

**American Medical Association (AMA) and its Membership Strategy and  
Possible Applications for the Japan Medical Association (JMA)**

**Yuji Noto**

**1998-99, Takemi Fellow  
Harvard School of Public Health,**

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## **Forward**

The Japan Medical Association (JMA)'s mission as a professional society is to promote policies which protect the health of all citizens, and the autonomy of physicians, at the national level of healthcare policy planning. For the JMA to have an effective impact on national policies, it must represent all physicians, and thus maintain a high level of participation in its organization. The object of this research, the American Medical Association (AMA) is facing a critical long-term decline in membership, as are state medical societies. At the 1997 Interim Meeting, a delegate from Texas made a statement on the problem of long-term decline. This led to the formation of a task force, composed of top leaders of the AMA across existing functional divisions. The AMA has a distinguished 150-year history, a highly professional permanent staff of over 1200 people, and operates a successful large publishing division. But from the standpoint of a professional membership organization, the AMA must increase its membership participation ratio, in order to participate as effectively in policy decisions as has the JMA.

The AMA Task Force on Membership issued survey reports and proposed several policy measures to the June 1998 Annual Meeting and the December 1998 Interim Meeting. Its final report will be issued to the June 1999 Annual Meeting. Even before the Task Force met, the AMA was operating membership outreach programs to promote recruitment of younger physicians. The AMA also conducted extensive membership marketing research, which surveyed physician needs, what physicians wanted from the AMA, and problems they had with the AMA. Membership policy reflected the results of marketing research. In addition, Special Interest Groups had already been created to classify members into different categories, in order to convey the concerns of individual physicians of all kinds to the AMA. This research builds on the report of the Task Force on Membership, to examine the experience of the AMA with membership strategy. It examines whether the concepts used for membership outreach, particularly for younger physicians, are applicable for the JMA and its membership strategy.

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This report was conducted under the guidance of Dr. Michael Reich, Taro Takemi Professor of International Health Policy, Director of the Takemi Program, Chair of the Department of Population and International Health, Harvard School of Public Health and Mr. Paul Talcott, Ph.D. candidate, political science, Harvard University.

This research was supported and funded by the Takemi Program Fund of Japan Foundation for the Promotion of International Medical Research Cooperation.

## **1. Introduction**

### **1-1. Research Objectives**

This research was conducted under the guidance of Dr. Michael Reich, Takemi Taro Professor of International Health, School of Public Health, Harvard University. It is a continuation of three other studies led by Dr. Reich: "The Process of Policy Formulation and Lobbying Functions of the AMA" (March 1997), "The Role of the AMA Executive Vice President" (August 1997), and "Health Policy Formulation Practices Comparative Analysis of the AMA and the JMA" (August 1998). As a first step, this research identifies the particular membership structure and the broader healthcare environment in which both medical associations operate. Next it examines issues facing both medical associations regarding membership and the measures they implement to address them. Finally, it examines the membership strategy of the AMA, and investigates the possibility of adopting "best practices" for JMA membership strategy.

### **1-2. Object of study**

This report describes the characteristics of physicians in Japan and the United States, the membership structure of the AMA and the JMA, and the membership strategies, particularly of the AMA. Materials for this study include minutes and resolutions of the Annual Meeting, Interim Meeting, and the report of the AMA Task Force on Membership. It also summarizes the concepts behind the founding of, and activities of, individual Special Interest Groups, including the Medical Student Section (MSS), the Resident and Fellows Section (RFS), the Young Physicians Section (YPS), and the Women Physician Section (WPS) among others.

### **1-3. Method of study**

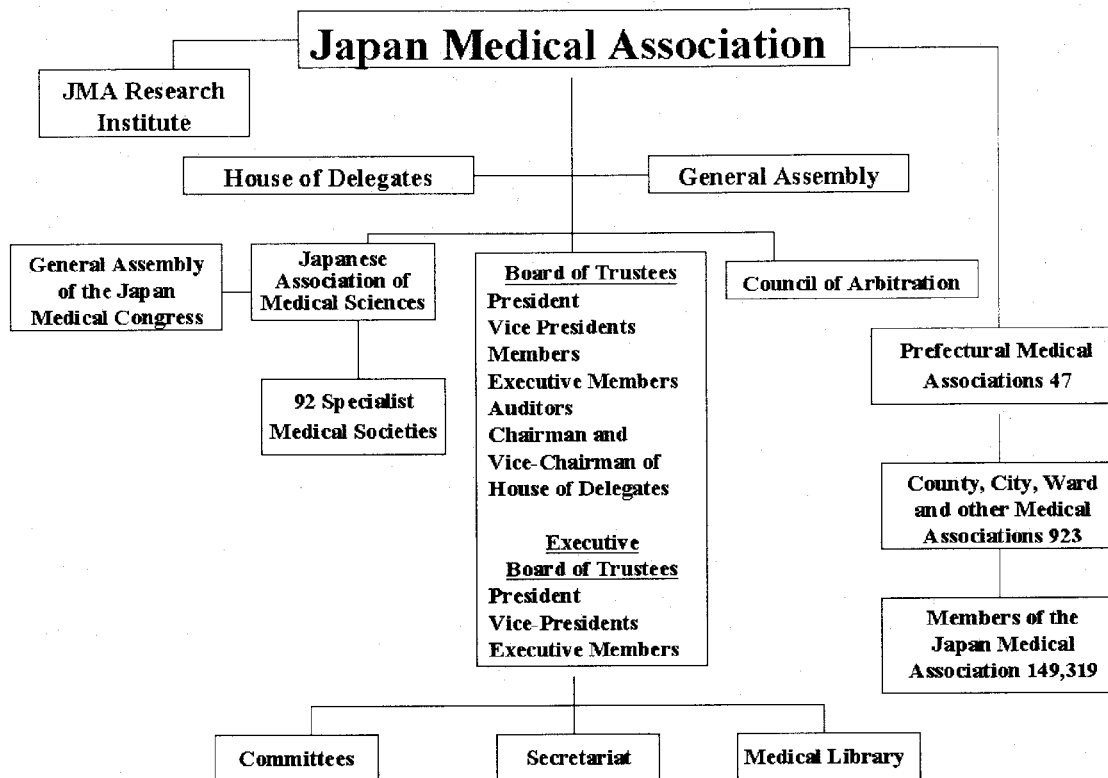
Research interviews were conducted in the AMA headquarters in Chicago, and the AMA Washington Office. Persons interviewed included staff officers for the MSS, RFS, YPS, and Membership Marketing Division in Chicago, and the Grassroots Action Center staff supporting lobbying activity in Washington. Materials and interview responses were used along with extensive background information available on the AMA web-site. All of the preceding sources were used to analyze membership issues facing the AMA, and the membership strategy developed to deal with these issues, their particular features and impact, as well as the process by which particular policies were planned and implemented. The results of this analysis of AMA membership strategy were then evaluated for possible applications for the concept of JMA member strategy. Finally, concrete directions for JMA member policy are presented.

### **This study was conducted using the following materials and media:**

- AMA marketing material
  - AMA strategic market research qualitative interviews
  - AMA strategic membership research study: in-depth interviews
- AMA web-site <http://www.ama-assn.org>
- AMA research interviews, January 1999 and May 1999
- Residents and Fellows Section Leadership Handbook
- Medical Student Section Internal Operating Procedures guide
- New York Times articles / Boston Globe articles
- Ministry of Health and Welfare, "Survey of Physicians, Dentists, and Pharmacists 1998"
- Internal documents from JMA concerning membership

## 2. The Japan Medical Association (JMA) Membership Analysis

### 2-1. Features of the Structure of the JMA



Source: JMA 1998

The first characteristic of JMA structure is the placement of the Japanese Association of Medical Science (JAMS) as part of its organization. The JMA bylaws state that its purpose is to contribute to the improvement of medical science and healthcare, through the promotion of scientific and technical research in medical science, in close cooperation with the JAMS. The JMA maintains the fundamental concept that the JMA and the JAMS are inseparable partners in the promotion of healthcare in Japan.

Another feature of the JMA structure concerns the relationship between the national JMA and prefectural and local medical associations. To become a member of the JMA, a physician must first join the county or municipal medical association in his area, then the prefectural medical association. Although this makes the burden of membership dues heavier for individual physicians, it also makes it possible to receive support at the local level, prefectural level and also the national level for medical practice. On the opposite side, the JMA is able to manage the membership through coordination and cooperation with local and prefectural medical associations.

The existence of the Japan Medical Association Research Institute (JMARI) is another feature of the JMA organization. Founded in 1998, its purpose is to provide better healthcare for all, through healthcare policies researched and proposed by the JMA. The goal is to build a new policy-making process by which citizens have the ability to choose among alternative policy proposals. JMARI also establishes two-way information networks, to gather and evaluate healthcare information, and contribute to the development of policy positions by the JMA. JMARI activities include spreading information to JMA members and all parts of Japan's healthcare community, through all forms of information media. This kind of activity makes it possible to build a more concrete image of the JMA among its members.

## 2-2. JMA Membership Categories and Dues

The JMA has the following categories of membership:

- **A1 members:** Self-employed physicians, who operate or administer clinics or hospitals, enrolled in JMA medical malpractice liability insurance
- **A2 members:** Employed physicians other than A1 physicians, enrolled in JMA medical malpractice liability insurance
- **B members:** Same as A2 but not enrolled in JMA medical malpractice liability insurance
- **C members:** Physicians-in-training, as defined by the Basic Law on Physicians

Member type	Dues		Notes
A1	115,000 yen	\$960	includes 55,000 yen (\$460) for annual medical malpractice liability insurance premium
A2	83,000 yen	\$690	(same as above)
B	28,000 yen	\$230	
C	6,000 yen	\$ 50	

### Membership benefits include:

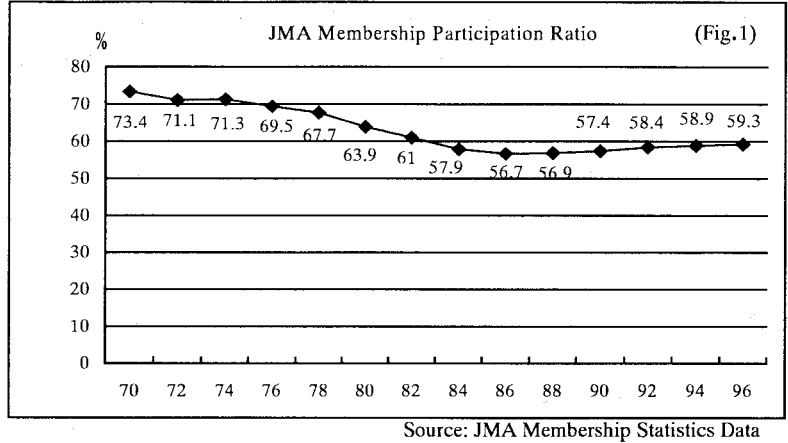
- JMA Journal and JMA News, both biweekly
- Eligibility for participation in Physician Pension Program and Physicians and Employees Pension Fund
- For A1 and A2 members, JMA medical malpractice liability insurance
- Use of JMA Medical Science Library

Other benefits include direct information about official health insurance fee schedule changes. The Ministry of Health and Welfare (MHW) informs the JMA, which transmits the information to prefectural medical associations, which give information directly to members. The JMA also gives members information about continuing medical education seminars and study courses.

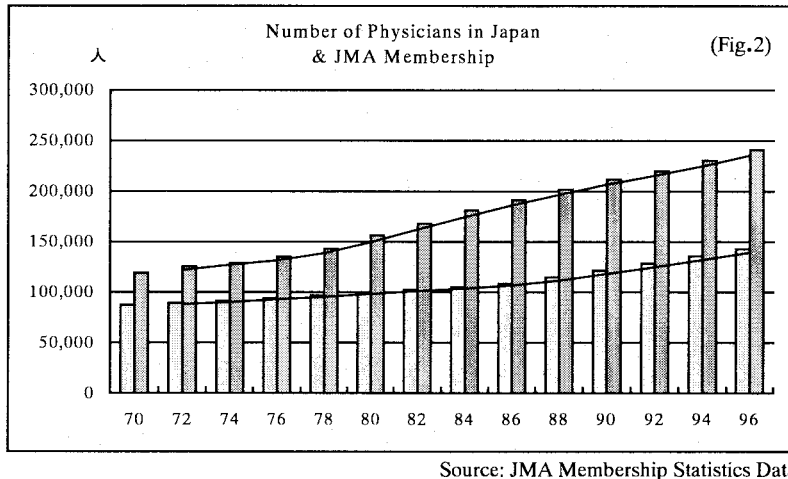
## 2-3. Analysis of JMA Membership Issues

### 2-3-1. Trends in JMA Membership Participation Ratio

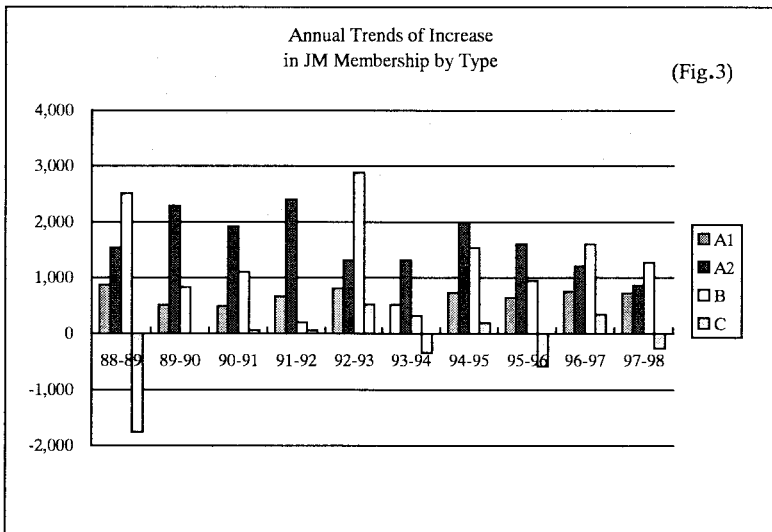
Figure 1 shows the slight decrease in JMA membership participation ratio from a peak of over 70% in the 1970s to just under 60% in 1996. Figure 2 displays the trend in membership and the total number of physicians in Japan over the past 30 years. The growth of membership in the JMA is rather stable, particularly in comparison with the corresponding data for the AMA, Figure 11 (“Total Number of Physicians in U.S. and Trends in AMA Membership”).



Assuming an increase of about 5,000 physicians per year in Japan, the JMA must recruit 3,000 new members each year to maintain its present 60% participation ratio. In reality, the JMA has recruited an average of 3,460 members per year over the past ten years—673 of Type A1, 1,643 of Type A2 and 1,321 of Type B. Only Type C members have fallen, by an average of 177 per year.



Annual trends of increase in membership by category for the JMA are shown in Figure 3. Employed physicians have grown considerably over the past decade. There is no clear trend, however, in changes in membership of physicians in research and training programs.





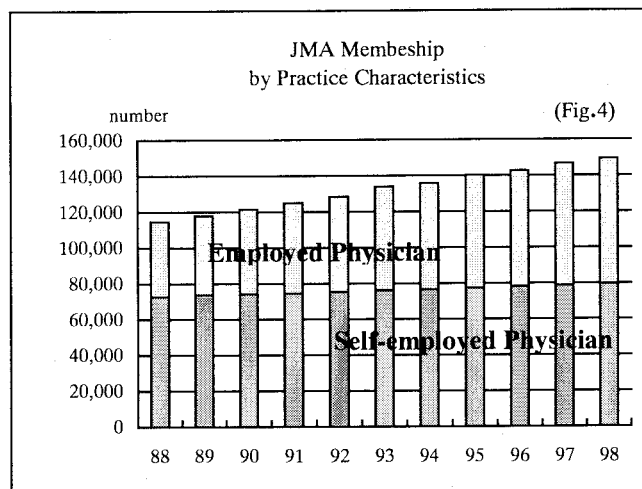
## 2-3-2. Structure of JMA membership, by age, practice characteristics, and gender

Two-thirds of JMA members in 1988 were self-employed physicians, and one-third were employed physicians. In the past decade, their relative shares have become almost even. An average of 700 self-employed physicians joined per year, but over 2,800 employed physicians joined each year on average.

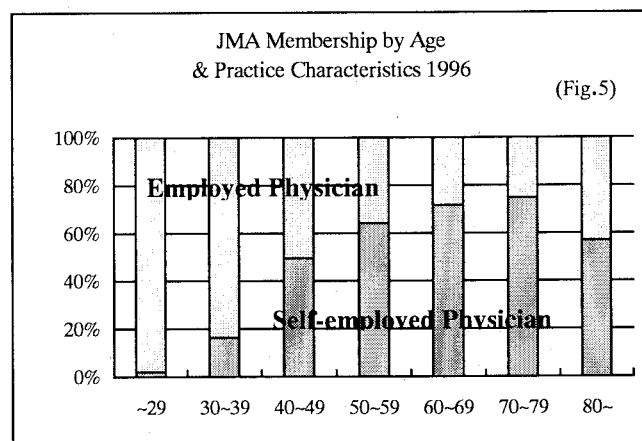
By 1998 self-employed physicians had a bare majority of 53% of JMA members, and the share of employed physicians had risen to 47%. The types of practice of JMA members by age are shown in Figure 5 for 1996. Physicians in their thirties and younger are nearly all employed physicians. Physicians in their forties are evenly split. Self-employed physicians are a greater share of physicians in their fifties.

Considering the trend of the growing total number of physicians in Japan, the number of employed physicians among younger physicians will likely continue to rise, and the number of older self-employed physicians will decline through retirements.

As suggested by Figure 4, the number of employed physicians can be expected to exceed the number of self-employed physicians in the near future.



Source: JMA Membership Statistics Data



Source: JMA Membership Statistics Data

### 2-3-3. Age distribution of physicians in Japan, and JMA membership share

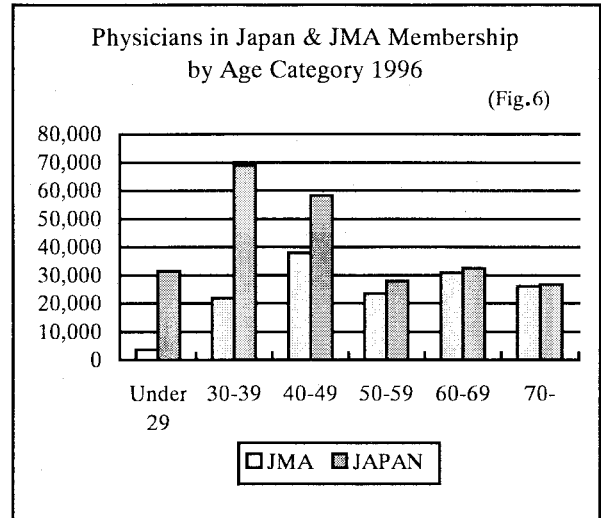
Figure 6 shows the age distribution of physicians in Japan in 1996. The largest number of physicians in Japan are 30 to 49 years old. But age categories with the largest number of JMA members are 40 to 49 years old and 60 to 69 years old. Figure 7 shows the participation ratio for age categories in the JMA. Physicians over 50 have a participation ratio greater than 80%. The reverse is true for younger physicians: physicians younger than 39 join the JMA at a much lower rate. The total participation ratio for the JMA was 59.3% of all physicians in 1996.

Much higher participation among older physicians compensated for much lower participation by younger physicians. Participation in the age category with the highest number of JMA members, physicians 40 to 49, was 65%. As many physicians of this age group begin to open their own clinical practices, it is possible that they will join the JMA at that time if they do not already belong.

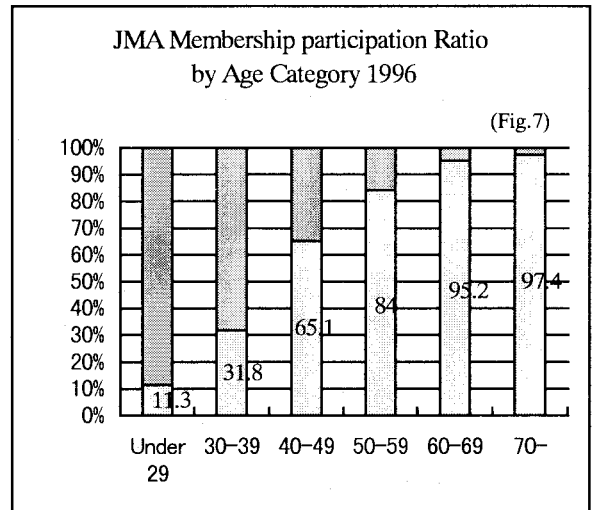
Therefore, in order to maintain the current high participation ratio, the JMA must develop policies to encourage membership among this group of physicians, particularly employed physicians.

The distribution of physicians in Japan by gender and age shown in Figure 8 highlights that although the percentage of women as a share of all physicians is 13.4%, this number is much higher among younger physicians—26.6% among physicians under 29 years old. This condition suggests that in the future the number of women physicians, as a share of total physicians will rise substantially in the future.

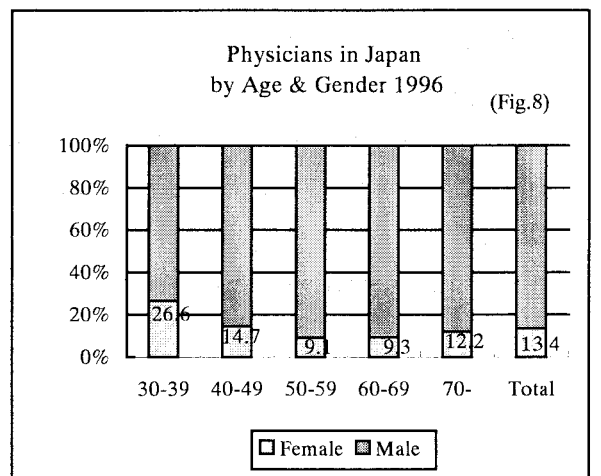
In 1997, 11.2% of JMA members are women. Given the growing number of women physicians, It will be necessary to develop membership strategies to attract women physicians as well as younger physicians more generally.



Source: JMA Membership Statistics Data



Source: JMA Membership Statistics Data



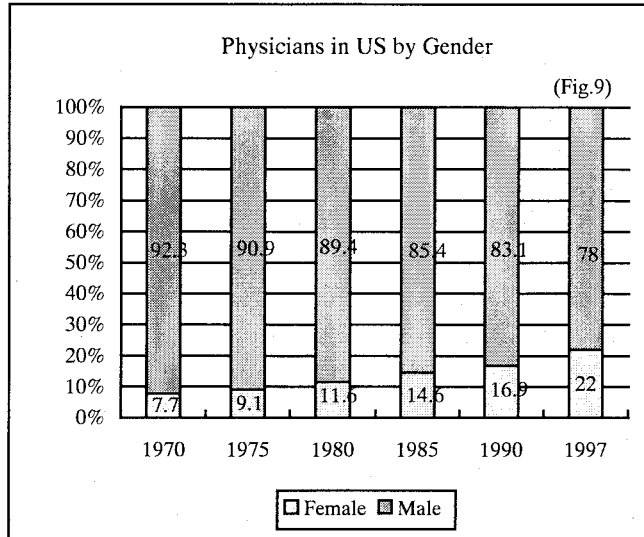
Source: JMA Membership Statistics Data

### 3. The American Medical Association (AMA) Membership Analysis

#### 3-1. Distribution of Physicians in U.S. by Gender

Figure 9 shows that 22% of all U.S. physicians in 1997 were women. As women have come to seek female physicians for examinations and consultations on women's health issues, female physicians have expanded their presence in the United States.

The demand for female physicians is also rising due to demand from group practices seeking female physicians to attract women to sign up for their plans. At the same time, the supply of female physicians is also expected to rise in the future, as the numbers of male and female medical school students are almost even.



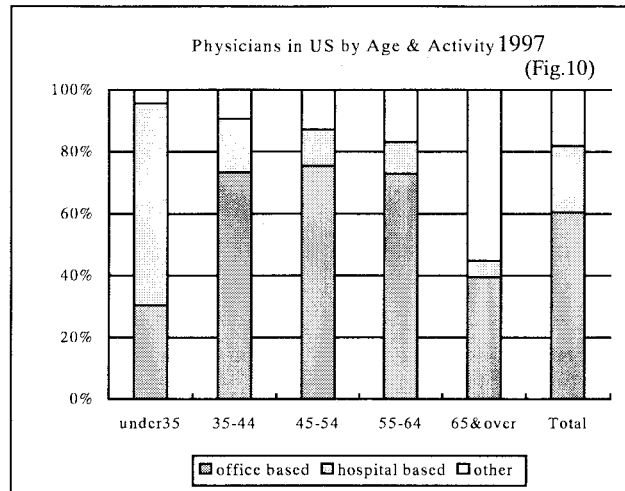
Source: Physician Characteristics and Distribution in the US 1999 Edition, AMA

The current AMA President, Dr. Nancy Dickey, is committed to addressing problems facing female physicians, including improving the status of women physicians in managed care organizations, and expanding opportunities for leadership. Moreover, she launched a variety of initiatives in the AMA organization, including the Women Physician Congress and a special page on women's health issues for women physicians and female AMA members on the AMA web site.

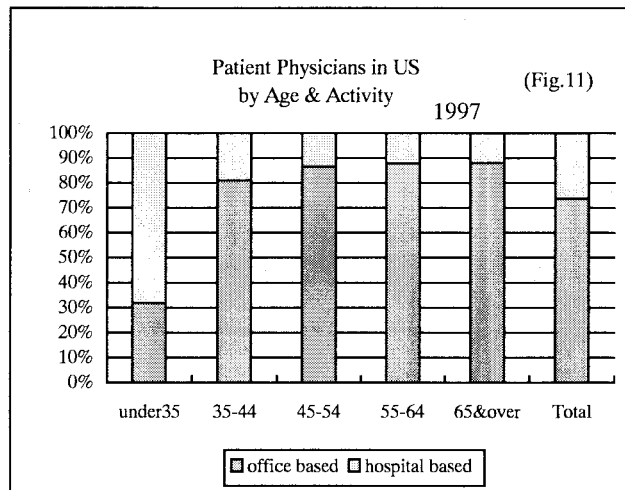
### 3-2. Practice characteristics for U.S. Physicians

One feature that distinguishes U.S. physicians from Japanese physicians is that the majority of physicians have an independent practice in their own clinic (office-based physicians).

Figure 11 shows that 74% of physicians involved in patient care (60% of all physicians / fig10) have an office-based practice. They see patients in their own clinic, but as necessary, have admission privileges for their patients in nearby hospitals, and continue to supervise their inpatient care. Most (62%) of physicians employed by hospitals, however, are residents or fellows. They provide most of the direct care for inpatients as part of their graduate medical education (GME).



Source: Physician Characteristics and Distribution in the US 1999 Edition, AMA



Source: Physician Characteristics and Distribution in the US 1999 Edition, AMA

## AMA Terminology concerning Physician Characteristics

### Patient Care

- **Office Based Practice:** includes solo practice, two physicians' practices, group practice, etc. These physicians operate their own clinics but are also able to supervise inpatient care at nearby hospitals by contractual arrangement
- **Hospital-based practice:** includes Resident/Fellow, Full-time staff. Along with regular physicians employed by hospitals, this category includes residents and fellows who care for inpatients directly while undergoing graduate medical education (GME).

### Non Patient Care

- **Medical Teaching:** Medical School Teacher, Teaching Hospital, Nursing School educators
- **Medical Research:** Medical researchers
- **Administration:** Hospital management, healthcare organization executives, clinic or group practice managers
- **Other activities:** Physicians who are insurance company employees, pharmaceutical company employees, ordinary companies, charitable organizations, medical society employees, and physicians outside the United States.

### 3-3. Healthcare environment of U.S. physicians

Physicians in the United States face an uncertain future. Managed care organizations are changing the face of medical practice, in both private insurance and government health insurance programs. Although most physicians are self-employed, most have some connection to managed care organizations. Organized medicine, therefore, must recruit and retain members in the face of rapid changes and pressure to cut physician reimbursements, from government and private sector insurance alike.

One product of the spread of managed care is an increasing number of university programs training physicians in managed care. The *New York Times* reported that several universities, including Boston University and the University of Tennessee, offer specialized business school postgraduate courses for physicians. Even solo practitioners are taking these courses, whereas before only hospital executives usually studied for an MBA degree. A poll by the Massachusetts Medical Society's 17,000 members found that ten percent wanted to pursue a business degree. The Society then joined with Boston University to design a physician MBA program. Business courses aim to train doctors to make business decisions different from old-style, cost-is-no-object medical practice. Some doctors protest the changes, and refuse to consider medicine as subject to the same calculations as businesses, particularly about profit.

Managed care itself faces a new round of mergers and consolidations. The AMA sees Aetna's proposed purchase of Prudential Health Care as a threat to physician autonomy. The new HMO would insure one in ten Americans. Physicians fear that the new behemoth would extract larger concessions from physicians, eroding both physician income and the quality of care. State medical societies fear the merger would limit choice and reduce competition. The AMA may have an ally in large employers, who are concerned that lower competition in the insurance industry would limit the ability of companies to get the best deals for their employees. Until recently, large mergers were not seen as subject to anti-trust laws, while smaller mergers between local hospitals were supervised quite closely.

Finally, state experiments with managed care have begun to shift away from ambitious goals in administering the low-income healthcare program Medicaid. For example, Tennessee is considering revisions to its TennCare program, which insures 24% of the population in the state. It was designed to cut medical spending by insuring even otherwise uninsurable patients, with AIDS or pre-existing conditions which made them unlikely to find insurance on the private market. As its costs increased by 12% in 1998, the governor plans to freeze enrollment for other than Medicaid recipients. Since many Tennessee employers do not provide health insurance at all, TennCare coverage allowed workers with chronic conditions to remain on the job, rather than quit to receive welfare and Medicaid benefits. Advocates say the program helped the chronically ill to remain self-sufficient. Part of the measures to keep TennCare afloat involve reducing physician fees below the cost of providing care, raising objections from the Tennessee Medical Association.

## 4. The American Medical Association (AMA) Membership Analysis

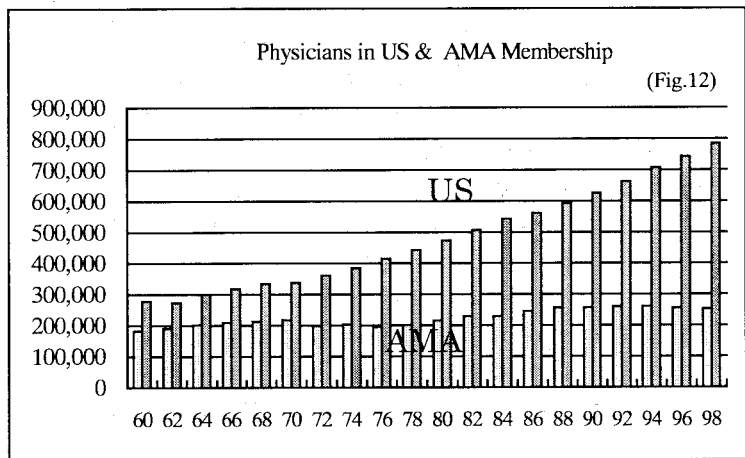
### 4-1. Analysis of AMA Membership Structure

In the past three decades the number of AMA members has gradually decreased. At the same time the total number of physicians in the U.S. has risen each year. As a result, the AMA membership participation ratio has been falling.

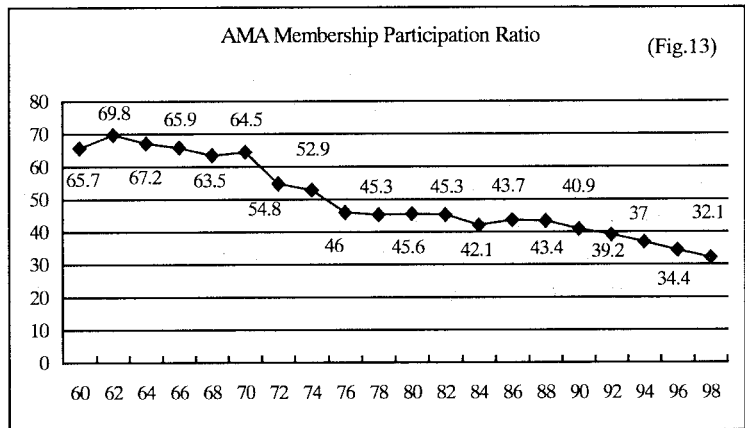
In addition, since AMA members now include medical students, the number of licensed physicians in the AMA as a share of all U.S. physicians has fallen to 32.1% (252,072 of 784,147) by 1998.

By contrast, in 1960, 183,000 of 278,000 physicians were AMA members, as shown in Figure 13, for a membership participation ratio of 65.7%.

In the intervening 38 years, the total physician population increased 280%, or an average of 17,000 to 18,000 physicians per year, while AMA membership increased only 140%, or an average of 1,830 members per year. Thus the AMA membership participation ratio has fallen almost in half.



Source: AMA



Source: AMA

The decline in AMA membership has been particularly acute in the past few years. A recent survey found that each year about 30,000 new members join, but 31,000 members cancel their membership. As a result of this situation, the AMA naturally places increasing importance on programs both to recruit new members and retain existing members.

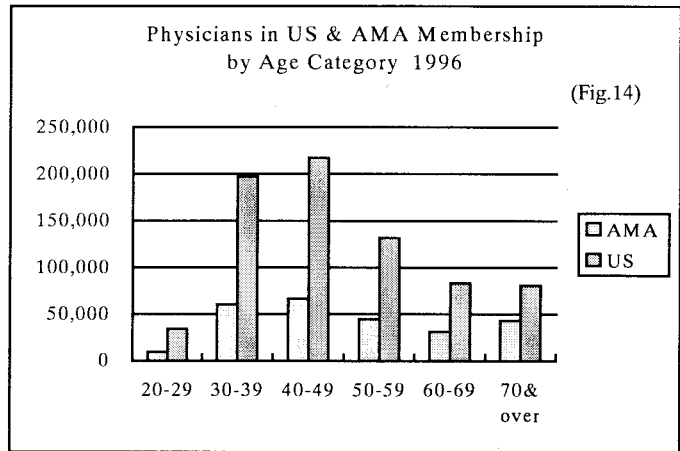
Figure 13 displays the result of the actual trends in membership and number of total physicians: the gradual reduction in the AMA membership participation ratio. Each decade the ratio declines by 10 points: 60% in the 1960s, 50% in the 1970s, 40% in the 1980s, and 30% in the 1990s. If the total number of physicians continues to increase at the same rate, the membership participation ratio will become even worse, assuming continuation of present membership losses.

This trend is not only affecting the AMA but also state and county medical societies. Many state medical societies reported lower membership ratios to the 1997 Interim Meeting, and passed resolution calling on AMA leadership to develop programs to attract more members. These resolutions resulted in the formation of the Task Force on Membership with representatives from all sections of the AMA. While earlier efforts at increasing membership through an outreach program and a retention program had been developed, they have not at this point resulted in an increase in total membership.

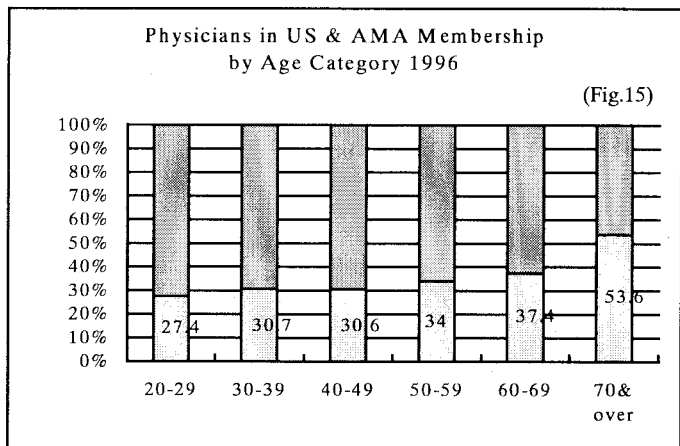
## 4-2. Age Distribution of U.S. Physicians and AMA membership

Figure 14 shows how most physicians in the United States are in their 30's and 40's, and looks much like the similar data from Japan (in Figure 6). Low physician participation ratios in the AMA among younger physicians also mirror similar conditions in Japan.

When comparing participation ratio among older physicians, particularly in their 50's, the contrast is stark. Over 80% of physicians in Japan over 50 belong to the JMA, but in the U.S., about 30% of physicians from 60 to 69 years old belong to the AMA, the same figure as for physicians between 30 and 39 years old. And while AMA has a 53.6% share among physicians over 70 in the U.S., there are not many physicians in this category, so this high share has little impact on the overall AMA membership participation ratio. As part of its overall membership strategy, the AMA has developed



Source: AMA Fact Book 1996



Source: AMA Fact Book 1996

“Special Interest Groups.” Each group is designed to attract and retain members with programs tailored to different constituencies, in order to increase overall membership. The MSS\*, RFS\*\*, and YPS\*\*\* encompass the youngest members of the AMA, and thus its future.

They plan incentives to attract early membership, and programs designed to overcome the problem of members leaving at transition points in their careers, including the transition from medical student to resident, and the transition from residency to regular physician.

These three groups are also the most active of the AMA's Special Interest Groups, and contribute to the vitality of the organization overall by participation in the AMA policy-making process. For the JMA to maintain its current high participation rate among older physicians, it will be necessary to increase the rate of participation among younger physicians.



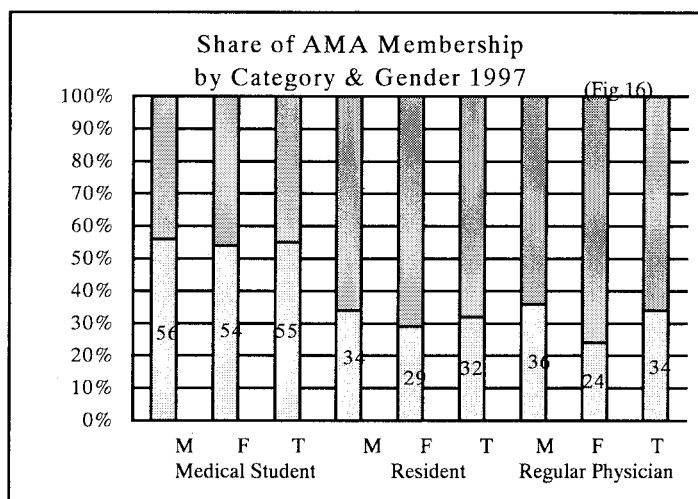
### 4-3. AMA Membership by Category & Gender, 1997

(Table 1)

Membership Category	Male	Female	Total
Medical Student	22,636 / 56%	15,540 / 54%	38,136 / 55%
Resident	21,001 / 34%	10,959 / 29%	31,960 / 32%
Regular Physician	192,373 / 36%	31,158 / 24%	223,531 / 34%

Source: AMA Web Site

The Table1 shows share of AMA Membership by Category and Gender, and Figure 16, shows that while over half of medical students join the AMA, the rate falls by 20% for residents. The AMA is also developing programs to cover this critical transition period. One measure under discussion will give medical students who join for four years a free year of membership as a resident.



Source: AMA Web Site

Still, residents are much busier than medical students, spending most of their time treating patients in hospitals and taking GME\*, and have less time to spare on membership activities. This may account for some of the decline in participation. For regular physicians, the rate of female physician participation drops again to 24%. In the past, women had not been a part of the central leadership within the AMA and organized medicine generally.

But with the arrival of President Dickey, the number of female physicians in the AMA can be expected to rise somewhat. At the same time, the participation ratio of male physicians rises slightly from residents to regular physicians. They may join the AMA because they feel the AMA supports them in issues that affect their day-to-day practice.

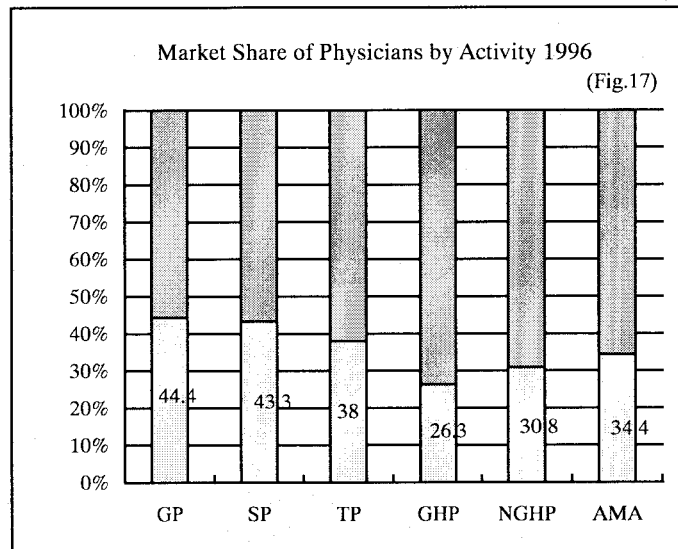
#### 4-4. AMA Membership by Practice Characteristics

(Table2)

Overall Participation Ratio, 1996	34.4%
<b>Office Based Physician</b>	
• Group Practice (GP)	44.4%
• Solo Practice (SP)	43.3%
• Two Physician Practice (TP)	38.0%
<b>Hospital Based Physician</b>	
• Government Hospital (GHP)	26.3%
• Non Government Hospital (NGHP)	30.8%

Source: AMA Fact Book 1996

As Table 2 and Figure 17 show, the practice category with the highest rate of participation in the AMA is the Group Practice category, with 44.4%. Solo Practice follows with 43.3%, and Two-Physician Practice (TPP) with 38%. All of these office-based practices had participation rates higher than the average rate of 34.4%. The AMA is particularly useful in supporting physicians in the rapidly-developing world of managed care, and this is reflected in the higher rate of participation among physicians in group practice.

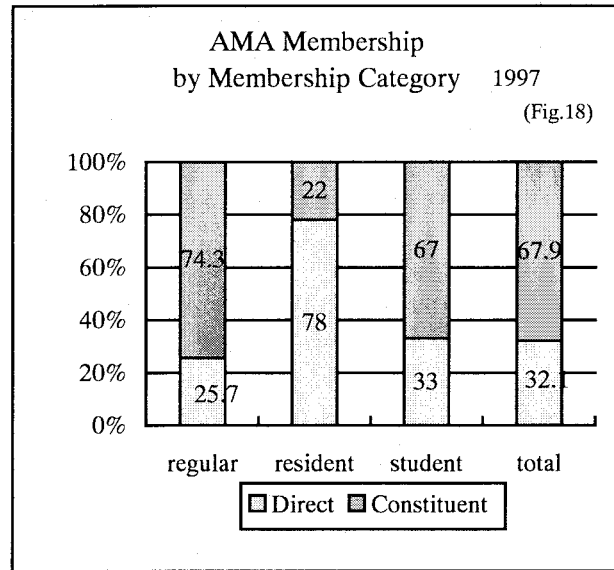


Source: AMA Fact Book 1996

On the other hand, physicians in government hospitals (GHP) and non-government hospitals (NGHP) alike had lower-than-average participation rates, of 26.6% and 30.8% respectively. Physicians in the military and government service also have lower than average participation rates, and lower the average for the entire AMA.

#### 4-5. AMA Membership Structure

The most distinctive feature of the AMA is that its membership includes medical students as regular members. Another feature different from Japan is the existence of "Direct Members" who join the AMA without joining a constituent state and county medical society, through the AMA web site or through the mail. Most residents join this way, as shown in Figure 18.



Source: AMA Fact Book 1996

AMA members formerly had to join through their state societies, but since the 1970s state after state removed this requirement. Only Illinois, Ohio, Delaware, and Mississippi retain this requirement in 1999. Nevertheless, as shown in Figure 18, 74.3% of regular AMA members join through their state medical society. For all AMA members, 68% join through their state society, and 32% are direct members. Medical students in particular join state medical societies at a high rate; heavily discounted memberships are one reason for their success.

#### Types of AMA members:

##### 1. Active Constituent:

Members of constituent associations who are entitled to exercise the rights of membership in their constituent associations, including the right to vote and hold office, as determined by their respective constituent associations and who fulfill at least one of the following requirements

##### 2. Active Direct:

Active direct members are those who apply for membership in the AMA directly rather than through a constituent association. Applicants residing in states where the constituent medical association requires all of its members to be members of the AMA are not eligible for this category of membership unless the applicant is serving full time in the United States Army, the United States Navy, the United States Air Force, the United States Public Health Service or the Department of Veterans Affairs. Active direct members must fulfill at least one of the following requirements:

The above two types of members must meet the following conditions:

- a. Possess the degree of Doctor of Medicine or its equivalent.
- b. Possess an unrestricted license to practice medicine and surgery.
- c. Are resident physicians serving in medical or osteopathic training programs approved by an appropriate accrediting agency.
- d. Are medical students enrolled in a medical school or in a college of osteopathic medicine, approved by an appropriate accrediting agency.

### **3. Affiliate Members:**

Affiliate members may attend AMA meetings but may not vote, hold office or receive publications of the AMA except by subscription. Affiliate members are not subject to dues or assessments.

- a. Physicians in foreign countries who have attained distinction in medicine and who are members of their national medical society or such other medical organization as will verify their professional credentials.
- b. American physicians located in foreign countries or in possessions of the United States who are engaged in medical missionary, educational or philanthropic endeavors.
- c. Dentists who hold the degree of D.M.D. or D.D.S. who are members of the American Dental Association and their state and local dental societies.
- d. Pharmacists who are active members of the American Pharmaceutical Association.
- e. Teachers of medicine or of the sciences allied to medicine who are citizens of the United States and are ineligible for active membership.
- f. Individuals engaged in scientific endeavors allied to medicine and others who have attained distinction in their fields of endeavor but who are not eligible for other categories of membership.

### **4. Honorary Members**

Physicians of foreign countries who have achieved pre-eminence in the profession of medicine and who attend a meeting of the House of Delegates of the American Medical Association may be honorary members of the AMA

Honorary members may attend AMA meetings but may not vote, hold office or receive publications of the AMA except by subscription. Affiliate members are not subject to dues or assessments.<sup>1</sup>

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<sup>1</sup> Source: AMA Bylaws

#### 4-6. AMA Membership Dues Categories

(Table3)

Table3 shows AMA Membership Dues Categories and the particular structure of discounts offered to different kinds of physicians. Regular members pay \$420 per year, but if they join for five years, they receive one year free, and pay the reduced amount annually for five years.

New physicians receive discounts for the first two years of practice. Physicians employed in military medical facilities also receive discounts. Residents pay \$45 for one year of membership, or \$120 for a discounted three-year membership.

Residents and regular physicians alike are not enrolled in medical malpractice insurance through their membership fees.

#### AMA Membership Dues Category

##### Physicians

Annual Regular Membership	\$420
First Year in Practice	\$210
Second Year in Practice	\$315
Military Physicians	\$280
*Special 5 Year Membership	\$336/yr

##### Residents

Single Year Membership	\$ 45
3 Year Membership	\$120

##### Students

Fourth Year Student (1 year)	\$ 20
Third Year Student (2 years)	\$ 38
Second Year Student (3 years)	\$ 54
First Year Student (4 years)	\$ 68
Single Year Student Membership	\$ 20

##### Retired Physician

Fully Retired	\$ 84
Semi-Retired	\$210

\*All dues, regardless of category, are paid annually

Source: AMA Web Site

Medical student members can join the AMA for \$20 per year, and receive a discount for 2-year to 4-year memberships. Medical students who joined for three or four received an essential reference work, *The Drug Book*, as a special membership premium though 1999. Beginning in the fall of 1999, however, this premium will be changed to *Steadman's Medical Dictionary and CD-ROM*. These kinds of premiums have been successful in increasing the number of long-term medical student memberships, and the new premium is also expected to increase membership further.

The topic of reduced revenue because of multi-year membership discounts will be addressed in more detail later in this report. On one hand, total revenue from membership decreases. But on the other hand, the reduction in the cost of membership is part of an overall membership promotion program, and offers several benefits to the AMA, including the ability to continue communication with members, and further ascertain their needs.

#### 4-7. Membership Special Interest Groups

The AMA creates the Member Special Interest Groups for the purpose of ensuring each member's opinion can be heard. So that any member can have a meaningful voice, there are ten special interest groups that amplify the voices of smaller affinities within the AMA.

The AMA has nine Special Interest Groups designed to give a voice to individual physicians within the AMA.

- Medical Student Section
- Resident and Fellow Section
- Young Physicians Section
- Organized Medical Staff Section
- International Medical Graduates Section

The above five groups are structured as representative bodies just as the House of Delegates is for the entire AMA. Resolutions are debated within each Section Assembly for consideration for sending to the AMA House of Delegates, assigned to a Section Governing Council for action, or rejected.

- Senior Physician Services
- Women Physicians Services
- Minority Physicians Services
- Group Practice

These specialty groups advise the AMA Board of Trustees directly. They give a voice to healthcare and workplace issues of their constituencies, and policies to address their needs.<sup>2</sup>

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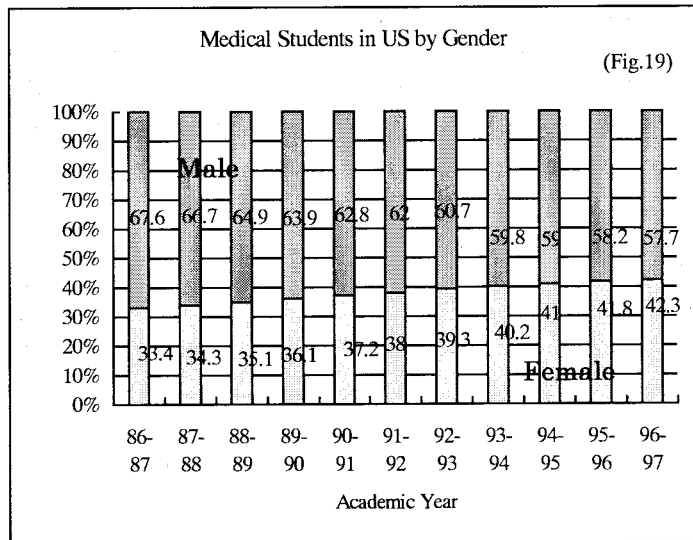
<sup>2</sup> Source: AMA Web Page

#### 4-7-1. AMA Medical Student Section (MSS)

1) Established: 1978.

2) Purpose:

- Addressing issues such as promoting public health, service to the community, medical ethics, and participating in the healthcare policy process
- Distributing information on medical education, residency training, internship opportunities for medical students
- Providing value for medical student members

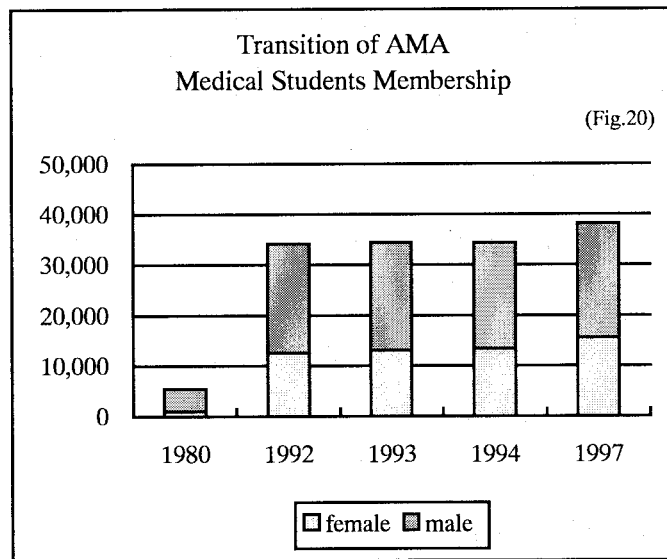


Source: AMA Web Page

3) Number of members: 38,136 / 1997

4) Meetings:

Medical Student Assembly prior to AMA Interim Meeting and AMA Annual Meeting



Source: AMA Web Page

5) Leadership: MSS Executive Council with regular meetings throughout the year. MSS sends one voting representative to the AMA Executive Council, AMA Committees and the House of Delegates.

6) Policy Advocacy Activities:

Protecting the freedom of medical students to choose their own specialization, while promoting greater incentives to increase the number of primary care physicians

The AMA gives grants of \$2 million annually to 141 medical schools through the AMA Education Foundation. The purpose of these grants (an average of \$16,000 per school) is to promote medical education and activities of medical students associations. Each school has a Medical Student Chapter, which is not a direct organ of the AMA, but serves as a liaison for the AMA-MSS. Medical students have more free time than other members of the AMA, and over 50% of them join the AMA, due to the membership promotion activities of these school chapters. One such program involves a competition among chapters for recruiting new AMA members.

The most successful chapters are given \$200 prizes. Although the amount of money is almost trivial, such incentives have been highly successful in attracting large numbers of new recruits. The champion chapter increased the participation rate at its medical school to 79% among first-year medical students. As mentioned in the previous section on membership fees, the rate for medical student members is a small fraction of membership for regular physicians (\$20 compared with \$420 per year). Until this year student members also received a textbook on pharmaceutical drugs, necessary for the second year of medical school, if they joined for three or four year memberships.

The retail price of *The Drug Book* was \$120, a much higher value than the \$54 for a three-year membership or \$68 for a four-year membership. This high value gave medical students a compelling reason to join the AMA. When introduced in 1988, *The Drug Book* contributed to a 10% increase in the membership rate among medical students. This year, a new premium will be substituted: *Steadman's Medical Dictionary and CD-ROM*, with a retail price of about \$35. The attraction of the new premium is that it will be distributed at the time of signing up for membership, while *The Drug Book* was distributed five months after the beginning of the school year.

The *Medical Dictionary* will also be imprinted with the AMA logo, and include promotional materials welcoming new members, to increase awareness of the AMA. This program has been tested in several states as a pilot program, and met with considerable success. It is expected to increase the participation ratio among first-year medical students. Nevertheless, it remains to be seen whether the reduced retail value of the new premium (\$35 compared with \$120) compared with AMA dues will be as effective.

New Medical Students:	17,000 – 18,000 per year	
New AMA Medical Student Members	8,090 (1997-1998)	participation rate 45%
	9,350 (1998-1999)	participation rate 52%
	13,000 (expected 1999-00)	expected rate 72%

Multi-year memberships for medical students reduce the retention costs dramatically, even though at the same time AMA revenue appears somewhat lower. As part of membership strategy, the value to the AMA of multi-year membership is perceived to outweigh the costs. Multi-year membership allows the AMA to spend less on retaining members, and to remain in contact with members.



In order to address the problem of falling membership rates among residents (only 35% compared with 53% among medical students), the AMA is conducting a pilot program to give a free year of resident membership to medical students who join for four years. In return, students who sign up for this program agree to fill out a detailed survey. The benefits for the AMA are in obtaining useful information and maintaining effective communication.

Other membership benefits for medical student members including a subscription to MS-JAMA. It contains articles drawn from JAMA, but also special features aimed at medical student life in general. In a survey of medical students, 65% mentioned MS-JAMA as the main reason for joining or renewing their AMA membership. Another version is being developed for distribution via e-mail, which will allow the AMA to communicate effectively with medical students about information of special interest. The same survey found that 79% of medical students would see an e-mail newsletter as a reason for joining or renewing, and is thus expected to have a large impact.

While incentives are worth pursuing, the AMA as an organization must also exercise discretion in deciding which benefits members really want, as well as balance the needs of members and the costs of incentives. The MSS section in particular provides a high level of benefits for a very low cost to members through multi-year memberships. Even though the cost of providing benefits is not low, it has been demonstrated that the value to the AMA is high, since MSS members are the future of the AMA. In the AMA, expenditures for medical students are considered to be an investment in the people on whom the AMA will come to depend in the future.

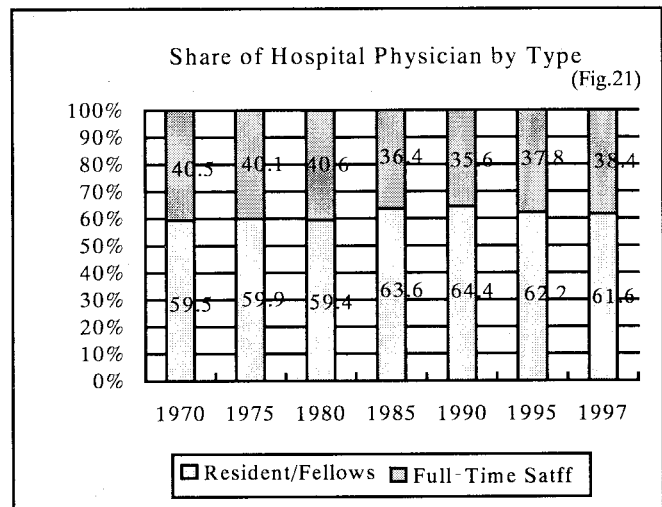
MSS activities are supported by the Department of Medical Student Services of the AMA. This division supports membership recruitment programs and membership retention programs through liaisons with chapters at each medical school. The MSS also has a voting representative on the Executive Board of the AMA and each committee, as well as in the House of Delegates. The MSS Assembly also included members of the Medical Student Sections of other specialist medical societies. Each medical school chapter also sends representatives to the MSS Assembly. The AMA gives each chapter information about how to conduct membership recruiting. In addition, the AMA pays chapter representatives travel expenses and subsidizes chapter activities. In 1998 at the MSS Assembly before the Interim Meeting, each chapter tried to send as many representatives as possible, by raising the recruitment rate.

#### 4-7-2. Resident and Fellows Section (RFS)

1) Founded: 1974

2) Purposes:

- Educate residents and fellows about graduate medical education and healthcare policy issues
- Build a representative capable of exercising influence over AMA policy
- Developing leaders among younger physicians



Source: Physician Characteristics and Distribution in the US 1999 Edition, AMA

3) Meetings: Assemblies prior to AMA Annual Meeting and Interim Meeting

4) Leadership: Executive Council, meeting throughout the year as needed. RFS sends voting representatives to the AMA Executive Council and AMA committees, as well as to the House of Delegates.

5) Structure: States, territories, and the military send one representative for every 100 RFS members. Other specialty medical societies with RFS organizations send representatives or observers to the AMA-RFS Assembly.

6) Publication: “Resident Forum” in JAMA covers legal and regulatory issues and other topics of concern to residents and fellows.  
 “Code Blue” monthly newsletter devoted to issues of residents and fellows, including social, economic, and legal issues.

The AMA-RFS consists of resident physicians and fellows. Until 1998 it was called the Resident Physician Section (RPS). Its name was changed after a proposal the 1998 AMA Interim Meeting was approved at the 1998 AMA Annual Meeting. The AMA-RFS membership structure features a majority of direct members who do not join through their state societies. Most are also employed by hospitals, as shown in Figure 20. The AMA provides support for the AMA-RFS through the “AMA-RFS Awards and Grants.” Residents and fellows can propose projects to be funded by the AMA, which promote goals identified in AMA policies. Recipients of these grants must also receive support from their county medical society or specialist medical society.

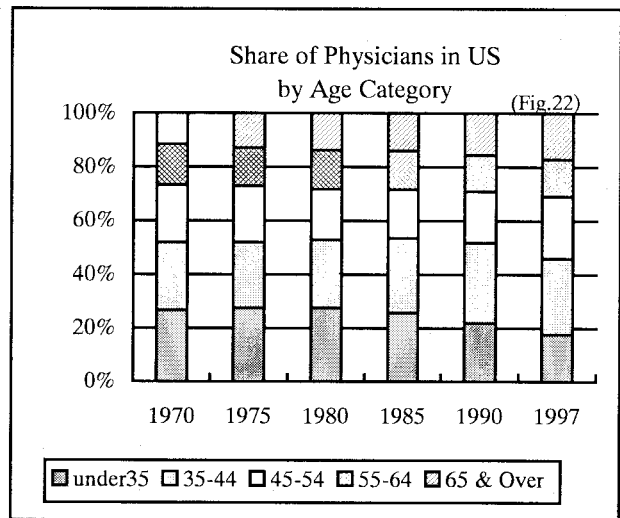
At the AMA Annual Meeting and Interim Meeting, the AMA also funds AMA-RFS members to participate in the AMA National Leadership Conference. This provides another incentive to participate in RFS activities.

The AMA also supports House Staff organizations. This group consists of residents in hospitals supported by GME training funds. These organizations consist of all RFS members in a particular hospital. They address issues of medical management of concern to residents, and at the same time provide the hospital with a single location to contact all residents. When a House Staff group is formed, the hospital usually covers the AMA membership fees of the residents. One example of a House Staff is in Tulane University Medical School. By forming a House Staff, the AMA gained 422 new members in a single hospital.

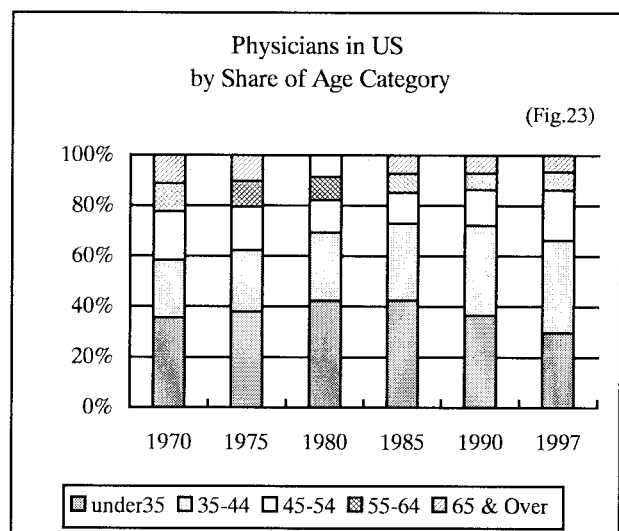
The AMA also takes an active policy stance opposing reductions in payments from the Medicare system to teaching hospitals for GME. The AMA Washington Office devotes considerable energy to lobby activities on this issue.

### 4-7-3. Young Physicians Section (YPS)

- 1) Founded: 1986
- 2) Purposes:
  - Increase number of younger physician members
  - Protect the interests of patients and physicians under managed care and in any legislative decision
  - Developing leaders among young physicians
- 3) Number of members: 50,000 / in 1996
- 4) Membership qualification:
  - Physicians under 40, or in the first five years of practice
- 5) Meetings:
  - Assembly before AMA Interim and Annual Meetings
- 6) Structure:
  - Young physicians representatives from each state society and 34 specialty associations with YPS sections
- 7) Leadership:
  - Executive Council, meeting throughout the year as needed. YPS sends voting representatives to the AMA Executive Council and AMA committees, as well as to the House of Delegates.



Source: Physician Characteristics and Distribution in the US 1999 Edition, AMA



Source: Physician Characteristics and Distribution in the US 1999 Edition, AMA

The age distribution of physicians in the U.S. indicates that 43% of physicians in the U.S. are under the age of 45. As Figure 22 shows, however, 66% of woman physicians are under 45 years old. This means that woman physicians have a large share of YPS membership. The first YPS member of the Executive Council, Dr. Benjamin, was a family practitioner from Alabama. The Woman Physician Council also has a high participation from younger women. Ways to improve the opportunities for women in leadership roles in organized medicine are an important issue for the YPS.

## **i. Measures to achieve goals and results**

### **1) Increase number of young physician members of AMA**

The YPS conducts its own membership recruitment programs, in addition to general AMA membership outreach programs. The YPS has recruited over 3,000 members in this manner. The YPS and the AMA have been developing specialized publications and services targeted at young physicians since that time.

### **2) Protecting patients' rights and the interests of physicians**

The YPS implements the following programs to achieve this goal:

- For emergency medicine, inserting clauses about the judgement of "prudent layperson" to ensure coverage for serious conditions
- Development assistance for AMA-approved programs
- Guide to contract negotiations for young physicians

### **3) Developing leadership**

The YPS operates a leadership development program at the YPS Assemblies to develop the next generation of leadership for organized medicine. This program trains future leaders by conducting seminars on such topics as public speaking and lobbying activity.

## **ii. Activities of the YPS and results**

### **1) Obtaining representation on the AMA Executive Council**

In 1994 the YPS succeeded in gaining representation on the AMA Executive Council. This assured that the views of younger physicians are heard when major policy decisions are made.

### **2) Removing Medicare provisions to reduce compensation to physicians in their first four years of practice**

The AMA-YPS won an important victory in 1993 when Medicare made payments to all physicians equal. Previously, physicians in their first four years of practice had received lower reimbursements under the Medicare system. The Washington Office of the AMA coordinated a successful grassroots campaign which mobilized thousands of young physicians nationwide to change the Medicare provisions which discriminated against physicians in their first four years of practice.

### **3) Community service**

The YPS sponsors and gives grants to programs of community service such as free medical care for the homeless and lower-income people, public health aware awareness events, disaster relief, overseas volunteer activities, efforts to prevent drug abuse, anti-tobacco campaigns, programs to stop domestic violence, volunteer programs at AIDS clinics, and mass media campaigns for health promotion.

### **iii. AMA-YPS 1998-1999 Strategic Planning Resolution (Draft)**

The AMA-YPS must advocate and lobby for policies to protect the rights of patients and the interests of young physicians. This mission includes promoting the development of medical knowledge and medical technology, and improving public health through the following measures:

- 1) Supporting the development of organized medicine for the future
- 2) Aiding young physicians to become more involved in AMA and regional medical society policy development

### **iv. Healthcare environment of young physicians and their medical practice**

The current environment in which young physicians practice medicine has become increasingly complex. Managed care threatens physician autonomy, changes the intimate connection between patients and their physicians into a more problematic relationship between contractual partners, and raises serious issues of control over the provision of medical care. It is not possible to exaggerate the economic impact of managed care on young physicians. The environment of organized medicine has not been open to young physicians. The AMA has not spoken for young physicians, who have neither the time nor the money to participate more effectively. As a result, there seems to be no reason for young physicians to participate in organized medicine. Therefore it is important for the AMA to recognize that young physicians are full members in organized medicine, and have the right to representation.

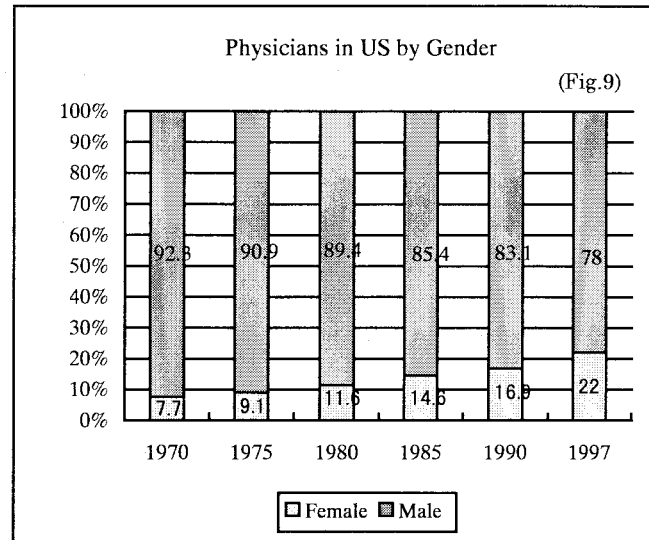
The YPS promotes young physicians as leaders in the AMA, regional medical societies, and their communities.

#### **Methods:**

- Improving the awareness among young physicians of leadership opportunities
- Sponsoring a leadership development seminar at the YPS Assembly
- Continuing support for organizing Young Physician Sections in state and county medical societies
- AMA Services and Resources useful for young physicians in their medical practice
- Managed Care
- AMA Advisory Network
- Limited to AMA members, the AMA provides a list of physicians, lawyers and business consultants involved in managed care.
- Study Meetings: Strategies for Handling Change

#### 4-7-4. Women Physician Congress (WPC)

- 1) Founded: June 1997,
- 2) Target: Women physicians and medical students concerned about issues facing women physicians
- 3) Purpose:
  - Providing a direct means of influence for women physicians in the AMA
  - Creating opportunities to affect national healthcare policy and make declarations on important issues concerning women's health and women physicians



Source: Physician Characteristics and Distribution in the US 1999 Edition, AMA

#### 4) Goals:

- Increase the share of women physicians in leadership roles at the highest executive levels of organized medicine, academic specialties, and in the workplace.
- Expand the role of the AMA in advocating policies important for women physicians
- Leadership development, training, and education to improve the professional capabilities of women physicians
- Build bridges for cooperation among the AMA, the American Women's Medical Association (AMWA), women physicians in specialist societies, and other organized efforts by women physicians
- Supporting a balance between professional life and personal life
- Establishing a mentoring forum for women physicians, and developing leadership networks and providing communication
- Monitoring trends and issues in workplace issues with an effect on women physicians
- Engagement with issues related to women's health
- Increasing the number of women physicians in the AMA and other organizations of women physicians

In 1997 the 167,517 women physicians in the United States comprised 22 % of all physicians. Their numbers are rising, and even within the AMA with the decline in membership among male physicians, the market share of the AMA among women physicians seems secure. By February 1998, 406 women had signed up for the WPC, but by May 1998 over 1,000 had joined. The AMA web site was updated to include a page for women physicians, and JAMA editor provided a new page called "JAMA Women's Health" covering women's health issues in recognition of the expanded effort to reach out to women physicians in the AMA.

The influence of women on leadership is small compared to men. The AMA declared September to be "Women in Medicine Month," and AMA President Dickey sent a special message to women physicians declaring that the AMA and organized medicine will work at all levels but especially at the national level to promote the interests of women physicians. The WPC is also establishing liaisons at the state and local level. In the future the WPC is expected to play a leading role in improving the position of women physicians in the AMA and organized medicine generally.





## **5-2. Retention Program**

The AMA retention program, like the outreach program, forms a key part of AMA strategy. As mentioned before, multi-year membership discounts for medical students and residents, and five-year membership discount plans for regular members, may appear to have a negative impact on revenue from membership dues. At the same time, multi-year memberships reduce the cost of retaining members. They also allow better control over information about members. Multi-year discounts are therefore seen as beneficial for the AMA.

### **1) Communication from AMA Leadership**

A strong leadership role for top AMA leaders to establish direct contact with the new members is seen as responsible for the success of the House of Delegates Outreach Program, and plays a large role in the retention program as well. Their priorities (in order) are with direct members, returning members, young physicians, and International Medical School Graduate (IMG) members. AMA leadership includes the AMA Board, Sections, the Executive Council, House of Delegates, and past AMA Presidents. Along with statements welcoming new members, the leadership is planning direct contact programs to improve member satisfaction with the AMA and encourage members to continue their membership.

### **2) Communication from the leadership is seen as having the following impact on members:**

1. Enhancing the value of membership for new members
2. Increasing awareness that AMA cares about membership
3. Provide opportunities for improved, two-way communication
4. Allow AMA leaders to be more effective in their roles by gathering direct feedback from membership.
5. Improve market share by reducing turnover among new members

### **3) Expected impact on federation**

1. Direct members are not members of state medical societies, but they can be recruited for membership in state societies.
2. Members of regional societies and direct AMA members both count in the calculation of the number of delegates which a state society sends to the House of Delegates
3. AMA members who are also members of specialty societies can vote to increase the number of delegates for a particular specialty society.

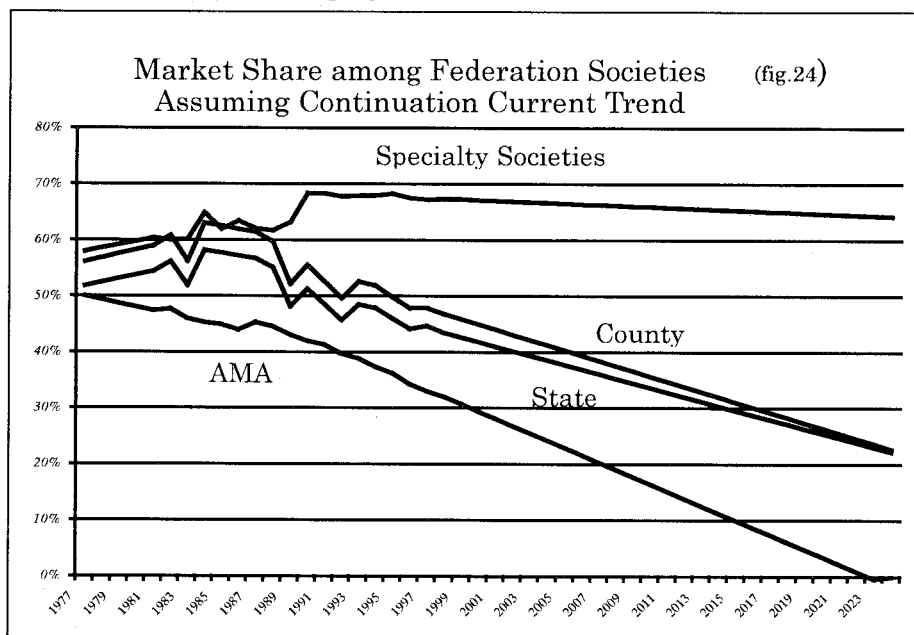
### 5-3. The House of Delegates Task Force on Membership

#### 1. Falling AMA Market Share

At the 1997 Interim Meeting, a delegate from Texas made a statement on the problem of long-term decline of AMA and State membership. This led to the formation of a task force, composed of top leaders of the AMA across existing functional divisions, charged with developing methods of recruiting new members and retaining existing members. The Task Force on Membership (Task Force) members were from the Medical Student Section, the Resident and Fellows Section, the Young Physicians Section, and the Minority Affairs Consortium, the IMG Group, the Organized Medical Staff Section, Group Practice Section. The appointment of representatives from each category of AMA membership signified the importance of concentrating all the efforts of the AMA in addressing membership issues.

The Task Force presented a report to the 1998 Annual Meeting. As shown in Figure 23, if the AMA did not change current membership policy, it was projected that AMA market share would

fall to zero by the year 2023. The report also warned that state society market share trends were similar to the AMA's market share trends lagged by twenty years.



Source: AMA Web Page

The Task Force also pointed out that both for nonmembers and members there was little connection between individual physicians and the leadership of organized medicine, and that both programs and policies provided few opportunities to reflect the opinions of the membership. First, the Task Force conducted hearings with each section of the AMA to find out where problems with membership existed. The following problem areas were identified:

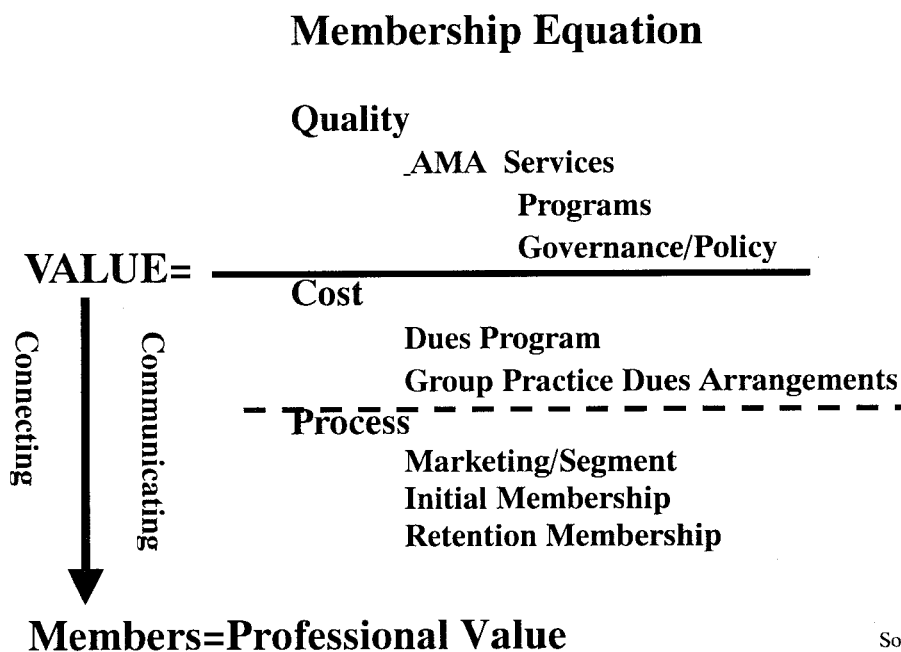
- lack of two-way communications between the AMA and grassroots members
- problems retaining members when they move, from medical student to resident, from resident to first-year physicians, and changes in location, specialty, and mode of practice
- Need to expand cooperation among AMA, state and county medical societies, and medical specialty societies
- Strategies for membership recruitment and retention, including dues options, benefits, and ways to attract members in group practice
- Wide range of AMA products and services available for providing benefits to members

- Addressing problems with membership service, existing problems and responses.
- Problems with membership application and approval process: different formats for state and county societies' forms, dues collection period differences, and other complex issues which work to discourage desire to join AMA

## 2. Value for Members

The Task Force considered value for members according to the diagram in Figure 25. Membership issues were considered to be linked directly with the relevance of membership for individual physicians. They found that the AMA should address needs of members of the AMA and local medical societies, by developing and implementing programs, products, policies, and services which address those needs directly.

(fig.25)



Source: AMA Web Site

The task for the AMA is to maximize value for its members. The AMA is also a business enterprise, with a large publishing operation and considerable investments in real estate. Revenue from business operations provides roughly two-thirds of overall revenue. In other words, membership dues contribute roughly one-third of AMA revenue. The cost to members is only the amount of their dues, but the quality of benefits provided can be three times higher. Thus, the value of membership far exceeds the cost of membership dues.

Furthermore, each category of membership and group practice arrangements allows for many kinds of discounts. But the benefits of membership are the same for all members, thus the value of membership varies greatly.

The Task Force placed high importance on individual members. Through ongoing research, they are considering the needs of members, and potential members, and programs, policies, services, and other activities to meet these needs.

### **3. Impact of Falling Membership Level**

- 1) Clear impact on revenue: reduction in dues collected
- 2) Weakening of influence of AMA in lobbying efforts as representative of all physicians. This reduces the value of the AMA to members and potential members.

### **4. Reasons for Decreasing Membership**

- 1) Structural changes in the culture of organized medicine. Physicians at the grassroots level feel distance from organized medicine. The AMA is perceived not to respond to this problem, and the leadership has not addressed issues sufficiently, nor have opportunities for communication with members and potential members been created in organized medicine.
- 2) When recruiting members, the procedures for joining medical societies, and for paying dues, are complicated and inefficient. Sometimes these problems deter new members and make delivery of benefits more difficult.

### **5. Friction between State Societies and AMA over Group Practice Discounts**

#### **Resolution H-555.975 Dues Reduction**

- (1) It is the constitutional duty of the AMA House of Delegates to set the membership dues structure.
- (2) Any reduction of the level of dues within each category of membership can only be done with the approval of the House of Delegates.
- (3) *The AMA Board of Trustees will actively seek the cooperation of the state and component medical societies before and during any negotiations on reductions in the level of dues for groups* (Res. 603, A-92; Amended by Task Force on Membership 2, A-98).

Recruitment and retention of membership is an important topic for organized medicine. Doctors, particularly younger physicians, are increasingly likely to practice medicine as part of a group rather than as a solo practitioner.

In 1990, the AMA developed a pilot project designed to raise membership among physicians in group practice. They planned to offer incentives in the form of memberships discounted according to the scale of the group practice. This strategy had both positive and negative effects. Many new members were recruited with the cooperation of state medical societies. However, according to AMA Policy 555.975 Section 3, the AMA was obligated to cooperate with state medical societies during the negotiations, and this restricted the ability of the AMA to proceed with many group practice recruitment efforts. This regulation was proposed in 1991 by the California Medical Society, as a solution for a case in which the AMA extended discounts without notifying the local medical society. There are some state and county societies which will not negotiate in conjunction with the AMA. They fall into three categories:

- States and counties which do not allow the AMA to contact members or offer discounts, even if groups express their willingness to the AMA
- States and counties which have longstanding barriers to AMA recruiting efforts in their area, in which group practice recruitment is also not possible
- States and counties which initially cooperate with the AMA in group marketing, but have suddenly excluded the AMA at the last stages of negotiations.

Policy 555.975 was designed to improve cooperation with the three kinds of local medical societies listed above. When the AMA offers discounts to physicians in group practice, that group can easily turn to state and local societies and request similar discounts. Local medical societies thus feel a direct impact in the form of reduced revenues. Furthermore, individual members are not happy that group practice physicians can join at reduced rates. And unlike the AMA which offers a free year of membership for a five-year membership paid in advance, most states and counties do not have a similar plan.

Because of these concerns, the AMA is revising Policy 555.975 since it blocks efforts to raise membership by direct negotiations with physicians in group practice. While the AMA continues to cooperate with state and county medical societies as full partners when possible, revision of the policy allows the AMA to approach groups directly in membership outreach events, and continue national outreach programs. These changes allow the AMA to increase membership among group physicians directly, but on the other hand many state medical societies are not pleased with this kind of outreach by the AMA. They fear the increased use of discounts will force future discounts for non-group members as well. It also raises questions about the meaning of the concept of "federation" under which cooperation between the AMA and local medical societies is highly valued. Future development of the AMA depends on continuation of this concept.

### **Example of AMA recruitment of group practice physicians:**

#### **● Henry Ford Health Plan**

In cooperation with the Wayne County, Oakland County, and Michigan State medical societies, the AMA succeeded in recruiting the 1,500 physicians in the Henry Ford Health Plan into group membership. This was the largest number of members recruited in any single case before. However, this case also highlighted the existence of different procedures required for membership for the county and state medical societies. The complications resulting from different membership procedures suggests the possibility of developing a single unified model to simplify membership procedures.

### **Second Report of the Task Force on Membership at the 1998 Interim Meeting**

#### **1. Short-term issues**

##### **i) Issues in administration of membership**

- 1) Items related to recruitment, membership procedures, and payment of dues  
The complications of different procedures of applications and dues payments for different societies were identified as a barrier to recruiting. New procedures for a universal application form and dues collection should be developed
- 2) Sending information  
A new goal was set for improving the exchange of information between the AMA and state medical societies, and extending assistance to state medical societies that do not have computerized record systems.
- 3) Credit cards  
Extend assistance to states that do not allow payment of dues by credit card
- 4) Lack of coordination on dues payment deadlines

Differences in dues periods are a barrier to recruitment and retention programs.\* The Task Force supports a resolution which would require conversion of dues payment deadlines of the AMA and all other medical societies to March 1<sup>st</sup>, effective 2001.

\* The AMA has developed recruitment and retention activities for certain time periods. But in some states during the same time period, there are some members whose do have not come to the end of their state membership period. The outreach and retention efforts by the AMA do not discriminate between members and nonmembers, and have the disadvantage of making members dissatisfied with the AMA.

## **ii) Cost of Membership**

The AMA is considering revising its dues structure into a three-tier structure, and conducted a survey to assess member response. Pilot projects are also being conducted in which state and county societies receive incentive payments according to their success in recruiting new members for the AMA. Further development of similar projects is planned for the future.

The Task Force is not advocating an organization based entirely on low dues. Rather, it emphasizes building an effective organization that increases value so that members can be more effective in their medical practice.

## **iii) Membership Services**

Many members and constituent medical societies expressed dissatisfaction with the level of service and information available from the AMA, including:

\* Unanswered phone calls \* unanswered mail \* insufficient or incomplete answers

The Task Force recommended improving the AMA service center to address this issues.

## **2. Long-term issues**

Many physicians feel no connection to the AMA and organized medicine generally. This kind of physicians have no opportunity to make their views known about the use of membership dues, the selection of leadership, and determination of policies. Many intangible benefits are not widely known to members, and they question the value of membership. The AMA and other medical societies also are perceived to have little knowledge of the changing needs of members and potential members. Two-way communication with physicians at the grassroots is also seen as insufficient. In particular, the rapid growth of managed care has an immeasurable impact on every aspect of medical practice. But despite the hopes and expectations of many physicians, for many reasons the AMA is not seen as taking leadership or supporting physicians on these issues.

## **i) Special Interest Groups**

Time-limited interest groups (MSS, RFS, YPS) are perceived as important for recruiting and retention efforts, because they bear the future hopes of the AMA.

### **1) Importance of the Life Cycle Approach**

Example: medical students who join for four years receive their first year of residency membership for free. Also, medical students are encouraged with discounts and other incentives to join as multi-year resident members before graduating medical school.

The RFS sponsored a project by the Tulane Housestaff Association, the organization of residents at Tulane University Hospital. The university sponsored membership for residents in the AMA, and local and state medical societies.

For the MSS and RFS, member benefits are adjusted to the level of training. The AMA requires very low dues of medical students, and views them as an capital investment in the future of the organization.

**2) Importance of developing improved communication methods with leadership of each section**

Establishing a liaison person in charge of communications with each medical school and resident program will improve the ability of medical students and residents to participate in organized medicine and propose policies for reform.

**3) Mentoring activity: support from established physicians**

Targets: Medical students, women physicians, minority physicians

Location: Local areas

Method: Chapter advisors for medical student chapters, development of guidebook for mentors, and development of virtual mentoring programs for woman physicians and minorities

**4) National Leadership Development Conference**

Each year in March the AMA sponsors a seminar to train future leadership, and invites political leaders as guest lecturers for question/answer sessions. In 1998 President Clinton was the guest of honor, and in 1999 former President George Bush will speak. The AMA is developing programs to support participation, particularly for medical students and residents.

## **6. Proposals: Possibility of Applying Lessons from Study of AMA**

### **6-1. Features of AMA Membership strategy**

The AMA conducts activities at the national level, speaking for the medical profession on issues beyond any one region or specialty. It makes the views of organized medicine known to the national administrative, judicial, and legislative bodies of government and to the public at large. It is the only organization capable of doing all of the above to express the position of physicians in clinical and medical education settings. Therefore, its mission is to seek out the opinions of its members on issues they consider of vital importance, and take charge of resolving these issues. The main consideration of members of the value of the AMA as the national medical society is not tangible benefits, but efforts by the AMA to provide programs and advocate policies that support physicians in their lifelong commitment to the medical profession.

The AMA's mission is to increase this kind of value for its members. The AMA taskforce proposes timely programs to support the needs of individual members in a timely and targeted fashion. To ascertain the changing needs of physicians in a rapidly changing healthcare environment, the AMA makes extensive use of marketing research expertise. At the same time, it has created Special Interest Groups to address the various needs of different kinds of physicians. The three groups for the youngest members—the MSS, RFS, and YPS—are also the most active groups, and contribute greatly to AMA activities. Moreover, with the rising number of woman physicians in the U.S., the Woman Physicians' Group provides support for expanding the opportunities for women to rise to top leadership roles in organized medicine. This effort further raises the image of the AMA among woman physician members of the AMA. Under the leadership of President Dickey, increased activity of the Woman Physicians' Group is spreading throughout the membership. The awareness of the importance of members in a membership organization and the development of further policy advocacy activities representing the medical profession are part of the AMA's strategy. The various components of the AMA membership strategy, which involve meeting particular needs of particular kinds of members, is expected to turn around the declining AMA membership rate, and result in increased membership. The following excerpt from AMA Board of Trustees Membership Issues Committee on membership Chairman J. Edward Hill, MD, to the 1998 National Leadership Conference illustrate these ideas:

### **The Three Rs For Leaders of Organized Medicine to Handle Membership Issues**

- **Responsiveness**

The current healthcare environment is changing rapidly; so, too, are the expectations of physicians and their demands on organized medicine. Leaders must be prepared to respond to these changing needs.

- **Relevance**

Leaders must address the needs and concerns of physicians. As leaders we must convey what we are already doing and what we will do for their patients, for their medical practice, and for their workplace concerns.

- **Reality**

A sense of commitment should also be accompanied by a good sense of reality. Do not simply say something and be blamed?

Summing up the lessons of this research on AMA membership strategy, it is clear that these three Rs are already a part of the ordinary activities of the AMA. It is a very large organization, and it is usual for the activities in a large organization to be overlooked by its membership. Aware of its immense size, the AMA must extend its own hand to members, beyond cooperation and coordination with state and local medical societies. The AMA feels directly responsible for the



needs of its own members. Nevertheless, the AMA's role as discussed above is primarily as a voice for the medical profession in policy advocacy at the national level. Most members consider this the most important role for the AMA.

If the AMA loses its clear stance as the lobbying representative of physicians, it is possible that the trend of losing membership will continue into the future.

The strategy of the AMA for improving its membership participation ratio involves the following three elements. First it must continue its role as the representative of physicians in lobbying activities. This means identifying a leader of the AMA, and responding to the needs and concerns of members. Second, the AMA must build the confidence of its members. Third, it must provide services and benefits for members, including publications, goods, and a web site, and a support staff. These efforts will probably result in an increase in membership.

Along these lines, passage of the bipartisan patients' rights bills under discussion in Congress will bolster the AMA's position. Many state legislatures have passed their own versions of the law, but President Dickey considered national legislation to be a key priority for the AMA. If a patients' rights bill passes, the negative impact of managed care on the medical practice by self-employed physicians will be somewhat mitigated, and the autonomy of physicians will be protected.

Moreover, this legislation will be seen as a successful lobbying effort led by the AMA to protect patients and represent the concerns of physicians, which may in turn lead to an increase in membership. On the other hand, anti-tobacco advocacy by the AMA did not lead to increased membership. It is probable that anti-tobacco lobbying was not a direct concern to members. Managed care, on the other hand, is clearly a concern for most members, and its future mission lies in addressing their needs directly.

The AMA is naturally already considering many of these measures. Nevertheless, many physicians consider the AMA to be a conservative, traditional organization. The image of the AMA, rather than its activities, may be the reason for declining membership.

## **6-2. Possibility of Application of concepts of AMA membership strategy to the JMA**

This section develops the concepts behind AMA membership strategy and the tools it uses, then explores the possibility of applying them to the JMA.

### **i) Application of marketing techniques to membership**

The AMA conducts surveys, not only of members, but also of all physicians nationwide. They do so using their masterfile of all physicians in the U.S. The masterfile is an enormous database equivalent to the lists kept by the Japanese Ministry of Health and Welfare as a result of the Physician, Dentist, and Pharmacist Census studies. Using the masterfile data, the AMA has constructed three services on their web page: Doctor Finder, Group Finder, and Hospital Finder. These services allow online access to current locations of all doctors, groups and hospitals nationwide.

Members have listings with greater detail than nonmembers, and all are open to the public. From the surveys conducted using the masterfile, the AMA applies marketing research methodology and techniques to obtain information. This data becomes one influence on AMA policies and programs.

One organization in Washington, D.C. serves as a clearinghouse for general ideas about membership organization operation: the American Society of Association Executives. The AMA implemented ideas found in the ASAE publication *Keeping Members* in developing its own membership strategy. This book emphasizes the importance of market research for solving membership problems. As the environment in which healthcare is provided changes, market research is necessary to collect information and ascertain the changing needs, desires, and demands of members.

The JMA may also need to address changes in its membership structure, the age structure of physicians, and the healthcare environment in order to maintain its high membership rate.

### **\* Suggestions for the JMA: Implementing Market Research**

Questions effective for membership opinion surveys, seen as effective in market research

#### **1. The value of benefits of JMA membership**

- Setting medical ethics standards
- Policy advocacy, representing all physicians
- Developing policy proposals
- Assisting physicians in their medical practice
- Providing member services
- Members-only web page

#### **2. Suggestions for policies that the JMA should undertake for patients and physicians**

- Display several options

#### **3. The value of publications**

- JMA Journal
- JMA News
- AMJ

#### **4. The value of information provided for clinical research and medical practice**

- Special information for clinical research
- Special information on medical management
- Employment opportunity information

#### **5. The value of various methods of obtaining information**

- Mail
- Telephone
- Fax
- Electronic media: email, CD-ROM, floppy disk, web pages, other online services

#### **6. Value of consulting services**

- Fee schedule
- Legal counsel
- Medical management

#### **ii) Special Interest Groups**

As discussed above, the AMA created Special Interest Groups to reflect the concerns of various kinds of members in AMA policy. The concept behind their creation is that individual members have individual needs and concerns. There are currently ten such groups, but they have not spread to cover all members. The major groups are the three younger member groups, the MSS, RFS, and YPS, and since they are the generation that will support the AMA in the future, the AMA invests heavily in their support.

This study indicates a need for the JMA to target younger physicians, particularly employed physicians, and woman physicians, in order to preserve its relatively high membership participation ratio. State and local medical societies, and specialty medical societies in the U.S. have also begun to build their own younger member special interest groups. It is possible that these groups will solidify representation of each member category. Even states without a dedicated special interest group usually have a liaison responsible for coordinating activity in a given member category. All of these groups signify the importance of a unified voice for each category of membership in determining the direction of lobbying activity.

#### **\* Suggestions for the JMA: Create Special Interest Groups**

##### **1. Possibility of application of Special Interest Groups in Japan:**

- Trainee Section
- Employed Physicians Section
- Young Physicians Section
- Women Physicians Section
- Other Sections

Each of these sections would operate at the county, prefectural, and national levels. In each location, a liaison would direct its activities, just as the AMA has contact people in state medical societies. The benefits of these sections would be to identify needs of all physicians in each category, and make possible the collection of requests and suggestions. They will also contribute to the activities of the JMA.

### iii) **Establishing a Web Forum for Members**

The AMA members-only web site has fourteen separate forums where members can express their opinions on various issues. Forums are used as a valuable tool for the AMA to shape policy in response to concrete requests from member feedback. One of the elements identified by the Task Force, as a cause of the decline in membership was poor communication between grassroots members and the AMA. These member forums allow the leadership to respond directly to members, and establish two-way communication. They are an important method for bridging the distance between grassroots members and the AMA. Market research conducted by the AMA found that most members desired communication by mail. Among younger members, and especially medical students, communication by e-mail was the most preferred method. Since there is no data on the extent of personal computer ownership by members or their usage, it is not known how often these web forums are used. Nevertheless, it is likely that the possibility of two-way communication has contributed to an image of the AMA as a more open organization.

#### **\* Suggestion for the JMA: Create a web forum on the members-only web page**

- Several forums based on different themes
- Suggestions from members (to complement existing members-only fax line)

Although the extent of computer usage by JMA members is not known, it is likely that such a forum would increase the image of the JMA as an open organization. A pilot project of this forum has been implemented already on the JMARI web page.

### iv) **E-mail Members**

AMA lobby activities conducted in the AMA Washington D.C. Office are designed to influence national policy. They have established "e-mail members" and use email to send news to members at the grassroots level every Friday. Members are given information about how to lobby from the local level up to the national level. There are about 9,000 email members at present. Medical students have been particularly interested in receiving news by email. Email contact is reported to have a high impact on member recruiting and renewals.

#### **\* Suggestions for the JMA:**

##### **1) Send news to email members by email**

There are many instances where email members are being registered online to receive current news. The JMA homepage also displays articles from the current JMA Journal, JMA News, and notices from the Board of Trustees.

##### **2) Allowing members to use an email address that contains "jma"**

Many universities in the U.S. have developed programs to allow alumni to maintain permanent addresses that contain the name of their university. Giving members an email address that contains the name of their organization is thought to be one effective method to improve the adherence of members to the organization.

### v) **Providing opportunities for mentoring**

The AMA encourages opportunities for local mentors to meet with residents and medical students. Established physicians give advice on professional development. The experience of these physicians provides valuable lessons that are not taught through medical school, internships, GME, or CME. This service is most important for residents.

**\* Suggestions for the JMA: Build mentoring opportunities**

- Target: trainees, woman physicians, employed physicians, young physicians including both members and non-members
  - Location: at the local level
- Mentoring will lead to increased recruitment and retention, and broaden opportunities to participate in JMA activities

**vi) Provide Consulting Services**

The AMA has an advisory network that gives members information from experts in managed care, including physicians, lawyers, and consultants. These activities are particularly valuable for younger physicians beginning their medical practices. The AMA also publishes a series of guides for medical practice.

**\* Suggestion for the JMA: Establish a Consulting Service on Medical Management**

- Publish a series on management of medical practices
- Sponsor seminars by healthcare consultants
- Create a section on the JMA web site on medical management issues

## 7. Conclusion

The AMA is a large organization with a 150-year history, a 1200 member staff, and a Washington, D.C. office dedicated to lobbying. The AMA also operates as a business enterprise with considerable investments in real estate, and a large publishing business. One must remember that the AMA is also the national organization of physicians. To learn about the organization, one can obtain vast amounts of well-organized, high-quality information directly from its web site. The AMA provides extensive services for its members, and appears to provide an organization commensurate with its membership dues. But the AMA has been troubled by a continuing decline in membership. Excluding medical students, the AMA membership as a share of all physicians has fallen well below 40%.

By creating special interest groups, the AMA hopes to build an organization for all members of each type, and ascertain issues and needs specific to each group. Ultimately, special interest groups are designed to make it possible to convey the voices of individual members to the central leadership of the AMA, and give them some influence on the direction of AMA policy. Members of the Medical Student Section, the Resident and Fellows Section, and the Young Physicians Section are particularly active in the AMA policy process, and their positive participation reflects the spirit of the younger generation of AMA members. There are many generations in the AMA, and many different categories of members. Each member may perceive different issues, needs, get different value out of AMA membership, and have different ideas about the direction of AMA policy. Issues thus emerge out of a bottom-up rather than a top-down process. It is much more important to have policy generated from the voices of grassroots members, rather than the projections of top leadership.

The AMA also generates revenue from operations other than membership dues. Thus, members receive benefits in excess of what their membership dues alone would support. The vast volume of information generated by the AMA, however, may lead individual physicians to wonder how to use all of it, and precisely what benefits are available to them. The AMA, beginning with the Task Force on Membership, is assessing ways to address the needs of all of its members, establish new means of two-way communication, and develop ways to deliver appropriate benefits. Sometimes the top leadership places “welcome calls” to individual new members.

The AMA is a huge organization with a highly refined organization. More than simply increasing members, its traditional mission has been at the heart of the healthcare policy process. In the U.S. if the AMA were to increase its power, it could alleviate some of the problems caused by managed care. Reduced freedom for physicians and the increased direct regulation of medical treatment is good for neither physicians nor patients. If patients’ rights legislation becomes law, the AMA hopes that it will be able to reduce the power of HMOs even to a small degree. Still, it is possible that not every member supports the AMA’s mission to return physicians to their former power as healthcare providers through political action. The value of joining a weakened AMA may be questionable for nonmember physicians.

For the AMA to represent all physicians, and maintain its influence over national healthcare policy and issue policy statements, it must regain a high level of membership participation, like the JMA has. For the AMA to attract and retain members, it must strengthen the foundations of its membership quickly. The AMA should also strengthen its leadership, and have a clear voice to convey vitality and energy and gather members.

The JMA must find ways to strengthen its presence as both a professional organization and a policy advocacy organization, in its mission to protect the health of all citizens, and represent the voice of physicians in national healthcare policy. In order to achieve these goals, the JMA must maintain its current high level of membership participation. This report suggested several relevant strategies used by the AMA to improve its organization that may be useful for the JMA to consider when planning its own strategies.

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