‘Co-producer’ or Passive Beneficiary?

Findings from a Survey of Cooperative Health and Eldercare in Japan

Yayoi Saito, Osaka University (Japan)
ysaito@hus.osaka-u.ac.jp

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Abstract

Today many countries that are attempting to cope with an ‘aging society’ have developed different approaches designed to involve citizens and service users in providing services. Sometimes citizens are expected to influence the service design and/or quality and sometimes they are expected to function as unpaid workers who can indirectly contribute to the budget.

This paper is based on the idea that service users and citizens can play a more active part in the provision of their own health care and eldercare services. Three key concepts are discussed in this paper: co-production, multi-stakeholder dialog and governance. The concept of co-production was originally developed by Elinor Ostrom during the 1970s to describe and delimit the involvement of ordinary citizens in the production of public services (Ostrom 1999). Recently there has been a renewed interest in the study of co-production (Pestoff 2019, Alford 2009, Pestoff et al 2011, OECD 2011). Co-production can achieve better quality services and/or result in the provision of more services than is possible without citizen or user participation.

Japan has a unique type of health care provider, which is ‘user-owned’ health care and eldercare cooperatives. They have nearly 60,000 hospital beds (5% of total hospital beds in Japan) and they also manage 3% of total eldercare services. Not only staffs but also service users and volunteers have a means to express their opinions and voice in ‘user-owned’ health and eldercare cooperatives. And they know that their voices are being reflected in their services.

This paper make it clear the contributions when professionals, patients/users, and volunteers act as ‘partners’ or ‘collaborator’ and where these stakeholders co-produce the service through their mutual contributions.

This paper treats a part of results of the Survey of Japanese Health Care Cooperatives with Prof. Victor Pestoff (Ersta Sköndal University College, Sweden), which was conducted in 2016 and 2017. The empirical materials stem from questionnaire data collected from the staffs, service users and volunteers at health care and eldercare cooperatives and public hospitals. The staff samples from the 10 organizations (8 cooperatives and 2 public hospitals) reaches a total of 6,859, for a response rate of 72.1%. The user samples reaches 631 and the volunteer’s samples reached 236 from 4 cooperatives. The analytical model is comprised of three pillars: 1) the national and regional institutional and environmental conditions for provider, 2) each provider’s organizational setting, 3) the intervening variables for closer scrutiny.

The results from the analysis show that user’s satisfactions are higher in providers that have better the work environment and more a multi-stakeholder dialog between the staffs and clients. Providers that promote a multi-stakeholder dialog between the staffs, users and volunteers can also facilitate better service quality. Their social values which they produce are reflected in their governance model and relations between the staff, patients and volunteers. Users and volunteers can be ‘co-producer’ for better service, and they also might become passive beneficiary on the circumstances.

Key Words: cooperatives, health care, eldercare, volunteer, user, professionals, “Community-based integrated care system” in Japan, co-production, co-producer

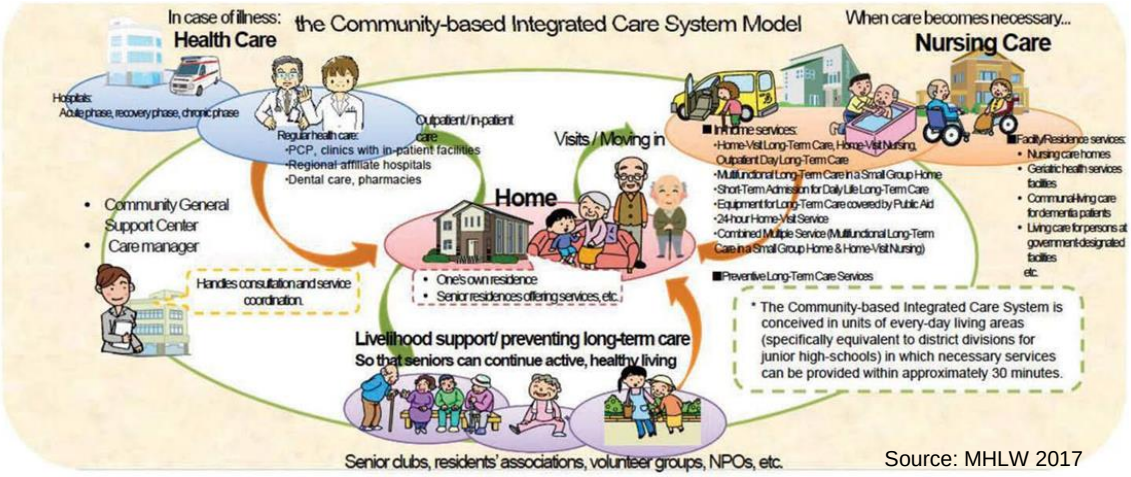
1. Introduction: ‘Community-based Integrated Care System’’?

Introduced in 2000, the Long-term Care Insurance (LTCI) system had a goal of providing high-quality care service that would allow the elderly to continue living in a familiar environment in safe even when care becomes a necessity. Home care services provided by the LTCI system was thought to improve the quality of care service because the elderly could freely select the appropriate service because commercial companies (newly authorized to enter the market), cooperatives, NPOs, etc., were competing in the

service market with business operators such as social welfare corporations (authorized by the Ministry of Health, Labour and Welfare).

Japanese government wants to establish a “community-based integrated care system” (*Chiki Houkatsu Kea Shisutemu*) based on the LTCI system and integrate it throughout Japan until 2025. It is expected that public spending for medicine and elder care will peak in 2025 because about 6.5 million baby boomers will turn 75 or older in 2025, constituting one-fifth of Japan's total population. Figure 1 shows a model of “the community-based integrated care system”. This system is designed for those elderly persons who require care, are living at home or in housing for the elderly with home-care services provided, receive medical service during times of illness, receive nursing care service when required, and get everyday life support or care prevention activity provided by senior citizen clubs, resident organizations, or volunteer groups in the area. In addition, the system is implemented in a small local district (i.e., junior high school area), functioning in areas where a needed service can be delivered within 30 minutes. This concept has been in effect since around 2011; in 2017, new legislation enhanced the system implementation.

One of major features of “the community-based integrated care system” is resident participation in their local area .The system expects active volunteers’ work. In this system local people might be serve users, but on the other hand they are also expected to be care providers, engage in prevention activities and to contribute small practical work (like cleaning and shopping) as volunteers. However, if the care service infrastructure is not completed, resident participation may be used to fill the gap in insufficient services. In Japan, the cooperative health care service and the cooperative eldercare service has been based on the idea of resident participation and has been built up by professionals and local residents. These health care and eldercare networks have been built up over the years through a bottom-up approach; the service operations are funded by the health care insurance system and the LTCI system. If funding is required to launch a new business, members often raise the funds through their own efforts.



<Figure 1> “community-based integrated care system”

A purpose of this paper is to be clear the reason that citizen (service users and volunteers) are active in “community-based integrated care system” managed by the cooperative health and elderly care. This paper tries to show that integrated care system provided by health care and elderly care cooperatives has been developing differently from the government plan. Results of the survey on health and elderly care cooperatives explain us their characters and differences.

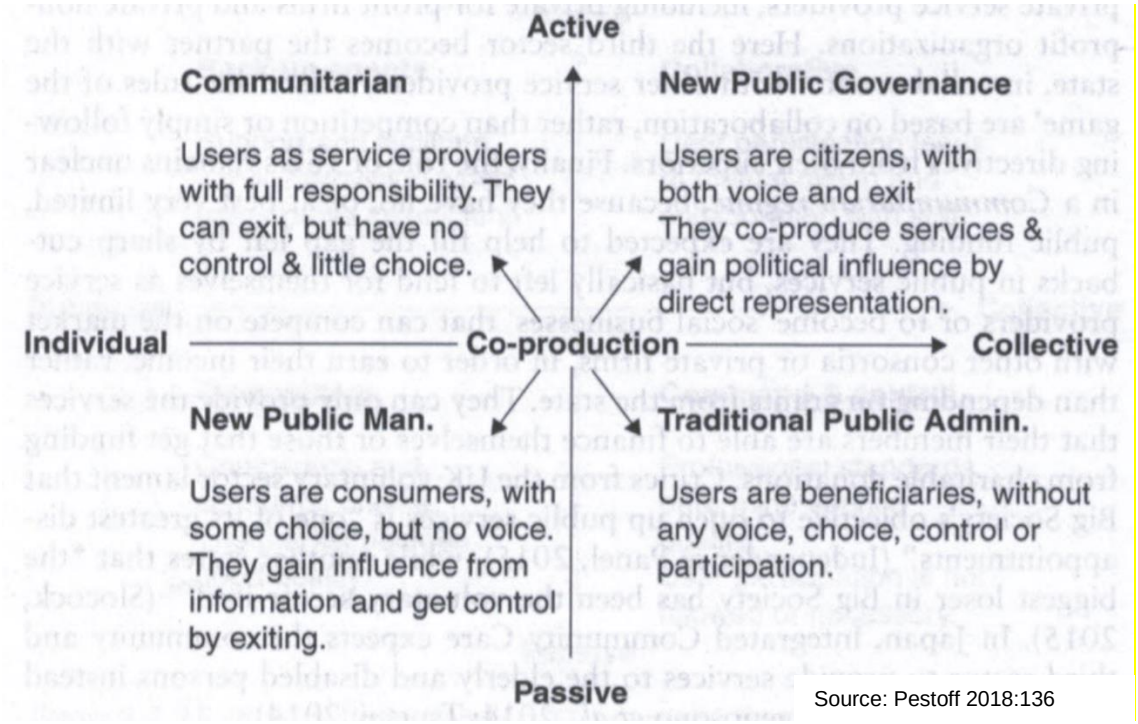
2. Volunteers and Users are ‘enforced’ service providers?

(1) Co-Production at the Crossroads

The concept of “co-production” has been discussed since the 1970s by Elinor Ostrom, et al., and has been inherited by the field of civil society research or third sector research. Service quality can be improved by pointing out the bureaucratism seen in public service and by users who participate in the production process of public service. “Co-production” means cooperative work by which public service providers, users and citizens contribute to the provision of public services.

Victor Pestoff conducted a study in the 1990s on the users of public childcare and cooperative childcare in Sweden and verified that the satisfaction level of users at cooperative childcare was high (Pestoff 1998). Pestoff pointed out the reason for this high level was that parents were involved in so many ways in the childcare in cooperative organizations; the childcare service was co-produced (*ibid.*).

In recent years, “co-production”, which is different from its primary meaning, has been used in many scenarios. To be clear differences of them, Pestoff (2018) describes the public administration regime (PAR) by categorizing it into four types: traditional public administration, new public management, new public governance and communitarian (Figure 2) (Pestoff 2018:130). *The traditional public administration regime* assumes that everyone will be equally treated and public service will be provided by public servants. The service quality is determined by bureaucratic standards and the policies made by professionals are emphasized (*ibid.*130-131). *The new public management regime* is based on the public choice theory and pursues efficiency and lower cost to provide public service. This concept manifests against a background of criticism for inefficiency of the traditional public administration, promotes commercialization of public service and tries to increase the productivity of the public sector (*ibid.*131). *The new public governance* is based on the network theory and shares the responsibility of public service provision among various actors. The root of this concept is the participatory democracy or neo-corporatism. A public service is operated through a network or partnership and third sector and social enterprise play critical roles. A citizen is defined as a co-producer of public service (*ibid.*). The theories *the communitarian regime* is based on are a mixture of theories: market and community, volunteer, and charity. Citizens are responsible to produce the services they need. Because service provision takes many shapes and ways, it is difficult to continuously provide high-quality service (*ibid.*).



Source: Pestoff 2018:136

<Figure 2> Co-Production at the Crossroads

Pestoff indicates also the role played by citizen/users and the professional staff (Table 1). New Public Governance is based on ideas of establishing a partnership between citizens and the government, where citizens are considered co-producers of public services (Pestoff 2018:133). And New Public Governance emphasizes collaboration and negotiation between partners, regardless of whether public, private, or nonprofit. User participation and mutual dialog between service users and the staff replaces professionalism or competition as the main guarantee of service quality (*ibid.* 135).

<Table 1> The Role of Citizens and Professionals in Different Public Administration Regime

	Citizens as Users	Professionals
New Public Governance	*Co-producer* Voice and exit. Participation. Political influence. Representation.	*Collaborative* User participation leads to mutual dialog and collaboration with staff.
Communitarian	*Service Provider* Full responsibility for their own service provision. Some exit, but no control and little choice.	*Back-up agents* Support and facilitate service provision when user prove insufficient.
New Public Management	*Consumer* Choice without voice. Search for information. Control through exit.	*Competitive* Competition and consumer choice. The market decides good quality.
Traditional Public Administration	*Beneficiary* No voice. No choice. No control. No participation.	*Command & Control* Professional standards determine service quality. User participation is not allowed or necessary.

Source: Pestoff 2018

(2) Is a "Community-based Integrated Care System'' communitarian regime?

Japan's "community-based integrated care system" be defined as a communitarian regime? That is, is it emphasizing that family, community or NPOs should be filling the gap created by a large reduction in the public service budget?

As the population aging rate increases, the budget for the LTCI system continues to increase. When the system was implemented in 2000, the budget scale for nursing care insurance was 3.6 trillion yen; in 2017, it reached 10.7 trillion yen, a threefold rise. For user's, however, the service provision did not increase. Figure 3 shows the rate of users of nursing care service provided for those older than 80 by the LTCI system. The usage rate for the "home help" service increased until 2006 but has declined since then. The usage rate for facilities remained unchanged until 2005 but has been decreasing since then (Saito 2018).

It is expected that these usage rates will decrease further. For those elderly who need low amount of service ("home help service for prevention" or "day service for prevention) had been receiving this in the past. But in 2015, the LTCI system terminated direct provision of these services, and they were integrated into a community support system, through which the respective local government provides those services. A community support system is a service partially funded by the LTCI but there is a push to replace it with initiatives carried out by volunteers or resident organizations. From the user's perspective, insurance premiums are going up every three years but service provision are not being increased (*ibid.*).

There is not so much favorable or critical discussion in Japan regarding "the community-based integrated care system", despite the fact that many people are interested in it. However, there has been some discussion related to "...some disparity that may be created among municipalities who are enthusiastic or not so enthusiastic in their efforts or among areas where civil movement is active or not so active" (MURC 2017). Other discussion had focused on a trend to entrust life support services for people with a low- level care need to volunteers or resident organizations. The plausibility of entrusting this to volunteers or resident organizations is being questioned and whether the trend is going against the principle of care prevention. A private think tank conducted a survey of municipalities in Japan to help identify those issues manifested when they implemented a "community-based integrated care system" with research fund of the Ministry of Health, Labour and Welfare. According to the results, about 70% pointed challenges such as "we do not know method which give motivation to residents" and "it is quite difficult to work as coordinator among professionals and organizations" (MURC 2017). They are having difficulty raising residents' motivation. Likewise, according to another survey for the Community General Support Centers (*Chiki Hokatsu Sien Senta*) in Japan (4,905 locations), more than 50% of centers responded that there were too many operations and tasks, and about 40% reported there was not enough manpower (*ibid.*). The Community General Support Center was implemented in every municipality in 2006 and they are expected to work as a hub function of a "community-based integrated care system".

Dahl (2018) pointed out that implementation of a "community-based integrated care system", "self-support" and "mutual support" emphasized by the implementation of the system, and social participation needs are seen as the result of a reduction in public

funding and that the concept of the “responsibility of the Japanese government” should be re-examined, based on his field research in Japan (Dahl 2018:12). Moreover, Dahl cited multiple researchers have shown that Japan's civil society was developed through a national policy of top-down projects (*ibid.*).

As an example of a communitarian regime, Pestoff points out the policy program called “Big Society” implemented by England's coalition government in 2010 (Pestoff 2018). This program seems to have been based on the sense of value of volunteerism, philanthropy, charity, etc., but it emphasizes that family, community or NPOs should fills the gap created by large reductions in the public service budget. This means that citizens are forced to be co-producers. Additionally, Pestoff cites Japan's “community-based integrated care system” as an example of a communitarian regime (*ibid.*135).

3. Cooperatives as health and elderly care provider

(1) Cooperatives as health and elderly care provider

It is common that there are two types of cooperative. A producers' cooperative where a producer (provider) is a member and a consumers' cooperative where the consumer (user) is a member. Although cooperatives comprising medical doctors as producers’ cooperative exist in other countries, the Japanese cooperative is different from them and it is unique because it consists of local residents (users) and professionals (providers) with both parties being capital investors, sharing equal rights, and defined as operators.

There are two different groups of health care and eldercare cooperatives, one is the National Welfare Federation of Agricultural Cooperatives (Koseiren) another is Japanese Health and Welfare Co-operative Federation. Both are cooperatives that provide health care and eldercare, and they are expected to build “community-based integrated care system”. Around 5% of health care service and around 3% of eldercare is provided by these two cooperative organization as third sector organization in Japan.

The idea of cooperative was imported to Japan from Europe at the beginning of 20th century. The first health care cooperative in Japan started in a small village called Aohara-mura (Shimane Prefecture) in 1919 (JA Zenkoren website). The residents in this farming community did not have a doctor and so they opened a clinic by financing and recruiting a doctor (*ibid.*). In Tokyo too, a cooperative clinic was opened and provided health care for those who were poor and in need (*ibid.*). It can be said that the cooperatives’ health care has been focused on providing universal health care for all. Japanese health care system was premised on a free market in 1874. The system was different from European countries where the government has set up health care institutions (Uenoya & Saito 2018).

Koseiren is an organization belonging to the JA (Japan Agricultural Cooperatives) Group and provides health care services in every prefecture in Japan. Koseiren has hospital facilities in 21 prefectures. It operates 110 hospitals, 66 clinics and 32 health care facilities for the elderly throughout Japan, and about 40% of those institutions are located in municipalities with a population less than 50,000. About one-fourth of these are the only hospital in the municipality. Historically speaking and even now, these hospitals have a role as the flagship hospital in rural areas. Koseiren hospitals have total

of 34,460 beds throughout Japan (JA Zenkoren website).

Saku Hospital (Nagano Prefecture) is a hospital operated by JA Nagano Koseiren. It consists of the main hospital, branch hospitals and clinics emphasizing community-based health care. They have a medical center that specializes in acute medical care, a hospital and a health care facilities for the elderly. Saku Hospital, upholding its "Together With Farmers" mission, has contributed for many years to the development of rural medicine. The village-wide health care activity carried out cooperatively by the hospital and residents has become a model of the Japanese physical examination system. In recent years, the hospital has been focusing on end-of-life care, and professionals in the hospital work to support the elderly at home with private clinics in their community (Uenoya & Saito 2018).

In a health and welfare co-op (HeW co-op), local residents and professionals have voting rights and eligibility, constitute the administrative board, operate the facilities, provide the services, and participate in the decision-making process. A total of 108 HeW co-ops are in operation throughout Japan and total of 76 hospitals and 344 clinics (HeW website). The scale of these hospitals is smaller than Koseiren and there are many clinics that provide health care and about half of Hew co-ops don't have a hospital. Instead, many institutions are offering eldercare services (home help, day service) provided by the LTCI system (*ibid.*).

Minami Health Co-op (Nagoya, Aichi Prefecture) has developed 66 businesses; Minami Medical Health Cooperation serves as the core and encompasses clinics, home-nursing care, home help service, group homes for elders with dementia, midwifery homes, etc. This endeavor was based on the experience of the 1959 huge damage of typhoon in Isewan bay area (near Nagoya) that killed about 5,000 people. A small clinic was established by residents who put up their own money. What stands out for this hospital is its "comprehensive resident participation". An annual general assembly meeting establishes the yearly plan and it develops new businesses and acts based on the plan. Residents search for doctors, nurses and other care staff to help overcome particular personnel shortages. Health care and eldercare are operated by the respective social insurance system but the residents raise funds and try to find the location to open a care facility. The hospital also holds frequent meetings with members (local residents) and exchanges opinions about the services they want (*ibid.*).

(2)Governance model of the two Cooperatives:

The form of governance is critical for examining co-op health care providers and co-op nursing care providers. Agency theory, stewardship theory, democratic theory, stakeholder theory, resource dependency theory, and managerial hegemony theory provide perspectives for viewing the form of governance (Spears, et al., 2014). Control and collaboration are elements essential to these theories; a balance of both is needed (*ibid.*).

Two different forms of governance can be found in Japanese cooperative health and elderly care providers: the stewardship model and the democratic model. Under the stewardship model, the manager seeks to provide better services and, in his or her stead as care provider, works to effectively utilize the resources of the organization. As a result, an organization's management and board of directors are seen as partners running the

organization (*ibid.*). The role of the board of directors is, first of all, strategic. It adds value to important decisions and improves the performance of the organization. Members of the board of directors are selected from those with expert organizational knowledge or specialized technical skills (*ibid.*).

In contrast, the democratic model is based on pluralism and the principle of one-person-one-vote. Representatives are chosen from among stakeholders representing different interests and are accountable to members for decisions made. The democratic model's philosophy is seen in the operations of public institutions and non-profit organizations. Under democratic governance, the job of the board of directors is to represent different interests in the organization. As a result, the board of directors' role is to reconcile views between different stakeholders. Members of the board are not strongly required to have expert knowledge or specialized technical skills. The governance model is usually the focus of the relationship between the organization operation and board of directors of a third sector organization.

To study the conditions of cooperative health and elderly care providers in Japan, semi-structured interviews of the CEOs of nine cooperative health care providers were conducted. The results revealed that *Koseiren*'s form of governance is similar to the stewardship model and that health and welfare co-ops' form of governance is similar to the democratic model.

For *Koseiren*, a board of directors is placed at the prefectural level. Members are composed of several municipal JA representatives, hospital directors (doctors), and directors of nursing (nurses) from municipalities in the *Koseiren* service area. For example, the 21-member board of directors of a *Koseiren* in A Prefecture, one of the *Koseiren* surveyed, is composed of 13 management committee members (all municipal JA representatives), five directors (of which two are directors of *Koseiren* hospitals in the prefecture and one is a nursing director in one of the *Koseiren* hospitals), and three auditors.

On the other hand, for HeW co-ops each organization has its own board of directors. Directors are mainly users, drawn from a wide range of stakeholders. For example, of the 35 board members of B HeW co-op, one of the organizations surveyed, 22 were co-op member representatives (user representatives) from local branches, and the rest were composed of administrative staff members (accounting, general administration positions), care managers, hospital directors (doctors), and elder care facility directors. About half of the directors were women.

4. Survey on Cooperative Health and Eldercare

(1) Survey outline

We created a questionnaires for staff, users and volunteers who are important stakeholders in a situation where medical care or nursing care service is provided by Koseiren and Medical Co-op. In August 2016, we surveyed staff, and received the cooperation of eight organizations (Koseiren: 4; Medical Co-op: 4). Staff (including workers of all job types and temporary workers such as part-time) from these organizations were surveyed. Table 2 shows survey outline.

To distribute the survey slips, we sent the questionnaires for the total number of staff to the managers of the respective institutions, requesting them to deliver the questionnaires to their divisions. We adopted a placement method to collect the responses. Eventually, the managers of those institutions collected the responses, which were sealed in blank envelopes, and collectively returned them to the surveyor.

The number of survey slips was 7,520. The number of valid responses were 5,414 samples (Koseiren: 2,562 / Medical Co-op: 2,852). The valid response rate was 72%. Additionally, we conducted the same survey the following year for staff (i.e., control group) at public and private hospitals (medical corporations).

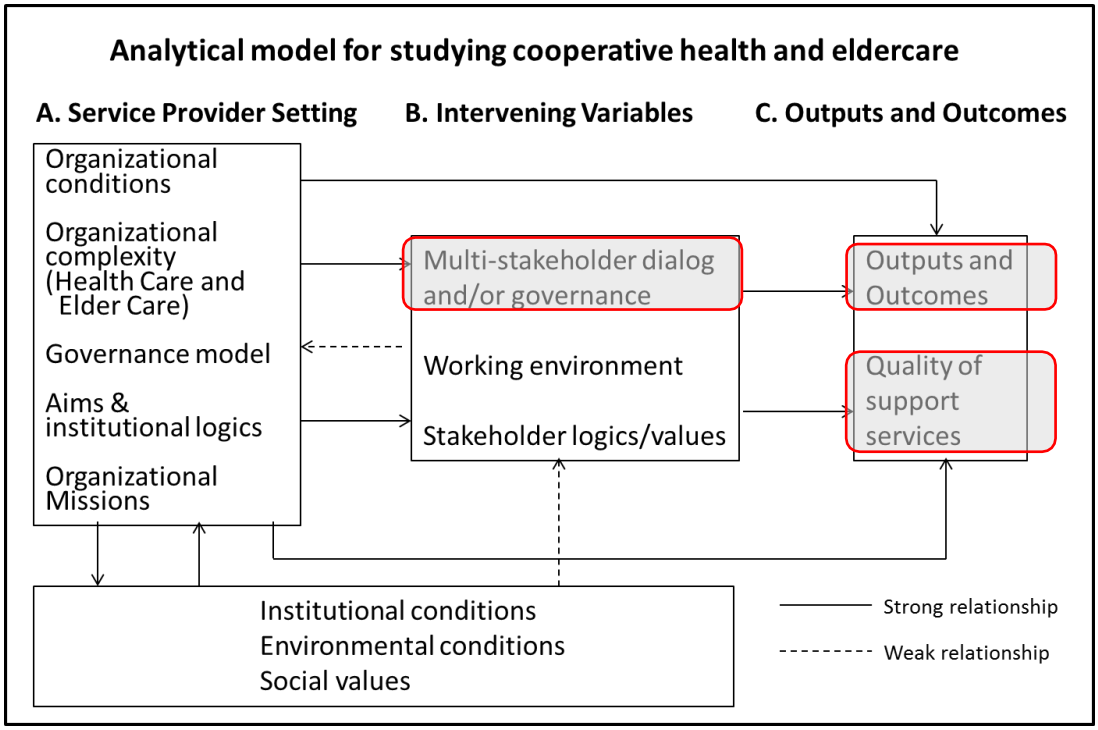
We conducted two surveys on service users and on volunteers in March 2017 by getting cooperation from two Koseiren institutions and two Medical Co-ops selected from among the institutions we surveyed. The survey on users consisted of 631 samples (Koseiren: 114 / Medical Co-op: 517). We sent questionnaires to the institutions to conduct the survey at the hospitals and clinics. We requested them to collect the responses in sealed envelopes. The survey of volunteers consisted of 236 samples (Koseiren: 64 / Medical Co-op: 172). We sent the questionnaires to the target volunteers in each institution to conduct the survey. We requested that they collect the responses in sealed envelopes. These surveys were examined and approved by the Graduate School of Human Science at Osaka University.

We did not conduct a survey on users and volunteers in public and private hospitals. We also did not conduct a survey on medical institutions or eldercare providers of other types of corporations. These are issues for the future.

<Table.2> Institutions cooperating in surveys, surveyed, survey period, no. of valid responses

	Public hospitals	Koseiren	HeW Co-ops	Private hospitals
Staffs	August, 2017 1445 samples	August, 2016 2562 samples	August, 2016 2852 samples	August, 2017 232 samples
Users (patients)	—	March, 2017 114 samples	March, 2017 517 samples	
Volunteers	—	March, 2017 64 samples	March, 2017 172 samples	

Figure 3 shows the analytical model for this survey. In this analysis, we focused on the multi-stakeholder dialog and governance especially for Koseiren and Medical Co-op, and analyzed the relationship among staff, users and volunteers assumed to be “co-producers”. Based on this analysis, we discuss the social value (outcomes) created by these cooperative health care and eldercare services and the quality of these services.



<Figure 3> Analytical model for survey of cooperative health and elderly care

5. Results

This paper focus on "Participation", "Stakeholder dialog" and "Social Value" as outcome.

(1) Participation

Majority of the volunteers in the cooperatives are females (85.6%) and 83.5% of them are 60 years old and over. The frequency of volunteer activities shows that 78.8% of volunteers work regularly. Table 3 shows variation of their participation. "Guide people in the facility" is at the top, "Talk with patients/ users", "Help at events" follows. Table 3 shows also volunteer activities, requiring more leadership, higher skills and higher motivation. "Donated to or invested in projects/activities" is as the top, and the answers of "participate in committee work", "act as a facilitator for local activities" follows. It is unique that 35% of volunteers donate or invest for their better service. When Minami Health Co-op built a new hospital as the center of its activities in 2010, the members (local residents) invested 2 billion yen as a part of total construction cost of 10 billion yen. In addition, when the co-op established a new care facility or community place, the local residents also created a plan by themselves and raised the funds.

Table 4 shows Users' participation. The users of cooperatives also participate (or participated before) in their events and works at the hospital or care facility. More than 60% of users make investments for their service provider's work. The users could be involved, probably as volunteers, in the hospital or care facility before they became service users.

Staffs also participate in their organization's activities. The data is comparable

between cooperatives and public hospitals in our staff survey. Table 5 shows staff's participation in the cooperatives and in the public hospitals. Majority of staffs who works in cooperatives are member of their organization. This is the reason for their higher participation rate.

Health care and eldercare make many kinds opportunities for volunteers, users and staffs to participate in their service.

Table 3. Variation of Participation (%) (Volunteers)

	co-ops	*public*	dif.
Guide people in the facility	36.9	-	-
Talk with patients/ users	35.6	-	-
Help at events (e.g. Health festival)	26.7	-	-
*Donate or invest in projects/ activities at this provider	35.2	-	-
*Participation in committee work	34.0	-	-
*Act as facilitator for local activities (e.g. physical exercise)	30.5	-	-

Q: What do you do here as a volunteer? (multiple answer available)
(* Do/Have you also engage/d in the following activities?)

Table 4. Users Participation (%) (Patients/Users)

	co-ops	*public*	dif.
Make investments and donations	61.1	-	-
Visit Hospital events (e.g. health festival)	47.9	-	-
Community activities (e.g. flea market, physical exercise)	39.3	-	-
Local membership meetings for cooperative members	34.7	-	-
volunteer (e.g. helping out at festivals, distributing newsletters)	29.9	-	-

Q: Do you participate in the activities provided by this provider? ("Often" + "Sometimes")

Table 5. Staffs' Participation with local people (%) (Staffs)

	co-ops	*public*	dif.
Hospital events (e.g. health festival)	57.3	25.3	32.0
Make investments and donations	45.1	5.7	39.4
Community activities (e.g. flea market, physical exercise)	35.1	8.2	26.9
Local membership meetings for cooperative members	22.2	-	-
volunteer (e.g. helping out at festivals, distributing newsletters)	22.5	9.8	12.7

Q: Do you participate in the activities provided by your workplace? ("Often" + "Sometimes")

(2) Stakeholder dialog

Table 6 shows condition of their dialog among stakeholders which was answered by volunteers. Volunteer people talk much with volunteers and patients/ users. Table 7 shows condition of their dialog among stakeholders which was answered by staffs. Compared with the staff of the public hospitals, staffs in cooperatives talk much more with users, volunteers and local community members.

Table 8 shows the way how users express their ideas and opinions. 45.2% of service users try "Talking to professional staff" to express their ideas and opinion for the services. And users has other channels to express them. The users voicing their opinion in committee meeting or in local cooperative members meeting. There is no data of public hospitals, however there could be no alternative to express their opinions and ideas in public hospitals. Almost all users except 3% of users have way to express their idea.

Table 6. Stakeholder dialog (%) (Volunteer)

	co-ops	*public*	dif.
Patients/ Users	60.0	-	-
Volunteers	80.1	-	-
co-op members	43.2	-	-
professional staff (e.g. doctors, nurses)	26.7	-	-

Q: How much do you talk about issues relating to this provider with the following people? ("Very much" + "Much")

Table 7. Stakeholder dialog (%) (Staffs)

	co-ops	*public*	dif.
Patients/ Users	61.6	50.9	10.7
Volunteers	25.6	15.2	10.4
Other healthcare and eldercare service providers	33.8	31.4	2.4
Local community members (e.g. neighborhood association)	15.3	7.8	7.5
Local government officials	7.3	6.1	1.2

Q: How much do you talk about issues relating to this provider with the following people?("Very much" + "Much")

Table 8. Way of expressing ideas and opinion (%) (Patient/ Users)

	co-ops	*public*	dif.
Talking to professional staff (e.g. doctors, nurses)	45.2	-	-
Voicing opinion in committee meetings	21.9	-	-
Voicing opinion in local cooperative member meetings	18.5	-	-
No way to communicate opinions	3.0	-	-

Q: How do you express your opinions/ ideas about the service provided here? (multiple answer available)

(3) Social contribution and service quality

Table 9 shows the outcomes of the service produce which volunteers and patients/ users chose. More than half of the respondents are agree that the organization “Promote patients and users participation in health promotion” and “Engages in preventive health/ elderly care”. It means that the cooperatives works not only for provision of services but also for prevention and health promotion.

Table10 shows the outcome of the service produce which staffs chose. The response is comparable between the cooperatives and the public hospitals. The score of “Health promotion”, “prevention”, promotion of “Community-based integrated care” is much higher in the cooperatives than the public hospitals.

The survey asked the volunteers and patients/ users to service quality. Some kinds of questionnaire to ask service quality in the survey. Here Table 11 shows the response to the question of “Would you recommend service of this provider to your friends and acquaintances?”. Around 70% of volunteers and patients/ users gave positive answers.

Table 9. Social Contributions (%) (Volunteers & Patients/ Users)

	volunteer	*user*
Promotes patients and user participation in health promotion	65.2	61.0
Engages in preventive health/elderly care	55.2	57.9
Promotes "Community-based Integrated Care"	35.7	33.1

Q: Please choose up to 3 of the below which best describes this provider.

Table 10. Social contribution (%) (Staffs)

	co-ops	*public*	dif.
Promotes patients and user participation in health promotion	50.4	26.7	23.7
Promotes "Community-based Integrated Care"	48.8	38.5	10.3
Engages in preventive health/elderly care	42.3	21.6	20.7
Promotes local development	18.8	11.4	7.4
Provide health and elderly care to uninsured patients	13.0	9.3	3.7

Q: Please choose up to 3 of the below which best describes your workplace.

Table 11. Service Quality(%) (Volunteers & Patients/Users)

	volunteer	*user*
Would you recommend service of this provider to your friends and acquaintances? ("Agree" + "Somewhat Agree")	74.2	68.8

6. Conclusion

The purpose of this paper is to be clear the reason that citizen (service users and volunteers) are active in “community-based integrated care system” managed by the cooperative health and eldercare.

For the overall “community-based integrated care system”, 70% of municipalities pointed several challenges such as “they do not know method how they encourage and motivate residents to work as volunteer” and “it is quite difficult to coordinate among professionals and organizations”. About half of “the Community General Support Centers” which are expected to be function as a hub for “the community-based integrated care system”, argues financial issues such as “they do not have enough manpower although they have too many operations and tasks”. Majority of Japan's “community-based integrated care system” should be categorized with Pestoff's “communitarian regime”. Role of citizens (volunteer and user/ patients) might be “enforced” housekeeping provider in this regime or users might be passive beneficiary without participation.

However, role of citizens in the cooperatives is quite different. They have several channels to talk their idea and opinion for the provider and professionals. They are active to invest or donate for funding of provider’s health and elderly care work. Many users also feel that their voices are being reflected, and that means that there is a well-established venue where volunteers and users can express their views and ideas. It is also important to note that it is not just about being able to voice their opinions but knowing that their voices are being reflected. Organization of cooperative seems to make Dialog among stakeholders active. Volunteers, users/ patients and professionals talk each other more than public hospitals. And citizens (volunteers and users/patients) are satisfied with service quality of the cooperatives.

The health and elderly care cooperatives could contribute for their community with

some other way. The cooperatives contribute for health promotion and prevention of health and elderly care in their community. They produce not only health and elderly care service, but also another social value. Community-based integrated care system which is created by the cooperatives should be categorize the New Public Governance regime. Citizens are co-producer of health and elderly care and professionals of the cooperatives are collaborative in this regime. Users and volunteers participation leads to mutual dialog and collaboration with staff. If majority of care providers' organization could change their model to democratic model, character of "community-based care system" might be changed from Communitarian to New Public Governance regime. And citizens might be changed to co-producer of high quality service from passive beneficiary.

This research has several challenges. As it was impossible to have users' and volunteers' samples from private (for-profit) and public providers this time, this paper unfortunately could not compare among them. However, their condition is roughly imaged, as these providers are not active to work with volunteers and users. And this research should be care for differences among professionals, physicians, nurses, and care workers for relation with citizens.

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