights that prevailed in other countries.

The Hashimoto national council superseded the usual policymaking channels of the LDP where physicians held a significant influence through the Party's Policy Affairs Research Commission for Medical Care. The Economic Planning Agency's inter-administrative negotiations identified policy priorities which were adopted in their entirety by the LDP Reform Headquarters and the Coalition Parties Health Insurance System Reform Committee. JMA-related LDP politicians were taken away from the main policymaking channels and the JMA was forced to negotiate with the MHW from within the Central Medical Council. Armed with a mandate from the executive, the Ministry of Health and Welfare, which had adopted a passive stance until 1997, determined the policy outcome through guidelines rather than legislative proposals.
Chapter 9

Reforming doctor’s taxation and fee schedule system

By precisely determining the value of medical treatments and services, we have created the conditions of a Soviet-style system. There is an absence of price competition and a lack of private initiative. It is important to increase the efficiency of health care services through market principles.

Shinshinto member Okada Katsuya

The Japan Medical Association has maintained its monopoly on the representation of physicians in Japan in great part due to the influence it has acquired in the advisory councils of the Ministry of Health and Welfare. This privileged position has granted the JMA the ability to affect the standard of living of physicians. Regulatory reforms that affect its central interests have always been potentially conflictive.

This chapter considers various attempts at reforming the preferential tax granted to physicians and the medical fee schedule system. It emphasizes three points: 1) The reform of the preferential tax treatment in 1979 is used as a historical case to show the difficulty in adapting regulations that directly affect the Medical Association. 2) During the 1980s, the JMA rejected any alternatives to the fee schedule in place, and extended the duration of deliberations through extensive studies of a DRG system in the 1990s from within the Central Medical Council, rather than consider other alternatives. 3) The Obuchi administration failed to maintain the momentum for reform after the entry of the Komeito party in the coalition government. These political contingencies made it impossible to achieve reform on an issue that touched the core of the JMA political activities and justified most of its membership. Were medical fees to be set independently under a
different system, the JMA would lose its most important *raison d'être*. Reforms were successful only in the area of "mixed treatments" where innovative research may be freely priced and only partially paid for by the national insurance. This is a story of policy failures that centers on the role of the Central Medical Council.

*The fee schedule in perspective*

The Japanese fee-for-service medical fee schedule system allocates physicians points for every service performed. It assigns a number of points (each equivalent to 10 yen) to hundreds of treatments for medical service appraisal according to consultations, examinations, diagnoses, treatments, surgeries, medications, injections, and hospitalization. This provides physicians the freedom to determine the number and type of treatments for each patient, and the related costs charged to insurers. Negative counterparts to this system include the lack of consideration for physicians’ expertise, experience or location in the payment of services, the propensity it creates for physicians to over-treat patients, and the difficulties this has caused in Japan in the supervision of medical and billing practices.

Private insurers have launched various attempts to establish a more comprehensive system to replace fee-per-service as a means to eliminate fraud and reduce prices. Under a more comprehensive system, such as the Diagnoses-Related Groups system implemented in the United States, doctors would be kept in check in terms of the type of treatments, drug prescriptions, and billing practices.

A historical investigation on past reforms that affect physicians’ income indicates

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how central the ability of the JMA to affect the revenues of physicians has become to ensure its monopoly on the representation of medical professionals.

The creation and elimination of the preferential tax treatment

An important issue treated as part of the financial reform of welfare provisions in 1975 was the question of the special tax treatment granted to doctors. The special tax treatment had been requested by the Medical Association as early as 1947 to help health care institutions cope with high administration costs. According to Takemi's own accounts, the granting of this request by the LDP was mostly due to his personal negotiation skills in convincing Finance Minister Ikeda in 1951 to reduce the physicians' total tax burden by 20-30 percent. Fearing "trouble from other groups" if he were to grant Takemi the 30 percent he requested, a 25 percent level was agreed upon and was later brought down to 20 percent by the National Tax Office of the Finance Ministry.²

In the end, more important than the personal links between the LDP executive and the JMA President, however, was the general strike called by Takemi in 1951. The granting of a reduction in taxes was offered to the JMA as a means to bring peace between insurers groups and the JMA over the value of the points determining medical fees. During the one-year negotiation to determine the value of the points, Takemi had refused to lower his demands below 18 yen per point, whereas the Kenporen and the MHW requested a rating

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² Amusingly, the story goes that drinking sake, Takemi would have called Ikeda "stingy" to refrain from granting more than 30%, to which the Minister would have replied: "You, you only have to care about how generous I am towards doctors, but for me the minute I grant you too much, I get in trouble with others – hoka no yatsu ga urusakunatte- so let's make it 25%." The cabinet approved 25% but faced the opposition of the Tax Office. Records of the Medical Association, 1983: 36-38. Parts are found in Arioka, Iryo no Go-ju Nen: 58.
of 10 yen per point.\textsuperscript{3} Negotiations had turned to disaster, with the JMA denouncing insurers as "troublemakers" on advertisements posted in public trains, provoking the anger of the Kenporen representatives refusing to sit in the Central Medical Council. Ten days before the deadline for negotiating the point system, the JMA called for all members to abandon their insurance affiliation. The JMA had shown it could unravel the system, and Takemi simply had to rub his medicine in: "the JMA is not stubborn about obtaining 18 yen per point as long as an alternative way to compensate our loss is found, by granting physicians a tax rebate for instance."\textsuperscript{4} The stakes were set at 60 percent of physicians' income to be made non-taxable.\textsuperscript{5} Negotiations with the Ministry of Finance proceeded hastily on the tax rebate while the 10-yen value for points in the fee schedule was implemented.

The special tax treatment had attracted criticism in 1975 under the reformist Miki Cabinet which promised changes with "the next review of the fee schedule" carried out by the Central Medical Council. The Council postponed changes twice, partly given the violent opposition of the Medical Association President, while the Welfare Minister agreed to an average 9.1 percent fee raise.\textsuperscript{6} At that point, political peace with the Association was more important than government finance and Finance Ministry Ohira vaguely delegated "the Welfare Minister to ask for specialists to be gathered and assume proper handling of

\textsuperscript{3} Arioka, Iryo no Go-ju Nen: 48-59.
\textsuperscript{4} Quoted in Arioka, Iryo no Go-ju Nen: 56.
\textsuperscript{5} This was justified by saying that 60% of treatment costs were to pay for medical materials or salaries. Thus 40% of total revenues would be considered as taxable income —amounting to a total 20% rebate-. Note also that farmers and small shop owners also had a percentage of their revenues not subject to taxation.
\textsuperscript{6} As Campbell and Ikegami note, the JMA had substantial authority within the Central Medical Council until the 1980s. Ikegami and Campbell, Containing Health Care Costs: 130-5.
the question.”

The creation of the Specialists Conference on Health care Problems [*Iryo Mondai Senmonka Kaigi*] promised changes. Had Medical Association President Takemi not been chosen as chairman, had he not been in charge of selecting the ten members of the conference among specialists closely linked to the Association, the special tax treatment might have been cancelled. From the beginning of the conference, Tanaka announced that “the investigation will be carried over a two to three years period”, making clear his own difficulty in dealing a blow to a powerful constituent. The conference drowned the Miki Cabinet’s public commitment to eliminate privileged tax treatments into technical jargon.

*Tax reforms and the influence of the Ministry of Finance*

In the LDP, factional dynamics undermined the Miki Cabinet. Ohira had temporarily allied the Cabinet as Finance Minister, but he openly resented Miki’s reformist agenda (particularly his attempt to centralize the finances of the party) and ultimately forced the dissolution of the cabinet with the help of the Tanaka and Fukuda factions. Although the LDP was affected both by the arrest of Tanaka Kakuei amid the Lockheed scandal and failed to gain a majority in the Diet during the elections which followed, Prime Minister Fukuda would rather pile up the dust than confront the JMA: “doctors do not receive any special treatment.”

In the Fukuda Cabinet, Welfare Minister Watanabe had become ready to confront

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8 As newspapers commented at the time: “The main opposition party to Miki is the LDP itself.” Tsuji and Hayashi, *Nihon Naikaku Shiroku* [History of Japanese Cabinets- Vol. 6]: 394-5.
physicians that had opposed him on elderly care reform, because “rejecting all reforms because of the issue of the tax privilege amount[ed] to pure egoism. It [could not] be maintained this way.”\textsuperscript{10} The comment had merely invited Takemi’s sarcasm: “Local tax officials could not imagine how beautifully the Minister expresses himself.”\textsuperscript{11} At that point, however, the question of the preferential tax treatment appeared in the report of the Government Tax System Study prepared by the MoF in October 1977, and “promises between bureaucrats and the LDP [were] dangerous” for the JMA.\textsuperscript{12} Following the MoF report, LDP Secretary General Ohira argued that “current times are not like old days when doctors could barely feed, nowadays doctors make a substantial income, and maintaining the tax privilege might do more in hurting relationships with patients than alleviating doctors condition.”\textsuperscript{13} Takemi agreed with a diminished version of the tax reform proposed by having the preferential taxes “abolished” more in appearance than reality.

Led by Secretary General Ohira, General Council Chairman Nakasone Yasuhiro, Political Affairs Commission Director Izaki Masumi, Tax Reform Commission Director Kaneko Ippei, and the Chairman of the Health Care Research Commission Nemoto Ryutaro, the Diet members closely linked to the Medical Association and led by Marumo Shigekida were asked to obey the party executive and to stop hindering reforms. The JMA-related members agreed to leave the issue to be decided by the party executive,

\textsuperscript{9} For the Dec. 5 1976 elections, the number of seats was increased from 491 to 511, of which the LDP secured 249 and allied to 14 independents to maintain power with 51.5% of seats. Ibid: 341.
\textsuperscript{10} Arioka, Iryo no Go-ju Nen: 336.
\textsuperscript{11} Records of the Medical Association. 1983: 207.
\textsuperscript{13} I take some liberty in the translation of the following part: “ima wa kuerushi, kogaku shotokusha ga fueteiru [shi] kore wa isha to kanja no shinrai kankei o warukusuru.” Arioka, Iryo no Go-ju Nen: 342.
as it became the most important issue of the Diet session.\textsuperscript{14}

Prime Minister Ohira, elected in November 1978, pledged to carry out a reform of consumption taxes, and the maintenance of partial treatments for certain groups would have been an easy target of criticism. The LDP Tax System Commission agreed to delegate the decision to an advisory committee whose chairman, Yamanaka Sadanori pre-arranged negotiations with Takemi. The LDP proposal was to make physicians' income taxable in four levels. Takemi wanted the proposal relaxed to account for "the lack of doctors in distant regions, where administrative costs are twice the average."\textsuperscript{15} Yamanaka refused, and negotiations were left for the Finance Ministry to complete.

Called by Takahashi the Tax Bureau Chief, Takemi defended his request for relaxation on the grounds that harsh taxation would chase doctors from the regions. The Finance administration added a fifth level to the taxation scheme for doctors. The scheme thus included exemption levels ranging from 52 percent to 72 percent in five categories.\textsuperscript{16} The preferential treatment was abolished in all appearances. Takemi had partly won his argument and a 28 percent taxable revenues for doctors with income lower than 25 million yen remained. Takemi was called for consultation at the LDP offices by Secretary General Saito Kuniyoshi to finalize the agreement a week later and warned that "the LDP does not always respect its word but better realize this one promise and maintain the 72 percent tax exemption for low income recipients." To the national media, he declared that "doctors who make high income should pay all their taxes. It was about time that doctors stop being

\textsuperscript{14} Arioka, \textit{Iryo no Go-ju Nen}; 344.
\textsuperscript{15} Arioka, \textit{Jiryo no Go-ju Nen}; 350.
idolized by the population.” In fact, however, the highest income earners still had 53 percent non-taxable revenues to cover for the administrative costs of running private clinics. The special tax treatment, in part, had become a hindrance to all other aspects of the financial reconstruction, and change, however minor, had become inevitable.

Eliminating doctor abuses: Attempts to reform the medical fee schedule

The Kenporen had insisted in its 1979 conference on ways to increase supervision on doctors and allow public disclosure of costs and treatments. It argued that “the sources of all problems in health care come from the current medical fee schedule system”, which made difficult any supervision over doctors practices. Japan’s point-based pay-per-service fee schedule system indirectly made possible a certain fraud on the numerous treatments conducted, as it was difficult for independent supervision to be carried out. Kenporen members thus looked into foreign systems, such as the pay-per-head system, to cope with these difficulties.

The Insurance Societies found a momentum for reform after cases of abuses had been made public by independent researchers. In September 1979, the first case had been reported in the media, and others followed in 1980. One case involved three medical institutions of Kyoto where, amid regular inspections conducted by the Welfare administration, elderly patients had been left untreated. Another involved a hospital in

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16 The revenue exemption categories were set as follow: 1) 25 million yen [appr. 225 thousand US$] and below, 72%; 2) 25-30 million yen, 70%; 3) 30-40 million yen, 63%; 4) 40-50 million yen, 57%; 5) 50 million yen and above, 52%.


18 These discussions took place during the Kenporen “Iryo mondai shinposium,” Dec.1979.
Chiba where unnecessary surgeries had been conducted to increase profits. These cases, and others, were to become important justifications for a review of the medical fee schedule system.\textsuperscript{20}

The Ministries of Welfare and Finance favored reform within the scope of the existing system, justifying a change toward a pay-per-client system only in the Elderly Health Care Insurance as a means to reduce expenses. Their proposal was part of larger proposals to review elderly care. All other insurance schemes would maintain the original payment system. For the Ministry of Finance, "the current fee schedule system which draws criticisms for allowing abusing treatments needed to be reformed within the new elderly health care system as [the status quo] would only have allowed further deficit accumulation."\textsuperscript{21} Financial precariousness thus became the main justification for deliberations.

\textit{Pressures from the Ministry of Finance to reform the fee schedule}

As for the other reforms discussed previously, the independent influence of the Ministry of Finance must be reckoned with. The Ministry of Finance gained entry in the policymaking process in 1980, and led to a partial reversal of the JMA position on the conclusion of the Elderly Health care Law. The Ministry of Finance was asked by the MHW to evaluate policy recommendations it had received from a deliberation body. The Medical System Council wanted to improve the quality of home services for the elderly

\textsuperscript{19} A similar point system exists in Germany, where capped budgets force a reduction in income for physicians exceeding average productivity by 40%.
\textsuperscript{20} As of September 1981, 1861 cases of abuse had been reported. \textit{Shukan Shakai Hosho} 1144 (28 Sept. 1981): 7.
while reducing their financial burden. These proposals inevitably required increased financial inputs, and while the MHW had little hope funds would be injected, it nonetheless called for the intervention of the Ministry of Finance. “The Budget Bureau will bite into those proposals like appetizers,” is how hopeful the Deliberation Council Chairman Okochi Kazuo reflected on their chances.22

The Ministry of Finance took this opportunity to ask for deeper changes into the fee schedule. Opposing the JMA, the MoF called for the implementation of a comprehensive (fixed price) fee schedule system to replace the costly fee-per-service system. This change would cover all elderly patients, while leaving regular patients covered under the previous system. Under a comprehensive system, physicians would only receive payment for either the number of patients they provide for, or for the number of days patients are treated. This would eliminate the tendency to multiply the number of treatments that occurred under a fee-per-service system. The MoF was unable to instill changes in the fee schedule system until 1990, however, and even then the changes affected specialized health care institutions, where a comprehensive payment method was implemented.23

The main difficulty for the MoF proposal was the influence of the medical associations in the Central Medical Council. This time also, the Ministry of Health and Welfare supported the reform proposal and attempted to create a separate decision-making body to avoid the JMA’s influence in the Central Medical Council. The new Elderly Health

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22 Arioka, Iryo no Go-ju Nen: 370-1
23 The comprehensive payment system is in fact not totally foreign to the previous system; it is a point-based system, where the number of points is determined on a daily basis rather than a per-service basis.
Insurance Council would be in charge of considering the change.\textsuperscript{24} Creating a new council required a few months. In spite of appearances, these technical procedures from the MHW administration were not meant to impede deliberations. Within the Ministry, a majority of officials supported the yet controversial change on financial grounds. The need for a new council was rather strategic. As a reform of the fee schedule would normally depend on the approval of the Central Medical Council, where the voice of the Medical Association would affect the final call, and deliberations could have been doomed from the start. MHW administrators thus redesigned decision-making institutions to carry out more impartial procedures in a framework gathering various economic experts.\textsuperscript{25}

This infuriated the JMA and their LDP supporters. In December 1981, the LDP Policy Affairs Commission denounced the administrative strategy and ordered that consultations be carried anew within the Central Medical Council. The administrative strategy had failed.\textsuperscript{26}

The review of the medical fee schedule dragged for months, partly due to pressures on politicians to abandon negotiations from the Medical Association. In turn, the Kenporen strategically abandoned its request for a total reversal of the system, and settled with the administrative side in requesting the introduction of a “pay-per-patient” system with closer supervision on doctors only within the design of the elderly insurance. This strategy would later backfire as it opened a wedge for opponents to criticize the creation of two parallel fee schedule systems as an accounting nightmare.

\begin{itemize}
  \item \textsuperscript{24} Arioka, \textit{Iryo no Go-ju Nen}: 372.
  \item \textsuperscript{25} Arioka, \textit{Iryo no Go-ju Nen}: 371-3
  \item \textsuperscript{26} The opposition denounced the LDP strategy. Japan. \textit{Diet Records. Lower House Social Labor Committee, 95\textsuperscript{th} Diet, 5\textsuperscript{th} Session (12 Nov. 1981).}
\end{itemize}
**LDP opposition and partial adoption of a comprehensive system**

The MHW did not abandon its quest to implement changes so quickly. By August 1980, more than a year after the first report from the Reform Council, the Ministry of Health and Welfare had made its reform plan clear. MHW Minister Hayashi, gathered with LDP members close to the ministry's administration, announced a reform process in three steps: a reform of health care fees, changes in government contributions to insurance plans, and a better redistribution of costs among social groups.

Health care costs would be reduced through the implementation of "standardized health care services," where all services covered by insurance would be catalogued according to the type of care and treatments necessary. This in essence was calling for the implementation of a comprehensive system under a different name. The Medical Association with other specialized groups would create a list of diagnoses and treatments. Services not "standardized" would be paid for individually.\(^{27}\)

Including the JMA in the design of diagnoses groups was fair at this point, and would ensure a prompt application of the measures. This division of tasks between the administration and the principal beneficiaries would ensure that any potential difficulty in the application of the policy be quickly pointed out. The JMA would not be docile enough as to comply with the request however. It simply rejected the idea as contrary to the nature of medicine. Doctors might require flexibility in applying treatments, rather than follow

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\(^{27}\)This idea originated in 1955. The Ministry then proposed to predetermine the scope of treatments covered by insurance, and leave other treatments for individuals to cover.
“standardized” recipes. “Bureaucrats,” the Association added, “are coercing medicine into limited methods.”

The LDP had already made its position known in February 1981 when, questioned by the Diet Budget Committee, MHW Minister Sonoda expressed his view that “the current system is criticized for its unfairness and might cause the ruins of our insurance system.” He further made clear his opinion that “our policy must first secure the moral behavior of practitioners, and resolve the financial gap of the system.” Sonoda called on administrators to give due consideration to foreign systems, such as the ‘pay-per-patient’ systems, as means to resolve the health care deficit. Such endorsement from a prominent LDP member re-ignited the competition between the Medical Association and the Insurers Association that confronted their views in all subsequent deliberation council talks. Yet, the Social Security Council sided with the insurers and the administration in requesting reforms, as did the Project Team on Elderly Health care of the Socialist Party.

The Medical Association mounted the pressure on the party in power to oppose reform with the astute but expected argument that “the creation of a separate system for elderly patients will mean that young patients and old patients will pay different fees, in what will become the most incomprehensible insurance system of the world.” Obviously, except for the personal views of his MHW Minister, the LDP did not seriously consider a

30 The March 10th 1981 discussions of the Social Security Council for instance stagnated in confrontation over the question of the honorarium system.
31 Ironically, the JMA defended such a separation under the Hashimoto national council. Declaration to the members of the Medical Association from President Takemi, on 6 January 1981. Tomen no iryo mondai ni tsuite kokkai giin no uttaeru [Appeal to Diet members on the current medical problems] 16 January 1981.
standardized comprehensive fee schedule. This is, the LDP Social Affairs Section argued, because insufficient studies had been conducted on the feasibility of parallel payment systems; because the report on the question from the Elderly Insurance Council was yet to be produced; and finally because of the insistence of the Medical Association strongly requesting to maintain the system intact. During private talks, the LDP executive and the Medical Association agreed that creating two different payment systems was impossible, and settled to maintain the fee schedule system based on the accumulation of points for each treatment. The MHW adopted a stance in line with the party in power, even if the Elderly Council was yet to produce its report on the question.

Forced to justify this sudden change in opinion to the Socialist Party and all actors backing reform, MHW Minister Murayama, (in what the Kenporen considers a “must see” of Japanese politics) declared that “the fact that we refuse to change the fee schedule system is not due to our support of the Medical Association.”32 Murayama was in part contradicting himself as he had previously pledged to the media to “leave the final decision on the fee schedule system for the Elderly Insurance Council to make.”33 Strangely enough the course of discussion followed a path opposed by all and supported by only one group, the Medical Association.34

Opposing the majority was not irrational politics for the party in power. As far as the Kenporen was concerned it had no direct political base and depended on the financial

34 The opposition confirmed this course of action: “Exactly one week before retracting its decision to have the Elderly Council decide on the issue, the LDP met with President Takemi who had declared that the Elderly Council would not decide on the issue, and by some kind of luck this is exactly what the LDP says now.” Declaration by Komeito Diet member Meguro in Japan. Diet Records. Lower House Social Labor Committee, 96th Diet, 8th Session (13 Apr. 1982).
support of industry associations not taking part in the debate. Deliberation councils would mostly follow the Ministry. And the Ministry had already changed its position to support the LDP. The only groups left to seriously maintain pressure were the Ministry of Finance and the Diet Committee on Social Labor to which a previous minister had promised reform. The opposition took charge during the October deliberations of the Committee to attack the minister on the question. Feigning that it would abide to the demands, the LDP erased its complete opposition to a revision of the system and proposed that “the fee schedule system will be investigated by the Central Social Insurance Medical Health Insurance Council and the final decision made by the Minister.” This decision took the Elderly Council away from the matter, on the ground that its twelve members were economists with no authority on welfare problems. This was no change of heart, and would certainly do little to relax the atmosphere; the Central Medical Council was under the influence of doctors and the road to reform was a dead-end. Denouncing this course of action, the opposition claimed that “to deny the Elderly Council of its decision-making power is to follow the desires of the Medical Association and allow the current system to prevail.”

In the Diet, the opposition expressed doubts on the process, since “even if deliberations are conducted on the question of the fee schedule system, the general opinion is that the influence of the JMA will be overwhelming.” JMA President Takemi, whose self-description was that of “a man who does not shy away from controversies,” added

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35 This is reported in Shukan Shakai Hosho 1153 (30 Dec. 1981).
36 As a Komeito member argued: “The JMA and the LDP completely changed the content of the legislative proposal behind the scenes.” Japan. Diet Records. Lower House Social Labor Committee, 96th Diet, 8th Session (13 Apr. 1982). See also Kenporen, 1993: 296.
37 Statement by Social Party Diet member Marutani Kaneyasu on Nov. 20th 1981. Comments by Minister Suzuki Zento during the same session suggest that the creation of the Elderly Council was an idea of the Kenporen rather than the MHW. Japan. Diet Records. Lower House, 95th Diet, 11th Session (20 Nov. 1981).
ironically that “the current proposal is not the fruit of secret negotiations by the Association, but a mirror of the leadership of LDP Diet members who understand our arguments.”

According to the Diet records, the Central Medical Council did not directly debate a potential reform of the pay-per-service system, but nonetheless made its position clear in December 1982. The Council did make some innovative recommendations on the question without supporting a reversal from the fee-per-service system. It suggested to reduce the dependence of doctors on the sale of medications as a means to reduce abuses, and supported the administrative position to create better home service supports for elderly people.

**Minor changes in the fee schedule system**

The problems related to the fee schedule mostly concerned the lack of supervision over doctor’s billing practices. To this effect the Kenporen, independent economists and planners supported information disclosure as a means to increase the responsibility of patients over services. Physicians with higher expertise to develop new treatments, it argued, should be rewarded accordingly. As of 1991, the Central Social Insurance Medical Care Council, prompted by the Kenporen, the MHW and independent experts, took up the issue and recommended a thorough study of the fee schedule system in order to solve some

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39 The difficulty to carry out reforms in the existing committees was clear: “The Central Medical Council is discussing some reform of the fee schedule, but not one that concerns the pay-per-service system.” MHW official: “The MHW agrees to having the Council discuss the issue. If the Council cannot discuss the issue, then there is no forum to discuss it (...) It is for the Diet to decide by itself.” Japan. *Diet records*. Upper House Joint Committee: Cabinet-Social Labor -Local Administration, 98th Diet, 1st Session (22 Feb. 1983).
of its main problems. Namely, the Council pressed the idea that patients should be provided with increased choices in health care, and questioned whether the fee-per-service system favored proper responses to patients' needs. "Wouldn't a more comprehensive system schedule bring about choices for patients and increase the flow of medical information?" The MHW's independent consultation body on health care, the Social Protection System Council, agreed: "the problems related to the fee-per-service system have been identified," it argued, "and the implementation of a fixed pricing system based on diagnoses-related groups is a possibility." Independent experts were to be called on.

By 1993, the Central Medical Council responded to financial concerns expressed by the Ministry of Finance by proposing, and implementing, a daily fee upon entrance for institutions specializing in elderly long-term care, avoiding deeper changes. The JMA had made its point and avoided deeper changes requested by the MoF by compromising on the issue of the drug pricing system, where price reductions were agreed upon in exchange for maintaining the fee-per-service system (Chapter 7). The reform affected little the authority of practitioners, while limiting the rise in expenses that elderly care caused. The LDP, showing some flexibility toward insurers' requests, adopted the position that as the point-based fee schedule was not correctly used by doctors, "the Party would ensure the improvement of the payment method in the future."^41

Prior to the Hashimoto national council, insurers from the Insurance Societies and the National Insurance maintained pressure on the Central Medical Council. They had the Council delegate independent experts with the responsibility to design reform in 1993. The

JMA immediately opposed any weakening of its grasp over the reform process, and insisted on the creation of a review group within the scope of the Central Medical Council. Compromising with the JMA, the Sub-committee on Honorarium Problems was integrated within the scope of the Council rather than as an independent body.\(^{42}\)

Were independent analysts to look into alternative fee schedule systems, the JMA would face the frightening possibility that politicians be rallied to their reformist ideas. The implementation of a comprehensive system, determining the number of treatments according to diagnoses, would reduce physicians' freedom and possibly reduce their income. Supervisory practices, made easy with a fee schedule based on diagnoses-related groups, would limit their autonomy. To keep its say over reform, the JMA had to act quickly and integrate any consultation into the institutional bodies it held under its influence.

The JMA did not monopolize but held significant influence over the proceedings of the Sub-committee formed of a majority of private analysts, university professors, and five members of various local medical associations. In its report submitted two years later, the Sub-committee agreed in principle with the need to "implement proper evaluation of doctors' practices, and respond adequately to patients needs and choices." In essence, the Sub-committee acknowledged the principles adopted by the Industrial Structure Council to rejuvenate the offer of services in health care, but nor would its conclusions displease the JMA. It agreed with the need to "carry a thorough study of comprehensive fee schedule systems," while restating the insiders' learned-by-heart catchphrase and argument that "a

\(^{42}\) Shukan Shakai Hosho 1759 (4 Nov. 1993): 44-47.
comprehensive system constrains health care and limits the capacity to adapt treatments to individual patient needs.\textsuperscript{43} The main difficulty was that the JMA would have the authority, within the Central Medical Council, to order numerous years-long studies on the feasibility of alternative systems. The institutional framework of reform threatened it at the core, unless politicians intervened to redefine the decision-making process.

\textit{Re-institutionalization of the reform process under the Reform Council}

The day Prime Minister Hashimoto announced that his Reform Council would tackle the issue of the fee schedule system, the Medical Association remained passive. It issued no comment to the media. It simply kept silence. For analysts of health policies in Japan the meaning was clear: “This [was] interpreted as a sign that an extremely steep wall [stood] on the road to reform.”\textsuperscript{44}

The national council offered a chance to create a consensus strong enough to unite factions in the LDP, and shift the balance in the Central Medical Council. Economic planners, however, had a weaker position concerning the implementation of a different fee schedule system. They did not originally propose any particular solution to reform the system. Rather, they argued for the implementation of a series of principles covering all medical services and practices. They argued for the implementation of a system allowing closer supervision over doctors, the provision of all relevant information concerning treatments for patients to be treated as consumers with choices, the creation of incentives

\textsuperscript{43} \textit{Shukan Shakai Hosho} 1759 (4 Nov. 1993): 44. This argument became the standard answer by JMA representatives in various councils.

toward research, and transparency in health care decisions. Specific proposals were identified in inter-ministerial negotiations, and the MHW given its expertise had an edge on the competing administrations.

Negotiations with the MHW concerning the means to make health care decisions more transparent to patients were negotiated in 1995-96 by the EPA’s welfare working group part of the Financial Reform Council. The participation of policy experts from a MITI roundtable in 1997 also made it possible to target the pay-per-service system as limiting incentives toward research for doctors, as it evaluated all doctors equally, regardless of age, expertise, or know-how.

The Financial Structure Conference added further justification to carry out investigations on other systems from a financial perspective. “Welfare costs are increasing amid a low-growth economy, and we must consider all possible ways to limit welfare expenses.” This would confirm the fears of the JMA, and yet attracted some support within the MHW when the undersecretary for the MHW, Yamaguchi Takehiko claimed “the current fee schedule system must be revised through considerations for alternative payment system such as the diagnosis-related payment system, or comprehensive payment method and compare their impact on costs.” The introduction of a comprehensive fee schedule system would, in the eyes of an analyst, “bring doctors down from their

46 Interview, MITI Health Care Research Group. 20 April 2000.
In parallel to these discussions, MITI’s panel of economists and health care specialists offered proposals on the means to reform the system. In essence, the JMA’s fears that a panel of independent economists would have a say over reforms materialized, although the administrative consultations remained outside of the scope of the MHW and would mostly attempt to influence politicians. Under the coalition government of 1996-1998, the revision of the Health Care Insurance Law figured prominently in the Diet. The members of the Inter-party Committee on Health Care Insurance System Reform gathering representatives from the LDP, Social Democratic, and Sakigake parties, did not equally support the position of the JMA. In fact, the Inter-party Committee provided an evaluation of the fee-per-service system close to the opinion of economic planners. It judged the fee-per-service system as “inflating costs through excessive treatments” and that it “inhibited any evaluation of physicians’ practices and level of expertise.”

The parties were determined to “impose limits to increases in health care expenses caused by the fee-per-service system”; they would further ensure that “excessive fees” (referring to the over-billing practices) be curtailed, and that the evaluation of alternative fee schedule systems would be carried in a group of ten hospitals. Within the coalition, the Social Democratic Party and Sakigake most strongly advocated reform since “avoiding to expand the fixed-price system would jeopardize the future road to reforms,” whereas the LDP prudently professed “a closer harmonization of the fixed and fee-per-service systems.” After seven

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days of negotiation between the Research Committees of the respective parties, they agreed that “a fixed system will be put into practice in the areas of care where its efficiency is proven, while we aim to harmonize its use with the fee-per-service system."51 Rhetorical niceties aside, the position of the coalition was flexible enough to claim open support to reforms while cajoling the JMA.

The institutionalization of the policy process within a broader framework integrating competing administrative actors inflicted a measure of flexibility to the JMA. In April 1997, the JMA met with the Lower House Committee on Health and Welfare, and expressed relative support for the change. “If the new system allows flexibility in responding to patients’ condition, we do not necessarily oppose reform.”52 The benefits of alternative payment methods were to be investigated by setting up a comprehensive payment method with diagnoses-related categories (183 diagnoses categories in this first attempt).

As noted before, the Insurance Bureau has been the main supporter of reform within the MHW. The Bureau gathered in April 1998 its Medical Insurance and Welfare Deliberation Council aiming at “eliminating the bias toward providers of care” and turn attention to consumers of services.53 The Ministry had set up an independent decision-making body in 1997, following MITI’s expert committee on health care. This Medical Insurance Welfare Council composed of specialists failed in its aim to bring reform to the Diet, but instilled a measure of flexibility into the JMA’s position. In its deliberation, the

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Vice-president of the JMA, Itoh Eiko made clear "it is correct to implement a fixed price system for long-term care, but for emergency [short-term] care where there can be multiple illnesses, a comprehensive pricing system would reduce patients' options."54 Ironically, this was a solution that the Kenporen had sponsored but that the JMA had declared inconsistent all through the 1980s. The compromise forged between the JMA and the ambivalent LDP thus endorsed a division of the fee schedule between long-term and short-term services. The latter would be kept under a pay-per-service system, and long-term services would be rearranged under a DRG system with comprehensive payment schedules. Elderly long-term care would be maintained under the comprehensive fee schedule system.

Coalition change and JMA control

With the LDP difficulties in the July 1998 election, and the time required until the Komeito joined the LDP-Liberal Party government, the reform process relapsed into its previous torpor after Hashimoto resigned from office as factions had turned against him. The JMA was also very stubborn about maintaining its strong position in the determination of prices in the previous fee schedule. Certainly, the study carried out in national hospitals on the introduction of the Diagnoses-Related system was pursued, but the JMA could suddenly voice its disinterest and "lack of confidence in a study carried by the MHW Secretariat" for reform it judged unnecessary "as the current system does not require any

change.” The physicians’ opposition to changes concerned particularly private medical institutions “depending on the fee schedule to survive.”

The Kenporen representative could only express doubt as to the future of reforms if politicians retreated from the previous coalition report. “As the studies of the new fee schedule system are being carried from within the Central Medical Council, we can express doubts as to whether the debates will aim at reform.” For its representative, the will to pursue the previous reform proposal was lacking: “If that is the kind of Council we have, we had better dissolve it!”

The LDP had always kept its position flexible enough so as to avoid being caught in between reformers and the JMA. The Director of the Social Affairs Section of the LDP, Nakase Jinen, had expressed this ambiguous attitude. “We aim at developing the strong side of a pay-per-service system and combining it with the advantages of a comprehensive payment system.” Expressing the ambivalent position of the party between the JMA and reformist administrators in the MHW and the EPA, the LDP apparently aimed at reducing the excessive number of treatments and tests carried out by physicians under a pay-per-service system, while maintaining doctors’ autonomy in treatment choices. Ultimately, the LDP argued that “the pay-per-service system allows for the best kind of care to be administered.”

Contrary to the issue of the medicine pricing system which could be decided hastily with the support of labor unions, industry associations, the MHW and other insurers, studies on comprehensive systems had yet to be completed by the end of the

56 Ibid, 48.
Hashimoto Council. In fact, the Central Medical Council ordered the DRG study conducted in ten hospitals to start anew because it had been conducted with one hundred eighty three treatment categories, a variety judged insufficient to evaluate the impact of the new system. The new study would be conducted with a more internationally employed categorization of five hundred thirty two treatment types.\textsuperscript{58} Implementation is expected by 2002 as Health, Welfare, and Labor Ministry Sakaguchi insists that “once the basic frame will be determined, we will proceed with reforms quickly,” a prospect yet judged “difficult” by the medical associations.\textsuperscript{59}

\textit{Economic planners in contractual and profit-oriented services}

Most administrators in the MHW abhorred the creation of profit-oriented services, although suggestions had been made in this direction in the Hashimoto national council. The promotion of research through partially privatized services has proven to be an effective way to attain technological advances in France. In the French system, a limited number of physicians are allowed to charge higher fees for services but forbidden from refusing low-income patients supported through the national insurance. The national insurance only pays for the provision of basic services and the difference is directly charged to individual patients. The French system has promoted research while preserving equality although at higher overall welfare costs.

The Service Bureau of MITI has promoted a similar system in Japan to allow profit making for some services, where new technologies and services would be paid for

\textsuperscript{57} Interview, Director of the LDP Social Affairs Section in \textit{Shukan Shakai Hosho} 1936 (28 Apr. 1997): 7.
\textsuperscript{58} See for instance \textit{Shukan Shakai Hosho} 2122 (Feb. 5 2001): 52-4.
\textsuperscript{59} Press conference by MHWL Minister Sakaguchi, 12 Jan. 2001.
individually. The MHW refers to these types of services as “mixed treatments,” as they are partly covered by insurance and in part by patients. For the physician’s representative, “the current system allows mixing treatments, but the idea to let patients assume all costs as in a genuine market will simply increase their share.”60 Based on the existing 1984 Law on mixed treatments and amid its original reluctance, the new Ministry of Health, Labor and Welfare [MHLW] implemented a similar service on a limited scale in 2002. The “special medical fee system” allows charging patients for new types of treatments, transplants and beds.61

The Medical Problems Research Committee of the newly created Ministry of Economy, Trade, and Industry [METI], maintains that more profound changes in the current system should be allowed for profit making in health care.62 For the chairman of the National Social Protection Research Center, “if such private services imply that doctors will receive higher income, we totally oppose it,” while the Rengo representative argued that “the part of services which differs for patients who have money compared to those who don’t will become larger and we cannot support such idea.” Private industry representatives in the committee similarly argued that “it is not because health care fees have no limits that their quality will necessarily improve.”63

The MHW also discussed the introduction of contractual relationships for some services. The economic experts’ Research Committee on Social Welfare Services proposed to center home services on personal choice and contractual relationships.64

relationships were seen as guaranteeing more patient scrutiny over quality and costs, and were implemented as part of the creation of the Long-Term Care Insurance in 2000 while an expansion of "mixed treatments" to promote research was implemented in 2002.

**Conclusion**

As the investigation into the revision of the preferential tax treatment made clear, the Medical Association attaches greatest importance to questions related to the fee schedule, and is willing to devote most of its energies to the issue. Of importance here is the JMA's position that private medical institutions "depend on the fee schedule to survive." Since 81 percent of hospitals, 94 percent of general clinics, and 99 percent of dental clinic in Japan are private, the JMA itself depends on its negotiation power regarding the fee schedule to maintain its membership. The issue is also the most important one for the less politically influential Insurance Societies, which have denounced malpractices since the late 1970s as a means to force the hand of the government, and propose their own policies to reform the fee schedule. Interestingly, the MHW has also been unable to conduct deliberations on the fee schedule in politically independent deliberation councils. Its attempt was rejected by appeals to the LDP, which re-centered the process in the Central Medical Council.

Contrary to the issue of the medicine pricing system, where more transparent and "soft" market-oriented pricing mechanisms were created, the issue of the comprehensive fee schedule system never made complete consensus among policy actors. Studies were

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required to solidify this consensus, or drown the issue under years of data collection research.

The policy competition nonetheless instilled by the Hashimoto national council forced limited concession on the implementation of a comprehensive fee schedule for long-term care on the JMA, an agreement the JMA maintained until the Komeito joined the coalition cabinet. The end of the LDP-Social Democrat-Sakigake coalition government closed the opportunity window for reform that the 1996 Hashimoto administration had opened. Once the government coalition changed, the JMA returned to its previous argument that "the current system does not require any change," controlling reforms from within the Central Medical Council. The national council expanded the policy preferences of all actors because it included policymakers from all sides, but its temporary nature ultimately became its main weakness.
Chapter 10

Conclusion

The institutional complementarity of policy competition mechanisms

This study compared the decision-making process in the conflictive area of health care under two types of institutions: the ministerial and party committee structures versus the supra-partisan national councils. The ministerial advisory councils and the LDP Policy Affairs Commissions were depicted as sustaining the interdependency between politicians and organized interests that protected long-term policy commitments in health care. The national councils were presented as providing the prime minister with a greater ability to carry out regulatory adaptation. This separation of the policymaking processes into different channels and institutions offers a more accurate picture of Japan’s parliamentary system and its political processes than perspectives that emphasize the role of a single actor, either the bureaucracy or politicians, in the policy decision-making process. A focus on institutions highlights the particularities of Japan’s parliamentary system, a system in which numerous entry points are provided to interest groups into politics and where prime ministers have found a need to complement the policymaking institutions at party level by supra-partisan and supra-ministerial institutions. In addition, this thesis sheds light on domestic mechanisms for policy change in Japan, therefore contributing to an understanding of the role of domestic actors in the promotion of reforms. This conclusion compares the impact of these two types of decision-making institutions on policy outcomes in health care.
Health care reforms: the impact of vertical committees versus national councils

In health policy, the links between the JMA and the LDP as well as the influence of the JMA in the main decision-making body of the Ministry of Health and Welfare, the Central Medical Council, have guaranteed the professional autonomy of physicians from supervision and patient inquiries. The presence of JMA-related politicians in the Diet (the so-called welfare-zoku) has promoted a convergence between the policy preferences of the main organized interests and the party in power. These dynamics have encouraged expansionary policies despite pressures from the Ministry of Finance to reduce welfare expenditures in the 1970s.

Table 17. Policy commitments under the ministerial and party structures

<table>
<thead>
<tr>
<th>Date of proposal and sponsor</th>
<th>Main content of the proposal</th>
<th>Policy outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1975</td>
<td>- Co-payments for patients in NHI</td>
<td>LDP-JMA negotiation</td>
</tr>
<tr>
<td>MoF proposal</td>
<td>- Retiree insurance</td>
<td>Dec. 1977. 10% co-payment.</td>
</tr>
<tr>
<td>Finance Min. Yohira</td>
<td>- 2% insurance fee on yearly bonus.</td>
<td>- 600 \ per treatment/ 200 \ per day for hospitalization</td>
</tr>
<tr>
<td>MHW Min. Watanabe</td>
<td></td>
<td>- 1% insurance fee on bonus</td>
</tr>
<tr>
<td>1977</td>
<td>Increase patients' co-payment</td>
<td>Blocked in LDP Commission for Medical Care</td>
</tr>
<tr>
<td>MHW Min. Watanabe</td>
<td>30% co-payment for families</td>
<td>Postponed until Nov. 1980:</td>
</tr>
<tr>
<td>Jun. 1978</td>
<td>10% co-payment medicine</td>
<td>- 800 \ per treatment/ 500 \ per day for hospitalization</td>
</tr>
<tr>
<td>MHW Minister Ozawa</td>
<td></td>
<td>- 20% co-payment for employees’ families.</td>
</tr>
<tr>
<td>MHW Min. Sonoda</td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 1975</td>
<td>Introduce co-payment for elderly patients</td>
<td>Postponed until 1979. Block the LDP PARC and LDP executive.</td>
</tr>
<tr>
<td>MHW-MoF proposal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct. 1977</td>
<td>Introduce co-payment for elderly patients</td>
<td></td>
</tr>
<tr>
<td>MHW-MoF proposal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec-1979- Jan. 1980</td>
<td>Introduce co-payment for elderly patients</td>
<td>Blocked in LDP PARC Commission for Medical Care</td>
</tr>
<tr>
<td>MoF proposal</td>
<td></td>
<td>Postponed by party leaders Hashimoto and Ozawa.</td>
</tr>
<tr>
<td>MHW Min. Watanabe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sept 1980 – 1981</td>
<td>Introduce co-payment for elderly patients.</td>
<td>LDP PARC approved 500 yen co-payment but postponed implementation.</td>
</tr>
<tr>
<td>MoF- MHW proposal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MoF Min. Takeshita</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHW Min. Noro</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 17 summarizes the most important conclusions from the case studies covering the period from the first Oil Shock to the beginning of the 1980s. The Ministry of Finance and the Ministry of Health and Welfare along with the LDP Minister in charge jointly sponsored most reform proposals during the period. Prior to 1976, the case studies indicate a tendency for the LDP executive members themselves to counter or postpone reforms. After 1976, the LDP Policy Affairs Research Commission played an increasingly important role in the negotiation process. Minor changes were implemented with the introduction of co-payments in 1977 and 1980. The impact of the reforms on the reduction of welfare expenditures was mitigated with the increase in government contributions for family care from a level of 50 percent of family expenses on health care in 1972, to 70 percent in 1973, and 80 percent of hospital fees in 1980. The reforms were socially beneficial means to support family health care but added to the pressure on government finances already strained by elderly health care costs. Case studies indicated the tendency for political actors to expand government contributions to health care services until 1975. Patients paid 38.7% of all medical expenses in 1955 but only 11.0% in 1980.1

The creation of the national councils to carry out regulatory adaptation and administrative reforms under the Nakasone and Hashimoto administrations was justified by two economic crises. The first one was a crisis in government finance. The Oil Shocks pushed Japan into a period of slower growth and Prime Minister Nakasone faced the daunting task of reducing government expenses or increasing government revenues through taxes in the early 1980s. This economic situation led to the creation of a supra-partisan

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national council to achieve reforms in 1981. The Hashimoto administration was similarly under pressure to carry out administrative and economic reforms after the collapse of the bubble economy in the early 1990s. The economic crises called for regulatory adaptations that the usual policymaking channels of the MHW and the LDP committees could not achieve. Under the Nakasone Commission on Administrative Reform (1981-84) and the Hashimoto Administrative Reform Council (1997-1998), reforms that had been postponed or ignored since the 1970s were considered anew.

The two administrations proceeded differently in the organization of supra-partisan national councils for reforms. The Nakasone administration committed itself legally to the Diet by creating its Commission on Administrative Reform based on the National Administrative Organization Law in 1981. Prime Minister Hashimoto lacked a strong basis to support his reform efforts in the LDP and did not seek Diet approval to create his reform council. The Hashimoto administration nonetheless committed itself by law to reduce government expenses.

The procedures adopted under the Hashimoto national council did not bind the government to reforms by law but they allowed the cabinet to flexibly design reforms through the creation of inter-administrative working groups. Reform proposals were presented as a package of reforms to the parties in power. In particular, the proposals to increase information disclosure and change the medical fee schedule, which had been avoided by the Nakasone national council, became central parts of the Hashimoto national council in the area of health care. The negative counterpart to this implementation process based on ministerial guidelines rather than Diet approvals was that interest groups could alter or delay reforms from within the Central Medical Council of the MHW.
Table 18. Regulatory adaptation under national councils

<table>
<thead>
<tr>
<th>Date of proposal and sponsor</th>
<th>Main content of the proposal</th>
<th>Policy outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981-83</td>
<td>Introduce co-payments - 10% co-payment for workers - 20% co-payment NHI - 400 yen co-payment for elderly patients.</td>
<td>Approved by the LDP executive despite the opposition from PARC members. Implemented between 1984 and 1986.</td>
</tr>
</tbody>
</table>

Table 18 summarizes the major cases taken from a comparison of the outcomes of the two national councils in the area of health care. Nakasone who appealed for public support and was strongly supported by faction leaders in the LDP could carry out reforms on the conflictive issues of patient co-payments with a speed that surprised most interest groups. The Hashimoto Reform Council tackled controversial reform issues in the areas of medicine pricing, information disclosure, and the medical fee schedule. Interest groups played an important role in shaping the content of the regulations in the Central Medical Council on all issues. The reform efforts were successful in the first two areas, but delays
jeopardized the reform of the medical fee schedule.

The composition of the national councils played an important role in enhancing the public accountability of decision-makers. The Nakasone national council was created with a third of its members representing industry associations. Contrary to the decisions made in the LDP Research Commissions which can remain secret or the negotiations carried out in the MHW advisory councils, which are irregularly reported in the media, Prime Ministers Nakasone and Hashimoto committed themselves publicly to achieve reforms. Public commitments made it imperative for LDP faction leaders to silence opposition in the party, at least for the duration of the national councils. A shared characteristic of both the Nakasone and Hashimoto councils was their ability to obtain the support of the LDP for a broad package of reforms rather than tackling every issue separately in the Party and the Diet.

It would be an overstatement to say that party dynamics were completely superseded by the national councils. Nakasone compromised on his reform agenda by postponing tax reforms in the early years of his cabinet. He chose a course of action that protected him from resentment in the party in health policy by increasing the burden of the Insurance Societies rather than inflicting further financial pressure onto patients. The Nakasone national council also avoided conflictive issues concerning the fee schedule system and changes in the composition of the Central Medical Council that the parties in the opposition requested and that the MHW was considering. The Hashimoto national council had to make important compromises on all issues in negotiations in the Central Medical Council of the MHW. The ability of the national councils to achieve reforms on controversial matters rapidly is nonetheless clear.
National councils as complementary institutions

The core of this thesis served to demonstrate that despite the ability for interest groups to maintain regulatory commitments in ministerial and party committees, open policy mechanisms favored regulatory adaptation. Policy competition mechanisms involving economic planners from either the Ministry of Finance or the Ministry of International Trade and Industry with independent policy experts in the two national councils strengthened the leadership of the LDP executive to carry out substantial regulatory adaptation. The policy competition mechanisms formed under the national councils were a means to complement the existing policymaking channels of the MHW and the LDP.

Five factors explain the effectiveness of the councils in carrying out regulatory adaptation. 1) They were considered as extra-ordinary and temporary means to promote reforms by integrating the voices of administrative actors and independent specialists. Because of their temporary nature, the LDP welfare-related Diet members could be kept outside of the most important negotiations. 2) Inter-administrative negotiations widened the policy choices of the executive. 3) The national councils publicly committed the executive to reforms prior to consulting with party members and interest groups. 4) The national councils created a consensus among faction leaders and the prime minister could temporarily avoid opposition from the LDP Policy Affairs Commissions. In the case of the Hashimoto national council, this consensus eroded after July 1998 but the administration of Prime Minister Obuchi did not jeopardize the negotiations carried out in the advisory councils of the MHW. The Nakasone Commission on Administrative Reform gained stronger public support than the Hashimoto Reform Council, but the latter rested on a wider
consensus among the administrations of the MITI, the MoF, and the MHW.

The suitability of national councils for specific regulatory transactions

The case studies confirmed the theoretical proposition that interest groups' preferences are constrained for the regulatory transactions that involve important safeguards. The organization of the national councils created policy competition mechanisms that increased the chances for regulatory adaptation in such areas.

The issue that attracted the most opposition from the medical body under the Hashimoto national council concerned the medical fee schedule. This is because the creation of Diagnoses-Related Groups would have allowed administrative supervision on medical diagnoses and billing practices, designed as regulatory safeguards against abuses and discretionary medical decisions. The JMA had a very narrow policy preference for two reasons. First, prices and treatment choices would have been determined by the administration with the implementation of a DRG system. This would have limited the professional freedom of physicians. Second, the Japan Medical Association traditionally justified its own existence and membership fees by its ability to affect the income of all physicians. Because the DRG would determine both treatments and costs, it would have limited the role of the association in the policy process. The Hashimoto national council and the subsequent deliberations carried out by the MHW reached certain compromises with physicians. The JMA backtracked once a new coalition government was formed in July 1998. The JMA kept the decision-making authority on this issue within the Central Medical Council where it still lies today.

Information disclosure is a relatively non-conflictive issue in market oriented
health care systems, such as the American system. In the case of Japan's health services where physicians held a monopoly on medical decisions, information disclosure was promoted as the main market-oriented policy under the Hashimoto national council. Information disclosure increased patient choices among providers, allowed for second opinions by granting access to medical records, and promoted competition through a deregulation of publicity rules. The increased disclosure of information was justified as a watered down version of more drastic (profit-oriented) market mechanisms discussed before and during the national council. The issues of information disclosure and the provision of patient files were opposed by the medical association to the extent that they would render physicians liable in court. Once legislation on the issue was abandoned, and once physicians were granted the right to make final decisions regarding informed consent and the provision of medical files, the JMA stopped hindering reforms. The changes create a moderately competitive environment in health services.

The issue of the price determination mechanisms for medicines was of a more technical nature and attracted little opposition from the JMA. The only issue at stake for the JMA was that the creation of independent committees on medicine prices would have affected the jurisdiction of the Central Medical Council. Opening the door to reform on this issue would have invited steeper changes in the role of the Central Medical Council, as was requested by the insurers' side. The compromise reached with the MHW administration created two independent organizations to determine medicine prices under the jurisdiction of the Central Medical Council. The physicians lost their ability to influence medicine prices under the new organizations, but preserved intact the legal jurisdiction of the Central Medical Council. The case studies suggest that the most controversial issues concerning the
medical fee schedule and information disclosure would not have been tackled under the normal decision-making processes of the MHW and the LDP. Case studies similarly suggest the tendency for the LDP PARC on Medical Problems to protect the status quo and generally avoid the most conflictive issues.

The role of policy competition mechanisms in regulatory adaptation

These case studies indicate interesting relations between the attributes of the transaction as they affect the policy preferences of organized interests, and the flexibility of the regulatory framework in an advanced democracy:

The open policy competition processes of the national councils make it possible to consider a wide range of alternative policies, where particular actors are less able to influence the policy process to protect their own interests. Because national councils are organizationally costly, they are temporary means suited to the constraints of regulatory adaptation in areas where competing actors defend limited policy preferences.

By contrast, we can consider the role of the ministerial deliberation councils in the following way.

The ministerial and party committees protect the regulatory commitments negotiated with interest groups. Because ministerial deliberation councils are hierarchical organizations, they offer only a limited possibility for alternative policies to be considered. Their role is suited for decisions on relatively non-controversial (low safeguard) regulations and decisions that have limited impacts.

These relations help to shed some light on Lowi’s question regarding whether “policies create politics.” First, in the field of regulatory policies, we can generally
associate the attributes of the regulation (type of safeguard) to the width of the organized interests’ policy preferences, where limited policy preferences tend to protect a status quo. Second, we can associate the possibility to carry out controversial regulatory adaptation to certain institutional mechanisms, the ones promoting public policy competitions that limit tempering by organized interests. Inversely, non-controversial regulatory questions leave ample room to conduct adaptation within the hierarchy of a public bureau. If the scope of this research was widened to various sectors, we may be able to propose that because tempering (and interdependent relations between parties and organized interests) creates transaction costs in government relations, associating a proper institutional form to particular policy attributes may bring about more efficient governance in the state.

Thoughts for future research

Whereas the role of LDP policy groups has been the focus of an increasing number of studies, the dynamics through which they affect policy outcomes often remain unclear. Whereas this thesis focuses on some of the most organized interest groups of Japan, comparative analyses of policy groups in various sectors should be carried out through in-depth studies. Similarly, the central contention of this thesis that the creation of supra-partisan institutions complemented party-level commissions (in the sense that the former ensured the adaptation of regulations) should be tested on a wider scale and in various policy areas. In particular, case studies in the area of postal and telecommunications, finance and construction would provide a necessary complement to this thesis.
Appendix 1

A game-theoretical interpretation of policy-making in Japan:
The impact of national councils for reform on executive leadership

The rules of the game in LDP policymaking
Party committees and national councils in comparative perspective

Parliamentary systems are generally characterized by party discipline and the ability for the executive to retaliate by expulsion against members who oppose executive leadership. Japan has all the constitutional characteristics of a parliamentary system (including party discipline in the Diet) but its leading party, the Liberal Democratic Party, is formed by a coalition of factions. This affects executive leadership given the ability of party members to oppose legislative proposals in party proceedings prior to being sent to the Diet. This significantly affects the leadership of the prime minister.

This section shows how executive leadership could be increased under the Nakasone and Hashimoto administrations by designing supra-party policy-making institutions (national councils) to overcome party opposition. This demonstration proceeds with a game-theoretical interpretation.²

² On the application of game theory to policy decision-making, Michael Leiserson in particular provides an interpretation of LDP policy-making as a “coalition of factions” in Michael Leiserson, “Factions and Coalitions in One-Party Japan: An Interpretation Based on the Theory of Games,” The American Political Science Review 62.3 (Sept. 1968) 770-787. A more inductive approach is applied to the case of Dutch
The role of Policy Affairs Research Committees in the LDP

The LDP can be analyzed as a coalition of factions. Factions control the flow of finances in the LDP and promote the activities of zoku to ensure a flow of capital in preparation for elections. Because zoku members control decisions in the PARC committees, they may possess an interest in limiting executive proposals toward regulatory adaptation to protect the interest groups that sustain them.

Decision-making committees within the LDP play an important role in providing checks on any legislative proposal, as any proposal must first be approved in one of the Political Affairs Research Commissions of the LDP (PARC, or Seimu Chosakai). As of 1983, under the LDP Policy Affairs Research Commission, there were 17 divisions corresponding to ministries and Diet standing committees, with 93 special commissions. These party commissions play a more extensive role than the Diet's committees in controlling bureaucratic outputs. As these policymaking bodies possess a decisive power on whether to approve or postpone legislation reaching the Diet, they provide an indirect control over administrative actions.

The decisions adopted in the LDP Research Commissions may be reversed in the General Assembly of the Party (Somukai), which gathers LDP members from both the Lower and Upper Houses. The Research Commissions are the place where interest groups voice their demands. The capacity of these bodies to provide oversight on administrative coalitions in Michael Laver, "Divided Parties, Divided Government," Legislative Studies Quarterly 24. 1. (1999): 5-29.
3 Tsuchiya, Jiminto Habatsu koboshi: 33.
decisions has greatly increased with the creation of the LDP Executive Council in 1962, and further since the mid-1970s.6

Ultimately, whether interest groups achieve their policy objectives depends on the leaders of the party, and in particular on the faction leaders.7 A political game arises at this stage since faction leaders may reap higher payoffs by failing to instill discipline among faction members.

The intra-party procedures can be understood in three phases. A policy is proposed by the executive (or a party member), the PARC takes a position, and in the case of opposition faction leaders can discipline members in their faction. Thus, the policy process can be summarized in three phases:

Prime minister’s proposal \(\rightarrow\) PARC \(\rightarrow\) Faction leaders’ position
(Or Diet member) \(\rightarrow\) (Chosakai) \(\rightarrow\) (Discipline members)

Intervention by faction leaders and executive members of the LDP is the only means to reverse decisions taken in PARC. For this reason, whether the prime minister possesses the leverage to silence opposition in the party is crucial in understanding policy outcomes. If PARC supports the legislative proposal, the bill is sent to the Diet where party discipline applies among the various factions of the LDP. If PARC opposes, only faction leaders can discipline members into compliance.

5 For G. Curtis, "if there is anything comparable to the American congressional committee in the Japanese decision-making system, it is the division and not the Diet’s committee." Gerald L. Curtis, The Japanese Way of Politics (New York: Columbia University Press, 1988) 113-116.
Some variations can be identified in this process. First, faction leaders may choose to avoid disciplining members if they obtain political gains from doing so. This arises due to the difficulty for the prime minister to inflict costs on faction leaders if they fail to respect the executive leadership, and the higher payoff that faction leaders may obtain by opposing the party's executive.

Second, the prime minister can design supra-party decision-making committees, such as the Nakasone and Hashimoto national councils, if he fears opposition from the party. Such councils allow the prime minister to submit policy packages, rather than individual legislative proposals, and rely on a larger support from industry representatives and administrative actors, making zoku opposition more difficult. Zoku opposition becomes more difficult under such circumstances due to the payoff and costs functions that result from the policy procedure, as can be made clear in the policy games detailed below.

The game

The policymaking process can be disaggregated in three forms, depending on who supports the proposal and which policymaking channel (whether the LDP PARC or a national council) is adopted. Three possibilities are considered: a) a proposal directly emerging from the party executive channeled to the party, making policy proposals subject to factional consensus in party committees or Policy Affairs Research Commissions, or b) a proposal sponsored by the Party executive that originates from a ministry and is channeled to PARC, and c) a group of proposals channeled to a national council for reform, such as the Nakasone and Hashimoto councils, to design policy proposals independent from the party. For the purpose of the model, it can be assumed that all prime ministers have the
ability to rely on a national council, (which in reality may not be the case, particularly if the prime minister is not a faction leader or lacks authority in the party).

Figure 2. LDP Policy-making Game: Research Commissions Versus National Councils

Executive proposal

- Follow (1, -C2, 0)
- Punish (1, -C1, Rp)
- Defy
  - Ignore (-1, Pi, P0)

Executive/Adm. proposal

- Follow (-1, -C2 + Rm, 0)
- Punish (1, -C1, Rp + Rm)
- Defy
  - Ignore (-1, Pi - Rm, Pi - Rm - Rp)

Reform Package

- National council
- Follow (1 + Rc, -C2 + Rc, Rc)
- Punish (1 + Rc, -C1, Rp + Rc)
- Defy
  - Ignore (-1, Pi - Rp - Rc, Pi - Rp - Rc)

Executive LDP zoku/ PARC Faction leader

Key:
Pi: Payoff from interest’s groups to zoku members for opposing a proposal in PARC committees.
C1: Cost imposed on zoku members by faction leaders for defying the executive leadership.
C2: Cost of reprisal from interest groups to zoku members for following the executive leadership.
-Rm: Credibility hit in front of the administration for opposing a ministerial preference
+Rm: Credibility gain for supporting a ministerial preference
-Rp: Credibility hit inflicted to faction leaders for reneging on factional consensus
+Rp: Credibility gain obtained by faction leaders for disciplining zoku members.
-Rc: Credibility hit for opposing an inter-administrative agreement in a publicly open national council.
+Rc: Credibility gain in front of an inter-administrative agreement in a publicly open national council.
If a proposal is submitted to the party, zoku members in PARC have the option of following the executive or defying the proposal in LDP committees before the proposal faces the Diet. If decision-making is carried out in a national council, the executive has a choice between designing specific legislative proposals reviewed one by one in the party or having the party adopt a council’s report, then mandating the administration to design regulatory guidelines (Nakasone adopted the first option, Hashimoto the second). Figure 2 models through an extensive game the various strategic options that derive from these procedural rules and different channels. It is assumed that party members always have a choice between following or defying a proposal in the party, before the proposal is sent to the Diet. This game therefore concerns only the policymaking procedures in the party, and prior to a Diet vote where party discipline would apply.

Second, members of the Party Policy Affairs Research Commissions are situated in a triangular relation with the prime minister (which can only retaliate against members of his own faction), their faction leader (which can directly retaliate against PARC members), and organized interests (which can also impose costs to politicians who do not follow their preferences). Faction leaders may retaliate against recalcitrant members (call this retaliation cost C1). Also, call the cost inflicted on politicians who distance themselves from the preferences of an interest group C2 (greater or equal to zero), and the incentive to follow an interest group’s preference Pi (payoff from the interest group).

Politicians are concerned about maintaining their reputation in the party, in front of

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the administration, and in front of the public. Reputation in the party is important mostly to faction leaders in the mainstream factions (i.e. the factions that support the prime minister). Because such faction leaders have allied themselves to the prime minister (which by definition makes them part of the mainstream group), they must maintain their reputation in front of party members and sustain alliances with other faction leaders. Call this reputation $R_p$ (for Reputation in the Party: positive if it represents a gain, negative if it represents a hit). Generally speaking, it is easier to shirk on proposals coming from a weak prime minister coming from a smaller or financially weaker faction.

The ministries directly participate in policy-making as they often pressure politicians into adopting their policy proposals. Ministries cannot directly retaliate against politicians who oppose their preferences however, but defection may sever the relations between a ministry and particular politicians known to protect organized interests too closely. Remember that politicians rely on the administration for information given a lack of staff in the party. (Call this a credibility hit -$R_m$ imposed on politicians for distancing themselves from the administration in a vote in the party or in the Diet, and a credibility gain $+R_m$ when a politician allies the administration).

The public reputation of politicians is the last aspect considered. Because party proceedings in PARC are not open to the public and are unequally reported in the media, politicians and zoku members are not affected by the reputation gain (or loss) they may suffer from the public in such proceedings. The proceedings of a national council are, by

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contrast, widely reported in the media, making Diet members wary as to how the public will perceive them. Call the credibility gain obtained from supporting popular proposals in the council $R_c$ (and the credibility loss from the public $-R_p$).

Following these conditions, Figure 2 depicts the various payoffs that derive from the ability of LDP industry policy groups’ ability to defy executive proposals, and the role of faction leaders in carrying out discipline within the party. The game is primarily aimed at comparing the payoffs at the level of the party and at the level of a national council. It shows that due to the higher risks for faction leaders to face credibility hits in the open processes of a national council, their tendency to punish recalcitrant members will be greater than under the normal policy-making conditions of the party.

Situation 1. Party committee, no administrative input

The simplest situation this game gives rise to is that of a prime minister prompting the party to consider a policy proposal within LDP committees, a Policy Affairs Research Commission, to reach inter-factional consensus. If the prime minister obtains party members to follow his leadership, he obtains a payoff in the party (established at a value of 1), but PARC members that have followed the executive may suffer retaliation from interest groups ($C_2 \geq 0$ which may take the form of a reduction in financial contributions) for having adopted a position that counters their interests.

If PARC members defy the executive, then the game enters into a second stage depending on whether faction leaders decide to ignore the defiance from their faction members, or to threaten retaliation. The faction leaders of the mainstream factions should
consider punishing recalcitrant PARC committee members because they are allied to the president of the party and must maintain their reputation in the party (the game would thus take the form: EXECUTIVE PROPOSAL: DEFY: PUNISH, bringing faction leaders a benefit Rp and inflicting on zoku members a cost C1 for having defied the party executive (note that in practice faction leaders only threaten to inflict costs, which could take the form of expulsion from the faction or the party, and reduced financial support). However, ignoring the party members' defiance may bring a greater benefit from interest groups, enticing faction leaders toward the option EXECUTIVE PROPOSAL: DEFY: IGNORE, to reap benefit Pi (with the outcome being -1, Pi, Pi where both faction leaders and zoku members obtain a payoff from interest groups). On the committee members and zoku's side, defection brings a benefit from organized interests whose preferences they followed (Pi for payoff, interest group).

This game brings no obvious equilibrium, as the strategies necessarily depend on the importance for faction leaders of maintaining their reputation in the party, versus the financial benefits of interest groups supports. In such a case, the size of the prime minister's faction and the inter-factional support behind the executive determines the extent to which the prime minister is able to convince faction leaders to retaliate against zoku members to reverse the decision of the PARC. (Because such threats to retaliate are generally not credible, zoku members tend to follow interest groups' preferences.)

The strong faction maintained by Tanaka in the 1970s allowed him to maintain consensus in party committees due to its size and financial resources. The influence of Tanaka was also felt during the 1980s when the difference between mainstream and non-
mainstream factions vanished. The case study on the abolition of the preferential tax treatment also showed the importance of the inter-factional consensus in carrying out regulatory adaptation. The tendency may however favor a protection of the status quo and regulatory commitments. Concerning the Elderly Health Care Law in the 1970s, the ability of the Japan Medical Association to inflict costs on party members was seen as greater than the reputation hit that faction leaders would have suffered by failing to instill party discipline.

Situation 2. Party committee, administrative input (Ministry of Finance)

The second situation considers the possibility that the administration intervenes in the policy process. (The influence of the Ministry of Finance in the regulatory process is particularly taken into consideration). In this case, the game is exactly the same as above, except that a credibility hit (Rm, or reputation hit from the administration) is added to the equation.

In this case, the faction leaders follow the prime minister’s leadership if retaliation from the faction leader (C1) and the credibility hits (from the administration, Rm, and the party Rp) are greater than the ability of the organized interest to retaliate (C2). Because party members must rely on the Ministry of Finance to support programs that they want to consider, the credibility hit may be substantial and sufficient to support regulatory

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10 The division within the party reappeared under Prime Minister Miyazawa with the division of the Takeshita Faction into two groups, and the creation by Ozawa Ichiro of the Hata Faction which played a part in the June 1993 non-confidence vote against Miyazawa. Prime Minister Hashimoto originally avoided divisions in the party, although the Kato and Yamasaki Factions, which opposed him, later played a part in the creation of an inter-factional 78 Diet members’ group (the so-called Kaikaku Giin Renmei) in December 1998 under the Obuchi Cabinet.
adaptation. Thus, regulatory adaptation will be attained if:

\[ C_1 > C_2 - R_m - R_p \]

The equilibrium will be \( (1, - C_2 + R_m, 0) \) if PARC members follow the ministerial/executive proposal. The executive gains a payoff for having succeeded (value of 1), whereas the faction members who opposed interest groups suffer a loss \( C_2 \) but gain in terms of their reputation in front of the administration. Faction leaders are left out of the negotiation process.

This explains why involvement of the Ministry of Finance became necessary in promoting partial changes over such issues as the preferential tax treatment (1979), the implementation of a single-fee upon entrance for elderly institutions (1993), and the introduction of a medicine pricing system limiting the profits of physicians. These changes were incremental yet important, as they set the stage for a consideration of deeper reforms.

Various reform proposals were nonetheless opposed during the 1970s, even when proposals were jointly sponsored by the MoF and the party executive. In great part, this was due to the fact that faction leaders ignored the opposition of the PARC members (with the outcome: EXEC./ADM. PROPOSAL:DEFY:IGNORE and payoffs of \( (-1, Pi - R_m - R_p, Pi - R_m - R_p) \) where PARC members and faction leaders jointly reap the payoff from the interest group (Pi)).

**Situation 3. National council: Legislative settlements or administrative guidelines**

What happens if a national council is organized? The executive will carry out deliberations in the council and then submit the proposals to the LDP committees as a whole (that is, both Nakasone and Hashimoto submitted a council report to be adopted by
the LDP in its entirety, rather than submitting proposals separately). The payoff from achieving regulation through a national council may then be equal or even greater for the prime minister if public support is granted to the executive under an open policy process. The reputation gain from the council (Rc) provides an incentive for the prime minister to carry out more ambitious reform programs through open and public proceedings.

The reputation of Diet members is also at stake in open proceedings. Party members may, under such circumstances, take into account the payoff (1+Rc) of the prime minister if popularity is enough in reinsuring their re-election, by distancing themselves from organized interests even if they suffer a cost C2. So that 1+Rc>C3 would ensure party unity (with the equilibrium being NATIONAL COUNCIL-FOLLOW: (1+Rc, -C2 + Rc, Rc)) without looking into the various costs structure.\(^\text{11}\)

The tighter assumption that politicians act in their self-interest provides a more secure means to evaluate policy outcomes. The structure of the costs explains the relatively greater success of the council in regulatory reforms. That is, the cost inflicted from interest groups to politicians or factions that do not respect its policy preferences remains unchanged (C2). But given the public accountability of the council, the ability of the executive to undermine the reputation of faction members that would defy the voice of an independent council is increased (Rc > Rp).

The inter-administrative character of the national councils also adds to the pressure inflicted to Diet members to respect administrative proposals (Rc > Rm). Because the

\(^\text{11}\) Note that this would apply anytime the policy proposal attracts popularity. Under the Miki administration (1974-76), party members supported a watered down version of the Law on Party Finance even if they preferred no law at all, because of the prime minister's public appeals after the corruption scandals involving Tanaka Kakuei.
council is backed by administrative proposals and/or planning from various administrations, the credibility hit that opponents would suffer is also increased in the council, making $R_c$ greater than $R_m$. The credibility for opposing the Nakasone council included not only the MoF, but also backers from the most important industry associations, the Keidanren. The Hashimoto council relied on four administrative bodies and various proposals were separately supported by industry associations and labour unions. Popular support was greater for the less technical Nakasone national council.

Moreover, the threat of retaliation from faction leaders allied to a prime minister having made public commitments tends to become more credible, so that the cost ($C_1$) does not vary, but the ability to carry out the threat is increased (recall how Nakasone in particular made his re-election dependent upon the acceptance of reform by faction leaders in the 1984 Commission on Administrative Reform; note also that Hashimoto was not able to maintain this alliance with faction leaders and resigned). This increases the chances for regulatory adaptation, particularly if the council submits a large set of proposals to be accepted or refused altogether by the party. In such an instance, refusal to cooperate would force the prime minister to step down (this situation is however possible given that Japan has had nine prime ministers in the last ten years, and that Hashimoto was ousted in 1998 two years after instigating his Administrative Reform Council).

In the case of the Nakasone national council, legislation was required on the question of patient contributions, and zoku members who defied the executive faced expulsion from the party. Under this circumstance, the equilibrium was unique and stood at (NATIONAL COUNCIL: DEFY: PUNISH, with outcome $(1+ R_c, -C_2, R_p + R_c)$) where the executive gained a payoff from the council and a reputation gain $(1+R_c)$, whereas zoku
members were threatened with retaliation by their faction leader (C1). Faction leaders stood to gain by punishing recalcitrant faction members by reaping a payoff deriving from reputation gains in the party and in the council (Rp+Rc).

The game was repeated between 1996 and 1998 under the Hashimoto Administrative Reform Council. In this case, Prime Minister Hashimoto achieved factional consensus through the Inter-party reform committee, in a series of proposals on reforms adopted concurrently by the administrations and the LDP Reform Headquarters. This strategy superseded the zoku members, and presented the reform agenda as an entity that the party either entirely rejected or entirely supported in Reform Headquarters composed of reformist members linked to the commerce zoku. The party accepted the program in its entirety with minor reforms, with an outcome (NATIONAL COUNCIL: FOLLOW, (1+Rc, -C2 + Rc, Rc)). In this case, since no actor defied the voice of the executive and the voice of the national council, all actors gained in reputation (+Rc), while welfare zoku members remained under pressure from interest groups under the threat of being inflicted a cost C2.

The Hashimoto national council carried out regulatory adaptation through administrative guidelines to avoid having PARC committees reconsider every legislative proposal after the council. Carrying out regulatory adaptation through legislative amendments was considered repeatedly during and after the council between 1997 and 2001, but as this option implied a re-negotiation in the party and in the new coalition government, the administration supported by the mandate obtained from the October 1997 inter-party report, carried out regulatory adaptation from within the Central National Council and the MHW. The Obuchi administration supported such plans in its Economy Strategy Council, without making further commitments for reform.
Therefore, the Hashimoto national council was responsible for defining the mandate for reform, but the rules of the Central Medical Council in the Ministry of Health and Welfare applied to determine the exact content of the regulatory reform. Because there was a strong consensus established between the MHW, labour unions, industry associations, and insurers, the Council could decide to implement a reference pricing system for medicines, and determine the scope of information disclosure.
<table>
<thead>
<tr>
<th>Date</th>
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<tr>
<td>20 Apr. 2001</td>
<td>MITI Health Care Research Committee member.</td>
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<tr>
<td>20 Apr. 2001</td>
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<td>Foreign Pharmaceuticals Association. Health Care Specialist.</td>
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<td>5 May 2001</td>
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<td>Health Care Specialist. University of Tokyo.</td>
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<td>24 Dec. 2001</td>
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