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Co-production and Governance of Japanese Healthcare - a best practice for the post-Covid era?

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Abstract

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Abs.: The Covid-19 pandemic underlines the risk of hospital staff burnout and the need for greater citizen participation in achieving public health goals. This paper explores how governance models can contribute to the work environment of hospital staff and to patient participation in healthcare services. It is based on a survey of nearly 7,000 staff members at 10 Japanese hospitals affiliated with consumer co-ops, agricultural co-ops and public healthcare providers. It compares three models for governing healthcare: a democratic, multi-stakeholder; a stewardship and the more traditional model of public services. Participatory governance allows the staff greater autonomy and control, and promotes a multi-stakeholder dialogue that facilitates user/citizen participation. A stewardship model combined with a public-social partnership makes healthcare sustainable in sparsely populated areas. A smaller survey of patients corroborates these findings. Finally, a recent case study shows how the staff can work with and around the challenges of Covid-19.

Keywords: Cooperative healthcare, Covid-19, co-production, governance, Japan, work environment.

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A. Background - COVID-19 and the importance of citizen input

The COVID-19 pandemic has fundamentally changed our perspective on the role of citizens in public health systems worldwide. They are no longer primarily regarded as bystanders and/or passive recipients of medical services from healthcare experts and professionals. Now their resources and contribution are recognized as necessary, if not crucial, both to protect themselves and to achieve important public health goals. Citizens are reminded daily that they can and must play an active role in preventing the spread of COVID-19. Initially, they were asked to wash their hands, practice physical distancing from one another, not to gather in large crowds and wear masks, both for their own safety and that of others, as well as to help reduce the load on crowded healthcare facilities. These measures were politicized in some countries, sowing confusion and making it harder to elicit public support for and gain compliance with them. More recently, with the growing availability of vaccines in some countries, citizens are urged to get a COVID-19 vaccination. Once again, this is not only for their own safety and that of their family, friends and others, but also to help reduce the burden on crowded healthcare facilities. In addition, it also helps prevent the development and spread of new variants of the virus, which is necessary for reaching 'herd immunity'. These actions are designed to speed up the reopening of many businesses and social functions, including schools, that were 'shut down' during the pandemic. None of this would be possible to achieve without the support and participation of citizens.

Nobel Laureate Elinor Ostrom and her colleagues coined the concept co-production in the 1970s to describe the potential relationship between public sector professionals and ordinary citizens who often use and depend on public services in their daily lives (1996). Co-production is conceived as the potential relationship that could exist between 'regular' producers (street level police officers, schoolteachers or health workers) and 'clients' who want to be transformed into safer, better educated or healthier persons (1996; Parks, et. al, 1981). Ostrom also notes that while citizen participation is crucial for achieving co-production, they won't actively contribute to co-producing public services unless the latter reflect important needs that are of consequence to them. (*ibid.*).

Alford's comparative study of user participation in public service provision in Australia, England and the US, shows that client commitment to co-production in all but the simplest of tasks, usually depends on incentives other than financial rewards (2009). Solidarity and reputational rewards often comprise greater

incentives to co-produce than financial rewards. Pestoff (2012) links individuals' motivation to co-produce social services with the private value they experience as service users. Such benefits can also extend beyond themselves, and involve their family, loved-ones and friends. Alford and Yates (2015) show that in three policy areas, public safety, environment and health, co-production activities with high levels of personal benefit are more readily performed than activities resulting in mainly general public value. Letki & Steen (2021) argue that the willingness to contribute to general public value increases with community attachment and decreases with ethnic diversity.

'Administrative citizenship' refers to a perspective where citizens have rights and obligations that both permit and require their active involvement in the provision of some public services (Bertelli & Cannas, 2021). It argues that compulsory co-production is justified when individual participation in an activity is considered essential for proper service functioning and/or the pursuit of 'community public interests'. In fact, employees in several branches and sectors of the economy were declared 'essential workers' early in the pandemic and they could not, therefore, refuse to work for health reasons or the risk of catching Covid-19. Yet, extending this approach to ordinary citizens is highly contested and making co-production compulsory leads to a politicization of public health recommendations and citizen pushback. Many simply refused to follow public guidelines about wearing a mask, respecting physical distance and gathering in crowds during the Covid pandemic in 2020 and 2021. They protested over closing nonessential businesses and schools, which illustrates the challenges facing this approach in many countries. Now, demonstrations against such measures occur frequently in several countries, and sometimes they even turn violent.

Citizens have the resources, assets and capacity relevant to making a significant difference to the outcomes of modern society, especially during times of pandemic, and they are willing to engage in positive social purposes. However, the public sector is not designed, organized, incentivized nor experienced in making use of the rich potential of citizen contributions to co-production of public services (Loeffler, 2021). Ostrom considers several structural variables important for overcoming social dilemmas (2009). Similarly, Pestoff (2014) argues that focusing on small group interaction can provide a necessary strategy for achieving sustainable co-production. In order to realize the full potential of citizen participation in healthcare, it is crucial to expand our perspective from individuals and their motivation to the group level where clients can act collectively. The organizational structures of service providers are key since they can facilitate or hinder citizen/user participation. Therefore, this research project on Co-production and Japanese Healthcare includes a collective action dimension by considering cooperative healthcare providers.

In light of the radically changed reality brought about by the COVID-19 pandemic, recognition of the potential contribution of support and compliance by citizens for their own well-being and for achieving public health goals becomes an essential, but challenging aspect of post-COVID healthcare. Recognizing this may be necessary, but it probably is not sufficient for eliciting their long-term engagement as co-producers. Such a commitment may require empowering them in a way that is promoted by participatory models of healthcare. This, in turn, reflects questions about what kind of healthcare systems will develop after the COVID-19 Pandemic. Will they continue to focus mainly economics and market mechanisms, or will they expanding public healthcare provision to guarantee adequate service for all or most citizens before the next pandemic? This paper explores a different alternative and asks whether there is another way to provide healthcare, one based on collaboration and partnership between patients and professional providers. If so, can it realize some of the synergies promised by theories of co-production?

However, two important distinctions can dovetail here, causing confusion. The first is between individual and collective co-production and the second between acute and chronic illness. They have ramifications for the role of citizens and patients in co-producing their own and other's healthcare. Citizens and patients can play a role in both types of situations, but their role is usually perceived as being different. Individuals with acute Covid symptoms obviously cannot actively participate in their own healthcare at the time of hospitalization, but they can provide a warning example and promote public health goals, if and when they recover. In addition, their family, friends and loved ones can join hands to promote more and better community healthcare. Moreover, the fact that citizens are attributed an active role in one situation may have a spillover impact on our expectations in other situations. Requiring citizens to wear a mask in public, social distance and get vaccinated during the Covid pandemic may eventually result in adopting an 'administrative citizenship' perspective for access to healthcare. In the future this may not only concern mask and vaccination mandates, but also to access scarce public healthcare resources for life style illnesses, like smoking and lung cancer, type II diabetes, obesity, use of opioids, etc. How much individual responsibility are citizens willing to assume and how much individual and collective responsibility is society willing to give them?

B. Key concepts

Several key concepts are briefly introduced below to promote a better understanding of a new collaborative model of healthcare. They include cooperative healthcare, co-production, internal and external efficiency, work environment and governance.

1. Cooperative Healthcare in Japan

There was a serious problem of access to healthcare in Japan before WWII, particularly in rural areas. Civil society helped to fill the gap and the first health co-op was founded in Aohara village, Shimane Prefecture in 1919. Local people worked together to start a small clinic and hire a medical doctor from town. This movement spread to other rural areas in Japan. Similar developments took place in urban areas, where residents who lacked local medical services formed medical co-ops to provide them, often after a major natural disaster, like the Minami Health Co-op after a typhoon in Nagoya in 1959 that killed over 5,000 people. Later it became easier to start new clinics in rural areas and poor towns because of national insurance. In 1961 the National Health Care Insurance was expanded to provide universal coverage for the entire population, including not only employees, but also farmers, small shops owners etc., (Kurimoto, 2015).

A United Nation survey of cooperative enterprise in health and social care sectors (1997) noted the unique position of healthcare cooperatives in Japan, both with regard to their orientation and size. Cooperative health and social care services are often organized as professional or provider co-ops in many parts of the world. However, Japan has not just one, but two user-owned healthcare providers, both with a long history and they serve millions of members each year. Together, they have more hospital beds than all the healthcare providers of Denmark and Sweden combined. A few details about them are found below.

Koseiren (Federation of Agricultural Cooperatives for Health and Welfare) is affiliated with Japanese Agriculture (JA) and provides healthcare for JA members and the public, mainly in the rural areas. The Board of Directors of *Koseiren* hospitals are comprised of officers of the county JA associations. Historically, healthcare was provided by *Koseiren* after the end of W.W. II as a public-social partnership in remote areas where public services were not available. It became a core hospital in many rural areas and today nearly 40 percent of its hospitals are located in municipalities with populations of less than 50,000. In fact, it is the only healthcare provider in one quarter of the towns and villages where they are located (Kurimoto, 2015, 2018). It has no direct, individual members, but farmers and their families are indirectly affiliated through their membership in JA or one of its branch organizations. Their hospitals are classified as general hospitals and opened to anyone living nearby. In 2019, it provided healthcare services at 107 hospitals and 59 clinics, 99 home nursing stations, 33 rehabilitation facilities and nine nursing homes nationwide. It has a capacity of 33,483 beds and nearly 55,000 employees (Koseiren homepage, 2020).

By comparison, health co-ops mainly provide healthcare in urban areas. In 2010 the health co-ops associated with the Japanese Consumers' Cooperative Union (JCCU) joined together to form the Japanese Health and Welfare Co-op Federation (HeW CO-OP JAPAN). In 2018, it consisted of 105 health and welfare cooperatives with nearly 40,000 employees nationwide, including more than 2,000 doctors.

Moreover, the consumer co-op model is based on direct, individual membership and it claims nearly three million individual health co-op members. Representatives are elected to the Board of Directors at the annual general meeting of health co-ops. Lay members occupy three quarters of the seats, while the medical staff and managers, occupy the remaining seats, and nearly half of all board members nationally are women. HeW CO-OP JAPAN managed 75 hospitals with 12,000 beds nationwide. In addition, it operated 345 primary health centers, 79 dental clinics, 175 visiting nurse stations, 24 nursing care facilities and 195 home helper stations. (HeW CO-OP JAPAN, 2020). They will be referred to as Medical Co-ops in the text below.

2. Co-production

Prior to the Covid-19 pandemic there was a gradually growing interest in, and practice of, increasing public participation in healthcare provision. More than a decade ago the World Health Organization (WHO) maintained that there were basically three ways or mechanisms to channel public participation in healthcare governance: 'choice', 'voice' and 'representation'. Choice mostly applies to individual decisions in selecting insurance and/or services providers. Voice tends to be exercised at the group or collective level to express public or group views about service shortcomings or suggestions for improving them. Representation implies a formal, regulated and often obligatory role in the process of healthcare governance (2005). Co-production can potentially combine choice, voice and representation, by actively engaging citizens in the provision of public services (Pestoff, 2008; 2009). In the United Kingdom Hudson recently argued that public and patient engagement in healthcare is 'an idea whose time has come' (2014), while the Office of Public Management states that 'co-production is the new paradigm for effective health and social care' (Alakeson, *et al.*, 2013). The WHO now considers co-production a key element of healthcare (2016).

Co-production is often noted by the mix of activities that both public service agents and citizens contribute to the provision of public services. The former are involved as professionals or "regular producers", while "citizen production" is based on voluntary efforts of individuals or groups to enhance the quality and/or quantity of services they receive (Parks, *et al.*, 1981; Brudney & England, 1983; Ostrom, 1996). In advanced societies there is a division of labor and most persons are engaged in full-time production of goods and services as regular producers. However, individual consumers or groups of consumers may also contribute to the production of goods and services, as consumer producers. This mixing may occur directly or indirectly.

Peters (1996) states that mobilizing and harnessing resources beyond the command and control of leaders in the public and private sectors becomes increasingly crucial for the sustainability of society and the achievement of both public and private goals. Citizens provide critical resources today, both in their role as professional service providers and users/citizens or co-producers of public services. So, it is necessary to consider how best to mobilize and harness their resources. Moreover, in order to mobilize vast

latent or currently unused resources in the public sector a participatory administration model should focus on empowering the lower echelons of the service providers and their clients that would decentralize much of the decision-making to them (*ibid.*). This should be reflected in the staff's work environment, work satisfaction and how they perform their daily tasks. However, the public sector is not designed, organized, incentivized nor experienced in making use of the rich potential of citizen collaboration in the provision of public services (Leoffler, 2021).

3. Standardized and flexible services in healthcare

Healthcare, as a service, is not only subject to a high degree of asymmetry of knowledge between the professional providers and the service users. There is also a high degree of uncertainty about service quality and how to define it, both from the patient/user's and professional provider's perspective (Hirschman, 1970). Citizen/user involvement in service provision depends on the degree of complexity and uncertainty in terms of achieving good service quality. Standardized services often require a less complex or extensive form of citizen involvement in service provision, while services that involve a high degree of user/citizen uncertainty often demand a higher degree of their involvement in service provision (Blandi, 2018). Patient/citizen involvement in healthcare services, particularly chronic care, involves a lot of uncertainty on the part of citizens. These services are highly complex and subject to rapidly changing technology and technical advances in service provision, particularly with the advent of ICT solutions. In addition, patient/citizen experience increasing uncertainty about their own needs. Their needs may change with new diagnostic and treatment options, as well as changing life cycle circumstances or different stages in the development of a given disease and its treatment. Here service quality requires much greater patient interaction with the front line staff in order to identify and define the patient's needs, to discuss the alternatives available to them and finally to agree on the best and most realistic treatment (*ibid.*).

The need for greater citizen involvement in more complex services can, therefore, acquire an economic-political dimension not normally associated with simpler or less complex public services. This has clear ramifications for how best to organize healthcare services and promote efficiency and effectivity. Blandi distinguishes between internal and external efficiency, where high internal efficiency may require standardization or mass customization of services, yet some degree of flexibility may be necessary to achieve external efficiency (*ibid.*). Under such circumstances, the staff needs to interact with external actors, i.e., their clients, in a flexible fashion in order to help them identify and define their needs, including their changing needs. In cases of high user/citizen uncertainty, a service provider's efforts to achieve internal efficiency can, in fact, diminish its efforts to achieve high external efficiency, and thus, reduce the overall efficiency and effectiveness of a service. This implies a dual or split approach to organizing healthcare between the back and front office (*ibid.*). Back office staff can provide standardized services,

like booking visits, billing services, ordering supplies, arranging for maintenance, etc., while front office staff, like nurses and care workers, require much greater autonomy in their daily tasks to achieve the flexibility necessary for promoting a healthcare provider's external efficiency (*ibid.*). Moreover, this requires adopting a systems approach to complex issues involving feedback loops to guarantee appropriate organizational flexibility that can promote greater patient participation in healthcare design and delivery.

4. Work environment and 'unhealthy work'.

Karasek & Theorell (1990) note that work-life stress is related both to physical illness and lower productivity. They developed a two dimensional demand/control model to understand, analyze and explain work environment and its physical and psychosocial impacts on workers and organizations. They combined these two dimensions into a fourfold classification of jobs. Low demands combined with high control result in low-strain jobs, while low demands and low control lead to passive jobs. High demands combined with high control result in active jobs, but when control is low it produces high-strain jobs. The latter are usually considered most debilitating in work-life.

New Public Management (NPM) assumes that increased productivity, effectiveness and an organization's budget are more important than the staff's health and/or service quality, which makes tradeoffs with the latter unavoidable. From the staff perspective, when an organization and its needs become dominant, human needs will inevitably suffer. Many of them, therefore, experience stress from the growing gap between organization needs and what they conceive of as human needs, both their own and those of their clients, and his kind of 'goal stress' has increased considerably in recent decades.

Pfeffer's recent book on human resource management, *Dying for a Paycheck* (2018), laments the fact that management practices can literally sicken 1,000,000s and kill 10,000s employees annually, yet they fail to improve organizational profitability or performance. He notes that ill health from work place stress adversely affects productivity and drives up voluntary turnover that costs employers and society more than half a trillion dollars per year in the US (*ibid.*, 3). Yet, the costs of toxic workplaces result in social pollution that is passed on to various parts of the public health and welfare systems, not to mention individual employees in the form of ill health. He concludes that all organizations have a choice: they can continue polluting work places and implementing management practices that create physical and mental ill-heath, literally kill people, and drive up healthcare costs in the process, or they can make different choices that result in the opposite outcomes (*ibid.*, 211). Such choices are part and parcel of their corporate governance. Do their governance models only encompass the interests of a single stakeholder, the firm's owners, or can they perhaps comprise several of them, including the workers, and even their clients?

5. Governance

The concept of governance gained extensive attention about 25 years ago, and soon became a buzz word in

social sciences. It is used in a wide array of contexts with widely divergent meanings. Van Kersbergen and van Waarden's (2004) survey of the literature identified no fewer than nine diverse definitions of the concept; while Hirst (2002) attributes it five different meanings or contexts. He includes economic development, international institutions and regimes, corporate governance, private provision of public services in the wake of New Public Management, as well as new practices for coordinating activities through networks, partnerships and deliberative forums (ibid. 18–19), or New Public Governance. Hirst argued that the main reason for promoting greater governance is the growth of 'organizational society', noted as big organizations on either side of the public/private divide in advanced post-industrial societies that leave little room for democracy or citizen influence. This is due to the lack of local control and democratic processes for internal decision-making in most larger organizations, whether public or private. He argues, therefore, that the concept of governance points to the need to rethink democracy and find new methods of control and regulation that do not rely on the state or public sector having a monopoly of such practices (ibid. 21).

Governance at the micro level refers to systems and processes concerned with ensuring the overall direction, supervision and accountability of an organization (Cornforth, 2004). Spears, et al. (2014) present six different models of corporate governance for nonprofit organizations, including principle-agent theory, democratic theory, stakeholder theory, resource dependency theory and managerial hegemony theory. They note that both control and collaboration are essential elements of these theories, and there is always a need to balance them (*ibid.*). Accordingly, control helps to overcome human limitations through vigilance and discipline, while collaboration taps individuals' aspirations via cooperation and empowerment. From a business administration perspective, governance models usually focus on the relationship between the board and top management of a third sector organization (TSO) or cooperative. However, employing a more holistic or encompassing approach, based on different academic perspectives, like political science, social work or sociology, would call for broadening the focus. The CEO and board are very important, but they do not provide the whole picture, so we intend to include other major stakeholders in our purview, in particular the users/citizens.

Governance can play an important role for developing new methods and models for improving the work environment in enduring welfare services and including additional stakeholders. For example, the three models employed for studying governance in Japanese healthcare are the command and control model, the stewardship model and the democratic, multi-stakeholder model (Pestoff, 2019, 2021). The command and control model is based on the Weberian ideal for public bureaucracy. The stewardship model assumes that managers want to do a good job and will act as effective stewards of an organization's resources, in collaboration with the main stakeholders. As a result, senior management and the stakeholders or members

of an organization are seen as partners. The role of the board is primarily strategic and board members are selected on the basis of their professional expertise, skills and contacts and they should receive proper training. By contrast, the democratic model includes ideas of open elections on the basis of one member one vote, pluralism, representation of different interests and accountability to its members. The board is often recruited from lay members and its main function is to represent the diverse interests of the organization's members. (Cornforth, 2004).

Figure 1. Staff autonomy and stakeholder inclusiveness in three models of governance

Command & Control	**Stewardship**	**Democratic, Multi-stakeholder**
minimal	**intermediate**	**optimal**

Source: revised from Figure 9.1, V. Pestoff, 2021.

The three models proposed here can be distinguished by the degree of autonomy given to the staff in terms of their everyday work-life and the degree of inclusiveness of various stakeholders in discussions and decision-making. Differences between them can be visualized by the step-stool figure, where staff autonomy is represented by the vertical axis and inclusiveness on the horizontal. The higher up a governance model is on the stool, the more autonomy it gives to the staff and the farther to the right, the more inclusive it is of other stakeholders, while the lower down on the stool, the less autonomy given to the staff and the farther to the left the less inclusive it is.

C. The Japanese Project - Work Environment and Governance

We will now turn our attention to the project on Co-production, Work Environment and Service Quality in Japanese Healthcare for an empirical base to explore these questions and models. It includes an Organization Study, a Staff Study, a Patient Study and a Volunteer Study. Japan has a unique healthcare system with two user-owned cooperative healthcare providers (UN, 1997; Kurimoto, 2015). Together the Koseiren of Japanese Agriculture (JA) and the Health and Welfare Co-op Federation (HeW CO-OP) of the Japanese Consumer Co-op Union (JCCU) manage nearly 200 hospitals with almost 50,000 beds, which is more than the total number of hospital beds in Sweden and Denmark combined. Data for this project was collected by questionnaires to the staff at eight cooperative hospitals across Japan in 2016 and compared with similar data from the staff at two public hospitals in Osaka in 2017. The sample of the Staff Study from the 10 hospitals reached 6,859, with a response rate of 72.1%. Data for the Patient Study was collected in 2017 by questionnaires to patients at four cooperative hospitals and resulted in 631 completed questionnaires (Pestoff, 2021). Findings from these two studies provide the empirical basis for this paper.

1. Work environment and the Staff Study

The Staff Study employed about 100 questions which allowed us to develop half a dozen work environment indices that compare and contrast the contribution of work environment and governance to public financed healthcare services. Based on the Karasek & Theorell 'demand, control, support' model we expected that more staff control over their daily work-life would promote greater work satisfaction and more satisfied staff that, in turn, will provide better quality services than dissatisfied staff. The Karasek/Theorell Demand/Control model of work environment was highly relevant for exploring the relationship between work environment, governance and service quality in Japanese hospitals. Initially, we found a pattern where nearly one third of the staff at these ten Japanese hospitals have Low Strain jobs, one third have High Strain jobs, while the remainder is divided between Passive and Active jobs, as seen in Table 1.

Table 1. Karasek/Theorell Demand & Control model for ten Japanese hospitals.

Demands/Control	**low**	**high**
High	*Low strain* (35.2%)	*Active* (17.2%)
Low	*Passive* (14.4%)	*High strain* (33.2%)

Source: Table 6.1, V. Pestoff, 2021.

We also considered the stress level for different occupations. This study included six occupational categories: doctors, nurses, care workers, other medical specialists, administrators and other support staff. We also asked if they had any managerial responsibilities. The two occupation categories that show the clearest deviation from the average for the Demand and Control categories are doctors and nurses. Doctors are heavily overrepresented in the Low Strain category, while nurses are clearly overrepresented in the High Strain category. Concerning managers, they are clearly overrepresented in the Active category, as expected, and underrepresented in the Passive work life category (Pestoff, 2021).

Next, we documented the impact of these four work-life or job categories on several work environment indices including, Work Satisfaction, Influence, Personal & Professional Development and Service Quality. All the indices, except for Service Quality, were divided into roughly three equal parts or categories, high, medium and low. The work environment indices tables only report the proportion of staff falling in the high category of a given index, and a clear deviation from 33% is, therefore, noteworthy. For technical reasons Service Quality was only divided into two categories, high and low, and only the proportion of staff claiming to provide good quality services is reported. We also include information about a self-evaluation by the staff of their own health status, as found in Table 2.

Table 2. Work Environment Indices by work life categories (only % high)

Work Environment index:	Low strain	Active	Passive	High strain
Work satisfaction	48.7	34.5	25.4	13.6
Influence	57.1	41.2	19.0	12.9
Pers/Prof. development	54.6	48.1	28.9	24.3
Service Quality	62.2	46.8	44.8	27.0
Own health (% healthy)	80.8	57.3	71.2	46.8

Source, Table 6.3, V. Pestoff, 2021.

The Low and High Stress work life categories show the greatest variation, so our comments will concentrate on these two. Nearly half of the staff in the Low Strain category claim to be very satisfied with their work, while barely one of eight in the High Strain category do so. Nearly three-fifths of the staff in the Low Strain category claim that they have much influence at work, while once again barely one in eight do so in the High Strain category. In terms of Personal & Professional Development more than half of the staff in the Low Strain category claim they have good opportunities to do so, while one quarter in the High Strain category do so. These three work-life categories have a clear impact on service quality, where three of five staff members with Low Strain jobs claim high Service Quality, while only one of four staff with High Strain jobs make the same claim. In particular, we found that Work Satisfaction was closely related to Service Quality. More than two thirds of the staff that was highly satisfied with their job said that the service quality was high, while less than one fourth of those who were least satisfied claimed to provide high service quality. Finally, a self-evaluation of their own health status also shows a similar pattern for the Low and High Strain categories. Four of five in the Low Strain category claim to be “healthy”, while less than half do so in the High Strain category. The Staff Study shows that work environment and service quality are positively related. Thus, a healthy work environment not only results in greater work satisfaction, but it promotes better service quality, while an unhealthy work environment results in lower service quality (Pestoff & Saito, 2019).

The Karasek/Theorell Demand/Control Model of work environment comprises an ideal type approach for analyzing the work life of healthcare employees in Japan. Low and High Stress jobs exist everywhere, and, no single workplace is comprised entirely of Low or High Stress jobs, yet work life conditions vary greatly with different employers. Therefore, we will now shift our attention to the three hospital groups included in this study to see how well or poorly they fare in terms of work environment. The three hospital or healthcare providers included in this study are the Medical Cooperatives (MC), Koseiren (K) and Public (pub) hospitals.

2. The three hospital groups

Table 3 provides an overview of work conditions for the staff at the three hospital groups participating in this study. It shows that there is very little difference between the staff in terms of either Passive or Active jobs, less than three percentage points. However, the difference between hospitals is much larger for Low Strain and High Strain jobs, with approximately 20 percentage points difference between the highest and lowest hospital group in either category. In both these situations, the staff at Medical Co-ops is clearly in a preferential situation, two of five claim Low Strain jobs and barely one-quarter claim High Strain jobs. By contrast, the staff at public hospitals is less fortunate, since less than one-quarter of them have Low Strain jobs, while nearly half of them have High Strain jobs. Staff at the Koseiren hospitals falls in between the Medical Co-ops and public hospitals, both in terms of Low Strain and High Strain jobs.

Table 3. Combined Demand & Control categories, by Japanese hospital group.

Demands/Control	**Low**	**High**
High	*Low strain* MC: 42.8% K: 33.8% Pub. 22.6%	*Active* MC: 17.1% K: 17.0% Pub. 17.8%
Low	*Passive* MC: 13.3% K: 16.1% Pub. 13.6%	*High strain* MC: 26.7% K: 33.1% Pub. 46.0%

Source: Table 6.6, V. Pestoff, 2021. Key: MC = Medical Co-ops, K = Koseiren, Pub = Public hospitals.

Turning now to the work life indices for the three hospital groups, the pattern noted earlier in Table 2 is repeated. Staff at the Medical Cooperatives rates highest, while staff at the public hospitals ranks lowest on most of them. More than two-thirds of the staff at the Medical co-ops are very satisfied with their work situation, while only one-quarter of the staff at public hospitals make the same claim. Two of five staff members at the Medical Co-ops claim that they have much influence, while less than one quarter do so at public hospitals. Service Quality was dichotomized and more than half of the staff at the Medical Co-ops claim that their hospital offers high quality services, while only two of five do so at public hospitals. When it comes to the staff's self-reported health, we note a slightly different picture. Here the staff at Koseiren hospitals rank highest and public hospitals lowest, but differences between hospital groups is minimal.

Table 4. Work Environment Indices by hospital group. (only % high)

Work Environment index:	**Medical Co-ops**	**Koseiren**	**Public**
Work satisfaction	37.2	28.2	24.6

Influence	41.9	31.4	23.7
Pers/Prof. development	45.5	35.1	36.4
Service Quality	52.4	41.2	39.6
Own health (% healthy)	63.4	66.6	62.1

Source: Table 6.7, V. Pestoff, 2021.

3. Governance

Governance systems can help explain some of the most notable differences in work environment, in particular, work satisfaction, and service quality. Governance systems can be viewed from various angles. A key perspective is the degree of autonomy given to staff and clients to interact and resolve certain issues by themselves related to service provision and service quality. Also the degree of inclusiveness of various stakeholders or 'publics' is important to consider. The three governance models embody different levels of autonomy and inclusion in decision-making for both the staff and clients, illustrated earlier in Figure 1. Greater flexibility combined with more dialogue with key stakeholders seems to promote better service quality.

The first step is a hierarchical command and control, top-down model that allows for little autonomy or discretion to the staff and restricts the influence of stakeholders outside the organization, like patients. Traditional public services embody the hierarchical model. The middle step is a corporatist model based on a 70-year public-social partnership in Japanese healthcare that started at the end of World War II to provide healthcare to large groups residing well beyond the reach of the public services. Finally, multi-stakeholder organizations are found on the top step. They embody a bottom-up democratic model of governance that has existed and evolved in Japanese healthcare for nearly 80 years. It is worth noting that differences between these three steps or models do not simply involve the staff or the service users alone, but both groups together. To achieve the highest level of autonomy and become viable both groups need to be present and actively involved (Pestoff, 2021).

Finally, the Staff Study considered control and social support at Japanese hospitals in relation to their governance model. Table 5 presents some relevant data. Democratic multi-stakeholder models promoted greater staff control and social support than either the stewardship or command and control model, with nearly twice as many who claim high or much control or influence in the former than the latter. It also presents data about the frequency of contacts with two key stakeholder groups: patients and volunteers, i.e., the residents of the local community. It demonstrates that staff discussions with

these stakeholder groups about hospital affairs at democratic multi-stakeholder hospitals are more inclusive than such discussions at the other two hospital groups.

Table 5. Governance Models, Control, Social Support and Networking in Japanese Hospitals*

Governance model & indices	Command & control	Stewardship	Democratic, multi-stakeholder
Index of Control	22.8	33.1	39.7
Index of Soc. Support	22.7	34.1	42.6
Networking: patients	50.0	53.7	68.8
Networking: volunteers	16.2	19.3	31.1

Source: V. Pestoff, 2021. *the proportion responding high or much.

The proportion with 'high' answers for networking with patients ranges from over two-thirds at hospitals governed by a democratic model to just half for a command and control governance model. It ranges from nearly one third for networking with volunteers in a democratic model, to barely half that amount in a command and control governance model. This suggests that governance models are an important contextual or intervening variable between work environment and service quality that can promote more patient participation and co-production, as well as facilitate a more inclusive governance model (*ibid.*).

D. Patient participation and two kinds of co-production

The analysis of data from the Patient Study reflect a model of patient needs, hospital structures and enhancing institutions that can promote patient participation and influence and their service satisfaction. However, it only includes survey data from patients at the Medical Cooperatives and Koseiren hospitals, since similar data was not made available by the public hospitals. A brief summary of the Patient Study shows that these two patient groups have different reasons for choosing their healthcare provider that clearly reflect the hospital's social values. In addition to the hospital and/or staff's reputation, patients were either motivated by instrumental reasons like proximity or by values related to their membership in a health co-op, as noted in Table 6.

Table 6. Reasons for patients choosing their hospital.

Reasons*	Medical Co-ops	Koseiren
Membership	76.9	26.5
Reputation	70.8	55.7
Instrumental	53.2	103.5

Source: modified from Table 7.1, V. Pestoff, 2021. *multiple responses, patients could choose more than one.

However, patients at both types of cooperative healthcare providers were equally satisfied with their hospital's services, suggesting that they provide essential services to their core constituents, in spite of their different needs and notable demographic differences.

We also found that patients in Medical Co-ops participate more in community activities and in other types of activities. In particular, this included making investments in their healthcare provider, via a membership contribution, participating in various community activities related to healthcare, attending local membership meetings and volunteering at their healthcare co-op. In fact, two of five patients at the Medical Co-ops indicate that they volunteer at their local hospital, while less than one of eight do so at the local *Koseiren* hospital. This high level of volunteering provides the Medical Co-ops with unique social and human capital that is not available to other healthcare providers. However, a third of the volunteers at *Koseiren* hospitals express a willingness to volunteer more, making them a significant untapped resource that should receive greater attention and effort to mobilize in the future (*ibid.*).

Moreover, as members of a health co-op, they can voice their opinion on important issues in several different ways. Not only can they talk directly with the professional staff or use the suggestion box, they can also participate in hospital committee meetings and in local meetings of the health co-op, as seen in Table 7. Patients at the Medical Co-op also felt more capable of and willing to express their opinion about the hospital and its services than Koseiren patients. However, this study also demonstrated that patients at both hospital groups were generally quite satisfied with the hospital's staff and services, and nearly the same proportion of patients at both hospital groups, more than two-thirds of them, stated that they would recommend it to friends or acquaintances (*ibid.*).

Table 7. Channels of patient influence

Channels*	**Medical Co-ops**	**Koseiren**
Talk with the professional staff	44.5	48.2
Voicing opinion in committee meeting	26.1	2.6
Attending local health co-op meeting	22.1	2.6
Using the suggestion box	12.8	19.3
No way, never tried	16.8	24.5

Source: modified from Table 7.3, V. Pestoff, 2021. *multiple responses, patients could choose more than one.

The Patient Study suggests that being a patient at these two hospital groups does not mean the same thing. Patients at the Medical Co-ops are more than just patients, since they are also members of a health co-op.

This creates ties that bind and provides them with a feeling of ownership that gives them certain rights and responsibilities not shared by non-members. Thus, membership provides the social glue that enables and facilitates their working together for a common goal, i.e., the members' health and well-being. Koseiren patients, by contrast, were indirect members via their affiliation with a local or regional branch of the agricultural federation, Japanese Agriculture, and, therefore, remained primarily hospital patients or clients. These comparisons of patient participation in Medical Co-ops and Koseiren healthcare provision demonstrated that there are different levels and different kinds of patient participation, particularly when patients are members in health co-ops rather than simply a patient or client at a hospital. Thus, patients at the Medical Co-ops have the possibility of challenging traditional relationships of power, control and expertise in healthcare, rendering it the joint product of the activities of both patients and professional healthcare providers (*ibid.*).

In addition, health co-op members are encouraged to join Han study groups in order to bring their diet, exercise and life-style into balance, as part of their effort to promote preventive medicine. Moreover, members are recruited to relevant hospital committees and many of them also are board members and/or hospital directors. Such opportunities both foster and institutionalize the role of members as co-producers of their own and others healthcare. These opportunities are not available to the patients at Koseiren hospitals. They do not have the rights and responsibilities of health co-op members, rather they are patients at Koseiren hospitals. Lacking the features of transformative co-production, they are part and parcel of Koseiren's aspirational approach to co-production. Furthermore, given the hierarchical command and control model of governance found in public healthcare (Pestoff, 2019a), co-production in public hospitals will most likely be limited to the aspirational variety. Nevertheless, these two different approaches to co-production might have something to learn from each other in terms of best practices (*ibid.*).

This begs the question what hospitals can do to encourage and facilitate patient participation? The Medical Co-ops promote the active participation of patients in a variety of ways and they have institutions that can facilitate and foster patient inclusion in the internal workings of their healthcare provider. By expecting patients to become a member of the health co-op, the Medical Co-ops are able to extend the rights and responsibilities of membership in a very different fashion than in Koseiren, since it lacks direct individual patient membership. Membership turns citizens and clients into stakeholders by giving them a clear stake in the operation of their healthcare service provider as well as a clear path to exercise the rights and responsibilities it implies. Of course, not all members are active, but the possibility exists for them if and when they want. It is conceivable that Koseiren could develop institutions to engage their clients in a more active fashion. However, this seems more difficult for public healthcare providers. While they do

encourage volunteers, engaging citizens as active patient members, with rights and responsibilities, might appear contrary to the public service ethos for many observers. Moreover, citizens and service users are normally viewed as passive recipients rather than active service co-producers. Therefore, membership in a health co-op proves key to facilitating and fostering transformative co-production at the Medical Co-ops. Furthermore, patients who are direct members in health co-ops have more positive attitudes about most aspects of the healthcare services and they are more active in the provision of their own healthcare (*ibid.*).

Thus, the Patient Study illustrates that there are two kinds of co-production: aspirational and transformative. Aspirational co-production is limited to describing and recognizing the potential benefits of co-production, paying lip service to it, and accepting the marginal or ad hoc contributions of citizens to public financed services. This may eventually include finding ways to gradually accommodate the input of citizens to the provision of public services, in one fashion or another. However, in no way does it question or challenge the power asymmetry between the professional service providers and citizens. The primary purpose of aspirational co-production appears, therefore, to be legitimization of the status quo. Transformative co-production, on the other hand, includes encouraging co-production by actively facilitating, fostering and institutionalizing it. The primary purpose of transformative co-production is the democratization of service provision. This leads to the conclusion that if a healthcare provider wants to embrace transformative co-production in the 21st Century it must develop a proactive strategy for encouraging patients to participate actively in internal workings of their healthcare provider and including them in discussions about its services, its future, and in its decision-making. In order to achieve this, it needs a sustainable policy to fully facilitate and implement it. However, opening an organization for transformative co-production is a very long and complicated process; so, there is no quick fix (*ibid.*).

E. The Minami Health Co-op during the initial phase of the Covid-19 pandemic

The Minami Health Co-op (MMH) operates two hospitals, five clinics, one long-term care facility and seven home care support offices etc. in the southern part of Nagoya. It was started as a health co-op by doctors and local residents after the 1959 Ise Bay Typhoon that killed over 5,000 people. Today the main MMH hospital has 313 beds, divided into 26 departments, but according to its public health mandate, it does not treat infectious diseases, so it has no beds designated specifically for Covid-19 patients. This case study focuses instead on long-term care facilities and home care activities. However, given the threat that Covid-19 poses to elder citizens, this seems appropriate. During the initial phase, MMH developed a seven-point policy to respond to Covid-19 that allowed it to work with, and around, some of the challenges posed by the pandemic (Saito, 2021).

Nurses from MMH attended dozens of information meetings by and for staff of its home care services to respond to their questions and address their anxiety. They normally lack knowledge about infectious diseases and how to prevent them. Personal Protective Equipment (PPE) also became a key issue. The home care staff usually only wear an apron, rather than a medical uniform or scrubs and they don't change it between visits, since their clients don't normally suffer from infectious diseases. So, it was decided to require them to use hospital PPE that could be changed between home visits, to reduce the spread of Covid from one client to another (*ibid.*).

MMH estimates that 80% of the local residents living near the hospital belong to the health co-op, while 40% of health co-op members also volunteer, thereby contributing essential support and input to cooperative health and eldercare, not available to traditional services. Local members, residents and users can become involved in several different ways. The Community Support Center help network between staff at the hospital or long-term care facilities and residents in the local community. Japan faced a serious mask shortage between Feb. and June, 2020 and initially, hospital doctors were limited to one surgical mask per week. People rushed to the pharmacy to buy masks, but they were sold out everywhere. So, the Prime Minister, Abe promised to intervene and send surgical masks to all medical institutions and two cloth masks to each household in Japan. Nearly 200 M Euros was spent on this effort, but when they finally arrived in June they were usually too small or didn't fit right and most of the public had already bought them in shops by then. In the meantime, once local residents in Minami became aware of the mask shortage, they began making cloth masks for the healthcare and long-term care staff. After, they proceeded to make and distribute cloth masks to elderly people in the neighborhood. This allowed them to check on their health status, discuss their anxieties and report sick neighbors to the MMH hospital, a local clinic or their Community Support Center (*ibid.*).

At the outset of the Covid pandemic, people were encouraged to socially distance or isolate themselves. Yet, many elderly persons were worried about spending all their time at home. While distributing the cloth masks, MMH volunteers encountered people who wanted to restart their activities as much as possible, or experienced trouble because they were not able to go shopping or who experienced physical deterioration from not leaving home or going out for a long period. Moreover, Covid-19 interrupted home care services all over the country. The elderly and their families were hesitant to use them due to the fear of infection, without credible information to protect themselves. As a result, many care providers went bankrupt nationwide, given the decline in demand. So, local MMH volunteers and service users started study sessions (HANKAI) on preventing Covid infections for a small number of people in parks, and invited health specialists who worked at MMH to address them. They could learn how to prevent infection, so they

continued to use the MMH home care services. Now there are Park HANKAI throughout Minami to spread information and combat misinformation about Covid and Walking HANKAI so people can get some exercise, while keeping safe social distance (*ibid.*).

This case shows that MMH regards its staff members and local residents as equals or partners in health and eldercare and its policy promotes a shared responsibility for implementing it. Rather than merely being a response to the unique situation posed by Covid-19, it represents a continuation of MMH's efforts to engage its members as co-producers of their and others healthcare and long-term care (*ibid.*).

F. Summary and conclusion

Japan has a unique system with two user-owned or cooperative healthcare providers. Together they operate nearly 200 hospitals, 500 clinics and 50,000 beds. However, they differ from each other and from public hospitals, in terms of their work environment, governance models, service quality and social values. This paper compares two separate cooperative healthcare providers with public providers at ten hospitals across Japan and analyzes survey data from the staff in terms of their work environment and governance models, as well as from the patients at four of them in terms of their participation. Several key concepts were introduced to understand and appreciate the unique contribution of cooperative healthcare to achieving public health goals and outcomes.

Peters (1996) notes that citizens provide crucial resources for achieving both public and private goals, but today they have little influence on organizational decisions. So, it is necessary to consider how best to mobilize and harness resources beyond the control of leaders in the public and private sectors. One model for achieving that is by focusing on lower level service providers and their clients. Participatory administration decentralizes much of the daily decision-making to these specific groups (*ibid.*). Blandi (2018) distinguishes between internal and external efficiency in service organizations. Standardized services promote internal efficiency, while flexible services augment external efficiency. Flexibility is crucial in healthcare in order to overcome client uncertainty, due in part to technical advances and in part to the lack of knowledge by many patients about their own medical needs and care (*ibid.*). Adopting a participatory approach in healthcare allows front-line healthcare workers greater freedom to reach agreement with patients about the best possible treatments and help patients to overcome their uncertainty. It also recognizes and legitimizes an active role for clients in their own healthcare.

The Karasek & Theorell (1990) model for work environment expects that the level of demand and control experienced by the staff in their work-life determines whether they have low-strain or high-strain jobs, as well as their experience of personal health outcomes. The Japanese study shows that low-strain jobs provide healthy work conditions, while high-strain jobs correspond to Pfeffer's discussion of 'toxic work'.

It also documents that higher levels of staff satisfaction with their job are correlated with a higher evaluations of the service quality provided by their hospital and that notable differences exist between the three hospital groups in their work environment and service quality.

However, exploring staff autonomy and well-being alone is insufficient. Similarly, only focusing on the role of users/citizens in co-production also proves insufficient. Either approach only provides half of the story at best. It is necessary to consider both sides of the coin in order to understand the role of and the interaction between the staff and users/citizens. Only by studying the impact of different governance models on both of the main actors in co-production, the staff and users/citizens, can we begin to understand the importance of governance models for promoting participative public governance.

This study also explores the unique collaborative structures of cooperative providers that can facilitate, foster and institutionalize citizen participation in healthcare. The Patient Study underlines the importance of membership. Patients at the Medical Co-ops are more than just patients, they are also members of their healthcare co-op. Being a member creates ties that bind, and it also provides them with a feeling of ownership and attributes them certain rights and responsibilities not shared by non-members. Thus, membership provides the social glue that enables and facilitates their working together for a common goal, i.e., the health and well-being of all the members. This allows us to distinguish between aspirational and transformative co-production. The latter embodies an active healthcare literacy outreach policy that educates and engages members to develop and pursue an active role in their own and others' health and well-being. It encourages them to audit their own blood pressure, the salt and fat content in their diet, etc., and relates these basic heath facts to maintaining a healthy diet and getting regular exercise, together with others. This model relies on actively and collectively engaging healthy persons in life-style choices related to key healthcare issues.

Three models of governance were contrasted here, i.e., 'command and control', stewardship and participatory governance, represented by public, agricultural and consumer co-op healthcare providers respectively. The three different governance models were arranged in a step-stool fashion to illustrate the degree of staff autonomy and stakeholder inclusion. The first step is a hierarchical command and control, top-down model that allows for little autonomy or discretion to the staff or inclusion of the clients. Traditional public services embody the hierarchical model. The intermediate step is a corporatist model for providing healthcare and social services to a large group beyond the reach of traditional public services, citizens living in sparsely populated rural areas. Finally, multi-stakeholder organizations are found on the top step that represents the optimal level of staff autonomy and client inclusion. They embody a bottom-up democratic model of governance that exists in some non-governmental organizations, co-operatives and

social enterprises. It is worth noting that differences between these three steps or models do not simply involve either the staff or the service users alone, but rather both groups together. To achieve the highest level of autonomy and inclusiveness they both need to be present and actively involved.

Thus, this study demonstrates that participatory governance promotes a partnership between patients and professional healthcare providers that results in more satisfied staff, better service quality, more engaged patients, a robust health literacy outreach and a unique, coherent set of social values. Differences between hospital groups do not seem related to the profit orientation of a healthcare organization, whether it is public or private, nor of its ownership form, per se. Governance models appear more important for realizing participatory administration than ownership forms. Rather, healthcare governance reflects several other major factors that contribute to co-production in healthcare (*ibid.*). In sum, the three healthcare groups studied here demonstrate notable differences in their work environment, governance, service quality and social values. Taken together, factors like an empowering work environment, an inclusive and democratic governance model and social profiles based on inclusive values are key factors in fostering and institutionalizing transformative co-production in healthcare.

Finally, the case study of Minami Medical Co-op shows that it regards its staff, health co-op members and local residents as equals or partners in health and eldercare and its policy relies on sharing responsibility for implementing it. Rather than merely being a response to the unique situation posed by Covid-19, it represents a continuation of MMH's efforts to engage its members as co-producers of their and others healthcare and long-term care.

These findings provide the core elements of two potentially new post-COVID models of healthcare, one based on co-production and democratic governance, the other on a stewardship model combined with a public-social partnership for providing healthcare. However, it should be noted that greater citizen participation and attributing them an active role in their own and others health and well-being does not comprise a 'silver bullet' for resolving all the challenges facing healthcare today. This study identifies several key factors that can contribute to democratic governance and transformative co-production of healthcare. The Japanese Medical Co-ops demonstrate the full potential of a participatory model in practice, not just in theory. It has nearly 100 years of experience in providing healthcare that offers a new, unique healthcare model for a post-COVID-19 era and shows it is possible to make co-production work on a large scale. Moreover, healthcare provided by *Koseiren* with a stewardship model shows that large voluntary organizations are willing and capable of assuming responsibility for providing healthcare to their members and a large swath of the population living under sparse circumstances, when and where no public services are available. Rather than closing small community hospitals and expecting the residents to travel hundreds

of kilometers for childbirth, a serious accident or other urgent healthcare issues, local hospitals can be maintained and sustained through a public-social partnership of the type discussed here. Both of them can serve as a reference or best practice for attempts to sustainably engage citizens in promoting their own and other's health and well-being and achieving public health goals and outcomes.

Hopefully, one of the main lessons gained from the Covid Pandemic will be to recognize the need for greater participation by patients in the provision of healthcare, in a fashion that benefits them, their loved ones, their local community and society in general. Future public sector reforms, social innovations and research will help to determine if it is possible to extend some of the benefits of these cooperative models to public healthcare providers. Can the public sector develop methods and models for closer collaboration with civil society? Will this include patient groups in a fashion that allows them greater voice in the provision of healthcare services and decision making? If not, then a public-social partnership in healthcare, like the one between Koseiren and the Ministry of Health, Labor and Welfare, can serve as a 'second best' alternative.

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