



Co-production of Health and Elder Care – Cooperative models in Japan

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Abstract: *Health and elder care in most developed countries faces a complex and partly contradictory mix of financial, social and political challenges. Fiscal strains combined with New Public Management agendas have caused severe cutbacks and calls for greater efficiency in public and elder health care, resulting in a growing concern about service quality. The purpose of this project is to explore a possibility to address these issues from a new perspective that emphasizes greater user participation, based on the idea that the patients and clients can play a more active part in the provision of their own care services. This project proposes to explore how health and elder care services can be provided when professionals and patients/clients act as ‘partners’ and where the two parties co-produce the service through their mutual contributions. Institutions that promote a multi-stakeholder dialog between the staff and clients and those that enrich the work environment can also facilitate better service quality.*

Japan has a unique health care system with not just one, but two user-owned cooperative health care providers that also provide elder care to their members. Together, these two co-op health care systems have nearly 50,000 hospital beds (or about 5 % of total beds). However, they probably differ from each other and from public hospitals and ‘nonprofit’ hospitals or Medical Corporations (Iryo hojin) in terms of the social values they promote. Their social values will be reflected in their governance model, their relations with the staff and the relations between the staff, the patients and volunteers. This project aims to collect unique empirical data from patients, medical professionals and volunteers at nine different cooperative hospitals across Japan and compare it with similar data from two public or nonprofit hospitals. It will produce an extensive and rich material describing how the health care cooperatives in Japan organize their care according to the principle of co-production, but also in which kind of organizational setting this is possible.

Keywords: co-production, cooperative health care, stakeholders, Japan, social values

A. Background

Both health and elder care in Europe and most other developed countries are now facing a complex and partly contradictory mix of challenges. Fiscal strains combined with a New Public Management agenda have caused cutbacks and calls for improved efficiency in publically funded health and elder care. This development is a significant contributor to the growing concern about service quality in health and elder care while other developments such as increased demand due to an aging population and an increased level of individualization of services also add to the mix. The proposed solutions to these challenges in European health and elder care help to illustrate the severity of the problems. One solution suggested by market proponents is to further increase efficiency so that the existing resources can cover more care with better quality. The problem with this solution is that many European countries already have some of the most streamlined health and elder care sectors in the world and that there is probably a limit to how ‘efficient’ you can make health and elder care services while maintaining acceptable service quality levels. Another possible solution would be to increase public funding, but most European countries already have the highest taxes in the world. Thus,

given these alternatives, a key issue for future health and elder care in Europe is to find a way to provide high quality services to a greater number of patients at an acceptable cost.

A different kind of solution is found in the growing interest in and practice of public participation in health and elder care. A decade ago the World Health Organization (WHO) maintained that there were basically three ways or mechanisms to channel public participation in health care governance: ‘choice’, ‘voice’ and ‘representation’. Choice mostly applies to individual decisions in selecting insurance, providers and/or services. Voice tends to be exercised at the group or collective level for expressing public or group views. Representation implies a formal, regulated and often obligatory role in the process of health care governance (2005). Calls for greater public participation in the National Health Service (NHS) were recently reflected in the United Kingdom. Hudson argued that public and patient engagement in health care is ‘an idea whose time has come’ (2014), while the Office of Public Management states that ‘co-production is the new paradigm for effective health and social care’ (Alakeson, *et al.*, 2013). Some would argue that co-production can combine choice, voice and representation, by actively engaging citizens in the provision of public financed welfare services (Pestoff, 2009), including health and elder care (Pestoff, 2008).

B. Previous research

Nobel Laureate Elinor Ostrom and her colleagues analyzed the role of citizens in the provision of public services in terms of co-production (Parks *et al.*, 1981 & 1999). The concept of co-production was originally developed by Ostrom and the Workshop in Political Theory and Policy Analysis at Indiana University during the 1970s to describe and delimit the involvement of ordinary citizens in the production of public services (Ostrom, 1999). They struggled with the dominant theories of urban governance, whose underlying policies recommended massive centralization of public services, but they found no support for claims of the benefits of large bureaucracies. They also realized that the production of services, in contrast to goods, was difficult without the active participation of those persons receiving the service (*ibid.*). Co-production is, therefore, noted by “the mix of activities that both public service agents and citizens contribute to the provision of public services. The former are involved as professionals or ‘regular producers’, while ‘citizen production’ is based on voluntary efforts of individuals or groups to enhance the quality and/or quantity of services they receive” (Parks, *et al.*, 1981 & 1999).

Co-production can achieve better quality services and/or result in the provision of more services, often at a lower price, than is possible without citizen participation. Recently there has been a renewed interest in the study of co-production, as seen in the notable increase of

academic conferences that include or focus on co-production, and in the number of books recently published on this topic (Pestoff & Brandsen, 2006 & 2009; Alford, 2009; Pestoff, et al., 2012; OECD, 2012) as well as over one hundred journal articles recently devoted to co-production in major journals on public administration and management (Voorberg, *et al.*, 2014). This research shows that co-production can take place in a variety of different fields and contexts, ranging from local safety and police activities (Parks, *et al.*, 1981 & 1999; Meijer, 2012; Freise, 2012.); childcare (Pestoff, 1998, 2008; Prentice, 2006; Vamstad, 2007; Vancoppenolle & Verschuere, 2012); basic education (Davis & Ostrom, 1991; Porter, 2012); housing (Brandsen & Helderma, 2012); urban regeneration (Schlappa, 2012), etc. However, to date little has been written about co-production in health or elder care or about greater citizen participation in their own care.

C. The research problem

The purpose of this project is to explore the possibility to address the challenges facing health and elder care in OECD countries from the perspective of greater user participation, based on the idea that the patients and clients can take a more active part in the provision of their own health and elder care services. This may result in high quality services without adding to the costs for the public sector, or perhaps even reducing these costs. Health care, for example, is a highly professionalized service sector and most health care services are provided by advanced medical professionals without much involvement from the patients, their relatives or volunteers. The theory to be tested by this project is that a significant part of the health care services can be provided with professionals and patients as “partners in a continuing process of inquiry” Fotaki (2009, 2011), where the two parties co-produce the service by mutual contributions of information and treatment. This partnership can take many forms and it naturally needs to be fitted to the individual patient’s needs and abilities, but the general idea is that the information asymmetry between the professional and the patient can decrease through their communication and joint efforts to improve the health of the patient. This is done in equal measure by the professional teaching the patient about the health issue and the patient returning detailed and operable data on his or her condition as well as an informed opinion of what ought to be done about it. The ideal outcome of this interaction is better, more individualized care, active and more satisfied patients and a better use of existing resources or additional resources in terms of patient input. The patient input can vary in form and both be limited to providing information or be extended to taking responsibility for simple self-tests and journal keeping.

Vamstad (2014) argues that there are two potential paths to high quality individual social services at an acceptable societal cost: quasi-markets and co-production. Innumerable volumes

have been written about the advantages and disadvantages of quasi-markets, as well as their costs and benefits. By contrast, co-production is a lesser known alternative for achieving similar important social goals. In England the NHS has recently promoted various pilot projects related to the co-production of health and social care (Alakeson, *et al.*, 2013). These projects seek to unite the ‘lived experience of individuals with the learned expertise of professionals to improve health and well-being’ (*ibid.*). The NHS’s focus is on encouraging greater public participation at the individual level, where individuals and professionals work together to reach decisions and achieve improved outcomes. However, co-production also takes place at the group or collective level (Hudson, 2012). Individual co-production promotes customized and personalized services, while collective co-production emphasizes collaboration and collective participation in health care. The professional-patient cooperation can also be supplemented by increased interaction between patient self-help groups and professional providers, like those for persons with HIV/AIDS (Walden-Laing & Pestoff, 1997), diabetes (Söderholm Werkö, 2008); or persons suffering from a variety of other social, physical or mental problems (Karlsson, 2002). However, Pestoff argues that many of the activities provided by citizens are a mix of their individual and collective efforts (2012).

Thus, co-production is gaining recognition as a mediator of important social values, in particular for giving clients or users of public financed services more choice and a greater voice in determining the nature and quality of essential services that they depend on in their daily lives. It can also promote direct patient/client representation in health and elder care under certain conditions. Moreover, numerous studies show that user-owned services provide clients or users with more insights into and control of these essential services. User or client owned services are often organized as third sector organizations or co-operatives, in countries where legal structures permit. For example, research on alternative childcare in several European countries emphasized the importance of cooperatives in promoting user control that resulted in better informed users, more satisfied users, greater user influence, more dialogue between users and service providers, as well as more satisfied staff, greater staff influence, and better service quality according to both the users and staff (Pestoff, 2009; Vamstad, 2007 & 2012).

D. Further theoretical considerations

Two additional theoretical considerations are important for the development and design of the current project. They concern the existence of institutions that can promote a multi-stakeholder dialog or governance and institutions that can enrich the work environment. Both these institutions are expected to have a major positive impact of service quality.

1. Institutions promoting a dialog between the staff and clients

Vidal explores how multi-stakeholder techniques can promote cooperation between key stakeholders providing public services, in particular the collaboration between the professional providers and users of public services (2013). Their cooperation is both voluntary and it lasts over a period of time. She argues that a multi-stakeholder dialog and multi-stakeholder governance are two techniques that can help promote cooperation and a strategic partnership between them (*ibid.*). The concept of multi-stakeholder governance assumes that an organization's decision-making bodies include different stakeholders. So, they must engage in a dialog with each other and reach a compromise on many issues in order to survive and fulfill their expectations. This will result in an organization that does not promote the expectation of a single stakeholder, but rather one that defends various stakeholders' interests (*ibid.*). This is particularly important in the provision of social services, since users or clients are locked-in to such services, often for the life of the service from the user's perspective.

Multi-stakeholder governance implies a system of formal representation that provides both a voice and vote to all major stakeholders, while a multi-stakeholder dialog insures informal representation and a voice, but not necessarily a vote to all major stakeholders (*ibid.*). For example, in most parent co-op preschools in Sweden, the teachers attend the board meetings, they have a say, but not a vote on important issues. Parents do, of course, listen closely to the staff and weigh their arguments carefully before deciding. Vamstad shows that parent cooperative preschool services in Sweden promote a dialog between the parents and teachers that leads to higher quality services than those available in the public sector (2012). However, in traditional public preschool services there is little dialog or collaboration between the parents and staff. Parents can, of course, make spontaneous, ad hoc suggestions for activities and contribute to the Christmas or Spring Party, but little else.

In addition to promoting a dialog between the staff and clients, both these techniques can also help to avoid some of the negative consequences of asymmetric information and power relations between providers and users of social services. Asymmetric information stifles communication between users and producers of services, or between the parents and teachers of preschool services. The lack of information also results in frustration among service users and inefficiencies. One classical way to reduce such inefficiencies would be for clients to use their exit option (Vidal, 2013). But, as already noted, exit is not feasible in many social services. Thus, in the absence of exit, voice becomes a more realistic or at least a second best option. If the main stakeholders involved in the provision of a social service can be brought together and they enter into a continuous and systematic dialog with each other about issues important for all of them, then steps can be taken to alleviate the asymmetric information and power relations

between them, at least in part. (*ibid.*).

A closer look at Vamstad's comparative study of parent co-op and municipal preschool services in Sweden helps shed more light on this topic (2007 & 2012). He shows that parents in parent co-ops felt much more informed about the activities and operation of their preschool than parents in municipal services. Nearly three-fourths of parents in parent co-ops claimed “much” or “very much” insight into the activities, while barely one-quarter of parents in municipal services did so (*ibid.*). Moreover, concerning the asymmetry of power, his study also shows that nearly nine-tenths of the parents claim that they have “much” or “very much” influence in parent co-ops, while less than half of the parents do so in municipal services (*ibid.*). These differences even hold for the staff. Nearly three-fifths of the staff in parent co-ops make a similar claim to having much influence, while barely one-third of the staff do so in municipal services. Moreover, more than one-third of the parents and nearly three of five staff members in municipal services claim they want more influence, while barely one-eighth of parents and notably less than one-fifth and staff do so in parent co-ops (*ibid.*). Thus, the high level of communications that characterize parent co-ops facilitates reaching a mutual understanding of diverse problems, ranging from service quality to work environment, and also allows for such problems being addressed swiftly and in close collaboration between the parents and staff (*ibid.*).

2. Institutions that enrich the work environment

Elsewhere, Pestoff & Vamstad (2014) explored the potential contribution of social enterprises to enriching work environment and their ability to provide “good work”. The theoretical inspiration for these two studies was the Karasek/Thorell demand/control model of work environment (1990). The empirical data was taken from two separate studies of work environment at Swedish childcare facilities, one from 1994-95 and another more than a decade later from 2006-07. The article shows that work environment conditions in the public sector deteriorated radically in Sweden about 20 years ago and that these effects are still apparent today in public service. However, the empirical part of their study demonstrated that social enterprises in Sweden provided good jobs in the fullest meaning of the word and continues to do so today. In Karasek and Theorell's terms, work in social enterprises is psychologically demanding, but it provides high decision latitude, and high social support for the workers. These work life attributes stand in sharp contrast with those found in the services provided by the large hierarchical bureaucratic organizations often associated with the public sector services in Sweden. In this sense the social enterprise model cannot only help to transform social services jobs into active, participative and interactive jobs. It can also help to enrich the work life of

employees. They argue that enriching the work environment can make a major contribution to improving the quality of the services an organization provides for its clients and/or members.

E. Cooperative Health and Elder Care in Japan

Health and elder care are financed by mandatory insurance in Japan, while they are financed by taxes in most European countries. There are very few examples of user owned and controlled health and elder care services in Europe. By contrast, Japan has a unique health care system with not just one, but two different user-owned health care providers, according to the United Nations global survey (1997). They are the Agricultural Co-ops or *Koseiren* in rural areas and the Medical Co-ops¹ in major urban areas. Both the consumer co-ops and the agricultural co-ops (Japan Agriculture, JA) run full scale hospitals in Japan that have already addressed many of the challenges facing European and other health care providers today and, to an even greater extent, in the near future. These cooperative hospitals have a total of about 50,000 beds, which by far exceeds the total number of hospital beds in Sweden, where there are less than 30,000 beds found in all types of hospitals². These cooperative hospitals are nevertheless a marginal phenomenon in Japan and little is therefore known or documented about their impact on user involvement and service quality.

Kurimoto (2010, 2015) provides a historical and societal context to the cooperative health care sector in Japan, with special focus on co-production as a possible strategy for more patient oriented care. He concludes that “medical co-ops offer a unique experience combining user’s participation and professional expertise to reduce problems associated with asymmetric information” (Kurimoto 2007:159). His study also reveals problems related to funding, recruiting professionals and establishing a multi stakeholder arrangement with other actors and institutions at health care cooperatives, but his conclusions are promising.

The national settings clearly provide different contexts for health care in Japan and Europe, but the rationale behind the health care cooperatives in Japan shows that the health care sectors in many countries face some of the same challenges. Cooperative hospitals in Japan have developed and prospered as an alternative in spite of universal coverage in a publically funded health care system primarily for following reasons. First, through a nearly 70 year public private partnership (PPP) between the agricultural co-ops (JA) and state, JA or *Koseiren* provides health care services in rural areas where no public health care services were/are available. However,

¹ The term ‘medical co-ops’ will be used throughout to denote the consumer co-op health and elder care services.

² The number of hospital beds per 1,000 inhabitants is 13.6 in Japan, and the average length of hospitalization is 17.9 days. By contrast, in Sweden, the number of beds per 1,000 inhabitants is only 2.73, and the average length of hospitalization is 5.5 days.

JA members collectively “own” these agricultural health care services and can, therefore, influence them more directly as members of JA than ordinary citizens can influence the public services. Second, the medical co-ops can offer higher quality services and the added value of patient insight and influence through co-production in the major urban areas (Kurimoto, 2004: 136-137). Thus, cooperative health care and cooperative hospitals are, in other words, not merely a low-cost alternative, but rather they provide a unique type of health care, including a heavy emphasis on preventive medicine. They have managed to survive, grow and thrive in a health care system that otherwise is not all that different from the publically funded, universal health care system in Scandinavia and elsewhere in Europe.

These two user-owned health care facilities will be compared with each other and with public and non-profit providers of health care in Japan, allowing us to identify and isolate the factors that facilitate active patient co-production in their own health and elder care. This project aims to collect unique empirical data from both patients, volunteers and medical professionals at a total of nine different cooperative hospitals across Japan and then compare it with similar data from two public or Medical Corporations, i.e., ‘nonprofit’ hospitals.

F. Some important methodological considerations

Below we intend to explore the implications of three different approaches to the study of third sector organizations (TSOs) as providers of health care and elder care. It begins the conceptual discussion by presenting two distinct governance models for TSOs, a stewardship and a democratic model. It continues by discussing the institutional logics of complex organizations and groups or stakeholders within them. It concludes by considering divergent interests in complex multi-stakeholder organizations, like hospitals and eldercare.

1) Governance models

Governance is an important topic for this project on cooperative health and elder care in Japan. Governance of third sector organizations (TSOs) refers to systems and processes concerned with ensuring the overall direction, supervision and accountability of an organization (Cornforth, 2004). Major perspectives on governance include agency theory, stewardship theory, democratic theory, stakeholder theory, resource dependency theory and managerial hegemony theory (Spears, *et al.*, 2014). Both control and collaboration are essential elements of these theories. Accordingly, control helps to overcome human limitations through vigilance and discipline, while collaboration taps individuals’ aspirations via cooperation and empowerment. Yet, there is always a need to balance them (*ibid.*).

The two most central and relevant governance models for studying cooperative health and elder care in Japan are the stewardship model and the democratic model. The stewardship model assumes that managers want to do a good job and will act as effective stewards of an organization's resources, in collaboration with the main stakeholders. As a result senior management and the stakeholders or members of an organization are better seen as partners. The role of the board is primarily strategic: to add value to important decisions and improve organizational performance. Here board members are selected on the basis of their professional expertise, skills and contacts and they should receive proper training. By contrast, the democratic model includes key ideas of open elections on the basis of one member one vote, pluralism, representation of different interests and accountability to its members. Here the board is often recruited from lay members and its main function is to represent the diverse interests of the organization's members. (Cornforth, 2004).

Governance models usually focus on the relationship between the board and top management of a TSO or cooperative, from a business administration perspective. However, employing a more holistic or encompassing approach, based on different academic perspectives, like political science, social work or sociology, would call for broadening the focus considerably. In addition to the board and management, it would also include other major parts of the co-op, and involve most other major stakeholders in our purview, since the CEO and board are certainly not the whole picture. However, the CEO and board provide a natural starting point and they were interviewed with a semi-structured interview schedule in May, 2013. These nine co-op health care providers comprise the Organizational Study of this project. Preliminary results suggest that agricultural co-ops and the *Koseiren* comprise a stewardship model of governance, while the consumer and Medical Co-ops embody a democratic model. However, it is worth noting that these concepts are initially considered heuristic tools and it remains an empirical question how they actually differ in terms of their governance of the whole health care organization and the role of other stakeholders, like the staff, patients and volunteers.

2. Institutional logics in health and elder care

Institutional logics can be defined as 'the belief systems and associated practices that predominate in an organizational field' (Scott, *et al.*; 2000:170) and a given organization. The rapid diffusion of New Public Management (NPM) throughout the OECD countries in the 1990s contributed significantly to the spread of market mechanisms in many areas of public services, and health care was no exception. Van de Broek, *et al.* (2014) note a shift from the dominance of a professional logic to the dominance of a managerial logic through the spread

of market mechanisms in health care. Their study focused on the adoption and implementation of an apparently hybrid practice in a context where multiple logics were at play. Institutional logics can affect decision-making by steering the attention of decision-makers to certain issues and practices consistent with this logic and deflected their attention from other issues.

Health care is a field that is moderately centralized and highly fragmented, so it is likely to experience multiple institutional logics. Moreover, since hospitals have multiple occupations they also need to be able to balance professional and business goals in order to be perceived as legitimate (*ibid.*). Van de Broek, *et al.* (2014) studied the adoption and implementation of a healthcare project in Holland called ‘Productive Ward: Releasing Time To Care’. It was based on a UK model from the NHS. Both business-like (e.g., Productive Ward) and professional logics (e.g., Releasing Time to Care) were represented in this highly specialized Dutch hospital (*ibid.*: 3). However, in complex organizations they note that the users of an innovation, or persons who implement a decision, are not necessarily the same persons who decide to adopt it. So, the staff who implements a decision may promote or subvert the intentions of those who adopted it (*ibid.*).

This is especially true in an organization confronted by multiple logics, particularly if the decision-makers adhere to a different logic than the users of a new practice (*ibid.*: 7). For example, in a health care organization, the decision-makers are often board members, the director and senior managers, who often adhere to a business-like logic, while the users are primarily nurses, who adhere to a professional or caring logic. Their study concluded that these multiple and sometimes conflicting logics can complicate the implementation process and affect the extent of implementation of innovative practices (*ibid.*: 7). Similarly, Choi documented the different institutional logics surrounding the 2004 merger of Karolinska and Huddinge University Hospitals into a new entity (2011). The competing institutional logics between managerialism and professionalism seem to be the main driver of the merger process. So, in highly complex organizations it is important to recognize the contribution of various stakeholder groups to an organization’s output and outcome, and not focus on a single one, in particular not only on the management.

3. A Multi-dimensional & multi-stakeholder framework for analyzing stakeholder interests.

Cucciniello & Nasi evaluated the impact of innovation (e.g., EMR³) in the health care sectors of Spain and Italy (2014). They employed a multi-dimensional and multi-stakeholder method

³ EMR or electronic medical records.

to achieve an assessment of the main stakeholders involved in an innovation process, including their expectations and actual contribution to its implementation. (*ibid.*: 90). They argue that the characteristics of the individuals involved and the process of implementation suggests that different stakeholders have different interests in the implementation process that do not necessarily converge with its goals. They might therefore have the capacity to influence the innovative process (*ibid.*: 95), either positively or negatively. Their framework is related to the main stakeholders influenced by the innovation (e.g., EMR), including the top management and administration, nurses, physicians and patients.

Similar to the previous study, they propose a multi-dimensional & multi-stakeholder framework to measure innovation, one which embeds context and sector-specific impacts. Their findings show that certain organizational arrangements facilitated the adoption of innovation more than others. The degree of user (e.g., doctors & nurses) involvement in the planning and implementation of the project was notably different in both countries. Implementation in the two Italian hospitals was marked by a top-down approach, with no participation by personnel in the process, while the Spanish hospitals adopted a bottom-up approach noted by its participatory process for implementing and managing the EMR system (*ibid.*: 112).

Thus, it seems clear that we should employ a multi-stakeholder perspective in our project on cooperative health and eldercare. So we need to include more than one or two general staff categories in our data collection and we also need to include members/patients, both out-patients and in-patients and volunteers, when and where feasible in our empirical study, in order to encompass all the major stakeholders.

4. Some initial method considerations

Both these studies employed a multi-actor and multi-methods approach to generate a more complete picture of the process under investigation. This implies the use of a combination of quantitative and qualitative methods based on a multi-dimensional, multi-method approach to our subject matter. It will include collecting public and private documents, semi-structured in-depth interviews with the leaders of these hospitals, questionnaires to the staff and patients, focus group discussions, etc. This will facilitate triangulation between data sources, and it will also help to better capture and assess the diverse interests of various stakeholders who may promote different institutional logics inside the highly complex organizations under study. The purpose of choosing to employ this multi-dimensional, multi-method framework is primarily to explore the tensions and ambiguities that exist in hybrid organizations that promote more than

one goal, i.e., rather than maximize their profit or surplus, they attempt to achieve other political, social and cultural goals.

G. The Japanese project plan

The research project will be conducted within the framework of an established cooperation between senior researchers at Ersta Sköndal University College in Stockholm and the Faculty of Human Sciences, Osaka University. The framework consists of an interdisciplinary group of researchers in Sweden, representing both social science and nursing science, a group of social scientists in Japan and, perhaps most important, a network of the relevant cooperative health and elder care providers in Japan. The latter are comprised of four Koseiren hospitals from agricultural co-ops or Japan Agriculture (JA) and five medical co-op hospitals from the Japanese Health and Welfare Co-operative Federation HeW CO-OP JAPAN. The project consists of three parts, a field mapping study or the Organization Study; a pilot study of Saitama Cooperative Hospital, to fine tune our survey instruments; and a main study of the remaining eight cooperative hospitals and two public or nonprofit hospitals that includes a Staff Study, a Patient Study and a Volunteer Study.

Phase One - Field mapping study: Phase One involved the field mapping study that was undertaken in 2013. The JA and the HeW CO-OP formed a joint committee on cooperative health care in order to collect and share experience with the researchers. The consumer and agricultural cooperatives quite naturally represent entirely different membership and population groups and there have been very few previous exchanges of experience in health care or other such areas of common interest in recent decades. The joint committee of JA and HeW CO-OP invited the researchers to map experiences at nine different hospitals, representing both organizations. The nine hospitals were visited on-site in May, 2013, and actual care giving activities were also presented by the staff at these hospitals. This initial fact finding included semi-structured interviews with top management and/or directors as well as an introduction to the services provided at the facilities. This information comprises the Organizational Study of this project and is currently being analyzed. The information collected by the Organizational Study contributed to constructing relevant interview and survey instruments for the next phase of the project. In May, 2014 the staff and patient questionnaires were developed during a visit to Osaka. Later, they were refined and a Volunteer questionnaire was developed in November, 2014. Following this, the pilot study is ready to be initiated now that the field mapping is completed and measurement instruments are finalized.

Phase Two - Pilot study: The main result of the field mapping study was three questionnaires, one of which is directed to the staff of cooperative hospitals another is designed for patients and the third for the volunteers at the same hospitals. The second phase of the project has the purpose of testing these questionnaires and the analytical model described below in a pilot study at one of these hospitals, Saitama Cooperative Medical Center, north of Tokyo. It is the largest cooperative health center in Japan with nearly 230,000 members and over 3,000 of the characteristic self-help-styled *Han* health groups, involving nearly 21,500 group members in various health monitoring and education activities. Saitama is clearly not a typical case, being the largest medical cooperative hospital in Japan, but rather a “most-likely” case chosen because conditions to test the questionnaire and the analytical model are favorable in a large facility like Saitama. The pilot study will be carried out in close collaboration with the leadership and management of the hospital at the Saitama Cooperative Medical Center, as agreed in Nov. 2014. The information from the pilot study will be initially analyzed to discern if any major changes are necessary in either the measurement instruments or the survey strategy. Once this is completed and after eventual adjustments are made the project will move on to Phase Three.

Phase Three – the Staff, Patient and Volunteer Studies or the Main Study: The purpose of the main study is to employ the measurement instruments from the pilot study to a wider range of cooperative hospitals in the project, in order to gain a more nuanced understanding of how the cooperative health care functions, the role of co-production in cooperative health and its results. The main data collection will consist of survey studies carried out using three different questionnaires directed to the staff, patients and volunteers at the eight different hospitals, in addition to Saitama Medical Center from the pilot study. The different hospitals and the different groups and subgroups of respondents are described in Table 1 in the appendix. The materials from these nine hospitals will be compared with similar materials collected from one public and one nonprofit hospital.

Table 1 on sampling strategy in about here

The sampling strategy is aimed at collecting an even number of responses from all hospitals, thus ensuring equal representation of different stakeholders at the different hospitals in the data set. The hospitals vary in size and the proportional representation of each subsample therefore

also varies. The strategy is, in other words, to create a sample that gives all hospitals and all subgroups equal weight regardless of their absolute size. The reason for this is that it allows for both an analysis of all forms of cooperative health care and a comparison of the different subgroups. The survey studies of staff, patients and volunteers will be complemented by data from an extensive study of the organization of the nine different hospitals affiliated with the agricultural and consumer cooperative organizations that was undertaken in Phase One – the Field mapping study. In addition, two public hospitals will be involved in a similar study of their staff and patients, to provide a context neutral comparison of patient participation in traditional Japanese hospitals.

The analytical model of the project will primarily use the surveys as a measure of output and outcome while a study of documents and interviews from the hospitals will provide the necessary context in which to analyze the findings from the surveys. After an initial analysis of the findings from the Staff, Patient and Volunteer Studies, focus group interviews will then be employed to interpret and corroborate our findings or modify our analysis and conclusions. The analytical model is comprised of three main pillars: 1) the national and regional institutional and environmental conditions for hospitals; 2) each hospital's organizational setting and 3) the intervening variables for closer scrutiny. Taken together, the institutional and environmental conditions, a hospital's organizational setting and the intervening variables are expected to determine a hospital's outputs and outcomes. However, rather than examining economic and financial aspects of hospital performance, we will primarily focus on social aspects and the quality of its support services as shown by the surveys to better understand its outcomes.

Diagram 1. Analytical model for studying cooperative health care in about here

The institutional and environmental conditions or setting for each hospital are basic to understand their frame of reference and field of operation. Some of these institutional and expected relationship between and among the variables. The hospital's organizational setting (A) on the left hand side of the diagram includes the organizational conditions and organizational complexity of each hospital, its governance model as well as its aims and institutional logics. The intervening variables (B) in the middle of the diagram include the mechanisms for a multi-stakeholder dialog, the staff's work environment, the stakeholder logics and values and the staff's perception of the quality of support services to the hospital's members or patients. Variables found under A and B are expected to influence a hospital's outputs and

outcomes, in particular the quality of its support services. Here we will rely on and compare both staff and patient evaluations of service quality in order to determine the quality of a hospital's services.

We expect the two hospital groups to differ from each other and be distinct, as well as to differ from public hospitals and for-profit hospitals. Their social values will be reflected in an organization's governance model, its relations with the staff and the relations between the staff, patients and volunteers. We should also expect that some of these relations will be strong and others weak, as indicated by the lines in the analytical model.

The main study will produce an extensive and rich material describing how the health care cooperatives in Japan organize their care according to the principle of co-production, but also in which kind of organizational setting this is done. This is important for understanding what aspects of the cooperative health care model are unique for Japan and which ones could realistically be copied in other settings such as those found in Europe.

The three studies that make up this research project are organized in a step-by-step fashion that will lead up to a concluding analysis of the benefits and limitations of co-production in cooperative health care and its potential to improve service quality in Japan, and perhaps to suggest alternative approaches to health and elder care in Sweden and other OECD countries.

H. Summary and conclusions

Health and elder care in most developed countries faces a complex and partly contradictory mix of financial, social and political challenges. Fiscal strains combined with New Public Management agendas have caused severe cutbacks and calls for greater efficiency in public and elder health care, resulting in a growing concern about service quality. The purpose of this project is to explore a possibility to address these issues from a new perspective that emphasizes greater user participation, based on the idea that the patients and clients can play a more active part in the provision of their own care services. This project proposes to explore how health and elder care services can be provided when professionals and patients/clients act as 'partners' and where the two parties co-produce the service through their mutual contributions.

Co-production is noted by "the mix of activities that both public service agents and citizens contribute to the provision of public services. The former are involved as professionals or 'regular producers', while 'citizen production' is based on voluntary efforts of individuals or groups to enhance the quality and/or quantity of services they receive." (Parks, *et al.*, 1981 & 1999). The purpose of this project is to explore the possibility to address the challenges facing health and elder care in OECD countries from the perspective of greater user participation, based on the idea that the patients and clients can take a more active part in the provision of

their own health and elder care services. This may result in high quality services without adding to the costs for the public sector, or perhaps even reducing these costs. The theory to be tested by this project is that a significant part of the health care services can be provided with professionals and patients as “partners in a continuing process of inquiry” Fotaki (2009, 2011), where the two parties co-produce the service by mutual contributions of information and treatment.

Japan has a unique health care system with not just one, but two user-owned cooperative health care providers that also provide elder care to their members. Together, these two co-op health care systems have nearly 50,000 hospital beds. However, they probably differ from each other and from public hospitals and for-profit hospitals in terms of the social values they promote. Their social values will be reflected in their governance model, their relations with the staff and the relations between the staff, the patients and volunteers. This project aims to collect unique empirical data from patients, medical professionals and volunteers at nine different cooperative hospitals across Japan and compare it with similar data from two public or nonprofit hospitals. It will produce an extensive and rich material describing how the health care cooperatives in Japan organize their care according to the principle of co-production, but also in which kind of organizational setting this is possible.

These two types of user-owned health care facilities will be compared with each other and with public and non-profit providers of health care in Japan. This will allow us to identify and isolate the factors that facilitate active patient co-production in health and elder care. In order to do so, we have discussed some important theoretical and methodological considerations of the project. This includes governance models, institutional logics in health and elder care, and a multi-dimensional and multi-stakeholder framework for analyzing stakeholder interests. We have also outlined the different phases of the project that comprise a Field mapping study, development of the measurement instruments, a pilot study of one cooperative hospital, and the Staff, Patient and Volunteer Studies at eight other co-op hospitals and two public or nonprofit hospitals.

This project aims to collect unique empirical data from both patients, volunteers and medical professionals at a total of nine different cooperative hospitals across Japan and then compare it with similar data from two public or nonprofit hospitals. Greater client/patient participation or co-production has important implications for the quality and financing of health and elder care. These two cooperative models in Japan provide a unique opportunity for studying large scale co-production of health and elder care in a real world setting. The results of the comparisons proposed by this project can help inform the academic debate about co-

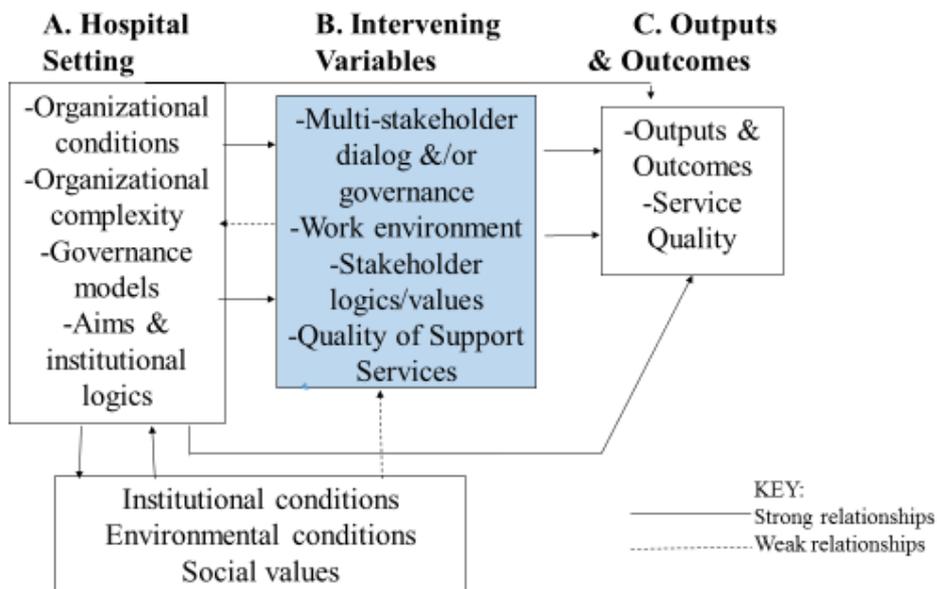
producing health and elder care in other OECD settings.

Table 1. Sampling strategy for the staff, patient and volunteer studies of cooperative health and elder care in Japan.

	Cons coop 1	Cons coop etc.	Sub- total	Agr. coop 1	Agr. coop, etc.	Sub- total	<i>Grand total</i>
Doctors	25	25	125	25	25	100	225
Nurses	25	25	125	25	25	100	225
Oth. Med.	25	25	125	25	25	100	225
Soc. workers	25	25	125	25	25	100	225
Admin.	25	25	125	25	25	100	225
Total staff	125	125	625	125	125	400	<i>1,125</i>
Patients							
Out-pats	100	100	500	100	100	400	<i>900</i>
In-pats	50	50	250	50	50	200	<i>450</i>
Total pats	150	150	750	150	150	600	<i>1,350</i>
volunteers	50	50	250	50	50	200	<i>450</i>

Sampling strategy 2015.

Diagram 1. Analytical model for studying cooperative healthcare.



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