Politics of regulating medical professions in Japan:  
Policy change under sustained equilibrium

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Abstract

This paper seeks to analyse how policy reforms related to the handling of medical errors and healthcare professional regulation in Japan have evolved over more than ten years, since several scandals set these issues on the policy agenda. According to Baumgartner and Jones’s theory of punctuated equilibrium (1993), issues alternate between stable equilibria in policy subsystems, and the more disruptive sphere of macropolitics. The paper questions this by tracing the decade of policy development, and argues that policy change needs subsystems under sustained equilibrium.

The paper also asks the question from a comparative perspective. Does party politics have any impact on how healthcare services are regulated? The paper compares the Japanese case to that in England, arguing that there are different patterns of political interaction between citizens and elected/non-elected officials when such issues are at stake. A parliamentary system with strong policy-based exchange tendencies has greater capacity to respond to the electorate. In contrast, a parliamentary system with clientelist exchange patterns exhibits greater resilience for protecting professional interests. Differences identified here seemingly derive from three factors: key decision makers in each health system, stability of political parties, and the historical nature of ‘contracts’ between elected officials and voters in the constituency.
Introduction

Among the major sources for policy change, incidents, disasters and scandals are often mentioned as catalysts for sudden change because these sharply highlight defects and failures in existing policies (Baumgartner and Jones 2005; Birkland 1998; Butler and Drakeford 2003; Birkland 2006; Dekker 2007; Lodge 2002; Smith 2002).

How an event is transformed into a scandal, and then becomes a watershed moment for a particular policy domain, is a political process in itself. The impact of an event does not depend solely on the scale of damage or the level of initial shock, but also on the existence or absence of institutional mechanisms that provide legitimacy to ideas that encapsulate solutions which will prevent the recurrence of such events (Béland 2005, Kodate 2012).

Applying Baumgartner and Jones’s concept of punctuated equilibrium (1993), this paper questions the immediate impact of dramatic scandals on certain political systems and policies. In Japan, while the events called attention to systemic issues, including negligence and risks to patients, the actual policy change began to take place only after public attention over these issues dwindled.

Background

In Japan, a serious medical malpractice case at Yokohama City University Hospital (YUC) captured the news headlines on 11 January 1999. A patient who needed a heart operation was mistaken for another patient who required a lung operation. The two patients underwent the wrong operation, and died within the year. The incident was followed by another at Tokyo Metropolitan Hiroo Hospital (TMH) one month later. A nurse injected a patient with sterile solution instead of a physiological salt solution mixed with heparin. The patient died within 2
hours. The two hospitals were publicly-run, well-reputed, regional hospitals. As a result, medical errors abruptly began attracting intensive media scrutiny.

The brief timeline of the event (1999 – 2002) is described below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1999</td>
<td>Jan: medical accident occur at YCU</td>
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<tr>
<td></td>
<td>21 Jan: internal committee established</td>
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<td></td>
<td>Feb: medical accident occur at TMH</td>
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<td>19 Feb: hospital Director and Faculty Head resign.</td>
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<td>23 Mar: report submitted</td>
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<td>28 May: report circulated through the Ministry of Health and Labour (MHL) to each prefecture</td>
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<td></td>
<td>3 June: 31 staff penalised</td>
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<td></td>
<td>23 June: MHL recommends withdrawal of accreditation</td>
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<td></td>
<td>7 July: case brought to public prosecutor’s office</td>
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<td></td>
<td>14 Oct: victim dies</td>
</tr>
<tr>
<td>2000</td>
<td>16 Feb: re-application for accreditation</td>
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<tr>
<td></td>
<td>10 Mar: reapplication turned down by MHW</td>
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<tr>
<td></td>
<td>21 Mar: deputy Manager stepped down</td>
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<tr>
<td></td>
<td>2 May: 2.5 million JPY (12,500GBP) paid as compensation (from the city to the victim)</td>
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<td></td>
<td>12 Jul: reapplication turned down, with some other incidents discovered.</td>
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<td></td>
<td>27 Jul: a public trial opened</td>
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<td>24 Sep: minister alerted health providers on safety issues.</td>
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<td>15 Dec: MHL announced its tighter regulation on special-functioning hospitals.</td>
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<td>21 Dec: reapplication accepted.</td>
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<tr>
<td>2001</td>
<td>7 Nov: ‘safety-awareness week’ is announced by the Ministry</td>
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<tr>
<td>2002</td>
<td>17 Apr: report on Comprehensive Safety Measures is published.</td>
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<td></td>
<td>30 Aug: an amendment to Medical Act, through Ministerial Ordinance.</td>
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<tr>
<td></td>
<td>7 Oct: Ministerial Ordinance on special-functioning hospitals.</td>
</tr>
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<td></td>
<td>13 Dec: MEC guideline on administrative procedures for disciplinary measures.</td>
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</table>

Table 1: Chronology (1999-2002)

The incidents came to be widely recognised as ‘watershed’ moments and became ‘catalysts’ for regulatory reforms in Japan. This paper makes use of two sets of data: the print media and policy documents. The period covered by this study primarily runs from January 1st 1994 to December 31st 2013.
In order to examine and compare the mechanisms of translating a focusing event into a policy change, this section applies John Kingdon’s three-stream model of agenda-setting. As explained in the introductory section, an important aspect of Kingdon’s model is the concept of ‘critical junctures’ where the three streams become joined together at critical moments in time, opening windows of opportunity for policy change.

The following two sections will outline the basic health governance structures and mechanisms for dealing with malpractice errors in Japan. Unless otherwise stated, translations of Japanese quotes through the rest of the article are the author’s.

Figure 1 Public attention over ‘medical incident’ in Japan, 1994-2013 (Source: Nikkei, Asahi, Mainichi, and Yomiuri)
Governance arrangements in the Japanese health sector

Weak political representation, fragmented bureaucratic structure

Japan shares some common features with the UK in their political (unitary/parliamentary) systems as well as their universal health coverage. However, the two countries are in sharp contrast in terms of publicly-perceived roles of the state in financing and providing health services. The Liberal Democratic Party (Jiyu Minshu-tou, LDP) ruled continuously except for a brief period between 1993 and 1994, and from 2009 to 2012. As a result, differences can be found in their modes of health care delivery (i.e. their respective public/private mixes of service provision), as well as in the levels of political commitment to the principle of universality (i.e. equal service for everyone across the country). In terms of the regulatory issues, however, the Japanese government is held equally responsible for health care sector, including the registration of medical practitioners.

Governance of health delivery in Japan can be characterized by weak political representation, combined with a centralised but fragmented bureaucratic structure. Health care in Japan is financed through compulsory social insurance schemes, through which patients have universal access to any facility (Tatara and Okamoto 2009). Hospital care is provided either through regional (15 per cent in total bed provision) or national (4 per cent) public hospitals, or through private hospitals (53 per cent). The remainder is accounted for by other types of providers including teaching hospitals, which are under the jurisdiction of the Ministry of Education, Culture, Science and Technology. The responsibility for overseeing public hospitals (national and local) is also split between two ministries: the Ministry of Health, Labour and Welfare (MHW until 2001, then Kōsei Rōdōshō, MHLW after the merger with the Ministry of Labour),
and the Ministry of Internal Affairs (Ministry of Health, Labour and Welfare 2008). Under these complex, diffused apportionments of responsibilities, the healthcare system in Japan does not hold politicians in parliament (the Japanese Kokkai) directly to account for delivery issues; instead semi-autonomous providers simultaneously have the discretion and carry the liability in this respect.

In terms of provision, the central government has allowed each prefecture (i.e. governors) to decide the number of hospital beds and respecting the discretion of private practitioners or university professors over many practical decisions. Technical decisions are often delegated to experts in the councils, which are commissioned by the MHLW. Given the quick turnover of ministers in Japan (e.g. there have been 45 health ministers between 1970 to present, in contrast to 18 for the counterparts in the UK), policy formulation must rely heavily on civil servants in the relevant ministries. As a result, the influence of each minister over health policy has inevitably been limited, and blame has also been shifted easily to someone ‘more in charge’, particularly the medical professions or individual hospital managers (who are also doctors). The bargaining for remuneration remains at the national level, however. The government thus does ultimately retain leverage against private providers (Campbell and Ikekami, 1998).

Another interesting feature of the governance structure in Japan is the consistent centrality of ministries, even after public administrative reforms led to the creation of ‘independent administrative corporations’ modelled on UK-style agencies in the early 2000s (Pollitt et al. 2001; Nakano 2004). The exception in health services is a third-party body, the Japan Council for Quality Health Care (JCQHC), which was set up and co-financed by the JMA and the MHW.
in 1995 for a new and voluntary hospital accreditation scheme. The agency was spawned out of initiatives by the medical professional community, rather than as part of any political reform (Ito et al. 1998; Hirose et al. 2003; Kodate 2010).

The functions of political representation and bureaucratic structure in the health service domain thus display some important differences in Japan and the UK. How professional interests are mediated and institutionalised within the macro-politics of each also has considerable impact on policymakers’ actions following major adverse events.

Figure 2 Basic model of three-way interactions between government, medical professions and the general public in constructing patient safety regulation systems (Kodate, 2010)
Mechanisms of reporting and tackling malpractice in Japan before the incidents

In terms of the mechanisms for dealing with malpractice errors, Japan does not have the counterpart of the General Medical Council (GMC). Instead, Article 21 of the Medical Practitioner Law in Japan postulates that upon the discovery of any ‘unnatural death’, medical doctors are obliged to report it to the police. When clinical errors are reported, disciplinary measures are taken by the Medical Ethics Council (Idou Shingikai, MEC). The MEC sits within the MHLW, which also licenses and regulates physicians, and consists of thirty members including the Presidents of the Japan Medical Association (JMA). The political arm of the JMA was a longstanding electoral supporter for the LDP (Kondo 2005). Conventionally, the MEC waited for judicial verdicts for such cases before deciding to sanction doctors or demand closures of their clinics or hospitals. The independence of the MEC, as part of the Ministry, has long been questioned, as has its power to regulate physicians. Although ‘unnatural death’ is a contested issue, direct police involvement in such cases in Japan caused great anxiety amongst the medical professions and later became the focal point for reform. Yet from the patient’s point of view, direct police involvement may be the only way of getting to find out the truth. The presence of lawyers in the public discourse around patient advocacy is also prominent in Japan, and suggests that the patient movement requires another strong professional group to fight the paternalistic culture in medicine.

Prior to the incident at YCU, most government-led health reforms had concentrated on cost containment and reduction of hospital beds. In this context, the incident at YCU came as a total shock to policy makers and the public. It broke out on 11 January 1999 when it was revealed that the wrong operations were conducted on two patients whose identities had been mixed up.
(Yoshida 2004). As previously mentioned, one month later, another incident was reported at TMH. The two hospitals were publicly-run, well-reputed regional hospitals. These cases put safety and quality of care services on the political agenda, generating a series of discussions. Medical errors abruptly began attracting intensive media scrutiny.

**Policy debates and developments after the incidents**

**Phase 1 [1999-2004]**

**Blame game with varying degrees of central government involvement and transparency**

Firstly, the hospital manager of YCU explained that their decision to hold an internal inquiry only was based on harmed patients’ right to privacy (AS, 14 January 1999; YS, 15 January 1999). The directly-elected Mayor of Yokohama, Hidenobu Takahide, criticized the hospital managers’ use of ‘patient rights’ as an excuse for not giving sufficient information to the public. In response to his intervention, the decision was reversed. The case inevitably sparked huge public concern and media reports, particularly because YCU had been a government-authorized, special-functioning hospital. A ‘special-functioning hospital’ (Tokutei Kinou Byouin) is a large hospital with 500 beds or more, ICUs and more than 10 specialties, with advanced treatments on offer for patients as well as higher training for the medical staff. ‘Special-functioning hospitals’ were created by the second amendment to the Medical Service Act in 1992. Once accredited, a special fee schedule and tax cuts are granted to such institutions, and this incident revealed that the MHLW had no power to withdraw its status.
**Restoring coordinating functions of central government**

In Japan, the YCU scandal immediately prompted a review of the accreditation system by the MHW. However, in contrast to the Swedish example, the focus was to strengthen the power of the ministries rather than to tighten grips on local authorities, and the process took much longer. In October 1999, the MHW decided to amend the regulation itself, empowering itself to withdraw accredited status as needed. In November, the Medical Research Council (now part of the Social Security Council, under the MHLW) ruled that there would be an amendment to the ministerial ordinance, enacted in April 2000, which requires all Special-functioning hospitals to have guidelines for accident prevention and an internal committee for risk management.

The diffused responsibility for the hospital sector in Japan across multiple ministries signifies that important initiatives derived from ministries other than the MHLW. Soon after the incident at the YCUH in July 1999, the Board of National University Hospital Directors jointly with the Ministry of Education, Culture, Science and Technology established a working group for formulating measures to prevent medical errors. In 2002, the National University Hospitals’ Patient Safety Assembly was set up under the Permanent Committee of the Board. The assembly consists of 42 national university hospitals nationwide, and meets twice every year to discuss patient safety issues.

Furthermore, within the MHLW, a Patient Safety Unit was also created in April 2001. In May 2001, the government set up a consultative body named the Council on Patient Safety Measures, with several subcommittees. The interim report recommended that every healthcare provider should establish a risk management system. In order to provide an official complaints resolution system, Medical Safety Support Centres were also established in every prefecture and major
cities. However, the decisions regarding crucial and sensitive issues (e.g. the setting up of a judicial body which had power to remedy a situation or penalise hospitals in the case of adverse incidents) were delegated to another set of subcommittees. In October 2002, the MHLW amended the Ministerial Ordinance, obliging accredited health providers to ensure safety measures by reporting medical errors (enacted in October 2004).

The government delegated the task of gathering and analysing this data to the previously-mentioned third-party body, JCQHC. As a result, the JCQHC now provides two major functions by means of two different divisions – hospital accreditation (which is not mandatory and independent of the government) and adverse/near-miss event data collection and analysis (approved by the government). Although the initial small number of applications for inspection due to voluntary participation was criticised when the JCQHC was set up, increasing awareness of safety issues following high-profile incidents has led to a steady increase in the number of applicants for inspection. This lack of transparency was also mentioned as a weakness of the autonomous nature of the organisation, because the Council only published the names of ‘good’ hospitals but not the names of ‘failed’ hospitals.

Although there is still a relatively low rate of civil litigation over medical injury in Japan (Leflar and Iwata 2005), the filing of public prosecutions increased dramatically since the YCU case (10 cases in 1999 to 91 in 2005). Prosecutors’ standard charge against medical personnel under the Japanese Criminal Code is “professional negligence causing death or injury” (Keihou, Criminal Code, art. 211). The rare convictions for unintentional medical acts in the UK or elsewhere
almost all involve charges for *gross negligence* at least, while in Japan, *mere negligence* is sufficient for convictions (Komatsu 2004; Lefler 2009).

In April 2005, while the JCQHC made progress in the area of public access to information by announcing the very first statistics on the medical errors of large hospitals (276 hospitals as of March 2005) after a three-year pilot study, the credibility of a purely clinical evaluation by the Council was questioned when the former JMA president, Eitaka Tsuboi, was appointed as the President of the Council in 2004. Just as with the scepticism over the MEC’s self-regulatory function, the recurring question concerning the independence of the JCQHC was raised once more.

Later in the same year, tensions also arose with regard to transparency of data. Following the first publication of adverse incident details in large hospitals, the Council for Regulatory Reform within the Cabinet Office called for the mandatory publication of death rates in hospitals. Yet the MHWL was opposed to this, claiming that crude death rates could be misleading unless the data were modified to rightly reflect the critical status of patients and their disease profiles (AS, 30 October 2005). The lack of political intercession on behalf of patients and the public in all of those issues in Japan point to the absence of channels through which citizens’ voices can be translated into policy-making.
Figure 3 Public attention over ‘medical incident’ in Japan, 1994-2013 (Source: Nikkei, Asahi and Mainichi, excluding Yomiuri)

Phase 2 [2004-2008]

Search for solutions, entangled in political quagmires

Though the level of public attention regarding patient safety began to stabilise (or decline in the case of Nikkei Newspaper) by 2004, this did not mean that policy solutions were found either for the medical professions or patient groups.

There was one further major development in April 2004. The Supreme Court convicted the COE of TMH for failing to notify police of an ‘unnatural death’ at the time of another medical incident in 1999. This verdict hit the professional community as a huge shock. The incident resulted in the publication of a report by the independent government advisory body, the Science Council of Japan and the launch of a model project for the investigation and analysis of medical practice-associated deaths in four regions in the following year.
In March 2006, a gynaecologist at Ōno Fukushima Prefectural Hospital was arrested again, although a reconciliation process with the victim and her family was under way. ‘Unnatural deaths’ became a focal point of ensuing discussions and criticisms, and the public made a protest against the arrest (Leflar 2009). The lack of gynaecologists in Japan and the worsening environment for doctors prompted this public apprehension and led to another outcry, in favour of the professionals. In July 2006, the JMA set up a working group to discuss the possibility of establishing an Alternative Dispute Resolution mechanism.

In March 2007, the MHLW commissioned a task force, endorsing the basic idea of establishing an ADR mechanism as a solution to the long-standing problem of the criminalisation of medical practitioners. In April 2008, the Ministry published a draft plan, and the Bill was being prepared for submission to the Parliament. However, this process coincided with the waning power of the LDP-led coalition government. In the Upper House election held in July 2007, the LDP was defeated for the first time since 1955 by the Democratic Party of Japan (DPJ).

Opposition to the Bill began to be expressed from well-known medical practitioners on the grounds that the Bill was flawed and would not achieve the intended goal of lesser involvement by the police in malpractice cases. It was pointed out that by the time that the Bill was prepared, the sense of acute public criticism of the medical professions had dissipated, and therefore, there was no urgency on policy makers or medical practitioners. In fact, the number of prosecutions began to stabilise since 2008, moderating the trend towards criminalisation (Lefler 2009).

The emergence of the ‘twisted parliament’ (Nejire Kokkai, which literally means contorted Diet) complicated the dynamics within the policy subsystem. It meant that the largest opposition party, the DPJ, was now required to propose their own policies, distinct from the LDP’s, in order to
raise their profiles. The new mode of party competition emerged, with a much clearer emphasis on policy differences between government and opposition. The new type of political dynamics galvanised the voice of maverick-type leaders in the medical profession, which led to a split in opinions among the medical professions and the subsequent demise of the Bill. Therefore, the DPJ government began forming new alliances within the formal governance structure, dealing with the government and the medical practitioners, rather than reach out to the general public.

DPJ, the opposition party in the House of Councillors (Upper House) put forward an alternative proposal, which focused on the abolition of Article 21 and the establishment of a completely new body for investigating unnatural deaths. The obligation of reporting unnatural deaths to the third-party agency was also eliminated. According to the survey conducted by M3, Inc. (a company offering a portal site for medical practitioners in Japan) in July 2008, 43.1 percent of the doctors surveyed favoured the DPJ’s proposal, while only 13.2 percent supported the MHLW’s proposal.

In August 2008, the Fukushima District Court judged that in all cases the defendant (a gynaecologist at Ōno Fukushima Prefectural Hospital) was innocent (Sawa, 2012). This sentence underlined the importance of clinical judgment in the prosecution process, while simultaneously antagonising the relationship between the medical professions and the police/prosecutor. The main newspapers were divided on the issue. Asahi, Yomiuri and Nikkei supported the sentence, criticising the prosecutor side, whilst Mainichi questioned the validity of the verdict, favouring the medical practitioner over the patients (AS, Mainichi, Nikkei, and Yomiuri, 20 August 2008).

Among many structural problems exposed by the YCU and TMH cases, criminalisation of the professionals became the main issue for stakeholders. In the absence of policy devices for
coupling streams, subsequent reform process was driven by the professional societies who feared that their surgical mistakes could become subject to scrutiny by the police as possible criminal acts of manslaughter. The increased number of prosecutions has accentuated the desperate need for government intervention to design a new process for mediating malpractice cases. In August 2009, the DPJ marked the landslide victory

**Phase 3 [2009-2013]**

**Breakdown of policy subsystem with the change of government**

The change of government marked a radical departure from the long dominance of the LDP. The "iron triangle" of lawmakers, bureaucrats and industries were severed, and the medical practitioners were divided between the LDP and the DPJ.

![Diagram of policy making under the LDP-led government](Takahashi, 2010: 19)

**Figure 4 Policy making under the LDP-led government (Takahashi, 2010: 19)**
Under the LDP regime, appointment of ministers was merely a token gesture. Bureaucrats similarly nurtured a culture of serving their own bureaus’ interests first. The culture was criticised using the saying ‘bureau’s interests before ministry’s, section’s interests before bureau’s’. The DPJ government sought to transform the system by creating the ‘three key elected officials’ (Seimu san yaku) in each ministry, who propose, coordinate and decide policies. In creating a politician-led government, the DPJ had founded a new mechanism. Under the Cabinet Office, the National Strategy Bureau (Kokka Senryaku Kyoku) and the Administrative Renewal Council (Gyōsei Sasshin Kaigi) were established.

Figure 5 Policy making under the DPJ-led government (Takahashi, 2010: 23)
From competing ideas to decision making under restored sustained equilibrium

However, as a result of all these systemic changes, the two competing ideas of the DPJ and the MLHW regarding the third-party body for investigating medical incidents became embedded in the party political power game, while the priorities for such legislation were also de-escalated. In order to reduce the government's massive budget deficit, the Administrative Renewal Council decided to introduce a new mechanism called Shiwake (sorting out), and the successfully-run model project for the investigation and analysis of medical practice-associated deaths became the target for abolition.

The irony was that the new DPJ government was elected, winning the hearts and minds of the people, under the banner of ‘supporting people’s lives’. Yet the policy resulting from the change of government was so adverse to victims of medical incidents and their families that they began campaigning once again, calling for an early establishment of the third-party body, proposed by the MHLW (Yomiuri, 11 April 2009; AS, 13 May 2010).

In July 2011, the JMA proposed a new policy, outlining that medical incidents be investigated first by an independent committee set up internally in every hospital. Instigated by this move, the MHLW re-commissioned a task force to discuss this issue in February 2012. Due to political infighting and disarray, the DPJ government became extremely unpopular within three years. At the 2012 general election, the LDP led by Shinzo Abe regained power in December. Although the ‘twisted parliament’ continued to exist for several months, the Upper House election in July 2013 cleared up the situation, securing the majority of the LDP-led ruling coalition. As the subsystem was restored, the final report by the task force was submitted to the MHLW in May
2013. In January 2014, the Cabinet finally approved the proposal, and the Bill is due to be submitted to the Parliament during the current session.

**Conclusion**

Policy decisions relating to how to deal with medical incidents in Japan were deeply ‘nested’ in governance arrangements (Hill and Hupe 2006; Kodate 2012). By means of analysing the long-term development of policies, the paper illuminates the fact that the seemingly technical policy issue such as patient safety regulation can be influenced not only by the focusing event, but also by the formal governance arrangements. The dynamics of policy change is determined by how actors, including the media, constantly seek to scrutinize the system by proactively setting the agenda around ‘priority problems’. In the case of Japan, a higher level of political accountability led to elected officials taking a greater role not so much in promoting reforms, but in creating divisions of opinions and delaying reforms. It is worth examining further the long-term effect of such focusing events from the perspective of institutional design.

**References**

*Asahi Shimbun (AS).* January 14, 1999; March 25, 1999; May 1, 1999; May 14, 1999; May 26, 1999; October 30, 2005.


