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Table of Contents

Research Articles

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RESEARCH ARTICLE

The Political Process Involved in Formulating Healthcare Policy in Japan: With a Particular Focus on Advisory Councils, Interest Groups and Medical Officers

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Medical Officer

ABSTRACT

Japan's healthcare policy is defined by a universal health insurance system that guarantees affordable healthcare for all citizens at any time and in any location. The system was established in 1961 and has since undergone a process of evolution through the implementation of national healthcare policies. Despite the existence of conflicts and issues, the mechanism of the Central Social Insurance Medical Council ("Chuikyo") has continued to advance national healthcare interests. Nevertheless, this resulted in the commencement of criminal proceedings in 2004. The current demographic shifts present a challenge to the long-term sustainability of the national health insurance system, the long-term care insurance system, and the public pension system. This is occurring against a backdrop of rising costs associated with healthcare and long-term care, as well as an unsustainable national budget. The Chuikyo system is confronted with a multitude of challenges. This paper analyses the roles of three key actors in the Japanese national healthcare policy-making process. These actors include advisory councils such as Chuikyo, interest groups such as the Japan Medical Agency, and medical officers of the Ministry of Health, Labour and Welfare, who play a pivotal role in the policy-making process. The incremental improvements that Chuikyo produces are insufficient to address the long-term challenges facing the national healthcare policy. Japan's healthcare model requires reconstruction to align it with the needs of an ageing society with a declining birthrate. Prior to embarking on this important policy work, it is essential to determine who should lead it. It is recommended that the Prime Minister and the Cabinet Office spearhead a study on radical reform, with strong political leadership and a capable technocrat team to facilitate collaboration with the National Diet and the public. Furthermore, it would be crucial to achieve a consensus through national forums on the fundamental concepts that citizens, as consumers, desire and are prepared to forego from a bottom-up approach. It is essential that the governance structure of the national healthcare system is changed to a decentralised structure so that citizens can be proactively involved in healthcare issues and make autonomous decisions.

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Introduction

The national health policy in Japan has been shaped through a complex political process based on the national health insurance system for all nationals. The Japanese healthcare system is distinguished by three fundamental characteristics: universal health insurance, free access to medical institutions, and in-kind payment for medical services (Shimazaki, 2020). The national health insurance system provides coverage for healthcare services that are explicitly outlined in the insurance policy, including select dental procedures. Furthermore, the costs associated with pharmaceuticals covered under the public health insurance scheme are determined at the official level. In a free-market economy, healthcare is the sole exception, being based on the national insurance system and governed by medical fees and pharmaceutical price standards set by the government. It is a special public sector that is located outside the market economy.

The Japanese healthcare system is characterised by a mixed system of public and private healthcare service providers based on the national healthcare system. Large-scale medical institutions are those operated by public entities, including universities and governments, which collectively account for approximately 20 per cent of the total healthcare provision capacity. Private medical institutions, which include clinics and small and medium-sized hospitals operated by individuals or medical corporations, account for a total of 80 per cent of the healthcare provision capacity.

A comparative analysis of the Japanese healthcare system with that of other countries reveals the distinctive features of the former (Shimazaki, 2013/2020: 29; Seaton, 2023). National health insurance systems like Japan, Germany, and France are distinguished by a higher proportion of public healthcare institutions within their healthcare delivery systems. In contrast, the United Kingdom and Sweden have a tax-based healthcare system, with healthcare provided by public healthcare institutions that serve as gatekeepers.

In the United States, the provision of healthcare is primarily the responsibility of private healthcare institutions, which operate under private health insurance schemes as defined by the terms of their insurance policy. Notable exceptions to this are Medicare, which provides healthcare for the elderly and persons with disabilities under a social insurance scheme, and Medicaid, which provides healthcare for low-income individuals under a tax scheme.

The objective of the national healthcare policy in Japan is to guarantee that all citizens have equitable access to quality healthcare at the lowest possible cost. This requires three fundamental considerations: the quality of medicine, equality of healthcare access, and a minimal cost burden (Shimazaki, 2020: 20). It is evident that the Japanese national healthcare system has successfully achieved all three of these objectives. However, this has resulted in a notable increase in national healthcare expenditure as the population has aged.

In the year 2021, Japan's healthcare expenditure increased by 4.8 per cent in comparison to the previous year (Ministry of Health, Labour, and Welfare of Japan, 2023). The mean expenditure per capita was ¥358,800 (based on an exchange rate of US$1 to ¥150, this equates to US$2,392), representing a 5.3 per cent increase. Healthcare spending constituted 8.18 per cent of gross domestic product (GDP), representing an increase from the previous year's figure of 7.99 per cent. The expenditure data, disaggregated by age group, yielded the following figures: The expenditure for individuals aged 0-14 was ¥2.42 trillion (US$16.13 billion); for those aged 15-44, it was ¥5.37 trillion (US$35.80 billion), for those aged 45-64 it was ¥9.94 trillion (US$66.27 billion), and for those aged 65 and above it was ¥27.30 trillion (US$182.00 billion). The mean expenditure for individuals below the age of 65 was ¥198,600 (equivalent to US$1,324), while those aged 65 and above spent, on average, ¥754,000 (equivalent to US$5,027).

As illustrated by the figures, the ageing of the population is exerting a considerable influence on the growth in healthcare expenditure, which gives rise to a potential intergenerational conflict of interest. The ageing population is being countered by a rapid decline in the birth rate, which gives rise to questions regarding the long-term viability of the national health insurance system. The aged care insurance system for the care of the elderly has become a significant challenge due to rising care costs and a shortage of caregivers. It can be argued that the Japanese healthcare system, which was developed in the post-war era, is now on the verge of crisis.

The aim of this paper is to examine the role of three key actors in the Japanese healthcare policy-making process regarding the reimbursement mechanism of the national health insurance system. These are advisory councils, interest groups, and medical officers. The rationale for addressing this subject is that an understanding of the processes through which healthcare policy is formulated is indispensable for the analysis of the Japanese healthcare system. This paper aims to respond to the research question, "What is the political process involved in formulating healthcare policy in Japan? How is this process evaluated? Moreover, how should the healthcare policy in Japan be reformed?"

Methodology

A substantial corpus of literature in Japanese exists on the specific subject of Japanese healthcare policy. Some studies of Japanese healthcare policy adopt a social security law perspective (Kikuchi, 2019), while others employ administrative policy science (Fujita, 1999; Shimazaki, 2013/2020; Ryu, 2018), historical analysis (Somae, 2020), studies of Japanese healthcare politics (Campbell and Masuyama, 1994; Ikegami and Campbell, 1996; Talcott, 2001; Yuki, 2004/2006; Yamaguchi, 2016), or the role of healthcare administration (Mizuno, 2005; Murashige, 2010; Morita 2013/2014; Morita, 2016; Sato, 2018), and other related fields. Moreover, a corpus of English literature has been produced about Japanese healthcare policy (Sams, 1986; Ogura et al., 2019; Rand and Kesselheim, 2020; Yamagishi, 2022).

Nevertheless, few articles adopt a macro-level perspective and examine the processes through which the national healthcare policy is formulated, its structural components, and the key actors involved (Ikegami and Campbell, 1996). This article takes a macro-level view of Japan's healthcare policy through the lens of consumers, focusing on the mechanisms for determining reimbursement in the national health insurance system and analyses the mechanisms and major actors in the decision-making process.

The article presents the findings of a comprehensive literature survey of interdisciplinary studies in Japanese and English. These sources are subjected to critical analysis through the lens of the discipline of political science. The author conducted research on the topics of this article at the Graduate School of the Institute of Science Tokyo (formerly Tokyo Medical and Dental University) from April 2023 to March 2025 from a medical policy studies perspective. The findings of this research have been published (Sakurai, 2024ab).

The following section will provide an overview of the historical background of Japan's healthcare policy and the main actors, with a particular focus on the public councils, interest groups, and medical officers. Subsequently, the advantages and disadvantages of the existing healthcare policy-making process will be analysed through the reimbursement of the national health insurance system. Furthermore, the potential avenues for reforming the healthcare policy in Japan to ensure long-term sustainability will be discussed. Finally, a conclusion will be reached.

A Historical Review of Japan's Healthcare Policy

The historical development of Japan's healthcare policy can be traced back to the Meiji era (1868–1912) when Western medical systems were first adopted in the modernisation of Japan. Japan sought to emulate the German model of healthcare, striving to implement a contemporary medical infrastructure and enhance social health. In the post-war period, the universal health insurance system was established in 1961, thereby guaranteeing that all citizens had access to medical services. This development was made possible by the collaboration of the government, medical institutions, healthcare professionals, and the public in the process of restoration of the national economy and improvement of quality of life.

The historical evolution of universal health insurance coverage in Japan can be delineated into three distinct periods (Shimazaki, 2020). The initial period, spanning from 1922 to 1945, encompasses the establishment of the foundational framework in the aftermath of Japan's defeat in World War II. During this period, two pivotal programs were established: the Employees' Health Insurance Act (1922) and the Community-based Health Insurance Act (1938). The objective of these programs was to extend health insurance coverage to the private sector, including farmers.

The second period, spanning from 1945 to 1955, is characterized by recovery and reconstruction efforts. These efforts were concentrated on the restoration and reconstruction of the health insurance system, which had been severely disrupted by the war. In 1948, the role of insurer for Community-based Health Insurance was assumed by municipalities with the objective of reinforcing the administrative foundations. Moreover, in 1953, the government introduced a subsidy program for benefit payments.

The third period, spanning from approximately 1955 to 1961, is characterised by the planning and implementation of universal health insurance coverage in Japan. During this period, Japan was experiencing a rapid economic recovery, yet a persistent social issue remained: poverty among those lacking health insurance, who were forced to bear the full financial burden of medical expenses. In this context, achieving universal coverage became a pivotal political objective. The 1958 revision of the Community-based Health Insurance Act facilitated the nationwide implementation of the insurance program in all municipalities by April 1961, thereby achieving the objective of universal health insurance coverage.

Significant developments in healthcare can be attributed to the establishment of local-level health administration during wartime, the introduction of post-war national health insurance, and a notable shift in disease patterns, with a decline in tuberculosis and an increase in surgical procedures in the post-war period (Somae, 2020). Since the introduction of universal health coverage in 1961, the Japanese healthcare policy has been designed with the objective of guaranteeing that all nationals have access to quality healthcare at any time, in any location, and at a low cost. During the period of high economic growth in the 1960s and 1970s, the ratio of healthcare expenditure to GDP was reported to have remained relatively low in comparison to other major industrialised countries (Sato, 2018).

Since the 1980s, the Japanese government has employed a range of strategies with the objective of regulating national healthcare expenditure. In the 2000s, while significant reductions in medical fees and pharmaceutical prices were enacted, the depletion of the medical frontline (hospitals) and the influx of emergency patients became a pressing concern, given the lack of resources to cope with the increased demand. The quality of medical care was called into question.

Moreover, the rise in the co-payment rate for patients to 30 per cent and the subsequent focus on the shortage of medical doctors has led to a heightened awareness of the difficulties in accessing medical facilities. The understanding of the relatively low cost of healthcare to GDP has been

demonstrated to be erroneous (Sato, 2018). The term "medical fees" is used to describe the fees paid to medical institutions and pharmacies as compensation for the provision of medical care.

For individuals of working age, the patient is liable for a co-payment of 30 per cent, while the insurer is responsible for the remaining 70 per cent of the fee to the medical institution. The co-payment rate is subject to variation according to age and income bracket. Preschool children are liable to pay 20 per cent, while those aged between 70 and 75 are subject to a rate of either 20 per cent or 30 per cent, depending on their income. Individuals aged 75 and above are required to pay 10 per cent or 30 per cent, depending on their income.

There are numerous issues that require resolution in Japan's healthcare policy. The long-term sustainability of the national health insurance system is currently regarded as a significant challenge, largely due to the demographic shifts associated with a declining and ageing population (Kikuchi, 2019). The cost of national health insurance premiums for the insured continues to rise. When the burden of long-term care insurance, income tax, and consumption tax is added, it could be argued that the public is approaching the limit of its ability to bear the burden. Japanese workers have their taxes and social security contributions deducted from their salaries by their employers, so non-payment is extremely rare. However, their take-home pay is falling.

Regarding the provision of healthcare, the uneven distribution of medical professionals across regions has emerged as a social concern. There is a growing need to address the pressing issue of improving the challenging working environment for medical doctors and other healthcare workers. In recent years, there has been an increase in the number of cases where patients and their families have lodged complaints about the way healthcare professionals have treated them, as well as instances of inappropriate harassment or inconvenience.

In response to the spread of the novel coronavirus in 2020-2022, the provision system for medical care was severely strained in some regions, resulting in patients being unable to receive the medical care they required. This was regarded as a significant problem, as the Japanese government was unable to intervene with private healthcare providers through policy. The perception of quality healthcare as inexpensive and accessible at any time and in any location has unfortunately collapsed.

The field of medical technology, exemplified by genome medical research, is developing at a rapid pace with the objective of attaining precision medicine tailored to the individual. This has resulted in an increased focus on the early detection of cancer, which was previously considered an incurable disease. However, there is a fundamental problem in that medical policy has not been able to keep pace with these changes in the social environment and advances in medical technology, which are occurring at a rapid pace.

Three Key Actors in the National Healthcare Policy-Making Process

Advisory Councils: Chuikyo

Advisory councils provide a forum for the gathering of opinions from a range of experts and stakeholders during the planning and revision of national healthcare policies. They function as forums for aggregating opinions from experts and stakeholders, guiding the direction of policies. This process guarantees that the policies reflect a multiplicity of perspectives. The advisory councils facilitate the discussion of salient issues pertaining to national healthcare policy, and their findings are subsequently integrated into the policy formulation process. A system for the deliberation and determination of medical fees and pharmaceutical prices has been established.

This system is operated by three advisory councils that have been established within the Ministry of Health, Labour, and Welfare ("MHLW"; Shimazaki, 2020). These are the (a) Medical Care Section of the Social Security Council (社会保障審議会医療部会), (b) Health Coverage Section of the Social Security Council (社会保障審議会医療保険部会), and (c) Central Social Insurance Medical Council (中央社会保険医療協議会、中医協). The responsibilities of the councils are distributed among the following entities: (a) the healthcare delivery system and healthcare planning (Secretariat: Medical Policy Bureau, MHLW), (b) the health insurance system (Secretariat: Insurance Bureau, MHLW), and (c) the revision of medical fees (Secretariat: Medical Division, Insurance Bureau, MHLW).

These three advisory councils engage in deliberations pertaining to the national healthcare policy, national health insurance policy, and reimbursement and are vested with the authority to determine policy. Consequently, in the absence of legislative action pertaining to healthcare policy, the policy and pricing mechanism functions are conducted under the purview of the administrative body rather than the National Diet. This paper particularly focuses on the Central Social Insurance Medical Council, which is commonly referred to as the "*Chuikyo*" (中医協), to examine its system and relevant stakeholders in greater detail (Ogura et al., 2019; Rand and Kesselheim, 2020).

The *Chuikyo* is the entity charged with conducting public deliberations on the revisions. This is an obligation enshrined in the pertinent legislation, and the *Chuikyo* is further tasked with providing advisory services to the Minister of Health, Labour, and Welfare. In accordance with the "revision rate" determined by the government and the "basic policy" established by the Social Security Council, the *Chuikyo* engages in deliberations pertaining to specific points and calculation requirements. Based on these discussions, the *Chuikyo* presents a report to the Minister for their consideration. The *Chuikyo*'s report is particularly focused on the management of medical institutions.

The council is constituted of tripartite representatives, comprising seven insurers, seven healthcare practitioners, and six public interest representatives (Sato, 2018). The council is chaired by an academic scholar. In accordance with the pertinent legislation, the appointment of the chair and public interest representatives is subject to the prior consent of both Houses of the National Diet. The term of office for each member is two years, with half of them being appointed each year. In addition to the members, up to ten expert members will be appointed on each occasion.

In *Chuikyo*, those deemed capable of adequately representing the position of those who bear the financial burden of healthcare include Directors of the National Health Insurance Association and the National Federation of Health Insurance Societies, among others (Sato, 2018). Those healthcare practitioners who are recognised as being able to adequately represent the position of those who provide local medical care consist of the Vice Chair and Directors from the Japan Medical Association (JMA), Japan Hospital Association (JHA), the Japan Dental Association (JDA), the Japanese Nursing Association (JNA), and the Japan Pharmaceutical Association (JPA). The public interest representatives comprise academic scholars or representatives of public corporations.

The *Chuikyo* organisation is structured according to a multilayered council system. In accordance with the *Chuikyo* General Assembly, five specialised committees have been constituted to address issues pertaining to pharmaceutical prices, insured medical materials, cost-effectiveness assessment, a joint committee of these three issues, and the verification of the results of the revision of medical fees (Sato, 2018). Furthermore, two subcommittees have been established to oversee the revision of medical fees and to conduct research surveys. The findings of these subcommittees are presented to the *Chuikyo* General Assembly for consideration. The *Chuikyo* General Assembly solicits input from specialised organisations engaged in the production of medical reports and surveys, as well as those involved in the calculation of pharmaceutical costs.

The *Chuikyo* will demonstrate its healthcare policy through the implementation of remuneration and pricing mechanisms, which will provide incentives for medical price inducement. One illustrative example of the *Chuikyo* decision is the proposal to augment the additional points allotted to guarantee the regional healthcare system from 100 to 120. The amount payable is calculated by adding together the number of points allocated to each medical treatment. In addition to the basic medical fees, such as those for an initial consultation, there are special medical fees for approximately 5,000 medical procedures. The medical fees are calculated based on the assumption that one point equates to 10 yen, and these points are the same throughout the country.

It can be argued that the *Chuikyo* system provides a platform for public debate among representatives of various stakeholders in accordance with the law. It seeks to balance conflicting interests to adjust the national healthcare policy in a moderate manner, particularly through the revision of medical fees and associated matters (Ikegami and Campbell, 1996). This system may substitute the private market mechanism in the healthcare industry and thus has limitations in terms of its ability to contribute to the real demand and supply.

Interest groups: Japan Medical Association

The evolution of the Japanese health system can be viewed as a series of conflicts between competing interests among stakeholders (Campbell and Masuyama, 1994). It has been observed that interest groups representing various sectors of the healthcare industry engage in lobbying activities with the intention of influencing the formation and implementation of healthcare policies. Notable examples include the Japan Medical Association (JMA) and other relevant groups mentioned above. These groups have been identified as playing a significant role in the policy-making process, exerting considerable influence over the direction of healthcare policy while protecting their respective interests. These groups engage in conflict with one another regarding medical issues and divergent interests.

The present paper focuses on the Japan Medical Association (JMA). The JMA is a private, academic and professional association with 176,000 members (as of 1 December 2023), representing 51 per cent of the registered medical doctors in Japan (JMA, 2024). The JMA is comprised of members from 47 prefectural medical associations, each of which is an autonomous legal entity. The membership is comprised of two distinct categories of medical doctors: those who are employed and those who are independent. The latter are typically engaged in the operation of clinics or the management of medical corporations.

The JMA was established in 1916 by Shibasaburo Kitasato (1853–1931) and other pioneers in the field. It was formally recognised as an incorporated association in 1947 and subsequently designated as a public interest incorporated association in 2013 (JMA, 2024). The JMA's activities are diverse, encompassing the advancement of the medical profession, the enhancement of medical education, the promotion of general medical and related scientific progress, and lifelong education. The JMA operates a research institute, the Japan Medical Association Research Institute (JMARI).

From the 1960s to the early 1980s, the JMA exercised considerable political influence under the powerful leadership of Taro Takemi (1904–1983), who served as president for 25 years from 1957 onwards. During this period, the JMA severely conflicted with the Ministry of Health and Welfare but fostered close ties with the Liberal Democratic Party (LDP), which has been the ruling party since 1955 (Ikegami and Campbell, 1996).

The JMA's political role was continued under the tenure of subsequent chairmen. While the JMA has consistently aligned itself with the LDP, there have been instances where the two parties have held divergent views on specific aspects of healthcare policy. The JMA's defensive stance in the

context of the novel coronavirus infection, which involved clinics and small and medium-sized hospitals of the JMA members refusing to see patients, was met with disappointment from both the LDP and the public.

It can be argued that the JMA is engaged in political activities, operating as both a policy institution representing the interests of medical professionals and a political pressure group (Yamaguchi, 2016). Indeed, the JMA has established political institutions, including the Japan Medical Federation ("*Nichi-Iren*"), which have made donations to the LDP political fund management entity and the political fund institutions of healthcare-related LDP lawmakers. In 2021, the *Nichi-Iren* made donations amounting to 14 million yen (US$ 93,300) to former Prime Minister Fumio Kishida and 11 million yen (US$ 73,300) to former Minister Keizo Takemi (Tokyo Shimbun, 2023).

Similarly, other healthcare practitioner institutions, including the Japan Hospital Association (JHA), the Japan Dental Association (JDA), and the Japan Pharmaceutical Association (JPA), exhibit structures and functions comparable to those of the JMA. These institutions can be considered interest groups that exert pressure on the Japanese government, both within the *Chuikyo* roundtable and beyond. Other relevant actors involved in the *Chuikyo* dialogue include the Ministry of Finance, which plays a role in national budgetary decisions, as well as healthcare-related LDP and Komento lawmakers, who together form a leading political party.

It is relevant to note that an investigation into criminal activities was eventually conducted in relation to the *Chuikyo*. This case concerns allegations of corruption by the JDA's political funding body, the Japan Dental Federation (JDF), in relation to dental fee revisions. Furthermore, the investigation encompasses allegations of embezzlement connected to the election of the JDA president, as well as the solicitation and acceptance of illicit donations related to politics. The initial revelation of these allegations occurred in April 2004.

A total of 16 individuals were indicted, comprising six executives of the JDA, two members of the *Chuikyo*, two LDP lawmakers, the LDP faction treasurer, and five local assembly members, all of whom were subsequently convicted. The two members of *Chuikyo* are a former director-general of the Social Insurance Agency who previously held the roles of medical officer in the MHLW and a vice-president of the Federation of Trade Unions.

The incident prompted a re-evaluation of the *Chuikyo* composition, leading to an increase in the number of public interest members. Furthermore, measures to enhance transparency were implemented, including the public disclosure of proceedings and amendments to the Political Funding Regulation Act (Sato, 2018). Despite the absence of criminal cases since that time, it is evident that the *Chuikyo* system has the potential risk for corruption. Indeed, there is evidence that political funding and profiteering are occurring in a manner that is not in violation of the law. This is evidenced by the continued donations made by interest groups to the funding entities of the LDP and its members.

It can be argued that the *Chuikyo* system is based on a combination of an administrative-driven public market system and a profit-driven political system. Profit-driven politics has the potential to distort healthcare remuneration revisions by introducing artificial considerations into the realisation of fair and equitable national healthcare policy. While healthcare is a high-profile public interest business that is not suited to private market-based price adjustments, it is nevertheless concerning when profit inducements are made by healthcare providers as interest groups (Shimazaki, 2020). This mechanism introduces complications into the discussion on healthcare policy.

Medical Officers: Ministry of Health, Labour, and Welfare

Medical officers of the MHLW are specialists tasked with the planning, drafting, and implementation of healthcare policies within governmental bodies and associated institutions (Mizuno, 2005). Medical officers play a pivotal role in formulating policies based on medical knowledge and the realities of the field, ensuring scientific validity and alignment with international standards. The medical officer serves as the *Chuikyo* secretariat, facilitating the deliberations. Although the duties of bureaucrats are defined by law, medical officers are required to maintain relationships with the Ministry of Finance, ruling party politicians, and medical interest groups due to the vast national budgets they manage and their significant social influence.

Japanese nationals who possess a medical or dental license and have successfully completed the requisite national qualification examinations are eligible to be employed as medical officers if they apply and subsequently pass the recruitment examination offered by the MHLW (Ministry of Health, Labour, and Welfare of Japan, 2024). While national civil servants are required to take the National Personnel Authority's National Civil Service Examination, medical officers are exceptionally recruited by the MHLW outside of the system. This distinctive recruitment policy has been adopted to meet the specific requirements of medical officers with specialised expertise.

Other examples of technical officers with similar qualifications include those working in the fields of construction engineering in the Ministry of Land, Infrastructure, and Transport, agricultural and civil engineering in the Ministry of Agriculture, Forestry and Fisheries, and nuclear engineering in the Ministry of Economy, Trade and Industry. All these individuals have completed the examination (Mizuno, 2018). These groups are engaged in public works projects and are allocated a considerable budget despite their relatively modest personnel numbers.

To gain a comprehensive understanding of the rationale behind the establishment of this distinctive recruitment system, it is essential to conduct thorough historical research, tracing its origins back to the national bureaucratic system and, ultimately, to the Meiji era. Subsequently, during the period of US occupation between 1945 and 1951, the current system for the employment of medical officers was established and developed based on the US public health and healthcare personnel system. Brigadier General Crawford F. Sams, a US Army officer and medical doctor, was a key figure in promoting this system (Sams, 1986: 214–215).

The appointment of medical and dental doctors to medical administration is a practice observed in other countries, and this is not a system unique to Japan (Wilsford, 1991). Rather, they were heavily employed during the US occupation as personnel to improve public health and healthcare at an early stage. After 80 years, this personnel system for medical officers remains unchanged and takes administrative responsibility in a broader area related to public health and healthcare as time passes.

The mean number of medical officers recruited annually is approximately 10, resulting in a total of between 250 and 300. This constitutes a relatively modest cohort within the broader population of national civil servants. Medical officers possess a distinctive set of professional skills and experience, drawing on the expertise of medical and dental doctors. This background informs their approach to their role as technocrats. A relatively small number of medical officers are deployed in public health and healthcare-related positions that are considered important. Consequently, they are perceived as elites, and they must adapt their performance to comply with the requirements of the various positions for which they are responsible. In fact, they are frequently transferred between positions every two years.

They are employed in a variety of roles within the public health sector, including research into the prevention of infectious diseases, public health departments, and the WHO. They are engaged in a range of healthcare-related activities, including dentistry, national health insurance, aged care insurance, and medical equipment. Approximately 170 medical officers at the MHLW are

responsible for public health and healthcare-related roles, including the Medical Policy Bureau and the Medical Insurance Bureau. This also applies to other ministries, local governments, public health and healthcare institutions, and so forth (Fujita, 1999).

It is a common practice among medical officers to resign from their civil service roles and transfer their employment to medical institutions or universities. This enables them to utilize their licenses as medical or dental doctors. In such cases, there is a notable increase in the annual income. In other words, medical officers receive the lowest remuneration as licensed doctors but can make a valuable contribution to the public sector with a missionary mindset.

The diversity of their professional backgrounds means that medical officers are perceived as a unified group. It is observed that a certain degree of distance exists between administrative officers and technical officers, including medical officers, within the MHLW (Nakajima, 2017). The delicate balance between administrative officers and technical officers, including medical officers, represents a challenge to the formation of a unified institutional identity within the MHLW.

Since 2014, the Cabinet of Japan has collectively administered the personnel affairs of each ministry through the Cabinet Personnel Management Agency. This system was established during the tenure of former Prime Minister Shinzo Abe (1954–2022). It enables the Cabinet to exercise control over each ministry or public agency, thereby allowing the Prime Minister to assume the role of a President (Kamikawa, 2018). However, medical officers seem to have continued to pursue their personnel initiatives.

In July 2017, the MHLW established a new vice-ministerial-level position, the Chief Medical and Global Health Officer, through legislative reform (Ministry of Health, Labour, and Welfare of Japan, 2024). This position is intended for medical officers. This officer represents the third vice-ministerial-level position within the MHLW, situated beneath the administrative vice-minister and the counsellor for health, labour, and welfare. This position oversees a diverse range of medical matters and is positioned to play a pivotal role in the international advancement of health and medical policies.

Despite the enhancement of the status of medical officers, the shortcomings eventually became evident in the context of the novel coronavirus pandemic. Medical officers, in collaboration with officers from the MHLW, allocated considerable national resources and made a series of missteps in their response to the outbreak. Suspicions have been raised that medical officers are a group of specialised technical officers so obsessed with their position that they do not necessarily contribute to the welfare of the public (Murashige, 2010).

Discussion

Contributions and Limitations of the Chuikyo System

The most noteworthy feature of Japan's healthcare policy is its universal health insurance system, which ensures the provision of affordable healthcare services to citizens at any time and in any location. However, this advantage is confronted with numerous challenges. The total annual cost of healthcare in Japan reached \45 trillion (US$300 billion) in 2023 and is projected to rise in the coming years. The most significant challenge is to ensure the long-term sustainability of the health insurance system. Moreover, there is a concern regarding the sustainability of long-term care insurance and public pensions. These issues are interlinked with the unsustainable national budget.

The objective of the *Chuikyo* system is to facilitate the balancing of the interests of stakeholders in the healthcare sector by conducting a review of the reimbursement and related healthcare policy options for its operation. The scheme is a public business led by the government that is in accordance with legal requirements and with a view to maintaining consistency in healthcare administration. The existing *Chuikyo* system will be capable of maintaining the status quo and implementing incremental improvements. Nevertheless, a comprehensive reassessment of the national healthcare system will be imperative in the longer term.

It can be posited that in forums of public administration, a variety of interest-based coordination occurs in informal settings. The designation of the policy in question has resulted in the extension of policy preferences to healthcare providers, with political intervention contributing to this outcome. For example, when intractable disagreements arise during the process of coordinating opinions with interest groups, political intervention may be employed as a means of reaching a political settlement.

It is possible to resolve the conflict in a manner that does not constitute an illicit act and to address the compensation through the legal avenue of a political donation. This is illustrative of interest-aligned politics. For example, Hanako Jimi, a medical doctor, and member of the House of Councillors, who requested an increase in the revision of medical fees (Tokyo Shimbun, 2023), is the daughter of Shozaburo Jimi, a medical doctor and former member of the House of Representatives who served as Minister of Posts and Telecommunications. It has been documented that Jimi's political fund receives substantial financial contributions from the medical industry (Tokyo Shimbun, 2023).

It is notable that a considerable number of LDP members have inherited their political status through hereditary succession (Sakurai, 2024). It is not uncommon for LDP politicians to be affiliated with the interests of specific industries across generations despite the obligations of public office to represent the people in a fair and impartial manner. Furthermore, those engaged in the political sphere tend to direct their attention towards the financial implications of healthcare for the elderly within their respective constituencies rather than towards the broader economic health of the health insurance system (Talcott, 2001).

It appears reasonable to conclude that the democratic process, particularly in relation to the voting system, has failed to implement the necessary reforms to these significant national healthcare systems. This represents part of the failure of democracy. The current voting system functions to advance politics driven by self-interest rather than facilitating national consensus-building procedures (Yuki, 2004/2006).

The views of citizens are represented by the *Chuikyo* members, who are tasked with upholding the public interest. It is open to question whether these members are the most appropriate representatives of the public's views, although they are recognized by the National Diet. The effective management of an advisory council in accordance with the ministry's objectives is indicative of its exemplary bureaucratic performance (Morita, 2016). There is no avenue for citizens to challenge a public forum of stakeholders and experts convened within the framework of the *Chuikyo* system.

Japan Needs to Review Its Healthcare System

The Japanese healthcare system emerged within a socio-economic context shaped by a conscription system and a regulated economy under the wartime regime. Meanwhile, Japan's demographic structure is undergoing a significant transformation, which gives rise to important questions about the long-term sustainability of the current healthcare system. The United Nations and the Japanese government have published detailed projections of future demographic change up to the year 2070.

It is, therefore, imperative to consider prospective healthcare policy, including the objectives and the projected alterations to the population structure up to 2070.

In contrast, the issue of hereditary succession among medical doctors and dentists and the commercialization of healthcare to maintain this present a significant challenge to the rationalization of superfluous medical costs. It is crucial to examine the phenomenon of hereditary succession among politicians who espouse this ideology and secure electoral support. It can be reasonably argued that both the medical profession and politicians dedicate a significant amount of effort to maintaining hereditary succession as a family-run business (Sakurai, 2024a), which serves to maintain the existing system in a state of equilibrium.

One might posit that healthcare has become a political issue driven by the pursuit of economic benefits by medical professionals and the acquisition of voting power by politicians. There is a pressing need to transition away from a healthcare system that prioritises the interests of the medical profession and towards one that is truly patient-centric. The Japanese healthcare model needs reconstruction to align it with the democratic values of fairness, freedom, and equality as perceived from the citizenry's perspective.

The case of Yubari City, Hokkaido, where medical resources were eventually restricted due to financial considerations, offers a potential insight that may inform the future of healthcare (Morita, 2013/2014). The following context is provided for reference. Yubari City was a prosperous municipality, with a significant proportion of its economy dependent on coal mining. However, following the closure of the coal mines in 1990, the city experienced a rapid decline in economic activity.

In 2007, the Japanese government designated Yubari City, with a population of 10,000 (now 6,500), as a financial reconstruction organisation by law. This decision effectively recognised the city's financial default. Consequently, Yubari City was placed under state control, public facilities were abolished or downsized, and city hall staff had their salaries cut. The city's general hospital, which had 171 beds, was replaced by a clinic with 19 beds. At the time, it was predicted that the collapse of healthcare in Yubari City would be imminent.

However, subsequent events have demonstrated that life expectancy has not declined, and the quality of medical care has not deteriorated. It has been observed that elderly individuals who previously spent their final days in general hospitals are receiving home healthcare and dying at home. Additionally, the proportion of deaths attributed to senility has increased. The constrained availability of healthcare resources prompted a significant shift in mindset among medical professionals and the citizens of Yubari, who took the initiative to adapt their practices in response to the circumstances.

To gain a deeper understanding of the effectiveness of the proposed approach, it would be beneficial for other municipalities to engage in similar experiments. It is imperative that the results of these experiments be subjected to rigorous scientific analysis, and those outcomes may be used with a view to establishing a new approach to healthcare provision that is more economical and effective.

The prevailing approach to healthcare policy has been shaped in a centralised manner and implemented uniformly across the country, with minimal consideration for the diverse local characteristics. It is evident that municipalities' expectations of self-help efforts are misguided. To facilitate the ingenuity of local governments and medical institutions, it is necessary to devolve a certain authority to local governments and establish a system to provide efficient medical care suited to the region. It is crucial to address the question of who should spearhead such challenging policy work.

Proposal for the National Formation of Healthcare Reform

It is time to openly develop and deliberate on these fundamental policy scenarios. Should the current national health insurance system be maintained, it is necessary to determine what changes will have to be made to the system in the future. Conversely, should the current national health insurance system be changed, it is essential to ascertain what changes are possible and what health services will be provided to the public. Therefore, these fundamental policy scenarios must be developed and deliberated on by the public.

The formation of a capable cabinet and the collaboration with the National Diet based on the leading political parties to prioritize the necessary legislative amendments are prerequisites for the success of the reform. Such a formation requires the presence of a robust leadership structure with a clearly defined mission to achieve the desired outcome. It would be prudent to appoint an individual in the Cabinet Office who is suitably qualified and experienced to assume the role of head of the project team and who would be able to develop scenarios for national healthcare system reform.

It would be advantageous to appoint a Minister of State for Healthcare Reform to assume the role of Minister in charge, with the establishment of a Healthcare Reform Study Promotion Headquarters headed by the Prime Minister. The rationale behind the Cabinet Office's designation as the headquarters is to ensure the supervision of reforms by individuals with expertise in national budgetary matters or national economics. This contrasts with the involvement of medical officers of the MHLW, who would be required to assume a prominent role.

It is recommended that a special task force team be constituted within the Cabinet Office rather than within the MHLW, with the objective of overseeing the implementation of national healthcare reform. The MHLW is ill-suited to the management of national health reform for three principal reasons. Firstly, it is perceived that the organisation of MHLW lacks the requisite authority to effectively manage health policy at the national level. Instead, responsibility is distributed between the Chief Medical and Global Health Officer, the Director General of the Medical Policy Bureau, and other Bureaus, and health policy is dispersed across various departments, with routine work being allocated to those departments most suited to such tasks.

Secondly, the MHLW is responsible for managing a considerable national budget yet lacks the capacity to develop long-term policy strategies. The MHLW bears responsibility for the operation of social systems that have a significant impact on the lives of citizens, including healthcare, long-term care and public pensions. On occasion, a legal administrator was appointed as Director General of the Medical Policy Bureau to address a perceived deficiency. However, this appointment proved to be short-lived, and the position is currently held by a medical officer (Mizuno, 2005).

Moreover, the MHLW workforce is comprised of a diverse cohort of professionals, including legal, administrative, and technical officers with specialisations in fields such as medicine, pharmacy, nursing, and others. It is noteworthy that there is a lack of unified purpose across the MHLW. In this context, medical officers are required to assume the role of administrative officers, yet the full extent of their expertise is not fully utilised. This information was obtained from an interview with a former medical officer conducted in July 2024.

Thirdly, it is a common practice in business to separate the unit responsible for initiating the reform process from the unit responsible for implementing the resulting changes. It is typical for professionals in any business field to be protective of their area of expertise and reluctant to concede or lose their competitive advantage in the future. Consequently, they may lack the motivation to implement reforms, even when they are at risk.

The establishment of national forums comprising citizens will be instrumental in achieving a consensus on the fundamental concepts that citizens, in their capacity as consumers, desire and are prepared to forego. It is recommended that the national forum should include representatives of medical associations, academia, trade unions, and community associations. The objective of the national forums is to facilitate multilayered and multidimensional consensus-building dialogues, including various voluntary forums, with the aim of strengthening consensus-building channels based on a bottom-up approach (Tanaka, 2004).

This challenge may result in a reconciliation of top-down and bottom-up approaches, with the latter serving to complement the former. It would be beneficial to utilise information technology for the periodic reflection of public opinion on health reform and the examination of the national discourse. It is essential that the governance structure of the national healthcare system is changed to a decentralised structure so that citizens can be proactively involved in healthcare issues and make autonomous decisions (Shimazaki, 2020: 501). It is vital that the public is fully informed about this recognition.

Conclusion

This paper analyses the roles of three key actors in the Japanese national healthcare policy-making process. These actors include advisory councils such as *Chuikyo*, interest groups such as the Japan Medical Agency, and medical officers of the Ministry of Health, Labour, and Welfare, who play a pivotal role in the policy-making process. The incremental improvements that *Chuikyo* produces are inadequate to address the long-term challenges facing Japan's national healthcare policy. It is recommended that the Prime Minister and the Cabinet Office spearhead a study on radical reform, with robust political leadership and a capable technocrat team to guarantee collaboration with the National Diet and the public. Moreover, it would be imperative to attain a consensus through national forums on the fundamental concepts that citizens, as consumers, desire and are prepared to forego from a bottom-up approach. It is recommended that the governance structure of the national healthcare system be changed to a decentralised structure so that citizens can be proactively involved in healthcare issues and make autonomous decisions. However, it should be noted that this study is a literature analysis of overviews and does not include a detailed survey or interview to investigate the advisory council members, interest group members, and medical officers. Consequently, the study does not offer a comprehensive examination of each individual actor. Nevertheless, this limitation does not negate the importance of academic analysis of the research question. The present paper does not address the specific substances of healthcare reform policy and guiding principles, which require further systematic study. These issues will be discussed in a subsequent task.

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