Health and medical co-operatives in Japan:

As a force for the development of the capability of the family and the community to maintain health

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I Introduction

Medical co-operatives occupy a unique position in the area of co-operatives, in the area of medical care and in the world too. In Japan as late starter in capitalism, its capital accumulation process underdistributed resources to health and medical care and welfare. This severely affected the development of self-fulfillment. This situation caused poor health levels. Medical care utilization co-operatives were born in these historical conditions before W.W.II. Today's medical co-ops grew out of these pre-war co-operatives.

Medical co-ops are unique from various viewpoints; their historical perspective, their volume, the content of activities and the type of co-ops. Medical co-ops are not simply one specific type of management for medical care facilities. Medical co-ops are organized by the people regardless of health or ill-health. Members join in Han-groups as a basic unit of the organization, and on the basis of the Han they undertake daily health promotion activities in collaboration with health and medical professionals. Moreover, they are involved with the movement for a high quality social security system, the peace movement and so on. We can say that medical co-ops want to help people to develop the capability of the family and the community to maintain health through many kinds of health promotion activities based on a network of cooperatives.

To cope with an ageing society, the government is firmly implementing neo-liberalistic reform of the health and medical care system. Unfortunately these reforms are attacking the social security system and living conditions, so that people are concerned about whether or not they can maintain their lifestyles and living standards. In these circumstances, the number of people who are trying to restructure their living conditions through establishing a network of co-operatives is rising. This restructuring aims to create a communal way of life. The experience of medical co-ops movement is very important in deciding the roles of cooperatives in the restructuring of living standards. The

purpose of this paper is to sketch some aspects of medical co-ops movement in Japan.

Ⅱ Historical Development of the Medical Co-operatives Movement

1. Medical care utilization co-operatives as one of the historical ancestors of current health and medical co-ops.

In Japan, medical care business by co-operatives has a long history. Before W.W.II, there were many medical care utilization co-ops (medical care business by industrial co-operatives) all over the country.

Although "*The farmers' movement for medical care by co-operatives*" (by The National Welfare Federation of Agricultural Co-ops) is regarded as the authentic history of medical care utilization co-ops, we can't say that it shows the whole picture. Aside from that, medical care utilization co-ops started from the Aobara village industrial co-operatives which ran loan and saving, selling, retail, and utilization businesses in Shimane Prefecture in 1919.

However, medical care businesses run by co-operatives had ancestors prior to medical care utilization co-ops. They were known as "Jourei". Jourei were found in Munakata county, Fukuoka Prefecture from the late 19th century to the early 20th century. Jorei included the whole neighbourhood. People contributed rice, or one day's work in the case of fishing villages, according to the ability of people to earn. Through this, they could receive free medical care by doctors contracted to the Jorei.

When a medical care utilization co-op was first established in Aobara, medical care businesses were regarded to be something like a production business in which medical facilities, devices and services were regarded as equipments which maintained and enhanced the productivity of agricultural labour forces. This was because the Industrial Co-operatives Law at that time didn't have any provisions for a utilization business (later the production business was changed to be that of a utilization business). Since then, medical care utilization co-ops were born one after another in western Japan in 1922, Funaho, Okayama Pref., Takagi, Nagano Pref., in 1923, Jinnoshinden, Aichi Pref., Hashinoin, Nara Pref., and so on. These early medical co-ops were all established as one business run by industrial co-ops which included 4 kinds of businesses (loan and saving, selling, retail and utilization). Almost all early medical care co-ops had only a small medical facility (usually, one doctor, one nurse and one or two beds). This wasn't enough to meet the needs of members and so didn't last very long.

In 1923, the Tosei hospital in Aomori city (the current Aomori city Tosei hospital) was founded. After that, the period of "Large area and Single business" medical care co-ops began. (The period before that time is called "the period of early medical care co-ops"). Following on the heels of the Tosei hospital, the Kosei hospital in Kurayoshi-cho, Tottori Pref. (the current Tottori prefectural Kosei hospital), the Koryo hospital in Suzaki-cho in Kochi Pref. (the current Second Koryo hospital) were established. So far industrial co-operative usually covered area as large as towns or villages or smaller, and had run three or four businesses (loan and saving, selling, retail and production businesses).

In contrast, Large area and Single business co-ops covered areas larger than towns, usually as large as a county, and only ran medical care utilization businesses (or medical care-related retail and utilization businesses). Large ares and Single business co-ops usually included both urban area and country areas by networking hospitals and clinics. They also had travelling clinics. They tried to use local medical resources as efficiently as possible. Moreover, the class structure of members differed from that of the early medical care co-ops because they included more self-employed people working in industry or commerce as well as salaried worker (white collar), wage labour (blue collar). Because of the problems caused by the Great Depression, the number of Large area and Single business co-ops increased dramatically after the establishment of the Tokyo medical care utilization co-op (the current Tokyo medical co-op), by Toyohiko Kagawa, Inazo Nitobe and so on. They spread like wildfire all over the country. In particular, in Aomori, Akita, Iwate Prefecture, in which the industrial co-ops movement was until now underdeveloped, medical care utilization co-ops grew rapidly and they played important roles in community medicine. For instance, the Tokyo medical care utilization co-op engaged actively in health promotion activities such as visiting health activities for mothers and children, a camping school for children and so on.

In due time, some medical care co-ops merged and organized a federation in order to strengthen management ability. In the industrial co-ops enlargement movement from 1932 and in the Second enlargement movement from 1937, medical care utilization co-ops were given important roles by the government as a main force for human resource policy in rural areas under the military regime. At the same time, the government made a policy that medical care utilization co-ops would be reorganized into a federation composed of unit industrial co-ops. This policy actually meant the end of Large area and Single business co-ops.

In the period of federation, in central Japan, the Tokai region and the Kyushu region, many medical care co-ops were established. Some medical co-ops set up their own bus routes to help patients, supplied meals and set up a mutual association for medical care.

In 1941, medical co-ops were integrated into the Agricultural Association. After W.W.II, some medical care facilities of medical care co-ops were turned over to the prefecture or the municipalities in the Tohoku region, some facilities were turned to the Welfare Federation of Agricultural Co-operatives. Unfortunately, many medical care co-ops were disbanded.

Medical care utilization co-ops not only simply ran medical facilities, but also protected life and living standards of members through undertaking health care, and mutual

Table 1 Establishing of Medical care utilization co-ops

	4 kinds business (town or village)	large area single business	federation	unit co-ops belonging to
1919	1			
1920				
1921				
1922	2			
1923	3			
1924	4			
1925				
1926				
1927	4			
1928	2	7		
1929	1	1		
1930	3	3		
1931	3	1		
1932	2	7		
1933	4	13	2	37
1934	3	17	2	61
1935	10	6	2	97
1936	8	1	6	742
1937	9	0	4	150
1938	8	1	20	600
1939	7		8	319
1940	11		6	105
1941	4		7	1,289
1942	0		2	10
total	89	52	59	3,313
as of 1942	62	24	56	(3,475)

(Note) Ikuo AOKI, Some aspects of early medical cooperatives in Japan (1), *Journal of Hannan University, Hannan Ronshu, Social Science*, Vol.24, No.2, 1988.

association activities. They have also had some major effects on medical care. Firstly, the geographical prevalence of medical care. Medical care co-ops promoted the distribution of medical resources to areas of poor health, especially to areas without any medical facilities. Secondarily, the social prevalence of medical care, namely equal access to medical care. Medical care fees of medical co-ops were lower than the agreed fees of local medical associations. Thereby medical co-ops cut the amount of money that members had to spend on medical care and reduced the inequality of access to medical care. Thirdly, improving medical care. Medical care co-ops have encouraged the members participation in medical care by which they not only have increased the members satisfaction but also have secured democracy in medical care.

Table 2 Member and Contribution (1938)

	member			contribution (yen)			
	co-ops	members	average	co-ops	total	per co-op	per member
single	34	187622	5518	34	1393843	40995	7.4
4 business	56	32424	579	54	1448066	26816	46.6
federation	30	655377	21846	30	2734048	91135	4.2

Table 3 Medical facility and doctor (1938)

	ward			bed		branch facility		doctor				
	co-op	ward	/co-op	bed	/co-op	co-op	co-op having (%)	co-op	doctor	/co-op	co-op	member /doctor
single	33	1248	37.8	1595	49.5	33	17(51.5)	30	194	6.3	30	909
4 business	55	168	3.1	160	2.9	0		52	60	1.15	52	495
federation	33	1712	51.8	2309	70.0	33	12(36.4)	32	289	9.0	29	2245

Table 4 Percentage of member belonging to, composition of occupation (1938)

	co-op	ratio (%)	composition of occupation (%)						
			member	agriculture forestry	commerce	industry	salariate	wage labour	other
single	34	21.5	187622	56.2	17.5	7.2	4.9	3.5	10.7
4 business	56	88.2	32434	80.6	6.4	3.8	1.3	3.0	4.8
federation	30	55.2	655377	75.1	10.1	4.6	2.5	1.2	6.5

(Note) (1) The percentage of beds belonging to co-ops to total number of beds in Japan was 2.3.
(2) The percentage of doctor belonging to co-ops to total number of doctors in Japan was 0.86.
(Resource) Japanese Industrial Cooperatives Union, *Annual Report on Medical Care Cooperatives*, (1938)

2. Development of current Health and medical co-operatives movement

The existing medical cooperatives set up and run medical facilities as co-operative corporations under the consumers cooperative act. They are also regulated by the medical act. Some medical co-ops were established before the consumers cooperative act was enacted.

The Ministry of Health and Welfare officially allowed the establishment of medical co-ops under the consumers cooperative act by the notification dated 19th January, 1954. This notification provided that any medical facility set up by a medical co-op ". . . is a collective utilization facility that provides medicalcare only for the members of the medical co-op concerned".

When the Japanese Consumers' Co-operative Union (JCCU) set up the Medical Co-ops Committee (MCC) in 1957, only 12 medical co-ops joined it. Since then, medical co-ops have increased and developed dramatically. The number of medical co-ops which are members of the MCC grew to 120 co-ops by 1995. They are distributed over 37 prefectures and they have 82 hospitals (having 20 or more beds), 217 clinics, 27 dental clinics, and some welfare facilities. More than 1.8 million households are members of medical co-ops.

We are going to have a brief look at the history of medical co-ops. I have to note that apart from a few non-members (of the MCC), about 30 member co-ops don't usually attend the annual general meeting. Therefore the following is concerned with the history of a core part of the medical co-ops movement.

From the time before and after the establishment of the MCC, the Japanese economy entered into a period of high-growth, and in response to the policy for the mobilization of labour forces, a universal compulsory medical care insurance system and pension system covering everyone was set up and the social security system progressed. Development of these systems allowed labour to move all over the country.

However, as far as medical care delivery systems are concerned, the government dropped plans to construct a public hospital (state and local government owned) – centered system. The government made a policy to support and stimulate the development of private medical facility-oriented medical care delivery system. This policy restricted the number of beds in public hospitals by amending the medical act (1961), and provided financial support by establishing of the medical financial corporation (1962).

High economic growth had a disastrous effect on health levels. In these circumstances, people needed to organize cooperative networks to protect themselves. Medical

co-ops were one sort of cooperative network. Medical co-ops which were members of the MCC had increased to 50 by 1966. As the number of medical co-ops increased, the number of activities undertaken by the co-ops increased also.

Medical co-ops have some major characteristics of organizations. It's important to note that; 1) the "Han" (small group) forms the basis of the organization; 2) members improve the capability of families and communities to maintain health through voluntary health promotion activities usually in collaboration with health professionals. Tsuruoka medical cooperative (Yamagata Prefecture) was particularly successful and from 1965-1967 many conferences were held to spread Tsuruoka medical co-ops' methods throughout the medical co-ops network. By 1975, 2,300 Hans were organized, and about 40,000 members had joined Hans. Three out of ten members joined Hans. By 1985, 14,654 Hans were organized and about 238,000 members had joined Hans. 27.3% of members joined Hans. In this decade, medical co-ops grew by a factor of six. As the medical co-ops grew, they attached importance to organizing Hans. Unfortunately, the percentage of members belonging to Hans decreased to about 20%.

Health promotion activities are the heart and soul of medical co-ops. Since the period of medical care utilization cooperatives, health promotion activities became the main activities for members. These health promotion activities consist of health checks conducted by the Hans and the school for health which trains people to run health promotion activities. The number of Medical co-ops actively engaged in voluntary health promotion activities increased after 1974. In 1977, the MCC annual general meeting proposed institutionalising the school for health so that each medical co-op could train several hundred leaders for voluntary activities. The 1979 MCC annual general meeting made a strategic policy, "Principles of community health promotion activities" that proposed 1) demanding that the local government establishes human right, 2) a movement for high quality social security, 3) equality of utilization of community health care resources, 4) making a good community. After that meeting, the MCC encouraged community health promotion activities. They considered health promotion activities to be a force for changing living conditions.

During the 70's, medical co-ops established an action program of activities, health promotion activities and medical care activities, by which they laid the foundations for making rapid progress. By March 1982, 105 medical co-ops belonged to the MCC (at that time, 95% of active medical co-ops belonged to the MCC). The number of members of reported medical co-ops (89 co-ops) was about 640,000. They ran 63 hospitals and 149

Table 5 The Development of Medical Co-ops

age	co-ops	members	hospitals	clinics	beds
1957	12				
66	56	122,015			
67	62	135,429			
68	74	202,382			
69					
70					
71					
72	74				
73	78				
74	85				
75	86	349,504			
76	92		40	126	
77	94		49	123	5,657
78	99	455,000	49	127	5,676
79	102	500,000	55	138	6,393
80	106	600,000	63	136	7,358
81	105		63	149	8,069
82	110	567,010	67	151	8,397
83	110	663,663	68	155	9,299
84	111	698,747	72	157	9,612
85	116	785,343	75	169	10,337
86	118	866,425	75	178	11,211
87	116	945,378	80	181	12,320
88	117		80	183	12,197
89	117	1,270,000	80	190	12,699
90	120	1,401,883	83	194	12,973
91	117	1,505,580	84	199	13,061
92	117	1,608,872	84	213	13,061
93	118	1,709,812	81	233	13,075
94					
95					
96		1,997,988	79	272	
97	124		80	280	

(by. Keiko Kawaguchi, Ikuo Aoki)
(Resource) *Annual Reports of the MCC* and others.

clinics. They had 8,069 beds. This situation already compared favorably with public medical facilities such as the Japan Red Cross and Saiseikai.

Since the 80's, the conditions of public health, medical care and welfare was becoming worse due to the neo-liberalistic administration and public finance reform encouraged by the Second Temporary Committee for Inquiry on Administration. The following

things were carried out one after another. Enacting the Health and Medical Service Act for the Aged (1982); constraining national medical costs by constraining the demand for medical care (reduction of state subsidies to National Health Insurance, reduction of medical benefit ratio in Health Insurance); Amendment of the Medical Act and as result of that, Regional Medical Planning aimed at constraining national medical costs through constraining the supply of medical care (restriction of the number of beds in the secondary region for medical care provision; some parts of the reimbursement system were changed from fee-for-service to case-based in health care insurance). While the government insisted that Japan has become an affluent society, "the company-centred society" caused poverty and ill-health, for example "Karoshi" (death from over-work). In order to save lives, on the one hand people should depend on network of cooperatives, on the other hand people ought to claim to restructure social security as social basis of protecting health and living. We could say that in response to these circumstance medical co-ops have to protect the management of medical facilities and develop activities for enhancing people's capability to live and maintain their health more than ever.

The movement for high quality social security was also an important part of medical co-ops' activities. Medical co-ops combined this movement with teaching activities such as the school for social security and training living advisers. This movement was developed on the basis of using the existing social security system at a daily life level. The MCC prompted co-ops to exchange information with each other.

Also, each medical co-ops engaged in volunteer activities not only in medical facilities such as one-day nurse, but also in the community such as mutual support. These activities enriched the contents of the cooperative networks. Moreover, as the restriction of medical care provision became tighter, medical co-ops dealt with management and financial problems, and enhanced degree of members' satisfaction with medical care by meeting their medical needs. At the same time, medical co-ops attached importance to democratizing medical care by increasing the involvement of members, medical care audits and the utilization review committee. These activities crystallized into "The Charter of Patients' Right of Health Cooperatives"

Ⅲ Some aspects of Health and medical co-ops movement

Medical co-ops define themselves as; 1) Health co-operatives are the health care organizations composed mainly of healthy people; 2) Health cooperatives make much of

the prevention, health promotion and the building up of social systems such as the social security system guaranteeing these issues; 3) Health co-operatives own health care institutions. Members and residents are guaranteed for active participation in the field of health care through their own health care institutions; 4) Health co-operatives have Han-groups as basic unit of their organizations. Members of co-operatives engage in various activities. Most of these activities are carried out based on Han-groups. (Revised 1988). Namely, we can say that medical co-ops are networks of cooperatives based on the Han as a basic organization formed by members, and on the basis of the Han it's a movement that members can develop the capability of their family and the community to maintain health through self-education, health promotion activities, the management of medical and welfare facilities, movements for high quality social security, peace movements and so on. So, some co-ops call themselves Health co-ops not Medical co-ops. Recently, the number of Health co-ops is increasing. There are a few co-ops that don't run medical facilities (of course, they are in collaboration with another medical facility). Medical co-ops vary depending on the community, historical situation and the members. Therefore it's difficult to discuss medical co-ops as a whole. So, the following description is confined to some aspects of medical co-ops.

1. Member, Han, Organization

Members organize medical co-ops to maintain and promote their health and to secure medical care. In this sense, members are the lead actors and a source of activities for medical co-ops. Therefore, co-ops are organized depending on their own objectives and contents of their business as medical co-ops. If the medical co-ops only ran medical facilities and only the members used them, then the members would be nothing more than consumers. However, if the members usually have a health check and are involved in health promotion activities, they will need another organization for doing so. This is called a Han-group.

Hans, as noted above, were formulated based on the method from the Tsuroka medical co-op. The percentage of members in a Han is usually 20-30%, but the percentage of members attending Han meetings was less than 15%. Because the Han is a basic unit of organization and a starting point for all kinds of activities, it has always very been important for co-ops to encourage members to belong to a Han. This is one of the main four objectives of medical co-ops.

These activities are supported by the organization department. The activity of full-

time employees about organizational activity tends to be a command-style, when members' activity is in the early stages or remain at a low level. If the full-time employees' activities aim to empower members, their activity will become "enabler-style". Recently medical co-ops have organized "branches" at a mid-level between the Han and the board of directors. Branches are responsible for a particular neighbourhood or administrative area. If the members are increasing and their needs are diversifying, branches secure democratic management of the organization and represent the co-op at the neighbourhood level. In the end, members learn the significance of and how to form cooperative networks through the school for consumer cooperatives. Anyway, medical co-ops make it a principle to manage democratically and aim to develop and empower members and employees.

2. Medical care activity, Management of medical care facilities

Since the 80s, the government has implemented medical service reforms. We can say that the reforms undermine the human right to health by changing the responsibility for medical services; that is, shifting the cost burden from the public sector to the households, thereby reducing demand for medical care and restricting the supply of medical care. In these circumstances, the management of medical facilities run by medical co-ops have faced severe difficulties. In the last third quarter of 1989, the percentage of co-ops running in the black was 44.8%, this figure has been decreasing for the last three years. In particular, medical facilities having under 200 beds faced a catastrophic situation. The percentage of these medical co-ops running in the red was 64.6%. This financial situation was caused by an insufficient level of activities fulfilling the medical needs of members and by failing to create a satisfactory level of medical care.

This criticism of medical co-ops may be too severe. Indeed, medical co-ops have not only opposed the neo-liberalistic government's policies, but also made efforts to construct a medical security system that protects the human right to health. Medical co-ops have been one of the leaders of the movement for a high quality social security system and co-ops have tried to bring various groups and individuals into the movement for restructuring social security system. Forming this movement is very important for the future of health care in Japan.

Since the 80's, medical co-ops have concentrated on improving their financial situation. Fortunately, they have had significant success with this. In fiscal 1996, the percentage of co-ops running in the black was 84% (55.9% in fiscal 1997). However, hospitals

having 100-199 beds still face severe difficulties.

One characteristic of medical activities by the co-ops is that, at the same time as protecting the management of medical facilities, they create primary health care and secondary medical care appropriate for themselves based on the members' needs. Medical co-ops try to enhance the skills of medical professionals through peer review, evaluation of health and medical activities, the utilization review committee and so on. There are also many kinds of patient groups.

As the population ages, concern about welfare for elderly people is growing. Therefore, medical co-ops are now involved with in welfare-related activities and businesses, for example, nursing facilities, health service facilities for the elderly, visiting nurse centres, and so on. As public long-term care insurance is implemented in 2000, welfare-related activities have become much more important issues for medical co-ops than ever before.

Lastly, it's necessary to note that medical co-ops make clear accounting and management information available to members. That is a very important thing, because, generally speaking, it's difficult to understand the co-ops financial situation and some full-time employees tend to monopolize detailed financial information. Making financial information freely available is important for promoting "members involvement in medical care" and "democracy in medical care". This also leads to strengthening clinical governance and accountability.

3. Voluntary health promotion activities

In order to establish a healthy life style and develop the capability of the family and the community to maintain health, medical co-ops have to encourage members to educate themselves about health and to take part in many kinds of voluntary health promotion activities, for example, group check-ups, health checks within the Han (blood pressure, salt, urine etc.). I mentioned the development process of voluntary health activities of medical co-ops, before. Now, I'd like to talk about the "school for health" of medical co-ops. Nowadays, each medical co-ops has a school for health. The members of co-ops, mainly graduates of the school for health, participate in planning and implementing it. The school for health aims to train leaders of health promotion activities. Member learn about; 1) a comprehensive understanding of health from many different viewpoints; 2) health promotion activities; 3) the state of medical care and living, social security and the movement for a high quality social security system; 4) medical co-ops —

their mission, business and activities; 5) how to have an active and productive life in community; 6) the relationship between Han activities and medical care facilities.

The leaders of health promotion activities engage not only in health promotion activities in the Han but also in voluntary activities such as "the one-day nurse program", home help and so on. Since 1987, the MCC has held conferences for the exchange of health co-ops' health activities. Also, the MCC has institutionalized the correspondence course for health education. In 1997, the MCC proposed forming an educational movement to encourage 10,000 members to take the health correspondence course education.

Table 6 The Educational Activities of Medical Co-ops

School for	implementing co-ops	implemention by branch	implemention by co-ops	graduates	accumulated graduates
Health	82 (86)	200 (198)	55 (103)	2,545 (2,803)	36,533 (34,537)
Social security	47 (38)	54 (42)	49 (85)	886 (728)	8,420 (4,884)
Cooperative	16 (25)	— (—)	28 (35)	275 (562)	2,761 (2,515)
Volunteer	34 (35)	— (—)	73 (76)	847 (1,384)	6,229 (4,701)

31/3/98 (31/3/97)
(Resource) *Annual Reports of the MCC.*

4. Living Advisor, Volunteer activies

The medical co-ops movement as network of co-operation by people require enlargement of social security and social welfare system as they are public basis for life and living. At the same time, medical co-ops make good use of the existing system and intensify mutual help activities at a daily living level. These are responses to the decline in the capability of the family and the community to maintain health because of changes in the household structure and the community such as increasing numbers of nuclear households, aged households and two-career families. It is also a response to the difficulties of living caused by the neo-liberalistic reforms of administration. Medical co-ops have aimed to pave the way for enrichment of social security and social welfare through these activities.

Medical co-ops have engaged in these activities at a professional standard since around 1982. When the MCC held the first meeting of living advisers, 32 co-ops had held

schools for social security and there were about 300 advisors. Since then, these activities have developed rapidly. In 1987, 43 co-ops held schools and the number of advisors had grown to about 1,200. In 1997, 47 co-ops held schools and advisors had grown to 36,533. Living advisors are "voluntarily trained social workers" and the main leaders for "the network for security" in cooperation with professionals in co-ops and the public sector. They are organizers for volunteer activities too.

Voluntary activities of medical co-ops are undertaken by regular members as well as living advisor. Medical co-ops are trying to encourage the young generation to participate in volunteer activities through which the co-ops aim to develop "a sense of cooperation" in the young generation as they will be active members in the future. Voluntary activities include a bath service by a travelling bath vehicle, a meal service, summer evening parties, cherry blossom viewing, and so on. In mutual help for life and living, a partnership with retail co-operatives, that is cooperation between co-operatives, has been spreading. This means developing a partnership to comprehensively deal with health, medical care and welfare.

5. Evaluation of health and medical activities and Utilization review committee

In west European and north American countries, peer review of the quality of medical care is carried out, and bio-ethicists play a role in dealing with complaints from the standpoint of patients and in securing patients' satisfaction in medical facilities. In contrast with this, in Japan, these activities have seldom been carried out. Japanese doctors usually make decisions about the patient and see no need to explain to the patient what they are doing and why. Even informed consent hasn't been an important issue for medical professinals. In these circumstances, medical co-ops have tried to create better medical care through the evaluation of health and medical care by patients and members, the utilization review committee, as well as peer review. These activities encourage members participation in medical activities and in establishing democracy in medical care. As mentioned above, these activities have crystallized into "The Charter of Patients' Right of the Health Co-operatives" (the right to know, the right to decide, the right to privacy, the right to learn, the right to receive medical care, participation and co-operation) (1991).

Evaluation of health and medical activities are composed of; 1) an evaluation questionnaire — an objective review of the level of medical care; 2) a patient questionnaire — to check the users' satisfaction; 3) a self check of medical activities. There are 4 dif-

ferent kind of patient questionnaires; 1) outpatients; 2) discharges; 3) on nursing; 4) dental outpatients.

The utilization review committee deals with complaints and the demands of patients and members. Through this committee's activities, members are actively involved in medical care activities and the management of medical facilities. Because of these activities, co-operation between members and professionals is improving more and more.

Medical co-ops take the lead in the area of these activities in Japan. Other medical facilities, especially public medical facilities have to learn from the experiences of medical co-ops.

6. Healthy and sustainable community project, cultural activities, the peace movement

For people to be healthy, it's necessary that the conditions of living, work and environment are pro-health. Therefore medical co-ops as social organizations are involved with the healthy and sustainable community project, activities for supporting the arts and the peace movemenrt. These activities prevent the government from changing the health policy to a policy only making healthy soldiers. In the healthy and sustainable community project, medical facilities of medical co-ops are one of the life centres in the community, branches as representatives of co-ops in community have partnerships with other groups. Health promotion activities and living advisors make up an important part of the network for social contact and security in the community. On this point, it's important to note that medical co-ops make use of "community diagnosis" by which co-ops clarify the objects of health care, medical care and welfare.

In the peace movement, medical co-ops in Hiroshima and Okinawa and so on hold a school for peace. In August, the MCC holds a meeting of Health co-ops peace groups, appealing for the abolition of nuclear weapons and for a peaceful world.

Ⅳ In the end

The existence of the medical co-ops movement is unique in the area of co-operatives and in the area of medical care from a world viewpoint. Are there reasons it exists only in Japan? According to "*Cooperative Enterprise in the Health and Social Care Sectors — A Global Survey*" by the United Nation, there are various kinds of cooperatives in the health sector all over the world. Therefore in different social situations, if

people protect their own lives and living standards, they will organize a network of cooperatives as one way of protection. Of course, balance of public-cooperative-private sectors varies between countries. The uniqueness of Japanese medical co-ops have made them a forerunner in this area. From some aspects of medical co-ops' history and activities, we can understand that they are a network of cooperatives for life and living standards in the community. Because families and communities are always changing, medical co-ops have an essential object of developing the capability of the family and the community to maintain health.

Acknowlegement

I am grateful to Mr. Simon Hawell for his help.

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(2000年 7 月12日受理)