An excerpt from:
Better Health & Social Care: How are Co-ops & Mutuals Boosting Innovation & Access Worldwide?
An International survey of co-ops and mutuals at work in the health and social care sector (CMHSC14)
Volume 2: National Cases

For the research framework, the analysis of the national cases, and other research components, including a description of the research team members, refer to Volume 1: Report.

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JAPAN

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Health Check in a Japanese Health Co-op. Photo: HeW Co-op Japan.

HEALTH SYSTEM

In Japan, universal access to health and medical care has been guaranteed by the government since 1961. The universal health insurance system covers comprehensive and uniform services, including inpatient, outpatient, and dental care. This system has two parts: Employees Health Insurance (EHI) and National Health Insurance (NHI). The latter is intended to cover the self-insured, fisherman, farmers, the retired, and the unemployed.[1] However, with the challenges posed by an aging society, changes in employment patterns, and the emerging issue of the uninsured, it is understood that the social health insurance system is under threat.[2] Coupled with these demographic crises are the fiscal difficulties which Japan faces. With the sharp increase in national medical expenditures, a co-payments policy has been in place since 1984 for all medical services. Furthermore, the Japanese social welfare system underwent drastic changes during the 1990s when social welfare laws were revised to enable municipalities to outsource in-home services to non-public providers. Perhaps the most significant market reform came with the enactment of public, mandatory Long Term Care Insurance (LTCI) in 1997 and its implementation in 2000. This law is perceived to have opened the door to non-public entities, including cooperatives, to operate in the health care and social care sectors.[3]

Population (in thousands) total: 127,000

Population median age (years): 45.53

Population under 15 (%): 13.12

Population over 60 (%): 31.92

Total expenditure on health as a % of Gross Domestic Product: 10.1

General government expenditure on health as a % of total government expenditure: 19.4

Private expenditure on health as a % of total expenditure: 17.5

The worldwide problem of aging is most serious in Japan, due to a combination of declining fertility rates and rising longevity. Japan's total fertility rate dipped from 2.13 in 1970 to 1.37 in 2009 (far below the replacement rate of 2.1).[4] Over the same period, the average life expectancy for Japanese women and men was 86.44 and 79.59 years, respectively – the highest in the world.[5] By 2013, 32.3% of the Japanese population was over 60 years old; by 2050 this figure is projected to rise to 42.7%. With the aging trend, obviously, fewer young workers are available to support more retirees. In 2000, the aged dependents ratio (number of working people divided by aged dependents) was 3.9 active workers to each person 65 and above. By 2010, this figure was fewer than three workers per retiree.[6] In the long run this will likely bring about a decline in Japan's GDP.

With regard to work patterns, corporations in recent years have preferred to hire more irregular workers (i.e., temporary, part-time, and contracted out) in order to maximize profits. Since those working less than three-quarter time need not be enrolled in employee-based plans, the composition of health insurance enrollment has been transformed.[7] For example, the proportion of workers engaged in the primary industries has decreased from 42% in 1965 to 3% in 2008. In the meantime, the proportion of retirees and others not working has increased from 7% to 40%. The proportion of those who are employed, but not covered by employee-based plans, has increased from 25% to 34%.[8] Moreover, as Japanese women attain higher levels of education, their values with respect to work, marriage, and childbirth have changed considerably.[9] Many of them choose to work or to pursue other interests rather than purely family careers.

Finally, growing numbers of Japanese are unwilling or unable to enroll in social health insurance. According to a national survey,[10] 1.3% of the sampled population was not paying social health insurance premiums although their incomes were high enough to be taxable. That means 1.6 million people have no insurance, which "might bring into question Japan's status as a country with universal coverage."[11]

Coupled with those demographic challenges, the development of Japan's health care and social care sectors has been hampered by the national fiscal crisis. The copayment rate was first set in 1984, when the revision of the Health Insurance Act led to the introduction of a 10% employee co-payment. This rate gradually increased to 20% in 1997 and to 30% in 2003.[12] A flat amount for seniors reached 30% in 2006. The co-payment is now 30% on all services, except for people aged 70 and older on low incomes, who pay 10%, and for children under six, who pay 20%.[13] However, the increase in the co-payment rate has led lower-income patients to use fewer medical services, thus discouraging patients with acute conditions from accessing the health care system.[14]

Since the 1990s, Japan's social services provision system also has undergone drastic change. For example, up to the year 2000, exclusively municipalities and social welfare corporations provided elder care services.[15] With the implementation of LTCI in 2000, competition was introduced between for-profit and non-profit service providers. In the health care sector, the number of state and public hospitals has been falling. Currently they account for 17.8% of all hospitals in Japan.[16] Clearly, public institutions are "retreating from service provisions while concentrating their role as financers and regulators."[17] In particular, they are leaving in-home services to the non-profit and for-profit sectors, with only 6-9% of in-facility services.[18] Moreover, while all medical institutions must be non-profit according to the Medical Service Law, they operate under various organizational forms, including as medical corporations, public institutions,[19] private and other entities including health cooperatives.

In these heavily regulated markets, cooperative organizations are understood to provide better access to health care for the increasing number of Japanese excluded from services due to unemployment and low income. In Japan, cooperatives offer a variety of services to farmers in under-populated rural areas and empower urban consumers through learning and participation.[20] In Asia, Japanese health cooperatives provide assistance to other members of the Asia-Pacific Health Co-operative Organization (APHCO), participating in study tours and exchanges with cooperative hospitals or dental clinics in Nepal, Sri Lanka, South Korea, and Mongolia.[21] (They mobilized to help rebuild health infrastructure in Sri Lanka after the tsunami of 2004.) In summary, they present a pioneering example of the vibrant cooperative movement emerging in health and social care sectors worldwide.

HEALTH COOPERATIVES

In Japan, health cooperatives operate in two forms. Those operating in rural areas (i.e., Koseiren) are regulated by the Agricultural Co-operative Law of 1947; those functioning in urban areas are registered under the Consumer Co-operative Law of 1948. **Koseiren** federations are affiliated with the National Welfare Federation of Agricultural Co-operatives. They are secondary-level organizations owned and controlled by primary cooperatives, where individual members are the beneficiaries of

health and social services provided by hospitals and clinics. They were designated as public institutions to provide health services to the rural population. All 36 Koseiren federations initiated welfare businesses under the LTCI system in 2000.[22] In 2006, Koseiren service providers under the LTCI system included 130 hospitals and clinics, 110 visiting nurse stations, and 26 health facilities for the elderly.[23]

Most urban health and welfare cooperatives are owned and controlled by consumer-members. They generally provide medical and nursing care services to local residents. Any resident is eligible to become a member. Medical professionals, such as doctors and nurses, and almost all staff members are also members. To join one such cooperative, a member normally provides $9.75 USD (1,000 JPY) as share capital, although the minimum amount of share capital varies from organization to organization. Non-members may also use services up to a maximum of 50% of total business volume. Cooperatives strongly encourage non-member users to join up.

HeW Co-op Japan is a national federation of health and welfare cooperatives. The Federation comprises 111 member cooperatives and the Japanese Consumers' Co-operative Union (JCCU). HeW opened its doors in October 2010 after being a JCCU member since 1957 under the name Health Co-operative Association of the Japanese Consumers' Co-operative Union (HCA-JCCU). The cooperatives are found all over the country except on the island of Hokkaido. One of the main activities organized by these health and welfare cooperatives is health promotion in their home communities. They provide local citizens with opportunities for health checks (blood pressure, body fat measurement, health consultation, etc.). These health promotion activities are also made available to the local residents during certain special occasions, like annual festivals or "World No Tobacco Day." Moreover, local health and welfare co-ops also hold health workshops for children in order to raise their health awareness.[24] Finally, since their early days these cooperatives have promoted HAN, a fundamental unit of preventive health practice. HAN groups are cells of 10-20 citizens living in the same vicinity, on the same street, in the same neighbourhood. They agree voluntarily to meet at a local hall or a recreation centre for a few hours once a month on average and take part in an ongoing process of disease prevention. It is estimated that there are more than 25,000 HAN groups in the HeW network. In 2007 and 2010, two Canadian study tours came to Japan. As a result of these visits, the HAN model has been replicated and adapted by a number of health co-ops in Canada. (See the Canada national case, p. 31.)

In response, a HCA-JCCU delegation conducted study tours in Canada in 2004 and 2008, where they were introduced to health cooperatives in Québec and Saskatchewan, respectively.

A "World No Tobacco Day" Event
Photo: HeW Co-op Japan

Health Cooperative Data[25]

Number of cooperatives	111 health and welfare cooperatives (affiliated with HeW Co-op Japan)
Types of cooperative	User only
Number of members	2.84 million
Number of employees	35,131 (affiliated with the HeW Co-op Japan Federation) Doctors: 2,008 Dentists: 221 Nurses:18,966 Chemists: 418 Others: 13,518
Users	3.55 million[26]
Facilities	Medical facilities: 77 hospitals (12,511 beds), 348 primary health care centres, 69 dentist offices, 202 home-visit care stations (all managed by the HeW Co-op Japan Federation) Nursing care facilities: 26 nursing care homes, 181 helper stations, 161 ambulatory rehabilitation offices (all managed by the HeW Co-op Japan Federation)
Services offered	Health and welfare businesses, such as hospitals, primary health care centres, elder care centres, home-visit care centres, rehabilitation centres, outpatient care services, home care services, elder housing, etc. Illness/accident prevention Wellness and health promotion Treatment and cure Rehabilitation
Annual turnover	(HeW Co-op Japan) approx. $30.862 million USD (3,144 million JPY) (all member health and welfare cooperatives) approx. $3.122 billion USD (318 billion JPY)
Revenue sources	(all member health and welfare cooperatives) net sales of medical business (81%), net sales of welfare business (18.5%), other sales (0.5%)

Case Study

Saitama Medical Co-operative[27] is located in Saitama Prefecture, just north of Tokyo. With a population of 2.88 million people, this region is characterized as the most rapidly aging nationwide. It also has the lowest density of physicians. As of March 2013, Saitama had 242,098 members and 2,072 employees. It consisted of 153 branches and 1,340 branch committees. In that year, total share capital reached $61 million USD and the total turnover $189 million USD. It counted a total of 33 business facilities, including 4 hospitals, 8 medical clinics, 2 dental clinics, and 19 home care support offices. Of the 4 hospitals, Saitama Co-operative Hospital was set up in Kawaguchi City (population 580,000) in 1978. Today it has 401 beds and 18 diagnosis and treatment departments. On average it receives 1,044 outpatients per day. Because of the high quality of its medical services, this cooperative hospital enjoys a high ranking: second among 20 emergency hospitals in Kawaguchi City, and the best in the private sector.

Saitama has been a pioneer in the promotion of citizen empowerment and civil participation. Saitama encouraged its members to draw up activity plans, and to design and implement events not only for health promotion, but also network building.

Among its various domains of activity, Saitama has paid particular attention to health promotion and prevention. Co-op members, together with local residents, organize study meetings. Those who attend go on to lead and support other events (e.g., "Kenko Hiroba" activities). They organize physical exercise in local public facilities and parks, such as walking, dancing, practicing yoga, and other fitness activities. All activities are open free of charge to anyone. In total, 134 cooperative branches organize 573 events at 86 venues every month. Besides these regular events, Saitama organizes health promotion activities during special public occasions. For example, on "World Health Day," they provide health checks on blood pressure and body fat measurement in the street. On "World No Tobacco Day," co-op members work together with local doctors and nurses to conduct questionnaires and consultation to raise citizens' understanding of the risks of smoking. These activities all help to enhance the health awareness of both members and local communities.

Moreover, in coordination with local government and other social organizations, Saitama combines health promotion with local community development. For example, it organized a "Child-Raising Festival" as a commissioned Project of Saitama Prefecture City, with support from students of Saitama Prefectural University. Physical training instructors from the university offered local kids health promotion classes at a nursery, which helped raise their interest in working in the health care sector in the future.

As regards network building, Saitama members plan and organize community exchange programmes (e.g., "Anshin Room activities"). Normally they hold tea parties either in members' houses or in public or cooperative facilities. At these parties, members were able to take part in homemade cooking sessions, handicraft workshops, singing performances and games, etc. Like health promotion activities, these events too are open to everyone free of charge or for a nominal fee ($3.00-5.00 USD). So far, members of 65 Saitama branches have organized events at 86 different locations.

Through planning and organizing events by themselves, Saitama members have grown more motivated to participate in civil affairs not just in their co-ops but in their local communities. For example, they have engaged in activities based on the World Health Organization's concept of Age-Friendly Cities. They also lobby local governments with residents' opinions about how to make an area a better place to live. With the success of these activities, Saitama has witnessed a rise in its participant numbers. For Kenko Hiroba and Anshin Room activities, the number of participants has increased from 5,700 to 7,000 per month, and from 900 to 1,400 per month, respectively.

SOCIAL COOPERATIVES

No specific legal framework has been designated for Japan's social cooperatives. Nevertheless, a wide range of cooperatives provide social services under the LTCI system: consumer, health, senior citizen, Koseiren, agricultural, small- and medium-sized enterprise (SME), fishery, and so on. Of these, the first three are incorporated under the Consumer Co-operative Law; agricultural co-ops and Koseiren are regulated under the Agricultural Co-operative Law; and fishery co-ops by the Fishery Co-operative Law. In the absence of a legal framework for worker cooperatives, the latter are often registered under the SME Co-operative Law or the NPO Law.[28]

Together those various kinds of cooperative play a significant role in the provision of social services. As one source indicates,

> "consumer co-operatives started members' mutual help groups to provide domiciliary services in the 1980s and later entered the LTCI business. Agricultural co-operatives offered training for members' wives to become in-home caregivers to provide services [...]. Health co-operatives became largely involved in both in-home and in-facility elderly care services as a natural extension of health services in hospitals and clinics. Care workers have formed worker co-operatives to provide mainly in-home services, while self-help groups are organized to provide work places and residences for the handicapped."[29]

In 2005, there were 881 cooperatives providing home help services, 586 offering in-home care planning, 363 operating visiting nurse stations, 214 providing daycare services, and 218 engaged in leasing equipment for daily use by seniors.[30]

Note that Koseiren and consumer cooperatives were encouraged to enter the welfare business under the LTCI scheme because both had already mobilized a high percentage of rural and urban women to provide services as care workers.[31]In 1999, the Ministry of Health, Welfare and Labor issued an administrative notice to allow consumer cooperatives to do business with non-members in the elder care service sector. When the LTCI law took effect in 2000, 40 out of 160 consumer cooperatives started welfare businesses, already having been involved in home help services, in-home care planning, daycare services, and the like.[32]

Health and welfare cooperatives provide social services not only in-home and in-facility "as a natural extension of health services in hospitals and clinics," but also in the form of mutual help in the community. For example, they organize retired teachers as cooperative members to teach children in the community on a voluntary basis. They also provide transportation and shopping assistance to those living far from supermarkets. Finally, after the 2011Fukushima disaster, HeW Co-op Japan engaged in recovery and reconstruction activities. Besides medical supports, health co-operative members provided recreation opportunities to children who were forbidden to play outside for fear of exposure to radioactive materials.

This study uncovered data for neither health mutual organizations nor pharmacy cooperatives in Japan.

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