MUMBAI
I N D I A

THE SECOND MEETING OF THE HEALTH MEDICAL CO-OPERATIVES IN THE ASIA-PACIFIC REGION

ON NOVEMBER 02, 1996
AT HOTEL JUHU CENTAUR, MUMBAI, INDIA

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HOSTS :

Shushrusha Citizens' Co-operative Hospital Limited, Shivaji Park, Mumbai, INDIA

CO-HOSTS :

Medical Co-operative Committee Of JCCU, JAPAN

ICA ROAP New Delhi, INDIA

SECOND MEEETING OF HEALTH MEDICAL CO-OPERATIVES IN THE ASIA PACIFIC REGION, MUMBAI, INDIA

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PROPOSED PROGRAMME

Time		Item		Speaker
9.00 am	:	Registration		
		Welcome speech	-	Mr Dandekar - President, SHUSHRUSHA
			-	Dr Kato - Chairman, MCC, JCCU
			-	Mr Herath - Regional Advisor, ICA, ROAP
9.30 am	:	Inauguration and lighting of the lamp		
10.00 am	:	Key note address	-	Dr N S Laud - Chairman, SHUSHRUSHA
10.15 am	:	Inauguration speech-		Dr K S Goleria
10.30 am	:	Vote of thanks	-	Dr V M Deshmukh, Dean, SHUSHRUSHA
		TEA BREAK		

Time		Item		Speaker
11.00 am	:	CASE STUDIES	-	Mr Su-Cheong Lee, S.KOREA
			-	Dr Bharat Pradhan, NEPAL
			-	Mr Samarsinghe, SRI LANKA
			-	Mr E Narayanan, KERALA
				Chair Persons
			-	Mr P J Vaidya - Vice-Chairman, SHUSHRUSHA
			-	Mr Sakurai - Secretary, MCC, JCCU
13.00 pm	:	LUNCH BREAK		

Time		Item		Speaker
14.00 pm	:	Panel Discussion	-	Dr Shoji Kato - Chair Person
		- Foundation of IHCO	-	Dr Ogino, JAPAN
			-	Dr Deshmukh, INDIA
			-	Mr Gunawardane, SRI LANKA
		- Establishments of AHCO	-	Mr Bong-Sub, Choi, S.KOREA
		SUMMING UP		
17.00 pm	:	CLOSING		

Time		Item
19.00 pm	:	Reception dinner hosted by:
		Shushrusha Citizens' Co-operative Hospital Limited, Ranade Road, Dadar, Mumbai, INDIA.

LIST OF PARTICIPANTS

NO	NAME	PLACE
1.	Dr Shoji Kato	JAPAN
2.	Mr Toshio Ogino	"
3.	Mr Takashi Yoshioka	"
4.	Ms Nobuyo Michiki	"
5.	Ms Sachiko Minemura	"
6.	Ms Takako Yanaga	"
7.	Ms Toshie Murayama	"
8.	Mr Hiroyuki Inoue	"
9.	Mr Atsuo Nakata	"
10.	Mr Tsuneo Nisizaki	"
11.	Mr Ysuke Nakajima	"
12.	Mr Yuji Usui	"
13.	Mr Yasuhira Sakurai	"
14.	Ms Yoko Miyoshi	"
15.	Dr Bharat Pradhan	NEPAL
16.	Dr Peden Pradhan	"
17.	Mr Pranaya R Manandhar	"
18.	Mr Su-Cheong, Lee	KOREA
19.	Mr Ill-Mo, Rhew	"
20.	Mr Bong-Sub, Choi	"
21.	Mr I J Gunawardene	SRI LANKA
22.	Mr Lionel Samarasinghe	"
23.	Mr Sarath Wickremasingha	"
24.	Mr K K De Silva	"
25.	Mr M D Siripala	"
26.	Mrs Nalini Netto	KERALA
27.	Mr E Narayanan	"
28.	Mr Raveendran K	"
29.	Adv T V Gangadharan	"
30.	Mr Umakant R Warerkar	"
31.	Mr T Haridasan	"

STUDY TOUR TO SHUSHRUSHA HOSPITAL ON SUNDAY(3RD NOVEMBER, 96).

Transport Arrangements garage time	9am to 5pm
Departure from Juhu Centaur	9.30 am
Arrival at Shushrusha	10.00 am
Receiving the delegates at the gate	Dr. N. S. Laud Dr. Vijay Deshmukh Dr. B. M. Pai Dr. G. V. Acharya
Total number of delegates expected	35 persons. To be divided into groups of five members each (seven groups)

		GROUP LEADER
Group 'A'	SRI LANKA	5th floor - Dr. Meena Shringarpure
Group 'B'	KOREA	4th floor - Dr. B. M. Pai
Group 'C'	NEPAL	3rd floor - Dr. G. V. Acharya
Group 'D'	JAPAN 'A'	2nd floor - Dr. R. D. Kamath
Group 'E'	JAPAN 'B'	1st floor - Dr. R. H. Maniar
Group 'F'	INDIA	Ground Floor - Dr. B. V. Khare Dr. S. V. Weling
Group 'G'	OTHERS	Basement - Mr. Prabhakar Pansare Dr. (Mrs) A.M.Joshi

FUNCTION AT SHUSHRUSHA

Assembly of all the delegates on the 5th floor Hall at 11.00 am.

Anchor persons :	Dr. N. S. Laud
Information about Shushrusha Hospital : QUESTION AND ANSWER SESSION	Dr. Vijay Deshmukh
Vote of Thanks and announcements :	Dr. B. M. Pai

Delegates depart from Shushrusha Hospital at 11.30 noon for Lunch at 12 Noon at Jewel Of India (sponsored by Mrs. S. G. Thakoor)

CITIZENS' CO-OPERATIVE HOSPITAL LIMITED

698-B, Ranade Road, Dadar, Mumbai-400 028. Tel. : 444 91 61/62/63/64
Registered Under Maharashtra Co-operative Society Act, 1960.
Regd. No. Bom-Gnl 114 of 1964.

INTRODUCTION

The concept of Citizens' participation in "Health Care" started getting momentum as early as in the year 1960. This concept took concrete shape by starting a Co-operative Hospital of members under the guidance of Late Dr. Vasant S. Ranadive in the year 1964.

The Foundation Stone was laid on 6th March, 1966 by Late Hon. Shri Y. B. Chavan the then Chief Minister of Maharashtra State.

The Hospital with 80 beds and three storeyed building and basement was inaugurated at the hands of the then Prime Minister Late Smt. Indira Gandhi on 20th May, 1969. Our Maternity and Child Care Hospital at Vikhroli (East) started earlier in 1962. Today we are a full fledged Hospital of 130 beds at Shivaji Park, a busy residential and a Maternity Hospital of 15 beds at Vikhroli an Industrial Suburb area, of Mumbai.

The ever increasing membership stands at 7737 as on 31.10.1996.

The Hospital aims at providing high quality medical care not only to members but also to other Citizens at a reasonable cost without any discretion of caste, creed or religion.

'Shushrusha' belongs to the Community. The access to health services as an instrument of social renewal to promote health maintenance and prevention of illness, through continuous interaction and recommitment to co-operative values underline our strength.

OUR MAIN ACTIVITIES:

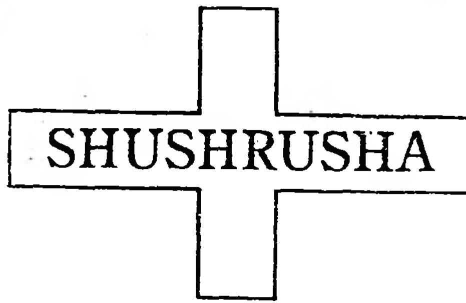
Shushrusha Citizens' Co-operative Hospital has following distinctive features:-

1) It is an Organisation of Citizens' and Doctors and local people interested in social work and Health Care.

2) Its Main emphasis is on Patient Care, Prevention of diseases and maintaining and promoting healthy people through health Education.

3) It has members participation in investment, use of medical facilities and services and also in Hospital administration.

4) Creating an atmosphere and philosophy of co-operation in Health Care that is cost effective and sophisticated.



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This Philosophy of co-operation allows the creation of shared support structure in a real climate of trust and mutual advantage.

Our Modern Pathology and Radiology Departments including Ultrasonology and Tomography are the service areas alongwith facilities of ECG, EMG, EEG and Audiology. The Cardiology Department with its I.C.C.U and Stress Test and 2 D Echo facilities care for critical cardiac

patients. The A.K.D Department established recently is catering to all chronic renal diseases and the Neonatalogy Department cares for the sick children. Respiratory Medicine Department and Obesity Clinic are additional facilities provided.

The Operation Theatre is well equipped to meet the needs of all speciality services, including Orthopaedic and Trauma Care, Neuro Surgery, Spine, Cancer and Facio Maxillary Surgery, Urology and OBGY operations, Microvascular and Reconstructive Surgery etc. The Hospital also cares for routine operations in E.N.T, Ophthalmology and General Surgery.

We periodically arrange camps for Eye and Skin Diseases including leprosy, early Cancer Detection Camps in men and women and Camps for detection of Hypertension, diabetes and Heart ailments which have proved to create awareness in the Community. We have looked after sports children from various Gymnasiums in the locality. Women above 35 years are periodically checked with pap smear for early diagnosis of Cancer.

We also run a free Immunisation Centre and run a Nurses Training School.

Shushrusha Hospital with the help of faculty members on its Panel arranges various Continuing medical Education programmes. Recently, we had a session on (1) Tuberculosis (2) Paediatric Gastro Enterology problems including diarrhoes and vomiting (3) Care of the critically injured patients and resuscitation (4) Phako emulsion a new concept in treatment of Cataract (5) Epilepsy in children.

WELCOME SPEECH BY MR. SUHASH DANDEKAR, PRESIDENT, SHUSHRUSHA HOSPITAL - ON THE OCCASION OF 2ND ASIAN REGION HEALTH MEDICAL CO-OPERATIVES CONFERENCE, ON 2ND NOVEMBER 1996, AT JUHU CENTAUR, MUMBAI.

Dear Shoji Kato, Distinguished Invitees, Ladies and Gentlemen,

On behalf of Shushrusha Citizens' Co-operative Hospital, my colleagues and over 7,000 members representing India's first and still acclaimed as a model Co-operative Hospital, I welcome the Office Bearers of Medical Co-operative Community of Japanese Consumers Co-operative Union and Delegates to this Historic Second Asian Region Health Medical Co-operatives Conference.

When I first had the privilege of meeting Mr. Shoji Kato in Japan and then in India, I learnt about the multifarious activities of Consumers Co-operative Union and its Medical Committee, I was astonished and convinced that there will be no parallel to such a dedicated co-operative movement both in terms of quality and numbers anywhere in the World. It is not surprising that its birth took place in a country where remarkable success has been achieved in every field due to the proper blend of technology and co-operation.

The citizens of some nations exhibit a distinct common characteristic - In case of United States, it is the Enterprise amongst people which has brought that Nation to the present level in the world. When it comes to United Kingdom, it can be described as Balance, in case of Japan, the core is Co-operation and Team-spirit.

I have no doubt that with the exchange of information and experience amongst the Delegates attending this Conference, the Medical Co-operative Movement in the Asian Region will get a further boost. On this occasion, developing countries in Asia can re-dedicate themselves to achieving the Goal of HEALTH FOR ALL by the year 2000 AD

I wish all the Delegates a comfortable and memorable stay in Mumbai.

The Hospital has Fixed Assets of Rs. 1,02,44,819.00 as under as on 31.3.1996.

	Rupees
I. Land and Building	
Land	548573.00
Building	1212422.00
II. Plant and Machinery	
Electrical fittings	282036.00
Furniture and Fittings	741109.00
Equipments	7354120.00
III. Ambulance	106559.00
	10244819.00

Deposits as on 31.3.1996	606069.00
Donations as on 31.3.1996	216127.00

Hospital Working - 1995-96	Nos.
MAIN HOSPITAL	
Consultations	17423
Admissions	5451
Operations	3870
X-Ray Films	17275
Pathology (Tests)	72832
Vaccination BCG	375
Deaths	270
Health check-up	185

VIKHROLI UNIT	Nos
Consultation	2034
Registration	821
Admission	1018
Operation	236
Deliveries	764
Vaccinations (BCG)	812

Share Capital as on 31.3.1996.	Rupees
Authorised	
75000 Equity Shares of Rs. 100/- each	7500000
25000 Redeemable Pref. Shares of Rs. 100/-	2500000
Subscribed capital 39928 Equity Shares of Rs. 100/- each	3992800
15000 Redeemable Shares of Rs. 100/- each	1500000
	5492800

MEMBERS OF THE BOARD OF DIRECTORS

YEAR - 1996-97

PRESIDENT : MR. SUBHASH DANDEKAR

BOARD OF DIRECTORS

(1) Dr. N. S. Laud
Chairman

(2) Mr. P. J. Vaidya
Vice Chairman

(3) Dr. Vijay Deshmukh
Dean

(4) Mr. P. D. Nadkarni
Treasurer

(5) Dr. B. M. Pai
Hon. Medical Superintendent

(6) Dr. G. V. Acharya
(7) Dr. R. H. Maniar
(8) Dr. R. D. Kamath
(9) Mr. P. R. Pansare
(10) Dr. Meena Shringarpure
(11) Dr. B. V. Khare
(12) Mrs. S. G. Thakoor
(13) Mr. Ramesh Medhekar
(14) Mr. R. D. Dhamankar
(15) Mr. Suresh Sarnobat
(16) Dr. J. Nathan
(17) Dr. (Mrs) A. M. Joshi

ADMINISTRATIVE STAFF.

Chief Executive	1
Chief Accountant	1
Supervisors	10
Part Time Lab.Technicians	1
Dieticians	2
Matron	2
Clerks	26
Telephone Operators	3
O.T Assistants	4
ECG Technicians	2
AKD Technician	1
X-Ray Technicians	5
Pathology Technicians	6
X-Ray Attendant	1
Pathology Attendant	2
Watchman	7
Electrician	3
Liftmen	2
Peons	6

The 2nd Health-Medical Co-ops' Meeting for Asia and the Pacific
Opening Address

November 2, 1996

Shoji Kato
Chairperson
Medical Co -op Committee
of JCCU

We are here to open the second Health-Medical Co-ops' Meeting for Asian and the Pacific, in the historical city of Mumbai. I would like to extend my gratitude to Mr. S. D. Dandekar, Chairperson. Dr. Deshmukh, as well as al l from the Shushrusha Citizens' Co-operative Hospital Ltd. for welcoming us warmly. I am also thankful to Mr. Sharma, Regional Director, and Mr. Herath, who are both from the ICA Regional Office for Asia and the Pacific for their efforts. I would like to extend my warmest welcome and solidarity to all of you.

Only four countries, India, Sri Lanka, Malaysia, and Japan participated in the first Regional Meeting for Asia held in Colombo, Sri Lanka in 1994. At that time other health co-operatives had already recognized in Singapore, Myanmar and the Philippines. Afte that Meeting we could start to exchange with one of the health co-operatives in South Korea. According to a report from Mr. Herath, there are health co-operatives in Israel, Jordan and Australia. Including them health co-operatives should be in 11 countries of the Asia-Pacific Region. It is also said that some other countries such as Nepal, Vietnam. Mongolia and Tonga are showing their strong interests in health co-operatives.

The International Co-operative Alliance (ICA) now represents 760 million individuals from 90 countries around the world. It consists of four regions --- the Asia-Pacific, European, American and African Regions. According to the United Nations documents issued in November, 1995, 28 countries of these regions had health and/or social care co-operatives. Of them, 25 countries had health co-operatives, and El Salvador, Lebanon and Poland had only social care co-operatives. If the findings from Mr. Herath had been included in the United Nations documents, 28 countries should have had health co-operatives. As a result of discussions, the Interim Steering Committee for the establishment of the International Health Co-operative Organization (IHCO) decided to exclude social care co-operatives from the components of the IHCO, because they cover such a vast rage of activities.

Of four regions, the Asia-Pacific Region has the most health co-operatives, followed by the Americas. The United Nations documents said that in the Americas, nine countries had health co-operatives – Bolivia, Brazil, Chile, Colombia, Costa Rica, Panama, Paraguay, Canada and America. Countries in Latin America were gathered at the regional meeting in the Americas, where Brazil was taking a significant role. The future issue is that how other countries in the Americas including Canada and America will work to enrich their exchange. In Europe, there are health co-operatives or co-operative pharmacies in six countries – in Spain, in Sweden, in Italy, in England, in Belgium, and in Checho. In Africa, only Benin whthin the jurisdiction of the West African office has 10 provider-owned health co-operatives.

These are the things I have heard about the worldwide distribution of health co-operatives. However, the situation of the health co-operatives haven't been fully grasped including those in the Asia-Pacific Region. The number of unit health co-operatives are unknown. It was only in September, 1992, at the first International Health-Medical Co-operative Forum in Tokyo, that we had a first international exchange. So the urgent issue is how we should promote further research to make the situation clear.

As Chairperson of the IHCO Interim Steering Committee, I would like to make a report about the establishment of the IHCO, which is the 15th ICA specialized organization. The reason why the establishment of the IHCO has realized quickly is that co-operatives, non-profit organization, in the third sector are gaining more attention under the circumstances where social security system is failing. Looking back on the history of the ICA, some co-operatives were facing various difficulties and others were unsuccessful especially in the 1970's and 1980's. Nevertheless, health co-operatives have steadily developed, and their unique activities have also attracted more attention. Advantages of the health co-operatives are abilities to tackle the social security crisis, and are gaining attention by not only the ICA but also other organizations such as the United Nations and the World Health Organization or some governmental institutions.

At the ICA Centennial Congress held in Manchester in September, 1995, the "co-operative values" was adopted again and the "Co-operative Principles" was revised. The ICA then got off to a new start toward the 21st century. The co-operative's identity, confirmed at the Forum, happens to positively support the progress of all our health co-operatives, and assures our further development. The IHCO has been prepared under such new circumstances of international co-operative activities.

At that Forum, the establishment of the IHCO was approved. I immediately organized, with the approval of the ICA General Assembly, the Interim Steering Committee, consisting of representatives from Spain, Brazil and Japan. After the eight-month preparation, the Committee submitted a proposal of establishing the IHCO to the ICA. On June 10, 1996, the establishment of the IHCO was unanimously approved at the ICA board meeting held in Beijing. In response to this, the Steering Committee met to plan the IHCO's founding meeting in Costa Rica on the 21st of this month. These have been our preparation for the establishment of IHCO.

As time goes by the IHCO should become able to share its role, and make a proper contribution to the ICA as well as to an international society. I believe the trends of the health co-operatives in the Asia-Pacific Region will have a great effect on the overall development of the IHCO. Therefore I urge that health co-operatives in the Asia-Pacific Region become active in the IHCO. Also I hope that activities for exchange and solidarity will develop in the Asia-Pacific Region, because I believe the development of the IHCO is assured by the enrichment of each regional activity.

Those are brief reports about the progress of the establishment of the IHCO and worldwide distribution of the health co-operatives. I would like to conclude by expressing my warmest welcome to all the participants and sincere hope for the success of the meeting. Thank you very much.

KEY NOTE ADDRESS

DR. N. S. LAUD

CHAIRMAN

SHUSHRUSHA HOSPITAL

HON. CHIEF GUEST, DR. GOLERIA
PRESIDENT SHUSHRUSHA HOSPITAL, MR. SUBHASH DANDEKAR
DR. KATO, CHAIRMAN, MEDICAL CO-OPERATIVE COMMITTEE OF JCCU
MR. HERATH, REGIONAL ADVISOR AND MR. TANEJA OF ICA FOR ASIA AND PACIFIC REGION
HON. REPRESENTATIVES OF HEALTH CO-OPERATIVES FROM JAPAN, KOREA, NEPAL, SRI LANKA AND INDIA.
MY FELLOW COLLEAGUES ON BOARD OF DIRECTORS OF SHUSHRUSHA
DISTINGUISHED GUESTS, LADIES AND GENTLEMEN.

I am indeed honoured to have been given the opportunity of delivering the Key Note Address at the 2nd Asian Region Health Medical Co-operative Meeting. As the host Organisation, graciously supported by ICA, I sincerely appreciate the confidence bestowed upon us to organize this meeting. To me this is an opportunity to appreciate the confidence, Asian and other regions have shown in our ability to conduct Health Care Projects efficiently within available resources in this part of world.

As the Chairman of the pioneering effort in Co-operative Health Care Project in India, I am proud to state that "our's" is the first and probably the largest clinical health care unit in India and most probably in this part of Asia.

I am also aware of the fact, that there are many Health Co-operative Units in India, these are however owned by medical or paramedical personnel. Shushrusha is an unique experiment undertaken by the citizens based on principle of "HEALTH CARE AS A RIGHT, WITHOUT EXPLOITATION WITH SELF PARTICIPATION".

This principle assumes greater importance in today's world of confused state of Health Care. Especially the projects run all over the world, whether Govt., Semi-govt., Charitable, NRI or NG Organisations. While in some countries Health Care is a superspeciality, high tech. service, some regions are deprived or unable to offer even basic care either to prevent diseases or cure a common melady. The health Care cost is rising at phenomal rate.It is controlled by market forces. Thus, disbursal of basic medical care remains a distant dream. Probable reason appears to be lack of infrastructural facilities, funds, and failure to analyse the complexities of todays Health

Care problems. In addition to Nutritional Disorders, Endemic diseases, Heart Disease, Arthritis and problems of Geriatric population, the mortality and morbidity is on the higher side also due to problems of Industrialization and Mechanization. "TRAUMA" has assumed endemic proportions even in developed countries, leading to loss of life in population below 40 years. The disability rate whether temporary or permanent is also on the rise. The Hospital bed utilisation doubles the number of beds necessary for Cancer or heart disease.

With rising cost it is just not possible for existing Health Care Units to offer adequate care. Many hospitals in Europe and even in America are closing down. Though private owned hospitals by NRIs or Insurance Companies have sprung up, the care offered is at prohibitive cost which a large majority of people are just not able to afford. The private health Insurance does not cover total care. It is against this state of Health Care in India, that we at Shushrusha are proposing "The Third Alternative". If I may, say so, the best and the most viable alternative of self provision for healthy existence. In the world of Industrial and Economic explosion, unless an average citizen educates himself about the health hazards and makes enough provision for future, he may find himself in great economic crisis to obtain emergency or routine health care. The number of avoidable deaths would mount. The disability percentage would continue to rise. The loss of working days and man power resources would continue to dwindle.

The work of Dr. Kato and his associates in Japan needs to be lauded. We all need to emulate this princple. We should initiate and introduce innovative and imaginative programmes towards healthy community existence.

The creation of International Health Co-operative Organisation is the step in right direction. I have gone through the draft rules. It is pleasing to know that the problems of even small units have been taken care of. The draft covers adequately about its charter, working and commitment. It appears realistic. However, it is also essential that it remains totally apolitical, not under any dominance and dedicated to problems and solution towards healthy community environment. We all must contribute and collaborate towards its success. It must remain an Organisation for sound, basic, realistic and useful data unit to help National, International and other bodies to plan and

propogate health care programmes for world Community. At the same time we must also ensure that it does not become "A Top Healthy Organisation".

Dr. Kato's address to first meeting in Sri Lanka gives enough insight into what has been achieved since the first Inaternational Health Medical Co-operative Forum held in October, 1992.

I am indeed delighted to know that our country can boast of an enlightened state of Kerala who has 67 Co-operative units. Obviously, the Asian Continent leads in this great movement. Existence of health Co-operative units in china, Malaysia, Indonesia, Phillipines and even Mongolia further adds to the need for co-operative health care in largest lands of human existence.

It is in fitness of things that United Nations at the first World Summit for Social Development has utilised useful information from various studies from Japan, India and other States. In his Key Note Address to Sri Lanka Meeting, Dr.Kato has said and I quote "To recognise and broaden our exchanges and deepen solidarity" I unquote, we must now pick up from where we left at Sri Lanka, deliberate and discuss, agree to disagree, but not leave a stone unturned to achieve our objectives. The policies and programmes directly affecting life of Community or Citizens towards prevention and cure of health hazards need be studied. The need for the future be discussed. The implementation be in time and may be ahead of time in some areas.

Today's world is not a safe environment to exist, physically, socially or psychologically. let us all use this opportunity to dedicate ourselves to the task of social commitment to recreate first. A situation, where Health co-operatives create health care facility for a Citizen to obtain adequate care at reasonable cost (for sure not free) within his or her reach locally, and secondly propagate health education programmes for healthy existence lest we forget "that its not the life, its the quality of life that matters".

THANK YOU.

KIND ATTN. DR VIJAY DESHMUKH

SECOND MEETING OF HEALTH MEDICAL CO-OPERATIVES IN THE ASIA-PACIFIC REGION MUMBAI, INDIA, NOVEMBER 2, 1996

INAUGURAL ADDRESS

Dr K S Galeria

I am one of you and therefore feel honoured to have been invited to inaugurate this second meeting of Health Medical Cooperatives in the Asia-Pacific Region. The only justification I can think of, for being so honoured is my long association with the Shushrusha Citizens' Co-operative Hospital and a small contribution towards its formation.

It was in the year 1963 that a few friends under the leadership and prodding of the late Dr Vasant Ranadive began meeting off and on to discuss the methods of rendering medical relief to what has been termed as 'middle classes'. These 'the middle classes' were endowed with education, knowledge and awareness, but had limited financial resources. In their hour of medical need they were faced with a Hobson's choice, between a private medicare system beyond their means and a grossly overloaded state medical system - an affront to their dignity and expectations. The middle class as you all know is the key to change in any society. We all belonged to the middle class. Our deliberations in those far off years led to the formation of a Hospital Co-operative Society - at that moment of time a unique concept. Dr Randive was its Chairman and I its Managing Director.

Of that group of friends, few have survived and among the survivors I am probably the most vocal. In accepting this honour therefore, I must of necessity share the credit with that pioneering group led by a dynamic visionary who was snatched from amongst us in 1971 by the will of the Lord.

Those were the days where the concept of a Hospital co-operative was unknown and it took a lot of effort to covince the authorities that we were neither a consumer co-operative nor a producer cooperative but a cooperative of the people and the medical profession to render health care to the community.

As I behold this audience, it thrills me to see that other communities in the other parts of the world also thought and developed along similar lines. It is therefore with an elated spirit and a joyous heart that I welcome my friends from abroad to this conference in the city of Mumbai, the land of 'Shushrusha'.

Since the time of starting 'Shushrusha' lots of water has flown down the Ganges and everything has changed. The people have changed, their needs have changed and the environment has changed. However, the concept of a co-operative effort towards health has held its own and grown, albeit slowly. It is essential to realise that to continue to grow, the content of co-operation too must change to absorb the changes around it.

Let me enumerate some of the changes to which it is time that we as co-operators in health care must respond.

A few decades ago the responsibility for guidance on matter of health fell on two Institutions. First the family and its traditional wisdom and second the family doctor, a friend, a philosopher and a guide. Both these Institutions today have almost disintegrated. The field has been taken over by self knowledge and knowledge disseminated by the media. The first theoretically laudable, sometimes becomes dissastrous under emotional stress of disease. The health knowledge disseminated by the media is conditioned by commercial considerations rather than by the needs of the people. The consequence of decisions made under such circumstances are disturbing.

The 'middle class' at least in our country has grown phenomenally and their financial clout too has improved considerably. Neither increasing numbers nor increasing money power can substitute for wisdom. Armed with the knowledge provided by the media they rush forth for a purchasable but not really needed expertise , greatly inflating the cost of medicare.

Change has affected not only the beneficiaries of medicare but also those concerned with delivering this care, the medical profession.

Two afflictions are the major manifestation of this change, Multiplicity and Isolation. Our Society is plagued with multiple medical systems, with no attempt at co-ordinating or defining their roles. Tall claims and confusion merrily merge with monetary greed and urge for media publicity to produce disastrous consequences.

Our times are also blessed with multiple specialities, functioning individually or jointly. With absence of an informed family doctor to guide them, the woes of the sufferer and the economic burden of the cofusion are severe enough, to concern us.

Add to this the biggest disaster of this century in the education of a doctor the removal of humanities from medical education. Thanks to this, the doctor of yore who was the patient's friend and guide is a dying species. We are living at a time when the concern for the techniques and technology overrules the concern for the individual.

We are thus living in an era when we have patients, who are hit by the diseases, by costs, by misguidance and by techniques.

The costs are automatically soaring and modern medicine is often beyond the means of even the affluent. There is a need for balance.

We have to balance between what is ideal and what is affordable. We have to balance between the intellectuals prowess of our medical personnel and lack of concern for the basic human problems. While sitting in the administrative chairs we have to balance the demands of the medical profession with the resources of the community. We have to find means for raising resources from a community whose demands for our services are high but whose willingness to contribute towards their cost is low.

The purpose of co-operative effort in health field is to restore balance in a situations full of conflict. It is obvious that the co-operative movement has not yet established mechanisms by which these balances can be established

I strongly feel that we who form the group assembled here are best conditioned and suited to face these problems and we should address ourselves to these.

I am extremely happy that the co-operative movement in the health sector is forging international unity which will give us strength. We should also go down into the community, involve them in their own health care, modulate their concerns and educate them. That alone will give us the base on which the international pyramid can be built up.

I have been delighted to see all of you from so many countries gathered here under one roof and to have the privelege to be one among you .

Welcoming you to our country I hope that our deliberations are useful and your stay here pleasant With these thoughts and wishes I invite you to commence your deliberations.

基調演説

主賓のゴレリア先生、
シュシュルシャー ホスピタル ソサエティー 会長 S．D．ダンデカルさん、
ＪＣＣＵ メディカル コーポレーティヴ コミッティー 議長 加藤先生、
ＩＣＡ アジア パセフィック リージョナル オフィスのヘーラトさん、シャルマーさん、
インド、スリランカ、韓国、日本の医学団体代表の皆さん、
私の同僚であるシュシュルシャー理事会の皆さん、
来賓の皆さん、
ＩＣＡの御協力のもとに、第２回アジア パセフィック ヘルス メディカル コーポレーティヴ会議を開催することができ、さらに、基調演説の機会をいただき、たいへん光栄です。この地の限られた状況のなかで、私達が医療プロジェクトを実行できるとの信頼をおいてくださったアジアその他の地域の皆さんに、感謝しております。

インドでの協同医療プロジェクトの開拓に努力してきたシュシュルシャーホスピタルの理事長として、私達の臨床ユニットが、インドで最初のものであり、また、おそらくインドで最大のものであり、さらには、おそらく、インドの位置するアジア地区でも最大のものであることを、誇りに思っております。

インドには、医学関係者の所有する多くのヘルス コーポレーティヴ ユニットがありますが、シュシュルシャーホスピタルは、そのなかでも、ユニークな位置にあると考えております。シュシュルシャーホスピタルは、「医療は侵害されることのない人権であり、個人が参加すべきものである」との原則を基本とし、市民が所有している実験的なものであります。

今日、医療プロジェクトは、世界中で、政府、公共機関、慈善団体、ＮＲＩ（海外在住インド人）、ＮＧＯ等の機関によって運営されていますが、それにもかかわらず、国によっては、医療は非日常のものであり、医療サービスの価格は高く、また、地域によっては、予防医療のための、あるいは、極普通の疾病治療のための基本的な医療すら施すことができない状況にあります。このような混乱した医療状況のなかでは、先ほど申し上げた原則は、非常に重要なものとなります。医療コストは、驚くべき勢いで上昇しており、それは、市場圧力に支配されています。そして、基本的施療は、未だに、遠い夢であり続けています。その理由は、基本的設備の欠如、資金不足、今日の医療現場の複雑な問題分析の失敗にあるようです。栄養不良、風土病、心臓疾患、痛風や老人病人口の問題に加えて、死亡率と罹病率が、工業化、ハイテク化のトラウ

マゆえに、より重要な問題となっています。これによって、先進国においてすら、風土病が、４０歳未満の人々にとって、死に至るものとなっています。身体障害の率も、一時的なものであれ、継続的なものであれ、上昇しております。病院のベッド数を見ると、癌患者および心臓病患者のためのベッド数が倍増しています。

コスト上昇によって、既存の医療ユニットでの充分な治療が不可能となってしまいました。ヨーロッパや、アメリカですら、多くの病院が閉鎖されています。ＮＲＩや保険会社の運営する病院が設立されてきましたが、それらの医療価格は、大多数の人々が支払うことのできないほど、高価なものであります。民間の医療保険も、これ全体をカバーすることができません。

このようなインドの医療状況に対して、シュシュルシャーホスピタルは、云うなれば「第３の選択支」を提供しています。それは、健全な生存のために、個人で用意できる最高にして最大限の選択です。産業経済が発達しきった今日、一般市民は、自ら医療危機の状況を学び、将来に対して充分な用意をしない限り、緊急医療、あるいは、継続的な治療を受けるための経済危機に直面してしまうということになります。不慮の死が増加し、身体障害の率が上昇し、労働可能期間が減少し、人材も減少してゆきます。

加藤先生方の日本での活躍は、賞賛されるべきものです。私達は、皆、「健全な社会生活のために、革新的で創造的な計画を導入、始動してゆかなければならない」という原則を見習わなければなりません。

インターナショナル ヘルス コーポレーティヴ オーガナイゼーションの創設は、そのための適切なステップです。私は、その草案を読みました。小規模なユニットの問題に対しても注意が払われているのは、たいへん喜ばしいことです。草案は、憲章、活動、公約を充分にカバーしていますし、現実的です。しかしながら、オーガナイゼイションが、政治的なものではなく、どのような外的な支配も受けず、健全な社会生活のための問題と、その解決に集中し続けるということも、重要なことであります。私達は、皆、これの達成に向かって、貢献し、協力してゆかねばなりません。オーガナイゼーションは、各国内外の団体が、世界に対して、医療プログラムを計画するのを助ける、健全で、現実的で、有用なデータユニットとして、存在しなければなりません。同時に、「頭でっかちな機関」とならないことにも、気をつけなければなりません。

加藤先生のスリランカでの講演によって、私達は、１９９２年１０月の第１回インターナショナル ヘルス メディカル コーポレーティヴ フォーラム以来、どのような

ことが達成されてきたのかについて、充分に理解することができました。

私達の国には、６７ものコーポレーディヴ ユニットを持っているケーララという優れた州があるということも、たいへん喜ばしいことです。アジア大陸が、この活動のリードしていることは、あきらかです。中国、マレーシア、インドネシア、フィリピン、さらには、モンゴルにまで、コーポレーディヴ ユニットがあるということは、この世界最大の大陸のコーポレーディヴ ヘルス ケアのさらなる必要性を示すものです。

国連が、社会発展のためのワールドサミット第１回において、日本、インドその他の国々から提供されたさまざまな研究の有益な情報を活用したことも、時宜に叶ったものです。「私達の交流を認識し、広め、連帯を深めること」、これは、スリランカでの会議における、加藤先生の基調演説からの引用です。私達は、今、スリランカで語り残した問題から始めて、熟慮、討議し、反対意見をも認めながら、小さなことまでひとつ残らず検討し、目標を達成しなければなりません。健康を脅かす疾病の予防、治療をする上で、人々や社会の生命に直接影響する施策や計画を、検討してゆく必要があります。将来的に必要となることがらも、討議しなくてはなりません。そして、その実施は、適切な時期に、あるいは、地域によっては、さらに早めに始めなくてはなりません。

今日の世界は、物理的にも、社会的、あるいは、精神的にも、生存のために、安全な環境であるとはいえません。まず、人々が、適切な価格で（無料というわけではありません）、各地域内で、充分な医療を受けられるような設備を、医療コーポレーディヴが創り出せるように、状況をつくりなおすこと、そして、健全な生活のための保険教育を推進するという、社会的責務に、この機会に、皆で、献身してゆきましょう。

「問題なのは、生きていることではなく、いかに生きているかである」という言葉を、私達は忘れてはいけません。

御静聴ありがとうございました。

Ｎ．Ｓ．ラール

South Korea

An-sung medical cooperative
chairman of the board of directors
Sucheong, Lee
Nov. 1. '96

Introduction

In Korea, health-medical system is based on free-practitionor system, as a result health-medical service is dominated by private sector. Health-medical system has been operated under principle of free market economy, and it caused various problems.
First, The level & number of medical facilities & medical workers have big difference depending on regions. Usually farmers, fishermen, city low income bracket have difficulties using medical facilities. 86% of the number of sick beds are in urban area. Only 14% of them are in rural area . In urban area, the number of doctors per 10,000 people is 3.4, but which of rural area is 2.6. It's because they don't want to open their medical facilities in rural area where there is less population & low income people compared with urban area.
Second, disease pattern is changing from acute, infectious diseases to chronic, degenerative diseases.That is the flow all over the world, and it has become main cause of death. So, the necessity of preventive health care service has been growing. But the medical system, in Korea dosen't meet the demand. It's beacause most of medical institutions, dominated by private sector, don't give priority to preventive service but to more benifical medical treatment.
Third, medical delivery system is not established efficiently. Role distribution between primary, secondary, tertiary medical institutions are not proper. Big hospitals in cities are overcrowded by patients and they have to take a lot of inconvenience. On the contrary, the effective bed occupancy rate of hospitals located in rural area is very low compared with that of hospitals in urban area. It is because secondary, tentiary medical institutions are not distributed on their proper places. Each hospitals have varying level of medical service but the reference system between medical institutions are not well organized.

Medical security system in Korea was launched in 1977 with the starting of company medical insurance system for waged workers. It was extended for public officials in 1979, and

regional medical insurance system for farmers & fishmen was started in 1988. At last, in 1989 , with the local medical insurance system for city dwellers, Korea completed "universal insurance system" in which medical insurance system has been applied to all Korean people. With the universal medical insurance system people can get medical service at hand with low cost. But the.e are problems still remained.

First, too many costly medical services are still out of insurance. The number of days you can get medical care being paid by insurance company is limited. Second, the burden of insurance bill between income brackets & between types of job is not fair. The insured of regional insurance should pay more money than the insured of company insurance. The same rate of insurance bill is levied however the income level is. Therefore, the burden is actually more heavier to the people who have low income . Third, the expense, insured patient should pay to the medical institution when they get treatment, is too high. When a patient get medical care from Geneal hospitals, he has to pay 55% of total money charged.

This is brief introduction to medical system & medical security system of Korea. Under those circumstances, medical workers movement to realize more better health-medical system has progressed since the late 1980. Part of medical workers with conscience, medical doctor, dentists, pharmacists, oriental medicine doctors, nurses, founded their own organization according to their occupation for medical reform movement. Some of them had activities joined with social reform groups of labors & farmers. The others made small clinics for the poor in cities & farmers. In 1986 they founded local clinic, Kuro Clinic, for the labors of an industrial area. They have been working to prevent & care, industrial disaster & occupational diseases. In 1989, a local clinic, Incheon Peace clinic, was founded with same purpose. This clinic have prepared for a long time to transform itself into medical cooperative. It will be accomplished this Nov. In addition, as a result of endeavor of health-medical workers with conscience, several medical institutions dental clinics, pharmacies, oriental medicine clinics, aimed at providing more better health-medical service have founded.

With the background of this history, after foundation of Ansung medical cooperative, one more medical cooperative, An-san medical cooperative, has already founded in a city this year. And as I told you above, the Incheon Peace medical cooperative will be launched this month.

Ansung Medical Cooperative

1. Introduction of our county

Ansung-Kun(county) which Ansung medical cooperative is located in, is near Seoul the Capital of South Korea.(It takes 1 hour by car from Seoul to An-sung)
The size is 55,308 km^2. The population is 123,523. 43% people of the population are farmers. It is a typical agricultural area. Pears, grapes & rice produced in Ansung plain is famous nationwide. It has proper configuration of land for dairy farm and 15,000 cattles are raised. It is near by city and because fruit cultivation & dairy farms are benificial, An-sung is richer county than other agricultural area comparatively . It has 2 hospitals, 25 medical clinics, 12 dental clinics, 7 oriental medicme clinics, 1 Health care center, 12 branch offices of health care center. Except 12 branch officies of health care center, those are public medical institutions almost all facilities are crowded in small downtown area.

2. The History of Ansung medical cooperative

"An-sung medical cooperative is a result of effort of community farmers reform movement(sound residents) & medical workers reform movement(medical workers with conscience) "

In 1987, in a village(Ansung-Kun Gosam-myon Gayou-ri) the youth group wanted to invite a small clinic for the residents. With the acception of doctors & medical students who were interested in farmer's health, the weekend clinic was started. Since '87 other types of medical workers like nurses, pharmacists joined and oriental midicine doctors joined in 1991. The joint medical service of western & oriental medicine appealed to the residents a lot. The medical service was given once every other week. In addition to give residents medical care, they gave housewives health care education, training of village health care leader, preventive inoculation, activities to reform the medical security system. Several years of steady activity brought the youth group trust from residents, and it helped them to organize community farmers' organization (Ansung farmers' association easily). The medical workers who had felt the limitation of weekend clinic made an organization 'Ansung medical group' aimed at establishing new local medical institation in October '91. In Nov. '92 a oriental medical doctor could afford to come down to Ansung, and several medical members invested together & they opened the

Ansung oriental medicine clinic. August in 1993, residents & medical members jointly made the Ansung farmers clinic foundation comittee. They orgamized investment movement to establish the clinic, and 130,000,000 won(162,500$) was invested from 253 residents & medical members. April ,the 24th in 1994 we held inaugural general meeting of Ansung medical cooperative. May the 2nd, Ansung Farmers' clinic had opening ceremony with Ansung Oriental Medicine Clinic which had moved into the same office. It was the day that the first medical cooperative in Korea was born.

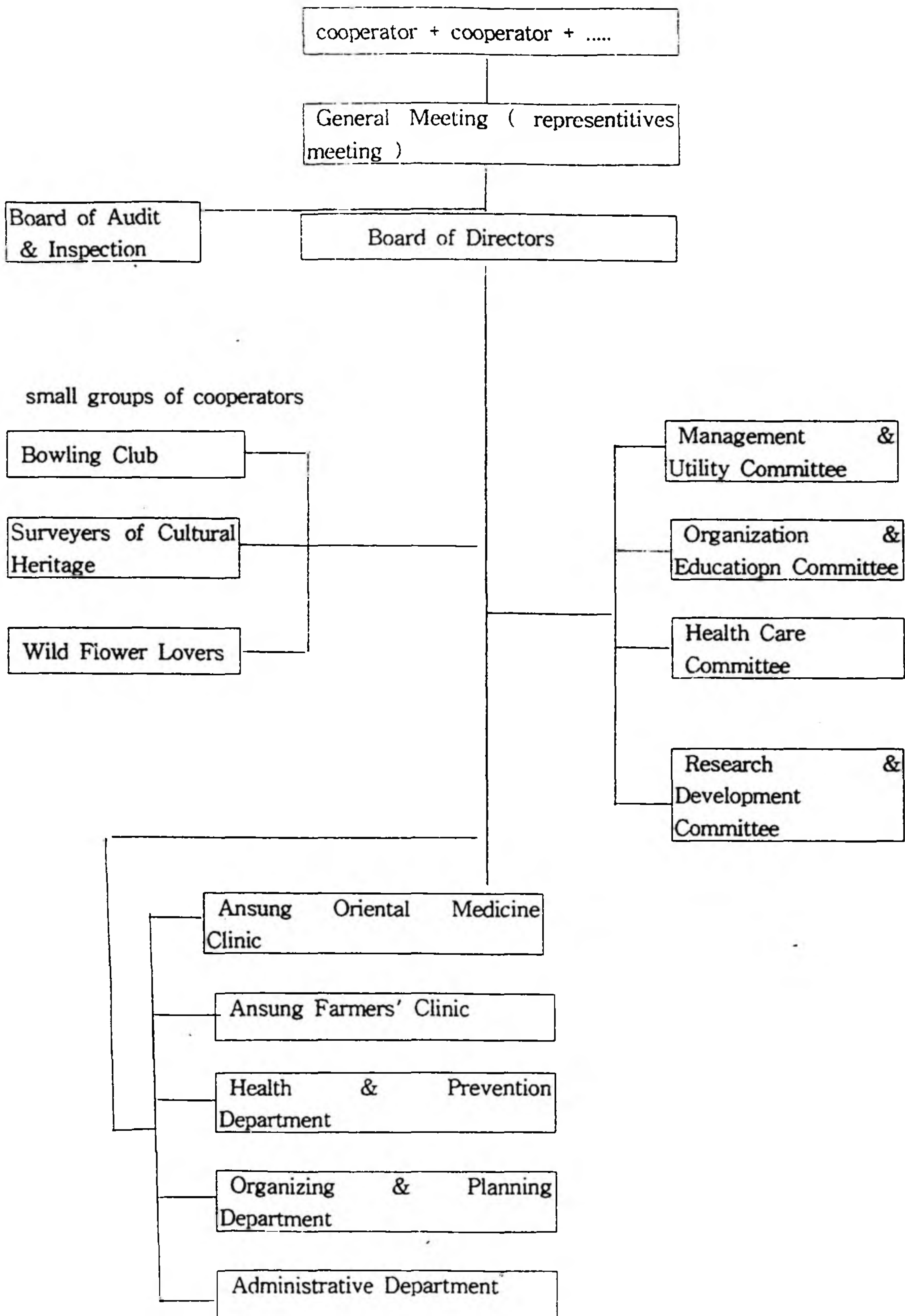
As I mentioned above, Ansung medical cooperative is an organization jointly made by residents & medical workers from the point of start. It was not built in a day. It was not built by couple of people, either. In the beginning of our efforts, we didn't have any idea that our organization could be called a medical cooperative. We hadn't heard about the existance of medical cooperatives outside of our country. We just have pursued a healthy medical institution made by voluntary investment & participation of local residents. And we found it was what you call medical cooperative movement.

3. The status of today & introduction of main activities

1) The status of today (September 30th '96)

number of cooperators	528	households	
invested fund from cooperators (share capital)	194,080,000 won ($ 242,600)		
total assets	350,000,000 won ($ 437,500)		
number of medical facilities	2	clinics (1 medical clinic & 1 oriental	
sickbeds	0		
number of employees	14	doctors	2
		planning executive	1
		regular nurses	3
		add nurses	3
		pathologist	1
		physical therapist	1
		clerical workers	3

2) organization



* principle of investments

We restrict the investment of one person between 1 stock (10,000won) - 1,000 stocks regardless of the number of stocks you have you can only have 1 vote.

* general meeting

It will be replaced by representatives meeting

composed of whole cooperators held once a year it makes final decision. top legislative organ

* board of directors

chairman(1 local resident)

directors(6 local resident, 3 employees)

it makes decison & implementation for practical problems

* committees

consited of directors, employees, cooperators.

* wild flower lovers : voluntary helper group

consisted of housewives

They visit asylum for the aged & handcapped and help them.

* Ansung oriental medicine clinic

1 oriental medicine doctor, 2 add nurses, 2 clerical workers

* Ansung farmers' clinic

1 doctor, 1 RN, 3 AN, 1 pathologist technician, 1 physical therapist

give primary medical care

* health care & prevention dept.

1 RN

medical check up for cooperatators, manegement of patients with chronic diseases, health care education, home vist & care, running a health care school.

* organization & planning depart.
  1 executive official
  management of cooperators.
  various organizing activities
  preparing a variety of events etc.

3) Main activities

(1) running medical institutions
average number of patients a day : 140 -200

(2) health care & prevention
life time regular medical check up for cooperators
manegement of patients with chronic diseases
health care education, home vist & patient care,
running a health care school & traning health care leaders.

(3) activities for community
- voluntary helper
- activities to promote solidarity in community

(4) cultural, educational activities

4. problems

1) Legal entity of Ansung medical cooperative is just a private medical institution in Korea.

Today we don't have "cooperative Law" so not only medical cooperatives but also other consumers cooperatives are not identified by law. Although it is unsatisfactory general consumers cooperative can be admitted as a corporation aggregate. Ansung medical cooperative is mbt admitted even as a corporation aggregate because of specialty providing medical care. Ansung medical cooperative have tried in every ways with a sense of misson as a pioneer of medical cooperative in Korea to get a legal position of corporate but we failed. Because we don't have legal identity we have problems implementing our works with confidence in community. And we have disadvantage in tax.(because we are not admitted as a

nonprofit organization burden of tax is too heavy) Korea consumer's cooperative federation has been trying to legislate "cooperative law" but it still has long way to go.

2) Weakness of finance

Under this medical environment in Korea, it's not easy to run a cooperative medical institution without deficit. Fortunately, because of the dedicated medical service of employees & continuous additional investment of cooperators we don't have compiling deficit, but we can not afford to improve & expand our facility. We rented our office , it dosen't have enought space but the burden of rent is too heavy. (Deposit money for office consists of 71% of our total assets)

conclusion

With correct medical cooperative activities which guarantee the paticipation of community residents, we will keep on trying to make community residents to have initiative of cooperative, to promote their ability to take care of their own health. In addition, we'll try to improve whole environment surrounding our daily life.

The catch praise of Ansung medical cooperative is "Healthy farmers, society living together." Against all our difficulties, we have confidence we can keep trying to realize our goal.

I hope you who started medical cooperative movements earlier than us give us alot of advice and cooperation. thank you.

MOVING TOWARDS SUSTAINABLE HEALTH CARE : The phect Experience

Dr. Bharat Pradhan
Director, Kathmandu Model Hospital
Executive Member, phect-NEPAL

Background Information:

Traditionally The Nepalese people relied more on the healing methods as inherent in their indigenous knowledge system. The practices in the healing systems were very close to most of the oriental methods and they comprised different form of faith healing , use of herbs , and the relatively more organised Ayurved. These methods still predominate in most of the rural areas with their own limitations and strength .

It was not untill the reign of the Rana Prime Minister Bir Shumsher, merely a hundred plus years back , that the western system of *treatmnet* (cf. the oriental *Healing* System) entered Nepal . As any new entrance of those days , the western system v.i.z. 'Allopathy' , was imported via the very narrow window of Hate& Love Relationship with the then British India .

Naturally, the health care delivery system of the country started to be very much influenced by the British System . The Official system of health care delivery became Allopathy . However , the indigenous healing methods and Ayurved remained important for most of the people . The western system was available for and served mainly the rulers at different levels .

At the later period , the Christian Missionaries with their own sense of religious mission entered the country . The impact produced by the missionaries can be interpreted and judged in different ways . But the impact on helath services on the whole was positive.

As the western made formula of 'Development' started entering the country during the sixties , the American prescribed health care deivery system gradually started becoming influential . Perhaps this was the starting point of our travel towards where we stand now - facing the Atlas of so called Free Market Economy with the ornaments of 'Structural Adjustment Program'.

Although the concept of cooporutives in Nepal is indigenous and indeed very old, the present day concept of cooperative entered through India as a part of the Gandhian philosophy. After fourty years of exercise , the cooperatives still fail to take the shape of a real movement . And this failure is also due to the increasing impact and influence of the new globalizing forces . At present , some achievements have been made in the positive direction as a result of the emergence of NGOs .

More radical concept of health is very new and the entrance was more incidental than a conscious effort . This was the Alma-ata declaration 18 years back . As the materialisation of Comprehensive Primary Health Care is very demanding in terms of political commitment , this has also been reduced to mere slogan.

Under these situations , the Public Health Concern trust was conceived with the objectives of creating

Our Beliefs

phect believes that Health should be understood in a broader societal context rather than in the narrow bio-medical context. Health problems can't be dealt with in isolation . They have to be dealt with at the level of their roots - the social causes . In other words, we believe in the concept of the Comprehensive Primary Health Care (CPHC) as agreed upon by the Alma-ata declararation .

It is unfortunate that nation-states have failed to materialise the concept even after all these 18 years that elapsed since that historical declaration .

This may be primarily because attempts were made to see CPHC implemented through governments . But , the essence of CPHC lies in the empowerment of the people Perhaps it was unrealistic and impractical to hope that the empowerment of people could be made possible through government *decrees* .

With the emergence of NGOs , and newer generaton of people's organizations , the empowerment of people is taking the shape of a new movement . It seems , now , provided real commitment for action , the realisaton of the concept of CPHC might be made possible through these people's organizations . It is important now to boldly act on the challenge of shifting the paradigm of health where it can be understood in the societal context and the cause of healthrights can be advocated .

Phect is trying to move consciously in this direction .

Objectives

The basic objective of phect is to create nongovernmental **model of sustainable, accessible** and **affordable** health care delivery **system**.

The system

The system of which we are trying to create the model has the following functional components :

Team of Local Health Conscientisers (LHCs)

These are the front-line volunteer health workers selected by the community . They get one week long intenive training organised by the Community Health Development Program (CHDP) in coordination with the Research/Training Division of phect . Continued further training is provided to these LHCs. This team of LHCs is responsible for the health education in the community , facilitation of the services in HISC(v.*infra*), bridging the communication within the phect network and other relevant health activities within the component.They also represent the interest of the members of the Rural Health Insurance Scheme .

Health Informationand Service Centers (HISCs)

These are the primary health care centers in the CHDP action areas . One HISC is established in each of the CHDP action areas . This center is manned with a Health Assistant and a Pharmacist and equipped by phect 's CHDP. A pharmacy is run with the seed money provided by the CHDP. The pharmacy dispenses only essential drugs and at a cost lower than the local market . A doctor visits each of the HISCs once a week. If any patient needs to be referred for further treatment, they are

3. Besides the potentially income generating organs such as the pharmacy, diagnostic facilities , etc. , which help sustainability to certain extent , possibilities for running other income generating Enterprises are under consideration.

Affordability and Accessibility

The organisation has tried to make the service affordable and accessible by various means such as

General clinic in the hospital : This is the clinic run by nonspecialists . This is open 24 hours a day . The fees are minimal. If the patient needs referral to a specialist , he or she will half of the usual fees. The patient will return back to the general clinic for followup . If somebody asks to be seen by a specialist from the very beginning , the charges will be higher.

Charity : Charity is the concept we tried to avoid from the very beginning . But we can not say No to any patient seeking service in the hospital . The poor patients get treatment in the hospital in charity .

For the people who are members of the rural insurance program , the charges are minimal. The insurance program was started to encourage the people to form their oen cooperatives. The fund collected by subscription to the program remains in the control of the villagers themselves.

Special service for 'Prajas': Prajas are one of the most deprived tribes of Nepal. They are given free treatment in the hospital .

REVIEW

All that has been mentioned above is the system we tried to create. But when translating an idea into action , in practice , some deviation, some evolution , some failures and some achievements are natural.

What did we achieve during this period ?

Achievements:

- Developed a cadre force
- Accessible and affordable service for a section of nonaffording people
-Establishment of infrastructure for CHDP and HOSPITAL
-Early experience in moving towards health coop in remote areas
-Some experience in working with the people for the people .

Failures:

- Failure to encourage adequate community participation in moving towards health co-op, especially in relatively privilaged areas .
- Failure to overcome the donor\recipient relationship
- Failure to help income generation programs.
- Failure to act on the alternative financial resources

Constraints /obstacles:

- Dificulty encountered in working with the heterogeneous community.
- Partisan politics which divides the community.
- Donor/ Recipient cult

Kathmandu Model Hospital (KMH)
This is a general hospital functioning as the referral Hospital within the phect network. The hospital service is run on cross-sectional subsidies and with donations.

Research Works
Need based research works are being carried on with the objectives of informing the people . Some research papers are already prepared and are in the process of publication . These include informations on the contamination of edible oils , the use and impact of nonpermitted colours in food , the impact of vehicle emission related polution on the child workers in transportation etc. Some Clinical researches are also being carried on in different fields.

Training
Different packages of training for frontline health workers , for industrial workers , continued education program for health workers including training on primary surgery for doctors working in remote districts are also being carried out . Some of the trainings are carried out in co-ordination with other oganization folowing the same working philosophy

All these activities are coordinated through the following organs:

Community Health Development Program (CHDP)
Kathmandu Model Hospital (KMH)
Research &Education Section
And in association with other organizations

Sustainability

As with any organisation , the problem of sustainability is most conspicuous in the comunity health program . During the inception of CHDP , it was presumed that the basis of sustainability for CHDP could be the following:

1. Community participation leading to Rural Health Co-ops . In order to help materialize health Co-ops, Rural Health Insurance Scheme with low Insurance charges, family insurance and industrial group insurance have been implemented in the local community.
2. Human resource generation from within the local community by training them, and
3. Income generation programs, e.g., school health program, local pharmacy, local pathology lab for simple tests and trainings, etc . Integration of other activities for income generation are being explored.

Running a hospital , especially if we try to make it affordable for the people , will also face the problem of financial sustainability. To make the hospital services affordible for the people and to make it financially sustainable at the same time naturally posed a big challenge.

It was presumed that the following could be the basis of sustainability for the hospital :
1. 'Cross sectional subsidy' . The hospital would provide services to different section of the people . The charges at sliding scale was thought to solve the problem of affordibility vs. sustainability to certain extent

2. The sense of MISSION among the physicians could bring down the cost of treatment to a large

Future Direction:

-To create at least one model of completely sustainable and affordable PHC program in one of the VDCs.
- To train/generate manpower locally and to hand over the program to the community.
- More co-operation with 'likeminded' organizations. In this direction , we are already a participant in 'VIKALPA' , a new movement of cooperative culture
- Focus on training /sharing, rather than in expansion.
- Strong and effective advocacy and lobbying/pressurizing for healthrights.

<u>PANEL DISCUSSION</u>

November 2, 1996

FOUNDATION OF IHCO

&

RELEVANCE OF APHCO

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My dear fellow Co-operators,

Nations health is its main wealth and we value it through co-operation amongst citizens' and their participation which once seemed to be an ambitious dream has now become a reality.

Health Co-operatives are highly relevant to the contemporary situation. It is characterised by a wide spread community oriented preventive health services which is badly needed and they are backed by curative and rehabilitative service which are affordable and appropriate.

We stress precisely such a combination of high quality and appropriate curative treatment with a broad preventive approach to health care involving a particular individual, family and community. There has to be efforts to establish healthy life styles and a health supportive environment.

Only a co-operative health care organisation ensures that level of commitment by the community which is required to make such an approach to health care work. Effectively, they are the only means whereby individual citizens are able to participate, to contribute and to achieve that environmental revolution which is an essential compliment to successful professional intervention. Only through user owned or jointly user and provider owned health co-operatives are the users able to exercise any control.

We should overcome the barriers of time, of cultures, and of politics and should bring people together in this unique model of Health Care System.

The success of Co-operative Health Care activity is judged not only by its growing members but also hard work and rigorous ethics.

When Citizens know that the Doctors are providing out of hours medical care and the aged mother is being looked after by a community care co-operative then they perhaps are more likely to adopt a positive attitude to the enterprise by virtue of its co-operative status.

When we the Health Co-operatives seek "Autonomy" the policy makers would ask about "Accountibility".

Its time that we the health care sector assert ourselves and put the things in the right perspective.

We should be more accountable to our members than the state.

A co-operative business believes that it came into existance not because there was capital to invest but because people had certain common needs. As users or consumers they felt they could themselves fulfill through joint efforts and investment.

Our mission is to develop a strong constituency of informed principled and committed leadership which could and would play a major role in reforming the co-operative environment and thereby the Health care co-operative movement.

The IHCO is a voluntary association of users and procedures in the health co-operative which would seek to provide high quality, cost effective community health care based on freedom of choice, integration of services and ethical working condition.

IHCO would provide a forum for discussion and exchange on issues relevant to all co-operative health care member organisations and help us expand our horizons by providing information to United Nations, National Governments and media and to improve public opinion about the unique role that a health co-operative has in the Society.

The future of co-operative movement depends on the quality and commitment of its leaders and on the loyalty of members on the performance of co-operatives themselves. The achievements of many successful co-operatives have demonstrated that self help, mutuality and the principles of co-operation can benefit those willing to fight, to protect and defend their autonomy. Such co-operatives would be an inspiration to others.

There is a growing interest shown in many countries in the formation and strenghtening of medical and health co-operatives as the response to market liberalisation which has resulted in reduction or withdrawal of subsidies available for hospital and social welfare activities.

In countries of Asia and Pacific these co-operatives have a long history. We have now to adopt a new set of co-operative principles which have widened the scope of co-operatives in serving communities which would contribute to sustainable human development. The formation of APHCO would be relevant at this point of time.

Our group of co-operative leaders in Asia have initiated this Health Forum with the hope of organising a global and regional network of health Co-operatives.

Our efforts in this area would strengthen the operations of existing health co-operatives and provide opportunities for new co-operatives to emerge.

Our major problems in this field has been absence or inadequate information of various health co-operatives in the region. This affects grossly the process of consolidation which seriously hampers future progress. Updated information and data of each country could be used to decide on the future strategies.

We have to explore the conditions relevant to promoting and supporting the health co-operatives and in some possible areas of collaboration take support of Government and Inter-governmental organisations including UN, WHO and UNICEF. The IHCO draft plan clearly emphasis this point which I feel is epoch making.

I am sure that there is a considerable scope both for expansion of such activities and for partnerships between co-operative sectors and other non co-operatively organised health care private sectors, NGO's and also some of the citizens movements concerned in health care at local, national and international level.

The first formal inter regional or global exchanges of experience and views was organised by Japansese Health Co-operative movement From November, 1991 to January, 1992 members of The MCC of JCCU undertook first international study tour in health co-operative sector. They visited Sri Lanka, India,Malaysia in the Asian region and also Sweden, Italy, Spain, Canada and United States.

Jointly with the national Welfare Federation of Agricultural Co-operatives the MCC organised the first International Forum at the time of ICA's Congress in Tokyo in 1992.

In April, 1994 the first Asian meeting of health co-operative movements took place in Sri lanka. We then started this important forum of exchanges amongst Asian Countries. Today the second meeting is being held at Mumbai, India.

We the representative of the Asian region are here to contribute and define the goals for the new body in ICA of the co-operative and social health care sector.

The exchange of experiences at the regional level help to promote interests in our health co-operatives.

A comprehensive and integrated international strategy for the enhancement of the capability of the co-operative movement to contribute to improved health be formulated and put into operation.

The function of bringing together all co-operatives for fomulation of such strategy and for promoting its implementation should appropriately form an International Co-operative Apex Organisation which we are in the process of forming.

This task can be achieved by means of a working group with the participation of representative of various health co-operatives in those regions.

We want to establish above all justice, social and economical in this important sector of Health Care. The liberty of thought and expression that we have and the belief, faith and worship in our endeavour would help our generation to carry the torch forward or even light it afresh if it gets extinguished by the gusts of indifferent, crazy and bizzare ideas that come to us

I hope we will be able to take this vast variegated international endeavour along the path of justice, liberty, equality and fraternity so that when the days work is done we can hand over to the next generation with pride a torch brighter than before to light their path for the future.

Presentation at Panel discussions

November 2, 1996

Toshio Ogino
Executive member in charge of
International Affairs
Medical Co-op Committee of
JCCU

Chairperson and the delegates, it is indeed a great honor for me to be given opportunity to speak at this meeting. Now I will report on the importance of establishment of International Health Cooperatives Organization(IHCO) and Asia-Pacific Health Cooperative Organization(APHCO).

As you know, the first International Health-Medical Co-op Forum was held in Tokyo, 1992, and the second forum took place in Manchester, in 1995. We could recognize the health-medical conditions and activities of health-medical cooperatives all over the world at these meetings.

In developed countries, such as western Europe and Japan, according to the change of economic, social, and political condition, the governments seek efficiencies and cut budget in the field of social security system. Under these circumstances, people are facing the reduction and privatization of public health-medical service. This began to be recognized as big social problem.

In developed countries health-medical cooperatives are operating fair and comprehensive enterprises . Japanese health-medical cooperatives place importance on satisfying needs from the majority of communities including the poor. We promote the participation of consumer members and operate the enterprises based on "Charter on the Patients' Rights".

Health-medical cooperatives in developed countries are steadily winning confidence and supports from members and medical staff by meeting their needs and expectations. The public health-medical services are apt to fall into inefficiency and bureaucracy and the privatization sometimes fall into commercialism. Health-medical cooperative activities have gained attention and expectation as the third way, alternative to set up against this tendency.

Next, I would like to make a statement on developing countries. The health conditions in the poorest countries, those which account for a quarter of population all over the world, are facing crucial difficulties. There is a large gap on the average lives and infant mortality between the

poorest and wealthy countries. This situation is caused by poverty, unsanitary environment, shortage of health-medical facilities, and insufficient education. Cooperatives must not ignore the fact that more than 35000 children are dying of preventable illness every day. Health-medical cooperative enterprise, which is based on cooperation, education, voluntary participation, democratic management by members, is one of the most effective way to improve the situation in the poorest countries. Phect-Nepal, who is attending this meeting, is carrying out splendid activities. Health-medical cooperatives are active in Benin of Africa as well. The establishment and progress of health-medical cooperatives in these countries are very important.

The advancement of health-medical cooperatives will take more and more important role in this situation in health-medical area all over the world. Under this circumstances the International Health Cooperative Organization(IHCO) is determined to be established as specialized body of the ICA. I believe it is an epoch-making event.

IHCO will play the main role to promote international exchange and solidarity and to improve activities of health-medical cooperatives all over the world. I hope many countries in the Asian and Pacific region will join the IHCO.

There are various countries existing in Asia. Some are small and other are big. Some are called as "developing countries". The economic, social, and political conditions of each country are different. And so is health condition. Above all, we still have some common problems as health-medical cooperatives. We, health-medical cooperatives, need to exchange our experiences and promote solidarity to understand each other in this region.

I will give some concrete proposals. First of all, we can promote human exchange in order to activate international exchange between cooperatives. We need to exchange members and medical staffs between each country. Training program and studying abroad system for young members, doctors, and nurses as the rising generation, are also needed.

I would like to stress the importance of establishment of APHCO, collaborating with ICA ROAP, to promote international exchange solidarity of health-medical cooperatives in Asian and Pacific region. I would like to propose two things. At first, the election of members for the APHCO preparatory committee at this meeting, and the second, the holding the founding meeting within 1997.

I believe that the establishment of APHCO will promote international exchange and solidarity of cooperatives in Asian and Pacific region and will develop our cooperative enterprises.

Thank you very much for your attention.

An Opening Speech of the Panel Discussion Made by an Anchor Person

I am Dr. Shoji Kato, chairman of Medical Co-op Committee of Japanese Consumers' Co-operative Union. It is my pleasure to preside at this panel discussion. As I mentioned in my opening address in the morning, the establishment of the International Health Co-operative Organization (IHCO), one of the International Co-operative Alliance (ICA) specialized organizations was decided at the second International Health and Social Care Co-operative Forum held in Manchester, England in September, 1995. The Interim Steering Committee for the establishment of the IHCO soon started its preparation, and the establishment was approved at the ICA board meeting held in this June. The founding meeting of the IHCO will be held in San José, Costa Rica on 21st of this month.

The IHCO will consist mainly of Spain, Brazil and Japan, and of health co-operatives in a few other countries. It is not satisfactory but natural that we should not expect many countries to join the IHCO from the outset, considering international exchange among health co-operatives started just few years ago, in October, 1992 when the first International Health-Medical Co-op Forum was held in Tokyo. However the Interim Steering Committee decided early establishment of the IHCO and later development of its activities, in respond to the severe medical situations around the world, and the strong expectations from outside and inside of the ICA. In any case this is epoch-making for international activities of health co-operatives.

Therefore progress of each regional meeting, Asia-Pacific, Europe, Americas, and Africa, is crucial to overall development of the IHCO. I think organization of the Asia-Pacific Region can be essential for the future development of the IHCO, since health co-operatives concentrate in the Asia-Pacific Region, playing active roles. Considering this, I bring up two points as the themes of this panel discussion. First I would like all of you to take the establishment of the IHCO positively, including the participation in the IHCO and discuss what you expect the IHCO to do. And second, to promote further exchange in the Asia-Pacific Region, I ask my colleagues to consider the formation of the APHCO.

Now I am pleased to introduce four panelists. First this is Dr. Deshmukh, dean of Shushrusha Citizens' Co-operative Hospital from India, Mr. Gunawardana, chairman of Galle District Co-op Hospital Society Ltd. from Sri Lanka, Dr. Kwon from South Korea, and Dr. Ogino, executive director of Medical Co-op Committee of JCCU from Japan. Then I would like each of the panelists to make a speech within 10 minutes. To deepen our discussion, additional and supplementary opinions from the panelists will be required within five minutes. Positive opinions from the audience are welcome so far as time permits.

NAME LIST OF PARTICIPANTS

Nation	Name	Position	Organisation
JAPAN	Dr. Shoji Kato	Chairman	Medical Co-op. Com of Japanese Consumers' Co-operative Union
	Ms. Ritsuko Yoshida	Member of Board	Medical Co-op. Saitama
	Ms. Toshie Murayama	Member of Board	Medical Co-op. Saitama
	Ms. Yoko Miyoshi	Secretary	MCC of JCCU
	Mr. Yasuhira Sakurai	Secretary General	MCC of JCCU
	Ms. Nobuyo Michiki	Interpretor	
	Mr. Takashi Yoshioka	Secretary	MCC of JCCU
	Mr. Toshio Ogino	Executive member in-charge of intl. affairs.	MCC of JCCU
	Mr. Hiroyuki Inoue	Manager, Dentist	Matsushima-Kolgan Clinic of Matsushima Medical Co-op.
	Ms. Takako Yanaga	Member of Board	Kochi Medical Co-op.
	Mr. Atsuo Nakata	Doctor	Kanamachi Clinic of Tokyo Katsushika Medical Co-op.
	Ms. Sachiko Minemura	Secretary	Tokyo Health Co-op.
	Mr. Yasuke Nakagima	Member of Board	Medical Co-op. Saitama
	Mr. Tsuneo Nishizaki	Director	General Hospital of Minato Medical Co-op.
	Mr. Yuji Usui	Chief of Dispensary	Kita Hospital of Kita Medical Co-op.
	Mr. Tetsuji Otsue	Manager	Himawari Clinic, Kobe Medical Co-op.

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Nation	Name	Position	Organisation
KOREA	Mr. Su-Cheong.Lee	Chairman	Ansung Medical Co-operative in Kyonggi-Do
	Mr. Ill-Mo. Rhew	Co-operator (Dentist)	Ansung Medical Co-operative in Kyonggi-Do
	Mr. Bong Sub Choi	Official Executive	Ansung Medical Co-operative in Kyonggi-Do

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NEPAL	Mr. P. R. Manandar	Administrative Chief	Public Health Concern Trust (Phect-Nepal)
	Dr. Bharat Pradhan	Executive Member	Public Health Concern Trust (Phect-Nepal)

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SRI LANKA	Mr. L. Samarasinghe	President	National Co-op. Council
	Mr. K. K. De Silva	President	Kurunegala Distict Co-operative Hospital
	Mr. M. D. Siripala	Director	Colombo People"s Co-operative Hospital Limited
	Mr. S. Wickremasinghe	Former Director	Co-operative Hospital, Gampal

****

KERALA

KERALA	Mr. T. Haridasan	Manager	Tellicherry Co-operative Hospital Society Ltd
KASA-RAGOD	Mr. T. V. Gangadharan	President	Kasaragod District Co-operative Hospital Soc.
SOLAPUR	Mr. U. R. Warerkar	Vice Chairman	Ashwini Sah. Rugnalaya & Research Centre
KERALA	Ms. Nalini Netto	Registrar	Co-operative Societies, Thiruvananthapuram
KERALA	Mr. Raveendran K	President	Wayanand Co-op. Hospital Society Ltd.

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AN OVERVIEW OF
THE HEALTH/MEDICAL CO-OPERATIVES
IN THE ASIA PACIFIC REGION

01. A Case for Health Care Co-operatives in The Asia -Pacific Region

The World Summit on social development in 1995 propagated people centred approach to social development and emphasised the need to have cross sectoral participation with the government in realizing the goals of social development. The Vision for 2000 adopted gives a target of achieving an overall life expectancy of 60 years, reduction of mortality rates of children by one third of the present level and maternal mortality rate by one half of the 1990 level. The vision also provides ambitious targets for accessing reproductive health through primary health care system and eradication of infectious deceases.

United Nations Economic and Social Commission for Asia and the Pacific has set up an interministerial committee for the implementation of the Summit Programme of Action, which again emphasises the involvement of Peoples participation in health programmes.

Why the emphasis on peoples organizations? In reality, Brettonwood financing institutions force transitional economies for structural adjustment programmes as conditions for lending which means reducing subsidies for social welfare such as education and health. The economic emphasis is on the liberalization of economy with least intervention of governments in the market. Deregulation of state enterprises is also in the agenda. When the government loses its dominance over the capital market and enterprises, the social expenditure would become a great burden. This situation affects all social expenditure as happened in CIS countries and former socialist countries in Asia. Asian Development Outlook for 1996 and 1997 by the Asian Development Bank states that old safety net has collapsed in many places while the level and the nature of the new public sector are not yet clear. It also states that in most of the transitional economies, teachers, doctors and social services administrators may now open or formalize private practices or sell their professions in alternative professions. Therefore, the people would need to take care of themselves. In this circumstances, the communities may need to look for co-operative alternatives.

The Human Development Report for 1996 indicates that in spite of improved health indicators in Asia, many countries have a trend to deprive major part of the population, access to health services. 20% of the people in developing countries do not have access. CIS countries are worse affected. More than half the malnourished children are in South Asia.

The situation leads to work on the peoples' own strength using the social capital. Working together with shared values beliefs and their own individual resources would reduce the transaction cost and create more productivity from their ventures. Eventually such efforts will be more sustainable in a competitive market environment Health care has become commodities in the marketplace. Such is the case for health care co-operatives.

The new co-operative principal Concern for Community - provides added recognition to undertake social ventures, defeating the early debate on the objective of a co-operative organization.

02. The Nature Co-operatives

In order to justify the existence of a medical or health care co-operative, there should be distinct values and character for such institutions. A co-operative should operate like a company. Therefore one has to ask why we should promote health care co-operatives.

Consider the emerging economic situation in terms of effects on an average family:

- The problem of health economics affects the average family with the rising cost of consultation, hospitalization and medication.
- Health is so basic to life that it should not be an individual responsibility but all in the community.
- Many of the diseases can be prevented, if the families had preventive medical care.
- Few families can afford to pay for specialized medical attention.
- Very few families can afford to pay for a comprehensive health care and payment in instalments is possible when they do it jointly.
- In a democracy, the governments should set priorities, and as such, individual initiatives maybe needed to balance the gap.

The existing examples of medical/ health care co-operatives- specially from Japanese medical co-operatives- have shown some principles of health care co-operatives:

* They are organized by healthy people who are interested in health care.
* The health care co-operatives place importance on preventive medicine, and maintaining and promoting health.
* Community participate in the democratic management of the medical and health services.
* The health care institutions respond to the health needs of the community.
* The health care co-operatives provide a package of health care and awareness.

Safeguarding the patients right is an important contribution by Japanese medical co-operatives. The Medical/Health Co-operative Committee of The Japanese Consumers' Co-operative Union (JCCU) adopted a " Patients Rights Declaration" in 1991 which set the rights of the patients as following:

* Right to know
* Right to self determination
* Right to protect one's privacy
* Right to study one's situation
* Responsibility for participation and cooperation

With these values and principles, the medical co-operatives have set high ethical standards for medical, para medical personnel as well as members of the co-operative.

There are four types of co-operatives has emerged providing direct or indirect medical/ health support:

1. Single purpose medical/health co-operatives providing direct medical care
2. Multi purpose co-operatives providing medical/health care
3. Co-operatives supplying pharmacy and medical supplies
4. Other type of co-operatives only providing health insurance facilities.

A joint study by the UN and ICA has identified factors which are favourable and unfavourable as following:

A) **Favourable factors:**

- Acceptance of the concept of citizens responsibilities for achievement and maintenance of health and social well being by his or her own actions and mutual help
- Familiarity with the values and principles of co-operative form of organization
- Availability of experienced individuals interested in promoting health and social care co-operatives
- Availability of capital
- Political support
- Pressures on the medical profession

B) **Unfavourable factors:**

- Over reliance upon public provision of health and social care services
- Opposition by health and social care professionals
- Shortage of health and social care professionals
- Political disapproval; of co-operative form of enterprise
- Lack of legislative legitimacy
- Perception of co-operatives as a component of discredited parastatal and state collectives
- The image of health co-operatives for being appropriate only for the poor or other disadvantaged sectors of society.
- Disinterest on the part of existing co-operative movements.
- Insufficient member incentive
- Difficulty in raising sufficient capital and income.

03. Country Profiles

01. India:

India has few health co-operatives owned by users, providers as well as some co-operatives owned by both providers and users together. A survey conducted by ICA ROAP has revealed that major concentration of these co-operatives is in Kerala State, which has 18 health co-operatives having about a total of 3500 members. It has also been reported (ICA-UN Study) that there are 15 hospital co-operatives in Maharastra and 69 in Goa and Karnataka states.

Sushrusha has been reported as the strongest co-operative among hospital co-operatives. These co-operatives provide different types of treatment such as allopathic, homeopathic and Ayurvedic medicines. Very few hospitals have proper facilities for surgery and diagnosis.

Indian medical co-operatives are mainly engaged in indoor and out door medical services only.

The problems identified by the ICAROAP Study are as following:

- Lack of working capital for meeting the cost of investments. Members share capital (only Rs. 900000 in Kerala) is marginal. It is unclear on the incentives by the government as health is a state subject.

- Non availability of modern equipments for diagnosis and surgery.

- Most of the hospitals are hosed in the rented out premises which cause problems of maintenance.

- Most of the institutions, specially practising Ayurvedic Medicine is planning to produce their own drugs, but no capital available.

- Some of the hospitals have difficulties of employing qualified doctors and para medical staff.

- Members of some co-operatives are apathetic towards the hospital functions.

- Governments in some states do not provide any incentive for co-operatives, not even the donations are exempted from income tax.

In addition, there are other provider owned health co-operatives outside the traditional co-operative sector, such as the one operated by SEWA which is a Women's trade union.

In India, medical care is not a state monopoly. Therefore, private sector is stronger in terms of operations than the state sector or the co-operative sector. Although India has comparatively a better ratio of a doctor to patients (2439 per doctor; high human development countries have 1661 -(1995)) the facilities in the rural areas are very poor due to heavy concentration of medical practitioners in the urban areas. Another incentive for the private sector to concentrate in the cities is the business through health insurance and company-based staff incentives.

With the liberalisation of foreign investments there are possibilities of joint ventures in the medical care business.

02. *Israel:*

Israel co-operatives patronise a voluntary mutual aid association called Kupt Holim Clalit (KHC) founded in 1912 , which is basically meant for health care of the immigrant workers. It is a non governmental non profit organization funded by the levies from the members inform of a tax which is channelled to the KHC . The membership which is about 3.5 million is divided into 8 districts who elect their executive committees to maintain the district-based facilities. The KHC has 8 general hospitals with modern facilities and also 7 specialised hospitals. The total work force is 29000. It is a user organization managed by the members themselves.

The KHC provides primary health care through 1250 clinics and regional health centres in addition to indoor and outdoor services, medical research, training, caring for the aged,

home visits, occupational health services, rehabilitation services.

One of the special features is the subsidiary companies operating under the KHC , dealing with medical data, insurance, nursing homes, employment services, manufacturing of drugs, dental clinics, and bio- medical engineering.

03. Japan:

Japan has largest number of medical/health co-operatives in the Region. Medical co-operatives numbering 116 have about 1.2 million members with a share capital of Yen 162,083 Million. The co-operatives are mainly user based. The Japanese co-operatives accounts for 1% of the total medical care. Unlike other countries, Japanese medical co-operatives follow a representative system of democracy, whereas others follow members direct participation. Han groups are unique members groups who provide directions to medical co-operatives.

There two types of medical co-operatives: the co-operatives supplying only medical care and other types of co-operatives providing medical facilities. Agricultural co-operatives undertake this function as a welfare activity.

Both types are federated at the national level. Single purpose medical co-operatives are federated with the Medical Co-operative Committee of the Japanese Consumers Co-operative Union and the medical co-operatives in the agricultural sector have been affiliated to the National Welfare Federation of Agricultural Co-operatives.

Japanese medical co-operatives maintain indoor and out door services as well as community health education services, and home visits. ICA/UN study reports that there are no provider owned health co-operatives in Japan.

03. Jordan

Medical and health care facilities provided through co-operatives are recent-phenomenon in Jordan. There are only two multi purpose co-operatives providing hospital and medical facilities for Gulf War Returnees established recently. These multi purpose co-operatives have been registered under the Co-operative Act. Founded in 1991 these co-operatives have 1600 members. The target group is 400,000 war returnees who are Jordanians as well as others. The hospitals are operating in the rented out facilities. These co-operatives are user owned.

Normally, medical services are provided by the government as well as private sector companies.

As the co-operatives are functioning for lower income groups, investment funding is difficult.

However, it has been reported that the number of patients under treatment in the co-operative hospitals was 10223.

04. South Korea

Although Korea has a long history of co-operatives, medical care has been looked after by other types of co-operatives. Agricultural co-operatives, Fisheries co-operatives and livestock co-operatives provide two types of facilities: supply of medical drugs and accessories and provision of medical insurance to members. This covers hospitalization too.

Medical care in South Korea has been undertaken mainly by the government and the co-operative sector.

05. Malaysia

Up to 1985, medical and health care was a government monopoly. In 1985, Government announced privatization of health care. The only providers medical co-operative - Koperasi Doctors Malaysia Bhd. was registered in 1988, as primary co-operative. There are 465 members operating through more than 500 clinics covering the entire country. They own their clinics which have private practice for general public.

In addition, Malaysian Insurance co-operative Society, (MCIS) has a long standing record of medical insurance to its members and policy holders.

Attempts are being made to organize a health care net work covering all co-operatives to make them into a strategic business alliance against growing private sector medical business. It is envisaged, that it will be possible to mobilise financial resources for heavy investment on modernization of facilities.

06. Mongolia

Mongolian co-operatives are prominently agriculture and consumer based and operating from the early part of the 20 th Century. During the transitional period in early 1990's, many new co-operatives have been mushrooming. Although Mongolia has about 4000 co-operatives at present, there is only one provider co-operative functioning in the medical field. This is Eneral Dental Clinic in Ulan Baatar, which is a worker owned dental service primary co-operative. The membership consists of dentists.

07. Philippines

There are provider owned as well as user owned medical co-operatives are operating in the Philippines. The first provider owned medical co-operative called Medical Mission Group Hospitals and Health Services Co-operative of the Philippines (MMGHHSCP) was set up in Davao City in 1991, which covers the entire country as the area of operation. By the end of 1995 it has spread to 40 chapters. However, the origin was in 1982 as a Medical Mission Group Hospital. The expansion has been accelerated due to the government decision to devolve the administration of government hospitals to local government authorities. The medical practitioners and workers took more than one hospital and managed efficiently, which prompted the authorities to allow the expansion. There are about 400 who are members of the co-operative.

The co-operative at first drew share capital from the members and in addition supported by a community health insurance scheme promoted by the co-operative which supported the working capital through premiums.

The co-operative publishes a monthly new letter titled " Coophealth ".

The Co-operative Union of the Philippines promoted a concept of Coop Health care Centres in 1992 to service the members of its affiliated primary co-operatives, but it confined to few generic drug stores opened in the provinces. The members would get discounts for their purchases.

Financial co-operatives, such as credit co-operatives, co-operative rural banks and insurance groups provide credit facilities to their members for hospitalization and other medical services. The MMGHHSCP is negotiating to tie up with these co-operatives to have a link up.

Sugar co-operatives in the Philippines too provide medical facilities for their members for hospitalization and consultancy services.

08. Singapore

NTUC has promoted a co-operative called "NTUC Healthcare Co-operative Ltd." in 1992 for its members. The membership of the co-operative remains at 20000 individuals and 66 institutions. The turnover for 1995 has been S$ 15 million. The co-operatives take care of medical check up of its members and provide health education to members. It operates a chain of pharmacies in collaboration with the NTUC Fair Price Co-operative. The Co-operative enjoys a market share of 10%.

The other medical co-operative is also promoted by the NTUC in 1971 for its members. It looks after only dental care and operates with 20 doctors and para medical staff. It operates 19 clinics and the number of patients last year has been 51,000. In addition to normal business, the co-operative provides public free screening and lower fees for senior citizens. The profit earned in 1995 has been S$ 580000.

09. Sri Lanka

Hospital co-operatives in Sri Lanka are only user owned. They have a history going back to 1930's. The peak was in 1975, when there were 13 Co-operative hospitals were functioning. The present number is seven primary co-operative hospital co-operatives. The individual membership in these co-operatives is about 20,000. There are no secondary or tertiary organizations.

In terms of type of co-operatives, there were two types- single purpose medical co-operatives and the hospitals functioning under multi purpose co-operatives.

These co-operatives usually offer indoor services as well as out door patients consultations. Some of the co-operatives conduct clinics in addition. They normally do not provide any health education or medical check ups for members. Therefore, members would get discounts, priorities for room allocation and patronage refunds.

Until now, the government provides free medical services to the community through hospitals, public health services such as home visits by health workers and health education. However, these facilities are inadequate. Recently, the government has allowed private hospitals for expansion.

The hospital co-operatives in 'Sri Lanka suffer from lack of finances for modernisation and expansion of facilities, lack of qualified doctors and medical equipment. Many of these co-operatives own their own premises.

In addition to these co-operatives, some of the multi purpose co-operatives provide pharmacy services to their members.

05. Conclusions

There is a growing concern for better health care facilities as a result of literacy and awareness of people which has increased a life span of all communities. The demand is increasing in the affluent countries due to increase in ageing population whereas new problems have emerged with the growing incidence of epidemics and socially transmitted deceases.

Globalization and open economic systems have forced the governments to withdraw many natural monopolies including health care. Even in the transitional economies, private

sector is entering into health care business which affect the poorer sections of the people who are in majority. Therefore, there is a potential for health co-operatives to engage in viable enterprises owned by the people.

Many transitional economies as well as opening economies in the Region have entered into peoples health care co-operatives. except in Japan. The countries with long history of health co-operatives such as Sri Lanka, and India have never been able to grow due to the governments prominent role in providing health facilities to the people free of charge.

There are four types of health care co-operative efforts being made in the Region: single purpose health co-operatives, other types of co-operatives having health care as one of the activities, co-operatives supplying only health supplies and co-operatives providing health insurance only.

Many countries in the Region have linked health care as apart of insurance and also have entered into business alliances. Considering the heavy investments involved in health care and the members being less affluent people such arrangements are necessary for the survival and growth.

Very few countries have apex organizations for health co-operatives which is a disadvantage for strengthening co-operatives. In the countries such as India and Sri Lanka, such vertical integration is required for health co-operatives to grow.

Successes of the health co-operatives depend on the loyalty of the members as well as the medical staff. The close relations have been a factor which determines the success. Sri Lanka has suffered from this problem whereas Sushrusha having membership and places for medical staff at the decision making level has shown much promise. User co-operatives with mixed membership would be a better compromise.

Provider co-operatives have shown limited success as shown from the cases of Mongolia and Malaysia. In the absence of user participation the expansion is limited and the success will entirely depend on the market competition with other private ventures.

Very few health care co-operatives have gone into the preventive health extension services to the members which make co-operatives unique in Japan. Many have confined to the hospitals and clinics, which affected the growth of such co-operatives.

Very few governments have been subsidising or supporting health care co-operatives. In some cases, the training of para medical staff has been supported by governments. In the light of the commitments the governments made at the Social Summit, they will be under pressure to support co-operatives provided the co-operatives are active.

06. Issues for the Future

- creating awareness between co-operatives and potential members on the potential of health care co-operatives to provide health care facilities to the communities
- Vertical integration of existing health care co-operatives
- Capital formulation and mobilisation of additional capital for modernization of existing health care co-operatives
- Business alliances among existing co-operative for health supplies and equipment as

well as sharing expertise

- Linking health care with co-operative health insurance and tie up with insurance co-operatives
- Training of medical and para medical staff
- Institutional capacity building by extending institutional membership to other co-operatives
- Gaining political and government support for health care co-operatives without compromising on the autonomy and independence of health co-operatives.

W U Herath
Regional Advisor (Consumer Co-operatives)
ICA Regional Office for Asia and the Pacific
New Delhi, India

ASHWINI SAHAKARI RUGNALAYA & RESEARCH CENTRE. SOLAPUR.

1988 - 1996

625300, 625301,620921

ASHWINI SAHAKARI RUGNALAYA & RESEARCH CENTRE

NORTH SADAR BAZAR, SOLAPUR. - 413 003.

Ref. No. : 534/96 **Date :** 01.11.1996

Fellow Delegates,

The attached brochure given in breif relevant information pertaining to **ASHWINI SAHAKARI RUGNALAYA & RESEARCH CENTRE, SOLAPUR.**

Your comments on it, if any, are welcome.

DR. U.R. WARERKAR
VICE CHAIRMAN

Reg. No. : SUR/NSUR/GNL/901/83 Reg. Date : 23/02/1983

ASHWINI SAHAKARI RUGNALAYA & RESEARCH CENTRE

NORTH SADAR BAZAR, SOLAPUR. - 413 003.

Authorised Share Capital	1,00,00,000/-
Member's Share Capital Issued & Subcribed	15,56,375/-
Government Share Capital	08,81,450/-
Number of Share Holders	2,193
Number of Government Share Holders	1
Audit Class	"B"

SHARE CAPITAL PARTICULAR	YEAR 95-96
01. Individual	1,955
02. Doctors	238
03. Government	1
04. Shareholder Share Capital	15,56,375
05. Government Share Capital	8,81,450

Ashwini Sahakari Rugnalaya is a co-operative Hospital registered under co-op. societies act and established in March 1988.

It started as a patients O.P.D. service in 1982 and gradually envolved into a 150 bedded hospital with all modem equipment services at public demand.

It has 2000 shareholders, the value of each share being Rs.100/-

The state govt. has leased 87,000 sq.ft. of land for 99 years at a nominal rent of Rs. 1/-.

The Hospital is housed in 40,000 sq.ft. built up area and has the following facilities :-

1. O.P.D. catering to 250 patients daily
2. An upto date pathology, microbiology, & biochemistry laboratory with two post graduate qualified Doctors and a staff of twenty technicians and other staff.
3. An X-Ray department with 800 M.A. machine with facilities for all invasive procedures.
4. An Intensive Care Unit of 15 beds with monitors,ventilators, pulse oximeter and trained and qualif ied staff and under supervision of top medical personnel in the field.
5. A Neonatal Intensive Care Unit with 6 beds with warmers, incubators, phototherapy units, and facilities for rooming in with mothers. The unit is managed by a post graduate qualified Peadiatrician and trained Nursing personnel.

6. Besides these special services , the Hospital has indoor facility for 120 beds catering to Medical, Pediatric, Gynaec-Obst.,Surgical, Orthopaedic patients.

7. The No. of O.P.D. patients last years :- 40,131

   and No. of Indoor patients last years :- 8,326

8. The Hospital has the services of super-Specialities in Cardiovascular Surgery, Neuro-Surgery, Pediatric, and Neonatal Surgery, and Uro- Surgery.

9. The Hospital has taken help of Lokmanya Industries Bombay. and provided the services of C.T. all body Scan, a Colour Doppler, Computerised Stress-Test and E.E.G. machine. All these facilities have been well utilised by the public and have come as a boon to them, The hospital had rendered yeomen services to the earthquake victims in 1993.

10. The hospital provides facilities for the ward patients on No Profit No Loss basis. The private room patients are charged at moderate rates keeping in view the financial needs of the hospital as also the needs of the paying patients.

11. The hospital has raised its capital through public support of the hospital, some donations and meagre government matching share capital of Rs. 8,00,000/-

12. The assets of the hospital at the moment including buildings, equipments, and dead -stock are worth Rs. 05,00,00,000/- (Five Crores only.)

13. The hospital has at present debts (mainly to banks) of Rs. 60,00,000/- the debts were more than a crore two years ago but has been able to have it through regular repayments to the creditors.

14. The hospital seeks to further expand its activities in emergency services, training of Nursing personnel with a Nursing school, a library, Resindential premises for Nurses and Doctors are at the planning stage. The hospital is seeking the recognition for DNB courses in order to upgrade the standards of medical services in the hospital. The hospital has gained enormous respect and popularity by its top standards of service and academic excellence. All the 25 consultants are of high academic excellence and the Vice Chairman is an emeritus professor and a Fellow of the Indian Academy of Pediatrics. He is the recipient of President's award for work on Underfives through Red-Cross.

What the hospital urgently needs is the support of institutions like yours who donate munificently to deserving cause. If there is a deserving cause for your consideration, then this hospital is the one that needs it most.

Do help it grow, to serve the common man better in the field of health.

BOARD OF DIRECTORS NAME LIST

	NAME & ADDRESS		PHONE NO. Res.	Office
1>	Shri. Gangadharpant Sidramappa Kuchan 386,Jodbhavi Peth, Kanna Chowk,Solapur.	(President)	23884	--
2>	Shri. Dattatraya Sakharam Surwase 145,Siddheshwar Peth, Solapur.	(Chairman)	23135 28543	600681
3>	Dr. Umakant Ramchandra Warerkar Behind Hotel Kinara, Hotagi Road,Solapur.	(Vice Chairman)	600641	23412
4>	Dr. Vasant Marutirao Kale 157,Railway Lines,Solpaur.	(Secretary)	22171	29812
5>	Shri. Ranglal Motilal Toshniwal 50/A Jodbhavi Peth,Solapur	(Member)	20512	27917
6>	Shri. Bipinbhai Mahiji Patel 15,Sarvodaya Society, Hotagi Road,Solapur.	(Member)	601381	26295
7>	Shri. Sudhakar Keshavrao Patni 150,Railway Lines,Solapur.	(Member)	20711	23067
8>	Dr. Vishwas Nilkantha Jeurkar Solapur Housing Society, South Sadar Bazar,Solapur.	(Member)	612689	611268
9>	Dr. Kishore Chhaganlal Yadav Near Prateek Appartments, Gandhinagar,Solapur.	(Member)	612526 612352	
10>	Dr. Prakash Krishnat Joshi 157/B, Railway Lines, Solapur.	(Member)	22758	29812
11>	Dr. Vijay Rajaram Kanetkar Opp. Hotel Maharaja, Railway Lines,Solapur.	(Member)	26652	27252

Cont. 2

12> Dr.(Mrs.) Sadhana Pramod Deshmukh (Member)
Vikas Nagar,Hotgi Road, 601253 600017
Solapur.

13> Smt. Kalindi Amrut Gandhi (Member)
"Sanmati" Behind DAV College, 24618 625160
Solapur.

14> Smt. Yashodabai Nandalal Daga (Member)
"Yashoda",Prabhakar Society, 23891 --
Samrat Chowk, Solapur.

15> Shri. Ashok Aannarao Lamture (Member)
B/2 Room No.23 Staff Qut., 24221 (Ext. 392)
Civil Hospital,Solapur.

16> Shri. Suresh Panditrao Wadtile (Member)
Ganesh Builders Hotgi Road,Solapur.

	NAME		PHONE NOs. Office	PHONE NOs. Resident
01>	Dr. Aradhye C.V. Mugdha Appartments Railway Lines,Solapur	MD.(Path.)	624282	20383
02>	Dr. Banawalikar S.V. A/3, Kadaki Nagar, Near Hotel Kinara, Hotagi Road, Solapur.	MS.(Gen.)	---	602311
03>	Dr. Chidgupkar S.M. Samrat Chowk Solapur.	MS.(Orth.)	26841	28994
04>	Dr. Chavan V.M. Indira Nagar,Solapur.	MD.(Ana.)	--	611496 (P.P.)611306
05>	Dr.Mrs.Deshpande V.S. Ameya Building, Railway Lines, Solapur.	MD.,DCH.	29740	27730
06>	Dr.Mrs.Deshmukh S.P. Vikas Nagar,Hotgi Road, Solapur.	MD.(Gyn.)	600017	601253
07>	Dr. Dekhane A.D. Behind Hotel kinara, Hotgi Road,Solapur.	MD.(Path.)	24144	600703
08>	Dr.Mrs.Hirekerur J.V. 8389/2B-5,Railway Lines, Near Shantisagar Mangal Karyalaya, Solapur.	MS.(ENT)	---	20237 25564
09>	Dr. Hirekerur V.L. 8389/2B-5,Railway Lines, Near Shantisagar Mangal Karyalaya, Solapur.	MD.,DCH	---	20237 25564
10>	Dr. Irani G.B. Ice Factory,98,Railway Lines, Solapur.	MD.(Ana.)	--	29823
11>	Dr. Jeurkar V.N. Solapur Housing Society, South Sadar Bazar,Solapur.	MD.	611268	612689

Cont. 2

12> Dr. Joshi S.A. MBBS,DA -- 600284
43, Gurusiddha Hsg. Socy,
Solapur.

13> Dr. Joshi M.M. MS.(Orth.) 28797 23122
Vidya Nagar,
North Sadar Bazar,Solapur.

14> Dr. Joshi N.K. MBBS,DVD 28797 22758
157/2B Railway Lines,Solapur.

15> Dr. Kale V.M. MBBS,DVD 29812 22171
Railway Lines,Solapur.

16> Dr. Katikar D.B. MS,MCh(Neuro) 25156 26650
Vidya Nagar,North Sadar Bazar, **{Pager Code No. : 008**
Solapur. **{Pager Phone No.: 622571, 622572**

17> Dr. Kelkar A.K. MS,DORL 26627 23019
Samarth Nagar,North Sadar Bazar,
Solapur.

18> Dr. Kulkarni A.A. MD,DCH 21005 612867
Vyankatesh Nagar,
South Sadar Bazar,Solapur.

19> Dr. Kulkarni D.N. MS 612424 612424
158, Railway Lines,Solapur.

20> Dr. Kulkarni P.T. MD,DCH 27080 23370
78,Railway Lines,Solapur

21> Dr. Kothadia N.J. MS. 23050 27277
`Snehal´, Samarth Nagar,
North Sadar Bazar,
Solapur.

22> Dr. Patil V.K. MS(Gen.) 27252 27177
Vijay Clinic, MS(Ped.)
Railway Lines,Solapur.

23> Dr. Ray M.P. MD - 20399
Shama Appartment,Railway-
Lines,Solpaur.

24> Dr. Raghoji V.D. MS,MCh.(Uro.) 29748 612371
Vijay Clinic,Railway Lines,
Solapur.

25> Dr. Raichur H.B. MS,DOMS 25815 611558

Cont. 3

26>	Dr. Rudrakshi S.M. 165/4A,Railway Lines, Solapur.	MD.	21277	23036
27>	Dr.Mrs.Rudrakshi S.S. 165/4A, Railway Lines, Solapur.	MD. (Path.)		23036
27>	Dr. Shah N.A. Shukrawar Peth,Bhande Galli, Solapur.	MBBS,DOMS	29396	26844
28>	Dr. Shah R.C. Sanjeevan Nsg. Home, Datta Chowk,Solapur.	MD(Gyn.)	28797	23122
29>	Dr. Shah Rajula M. 8,Rahul Automobiles, 51,Railway Lines,Solpaur.	DA	--	29484
30>	Dr. Shaikh I.M. C/o Ashwini Hospital, Solapur.	MBBS,DMRD	--	600457
31>	Dr. Vaidya S.S. Chati Galli,Solapur.	MD,DCH	23533	624554
32>	Dr. Warerkar U.R. Behind Hotel Kinara, Hotgi Road,Solapur.	MD,DCH	23412	600641
33>	Dr. Yadav K.C. Near Prateek Appartments, Gandhinagar,Solapur - 03	MS,MCh. (Cardiac Surgeon)	27917	612526 612352
34>	Dr. Zambre M.G. Sushrut Nsg. Home, Panjarapol Chowk,Solapur.	MD	23464 27613	612689 612036

OTHER VISITING DOCTOR

01>	Dr. Joshi P.K.	MD	29812		22758
02>	Dr. K.Y. Sathe	MD.(Gyan.)			
03>	Dr. Valsangkar S.P.	MD	611386		612758
04>	Dr. Bakle A.H.	MD,PGSC	28633		--
05>	Dr. Akkalwade V.S.	MS	27312		29300
06>	Dr. Parale G.P.	MD,DM	--	(Wadia)	611201
07>	Dr. Ausekar B.V.	(Cancer)	600088		600550
08>	Dr. Kanetkar V.R.	MS	27252		26652
09>	Dr. Karkamkar S.R.	MD	22559		26151
10>	Dr. Basade M.M.	MD (Barshi)			

ASHWINI SAHAKARI RUGNALAYA & RESEARCH CENTR
PHONE Nos. :- 625300, 625301, 620921

LIST OF EQUIPMENTS

Physiotherapy Department

Sr. No.	Equipment
01>	Int. Pelvic Traction
02>	Int. Cervical Traction
03>	S.W.D. per area
04>	Ultrasone per area
05>	Muscle Stimulator
06>	C.P.M.
07>	Knee Exercise
08>	Exercise for Hemiplegic
09>	Manual Exercise
10>	Examination on 1st Day
11>	Manual Muscle Testing
12>	T.N.S.
13>	Wax Bath
14>	Infra & Ultra Violet Rays
15>	I.F.T. (Interferential Therapy)

PATHOLOGY DEPARTMENT

Sr. No.	Equipment
01>	Semi-Auto Analyzer
02>	Ion. Selective Electrolyte Analyzer
03>	Eliza Reader
04>	Histopathology Section
05>	Full fledged Microbiology Section

I.C.C.U. DEPARTMENT

Sr. No.	Equipment
01>	Cardiac Monitors
02>	Ventilators (Servo)
03>	Infusion Pumps
04>	Ultrasonic Nebulizer
05>	Pulse - Oxymeters
06>	Capnographs

S.I.C.U. DEPARTMENT

Sr. No.	Equipment
01>	Steel Suction Machine
02>	Nebulizer
03>	Pulse Oximeter

X-RAY DEPARTMENT

Sr. No.	Equipment
01>	1000 M.A. X-ray Machine
02>	60 M.A. Portable X-ray Machine

OPERATION THEATRE

Sr. No.	Equipment
01>	Boyle's Apparatus
02>	Hydraulic Tables
03>	Heart-Lung Machine
04>	Ventilators (Servo)
05>	Pulse-Oxymeters
06>	Haemodynamic Monitors
07>	Capnograph

C.T. SCAN

Sr. No.	Equipment
01>	C.T. Scan
02>	Computerized Stress Test
03>	E. E. G.
04>	Color Doppler

N.I.C.U.

Sr. No.	Equipment
01>	Warmer
02>	Incubator
03>	Phototherapy
04>	Monitor
05>	Elec. Suction Machine
06>	Weight Machine
07>	Lenth Machine
08>	Urinometer
09>	Room Thermometer
10>	Hygrometer
11>	02 Hood
12>	Baby Carrier
13>	Betadine Scrub Stand

Casualty I.C.U.

Sr. No.	Equipment
01>	Monitor
02>	Suction Machine
03>	E.C.G. Machine

HEALTH - MEDICAL CO-OPERATIVES IN SRI LANKA

- CURRENT SITUATION -

Report presented at the 2nd meeting of
Health Medical Co-operatives in Asia Pacific., 1 - 3 Nov. 1996

By :-

1. *Mr. Lionel Samarasinghe*
President / National Co-operative Council of Sri Lanka.
Director / Co-operative Hospital, Gampaha.

2. *Mr K.R. de Silva*
President / Kurunegala Co-operatives Hospital Ltd..

NATIONAL CO-OPERATIVE COUNCIL OF SRI LANKA
No. 455, Galle Road, Colombo 3.
SRI LANKA.

HEALTH - MEDICAL CO-OPERATIVES IN SRI LANKA.

- Current Situation -

The Co-operative Movement in Sri Lanka.

The Co-operative Movement in Sri Lanka was started on the initiative of the state to relieve the rural farmer of indebtedness and to provide credit facilities to farmers on easy terms to protect them from exploitation by private traders. During the second World War the problem of shortage of food and equitable distribution at reasonable prices of what was available was solved through the Co-operatives. In recent times Co-operatives have proved to be a useful source to implement activities involving the masses and as a media of contact with the common man, and is the main contributor to the development process at rural level.

Today, in Sri Lanka, there are 15 major types of Societies with 10 Apex Unions serving a membership of 340,000 from all walks of life.

HEALTH - MEDICAL CO-OPERATIVES IN THE COUNTRY.

In Sri Lanka Co-operative Hospitals and dispensaries have been formed with the following objectives :

1. To provide easy access to medical facilities at low cost to mostly middle class and low income sectors of the population.

2. To relieve the members from indebtedness with regard to medical treatment.

3. To provide Special facilities to Maternity patients and children.

We will now briefly outline the present situation of the Health - Medical cooperatives in the country.

1. **The MOOLAI CO-OPERATIVE HOSPITAL** which is, the first Cooperative Hospital formed in the Northern Province, in Moolai, Jaffna was registered in 1936 and became a unique type of society.

It was started as a Cooperative Dispensary established by Pensioners. A Doctor and 2 Apothecaries provided medical services free of charge to all pensioners. By 1970 the membership was three thousand with a work force of five doctors, ten apothecaries and 42 Nurses.

By 1962 it was a fully equipped Hospital with a surgical unit. It provides medicine to members at a 20% concession and free medical facilities were provided with assistance from the Government. In 1961 they received a gift of medical equipment from Japan to develop the hospital. Today even with the turbulent conditions in the area, it is functioning actively and is one of the main Medical Institutions in the Northern Province, taking a leading role in providing health & medical facilities to a war torn area.

2. **KURUNEGALA CO-OPERATIVE HOSPITAL LTD.**

During a period when K'gala district was suffering from 'Malaria" this hospital was established under the guidance of a keen co-operator Mr. U.B. Wanninayake who was also the Minister of Finance at that time.

It was and registered in 1951. It is located on a land about one hectare in extent within close proximity to town, along Kurunegala-Colombo highway. The building covers almost 6/10 of the land. The buildings comprise of an Administrative section, Dispensary, Wards, Separate Rooms, X-ray Unit, Laboratory, Operating theater, Labour room, Channeling Rooms, etc. Patient accommodation consist of 10 wards and 18 separate rooms. The total number of beds is 72.

Membership :-

Present membership is about 1550. The area of operation is entire Kurunegala District which is about 4815 square Kilometers.

Board of Management :-

Board consist of 8 elected Directors from among the members. 1 Director is elected by the delegates of the affiliated Multi-Purpose Co-operative Society.

Services rendered :-

1. Medical Care

   a. By Consultants
   b. By Non Consultants - qualified Medical Officers

2. Surgical Care - By Consultants
3. Maternity Care - By Consultants
4. Psychiatric Unit - By Consultants
5. E.N.T. Care - By Consultants
6. Dental facio-maxillary Surgery - By Consultants
7. Pediatric Care - By Consultants
8. Eye Care - By Consultants
9. Skin Care - By Consultants
10. Orthopaedic Care - By Consultants
11. Neurological Care - By Consultants
12. Ancillary Services -

    a. X-ray
    b. Laboratory
    c. Physiotherapy

Staff :-

Visiting Consultant's

Physicians	3
Surgeons	3
V.O.G.s	4

E.N.T. Surgeons	1
Dental F M S	1
Paediatric	1
Anaesthetists	2
Orthopaedic Surgeon	1
Fulltime medical officers	
Medical Officer M O I C	1
Medical Officers	2
Relief Medical Officers	2
Nursing Staff	
Matron	1
Sisters	5
Nurses	26
Mid wives	4
Male attendants	13
Female attendants	10
Other Staff	
Over seer	1
Sanitary Labcurers	5
Garden Labourer	1
Dispensary Staff	
Dispensers	7
Pharmacist	1
Laboratory	
Lab Technologist	1
Lab Orderly	1
Office Staff	
General Manager	1
Secretary	1
Accountant	1
Clerks	4
Typist	1

Cashiers	2
Peon	1
Security Officer	1

Other Services

Canteen
Training in Practical Nursing
(at the moment we have 15 trainee nurses)

Pharmacy (Osu Sala)

Staff

Pharmacist/Manager	1
Dispensers	2
Sales Girls	1
Cashier	1
Labourer	1
Security Officer	1

With the increase of the rapid patient bed strength action is being taken to increase the staff cadre.

As the space now available is hardly sufficient for the in-coming patients action is being taken to put up a new 2 storied building to expand the activities carried out by the hospital. This scheme is to be completed with from aid JAICA (Japan) and sponsored by the Dept. of Co-operative development and the Ministry of Co-operatives. For this purpose all documents & reports are now prepared and forwarded by the unity for approval.

The Board has inaugurated a fund called 'Members Welfare Fund' in order to help the members who are financially handicapped and are unable to pay up their bills and also to uplift the health condition of the members. All members and their dependents availing the services of the hospital are entitled to 20% discount.

A Clinic is also in operation once a month for members and their dependents to have their health conditions tested by

well qualified consultants and Doctors and records are also maintained in respect of each member and dependent. All these services are given free and drugs are also issued to the needy, free of charge for a considerable period of time. These expenses are borne by the "Members Welfare Fund", This clinic has become very popular among all the members.

The Board of Management has always in mind that we must maintain the spirit of Co-operative values and humanity as this is a people's movement with people's energy. Our task is to give our members quality medical care at a reasonable price and with this in mind the Board of Management seek your Co-operation and guidance to fulfill our ambition. This will tighten our mutual understandings.

3. THE GALLE DISTRICT HOSPITAL CO-OPERATIVE SOCIETY LTD.

This society was registered in 1962 and has a membership of 2083. Now it has 101 permanent employees including 52 Nurses and 25 Consultants, 3 House officers and 1 Radiologist working part time in the Hospital. It also has 38 Visiting Specialist in the following areas.

Physicians	6
General Surgeons	6
V.O.G.	7
Dermatologists	1
Oncologist	1
Pediatricians	2
Anaesthetists	4
Chest Physician	1
Rheumatlogist	1
Psychiatrist	3
Orthopaedic Surgeon	1
Eye Surgeon	1
Dental Surgeon	1
Neurologist	1

E.N.T. Surgeon	1
Radiologist	1

Facilities presently available are :

Out-patients treatment
In-patients treatment
Operation Theatre
X-ray facilities
Laboratory
Dental Surgery
Eye Surgery
Physiotherapy
Channel Consultation
Labour Room
Ambulance Service

The Hospital has 8 wards and 18 rooms with a bed strength of 66.

4. GAMAPHA CO-OPERATIVE HOSPITAL SOCIETY LTD.

This Society was formed with the idea of building a hospital for the co-operative members in the Gampaha District. The hospital was established in Feb. 1962 in a private home in the Gampaha Town. At the beginning there were only six beds and an out patients' Dispensary with two trained Doctors, three Nurses and two Pharmacists.

In 1970 with assistance from the People's Bank a land was bought and a new hospital was constructed. There are 14 fully equipped rooms and 24 hour medical facilities provided. In 1980 a well equipped Operating Theater was built. Doctors from the Government hospital in Gampaha conducts special consultation clinics and a Physician, Surgeon, Gynecologist, Obstetrician, and Child Specialist work here.

For an year, an average of 15000 out patients and 120 resident patients receive treatment. About 500 operations are performed and 200 Maternity cases are attended to.

This hospital provides a very useful service to the people of Gampaha. But, as a Cooperative concern it cannot run at high profits. Plans have been completed to enlarge the hospital to a three storey building, but, lack of finances is hindering its progress.

5. COLOMBO PEOPLE'S CO-OPERATIVE HOSPITAL SOCIETY LTD. KOTAHENA.

This Hospital Society was formed and registered in March 1962.

The Hospital has a bed capacity of 50 and also has a modern Operating Theater. The Out patients' Dispensary is opened 24 hours. In 1993 there were 1285 indoor patient and 30415 outdoor patients, and present there are 122 permenent employees including 5 Doctors, 1 Matron, 6 Nursing sisters, 35 Nurses, 2 Pharmacists,
4 Dispensers and 2 Lab Assistants. The Nurses are given a 1½ years' training and awarded certificates at the conclusion of the training. The following facilities are made available by the Hospital Society :

1. X-ray & E.C.G. facilities
2. Laboratory
3. Maternity Department
4. Dental Surgery
5. Channeled Consultation services
6. Eye Clinic
7. Skin Clinic
8. E.N.T. Clinic
9. Intensive Care Unit

The Employees in the hospital are provided with Uniforms, free of charge.

The Out patients Dispensary was modernized recently. The first floor of the two story building is complete with an auditorium. The second floor is nearing completion.

The Intensive Care Unit has not yet been declared open due to lack of essential equipment. A lift is essential to transport patients and also an Ambulance.

In 1987 the society was selected the best at the National Co-operative Trade Fair & Exhibition, and in 1989 2nd place was awarded to the society as one of the best non'categorized societies.

The present facilities have to be streamlined and more modern equipment installed. The society will be definitely improve if these requirement are fulfilled.

6. MATARA CO-OPERATIVE HOSPITAL SOCIETY LTD.

This Society was formed for the benefit of the members in the Matara District. By March 1994 the membership was 1546. There are 9 members on the Board Of Director, 3 from the General Body, 3 appointed by Commissioner, of Co-operative Development and 1 society representative. The Staff consists of 13 employees including 2 Doctors and 20 Nurses.

The hospital has 60 beds, 23 rooms, 1 Surgery, 1 Maternity Ward and 1 Laboratory. A Maternity Unit and an Operation Theatre was constructed with assistance from the Architectural Unit of the National Co-operative Council.

7. CO-OPERATIVE HOSPITAL OF THE NUWARA-ELIYA MULTI-PURPOSE CO-OPERATIVE SOCIETY LTD.

This Hospital was started in 1992. It is a two storied building with an Operating Theater, E.C.G. facilities and a Laboratory. There are 3 residential Doctors in-charge; two of them are in attendance all the time. There is a Surgeon, V.O.G., Visiting Physician, and The District

Medical Officer, visiting for special consultations. There is a Dispensary, Dental Surgery and a bed strength of 28. There are six qualified Nurses and a Manager for overall supervision and administration. Daily attendance of patients to the out patients unit is about 100, with around 40 patients for specialist consultations., There are about 5 residential patients at a given time. The Society has yet to purchase an X-ray machine which is urgently required for the hospital.

8. HEALTH SERVICES UNIT OF THE ANURADHAPURA MULTI-PURPOSE CO-OPERATIVE SOCIETY LTD.

This service was started in 1991 and plans are now underway to construct a permenent building.

The hospital engages Doctors from the Government hospitals in Anuradhapura and provides following facilities.

1. Outdoor Patients Unit
2. Channeled consultancy service
3. X-ray and E.C.G.
4. Laboratory facilities
5. Dental Surgery
6. Nurses Training Unit

9. HEALTH - MEDICAL SERVICES OF THE RATNAPURA MULTI-PURPOSE CO-OPERATIVE SOCIETY LTD.

The daily attendence of patients is around 60-75. As this hospital is situated in a difficult area in the North Central Province, it requires much assistance and needs to be developed to Cope with requirments of the patients. The lack of an in-patient unit is a great disadvantage.
This service is in the from of a Consultation Clinic, which was started in 1977. The clinic is open from 6.00 a.m. daily. There are Doctors from the Ratnapura Government Hospital working here and 15 permanent employees. It has an X-ray Unit, Laboratory, Dental

Surgery and a Pharmercy. The number of patients is more then 500 per day, and the number is increasing daily. Therefore, the Architectural Unit of the National Co-operative Council has been consulted to enlarge the present building to cope with the increasing number of patients.

10. **Attanagalla Co-operative Hospital Ltd.:** This is a newly constructed Co-operative Hospital in the Attanagalla electorate run by the Multi purpose Co-operative Society Ltd.

Conclusion

The Co-op Hospitals in Sri Lanka are gaining strength. A new hospital is being planned for the Central Province by the Kandy MPCS Ltd.

However all these hospital could be developed to functioned better if they have more modern equipments.

Training of Nurses an ancilliary
Staff is also of high priority.

NCC/Comp.Div/J.N & C.V/29 Nov. 1996