CCIJ News

December 2004

No.43

Consumer Co-operative Institute of Japan
Plaza F 15, Rokubancho, Chiyoda-ku, Tokyo
102-0085, Japan
Tel. 81-3-5216-6025 Fax. 81-3-5216-6030
ccij@jccu.coop
http://www.co-op.or.jp/ccij/

Main Features

How Social Economy Can Improve User Access and the Capability of Health Services: The Case of Health Co-ops

Akira Kurimoto, Director & Chief Researcher

Introduction

Health care services are provided by various organizations, mainly public and non-profit, which are financed by medical insurance, taxes and user fees. How to reduce the overall medical expenditure in a rapidly aging society is a crucial problem for the national economy although the Japanese system has achieved a relatively good performance. The need to integrate health promotion, medical treatment and social services are widely recognized, but the linkage among them is hampered, due to both institutional and functional reasons. In addition, the problem of how to improve user access and capability in the medical industry, where asymmetric information prevails, is of foremost concern.

This paper analyzes how health services are organized and financed. It points out the disadvantageous position of users when dealing with highly professional health service providers. Finally it describes how organizations within the social economy in Japan tackle these problems by empowering users through learning to monitor their own health conditions, and by establishing patient's rights and networking various institutions to promote health, medical and social care.

Organization and Financing of Health Services

The Japanese health care system is characterized by a compulsory medical insurance system, with greater integration on the supply side and weaker consumer/user power on the demand side. Universal coverage under the public medical insurance system was enacted in 1961. The entire nation is now covered by one of eight public medical insurance schemes for workers, farmers, government employees, teachers, etc. Most of these schemes have accumulated enormous deficits due to their obligatory contribution to finance health services for the elderly. Over the years, although the government has tried to solve this, they have often come to a deadlock hampered by vested interests. Today health care services are mainly financed by medical insurance that is supplemented by taxes, while users pay 30% of medical

fees. The insurance companies have launched private medical insurance policies that offer supplemental coverage for hospitalization and specific diseases such as cancer.

The supply side ranges from hospitals to community clinics (general practitioners). These medical institutions are established as medical corporations, public corporations, individuals and other institutions including health co-operatives. They are all designated as not-for-profit entities as stipulated by the Medical Law. Although medical corporations are seen as typical nonprofits and not allowed to distribute surpluses, their corporate tax rate is identical to conventional companies. Medical corporations and individuals operate in the black, while public corporations and other institutions mostly operate in the red. There is a growing gap between oversupply in large cities and under supply in remote areas. There are weak liaisons among institutions, which sometimes cause problems such as failure by hospitals to admit emergency patients. There is a strong tendency towards horizontal and vertical integration through the formation of hospital chains and so-called "'medico-welfare complexes'" which integrate medical and long term care services within the same groups. Such trends tend to spur the commercialization of medical and social services.

The demand side of medical services is characterized by consumer free access to medical institutions. Users can visit any hospital or clinic, but the coordination of the delivery of the care from primary care to more advanced care is yet to be established. This situation results in heavy congestion in some large hospitals where outpatients receive "3 minutes diagnosis after waiting for 3 hours." Consumers have little opportunity to choose among medical services as hospitals/clinics are not allowed to advertise and therefore no comparative information is available. The fee-for-service payment system has led to excessive scheduling of examinations and over prescribing of medication, which in turn increases costs and often produces other side effects. The patients have to pay the extra costs for the services not covered by medical insurance, e.g. advanced medicine, hospital rooms with 1 or 2 beds and so on. Health promotion is also not covered.

As a whole, in the past the Japanese health care system performed well ensuring the longest life expectancy among advanced nations, the lowest infant mortality rate and a relatively low ratio of total medical expenditures to GDP (7.8% in 2000, placing Japan 16th among OECD countries). But it is certainly at a turning point with rising medical costs (in excess of 30 trillion yen), especially in view of its rapidly aging population and the accumulating deficits of medical insurance schemes. The supply of medical services is sufficient, but there is a growing concern about the quality of services, including QOL of the bedridden and terminally ill patients. While medical treatment is prioritized within the industry, preventive health promotion is undervalued and its linkage to long-term care is still weak.

The Need to Empower Users Facing Asymmetric Information

Users are placed in a disadvantageous position versus professionals and are generally deprived of the right of choice and the access to information. Traditionally doctor's decisions have been seen as final and absolute, leaving no room for questioning or second opinions. There were very few sources of reliable information on medical care and service providers, partly due to the restriction on advertising and partly due to medical institution's reluctance to engage in competition. Patients generally lack knowledge about diseases and cannot read case records even if disclosed. Once hospitalized, patients are left no choice, often having to pay extra charges for hospital

rooms only partially covered by health insurance. Even when they suffer from medical accidents or malpractice, many of which have surfaced only recently, most patients had to cover the costs. In the political arena they have had no voice while doctor's associations have exercised strong influence in the medical system particularly in terms of setting remuneration (fees). As such, user rights and interests have been largely neglected.

Therefore, there exists a strong need to empower users to take an active part in their medical care process and work together with providers to lead a healthy life. Pestov argued that the parent-day-care co-operative in Sweden could empower consumers as co-producers through their participation in the work combined with democratic procedures and parents holding honorary offices, thus meeting their wants to influence their children's life [1)]. This holds true for health co-ops. Both social and medical services are basically consumed where and when they are produced and users have the potential to influence how the services are provided. But the sheer asymmetry of knowledge and skill in medical care between providers and users requires more careful consideration of user involvement in the process.

How to Improve User Access and Capability

The problem is how to improve user access and capability in the medical industry where asymmetric information prevails. A number of initiatives to cope with this problem has emerged in recent years. Herewith I would like to present two cases: a nonprofit advocacy organization, and health co-operatives.

Citizens in Osaka set up the Consumer Organization for Medicine & Law (COML) in 1990 with the aim of promoting patient-centered medicine from the consumer's standpoint. It called for consumer's active participation to medicine under the motto, "We are masters of our lives and responsible for our health." It is an advocacy group to help patients solve their problems pertaining to diseases, treatments and finance through telephone counseling and dissemination of information. The telephone counseling, which was started by voluntary counselors, has grown to handle more than 4,000 inquiries a year. The operators do not give patients professional advice, but listen carefully to their problems and help them find solutions by themselves. It organizes consumer's medical forums every year to facilitate dialogue and exchange between patients and professionals and publishes newsletters and books to disseminate information obtained from these activities. It assisted the Ministry in publishing a guidebook entitled "10 Pieces of Advice for Patients When They Meet Doctors" that was widely distributed. COML also started organizing SP (simulated patients) groups where volunteer users meet and give feedback to medical service providers to help the latter improve communication with patients.

The health co-ops have strived for empowering users in a more systematic way and with much greater magnitude. The Japanese health co-ops are classified as user-owned by the extensive UN survey on co-operative organizations in the health and social care sectors [2)]. This is accurate since they are owned and controlled by members, overwhelmingly consumers, and registered under the Consumer Co-operative Law of 1948. The majority of the membership is consumers, mostly healthy people who wish to be prepared for the risks of illness while wanting to lead a healthy life. In this regard, health co-ops are different from organizations exclusively composed of patients. At the same time, medical professionals including doctors, nurses, technicians and chemists are also involved as members. According to the statistics for 2001

compiled by the HCA (Health Co-operative Association), there are 119 health co-operatives owned by 2.37 million members, out of which 22,026 (0.9%) are employees, including 1,605 doctors, 10,736 nurses and 3,898 administration staff. Health co-operatives seek to create a synergy effect by involving different stakeholders working together in the same organizations to attain common goals, i.e. promote, maintain, and support recovery and restoration of user's health. Users are expect to help providers create better services by committing themselves to the health care process, while providers will help users establish positive attitudes in maintaining health and tackling disease.

Figure 1. Evolution of Health Co-op's Members (HCA-JCCU Statistics)

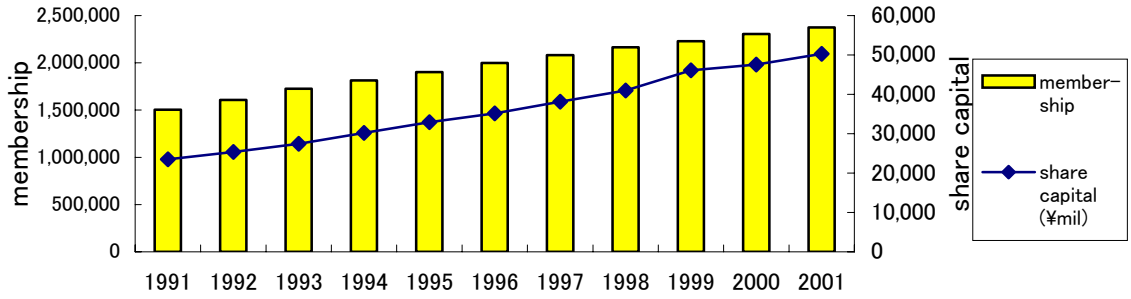
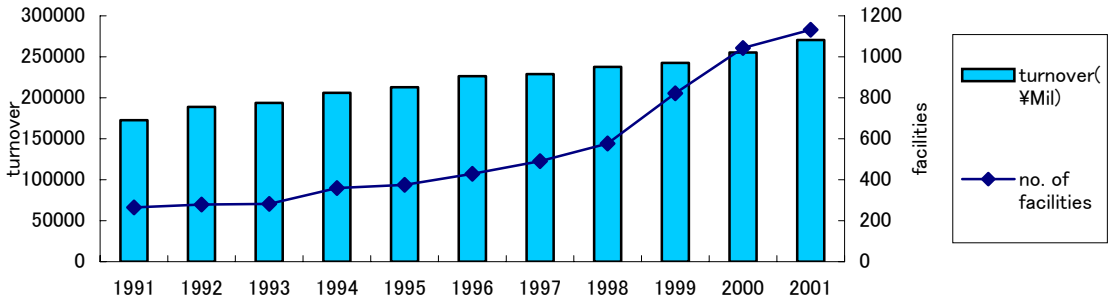


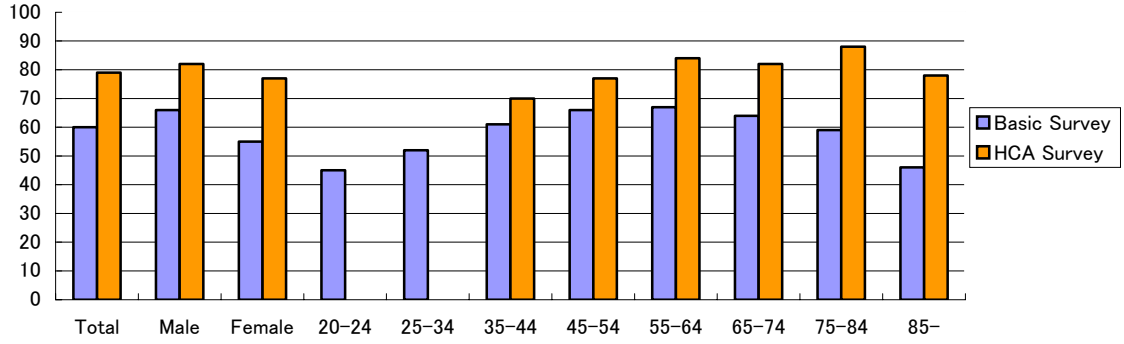
Figure 2. Evolution of Health Co-op's Business (HCA-JCCU Statistics)



The primary motive to organize health co-ops is to create a better quality of life by facilitating users to participate in health promotion and medical care, which has a strong tendency towards professional's domination due to asymmetric information. In order to attain such a goal, health co-ops have created a number of intermediary bodies between the board and members, aiming to encourage user participation. At the grass root level, user members are encouraged to learn about promoting health in 'Han' groups (small neighborhood groups), which meet regularly at members' houses. Over 243,000 co-op members belong to 25,731 Han groups (on average 9.4 members per Han). Members also attend various lectures and correspondence courses organized by health co-ops at the local, regional and national levels in order to become co-operative 'health advisors' who then lead voluntary activities assisting Han groups and act as the driving force for health promotion. The number of health advisors has doubled since the 1990s to more than 40,000. Members meeting in Han groups, with the initial assistance of nurses and health advisors, learn to conduct self-check-ups to assess their own health conditions by testing and keeping records of blood pressure, sugar and salt content in their urine, fat content etc. using simple devices such as automatic sphygmomanometer and urine test paper. If irregularities are found, members will then have health check-ups and meet doctors at health co-ops. These self-check ac-

tivities have proved to be effective for early detection and treatment of illness. In addition, district committees are organized in school districts to promote networks within the community, while user panels are attached to hospitals/clinics to reflect user's voices in the daily operation. Through these activities, users have more consciousness about their own health conditions, which enables them to play an active role in leading a healthy life and make collaborative decisions together with medical service providers to prevent or combat diseases rather than passively leaving his/her own health in the hands of the latter. As a matter of fact, health co-op members showed a higher percentage of annual health check-ups compared to the national average; 79% against 60% [3].

Figure 3. Percentage of Annual Health Check-ups



Since 1997, "The 7 Habits for Health" have been promoted by health co-ops as one of their user sensitizing programs [4]. The intent of the program is to change consumer's daily habits and remove activities or elements that could lead to disease. The HCA invited monitors from among the members and is now conducting an epidemiological survey of 4,000 families over a period of 5 years.

Health co-ops also seek to promote transparency and user participation in the medical practice through implementing a Charter of Patient's Rights [5] as a guideline to be followed by patients and service providers. It states that each independent person tackling disease and illness, has the following rights:

a) Right to be informed of disease, the medical care plan and drugs
b) Right to determine suitable medical care plan
c) Right to patient's privacy
d) Right to learn about their own disease, its treatment and prevention
e) Right to receive necessary and optimum medical service at any time

The "informed consent" is generally understood to be a concept to promote patient's human rights, but it can be a one-way communication from doctors to patients, as seen in the Japan Medical Association's translation of "'explanation and consent"'. The Charter emphasizes a patient's right to be informed, to learn and have self-determination. To this end, many co-ops started disclosing case records to patients to share information on treatment and medication, and provided members with a large number of opportunities to learn about health so that members can have the capacity to make the right decision on suitable medical care plans. Some co-ops started to organize SP groups aiming to improve communication between users and providers, while others are trying out "medical care by multi-professional teams" to enhance the quality of services by enabling collaboration among different departments and various stakeholders with patients position at the center. Thus they seek to bring about

openness and democracy in the medical industry, which tends to be closed and authoritarian. The HCA often organizes an exchange among the best practices that implement the Charter. In addition it regularly conducts patients' appraisals on medical treatment and nursing practices and national member's opinion polls to give feedback from user's voices to improve services.

Building Networks for Health Promotion, Medical and Social Care

The long-term care insurance system came into effect in 2000 and opened the way for competition among various types of service providers. Not only existing social welfare corporations, but also a number of private sector companies and nonprofits have entered into this field. After only few years, although it is still premature to assess the results, some investor-owned companies have faced serious setbacks, drastically reducing their operations while semi-governmental social welfare corporations seem to have succeeded in securing former clients. Many hospitals also rushed to provide long-term care services, thus integrating medical and social cares, which while providing convenience and concerted care provision to the beneficiaries, may generate the risk of profiteering from patients by enclosing them in the circle of subsidiary facilities.

There has been a longing in Japan to integrate health promotion, medical care and long-term care in order to address the changing pattern of diseases from acute/ contagious to chronic, generate better-coordinated services for beneficiaries and reduce the overall costs. But such a goal could not be easily achieved, mainly due to institutional and functional reasons. On the whole, municipal health centers and a large part of welfare facilities have been financed by taxes while most medical institutions have had to be financially self-sustaining and thus did not want to provide services that did not pay. The different approaches in these three areas have posed barriers to coordination, as there are very few peoples who have thorough knowledge in all three areas of care. This situation has hampered user's seamless access to the necessary services and caused a negative phenomenon called "'social hospitalization,'" which means patients continue to stay at hospitals after no treatment is necessary since they cannot come home for various reasons such as lack of caretakers.

Health co-ops have been increasingly involved in the provision of long-term care as a natural extension of health promotion and medical care, where they have accumulated experience and know how. They have made substantial investment in training personnel and building facilities for long-term care. In addition, they have promoted a campaign to create open health-medical-welfare networks based on citizen's participation. They mapped out where the local needs and resources existed, analyzed problems and possible solutions, and coordinated the integrated provision of prevention, medical and social care services. To this end, they are extending collaboration with other organizations including social welfare corporations and develop partnership with local authorities. It is not just consumers who are given "one stop services," which would be available in large-scale 'medico-welfare complexes,' but they can participate in maintaining their own health and well being as informed users and volunteers. Such development may lead health co-ops to be multi-stakeholder co-operatives for health and social care, where users, medical professionals, care workers and volunteers will work together to enhance the well being of citizens in the community.

Conclusion

Efforts to empower users by learning to self-monitor their own health and through establishing a balanced relationship between users and providers only began in 1990's. The experience of recent years demonstrates the great potential that social economy organizations can realize by involving users in the process as agents of change. It is our task to identify the best practices of human development by both users and providers so that they can collaborate more effectively toward the common goal of enhancing citizen's health and their quality of life.

Notes

1) V. Pestov, *Beyond the Market and State*, Ashgate, 1998, pp.98-102.

2) United Nations Department for Policy Coordination and Sustainable Development, *Co-operative Enterprise in the Health and Social Care Sectors*, 1997

3) Ministry of Health, Labor & Welfare, *Basic Survey on Nation's Life*, 2001; HCA, *National Survey on Health Co-op Member's Consciousness*, 2004

4) 7 habits in daily life promoted by health co-ops
- *To g et appropriate sleep (7-8 hours)
- * To avoid overwork and take enough rest
- * To avoid smoking
- * To avoid excessive drinking
- * To continue moderate exercise, regularly
- * To have a balanced diet with low salt/fat
- * To have regular meals including breakfast, avoid snacks

5) See Appendix. The Charter was adopted on May 11th 1991, at the Annual Meeting of the Health Co-operative Association of the Japanese Consumers' Co-operative Union

Editors Note:

This particle was presented at the CIRIEC World Congress held in Lyon on Sept. 27-28, 2004.

NEWS in Brief

New Book "Safety Net of Life Created by Citizens" Published

"Safety net of Life Created by Citizens" is the title of the new book edited by Prof. Kiyofumi Kawaguchi and Prof. Mari Osawa. Mr. Akira Kurimoto, the CCIJ Director, coordinated its publication by Nihon Hyoronsha in October. It is the outcome of CCIJ's research project on "consumer co-ops in the changing socio-economic system" chaired by the co-editors in collaboration with other authors. The book consists of the Introduction (Kawaguchi), Part I, Part II and the Epilogue (Kurimoto). Part I on the "Japan-style safety net coming apart" contains 3 papers while Part II on the "safety net created by citizen's co-operation" contains the best practices of co-operatives and voluntary sector organizations in the fields of food safety, housing, health and social care, environment, job creation and financing. The open symposium was held by CCIJ to commemorate the publication.

10 Researchers Granted Scholarship for the Asia-Pacific Co-op Research Conference

The 3rd Asia-Pacific Co-operative Research Conference was held on December 1-3 in Chiangmai, Thailand in conjunction with the ICA Asia-Pacific Regional Assembly and Co-operative Forum. More than 70 researchers and co-op leaders took part in the 3 day event, Mr. M. V. Madane, the Asia-Pacific Regional Co-operative Research Forum Chair, presided over the Conference, with opening remarks given by Mr. I. Barbelini, the ICA President, followed by remarks by Mr. S-K. Lee, the ICA Regional Director and Mr. A. Kurimoto, the ICA Research Committee Chair. The conference was organized around three themes: Widening the areas and scope of Co-operative Action, Co-operative Governance and Globalization and the Role and Dynamics of Women's' Co-operatives. Twenty-one researchers from Australia, India, Iran, Japan, Malaysia, Nepal, the Philippines and Thailand all presented papers. From amongst the presentations, 10 researchers were granted scholarship by the CCIJ, which received nearly 50 applications, but had to select only 10 scholars due to budgetary constraints.

3rd CCIJ Award/ Scholarship was Announced

The CCIJ, beginning in 2000, as a way to commemorate its 10 anniversary, began to grant awards for excellent research and scholarship. The award recognize the best books/papers published in the previous 2 years, while intending to encourage young researchers and practitioners to pursue rigorous scholarship and conduct research. The fields covered are: the changing consumer life style, consumer co-op's organization and operation and co-operatives' roles in a civil society. The selection panel is chaired by Prof. Otohiko Hasumi, the CCIJ Chairman, and consists of 6 persons representing the fields of law, economics, sociology, ecology, social welfare and women's education. The first award was granted in 2001 selecting 2 books and 7 projects. The second award was granted in 2003 selecting 3 books and 6 projects. In each case, the prizewinners were invited to the awards ceremony and their papers were published by the CCIJ. The 3rd CCIJ Award/ Scholarship guidelines were announced recently with a deadline of March 31st, 2005.

CCIJ News Now on the Web

Please note that CCIJ News is discontinuing its printed newsletter. CCIJ News can now be found only on this web site. post on their website. We welcome comments from our readers at: : ccij@jccu.coop.