Neoliberal Reform and Solidarity Economy in the Japanese Health Sector: the Case of Niigata Medical Cooperative

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Abstract

El sector de la salud en Japón ha estado atravesando importantes cambios en las ultimas décadas, en su mayoría como consecuencia del envejecimiento de la población, los crecientes costos médicos y por la larga recesión de los años 1990 a principios de los 2000 causada por sucesivas reformas neoliberales. Estas reformas han estado transfiriendo el creciente peso de los costos médicos hacia sus usuarios. Por otra parte, el aumento en el número de trabajadores irregulares y la creciente desigualdad de ingresos en Japón ha limitado la disponibilidad y accesibilidad hacia los servicios médicos a cada vez mas personas. En este contexto, ¿qué pueden hacer instituciones de la economía solidaria, como las cooperativas médicas, para garantizar el acceso general a los servicios médicos en Japón?

Keywords: Neoliberalism, structural reform, welfare state, healthcare, crisis

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Introduction

In two previous papers[1], comparisons were made between the neoliberal cycles in Argentina and Japan and the subsequent solidarity economies that developed as a result of these cycles. In this context, this paper will discuss the role of medical cooperatives, in particular the Niigata Medical Cooperative, in guaranteeing access and availability of medical services to the general population in Japan. The health sector in Japan has been going through some important changes in the last few decades. As a consequence of the aging of the population, rising medical costs and the decade-long recession of the 1990s in Japan, significant reforms in the context of neoliberalism have been promoted to rein in the increasing burden of the Japanese medical care system. Some of these reforms include shifting ever growing parts of this burden directly onto the users of medical services. As a result of this, with the increasing population of part-time and other irregular workers (who are sometimes not entitled to public health insurance for economic reasons), along with a general increasing income gap, there is a growing perception of a widening gap in the availability and accessibility to medical services.

In Argentina, medical cooperatives and mutual help organizations have a growing presence in the health sector. These include hospitals and clinics which have gone bankrupt and have been turned into medical cooperatives and managed by their workers (Alcorta [2007b] p.270). Cooperatives have seen their participation grow in the medical sector after the 2002 economic crisis by tending to the needs of those workers and their dependents affected by increased unemployment and unstable employment which have deprived them access to health insurance and proper medical coverage. The solidarity economy is an important participant in the health sector managing care to approximately 8% of the total Argentine population in 2006 (Garriga & Olego [2006] pp.5-7).

In view of this, as in Argentina, the role of medical cooperatives and other medical organizations related to the solidarity economy becomes increasingly important for the maintenance and preservation of the health of Japan's population. At the beginning of the 20th century, medical cooperatives were created to serve medically underserved rural areas and provide healthcare to urban low income earners. Today, cooperatives such as the Niigata Medical Cooperative, successor to other historic cooperative movements in the area and situated in one of the prefectures with the highest shortage of doctors in Japan, can probably serve as an example and shed some light on the role that medical cooperatives can play in this age of structural reform with its ensuing problems.

The structure of this paper is as follows. Part 1 gives an overview of the welfare state in Japan, describing its evolution and extension. Part 2 deals with the various neoliberal reforms implemented by successive governments and how they have affected the general population with respect to job security, income distribution and access to healthcare. Part 3 describes the role of medical cooperatives in the context of Japanese history. Part 4 introduces Niigata Medical Cooperative and its evolution in providing healthcare from the 1970s until today in the context of the neoliberal structural reforms. Next is the conclusion.

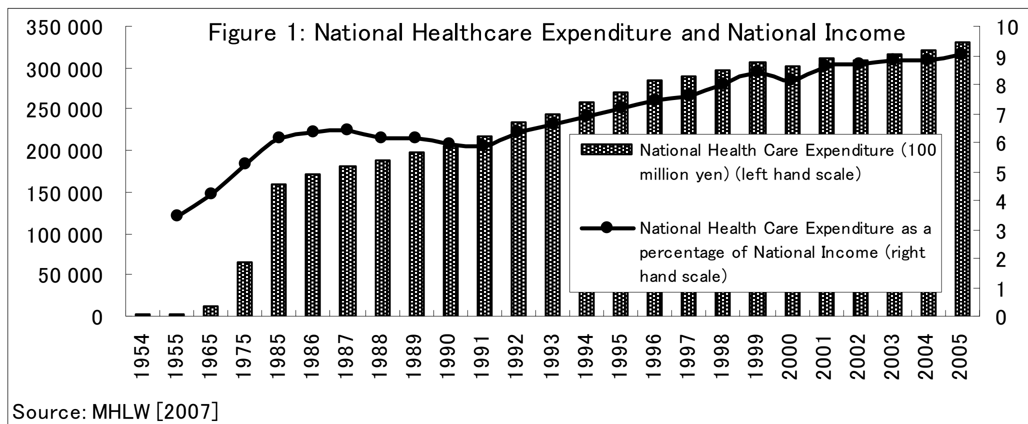
1. The welfare state in Japan: extent and limits

Due to its impressive contrast between limited social expenditures on one side and low levels of unemployment and poverty rate on the other side, the Japanese Welfare State (JWS) has been considered quite unique. This limited size of the JWS rests on three pillars which have worked as substitutes for the functions normally found in other welfare states in the OECD. They are (1) lifetime employment in large scale enterprises which has contributed to the low unemployment and provided welfare for employees and their families; (2) protective regulation policy for small and medium sized enterprises is another mechanism which has helped maintain unemployment low; and (3) Japanese familialism which has attributed the role of care givers to full-time housewives (Miyamoto [2003] pp.12-13).

The development of social security policy in Japan can be divided into three periods. The first one, called the development period, begins in the mid 1950s with the start of the high growth era, and ends in the mid 1970s. Developments during this time include the implementation of the universal pension coverage and health care system, the establishment of free elderly care, the increase of health insurance benefits for nonworking dependents, the introduction of the reimbursement system for large medical expenses, child allowance, etc. The second period is characterized as a period of welfare retrenchment. Due to rising costs, by the mid 1970s opposition to the expansion of the welfare state started to grow in favor of a Japanese-style welfare society (JSWS) which emphasizes self-reliance and mutual aid fostering family and company welfare as substitutes for state welfare. In the third period, from the mid 1980s, retrenchment continued but with a fading of the JSWS discourse as the continued aging and declining birthrate was starting to put an excessive burden on the family (Miyamoto [2003] p.18 and Shinkawa [2005] pp.329-331).

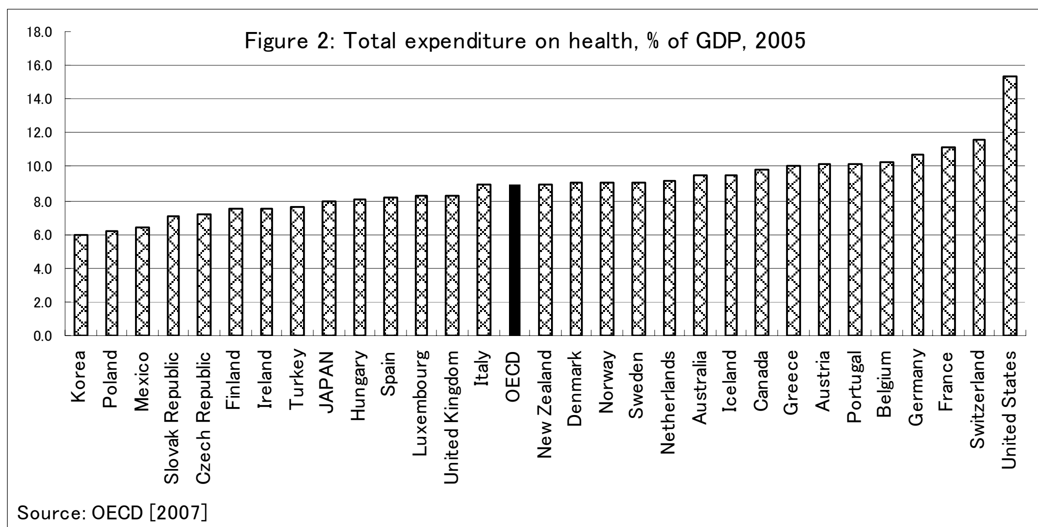
During the development period, the formation of social security policy, carried out to correspond to the structure of Japanese-style corporatism, has usually taken place among the Ministry of Health and

Welfare (MHW)[2], councils and ad-hoc committees. Of particular concern during this period are the policy initiatives coming from politics itself which the Liberal Democratic Party (LDP) proceeded to implement disregarding political rationality. When the universal pension coverage and health care system was established, the only concern of the LDP was to gather national support against the Japan Socialist Party[3]. Other policies include the Pension Reform of 1973 which improved the benefit level to 50,000 yen and free healthcare for the elderly, carried out despite opposition from the Ministry of Finance and the MHW about the excessive financial burden that this would impose. The reason for their implementation is due to the criticism received by the LDP in view of its industrialist policy which brought a deterioration of the environment and the backwardness of public welfare (Shinkawa [2005] pp.331-333).



The 1975 to 1985 period is characterized in Japan as being the first period of welfare retrenchment, when a Japanese-style welfare society (*Nihon-gata fukushi shakai*) (JSWS) was advocated. Conservative forces in the government feared the coming of a crisis as a result of the ever growing social security expenses, in particular healthcare (figure 1). It was suggested that Japan should avoid catching the 'developed country disease' related to welfare state expansion by promoting the instauration of a JSWS based on individual efforts of self-reliance, on family ties, and on the ties of solidarity in neighborhoods and local communities. This would enable the government to provide a more appropriate and efficient public welfare. Based on this ideology, under the Second Ad-hoc Council for Administrative Reform, the welfare state started to be trimmed. First in 1982, with the Law of Health and Medical Services for the Aged, free health care for the elderly was eliminated. In 1984, an amended Health Insurance Law introduced a co-payment of 10% to

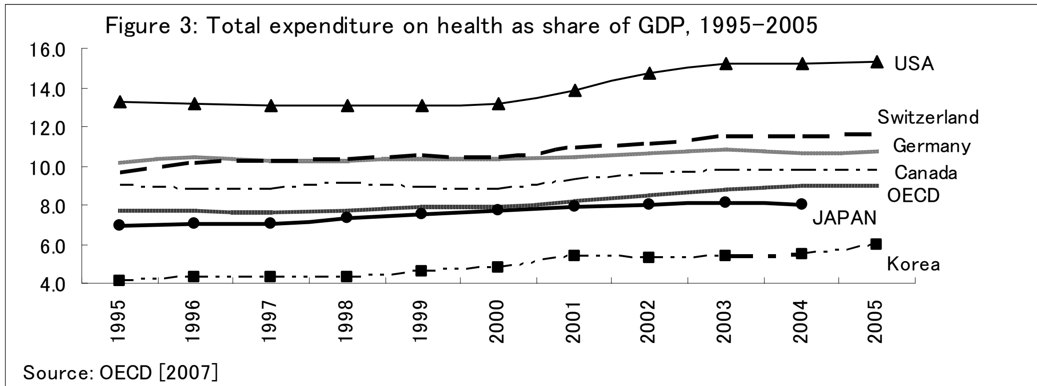
the insured. In 1985, the pension system was reformed unifying the many pension plans, gradually raising pension premiums while reducing benefits. These reforms had the effect of reducing the rate of growth of social security in Japan during the 1980s. As a result, in the 1990s, Japan still had the smallest government among OECD members and one of the smallest a decade later (figures 2, 3 & 4). Since the 1980s, the MHLW has advocated the need for reform due to the menace posed by the aging of society and its impact on welfare and the economy. In this context, the JSWS[4] is said to maintain the vitality of the private sector by keeping the national burden rate (taxes + social insurance premiums/national income) under control[5] (Miyamoto [2003] pp.14 & 19 and Shinkawa [2005] pp.281-286).

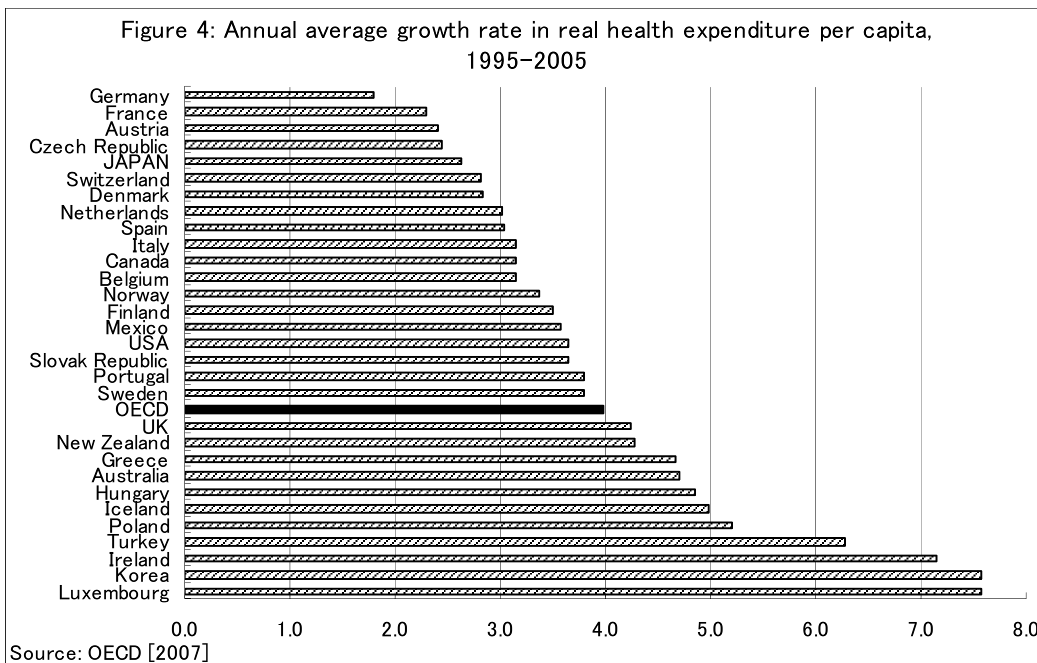


At the beginning of the 1980s, the healthcare and pensions sectors were already in a state of crisis. But this is less due to aging and more to the intrinsic weaknesses in the many divisions of the social security system. After WWII, healthcare and pension plans were divided according to an occupation-based system. The present system is a continuation of the one in place during the war where major manufacturing corporations provided welfare and age-based remuneration in order to secure skilled workers on long-term employment. Nowadays, establishments with more than 5 employees are obligated to be affiliated to a health insurance. These establishments, depending on their size, may have their own health insurance society which is separated from government managed health insurance. Also, many occupations established their own separate insurances (Shinkawa [2005] pp.286-289)[6] [7].

Since the mid 1980s, the JSWS has gone through some important changes. This third period is characterized not only by retrenchment but also by expansion towards universal welfare policy. In order to restore the soundness of public finances concerning medical insurance, a patient co-payment system was introduced, the flat charge system for medical service fees was reexamined, and corrective measures for drug price margins were carried out, among other things. The effect of these measures was to lower the increase in healthcare costs over national income from 10% in 1983 to 5-6% thereafter. Nonetheless, in the mid 1990s, this ratio started growing again. The background in these changes can be found in the promotion of policies towards home welfare services. This can be seen with the passage of the Ten-year General Strategy for the Promotion of Health and Welfare for the Elderly, also known as the “Gold Plan” in 1989, which planned for a vast expansion of community-based long term care by providing grants to local governments over a ten-year period. However, with expenditures rising throughout the 1990s, policymakers started to become concerned about the long-run costs of the Gold Plan on the government budget. This is when passage of the Long Term Care Insurance (LTCI) law was passed in 1997 and put into practice in 2000. Its main objectives were the “socialization of care” in which the state would assume a significant part of the responsibility for care of the frail elderly, expansion of local government responsibility for social policy, sharing of costs by elders via insurance premiums as well as co-payments, etc. This change of welfare policy from the Gold Plan to LTCI, does it represent a withdrawal from the JSWS? While some critics might say that this represents a failure of the JSWS others say that it represents a rectification. On one hand, the introduction of LTCI placed an additional burden on the budget by increasing state contributions into healthcare. On the other hand, the lack of facilities and manpower training in the 1980s and the increase in social hospitalization[8] contributed to a (useless) rise in medical costs. The corrective measures in the 1990s have tried to set the JSWS on a rightful track (Miyamoto [2003] p.21, Campbell & Ikegami [2003] pp.21-23 and Shinkawa [2005] pp.297-300 & 337).

Nonetheless, it is in the second half of the 1990s where the JSWS can probably be said to have started to fail. With the crumbling of Japanese-like labor-management relations (with the end of lifelong employment), corporate welfare (due to labor flexibilization) and family welfare (because of a higher percentage of women who go to work and are unable to provide care for the growing elderly population), it has become increasingly difficult to support the JSWS (Shinkawa [2005], p.308).

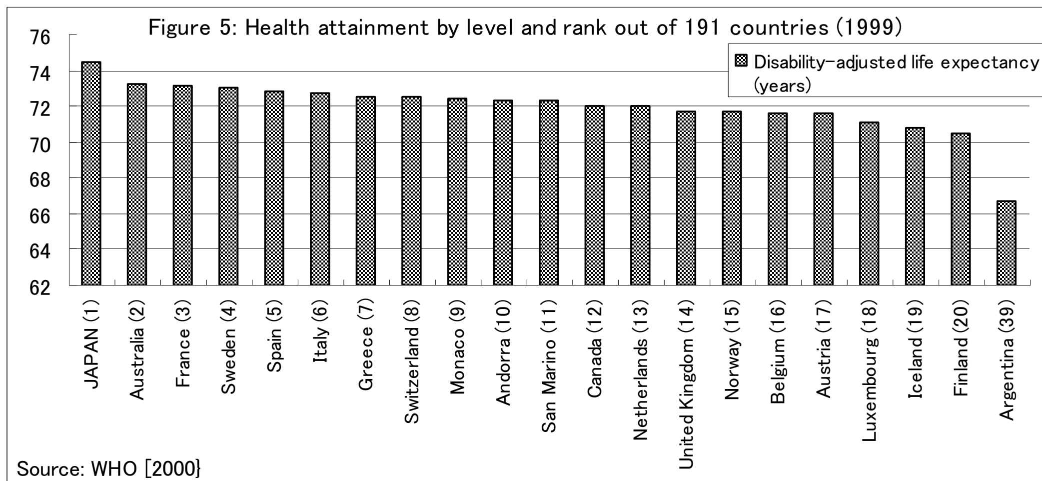


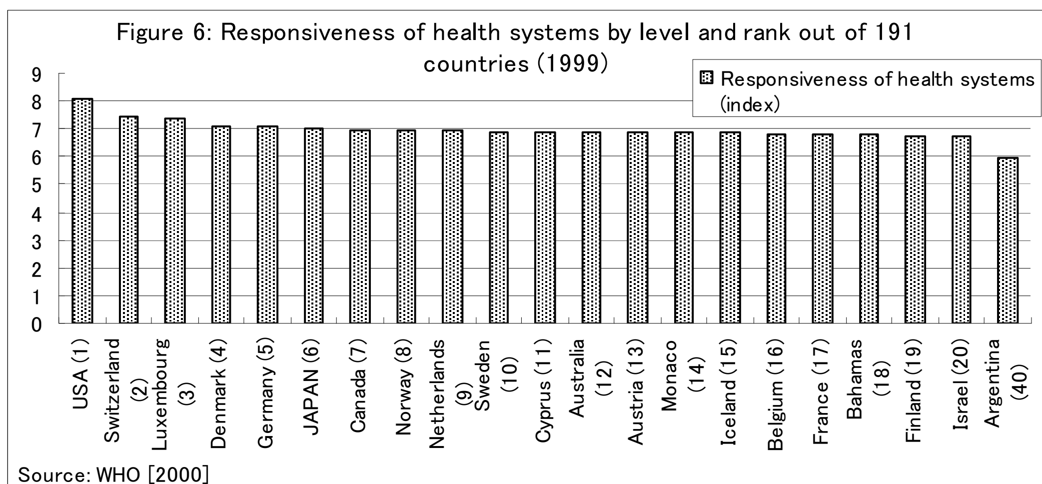


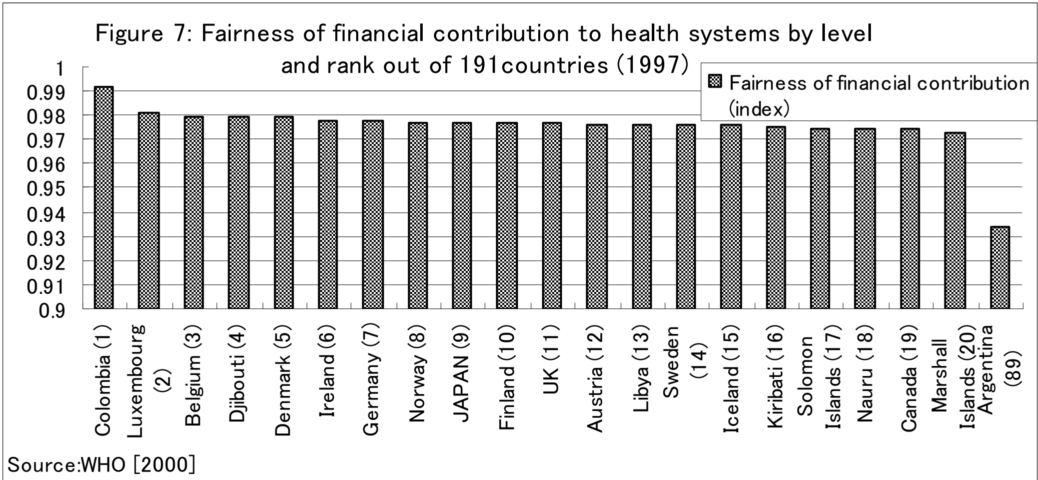
2. Neoliberal reforms and their effects

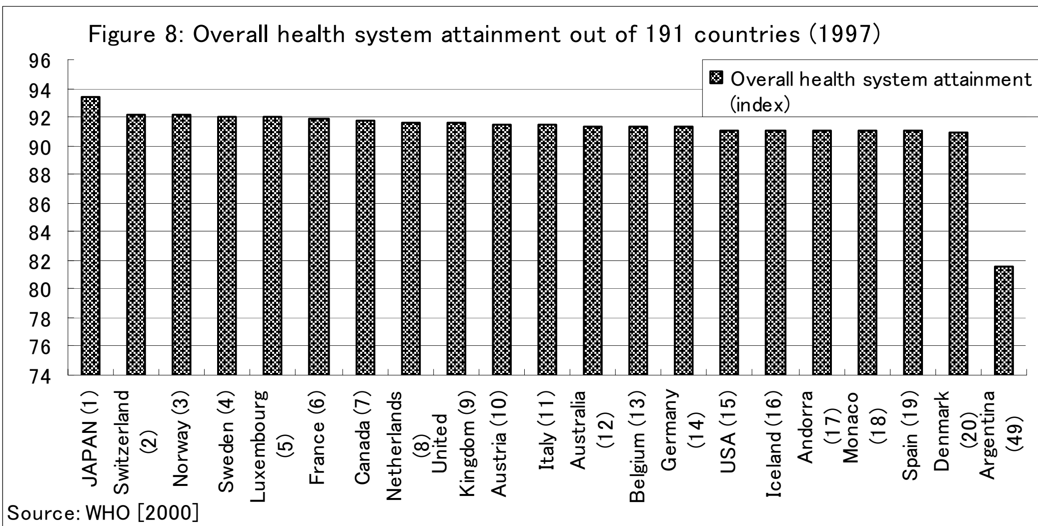
Japan is credited as having one of the best healthcare systems in the world, keeping its population exceptionally healthy at a lower cost than most other countries in the OECD group. In this respect, the World Health Report 2000 placed Japan first in 191 countries for overall health system attainment (WHO [2000] p.197). This ranking is a composite of other rankings which include health attainment[9] (1st) (figure 5), responsiveness of health systems[10] (6th) (figure 6), and fairness of financial contribution to health systems[11]

(8th) (figure 7) (WHO [2000] pp.176, 184 & 188). Additionally, in health system performance, it was ranked 9th (figure 8) (WHO [2000] p.200)[12]. Nonetheless, despite all these positive traits, significant inequities have been and are increasingly present in Japanese health care. These inequities include financial inequities between private and public hospitals[13], the number and quality of hospitals and physicians between rural and urban areas as well as inequities between users of medical services. The ongoing structural reforms, begun by the Ryūtarō Hashimoto governments and continued by its successors, have only deepened and exacerbated these inequities.







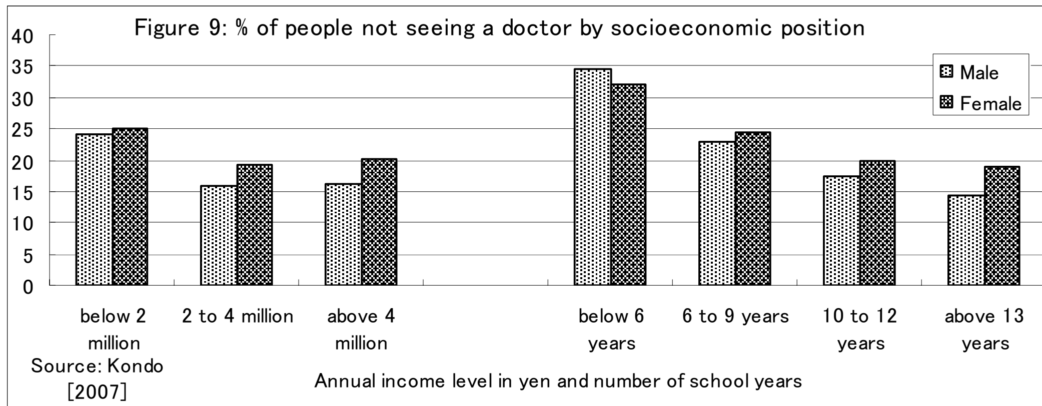


The various structural reforms, begun under Hashimoto and continued by Jun’ichirō Koizumi and subsequent governments, have made life more difficult for an increasing number of people. Many young people are being forced to live with low wages doing unstable jobs under harsh conditions. Old people have seen their living conditions worsen thanks to tax reforms which has increased their tax burden. Also, with the reforms in healthcare, their burden of medical expenses (out of pocket expenses) has also increased. In addition, with the revision of the Elderly Care Insurance Law, their nursing care services have been cut. The worsening living conditions not only apply to the young and old. The number of households on welfare (receiving livelihood protection) has increased from 751,303 in 2000 to 1,041,508 in 2005 (NIPSSR [2007a]).

Structural reforms have been carried out in order to help the corporate sector recover from the burst of the bubble economy. This has been done through an easing of regulations which saw labor costs being trimmed through labor flexibilization. In this respect, companies were given a free hand. The easing of regulations over capital led companies to reduce personnel costs. Company mergers and acquisitions did nothing to protect employees: many were dismissed and those who stayed on the job saw their working conditions worsen. In this way, the general condition of workers became more severe, especially for young people. Approximately half of those aged 24 and under hold an irregular job (usually without healthcare and/or pension benefits) as casual employees, working part-time, under contract or as dispatch workers earning one third of the income of regular workers. In line with the above policies, the Shinzo Abe government sought to further loosen labor regulations by implementing a 'labor big bang' policy. This included a reform of the social security system consisting of an increase in out-of-pocket medical expenses and a decrease in nursing care services. Abe upheld his vision to establish a sustainable social security system where those who finance the system (companies and the nation) would do it within a manageable range (Yanbe [2007] pp.4-7).

The structural reforms, with the insistence in shrinking an already small government, have increasingly made the government abandon the social responsibilities it is supposed to fulfill. This is perceptible in the growing gap among the regions in Japan. This gap, connected to the process of regional decentralization, is due to the reduction of tax allocations among the regions. The disparity of tax revenue, related to the interregional income disparity, leads to a difference in the quality of services provided by local communities. This difference in services creates a feedback effect concerning the income difference of people in these communities. In order to correct this imbalance, the thinking of Koizumi and later Abe has been to stimulate the rich by making them richer and making companies achieve higher profits. This would foster a trickle down effect towards the rest of society. This has not happened. Companies have hoarded their cash rather than pay more out in the form of higher wages. Also, the trickle down effect performed by the income redistribution policy of the welfare state in Japan is weak and with the lowering of taxes on companies and high income earners, the minimum level of taxable income has been lowered. This puts an additional burden on household budgets whose expenditure on healthcare and education already occupy a big part. The small government model advocates a relatively small amount of expenditure on public services, helping only a part of the poor through social assistance. It insists that people should really struggle and find ways to get ahead on their own. The model states that there are many easy-living false poor people receiving aid and that assistance should be narrowed down to those who are genuinely poor (Miyamoto [2007] pp.10-11).

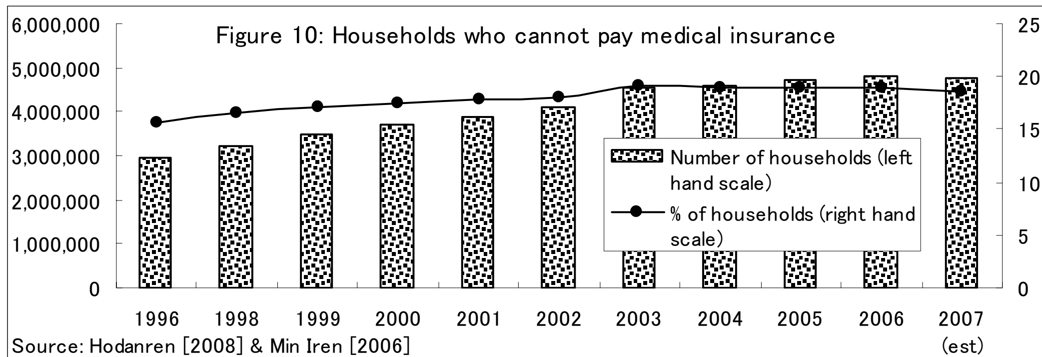
There is a growing perception in Japan that the structural reforms have brought about a widening income gap. This income gap has led to disparities in the healthcare people receive. According to a survey by Kondō [2007], for people aged 65 years and up, there is a socioeconomic gap in the access and availability of healthcare: a direct relation can be established between various health indicators (subjective sense of well being, depression, remaining teeth) and the level of income and education. Among the many causes in the socioeconomic disparity of healthcare, the most obvious one is the lack of financial means. After satisfying their everyday necessities, people are left without enough means to go to a hospital or see a doctor. The present ongoing healthcare reform, whose objective is to moderate national healthcare costs, has as a strategy to transfer an increasing part of medical costs onto patients. This has the effect of restraining people, who wish to receive medical treatment but can't afford it, to see a doctor and may thus contribute to their deteriorating health, in effect widening the healthcare gap[14]. According to the findings of the survey, unhealthy people who have low income and a low education levels tend to see doctors less (figure 9) (Yoshī [2007] pp.14-17).

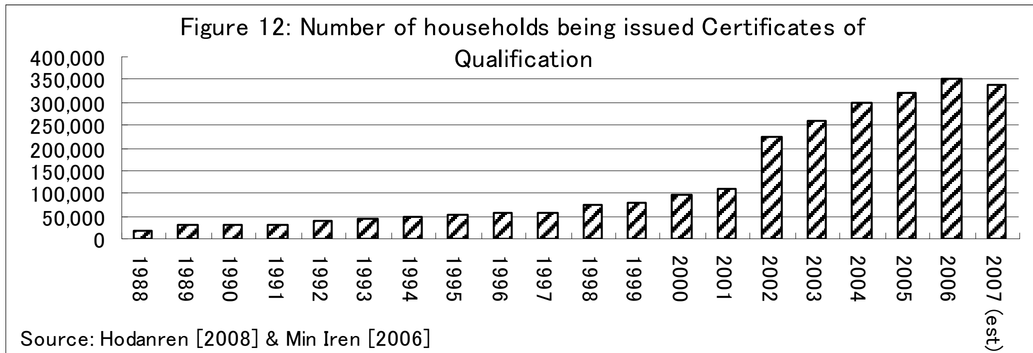


The reforms implemented by Koizumi and continued by Abe have brought great suffering to the Japanese. All over the country, serious cases are been reported of people who are refused medical treatment because they have been deprived of their National Health Insurance (NHI) card. The number of households affiliated to the NHI who cannot pay medical insurance remains high. In 2007, this number stood at 4,746,032 which is a slight improvement on the previous year whose number was 4,805,582 (figure 10) (Hodanren [2008]). In a two year survey (Jan 2005 – Dec 2006) by Min Iren [2007], affiliated establishments

in 16 prefectures across Japan reported 29 cases of death from deprivation of the NHI card.

The national government has been very strict about lowering its burden of medical costs, which have increased on a par with elderly health care. As it has done so, local communities have had to increase their health insurance premiums. The nation, which contributes to approximately half of the NHI finances, seeks to lower that proportion to 30%, which would need the NHI premium to rise to more than 10% of income. This is the same as being subjected to two or three times the burden of a salary man (usually affiliated to a corporate social insurance plan). This high premium will most likely produce more households which are unable to pay their premium, additionally worsening the finances of the NHI. When households stop paying their insurance, they receive a Short Term Insurance Card which lasts three to six months and are still able to receive healthcare (see evolution in figure 11). After that, they are issued a Certificate of Qualification (CQ), which despite its name, 'qualifies' a patient to pay 100% of the costs of medical treatment. This certificate is nothing more than a deprivation of the NHI card. The rise in the issue of CQ is preventing people from seeking medical care and leading many to their deaths (figure 12) (Hara [2007] p.22).





Starting in April 2008, the Medical System for the Very Elderly (MSVE) will be set up for the elderly aged 75 years and up. This system, by "establishing a more equal and transparent relation between costs and benefits across generations" (MHLW [2005]), will increase the burden imposed on the elderly. Already in October 2006, the co-payment of people aged 70 years and older with an income level equal to active wage earners went from 20 to 30%[15]. Moreover, those aged 75 and up will have to start paying insurance premiums. This also includes family nonworking dependents aged 75 and up. In total, this accounts for 2,000,000 people who will start paying premiums (besides what they already pay for LTCI). Those who cannot pay will undergo the same treatment applied in the case of the NHI. This will deprive a growing number of elderly people access to healthcare and nursing care (Hara [2007] pp.22-23).

The structural reform is creating an increasingly unequal society, leading to unequal access to healthcare, affecting the quality of life and health of people. With the implementation of the healthcare reform, whose number one goal is to decrease costs, Japan is fast becoming a society where only the rich can live a long and healthy life.

History and evolution of the health sector in Japan

1961	Universal health coverage
1973	Healthcare Reform (improvement of benefit level, introduction of the upper ceiling for patient cost-sharing). Free healthcare services for the elderly.
1983	Introduction of Health and Medical Services for the Elderly (HMSE). Free healthcare services for the elderly abolished. The elderly start paying 10% of their medical expenses.
1984	Introduction of a 10% co-payment for all medical services. Amendment of the High Cost Medical Care Benefits Law of 1973 (introduction of a cap on monthly co-payment set at ¥63,000 per month for middle and high-income families and ¥33,600 for low-income families).
1989	Gold Plan (Ten-year Strategy to promote Health and Welfare Services for the elderly).
1990	Welfare Reform (Home services, Health and Welfare plans for the elderly by municipalities). Introduction of prospective payment for chronic care in geriatric hospitals.
1994	Patient charge on inpatient meals. New Gold Plan: Angel Plan.
1997	Launch of “drastic reform” offensive in Healthcare (the co-payment is raised to 20%, introduction of patient charge on prescription drugs).
2000	Increase in patient cost-sharing. Start of the implementation of LTCI (Long-Term Care Insurance).
2001	Launch of a prospective payment system pilot program for acute care based on the Japanese Diagnosis-Related Groups (DRG). Proposal for expansion of the Special Healthcare Expenditure.
2002	Healthcare reform (repeal of the patient charge on prescription drugs, contribution based on annual earnings). Introduction of a 10% co-payment for the elderly.
2003	Experiment of DPC (Diagnosis Procedure Combination) Reform proposal on the healthcare system for the elderly. The co-payment is raised to 30%.
2005	LTCI reform
2006	Increase from 20% to 30% in the co-payment of the elderly aged 70 years and older whose income level is equal to active wage earners.
2008	Increase from 10% to 20% in the co-payment of the general elderly population aged 70 to 74 years.

Source: Fukawa [2005], Okamura et al [2005], Gotō [2002] and Yoshikawa et al [1996].

3. Alternatives to the neoliberal reforms: medical cooperatives – history and evolution

Before WWII, Japan did not have a single national hospital. Today’s national hospitals were all army and navy hospitals. After the war, approximately 150 of these institutions became national hospitals. Before, in agricultural communities, most farmers were poor and had no health insurance, in particular, they had no access to doctors. Doctors and hospitals were to be found in the cities, but they were still out of reach of the general population. It is in this context that the ‘socialization of care’ movement (which seeks equality in healthcare) is born (Takayanagi [2007] pp.12-14).

During the Edo period until the Meiji Restoration, the conditions under which the common person had access to medicine remained the same. Medical care was very expensive[16], and payments were made on an ability to pay basis. Payments were made during Bon Festival or at year end festivities. In theory, the rich

paid munificently, to cover the services provided to the indigent. At the start of the Meiji period there were 30,000 doctors in Japan, but most followed Chinese medical practices. Only a few practiced Western medicine, which had been introduced by the Portuguese in the XVIth century and later continued by the Dutch. The new government, in its attempt to create a 'prosperous country and strong army' decided to adopt Western medicine, following the German model, mainly for the support of the army, law and order and for the preservation of the *Kokutai* (the Emperor-centered national policy). In 1877, the Faculty of Medicine of the University of Tokyo was established. In most prefectures, medical schools were also established as annexes to national hospitals. Many private hospitals were also founded, totaling 626 by 1882. Nonetheless, the population at large had to resort to private practitioners as these new national hospitals were made available only to commoners with a high social standing and to those of samurai ancestry. Also, medical fees at private hospitals were quite expensive. In 1887, with the Matsukata deflation, the number of national and private medical schools decreased. National hospitals were either closed or transferred to private control. Private hospitals and private practitioners prospered. Nonetheless, the common man still had no easy access to healthcare. That same year, the Japanese Red Cross (JRC) was founded, renamed from the Philanthropic Society which had been active during the Satsuma Rebellion. Although a part of the JRC was devoted to helping the poor, its main purpose was to train human resources (army nurses) to correspond to the needs of the military and the Imperial Household. After the Russo-Japanese War, through the Medical Service Law, it became a public medical institution with 100 establishments all over Japan (Ikegami & Hasegawa [1995] p.34 and Takayanagi [2007] pp.14-20).

The government, in order to bring under control the revolutionary danger posed by the growing plight of workers, established in 1911 the Imperial Relief Association (*Onshi Zaidan Saiseikai*) in order to provide free medicine dispensation and aid to the poor and sick. The next year it started establishing hospitals. By 1936, it was composed of 15 hospitals, 61 clinics and 4 other institutions. Nonetheless, in the post World War I (WWI) depression, with the rise in the number of unemployed and poor, the Saiseikai could not meet expectations and went bankrupt. In 1924, with the termination of free dispensation of medicine in favor of fee-based medical care, the Saiseikai deviated from its original purpose. Cost Price Clinics (*Jippi Shinryōsho*) established in 1911, provided medical care to low income classes, comprised of minor officials, clerks, salespersons, teachers, patrol officers, students, apprentices, and other types of workers, i.e., those whose daily income was under 1 yen and 50 sen. While the objective of the Saiseikai was poverty relief, for the Cost Price Clinics (CPC) it was poverty prevention. The setting of these two models was seen as a way to ensure

the provision of a healthy workforce and to prevent the outbreak of dangerous ideas that would threaten public peace and the political establishment (the *Kokutai*). They formed the basis of the social insurance system that emerged after 1926. By 1929, there were 153 CPC around the country, including local communities. By charging one quarter of private practitioner's fees, they were fiercely opposed by the Japan Medical Association (*Nihon Ishikai* or *Ishikai*), nonetheless, they provided services to lower class city workers which were shunned by the Ishikai. With the establishment of Health Care Utilization Cooperatives (HCUC: *Iryō Riyō Kumiai*) in 1919 and the implementation of the Health Insurance Law in 1927, a system started to be created to fill in the role of CPC, which after 1930 suddenly declined. Providing health care to rural areas was especially difficult. Remote, out of the way poor villages were increasingly without doctors as fewer of them were willing to practice in rural areas. The number of rural towns and villages without doctors increased from 2,900 in 1929 to 3,200 in 1935, roughly one third of all towns and villages at that time. Also, another third were being served by a single doctor. In big cities there was a surplus of doctors, but only those with financial means had access to them. In the villages, trachoma, parasitic infections and tuberculosis were widespread. Since farming villages were the source of supply of workers and soldiers, the health problems of villages naturally affected the whole country. The army could not disregard this matter, consequently a National Health Insurance System was established in 1938. The task of providing healthcare to medically underserved rural villages was also carried out by Health Care Utilization Cooperatives. The relationship between farming villages and healthcare dates from 1900 with the establishment by Diet legislation of industrial cooperatives (*sangyō kumiai*) predecessor to today's *nokyo* (farmer's cooperatives). Initially, credit, purchase and sales services were created. Then in 1919, the first medical cooperative was established in the village of Aobara, county of Kanoashi, Shimane prefecture. At the beginning of the Showa period, with the financial crisis brought on by the bankruptcy of the Suzuki trading company, farming villages were hit especially hard. In this context where people's livelihoods were reduced to poverty, medical cooperatives spread across the country, including cities. In 1931, the Tokyo Health Care Utilization Cooperative was established. In 1933, there were 103 cooperatives which increased to 149 in 1937. By then, 20% of municipalities across the country were served by these cooperatives. The HCUC's main goal was the self-preservation of farmers and villagers. Their purpose initially was to ensure the provision of doctors and medical institutions, then to reduce medical costs. The HCUC model arose in opposition to the private practitioner system. Its fees were half or less than those established by the Ishikai. In 1936, the hospitals of the HCUC took on the responsibility to provide nationwide health coverage in order to guarantee Japan's

manpower resources. After WWII, the HCUC renewed this pledge through public welfare affiliated entities such as agricultural cooperatives hospitals, medical cooperative hospitals and prefectural hospitals (Ikegami & Hasegawa [1995] p.35, Takayanagi [2007] pp.21-29 and Irohira [2008]).

Proletarian Clinics (*Musansha Shinryōsho*) first appeared in 1930. Ideologically as a part of the Proletarian Liberation Movement, Proletarian Clinics aimed at the socialization of medicine, by revolutionizing the medical system and guarding the health and livelihood of workers, farmers and other working class citizens. Proletarian Clinics started as a volunteer organization, part of the Tokyo Imperial University Settlement, during the Great Kantō Earthquake. The Proletarian Clinics Movement was thoroughly against the capitalist moneymaking commercialization of medicine emphasizing the need to establish a system where everybody could receive medical care. In the early 1930s, in a population of 70,000,000, only 2,000,000 factory and coal mine workers had health insurance without including family dependents. By 1936, the movement had 1 hospital and 23 clinics established in ten prefectures. It was especially strong in Niigata with the Gosen and Kuzutsuka clinics which lasted until 1941, year when the Proletarian Clinics Movement disappeared. Some of the reasons for its disappearance are the way it was used as a political tool, its lack of connection with the general public and its lack of unity. Nonetheless, among the Cost Price Clinics, the Health Care Utilization Cooperatives and the Proletarian Clinics, it is in this last one that doctors themselves took a more active role in the socialization of healthcare. After the disappearance of the Proletarian Clinics, all medical organizations were absorbed into the wartime system. Under the slogan '*kenhei, kenmin*' (healthy soldier, healthy citizen), the army sought to secure healthy citizens in order to serve and fight in the war. For this purpose, it stationed health nurses and set up clinics in medically underserved villages, and established the Ministry of Health and Welfare in 1938. That same year, the Health Insurance Act instituted the National Health Insurance System. Together with the enactment of the Sailor's Union Law, the Employee Insurance Law (which gave health insurance benefits to dependents) and the Private Worker Pension Law, the general framework of Japan's social security system started to appear. After the defeat, major reforms were carried out during the occupation period (1945-1951). A new constitution was introduced in 1947 which states in its 25th article that the government is responsible for providing a minimum level to the people to help them achieve a healthy and culturally enriching life. This has formed the basis for Japan's public assistance programs. During the era of high speed economic growth, in 1961 the Universal Health Care Insurance System was introduced (Ikegami & Hasegawa [1995] p.37 and Takayanagi [2007] pp.30-38).

In the prewar and postwar periods, the private practitioner led Ishikai organization has long been

accommodating to the authorities, turning its back on the people, in this way not fulfilling its social mission. It has often been thought of as the embodiment of money-making. During the prewar period, the Ishikai, in its pressure to limit the number of hospitals established (in this way guaranteeing its share of patients) has caused many rural communities and other areas to be medically underserved. The establishment of medical cooperatives in these areas can probably be attributed to this policy by the Ishikai. In the postwar period, by submitting to the policy of low medical costs by the Liberal Democratic Party (LDP), it has neglected its duty to fight for the rights of patients and healthcare workers. However, nowadays Ishikai organizations across the country openly criticize the healthcare reforms of the government. In this respect, the Ishikai has been greatly influenced by the concerted efforts of the Medical Practitioners Association (Hokeni Kyōkai) and the Japanese Medical and Dental Practitioners for the Improvement of Medical Care (Hodanren) and by the growing awareness of citizens. The Ishikai believes that introducing a mixed medical system (not covered by medical insurance), as has been proposed by Prime Minister Koizumi, would lead to the collapse of public health insurance coverage for all Japanese. The division between citizens and the Ishikai, promoted by the government, may be slowly starting to close (Hanai [2005] and Takayanagi [2007] pp.39-40).

The Japanese medical system, under the Universal Health Care Insurance System, has made good use of the division of roles performed by public medical institutions and by private non-profit medical institutions. Since the Meiji period, private practitioners and medical institutions, such as national public hospitals, university hospitals, the Japanese Red Cross, the Saiseikai, Kōseiren[17] healthcare facilities and other categories of public hospitals have played a central role as providers of healthcare in local communities. This distinctive public and private mixed system has helped to guarantee the *publicness* or public nature of medical care[18]. Presently, the public and social nature of Japan's healthcare is supported by private medical institutions based on the public medical insurance system and the principle of non-profitability[19]. Private medical institutions include insurance associations, healthcare corporations[20], individual (physician) owned hospitals, cooperative organizations, etc. They represent 80% of hospitals, 95% of clinics and have 70% of beds. With respect to cooperative organizations, the Kōseiren hospitals and health care facilities, operated by the prefectural welfare federations of agricultural cooperatives (JA group), play a very important role in rural areas. Cooperatives in cities include Medical Cooperative Hospitals, part of the Health Co-operative Association of Japan Consumers' Co-operative Association (JCCU). Also, medical and public benefit corporations affiliated to the Japan Federation of Democratic Medical Institutions (Min-Iren)[21] can also be considered as cooperative organizations (Yoshikawa [1996] p.31 and Kakurai [2007] pp.62-68).

A characteristic that distinguishes these cooperative organizations from other medical institutions is their active citizen participation. The structure of the business operation of cooperatives includes not only the board of directors and representatives of healthcare workers, but also representatives of members of the cooperative. In the management of medical cooperatives, the opinion of patients and local residents is also reflected. Healthcare professionals together with user members strive to improve the medical and welfare system of cooperatives. Health cooperatives of JCCU number 116 and have around 2,600,000 members. Most of them engage in health precaution and promotion activities, have *han* (groups) which raise awareness on the social security and medical systems as well as in health issues, and include movements led by patients and local residents to improve the medical system. Moreover, certain cooperatives publish regularly their own newsletters with opinion articles for members to read regarding the change in the medical system, the revision in the medical service fee, etc. When medical cooperatives are in need of funds to build new medical institutions or acquire new equipment and machines, they usually don’t rely on the emission of shares and bonds, instead depending on the contributions of people from the local communities. Nonetheless, Min Iren does often take ‘special cooperation loans’ which pay very little interest from local residents (Iwamoto [2007] pp.92-93 & 100-103).

4. Niigata Medical Cooperative

In this paper, the Niigata Medical Cooperative, member of the Health Co-operative Association of Japan Consumers' Co-operative Association, is taken as the subject of research. The reason for choosing this cooperative, a successor to other historic cooperative movements in the area[22], include the fact that it is situated in one of the prefectures with the highest shortage of doctors in Japan (see figure 21). This phenomenon, which affects all areas of Japan, is more perceptible in Niigata prefecture. In this context, Niigata Medical Cooperative can probably provide valuable lessons to other medical cooperatives in Japan as to the role that they can play in this age of structural reform and how to cope with its ensuing problems.

The history of the Niigata Medical Cooperative goes back more than 30 years. In 1976, Kido Hospital, part of the Niigata Medical Cooperative, was opened in Kamedagō (a part of Niigata City) counting 1100 members. Kamedagō was formerly known as Ashinuma, a flooded muddy rice field. In the prewar period, Ashinuma was repeatedly flooded every autumn by the two big rivers Shinano and Agano making life difficult for farmers. This, in addition to the annual land tax, pushed many of them into extreme poverty. In

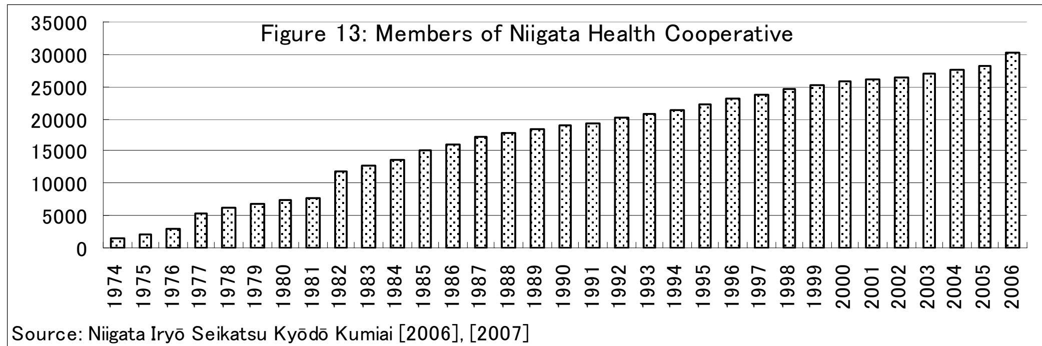
1922, in the middle of this life and death situation, a great peasant revolt broke out, which became known all over Japan as the Kisaki Dispute. The power of solidarity and reform of this prewar struggle became directly connected to the postwar emancipation of farming land and to the beginning of a grassroots movement towards local, social and livelihood improvement. The Ashinuma marsh was reclaimed in 1945 through the efforts of local farmers (Zenshinza “Akahige” [2007], p.2).

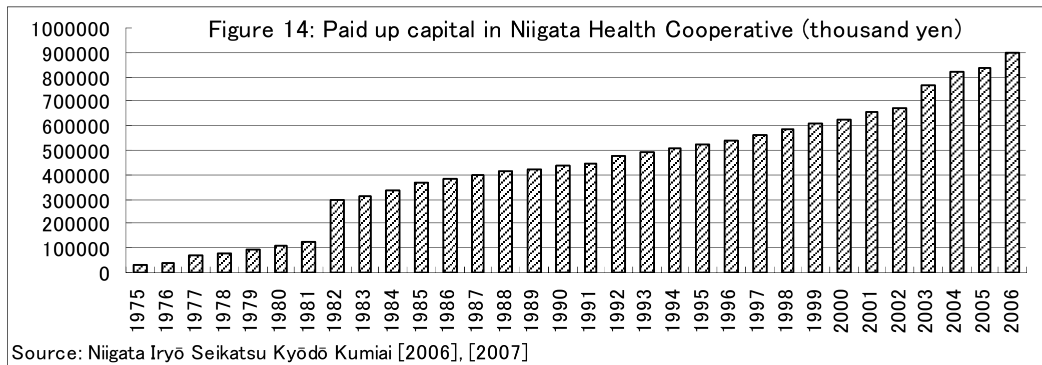
The Niigata Medical Cooperative itself was founded by a movement which has struggled to protect the land and livelihood of local farmers. The founding of the hospital reflected the wishes of the local citizens, promoting regional development based on the development of medicine and welfare. The factors behind the building of the hospital include: making a hospital for working people, establishing a place to protect the health and extend the lives of the common person while contributing to regional development and to create a hospital cherished by everybody. The growing need for the provision of hospital services became very apparent in the 1960s, in the context of the 1964 Niigata Earthquake, the 1965 outbreak of Minamata disease and floods in 1966 for the second straight year which demanded an increase in the availability of medical and relief services. Three very important people stand out concerning the establishment of Kido Hospital. They are Seiichi Sano, Communist Party city councilor, Tōzaburō Sano, chief director of the Kamedagō Land Improvement District and Shūhei Miyoshi, landowner and president of the Ishiyama First Farm Cooperative before the 1947 land reform. Together with the help from youth organizations, agricultural societies, land improvement board members, shrine parishioners, festivals, youth from villages and local doctors, they set out to establish a medical system. In 1974, in the preparatory meeting for the establishment of the Niigata Medical Cooperative, founding executive director Miyoshi donated land. After careful planning, it was decided to build Kido Hospital at Kamedagō. Tōzaburō Sano initially expressed his wish to develop a good medical policy which could guarantee the satisfaction of all and where money concerns would come later. This has been the objective of successive directors such as Hisashi Saitō, Shigemi Inomata, Itsuki Hama as well as the many pioneering doctors and other healthcare professionals. This cooperative movement to protect the work, livelihood and health of the socially vulnerable has in some way sought to emulate the Koishikawa Yojosho movement during the Edo period[23]. The Niigata Medical Cooperative seeks to carry out a system which consists in making the members of the cooperative and patients the main characters in the preservation of their health. Under the slogan “building a town where one can give birth, raise a child and grow old”, the cooperative has expanded to include one hospital, two clinics and four nursing care establishments and medical welfare institutions, rapidly developing into a local network[24]. The nursing care

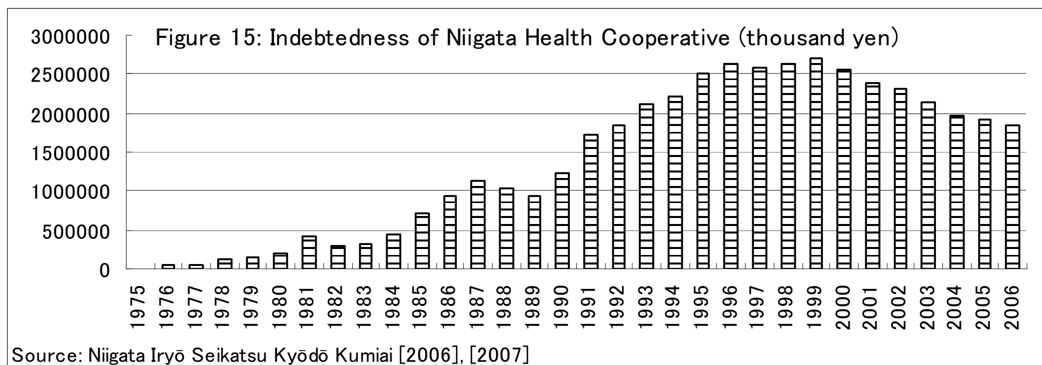
and welfare activities of the Niigata Medical Cooperative, its very own health examination center, the various health nurses systems in charge of the health monitoring of cooperative members and local citizens, and the measures for dealing with lifestyle related diseases have brought national attention to the cooperative. This includes the development of its night emergency reception system, unattended nursing as well as continuous nursing systems, nutritional management system, the implementation of a patient bill of rights, etc (Niigata Iryō Seikatsu Kyōdō Kumiai [2006] pp.2-3, 6-12 and Zenshinza "Akahige" [2007] p.2).

Despite these positive traits, Niigata Medical Cooperative has not been immune to the worsening conditions in the health sector brought on by the undergoing neoliberal reforms in Japan. Even though its membership has continually grown and with this the amount of paid up capital, and despite the decrease in the level of indebtedness (in order to improve the financial standing of the cooperative), gross earnings have only recently begun to grow while the number of outpatients has been decreasing with the number of inpatients remaining the same[25] (figures 13 to 18). In recent years, hospitals in Japan have been subjected to chronic operating losses due to increasingly lower medical fees (as a result of the cost containment policies of the structural reforms under Koizumi). This is visible in both public and private hospitals. Nonetheless, Public hospitals receive subsidies in order to continue operating. However, private as well as public hospitals have had to be closed down. Without subsidies, private hospitals are facing a more difficult situation. Despite this, private hospitals can become profitable if they concentrate on specific more remunerative sectors such cardiology, gastroenterology, and ophthalmology while withdrawing from less lucrative sectors such as the outpatient sector, emergencies and pediatrics and by shortening hospital stays. Hospitals have concentrated on inpatients transferring outpatients to clinics[26]. In this way, Niigata Medical Cooperative has had to find ways to use its available staff (nurses and doctors) in a more efficient way by giving priority to inpatients over outpatients (which require more staff), by giving more attention to patients with more serious illnesses, such as lifestyle related diseases, by taking measures to improve the daily life of patients and promote preventative medicine, etc. However, depending on these measures alone may have its limitations. In the background of continuing structural reforms, the income coming from the provision of healthcare services may level off. But Niigata Medical Cooperative does not provide only healthcare services like other hospitals. In addition, it provides welfare services to the elderly. Normally in Japan, these two sectors are offered separately, by different institutions. But Niigata Medical Cooperative makes sure welfare services are given to the elderly in the community, which are anxious about their future. Niigata Medical Cooperative does not only depend on the income generated by healthcare for its operations, it also relies on the income coming from welfare which

is expected to grow as the aging of Japanese society accelerates (Suzuki A. [2003] pp.3-4 & 13-14, Suzuki K. [2008a, 2008b], Iwamoto [2007] p.87 and Niigata Iryō Seikatsu Kyōdō Kumiai [2007] p.38).







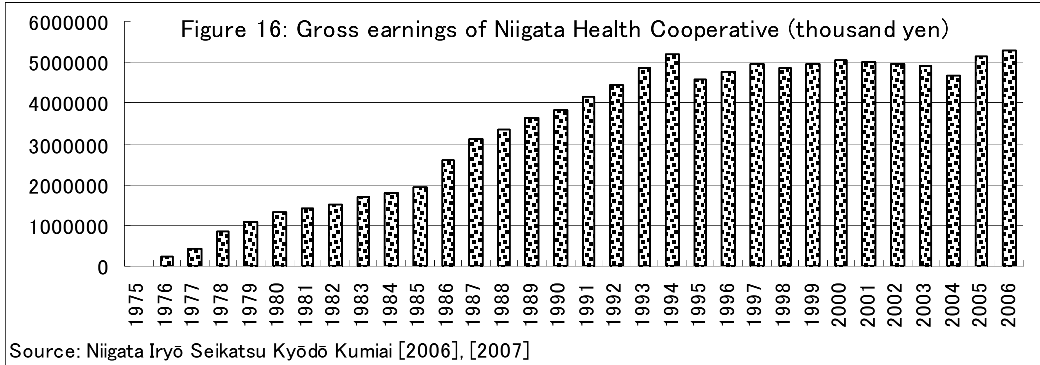


Figure 16: Gross earnings of Niigata Health Cooperative (thousand yen)

Source: Niigata Iryō Seikatsu Kyōdō Kumiai [2006], [2007]

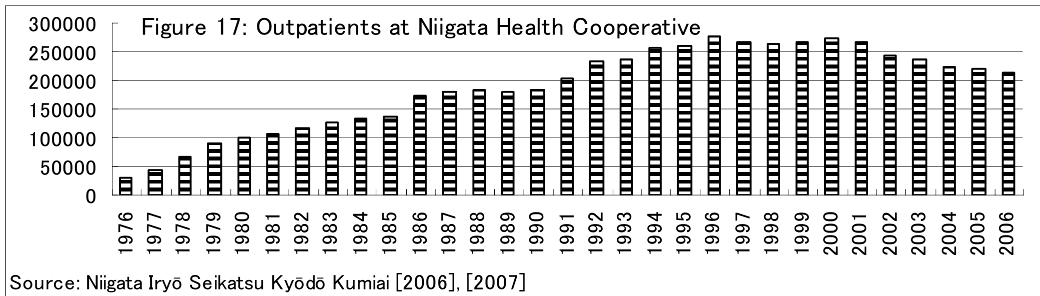


Figure 17: Outpatients at Niigata Health Cooperative

Source: Niigata Iryō Seikatsu Kyōdō Kumiai [2006], [2007]

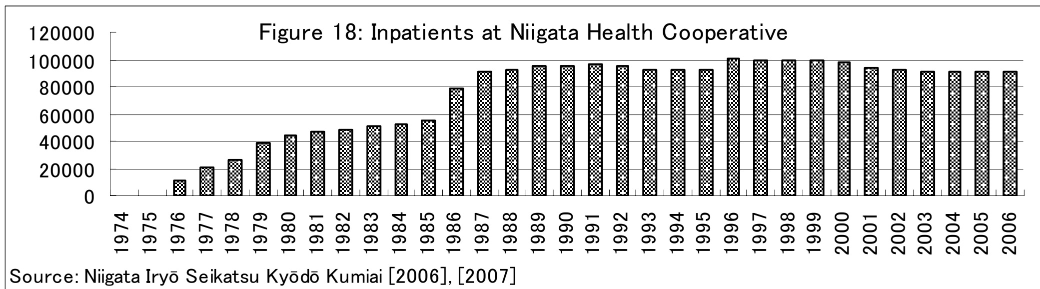


Figure 18: Inpatients at Niigata Health Cooperative

Source: Niigata Iryō Seikatsu Kyōdō Kumiai [2006], [2007]

Due to the efforts by the government to bring medical costs down, it is increasingly difficult to continue running private hospitals, which brings hardships to hospital workers who get terminated. To combat this, efforts have been made in Kido Hospital to raise earnings. This can be done not only by offering medical care, but also by offering services related to helping with livelihood problems. Accordingly, for this to happen, a new system with a bigger scale of operation is needed. At the present time, under the actual financial conditions, using income and profits to finance an expansion is difficult. In Kido, because of the close connection between members of the cooperative and the hospital staff, people from the community invest in it more and more, and so more staff is allocated to meet their needs. It's a symbiotic relation between the hospital and the community. The contributions from the community have made it possible for Kido Hospital

to continue to perform its work. The efforts of the hospital and the community, working together in cooperation, are what help improve the financial situation of the hospital and make it possible to offer better services (Suzuki K. [2008a]).

A new hospital is expected to be built. The plan for the construction was presented to the cooperative at the 2006 general representative meeting and approved, but it was determined that the number of doctors should be promptly decided (in the context of staff shortages in today's Japan) so as not to build a useless hospital. Due to the ongoing structural reforms, it is not possible to build a hospital depending on turnover and earnings. For this, members of the cooperative were consulted in order to help in the construction and to seek investment funds. One billion yens are needed in order to build the new hospital. Niigata Medical Cooperative does not want to rely on loans, reaching out instead to local citizens. But it takes time to gather interest free funds as well as to get the consent and understanding of local citizens. In addition, under the structural reforms, the income of citizens has probably decreased following the general trend observed in Niigata City (figure 19). There are approximately 30,000 members in the Niigata Medical Cooperative, but not all are expected to contribute, perhaps only half. If each one of these 15,000 were to invest 100,000 yen, the objective would be surpassed. Local citizens have understood that it is up to them to solve their growing fears and concerns about the future, that they cannot rely on the government. In October 2007, in a special general meeting, it was estimated it would take 5 years to collect the necessary funds for the new hospital. Construction is expected to start in autumn of 2008 (Suzuki K. [2008a, 2008b] and Niigata Iryō Seikatsu Kyōdō Kumiai [2007] pp.20-22).

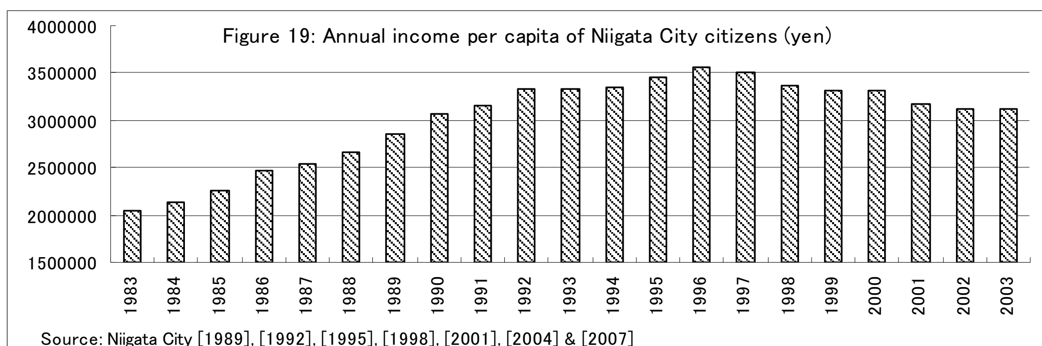


Figure 19: Annual income per capita of Niigata City citizens (yen)

Source: Niigata City [1989], [1992], [1995], [1998], [2001], [2004] & [2007]

Niigata Medical Cooperative appears so far to endure despite the conditions imposed by the structural reforms. But can it be a model as a way to cope against the worsening conditions in the medical

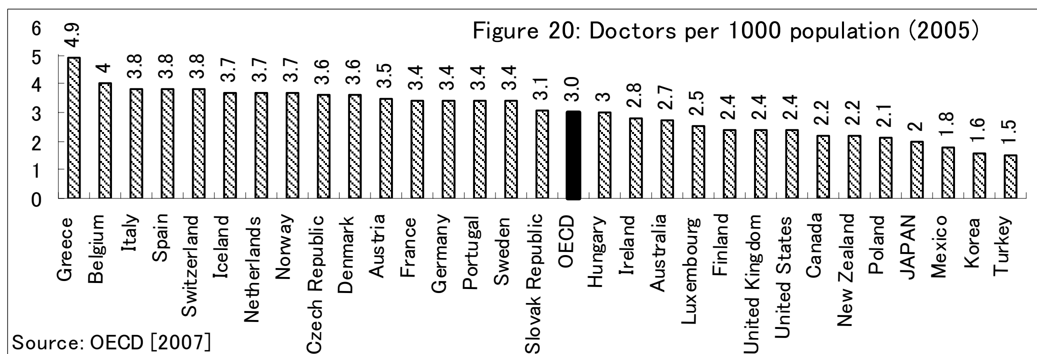
sector? Can the example of this cooperative be extended to other places in Japan? Niigata prefecture is witness to cases of perseverance such as shown by Niigata Medical Cooperative but it is also witness to failures as in the case of Himekawa Hospital, part of Itoigawa Medical Cooperative which went bankrupt in 2007. Himekawa Hospital was located in the city of Itoigawa (population: 50,000), in the southern part of the prefecture. Being a medically underserved area, 6,000 residents got together and established Itoigawa Medical Cooperative in 1985 contributing each with a share of 5,000 yen in capital dues, opening Himekawa Hospital in 1987. When it closed, it was fully equipped with the latest CT, MRI and SPECT machines. It included many departments such as internal medicine, respiratory diseases, cardiology, surgery, etc. The causes of its bankruptcy are: (1) the healthcare structural reform. Starting in 2002, medical service fees (paid to medical institutions under the medical insurance system) were reduced on three occasions. Each time, tens of millions of yen were lost in income. Income fell to 1.3 billion yen from 2 billion yen in 2000, its peak year; (2) shortage of doctors. The number of doctors went down from 14 in 2000 to six in April 2007. With this decrease in doctors, the income of the hospital also decreased; and (3) failure to rationalize management practices (NTV [2007], CB [2007] and Endō [2007]).

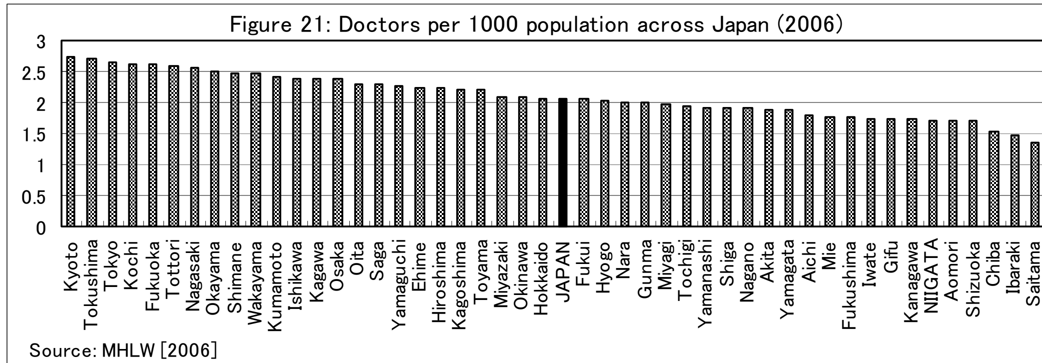
According to Katsuo Suzuki, executive director of the Niigata Medical Cooperative, the background and conditions under which Itoigawa Medical Cooperative developed, its management style and identity differed with Niigata Medical Cooperative and with other cooperatives throughout Japan. Niigata Medical Cooperative is part of the Health Cooperative Association of the Japanese Consumers' Co-operative Union (JCCU)[27], to which Itoigawa did not belong. Even though it was a cooperative, it had different ways of doing things and of thinking compared to Niigata Medical Cooperative. Around 25 years ago, due to the local unfulfilled need for medical care, local citizens demanded that a hospital be built in the area. Under pressure, the mayoral authorities and local leaders at first planned to build a city hospital, but under the difficulty of directly building a city hospital, it was decided instead to build a cooperative hospital by copying the setting up of the Niigata Medical Cooperative. Nonetheless, from the start the objective of the authorities was to make a city hospital, not a cooperative hospital, by using the contributions of local citizens for their own purpose. In the Niigata cooperative, the board of directors is a representative of the citizens of the community. Kido Hospital is managed by a director from the area. In Itoigawa, the board of directors did not have the same kind of connections with the community. Also, its management structure was more hierarchical. The director of the hospital received a substantially higher wage than the rest of the staff. The hospital did not perform as expected. The number of patients did not grow according to expectations. Managing the hospital

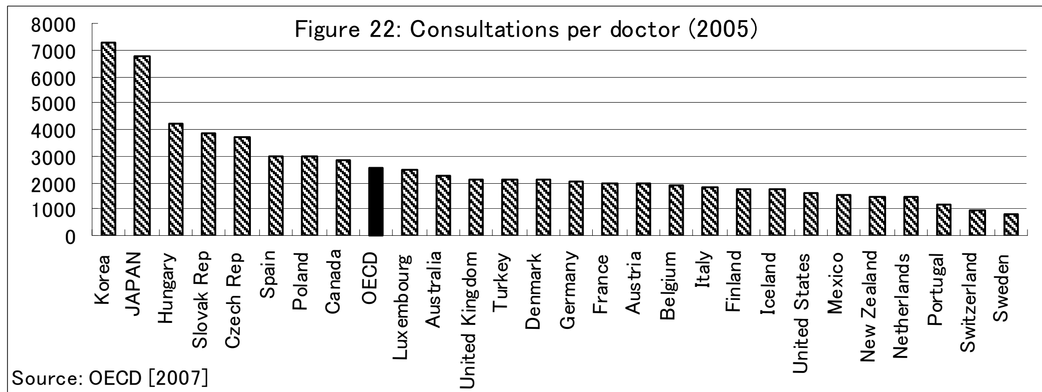
became difficult. In the context of the structural reform, the number of doctors started decreasing (Suzuki K. [2008a] and HCA － JCCU [2007b]).

With respect to the shortage in doctors one aspect that must be taken into consideration is the fact that a decreasing number of medical interns choose to practice in rural areas and other outlying regions and municipalities. In 2007, in Toyama prefecture, southwest of Niigata prefecture, at Toyama University Hospital there were only 20 medical interns, half the number three years earlier. This decrease, which makes it more difficult for doctors to be sent to rural areas, is also aggravating the workload of established doctors at the university hospital forcing many of them to quit, in this way creating a vicious cycle. In the present clinical training system introduced in 2004, medical interns were given a free choice to which hospitals they could apply for their training. The most popular choices are in the big cities (NTV [2007] and CB [2007]).

In comparative perspective, among OECD states, Japan is among the last in average number of doctors. It averages 2 doctors per 1000 population against an average of 3 for the OECD (figure 20). This means that there are approximately 260,000 practicing doctors in Japan. To reach the OECD level, Japan would need to increase the number of doctors to about 380,000. In addition, there is not a single prefecture in Japan whose number of doctors reaches the OECD average (figure 21). This puts a strain on the working conditions of doctors. In terms of the number of consultations per doctor, Japan is almost the highest, only surpassed by Korea, with each doctor handling 2.7 times the number of patients as the OECD average (figure 22). This is surely prejudicial to the quality of healthcare (OECD [2007] and MHLW [2006][28].







With the prospects of securing doctors diminishing and being riddled with debt, Himekawa hospital decided in a board of directors meeting in early June 2007, to close the hospital at the end of the month. In view of this, members of the cooperative got together to decide on what to do. They accused the board of directors of being negligent, of ruining the hospital. After the liquidation, the members of the cooperative have not received back any of their capital dues and have gone to trial. The amount in loans due to them reached a total of 1.22 billion yen, or an average of 3 million yen per person. This has brought severe hardships to these investors, most of them in old age, in the face of the impossibility of retrieving their money. The board of directors was irresponsible towards the people of the local community, which claim have been defrauded, and out of touch with their real needs (Suzuki K. [2008a], CB [2007] and Endō [2007]).

During the last month of operation, patients were gradually discharged and/or asked to be transferred to other medical institutions, such as the Kōseiren Itoigawa General Hospital. This general hospital, which has four times as many outpatients as Himekawa and whose waiting time for medical treatment is three and a half hours, has not been able to accept all of Himekawa Hospital’s former patients.

This has left many former patients of Himekawa Hospital without access to healthcare. To mitigate the situation, a former doctor of Himekawa Hospital opened a clinic on the premises of the former hospital by renting a part of it two months after its closing. Three nurses from the former hospital also work with him (NTV [2007] and Endō [2007]).

Conclusion

The growing complexities of the Japanese health sector in the context of the JSWS, together with the growing costs attributed to the expansion of medical expenditures, shortages of staff, and other problems, along with the general deteriorating economic situation of the population (increasing labor precarity, a growing income gap and poverty), is making it more difficult for the common person to have a somewhat fair and equal access to medical care in Japan. As in Argentina, as a result of the imposition of neoliberal reforms and to the subsequent development of the solidarity economy, medical cooperatives (including worker managed cooperatives), mutual help organizations and other like-minded institutions can probably play an increasingly important role to guarantee health services to the general population. This has been increasingly visible in Argentina after the 2002 economic crisis and the subsequent massive growth in the number of unemployed as well as those in unstable labor conditions. In Japan, medical cooperatives, like the Niigata Medical Cooperative, manage themselves without receiving any help from the Japanese government. With the continuing withdrawal of the welfare state in Japanese society, their continued existence and the role they can play in their communities might help guarantee local access to medical care. For the survival of medical cooperatives, it is essential that they develop deep connections with the community they serve, as Niigata Medical Cooperative seems to be doing and not as Itoigawa Medical Cooperative has done.

A change of policies from the Japanese government in the way it manages the healthcare sector is desirable. The government could divert some of the massive funds it allocates to public works into healthcare. Japan is probably the only country which gives precedence to public works (not always necessary) over healthcare (which is increasingly necessary) (Suzuki A [2003] pp.5-6). With this policy, the Japanese government is not following its most important law, the constitution, which guarantees the “minimum standard of wholesome and cultured living” through the “promotion and extension of social welfare and security, and of public health” (article 25). The introduction of private health insurance and more market participation in the health sector might help government finances, but it will not guarantee equitable and fair

access to healthcare by the general population. The change of the medical intern system in 2004, detrimental to the fair geographical distribution of doctors, could undergo some changes to guarantee access to healthcare in medically underserved areas. In the middle of worsening labor conditions, guaranteeing better access to healthcare for those working part-time, on a temporary basis, on contract and other unstable conditions will probably make healthier and thus more productive workers. Finally, the introduction of the Medical System for the Very Elderly in April 2008 is not bound to guarantee equal access to healthcare to the elderly, in particular to low income earners.

Endnotes

1 “Neoliberal Cycles in Argentina and Japan” (Alcorta [2007a] and “Solidarity Economies in Argentina and Japan” (Alcorta [2007b]).
2 The Ministry of Health and Welfare became the Ministry of Health, Labor and Welfare in 2001.
3 Now known as the Social Democratic Party.
4 Also known as ‘Active Welfare Society’ (Miyamoto [2003] p.19).
5 In this context, the “theory of the country ruined by medical costs” by Jin Yoshimura, casts a light onto the problems caused by unnecessary medical tests and treatments, fraudulent claims on medical expenses, corrupt doctors, etc. (Shinkawa [2005] p.334).
6 The Japanese health insurance system can be broadly classified into two parts: A Health Insurance (HI) for employees and National Health Insurance (NHI). The HI for employees is further subdivided into various types, such as Government-managed Health Insurance for employees of small businesses, Employees Health Insurance (for employees of large corporations), and mutual aid associations for public employees, teachers, etc. The NHI applies to farmers, the self-employed, the retired, and the unemployed (NIPSSR [2007b]).
7 One of the present overhauls being implemented in the healthcare system is the financial adjustment carried out in order to equally disperse elderly healthcare costs (Health Insurance System for the Elderly + Retiree Health Care System) among the many health insurance plans. This adjustment consists of correcting the imbalances between the various plans in order to build a stable social security system (Shinkawa [2005] p.330).
8 I.e., the hospitalization of elderly people for non-medical reasons due to shortages of nursing care facilities.
9 Health attainment assesses overall population health and thus judges how well the objective of good health is being achieved using the disability-adjusted life expectancy (DALE) indicator. DALE is understood as the expectation of life lived in equivalent full health, i.e., life expectancy estimated from mortality alone, without disability (WHO [2000] pp.27 and 146).
10 Responsiveness is not a measure of how the system responds to health needs but of how it performs relative to non-health aspects, meeting or not meeting a population’s expectations of how it should be treated by providers of prevention, care or non-personal services. The performance of health systems is evaluated regarding seven elements of responsiveness: dignity, autonomy and confidentiality (jointly termed respect of persons); and prompt attention, quality of basic amenities, access to social support networks during care and choice of care provider (encompassed by the term client orientation) (WHO [2000] pp.31 and 147).
11 Fair financing in health systems means that the risks each household faces due to the costs of the health system are distributed according to ability to pay rather than to the risk of illness: a fairly financed system ensures financial protection for everyone. A health system in which individuals or households are sometimes forced into poverty through their purchase of needed care, or forced to do without it because of the cost, is unfair (WHO [2000] p.35).
12 The index of performance on the level of health reports how efficiently health systems translate expenditure into health as measured by disability-adjusted life expectancy (DALE). Performance on the level of health is defined as the ratio between achieved levels of health and the levels of health that could be achieved by the most efficient health system. More specifically, the numerator of the ratio is the difference between observed DALE in a country and the DALE that would be observed in the absence of a functioning modern health system given the other non-health system determinants that influence health, which are represented by education. The denominator of the ratio is the difference between the maximum possible DALE that could have been achieved for the observed levels of health expenditure per capita in each country and the DALE in the absence of a functioning health system (WHO [2000] p.150).
13 Public hospitals receive subsidies from the government and are thus able to provide more intensive and expensive high quality medical care than private hospitals which are required to finance capital expansion and wage increases by either

increasing revenues or reducing delivery and facility costs (Yoshikawa [1996] p.33).
14 This is perceptible in the general population as a whole according to a study by Babazono et al [2008]. The study suggests that higher co-payment rates appear to cause consultation gaps among lower income enrollees and their dependents. In this way, the “equal access to medical care” system, for which Japan has been praised, could be collapsing.
15 Below this category, elderly people aged between 70 and 74 paid 10% as co-payment, rising to 20% after April 2008 (Hara [2007] p.23).
16 A day’s supply of medicine for one shō (1,800 cc) of rice (Takayanagi [2007] pp.14-15).
17 The Kōseiren (Prefectural Welfare Federation of Agricultural Cooperatives) was established in 1947 as a public welfare service for agricultural cooperatives. It is the successor of the Health Care Utilization Cooperatives (Iwamoto [2007] p.93).
18 According to Saitō [2000, pp.viii-ix], the concept of *publicness* has three meanings. The first meaning is that it is *official,* i.e., it concerns the activities that the state performs for its citizens through laws and policies such as public works, investment and education, etc. The second meaning is that it is *common*, i.e., it implies being a common good, asset, interest, etc. The third meaning refers to being *open*, i.e., that access is not denied to anybody.
19 Although this has not always been the case, as indicated previously by private practitioners and private medical institutions engaged in profit seeking activities in the prewar period. Nowadays, according to article 7 section 5 and article 54 of the Medical Care Law, it is illegal to operate health facilities on a for-profit basis and to distribute dividends, respectively (Kakurai [2007] p.68). Although dividends or profits are prohibited, private sector hospitals such as healthcare corporation hospitals, for example, are entrepreneurial businesses owned by a doctor (or doctors) operating under more or less the same financial incentives as for-profit enterprises. Japanese law merely prohibits the distribution of profits to noninsider shareholders. Consequently, although healthcare corporation hospitals may not distribute profits, they can be considered to be in between non-profit and for-profit hospitals (Yoshikawa et al. [1996] p.32).
20 Healthcare corporation hospitals, known as *Iryō Hōjin* hospitals, receive preferential tax treatment and represent over 75% of private hospitals and more than 30% of general hospitals (Iwamoto [2007] p.80).
21 Min Iren is the successor of the Proletarian Clinics (Iwamoto [2007] p.100).
22 Such as the prewar Gosen and Kuzutsuka Proletarian Clinics and the Kisaki Dispute.
23 The Koishikawa Yojosho was a healthcare facility established during the Edo period in 1722 by Tadasuke Ōka.
24 This includes besides Kido Hospital, Kamedagō Ashinumakai Nursing Care Institution, the Hohoemi no Sato Nursing Care Rehabilitation Facility for the Elderly, Kido Clinic, Ishiyama Clinic, and the Health Examination Center, etc (Niigata Iryō Seikatsu Kyōdō Kumiai [2006]).
25 This trend may have reversed itself in 2007 as the number of inpatients and outpatients have started to increase (Niigata Iryō Seikatsu Kyōdō Kumiai [2008]).
26 Nonetheless hospitals are facing a dilemma since they still have a duty and responsibility to provide healthcare to those in need and cannot refuse outpatients or patients from other deficit causing sectors (Suzuki A. [2003] p.14).
27 The Health Cooperative Association of the Japanese Consumers' Co-operative Union is composed of 116 cooperatives in 40 prefectures with 2,57 million members (HCA – JCCU [2007a]).
28 The Niigata Medical Cooperative, as other private hospitals, competes with prefectural hospitals in Niigata to hire its doctors. Most of them come from Niigata University. In order to differentiate itself, the Niigata Medical Cooperative tries to recruit doctors who have an interest in ‘community’ healthcare, who sympathize with the goals of solidarity and cooperation espoused by the cooperative (Suzuki [2008b]).

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