Secondly, the ruling party has lost its control. Although a member of the ruling party himself, Koizumi has largely ignored party committees—including those for health care. The association's historical grip on key committee members has therefore become meaningless. Furthermore, pollsters suggest that politicians need to look beyond the iron triangle to win the support of voters and re-election. A recent cabinet survey shows that health care is the number one policy area that concerns people—above economic growth and employment, even after 10 years of recession in Japan.[3] Another survey by a major newspaper shows that over 90% of the public is dissatisfied with the current healthcare system.[4] Strong public discontent, critical media coverage, and a more powerful opposition have all added to politicians from the ruling party seeking a support base broader than the Japan Medical Association.

Thirdly, the association, which is primarily a general practitioners' organisation, is under attack from hospital doctors and other medical professionals. Historically, Japan's high rate of economic growth could support the ever increasing costs of health care. With the Japanese economy stagnating, the healthcare budget has been kept under reign (despite an ageing population and a growing burden of lifestyle related diseases), and this has caused a fight over allocation. The association has fought for a bigger share for general practitioners often at the expense of other medical professionals. As a result the association is seen within the profession to represent less and less the overall interests of the profession.

On 12 July 2004, when the results of the election for the upper house were announced, the decline of the association's clout became clear. Back in 1977 the candidate nominated by the association gathered 1.3 million votes, representing 19 votes for every general practitioner member.[5] Such an ability to garner votes, coupled with political donations, gave the association unrivalled political influence. In 2004 the association could muster only 0.25 million votes for its candidate.[6] With 83 000 general practitioner members, this accounted for only three votes per general practitioner member—less than a sixth of the votes gathered in 1977. Considering that most general practitioners would have family members and employees, this number implies almost no influence outside their closest circles.

The impetus for the association's decline was Koizumi's rise to power. However, the root cause is more structural and likely to outlive the Koizumi era. The narrow interests pursued by select general practitioners had not addressed broader interests that became more pronounced and vocal over the years.

More fundamentally the association's decline begs the question about the role of medical associations in influencing healthcare policies. For the Japan Medical Association to reinvent itself, it needs to broaden its membership to represent the whole medical profession. It then needs to transform itself from a lobby group to an academically grounded professional association that is engaged with and accountable to the general public. In effect it needs to win the trust of the people—as a guardian of professional standards in policy debate as well as in medical practice and research.

These lessons are just as applicable to other medical associations around the world.

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Primary care trusts and primary care research

Research networks and academic departments can help to do much needed research

Primary care is central to the NHS and primary care research provides "the missing link in the development of high quality, evidence based health care for populations."[1 2] The recent development of primary care trusts, which are responsible for commissioning local health services, has changed the landscape for primary care research in the NHS.[3] In addition to their already formidable service duties, primary care trusts also have research responsibilities.[4] Unfortunately, the competing demands on primary care trusts for establishing research governance and meeting government targets have made primary care research a luxury that few trusts can afford.

Despite the government's documented commitment to primary care trusts and their role in primary care research, scepticism exists about the ability of the trusts to take on this role. In a 2002 House of Lords debate, Baroness Northover questioned the health minister on the responsibilities of primary care trusts, saying, "Many of us have doubts about primary care trusts, both in relation to their lack of preparedness for their responsibilities and their natural primary care orientation ... there can be no certainty that primary care trusts will commission in a way that promotes and safeguards education, training, and research."[5]

A recent joint ministerial review responded to these concerns.[6] The review supported the original assessments, identifying "a lack of understanding in primary care trusts about roles and responsibilities in relation to learning and research across the whole of health, social care, and education."[6] The review also found that primary care trusts "find it difficult to influ-

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ence their local research strategy as the bulk of NHS research funding is allocated, without reference to them, to secondary care organisations."[6]

Similarly, the financial support for primary care research is also a cause for concern. The 2002-3 allocation for primary care research was only a small proportion of the £540m NHS budget.[7] In addition, the recent annual research and development report from the NHS ranked the primary care focus of current NHS research programmes poorly, with about one quarter ranking weak.[8]

The key to supporting primary care research lies in successful partnerships between primary care trusts and the academic sector. Because many primary care trusts do not currently have expertise in research, primary care research networks and academic departments ought to be natural partners for primary care trusts. The development of sites for the national network for the management and governance of primary care trust research offers a location for the coexistence of management, capacity building, and partnership.

Since the 1980s primary care research networks, which are multidisciplinary networks of general practices active in research, have formed an important part of the backbone of primary care research.[9] Primary care research networks are unique in that they also offer a wealth of experience in research capacity building in community settings, which is precisely the need faced by primary care trusts.[10]

Many academic departments of primary care are keen to build partnerships with primary care trusts.[11] Such linkages would help universities build research capacity and enable primary care trusts to meet their education and research objectives. However, some medical schools fear that small scale, local health services research will not be highly rated in the impending research assessment exercise that will take place in 2007 and thus may be dissuaded from working with primary care trusts.

Many opportunities exist for primary care research and primary care trusts to have a central role in improving the quality of primary care in the NHS.[12] The new general practice contract has provisions that offer further opportunities for primary care trust leadership and collaboration in research and service development. Specifically, the new framework for the measurement of quality of care, requires substantial input and participation by primary care trusts. They will be responsible for developing data systems to track and monitor performance of general practitioners and ensure that the quality framework functions.

Over the next few years, the National Programme for Information Technology will also be rolled out, leading to the eventual creation of integrated health records across primary and secondary care. The existence of these data, alongside data from the new general practitioner contract, creates major opportunities for primary care research.

An essential prerequisite to taking advantage of these opportunities is clear guidance on national and local research and development priorities for primary care. This in turn needs to be combined with adequate levels of funding, both centrally from the Department of Health and locally from primary care trusts. Evidence suggests that this is happening, for example, through the requirement that the new clinical research networks have strong input from primary care. However, if this does not occur, primary care research may decline further, leading to major long term adverse consequences for the NHS and healthcare systems overseas that rely on the NHS to provide evidence to support their own reforms.

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Specialist palliative care in dementia

Specialised units with outreach and liaison are needed

In its latest report on palliative care, the health committee of the House of Commons recorded the Department of Health's admission that the lack of palliative care for patients without cancer was the greatest inequity of all.[1] In the United Kingdom, people die in hospices almost solely from cancer, although it accounts for only 25% of all deaths.[1] [w1] Yet patients dying from dementia have been shown to have healthcare needs comparable to those of cancer patients.[2]

The palliative care approach provides appropriate control of symptoms, emphasises overall quality of life,

Additional references w1-w18 are on bmj.com

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