

**Health Insurance Politics of Japan in the 1960s and the 1970s:
The Japan Medical Association and the Policy Development**

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Introduction

John Campbell and Naoki Ikegami have called the Japanese health care system “low-cost and egalitarian system,” and it has been seen as a model by some developing countries to learn.¹ But there has not been sufficient study about how Japan has adopted such system.

Japan introduced the legal structure of universal health insurance in 1958. Among many political stakeholders, the Japan Medical Association (JMA) has been seen a major political player to influence the path of health care policy. In particular, Takemi Taro, who served as the JMA’s president from 1957 to 1983, helped making the JMA more powerful in the policymaking process.

Media and commentaries paid much attention to Takemi’s strong political power. But how Japan’s low-cost health care system exists with the strong power of the JMA that should have an instinct to ask for higher fees. Some scholars have more cautiously studied how the JMA impacted the policymaking process. William Steslicke, for example, investigated how the JMA developed and became a powerful interest group against the government in health care reform.² Nomura Taku is another scholar to pay special attention to the JMA’s relationship with the government. Unlike Steslicke, however, Nomura argues that despite the JMA’s hostile attitude toward the government, especially bureaucrats, on the surface, the JMA often had the cooperative relationship with the government.³

This paper does not involve itself directly in this debate. Rather it demonstrates why the relationship between the government and the JMA appeared as it did to Steslicke and Nomura. It pays special attention to the institutional and political development in health care up to the 1970s.

This paper first overviews how the JMA developed as an interest group from the end of the Tokugawa era to the 1970s. Second, it demonstrates how Japan developed the health insurance system and how the government and the JMA affected

¹ John C. Campbell and Naoki Ikegami, *The Art of Balance in Health Policy: Maintaining Japan’s*

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

³ Nomura Taku, *Nihon Ishikai* [Japan Medical Association] (Tokyo: Keiso Shobō, 1976). Major works which study the development of Japanese health care in general include Kawakami Takeshi, *Gendai Nihon Iryōshi* [History of Modern Japanese Health Care] (Tokyo: Keisō Shobō, 1965); Sugaya Akira, *Nihon Iryō Seisakushi* [History of Japanese Medical Policy] (Tokyo: Nihon Hyōronsha, 1977); Mizuno Hajime, *Daremo Kakaranakatta Nihon Ishikai* [An Untold Story of the Japan Medical Association] (Tokyo: Sōshisha, 2003).

the policymaking process. Third, it analyzes how they struggled to solidify the universal health insurance system which was finally realized in 1961. The last section investigates why Takemi conducted the controversial “doctors’ strike” in 1971 and concludes with a discussion how the incident impacted the health insurance politics after that.

1. Birth and Development of the Japan Medical Association

In the Tokugawa era, Kanpō, Japanese adaptation of Chinese medicine, was the state medicine. After the Tokugawa Shogunate collapsed, the Meiji government took a strong leadership to westernize social and political system: medicine was included. The Meiji government took the top-down approach to promote western medicine by educating western medicine doctors (*seiyōi*).⁴

Western medicine doctors soon began to form their medical associations. In 1886, they established the Tokyo Medical Society (Tokyo Ikai) as the first major local association and similar regional associations began to be formed in other prefectures. Then they began to make efforts to form a national organization. They were given a strong incentive by that Kanpō doctors formed the Imperial Medical Association (Teikoku Ikai) for their survival when the Imperial Diet began its operation in 1890. They continued to push for their political leverage against Kanpō doctors and formed the Great Japan Medical Association (GJMA), a voluntary national-level association, in 1906.⁵

In 1923, evolving from the GJMA, the Japan Medical Association was established as a legal entity. Kitazato Shibasaburo, the former GJMA president and world-renowned bacteriologist, became its first president.⁶

World War II diminished the power of the JMA against the government. The JMA was absorbed in the war mobilization efforts by the government. As the war mobilization intensified, the government put more pressure on the JMA to control health care and make healthier soldiers and workers and to win the victory.⁷

⁴ For the history of the Japanese medicine from the ancient time to the Shōwa Era, see Sakai Shizu, *Nihon no Iryōshi* [The History of Medicine in Japan] (Tokyo: Keiso Shobō, 1982).

⁵ Kawakami, *Gendai Nihon Iryōshi*, 231-43. Also see Steslicke, *Doctors in Politics*, 38.

⁶ Kawakami, *Gendai Nihon Iryōshi*, 242. Steslicke, *Doctors in Politics*, 43-44.

⁷ For the historical development of the health insurance policy during the war, see Takakazu Yamagishi, *War and Health Insurance Policy in Japan and the United States: World War II to Postwar Reconstruction* (Baltimore: Johns Hopkins University Press, 2011); Gregory Kasza, “War and Welfare Policy in Japan.” *The Journal of Asian Studies* 61 No. 2 (2002): 417-35; Shō Kashin, *Nihongata Fukushi Kokka no Keisei*

Year 1942 was a critical historical moment for the JMA. The National Medical Treatment Law was passed in February to give the government more control over hospitals and medical professionals. As part of this law, the Japan Medical Corporation (Kokumin Iryō Dan) was established to lead the policy implementation. Then finally, the government made the JMA be a nationalized organization to supplement the Japan Medical Corporation. It now appointed the JMA president. The JMA was completely enmeshed into the government war mobilization.⁸

The war was over and the U.S.-led military occupation began. Demilitarization and democratization initiatives by the General Headquarters (GHQ) made it possible to break down the Ministry of Home and *zaibatsu*, big business conglomerates, and purge many politicians and bureaucrats. However, this reform did not much change the Ministry of Health and Welfare. Moreover, GHQ did not help the JMA restore its power against the government for its having deeply cooperated with the government to conduct the war.

In 1946, the JMA was turned back to be a private organization. But that was not the end. Crawford Sams, the head of the Section of Public Health and Welfare, in many cases sought to diminish the JMA's power. The JMA, from Sams' perspective, was an obstacle to realize GHQ's health care policies. Sams often intervened in what the JMA did. When the new JMA suggested new leadership, for example, Sams rejected them for their connection with the wartime regime.

Another example, at the level of specific policy, was that Sams denounced the Japanese doctors who earned income not by providing medical examinations and diagnosis but by selling drugs. He tried to separate service fees and drug fees. The JMA tried to oppose the GHQ's initiative by electing Tamiya Takeo as its president. But he ended up with resigning after he failed to resist. The JMA could not do anything but what GHQ ordered to do.⁹

to *Jūgonen Sensō* [The Fifteen-year War and the Formation of Japanese Welfare State] (Kyoto: Minerva Shobō), 1998.

⁸ Kōseishō Gojūnenishi Henshū Inkai, *Kōseishō Gojūnenishi: Kijutsu Hen* [Fifty-Year History of the Ministry of Welfare, Documentary Volume] (Tokyo: Chūō Hōki Shuppan, 1988), 423; Takei Gunji, *Kōseishō shōshi: Watashi no zaikinroku kara* [A Short History of the Ministry of Health and Welfare] (Tokyo: Kōseishō mondai kenkyūkai, 1952), 91-7.

⁹ Sugaya Akira, *Nihon Iryō Seidoshi* [History of Japanese Medical Institution] (Tokyo: Hara Shobō, 1976), 494. Arioka Jiro, *Sengo Iryo no Gojunen: Iryohoken Seido no Butaiura* [The Fifty Year History of Health Care: The Backstage of Health Insurance Policy] (Tokyo: Nihonijishinposha, 1997), 37-40. This movement to separate drug and service weakened after the Occupation ended (Arioka, *Sengo Iryo no*

To end the JMA's stalemate, Takemi Taro became the president. Takemi had a unique background to cast influence in Japanese politics. He married to a granddaughter of Makino Nobuaki who was son of a founding father of the Meiji government, Okubo Toshimichi. This marriage brought him kinship with Yoshida Shigeru who served as Prime Minister for many years after the war.¹⁰ They had a very close relationship: Takemi called Yoshida "Yoshida no oyaji," in English "Uncle Yoshida." Takemi served not only as Yoshida's personal doctor but also as his political assistant. Some called Takemi "political doctor."

Steslicke describes the role Takemi played in the development of the JMA that "it is only since Dr. Takemi's election and under his forceful leadership that the JMA has become of key importance in medical care administration and politics."¹¹ Takemi served as the JMA president until 1982, exceptionally long for twenty-six years (Figure 1 shows his voting rate).

2. Introducing Universal Health Insurance

The number of western medicine doctors increased with the government's policies. Meanwhile, doctors and medical facilities became more visible for the people. However, it became increasingly recognized that many people had financial difficulties to receive sufficient medical services. In the 1910s, some doctors began to open what was called "actual expense clinics (jippishinryojo)" which provided them with less expensive medical services.¹² On the other hand, the government officials studied what major European countries had done in the area of health care and began to push for the creation of public health insurance programs.¹³

The Health Insurance Law of 1922 was the first major public health insurance policy. It created two programs: Government-Managed Health Insurance and the Association-Managed Health Insurance. The former targeted manual workers who were employed by companies with more than 10 but fewer than 499 workers. The latter

Gojunen, 47, 81-2).

¹⁰ For Takemi's background, see Takakazu Yamagishi, "A Short Biography of Takemi Taro, the President of the Japan Medical Association," *Journal of the Nanzan Academic Society Social Sciences* 1 (January 2011): 49-56.

¹¹ William E. Steslicke, "The Political Life of the Japan Medical Association," *The Journal of Asian Studies* 31 (1972): 849.

¹² Sugaya, *Nihon Iryō Seidoshi*, 182.

¹³ Sugaya, *Nihon Iryō Seisakushi*, 35.

provided employees hired by larger companies. For the government, this Law was a means to soften the labor movement.¹⁴

Meanwhile, for the elite doctors in the Great Japan Medical Association, it was a great opportunity to have a legal status for their organization. The government had not developed public hospital and needed to establish the cooperative relationship with private doctors and hospitals to implement the new programs. Now with the passage of the Law, the GJMA was dissolved and the Japan Medical Association was formed as a legal association.

The war mobilization in the 1930s and 40s had great impact on the expansion of public health insurance. After the Manchurian Incident in September 1931, Japan became isolated in the international community. With the Marco Polo Incident in July 1937, furthermore, the Japanese government was urged to be prepared for a possible large-scale war.

As the government saw many young people failing in the conscription physical exam, it began to see health insurance policy as part of national defense policy. The National Health Insurance Law was created in 1938. It was a voluntary program mainly for self-employees, mainly targeting agricultural workers who were source for draftees.¹⁵ The JMA opposed the formation of the NHI, but they could not stop it in the midst of the patriotic mood.

The White-Collar Workers Health Insurance Law (Shokuin Kenkō Hoken Hō), and the Seamen's Insurance Law (Sen-in Hoken Hō) were added in 1939 to increase the number of the insured people. The White-Collar Workers Health Insurance was a small program but included a new fee system by which the government more easily made the fees under control. It set up a fee-for-service payment system based on an official point system (*kinrō teigaku shiki*). This was quite different from the Health Insurance Law of 1922 in which the payment to doctors was based on how many enrollees the particular doctor had (*jintō ukeoi shiki*). This change in the fee schedule, according to Kawakami Takeshi, allowed the government to maintain the upper hand in setting the fees and thus

¹⁴ Kenneth B. Pyle, *The Making of Modern Japan*, 2nd ed. (Lexington, MA.: D.C. Heath and Company, 1996), 170; Kasahara Hidehiko, *Nihon no Iryō Gyōsei: Sono Rekishi to Kadai* [Japanese Healthcare Administration] (Tokyo: Keio University Press, 1999), 81.

¹⁵ 85 percent of the draftees were from the countryside. See “Donzoko no Nōmin Kyūsai: Kyūbō ni Mikanete Rikugun mo Tsuini Tatsu [Relieving Farmers: The War Ministry Finally Got Involved in the Relief Project],” *Yomiuri Shimbun*, June 7, 1932.

reducing the power of the JMA.¹⁶

As the war mobilization intensified, the government took more radical steps to control health care. Koizumi Chikahiko, director of the Army's Medical Care Bureau, was appointed as the Minister of Health and Welfare in July 1941. He began to use a slogan, "All people soldiers and all people healthy." He expressed his vision to achieve universal health insurance in the near future by the government's strong leadership.¹⁷ The government's top-down health policy continued until the end of the war.

After the war was over, with the U.S.-led occupation's directives, the government maintained the basic structure of the existing health insurance system which was composed of multiple public programs. To react that many health insurance programs financially suffered in the postwar inflation, the government conducted patchwork reforms. The government, for example, passed a measure in 1948 to make municipalities administer the National Health Insurance program.¹⁸

While the basic structure remained, one technical but important change took place in the area of health insurance payment. Before the war, the government paid per capita health insurance fees to the JMA, and the JMA made reimbursement to doctors based on its fee schedule. In 1944, the system was entirely abolished and adopted the official point system which the White-Collar Health Insurance had for all programs. Now the government, with the consultation with the Committee on Health Insurance Medical Fees, made its own fee schedule and began to bypass the JMA and make reimbursement directly to doctors. After the war, the system was reversed for a short time, but again the reimbursement authority went to the government. In 1950, the government created the Central Social Insurance Medical Care Council (Chūō Shakai Hoken Iryō Kyōgikai, called Chūikyō) which it made easier for the government to restrain fees.¹⁹

The JMA lost the power both to make payment to its members and to decide the fee schedule. Although the JMA was included in the decision-making committee of

¹⁶ Kawakami, *Gendai Nihon Iryōshi*, 440-41; Kōseishō Gojūnenshi Henshū Inkaï, *Kōseishō Gojūnenshi: Kijutsu Hen*, 532, 543.

¹⁷ Kawakami, *Gendai Nihon Iryōshi*, 438-9.

¹⁸ For the background of health insurance policy reform in Japan during the occupation period, see Adam D. Sheingate and Takakazu Yamagishi, "Occupation Politics: American Interests and the Struggle over Health Insurance in Postwar Japan," *Social Science History* 30 No.1 (Spring 2006): 137-64.

¹⁹ Yoshihara Kenji and Wada Masaru, *Nihon Iryō Hoken Seidoshi* [History of Japanese Health Insurance] (Tokyo: Tōyō Keizai Shinpōsha, 1999), 125.

the fee schedule, the JMA and other health care providers had only ten members out of forty in the committee which was established in 1947.²⁰

Around the period when the occupation force left Japan in 1952, the government began to push for restructuring the health insurance system and introducing universal coverage. GHQ and some Japanese scholars and government officials began to advocate radical reforms and integrate and rationalize health insurance programs even in the early period of the occupation. In 1946, the Labor Advisory Committee, which was established in GHQ submitted a report to call for “a comprehensive reform of social insurance.”²¹ In 1950, the Advisory Council on Social Security (Shakai Hoshō Seido Shingikai), which was created as a cabinet-level organization, claimed that the divided health insurance should be reorganized into employment-based program and the National Health Insurance. The Committee’s chair, Ouchi Hyoue, called this “Japan’s Beveridge Plan.”²²

In March 1955, Special Committee on Health Security was established in the Advisory Council on Social Security. Encouraged by this, in July 1955, what was called “Seven-Persons Committee,” including scholars and former government officials, was established.²³ Although it was a response to the financial crisis of the Government-Managed Health Insurance in the early 1950s, the committee discussed rather broader health care problems.²⁴ After five-month discussion, in October 1955, the committee gave a report to the Ministry of Health and Welfare. Its proposal included introducing universal health insurance.²⁵

The Committee also proposed to extend the government’s authority to control the quality of doctors and hospitals. Under its proposal, in addition to the board exam, doctors would have to pass another exam to become health insurance doctors. Moreover, not only doctors but also clinics and hospitals would have to register as entity to deal with health insurance. The JMA opposed it because it would decrease doctors’

²⁰ Arioka, *Sengo Iryo no Gojunen*, 52.

²¹ SCAP PHW, “Advisory Commission on Labor First Interim Report,” 2, April 5, 1946, RG 331, Records of Allies Operational and Occupational Headquarters, World War II, 1907-1966, Box 9382, File 8, NACP.

²² Arioka, *Sengo Iryo no Gojunen*, 101.

²³ Members are Imai Kazuo, Inaba Shuzo, Kondo Bunji, Shimizu Gen, Takahashi Tyotaro, Nakamura Tateo, and Hirata Tomitaro.

²⁴ Arioka, *Sengo Iryo no Gojunen*, 84, 105. That was because there was discussion why tax money would be used only for those who already had health insurance but not for those who did not have one.

²⁵ Arioka, *Sengo Iryo no Gojunen*, 86.

autonomy.²⁶

As a reaction to the Committee proposal, the government introduced a bill to amend the Health Insurance Law in 1957. Many local medical associations held meeting to express their opposition. But the amendment was passed without major revisions in the Lower House. The bill was passed in the Upper House in March 31, 1957.

Now the government's push for the universal coverage could not be stopped. In October 1956, Special Committee on Health Insurance (Iryohoken Tokubetsu Iinkai) in the Advisory Council on Social Security reconfirm that Japan should introduce universal health insurance. These movements led to an amendment to National Health Insurance Law in December 1958 to realize universal coverage. It says that all municipalities would establish their National Health Insurance associations by April 1961. While the existing employment-based programs continued to exist, the amendment made National Health Insurance program mandatory for the rest of the people.²⁷

The JMA was confused. In the discussion about the amendment to the Health Insurance Law in 1957, there was a division between the JMA executives and local medical associations. The former did not want to cause unnecessary conflict with the government: the latter was frustrated by the JMA's weak negotiation power against the government. They introduced non-confidence vote bill for the JMA president, Obata Isei, to the House of Delegates and it was approved by 82-51.

3. Consolidating Universal Health Insurance

As the previous section described, the government increased and retained power over health policy during the period of the war mobilization and postwar reconstruction. On the other hand, the JMA faced "a lost decade." The JMA needed a president to break through long-term stalemate. Then Takemi Taro was elected in April 1957 after Obata had to resign by the non-confidence vote. But the basic structure of the health insurance system was already robust and Takemi could not have impact on it. With the universal health insurance system became in place, the government and the

²⁶ Arioka, *Sengo Iryo no Gojunen*, 87-9.

²⁷ For an overview of the process to introduce universal health insurance, see Tsuchida Takeshi, "Kokumin Kaihoken no Kiseki [A Track of Universal Health Insurance]," *Shakaihoshu Kenkyu* 47 (3) (Winter 2011): 244-56.

JMA fought to gain the power in the new institutional arrangement.

Takemi believed that not government bureaucrats but doctors should play the leading role in the policymaking process of health care. He wrote, “Now the medicine exists not for the people’s welfare but for the bureaucratic power. Doctors’ consciousness is meaningless. It is unforgivable that one technical officer who know nothing about clinical medicine instructs a respected veteran doctor.”²⁸ He criticized that the government had the dominant power in health care policymaking process.

One of the first major achievements by the Takemi presidency resulted from a direct negotiation with Kanda Hiroshi, the Minister of Health and Welfare, about the Health Insurance Law. The Ministry of Health and Welfare, following the Health Insurance Law amendment in 1957, were finalizing the government and ministerial ordinances for its implementation. According Takemi, they would be to reduce insurance fees and gain more control over doctors.²⁹ Through his personal connection, Takemi directly dealt with Kanda with help of University of Tokyo professors Kaneko Hajime and Ishii Teruhisa. He succeeded in revising the ordinance drafts. Arioka Jiro argues that this Takemi’s victory played a role in strengthening the basis of the Takemi presidency in its early period.³⁰

Takemi continued to show off his power against the influential politicians. He criticized that the government officials used the Provisional Council on Health Insurance (Rinjiiryohoken Shingikai) to introduce a fee system in order to greatly reduce health insurance fees. He threatened to withdraw from the committee and it was not held any longer. In July 1957, when Horiki Kenzo became the new Minister of Health and Welfare, he visited the JMA’s headquarter to greet Takemi. He feared of losing the cooperation from the JMA. The previous minister had never done such thing. This demonstrated that Takemi’s strategy to earn the negotiation power against the government was successful.³¹

Takemi’s offense against the government continued. In 1958, He boycotted the Central Social Insurance Medical Care Council which met every two years to revise the fee schedule. In the Council, the JMA could nominate four members. But some doctors who run large hospitals sought to depart from the JMA’s influence, create their

²⁸ Takemi Taro, *Suntetsu Igen* [An Epigram from a Doctor] (Tokyo: Nihonijishinposha, 1972), 5.

²⁹ Takemi, *Suntetsu Igen*, 117-8.

³⁰ Arioka, *Sengo Iryo no Gojunen*, 131.

³¹ Arioka, *Sengo Iryo no Gojunen*, 135.

own organization and nominate their member in the Council. Their movement matched the government's hope to diminish the JMA's power. Takemi opposed their plan and boycotted the Council.³²

Takemi's aggressiveness helped him reelected in April 1960. The opposing group in the JMA nominated Takahashi Akira as a candidate, a prominent scholar and the former and first president of the new JMA after the war. But Takemi won an overwhelming victory.

The JMA continued its aggressiveness to push the government to raise the doctors' fees. Around 1960, not only doctors but also nurses and other hospital staffs were frustrated by the low fees. Strikes by hospitals began and spread. In November 1960, 31 Red Cross hospitals conducted the strike.³³

In this mood, the JMA conducted to set one-day non-consultation campaign in February 1961. Furthermore, it sought to have its members decline their insurance doctor status in 1961. The JMA demanded that the fee raise should be done by increasing the unit price per an official point. It was to oppose the Ministry of Health and Welfare's proposal that the unit price per point should be fixed and the fee continue to be based how many points each procedure had.³⁴

At the end, Takemi again directly negotiated with an influential politician Tanaka Kakuei, Policy Research Council Chairman of the Liberal Democratic Party, and decided not to pursue the plan. Tanaka sent a note to Takemi saying only one sentence at the end, "With these conditions, the JMA will stop doing its plan." Tanaka wrote four conditions before the sentence: 1) a fundamental reform of health insurance; 2) the strong connection between the improvement of medical research and education and the improvement of the people's welfare; 3) the respect for free relationship between doctors and patients; 4) the establishment of a fee schedule based on the idea of free economic society.³⁵

With his strong negotiation power against the influential politicians on the surface, however, Takemi did not always get what he wished. He asked for integrating

³² Arioka, *Sengo Iryo no Gojunen*, 161. The JMA continued to be absent from until the Central Social Insurance Medical Care Council was reorganized.

³³ Sugaya, *Nihon Iryō Seisakushi*, 291; Arioka, *Sengo Iryo no Gojunen*, 184-5

³⁴ Arioka, *Sengo Iryo no Gojunen*, 188-9.

³⁵ Takemi Taro, *Jitsuroku Nihon Ishikai* [A True Story of the Japan Medical Association] (Tokyo, Asahi Shuppan, 1983), 119; Sugimura Hisahide, *Fuun wo yobuotoko* [A man who causes winds and clouds] (Tokyo: Jijitsushinsha, 1977), 128.

existing programs into a region-based program to diminish the government control and to achieve more decentralized health care. But the government did not give up its grip to control the Government-Managed Health Insurance which was key to retain the health care cost as both supervisor and administrator.

Moreover, Takemi could not stop the government from changing the fee system. The government succeeded to introduce the fee system which would make it easier for the government to control the fees, particularly the price of the drug which was still the large part of doctors' income. With the system, the government had less difficulty to make fees related to hospitals more expensive than fees for solo-practitioners.³⁶

4. The JMA's Revolt in 1971 and Aftermath

With his personal tie with the influential politicians, Takemi tried to change the fundamental structure of the health insurance system. But he had great difficulties to bring it because the basis of health insurance had been solidified by the time he was elected as the JMA president. What he could do was to gain the "peripheral" benefits and that became a strong drive for Takemi to be repeatedly reelected.

The JMA conducted the health insurance doctors' withdrawal from July 1 to July 31.³⁷ The event, according to Sugimura Hisahide, astonished the officials in the Ministry of Health and Welfare and the public. Although most underestimated the level of the JMA's seriousness, about 90 percent of the JMA doctors, about 70,000 doctors, followed the JMA's leadership.³⁸

Takemi had his own justification of his decision. Takemi wrote later, "When we pursued the withdrawal of health insurance doctors, journalists mistook it as 'strike.' ... They were totally ignorant because we did it to regain the unjust health insurance system which had been serving bureaucrats, business, and large labor unions to the people's hands."³⁹

Takemi also had to think about politics within the JMA. From 1957 to 1966,

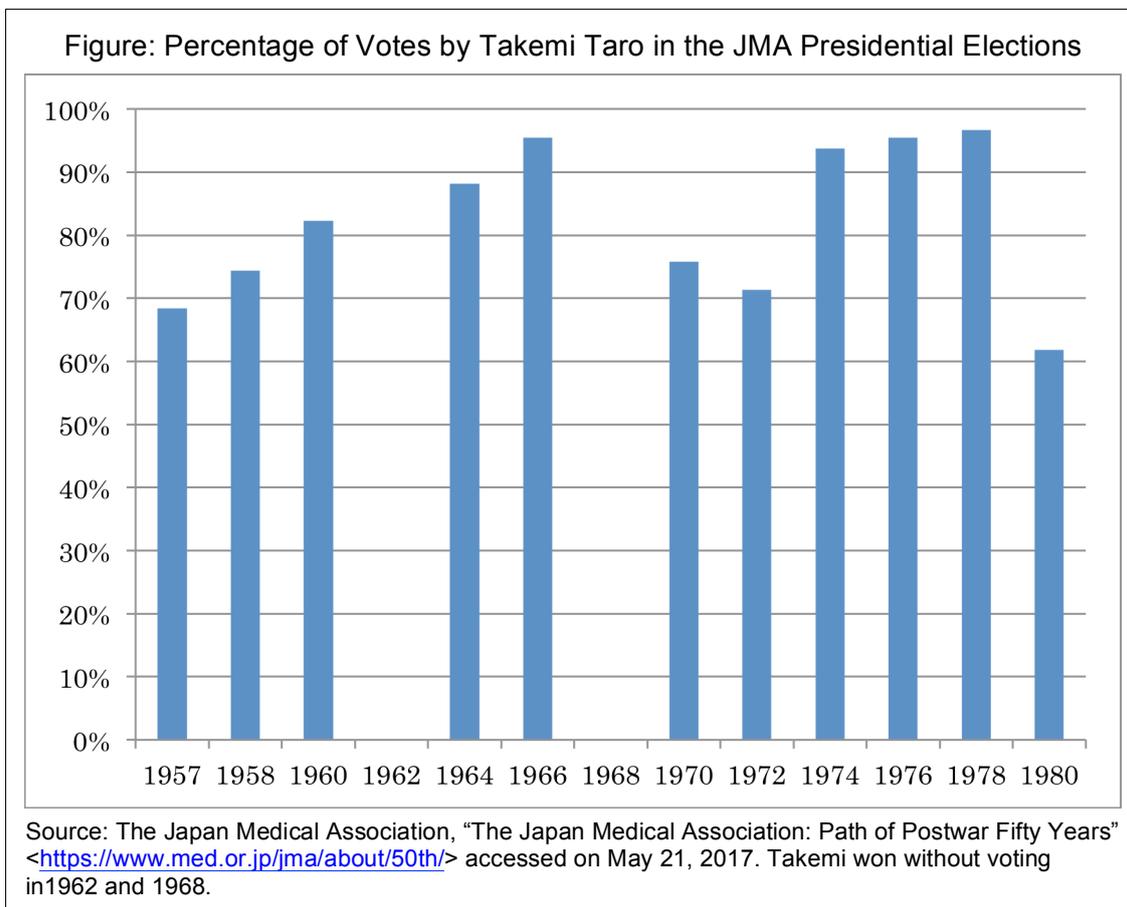
³⁶ Miwa Kazuo, *Mōi Takemi Tarō* [Fighting Doctor, Takemi Tarō] (Tokyo: Tokuma Shoten, 1995), 250; Arioka, *Sengo Iryo no Gojunen*, 139-141.

³⁷ The JMA made an exception to treat patient with the National Health Insurance program which was for self-employees.

³⁸ Sugimura, *Fuun wo yobuotoko*, 96-7.

³⁹ Takemi Taro, *Ishindenshin* [Heart-to-Heart Communication about Sincere Medicine] (Tokyo: Jitsugyononihonsha, 1976), 55.

as Figure shows, Takemi repeatedly won the presidential election by a big margin. The number of vote continued to increase. But for the first time in 1970, Takemi’s voting rate declined from the previous election. He needs to have new strategy to demonstrate that he was a still strong leader.



The JMA’s decision had a big impact. The government and major newspapers criticized it for Takemi’s irresponsible walkout. The public also saw it negatively because many people believed that doctors were wealthy and did not understand what the JMA was trying to do.⁴⁰ Takemi’s comment “If a person catches a cold during the strike, that is his or her fault” added fuel to the fire.⁴¹

The antipathy by the media and the public toward Takemi continued to rise. The government officials had been hoping to gain more control in the policymaking process. They used the opportunity to criticize the JMA. Particularly, the government

⁴⁰ Miwa, *Mōi Takemi Tarō*, 241.

⁴¹ Sugimura, *Fuun wo yobuotoko*, 97. Sugimura explains that what Takemi meant was that catching a cold is not a big deal.

used the preferential tax treatment for doctors as a target

The preferential tax was introduced in December 1954. The JMA was asking for raising the health insurance fees. But Finance Minister Ikeda Hayato did not agree for the financial difficulties. Instead, he offered to provide the preferential tax treatment to doctors, which allowed doctors to have 72% of their income as necessary expenses.⁴²

Takemi later mentioned that the preferential tax treatment was for a temporal measure until the government would make a fundamental health insurance reform. In fact, a supplemental resolution was attached to the law, which stipulated, “This is a temporal measure until the social insurance fee schedule is fairly adjusted. The government should swiftly make it happen.”⁴³ But the government did not realize it and the doctors began to see it as a vested right. Then in the 1970s, the government officials who sought to reform the health insurance system and fight back the JMA, began to sell to the public that the preferential tax treatment was unfair and luxurious treatment to doctors.

Takemi resisted the government’s attack. He states, “The government succeeded to force the low-cost health care on doctors in exchange of the preferential tax treatment. While the treatment grudgingly continued, doctors were forced to survive by kind of taking a commission from drug selling. It was not the JMA’s responsibility but the government’s one to keep the treatment for a long time.”⁴⁴

However, the public supported the government’s efforts to abolish the tax treatment. In October 1974, the Tax System Research Council (Zeiseichosakai) submitted a report to revise it.⁴⁵ The pressure by the government and the public eventually led the JMA to compromise to lower the tax exemption rate. This was retrospectively an important turning point for the JMA. The JMA became more defensive toward the pressure from the government that tried to oppress the health care cost. In January 1983, Yoshimura Jin, Director of the Insurance Bureau in the Ministry of Health and Welfare, claimed in a national conference that “the rise of health care cost will kill Japan.”⁴⁶ This is right after the same period when Takemi stepped down from the JMA presidency after 26 years.

⁴² Takemi Taro, *Choshinki* [Diary of Listening to the Heart] (Tokyo: Jitsugyononihonsha, 1978), 224-5.

⁴³ Arioka, *Sengo Iryo no Gojunen*, 82.

⁴⁴ Arioka, *Sengo Iryo no Gojunen*, 82.

⁴⁵ Takemi, *Jitsuroku Nihon Ishikai*, 203; Mizuno, *Daremo Kakaranakatta Nihon Ishikai*, 88.

⁴⁶ Mizuno, *Daremo Kakaranakatta Nihon Ishikai*, 146.

Conclusion

Takemi Taro was often depicted as the main actor in the health care politics in the 1960s and 70s. He politically maneuvered to gain benefits from the government. He often broke the bureaucrats' opposition by approaching powerful politicians.

However, as this paper demonstrates, Takemi looked powerful but he played on the stage which had been firmly established before he became the president. What Takemi gained was short-term benefits but his 26-year presidency might have harmed the JMA as a professional interest group in a long run.

According to Sugimura, Takemi had his own, though not understood by many, ideal about health care of Japan. He tried to achieve it, but because he was in the position to provide material benefits to the JMA members, what he did was to negotiate with influential politicians to gain "easy money." Gaining the material benefits, such as the fee raise and preferential tax treatment, had to be Takemi's priorities. Importantly, that helped him repeatedly elected as the president.⁴⁷

As he continued to achieve his short-term goals, he postponed pushing for a fundamental reform to realize his ideals. By the time Takemi's presidency was almost over, the public harshly criticized the JMA and its members just as money-seeker and great harm to Japan's health care.

Among many factors, it is important to have professional and active doctors association to make the health care system better. The JMA seems to have lost an opportunity to grow up in the postwar era. Because Takemi personally had power to get what he got, the members relied on his personal connection and ability. Because what Takemi got was not fundamental structural reform, moreover, members got used to gaining material benefits not thinking of what health care was for. After Takemi left the office, the JMA tried to change itself. But it faced hard time to overcome the legacy Takemi left.

⁴⁷ Sugimura, *Fuun wo yobuotoko*, 131.