

arteritis, and occasionally cerebral tumours may produce migrainous symptoms. However, these are in the minority, and the increased risks reported by Etminan et al are unlikely to be due solely to them.

Similarly, ischaemic stroke is not a single disease. Small or large vessels may be affected, with local thrombosis or thromboembolism from artery to artery or cardiac embolism. In migraine, cerebral blood flow has been shown to be reduced in certain regions and platelet activity is thought to be increased^{6,7}—two factors that might contribute to the risk of thrombosis. The possibility that treatments used in acute migraine might affect the risk of stroke needs consideration. Using vasoconstrictors such as ergotamine and the triptans in the presence of focal ischaemia is a theoretical concern. However, patients feel better with them, and we have no evidence that such treatment increases the risk of infarction.⁸ Furthermore, one would expect that some agents used in the prophylaxis of migraine—for example, β blockers and aspirin—should reduce the risk of stroke.

Most primary care doctors will not see a neurological deficit persisting after migraine. Even in neurological practice this is rare and then usually causes a visual field defect.⁹ In some instances, the ischaemic event is not related to an obvious acute attack of migraine with cephalgia.² In such a situation, another condition may possibly cause both—the ischaemic event and migraine.

In the absence of robust evidence of what might help, what advice may be appropriate? In an otherwise healthy young person, no cause for concern exists because of the very low absolute risk of stroke. Advice to stop smoking seems prudent, as does prescribing oral contraceptive pills containing low dose oestrogen or only progesterone to young women with migraine. Anecdotal evidence has prompted most neurologists to advise stopping oral contraceptive pills if migraine

becomes more frequent or changes in character, with a more prominent or prolonged aura, although some evidence indicates that these worries are not necessarily real.² If a middle aged woman with migraine continues to smoke or if other risk factors exist, coming off the oral contraceptive pills should be considered. Although discontinuation seems prudent, we have no evidence that this will reduce the risk. And as migraine is usually under-reported,¹⁰ doctors, when they are prescribing oral contraceptive pills, should ask these women if they have migraine and see if any change in its frequency or character occurs.

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The iron triangle of Japan's health care

The Japan Medical Association is losing its grip on healthcare policy

Medical associations around the world influence healthcare policies in their respective countries. Policy makers turn to professionals for guidance on complex issues, so it is only natural that medical associations exert their influence through their knowledge. However, expertise alone cannot explain the influence of the Japan Medical Association on healthcare policy in post war Japan. The association's post war foundation was built during the 25 year presidency of Taro Takemi from 1957 to 1982. Takemi's uncle-in-law, Shigeru Yoshida, was Japan's first post war prime minister. This connection gave Takemi and the association unrivalled access to Yoshida and his successors in the ruling party. Through its influence on the ruling party, the association forced Japan's Ministry of Health, Labour, and Welfare to take heed and dictated much of healthcare policy.

Building on the legacy that Takemi created, currently the association boasts a membership of 159 000, a budget of 16bn yen (£83.4m; \$155m; €119m), and an annual political donation fund of 1bn yen.¹ The success-

ful formula that Takemi created—linking the Japan Medical Association, the ruling party, and the bureaucrats into an iron triangle—worked well for the association until the Koizumi cabinet was formed in 2001. Iron triangles exist in sectors where the government can influence pricing and output—for example, public works, road construction, farming, and retail.

The association and the iron triangle that it controlled have been on the defensive ever since. The iron triangle is being attacked at all three corners.² Firstly, Koizumi has taken power away from the Ministry of Health, Labour, and Welfare, and has used his cabinet office to set the overall direction of healthcare policy. Committees of the cabinet office are now largely headed by private sector leaders who are outside the sphere of influence of the association. They have spearheaded major reforms to control public spending on health care, while introducing more private competition among providers—steps vigorously opposed by the association but implemented none the less.

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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