# Health Policy Formulation Practices of the American Medical Association (AMA) and the Japan Medical Association (JMA)

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# I. Introduction

## 1. Objectives of the Study

With the advent of the 21st century, Japan is faced with a rapidly aging population that is exceptional even among the advanced nations. Against this milieu, the Japanese government is under pressure to restructure its social security system in terms of structure and economic efficiency. It can not be said that the approval of bureaucratic reforms implemented under the traditional model of leadership provided by the Ministry of Health and Social Welfare are in the best interests of the Japanese people.

The Japan Medical Association (JMA) established the Japan Medical Association Research Institute in July 1997. The objective of this institute is to explore new decision making processes of health policies which have traditionally been carried out by the JMA, in its capacity as an organization of professional medical specialists representing the interests of the Japanese people on vital issues that will determine Japanese health care policies and practices in the 21st century. In addition, it will seek a wide-ranging consensus from all levels of Japanese society on the impact of health care policies; and it will strive to enact their legislation based on this consensus.

In view of this basic stance on health policy by the JMA, the feasibility of legislating health care policies formulated by the JMA, especially the feasibility of legislation by Japanese Diet members which is rarely achieved, was studied.

This study has been implemented as an ongoing topic of research in the wake of the paper entitled, “Policy Analysis Capacity at the American Medical Association”, compiled in March 1997 and the paper entitled, “Research on the Role of Executive Vice President at the American Medical Association (AMA)” which was compiled in August 1997 by Professor Michael Reich of the Harvard School of Public Health under the Takemi Program in International Health.

## 2. Study Approach

As mentioned above, an analysis of AMA’s policy formulation practices and the role of the Executive Vice President were reported in the two research papers, “Policy Analysis Capacity at the American Medical Association” and “Research on the Role of Executive Vice President at the American Medical Association (AMA)”. Based on these two studies, the real influence of AMA’s House of Delegates on health care policies was explored by utilizing data obtained from an interview survey carried out at the AMA and the Japan External Trade Organization (JETRO) in New York and by researching written material, etc. on the feasibility of applying such policy formulation practices by the JMA.

Particularly, in the area of AMA health care policies, an understanding of the overall organization of the AMA is necessary in order to understand how health care policies are promoted. As a result, a segment of the information contained in this report duplicates the content of the two papers mentioned above.

## II. Organization of and the Process of Health Policy Formulation at the AMA

A summary of the organization concerned with health care policy within the AMA and the process by which health care policies are formulated have been presented, based on interviews with the AMA personnel in charge of health policies.

### 1. Demographic Composition of Physicians in America

There are presently about 750,000 to 800,000 physicians in the United States. The number of so-called general practitioners has continued to drop; and they comprise approximately 5 percent of the overall population of physicians. Primary care family physicians, general internists, pediatricians, obstetricians, and gynecologists follow them; and their total comprises about 35 percent of all physicians. The remaining 60 percent are specialists. The trend in an excess of specialists is due to the high income earned by specialists which allow these physicians to work in an environment that is commensurate with their educational costs.

There are many remote regions and rural areas in the United States and although physicians who work in such areas are to be commended, it is difficult to allocate specialists to such areas. As a result, there is a surplus of specialists who are overly concentrated in urban areas.

Federal government decision-makers are of the opinion that high health care costs are partly the result of a surplus of specialists. In addition, they believe that physicians are unable to maintain an appropriate level of technical knowledge. Consequently, they would like to change the share of specialists and other physicians to a ratio of 50:50.

### 2. AMA and Membership Recruitment

#### (1) Number of AMA Members

There are approximately 300,000 members as of November 1997. About one half are specialists; 20,000 are medical students, and 30,000 are residents. Together, they comprise 42% of the entire population of physicians in the United States and the AMA membership ratio of physicians has tended to decrease yearly (see graph). However, due to the existence of numerous AMA associated sub-organizations, all physicians are affiliated to the AMA in some way.

For example, a surgeon who is a member of the American College of Surgeons, but who is not a member of the AMA, has a substantial impact on AMA views, activities, and their management through the representative of the American College of Surgeons who attends the AMA's House of Delegate meetings and votes on AMA resolutions on behalf of the society. In other words, it can be said that nearly all physicians in the United States are affiliated in one way or another to the AMA's policy decision making process. However, the ideal goal of the AMA is to achieve a 100 percent membership ratio and the AMA continues to strive for a gradual increase of its membership.

#### (2) Merits to Joining the AMA

The AMA has listed the following advantages to becoming a member of the association.

1) Members have the right to voice their views to the AMA and they receive copies of the Journal of the American Medical Association (JAMA) and the American Medical News. In addition, toll free numbers are available to members calling for various information, and they are eligible to receive publications, discounted prices on products,

etc.
2) In particular, members are eligible to utilize the services of AMA's representative negotiating units to negotiate with hospitals and managed care plans. In addition, the AMA provides information to members on new laws and their impact on the medical field.
3) The AMA requires that its members abide by the medical ethics for physicians that are promulgated by the AMA.

**3. Summary of the Organizational Structure**

The AMA employs approximately 1,100 administrative staff members to implement the work of the organization. The organizational structure of the association is comprised of five groups as shown in the attached organizational chart (Professional Standards, Health Policy Advocacy, Strategic Management & Development, Membership Constituency & Federation Relations, and Business & Management Service). The role of each group is explained below. The following discussion describes the organization as of November 1997 (as shown on Appendix 1). It is important to note that the AMA in 1998 is undergoing wide-ranging reorganization. The structure changed first in February 1998 (as shown on Appendix 2) and is expected to change again in June following the meeting of the House of Delegates.

**(1) Professional Standards** (200 staff members)

For medical education, the AMA is the parent organization of two bodies able to accredit medical school programs: the Liaison Committee on Medical Education (in partnership with the Association of American Medical Colleges), and the Accrediting Council on Graduate Medical Education. In addition, it is also a member of the organization that accredits Continuing Medical Education (CME) courses, the Accrediting Council on Continuing Medical Education.

For medical facilities, the AMA is a member of the Joint Commission on Accreditation of Health Care Organizations (JCAHO). It has plans for a new system of the American Medical Accreditation Program (AMAP), in which the AMA would issue a "seal of approval" after reviewing physician and specialist licensing and accreditation. Finally, to implement its programs on professional standards, the AMA employs academic specialists in pharmaceuticals, HIV, geriatrics, cigarette smoking, public health, etc.

**(2) Health Policy Advocacy** (200 staff members, including 100 staff members of the Washington office)

This group is responsible for promoting a diverse range of AMA policies, in addition to formulating policies on government planning, relations with the private sector, and other issues related to financial problems. The councils (comprised of appointed or elected physicians) guide the staff on policies. In addition, it is in charge of the administrative tasks of the HOD and the Board of Trustees (explained below in section "4").

**(3) Strategic Management & Development** (65 staff members)

The Strategic Management and Development group is responsible for assessing what the AMA should do at present and the needs of its members, and for developing plans that meet these needs. It is also responsible for increasing the membership constituency (to increase the organization's coverage ratio), an extremely important

issue for the AMA. Since the AMA is a voluntary organization, physicians are not required to join the association and there are many nonmember physicians. As mentioned earlier, the current ratio of members is 40 percent of all physicians in the United States (see the graph on the organization's ratio of members).

**(4) Membership Constituency & Federation Relations** (125 staff members)

This group is responsible for increasing the number of association members. It is in charge of relations with all member medical societies.

**(5) Business & Management Service** (500 staff members)

This group is responsible for all business-related matters. The publishing activities of the AMA are an especially large source of revenue for the association. JAMA, which is an international publication, is one of AMA's vital publications. The computer section is also included in this group.

**4. Summary of Groups Concerned with Health Policies**

**(1) Role of the Health Policy Advocacy Group**

The Health Policy Advocacy group fulfills three major functions. The first function deals with communication or liaison with the press and mass media. Public relations personnel are in charge of answering telephone inquiries and setting up press conferences.

The second function is fulfilled by AMA's Washington office, which is in charge of overseeing government related issues on a nationwide level. Staff members are in charge of overseeing communications with Congress. This section is concerned with government administration, the White House, and Congress. AMA's political activities are carried out through its Washington office. Election funds are collected through the American Medical Political Action Committee (AMPAC) , which also serves to educate physicians on the political process. There is also a system that recommends physicians for government positions and a system, which promotes communication on specific issues between physicians and members of the Senate and House of Representatives. Presently, information and requests are faxed to this section from the entire country and an electronic environment has been established which allows information to be sent via telephone and e-mail (presently, paper, newsletter, and emergency reports are used, but these forms of communication are costly and time-consuming).

The third function mainly involves physician education and requests to address specific issues in health policy. In addition, it supports the councils in the areas of legislation, ethics, agreements and articles of incorporation, medical services, academic issues, medical education, long-term planning, etc. The councils are comprised of AMA members.

**(2) How the AMA Determines Policy**

In principle, activities are based on the demands of members that are presented to the HOD through delegates. Members are able to submit resolutions to the HOD through their representatives from a state medical society or medical specialty societies. The HOD meets twice yearly, in June and December. To handle the resolutions, it convenes reference committees at which any HOD member may testify (though few do).

Reference committees are composed of members of the HOD. Each reference committee votes whether to recommend adoption of the resolution by the HOD, non-

adoption, or substitute language for the resolution. At the House of Delegates, members vote on recommendations from the reference committees. It can vote to accept, reject or refer resolutions to the Board of Trustees. It can also substitute new language for resolutions. AMA policy is the result of votes by the House of Delegates and can take the form of statements ("the AMA opposes human cloning") or directives ("the AMA staff shall communicate x to Congress"). If a resolution is referred to the Board of Trustees, it decides whether to recommend the policy to the HOD. These recommendations are debated in the HOD and they are referred to a Reference Committee, similar to the process in which a resolution is decided, and finally voted on by the HOD. For example, if a resolution has been adopted as a policy, it is published in the Policy Compendium of that year and implemented.

Each reference committee is organized only during the duration of a HOD meeting and they are disbanded at the end of each meeting; and new reference committees are created at the following HOD meeting. Each committee is comprised of physicians. They are responsible for reviewing all the proposals and they submit their recommendations accordingly. The hearing of each delegate is freely conducted and each delegate casts his or her vote based on the recommendations that are made.

In the case of emergencies, the Board of Trustees is empowered to take action based on decisions made by the Board independently of the HOD. In such cases, the administrative staff is instructed accordingly and the decision is implemented. Although measures to hold emergency HOD meetings exist, in actuality, they are used, but are debated at the next HOD meeting. The Executive Vice President (EVP), who is appointed by the Board of Directors, holds the actual reins of leadership (see "Research on the Role of Executive Vice President at the American Medical Association (AMA)" for further details).

**(3) Relations Between the Board of Trustees and the Councils**

The Board of Trustees is comprised of 21 members, the HOD has 477 delegates, and the number of members, which comprise a council, differs accordingly. The Council on Legislation is comprised of 13 members and one professional staff member.

The HOD elects the Board of Trustees and all members may stand as a candidate for the Board. There are some posts where young physicians, residents, and medical students are slotted. Numerous committees and six councils support the Board of Trustees, which is responsible for the day-to-day operations of the association. The Council on Legislation is the only council created by the Board of Trustees and the HOD elects the remaining councils.

The councils are expected to function according to AMA policies, which are established by the HOD. Council members are elected from among HOD delegates or medical student members and the professional staff supports them. Their term is limited to eight years, but the term of professional staff members is unlimited. This is an extremely important factor when implementing policy (see Appendix 3).

The proposed resolutions and demands are thoroughly debated by the councils and the HOD who vote on the recommendations submitted by the councils. Numerous committees existed until 1975, but due to subsequent problems involving cost and operations, many were integrated or disbanded into the six councils that exist today. When the committees were integrated into councils, it became important to establish continuity, due to the extremely large scope and range of information; and as a result, staff members were allocated to the councils. Consequently, professional staff members

are placed under the leadership of the physicians and they are responsible for following up the work.

**(4) Policy Compendium**

The Policy Compendium is mainly concerned with legislation, health care services, scientific and medical education, agreements and articles of incorporation, long-term planning, etc.

Policies in these areas are decided by the HOD and implemented by the Board of Trustees. In the event a decision is not reached, the Board of Trustees will submit their recommendations at the next HOD meeting. Recommendations are either passed or vetoed by the HOD. When a recommendation has been passed, the Board of Trustees instructs the staff on its implementation. However, the Board of Trustees is required to compile a report on recommendations that are not passed if additional information is required.

The councils, which are manned by professional staff members, are often requested to compile reports by the Board of Trustees, in addition to reports that are compiled independently by the councils.

Although not all of the adopted issues are recorded in the Policy Compendium, many of them are. As a rule, action is taken on requests for letters or items that are unrelated to policy principles, but they are not recorded in the Policy Compendium.

All policies that are adopted are recorded annually in the Policy Compendium; and they are reviewed, carried over, revised, or deleted every ten years. However, these changes are relatively minor. In addition, due to the enormous volume of the Policy Compendium, it is also available on diskette to enable data search by computer (Windows program).

The Policy Compendium is a compilation of the goals of the AMA and it contains the policies that are the backbone of AMA activities.

**(5) Grass Roots Political Activities**

Grass roots political activities are also considered important in AMA health care policies. A case example of one such movement is presented below.

Under American law, physicians have the obligation to extend care to all patients in need of treatment. A reasonably informed person who goes to the emergency room is legally entitled to care. Under this law, the doctor bears the risk of treatment. For example, the emergency physician suspects a patient under the managed care system that is in pain and seeks emergency medical services, as suffering from a heart attack. However, he is found to be suffering from a stomachache on further examination. The insurance companies, which will cover the costs of emergency care for a heart attack, will not do so in the case of a stomachache. The physician will insist that the examination fees be paid since the patient received an examination, but the insurance company's stance is that medical fees will be paid in the case of a heart attack, but not for a stomachache. Due to the conditions of the contract signed between the insurance company and the patient, the patient cannot be billed. Despite the fact that the physician provided the patient with medical care, judging him to be an emergency case, the services, which were provided nonetheless, become free of charge.

In cases where the patient's condition has been appropriately judged as an emergency, AMA's stance is that the insurance company should pay the medical costs. Although the AMA will request the insurance company to change its policy, rarely have insurance companies cooperated. Insurance companies will usually insist, "No, we can

not pay these costs. The insurance contract has already been drawn up." Consequently, the AMA and the state medical society will present the case to state legislatures; and with a revision of the laws, they will demand that the insurance company pay the medical costs.

A large segment of such activities require financial and administrative guidance and with the establishment of legal standards that stipulate where the responsibility lies, in effect raises the quality of the care provided to patients.

**5. Collecting Information as a Means of Policy Assistance**

**(1) Data File on All Physicians Within the United States**

The AMA possesses a master file on all physicians in the United States irrespective of whether the physician is an AMA member or not. Data on the physicians' life insurance address, specialist training, medical university, and other data are maintained. This information is collected and owned independently by the AMA and it is utilized in each report that is compiled. Physician data summaries are also reported to the HOD.

**(2) Policy Promotion Surveys**

A survey and analysis staff that is responsible for promoting AMA policies is comprised of 15 members who are mainly economists and computer specialists.

In surveys where continuous data are required, such as long-term information on the activities of physicians, the same questions are used in the annual questionnaires, but space is also given for new questions that are included only for that year in conjunction with a special project.

For example, major changes have occurred in private medical practice over the last ten years and an investigative study on the developments taking place among small medical groups, specialized medical fields, and private medical practitioners is being conducted. The results of the study indicate that many physicians have joined large medical groups, numerous specialist groups or have become employed by hospitals or medical health insurance related hospitals; and there is a decline in physicians engaged in private practice. This information has enabled the AMA to formulate basic medical policies that meet the needs of physicians through an understanding of the actual environment that surrounds them. The government has also requested this data, but the AMA on a case releases it by case basis.

The number of samplings undertaken by the study contains about 1500 samplings that are ascertained as statistically effective; and they are divided into members and nonmembers. In addition, survey reports that investigate the views of other researchers are used to promote policies. Personal interviews are also carried out, but only ideas are solicited in such interviews and they do not appear to be very effective in terms of the cost involved. Telephone surveys are also conducted.

**(3) Use of the Internet**

The AMA maintains a web home page (for both the general public and members); and plans are under consideration to implement a questionnaire survey that targets physicians utilizing the Internet in future. However, a major precondition is that physicians have access to the web site.

Due to the large numbers of physicians who still do not possess a computer, do not type, or do not access web pages, it is difficult to a collect sample suitable for survey implementation. However, the spread in the use of the Internet among physicians in future is an undisputed fact; and its potential use as a new survey tool is anticipated.

**6. Expenditures in Health Care Policy**

Approximately 60 to 70 percent of the AMA's annual income is generated from business and the remaining amount of its revenue stems from membership fees. The total annual ratio of expenditures pertaining to health policies ranges from 10 to 12 percent.

## III. The AMA and Its Political Activities

### 1. Role of the AMA Washington Office

The major responsibilities of the AMA Washington office are to investigate what is occurring in the Congress in the area of domestic legislation, to determine what is needed for AMA policies, and to study what action needs to be taken in order to promote them.

In other words, the lobbyists at the Washington office are responsible for continually communicating AMA policies and important issues to both the House of Representatives and the Senate and their respective staff. They are also responsible for appealing AMA's interests to the President, the White House, relevant government departments and agencies, and especially Health and Human Services. A vital role of the Washington office is to negotiate the health system with relevant parties based on directives from the AMA Chicago headquarters. Both the AMA headquarters and the Washington office maintain close communication through telephone and e-mail, as well as frequent trips by personnel between the two offices. The Washington office will put pressure on Congress, promote AMA countermeasures, and obtain information on movements in the federal government and the House of Representatives.

A case in point is the Medicare system where the federal government expends approximately $200 billion annually to cover the medical costs of the handicapped and of citizens over the age of 65 years. This system is extremely unstable. There is a tendency for financial expenditures in health care costs to be suppressed in advanced countries, irrespective of the required health care costs of its population; and the United States is no exception. As in other advanced nations, America also faces an aging population and the working population has tended to decrease in comparison to the retired population.

Consequently, a review of the Medicare system, its financial resources and its administration will be submitted to Congress in 1999. A federal committee to review the functions of the health insurance system and the quality of health care will be created in 1998. Based on this committee's report, legislation will be debated in 1999. As of March 1998, however, this plan had not been implemented. The demands of the AMA members are to stabilize financial resources for the Medicare system and to prevent the government from interfering in the patient and physician relationship. The AMA is considering policy measures that will incorporate its views in the Medicare system and it is planning a policy proposal that it intends to submit to Congress.

### 2. Strategy of the Washington Office Activities

The strategy of the Washington office is to put pressure on the government and Congress on health care policy changes with the cooperation of other medical related organizations that have the same concerns on specific funds and funding plans. In addition, the strategy of AMA's grass roots political activities is to recruit physicians who will communicate with Senators and Representatives. Senators and Representatives make it a point to know the views of the electorate in their electoral districts, in order to gain an advantage in the election. The AMA asks these physicians to fax or telephone in the views and policies of the association on relevant bills that are important to the organization. The physicians who are contacted will communicate with the Senator or Representative of their respective district by telephone or other means and request that an appropriate decision is made on a relevant bill. The physician electorate in each district will carry out the same action. As a result, due to the large

influence which physicians exert on the Senators and Representatives and their staff, the steps taken by these physicians are combined with that taken by the professional lobbyists and their multiplied impact can be significant. In the event a physician has a problem related to health care services on an individual level, the AMA staff will request a meeting with a Senator or Representative when he or she has returned to their electoral district to discuss the problem. The AMA's stance is that its policies side with the patient.

America's political system differs from the British parliamentarian system and its citizens directly elect the President, who holds the highest office of the nation. As a result, despite the fact that the Republican Party controls Congress, President Clinton was elected from the minority Democratic Party. Since the political party that has actual control of Congress and the political party of the Cabinet members appointed by the President differ, the influence wielded by present day Congress is the antithesis of that which stems from a united Congress and Cabinet. As a result, mainly individual committees in what are referred to as committee politics carry out legislation. Lobbying is an effective means of advocacy under such a system.

## IV. Present of Legislation Initiated by Japanese Diet Members

A brief summary of the Japanese parliamentary system is introduced, followed by an explanation of the present system of legislation initiated by Diet members, specific examples of such legislation, and the future of such a system. The aim of this report is to explore the current condition of legislation initiated by Diet members and its possibilities. Political issues that are related to this legislative process will not be dealt with in depth.

### 1. Japanese Parliamentary System

The Japanese parliamentary system was modeled on the parliamentary system of the West in the latter half of the 19th century. However, in accordance with the Japanese constitution, which was enacted after WWII, the state authority was strictly divided into three independent divisions of legislation, judicature, and administration (tripartite system). The Diet was established as the nation's supreme body of state power based on the parliamentary system (Article 41 of the Constitution) and its legislative powers are in principle, based on general elections.

The Diet is comprised of the House of Representatives (500 members) and the House of Councilors (252 members). It is empowered to designate the Prime Minister who is the head of the Cabinet, the core administrative power, from among the Diet members through an electoral process (Article 67 of the Constitution). The Prime Minister is empowered to appoint the ministers of state (Article 68 of the Constitution) and to organize the Cabinet. Thus the Cabinet is formed with the confidence and support of the Diet to which it is politically and collectively responsible to (Article 66, Item 3 of the Constitution). Conversely, the Prime Minister has the authority to dissolve the House of Representatives. This authority allows the Prime Minister to seek a declaration of intention from the electorate which is responsible for electing Diet members and it allows a system of checks and balances to exist, ensuring the fair distribution of power between the Diet and the Cabinet.

The Japanese parliamentary system that is comprised of a Cabinet and a Diet elected by the people in whom the sovereignty of the state is vested in, is based on what is known as a unified parliamentary cabinet system. This system allows the will of the electorate, i.e. the will or opinion of the people, to be known to the Diet through elections and subsequently, it is reflected in its administrative power (Cabinet).

However, in reality, the majority of the candidates enter the national elections with the support of a political party and the winning candidate enters the Diet as a Diet member. As a result, the leadership of the Diet lies in the hands of several parties and electing a Prime Minister from within their rank forms the Cabinet. The Cabinet and the political parties of the Diet are united. Instead of a balanced control of power between the Diet and Cabinet, a Cabinet controls the Diet whose base of support is the majority party. Subsequently, legislation submitted by the Cabinet is passed easily by the Diet and administrative power tends to predominate. It is generally said that the existence of the opposition parties that provide the impetus for a possible turnover in administrative power is an essential factor, which prevents this from becoming a permanent reality.

## 2. Role and Characteristics of the Diet

As explained earlier, the Diet is the supreme body of state and it is the sole legislative body in Japan (Article 41 of the Constitution) with the power to decide the rights and duties of Japanese citizens and to enact laws. Some of the other major roles fulfilled by the Diet include the power to nominate the Prime Minister, to monitor the administration and judiciary, etc.

Although the Diet adopted the two-house parliamentary system of Great Britain, the American congressional system of committees was introduced in the aftermath of WWII. Consequently, all reviews, particularly those pertaining to legislative matters are submitted to the committees. At the end of committee deliberations, the respective committee chairman submits a review to the Diet and the Diet makes a ruling on these reviews (single review system). This implies that deliberations on legislative matters are concentrated in the hands of the committees rather than in the plenary sessions of the Diet (system of committee referendum).

There are two types of committees, the standing committees and the special committees that are established with each session of the Diet. There are 20 standing and 9 special committees in the House of Representatives and 17 standing and 8 special committees in the House of Councilors. Although the plenary sessions of the Diet are open to the public, the committees are not, with the exception of the mass media and persons with special permission from the committee chairman.

When both houses pass a bill, it becomes a law. If both houses differ on a bill, the decision to pass a bill by the House of Representatives takes precedence over that of the upper House. In other words, if the House of Councilors vetoes a bill, it will be established as a law if it is passed by more than two-thirds of the attending Diet members in the House of Representatives.

## 3. Existing Conditions of the Legislative Process

### (1) Power to Submit a Bill

All the laws of Japan are established by the Diet, the sole lawmaking institution of the nation in which the upper and lower Houses base legislation on decisions and through committee referendums.

The Diet members and the Cabinet are the two bodies that have the power to submit bills for approval, but these measures are submitted according to three categories - bills that are submitted by the Cabinet, measures that are submitted by the committee chairmen of both houses, and bills that are submitted directly by an individual Diet member. Although the power of the Cabinet to submit bills to the Diet is not specifically stipulated in the Constitution, it is in accordance with Article 5 of the Cabinet Law. The remaining two categories are widely known as “Diet member legislation” which is narrowly defined as legislative measures that are initiated by individual Diet members (therefore, the use of the term “Diet member legislation” in this report will also be used in this context).

### (2) Differences in the Legislative Process

Bills, which have been passed by the Cabinet, are submitted to the Diet. In summary, prior to their submittal, the Cabinet will request the relevant ministry or agency to draw up the bill for deliberation. Bureaucrats from that ministry or agency with the expertise on that particular subject matter will prepare the bill. As a result, bills that are submitted by the Cabinet have the vast resources of the various ministries and

government agencies at their disposal. In some cases, other ministries deliberate the bills and agencies if required, are debated by a committee, or are submitted to the Cabinet following a review by a departmental council. As a result, bills submitted by the Cabinet have been debated and negotiated by the majority parties prior to its submittal to the Diet. Therefore, bills that have gone through this process have in all likelihood been passed de facto by the time they are submitted to the Diet.

In contrast, bills submitted by Diet members are compiled using the individual resources available to the Diet member, i.e. their secretary, the office of their political party, the Diet library, plenary session research room, collecting information and data and seeking the cooperation of relevant ministries and agencies, etc. The Bureau of Legislation for either the House of Representatives or the House of Councilors will draft the bill and after the required number of Diet member signatures endorsing the bill has been collected (Article 56, Diet Law), the bill is submitted to either the Speaker of the House or the President of the House of Councilors (see Appendix 4). However, since the majority of the Diet members belong to a political party or a political faction, in many cases, the bill will be debated and modified by the party of the Diet member initiating the bill prior to its official submittal to the Diet.

**(3) Existing Conditions of Proposed and Adopted Bills**

The bills submitted by both the Cabinet and individual Diet members must be passed by the relevant Diet committee and the plenary session of both Houses, before they are enacted as laws. As explained earlier, the likelihood of Cabinet sponsored bills to be adopted by the Diet is extremely high since the bills have the cooperation and support of the majority parties. In contrast, members of the opposition parties generally submit bills sponsored by individual Diet members, with the exception of bills submitted by a committee chairman. The likelihood of such a bill being passed is low, with the exception of special cases, because when a political party or a faction adopts a bill, it becomes restricted to the confines of a party platform. In party politics, it is inevitable that a political party's raison d'être is tied to its platform. This is a restrictive factor inherent to the parliamentary system.

Data on the number of bills sponsored by the Cabinet and individual Diet members over the past ten years is shown below. As can be discerned from this data, the ratio of bills initiated by Diet members in 1997 was 42.9 percent of all bills sponsored for that year. But the ratio of Diet member initiated bills that were actually adopted by the Diet was 13.6 percent of all bills passed. Nearly 90 percent of all the legislation adopted during this ten year period was Cabinet sponsored bills and the remaining 10 to 15 percent were Diet member initiated measures. In addition, bills that submitted by Diet committee chairmen are also included in the latter group. Consequently, it would not be an exaggeration to conclude that Diet member sponsored legislation, as it is narrowly defined has a low ratio of success.

Fig. 1 Ratio of Diet Member Legislation of the
Total Number of Bills Submit

| | '88 | '89 | '90 | '91 | '92 | '93 | '94 | '95 | '96 | '97 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total Bills Submitted | 115 | 39 | 210 | 35 | 129 | 155 | 120 | 180 | 154 | 196 |
| Number of Diet Member Bills | 20 | 26 | 45 | 15 | 35 | 59 | 26 | 61 | 43 | 84 |
| Ratio of Diet Member Bills (%) | 17.4 | 66.7 | 21.4 | 42.9 | 27.1 | 38.1 | 21.7 | 33.9 | 27.9 | 42.9 |

Source: Diet Dictionary Third Edition, Edited by Ichiro Asano, Bureau of Legislation, House of Councilors
Note: Deliberations on bills carried over from the previous session are not included.

Fig. 2 Ratio of Diet Member Sponsored Bills of the Total Number of Bills Adopted

| | '88 | '89 | '90 | '91 | '92 | '93 | '94 | '95 | '96 | '97 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total Bills Passed | 94 | 32 | 169 | 27 | 110 | 103 | 113 | 137 | 120 | 132 |
| Number of Diet Member Bills | 10 | 7 | 18 | 6 | 14 | 14 | 17 | 18 | 12 | 18 |
| Ratio of Diet Member Bills (%) | 10.6 | 21.9 | 10.7 | 22.2 | 12.7 | 13.6 | 15.0 | 13.1 | 10.0 | 13.6 |

Source: Diet Dictionary Third Edition, Edited by Ichiro Asano, Bureau of Legislation, House of Councilors

The success rate of government initiated bills in Western countries with a parliamentary system is similar to that of Japan. It is higher than 90 percent in Great Britain, 70 percent in Germany, and 60 percent in France. Even in the United States where legislative initiative lies solely in the hands of Congressmen, the success rate of legislation or bills supported by the White House is said to be about 80 percent (source: A Study of Legislation by Diet Members, edited by Nakamura, Mutsuo, published by Nobuyama Co.).

## 4. Review of Diet Member Legislation

### (1) Existing Conditions and Issues in Diet Member Legislation

As explained earlier, Article 41 of the Japanese Constitution defines the Diet "as the supreme body of state and the sole lawmaking body in Japan". Therefore, it is logical that Diet members, who have been elected by the Japanese electorate as their representatives, are given the power to initiate legislative bills and to practice that authority.

However, although individual Diet members have the power to initiate a bill, they are required to obtain the endorsement of more than 20 members of the House of Representatives and more than 10 members of the House of Councilors in order to initiate a bill in accordance with Article 56 of the Diet Law. However, in the case of a

legislative bill that requires a budget, the endorsement of more than 50 members from both Houses is required.

This law aims to prevent Diet members from abusing their powers of legislative initiative and impeding Diet operations and to prevent the misuse of this power for purposes of self-interest. However, this law restricts the freedom of legislative initiative of individual Diet members and small factions. Consequently, in order for Diet members to practice this legislative initiative, they must belong to a political party or faction of a certain scope and size. Inevitably, bills that are compiled and sponsored by Diet members are deliberated within their party or faction.

**(2) Significance and Need for Diet Member Legislation**

As can be seen from the data, laws that are enacted by the current Diet are overwhelmingly Cabinet sponsored legislature. Legislation which has been initiated by Diet members are few and Diet member legislation, in accordance with its very narrow definition, which has been successfully enacted are generally exceptions to the rule. This implies that virtually all of the activity involving the preparation of the bills and the reviewing process are in actuality, based on government bureaucrats. Since the bureaucrats in each respective ministry or agency are experts in a specific field, this legislative process is not completely without its advantages. However, when this process becomes an ingrained practice, there is a decided tendency for legislative measures to reflect the expedience of the government rather than the interests of the public. It is natural and desirable for legislation to reflect the majority will of the people rather than the unilateral interests of the government.

Presently, the ruling parties often debate legislative measures initiated by Diet members by the opposition parties and rarely. Diet member legislation should not be utilized by the opposition alliance as a means of opposing measures initiated by the majority parties, but it should be viewed as a very legitimate vehicle of legislation by the nation's sole lawmaking body. Although the final concluding decision is based on majority rule, it is also the basic right and duty of Diet members to review and fully debate the contents of legislative bills within the Diet in accordance with its original function.

The merits of Diet member legislation is that "Diet members who are in close proximity to and have an understanding of the people and their will, have the means of initiating immediate measures through Diet member legislation. This ensures their timely adoption by circumventing the time-consuming procedures of complex proposals when they are initiated as government sponsored bills" (source: A Study of Diet Member Legislation, pg. 534, edited by Nakamura, Mutsuo, published by Nobuyama Co.). In addition, all Diet members should put aside their partisan differences when faced with important issues that affect the entire nation and which are beyond the scope of political parties and factions. It is important that members with a nonpartisan outlook who act on behalf of the public interest debate such issues in the Diet.

## V. Prospects for Diet Member Legislation of JMA Sponsored Health Policies

The organization, health policy decision-making process, and the political activities of the AMA were discussed in Chapters II and IV. In Chapter V, the present conditions surrounding the organization, which serves as the foundation of the JMA's health, policy decision-making process as well as the environment pertaining to legislation through Diet members are discussed.

### 1. Organization of the JMA (see Appendix 5)

#### (1) House of Delegates, Board of Trustees, and Executive Board of Trustees

The organizational structure and process whereby the House of Delegates elects the President, the Board of Trustees, and the Executive Board of Trustees are similar to that of the AMA. However, the two associations differ in the area of health policy formulation and promotion activities carried out by the Executive Vice President. The AMA is currently in the midst of reforming their organization and the organizational structure of the two associations may differ in other areas as well depending on the future reforms and changes that will be implemented by the AMA.

#### (2) Committees

The JMA has traditionally appointed committees to investigate various issues surrounding each area of health care. Committees are comprised of about ten members and each member serves a term of two years. They meet on an average of about six times a year. In the past, these committees have deliberated on health policy issues as the need arose. However, a major drawback of these committees is that they are unable to conduct intensive sessions in order to cope with issues that need to be resolved immediately and they are unable to deal with issues that demand continual data collection or analyses.

#### (3) JMA Research Institute

In an attempt to resolve major issues pertaining to health policy formulation and existing internal organizational issues, the JMA established a think tank, the JMA Research Institute, in July 1997. Researchers have been already been employed and the institute has begun operations.

#### (4) Administration

120 members who have been assigned to various sections presently staff the administrative office. Their task is to support the board and the committees. In contrast, the AMA has an administrative staff of 1,100 members. The major difference between the JMA and the AMA is that the JMA is a nonprofit organization and its sole source of revenue is its membership fees, whereas approximately 70 percent of the AMA's revenue stems from its publishing activities and other business activities (membership fees comprise about 30 percent of AMA revenue).

### 2. Prospects for Diet Member Legislation

There are many issues, which must be resolved before legislation by Diet members can be successfully achieved. Summaries of the issues that must be addressed in order to enhance Diet member legislation are presented below.

#### (1) Collecting Information

As explained earlier, the resources of the Diet Library, the standing committee

research room, the cooperation of a Diet member's political party office, and a Diet member's secretariat, and other agencies and ministries are utilized as a source of information and data when the prospectus of a legislative bill sponsored by a Diet member is being compiled. Whether or not the Diet member sponsoring the bill has been provided with adequate information and data during the compilation process remains a moot issue.

Each Diet member is presently permitted to have a publicly employed secretariat comprised of three staff members. In the case of the United States, a member of the House of Representatives is allowed to have a publicly employed staff of about 16 to 17 staff members and a senator is permitted to have a publicly employed staff of about 43 members (source: Diet and Diet Member Legislation, Konin no Yusha). In view of this fact, the difference between the capabilities of Diet members initiating legislative bills with that of US Congressmen is inevitable. Even if Japan were to adopt a system of employing qualified staff members in charge of preparing legislative bills, it would be impossible to implement given the current number of only three publicly paid staff members who are assigned to each Diet member.

Compounding the issue of whether adequate information and data is provided by the Diet Library and the standing committee research room, is the problem of whether legislative bills sponsored by Diet members are given the same level of cooperation or information that are given to Cabinet sponsored bills by relevant agencies and ministries.

**(2) Before a Bill Is Submitted to the Diet**

A legislative bill prepared by a Diet member can not be submitted immediately to the Diet. The bill must first be deliberated and amended by that Diet member's political party or faction. If the bill does not undergo this initial process, it will not obtain the required number of supporting Diet members needed to submit it to the Diet, in accordance with Article 56 of the Diet Law (see section (1), Chapter 4).

In advanced West European nations, the system of Cabinet responsibility as practiced in Great Britain, Germany, and France and the presidential system of the United States do not require a legislative bill to be deliberated by a political party or faction nor is a decision made as to whether or not a bill is to be submitted to Parliament by such parties or factions, as in the case of Japan.

In the case of the United States, a legislative bill prepared by a Congressman is placed in a box known as a hopper by the Congressman himself. As a result, a Congressman is able to submit a bill freely and the decision to accept or refuse a bill is deliberated by the relevant committee. This type of system as practiced by the industrialized nations of Western Europe and the United States can also be adopted in Japan.

**(3) After a Bill Is Submitted to the Diet**

In Japan, when a bill has successfully completed the initial process explained earlier and has been submitted to the relevant committee for deliberation, it is still generally difficult to determine the direction it may take based on an active debate of its content. Basically, the support of a large number of other Diet members is required due to the strong domination of party platform restrictions. This reveals the limitations of political party politics. However, each political party and faction can still make changes regarding the current situation.

In summary, the cold war period between the East and the West ended and the

confrontation between the world's two major ideologies disappeared. Correspondingly, in the world of Japanese politics, the ideological differences that existed between political parties have blurred with the creation of a coalition administration comprised of the Liberal Democratic Party and the Socialist Party. The antagonism between the ruling and opposition parties no longer stem from ideological differences, but appear to be due to other reasons. Due to this political milieu, legislative bills that concern fundamental issues, which affect Japan's future or are separate from the interests and authority of a political party should be actively submitted to the Diet and debated. Each political party and faction should carry out a comprehensive review of its practice of subjecting Diet member sponsored bills to party platform restrictions and take a more flexible approach when reviewing such legislative bills.

**(4) Case Example of a Diet Member Sponsored Legislative Bill**

The bill to recognize organ transplants which was sponsored by Diet member Taro Nakayama of the ruling LDP party (former Foreign Minister) was amended by both the ruling party and opposition party Diet members and passed by a majority approval of the House of Councilor's Special Committee on Organ Transplants on June 16, 1997. The plenary session of the House of Councilors on the following day, June 17, with a majority vote of 181, an opposing vote of 62, and 9 defaults adopted the amended bill. It was then voted on and passed by the Lower House on the same day with a majority vote of 323, an opposing vote of 144, and 33 defaults. With the exception of the Communist Party, each political party and faction adopted the bill without subjecting it to the restrictions of each party's respective platform.

The aim of this report is not to cover the study of tactics and ulterior motives that exist between these political parties or to delve deeply into the contents of the amended bill. However, it is important that when legislative bills concerning vital issues which are sponsored by Diet members and are subject to revisions by respective political parties or factions, they should be adopted without being held accountable to party platform restrictions.

Table 3 Ratio of Health Related Laws Among the Total Number of Laws Adopted

| | 1995 | 1996 | 1997 |
|---|---|---|---|
| Total Laws Passed | 137 | 120 | 132 |
| Number of Health Laws | 5 | 7 | 7 |
| Ratio of Health Laws (%) | 3.6 | 5.8 | 5.3 |

Source: Bureau of Legislation, House of Councilors

Table 4 Ratio of Diet Member Sponsored Laws Among Total Health Laws Passed

| | 1995 | 1996 | 1997 |
|---|---|---|---|
| Total Laws Passed | 5 | 7 | 7 |
| Number of Health Laws | 1 | 2 | 1 |
| Ratio of Health Laws (%) | 20.0 | 28.6 | 14.3 |

Source: Bureau of Legislation, House of Councilors

## VI. Conclusion: Moving Towards Health Policies Legislated by Diet Members

As mentioned earlier, the task confronting the JMA as a leading organization of health professionals and as a representative of the interests of the Japanese people during this crucial time when fundamental reforms of Japan's health insurance system are in demand, is to take the initiative in exploiting the possibilities of legislating appropriate health policies that will determine the future of japan in the 21st century.

It is the conclusion of this report that it is possible for the JMA to draw up health policies and to have them legislated through the process of Diet member legislation. Recommendations on structure, environment, and policy, which are needed in order to enable its Board of Directors to carry out activities in this area, are suggested below.

If the JMA is to be successful in moving to a strategy of relying on Diet member sponsorship of health care legislation, then the AMA's organizational structure, policy-making process, and its relationship to Congress may prove instructive. Naturally, differences in the political system and health care system make it impossible (and undesirable) to adopt all the features of the AMA organization. Nevertheless, this study of the policy-making structure of the AMA provides the spark for several suggestions to strengthen the organization and policy-making apparatus of the JMA.

### 1. Organization and Staff Needed to Formulate Health Policies

#### (1) Strengthening the Section on Health Policy Formulation

A section responsible for formulating and implementing health policies should be created within the JMA organization (or external to it). The employment of legal professionals (lawyers, etc.) should strengthen the section.

#### (2) Create a Section to Analyze the Socio-economy

A section responsible for monitoring and analyzing the socio-economy and staffed by political scientists and economists should be created.

#### (3) Strengthen the Information Management Section

Strengthen the information collection and compilation capabilities of the Information Management Section. The section should create its own data base and develop a position of leverage within an information society.

#### (4) Foster Human Resources

A system of educating and training young staff members should be established and efforts to secure qualified personnel should be made.

### 2. Policy on Implementing Health Policies

#### (1) Compile a Policy Handbook

In order to ensure consistent and sustainable health policies, the JMA should publish a policy handbook over the long-term, which clarifies health policies that have been adopted for implementation.

#### (2) Activities Related to Policy Implementation

Various support activities are needed in order to implement policies. These activities include the following.

1) Conduct grass roots activities
2) Solicit the cooperation of JMA's 140,000 members
3) Implement public opinion polls
4) Implement activities targeting the mass media

### 3. Solicit the Support of the Japanese Public

#### (1) Public Relations

The mass media should be utilized to publicize JMA's activities that target the Japanese government and to inform the public that the JMA is an important factor in the national health policy decision-making process, and thereby solicit the understanding and support of the Japanese public.

#### (2) Disseminate Information

The JMA should disseminate serviceable information to patients and the public and promote the image of being an open and accessible organization. The association should strive to establish mutual understanding between the public and physicians with the help of its members.

### 4. Cooperation with Other Organizations

In conjunction with its goal of legislating its health policies, the JMA should not only maintain consistent legitimacy in its activities, but it should also coordinate its activities with other organizations that have the same policy objectives rather than pursue an independent and separate course of action. This kind of flexible approach to policy related activities will serve to further strengthen the JMA's efforts to achieve its goals.

### 5. Activities to Support Legislation by Diet Members

#### (1) Solicit the Cooperation of Diet Members

Activities that will help solicit the understanding and cooperation of numerous Diet members for JMA' s health policies are crucial.

#### (2) Provide Health Related Information

It is important that the basic information and data needed to formulate health policy bills by Diet members are provided by the JMA. In order to carry out this function effectively, the JMA must become an important center of health related information.

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