Why Japan’s Hospital Volunteer Program Has Failed: Civil Society or Mobilization?

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The purpose of this paper is to analyze why Japanese hospital volunteer groups are not utilized as much as they could be and why such services are not being expanded as in Canada and America. The conclusion is that it is due to the government’s lack of recognition of behavioral inefficiencies, contributing to the insufficient mobilization of volunteers into hospitals. While the government was eager to place volunteers, the hospitals were not able to make full use of them. This gap of information between the government and the hospitals is likely to have been responsible for the failure to successfully mobilize hospital volunteers in Japan.

Keyword: hospital volunteer, civil society, stakeholders

1. Introduction
The number of hospital volunteers in Japan suddenly increased in the 1990s when the government began to mobilize citizens into hospitals as volunteers. The government recognized this as saving on personnel costs in administering medical services. The history of government mobilizing volunteers into hospitals (for the purpose of reducing direct personnel costs or curtailing labor shortages) in Japan was similar to that in Canada and America.
In the 1970s, America sent volunteers into hospitals during the war in Vietnam to fill labor shortages. In the late 1980s, Canada mobilized volunteers into hospitals to cut costs of increased demand for medical services from its aging population. Among similar histories, only the Japanese hospital volunteer program has not been fully utilized or been enlarged as those in North America. Why is this the case?

2. Hospital Volunteers’ Role
If governments could supply each of its hospitals with sufficient funds for medical services, volunteer movements would have little cause to exist in any society. Hospital volunteerism generally arises only when there is a shortage of paid personnel services. Figure 1 shows a model of the relation between medical needs and the volunteer mobilization policy in hospitals.

![Fig.1 Medical Needs and Volunteer Mobilization Policy into Hospitals](image)

While some societies argue whether or not volunteers should assume roles in hospitals, others have already decided affirmatively and have organized volunteer services and successfully provided this service to hospitals. Within Japanese hospital volunteer organizations, however, there may be problems regarding the number of available volunteers and/or the ability of these volunteers to act or assume roles fully because of structural reasons within the hospital itself. It is useful to clarify the reasons why hospitals have difficulty in realizing their volunteer contributions in full measure positively, and whether or not there may be a need for policymakers to override these problems. The purpose of this paper is to examine one such example.

3. Difference in Magnitude of Stakeholders
One of the big differences between the North American and Japanese hospital volunteer systems is the magnitude of stakeholders surrounding such volunteerism. By comparison, Japanese hospital volunteers may have connections to the nursing staff, the hospital administration and/or the government. In the case of Canadian hospital volunteers for instance, working in childbirth, a significantly larger number of stakeholders is evident. According to Lagendyk (2005), these include the following groups:
(a) Original Canadian Stakeholder Groups
• Volunteer co-ordinators from the community and hospital sites
• Public health nurses who currently refer clients to community programs
• Nursing staff from three hospital sites
• Regional health authority maternal/child health managers
• Volunteers from both community and hospital programs
• Clients who already participated in hospital programs
(b) Additional Canadian Stakeholder Groups
• Physicians who had experience with doulas
• Midwives who practised in hospitals

While Canadian hospital volunteers enjoy multiple programs that numerous stakeholders support, such a level of support is not yet employed in Japan. Also, most Japanese hospital volunteers choose to deliver their program services based on each hospital individually and do not generally share information across hospitals. A few hospital volunteer groups will, however, sometimes share information through working together.

4. Case Study Methodology
As a typical mobilizer of hospital volunteers, hospital A described below, will be examined. The observations pertain to a municipal hospital in Nagano Prefecture. The hospital, located in the city of Saku, has 323 beds. The research was done in two separate stages: February 23 to March 9, 2006 and February 8 to February 21, 2007.

I interviewed the hospital volunteers working at hospital A, and the volunteer coordinator who was also one of nurse managers, as well as the staff nurses. Moreover, I received permission from the volunteers, nurses and hospital administration to copy the texts of 14 journals.
spanning 7 years. The journal entries were made at random by staff and volunteers beginning soon after the volunteer program had been established in 2000. I categorized each entry into one of three groups and then compared them to see firstly, how each volunteer group had adapted its activities to the hospital environment, and secondly, how the hospital evaluated each group’s activities. I also noted whether each group’s activities were being expanded or curtailed.

5. Findings
Analysis of the three groups’ journal entries in hospital A indicated that each group had its own unique set of difficulties in maintaining their volunteer activities since hospital A began recruiting volunteers in 2000.

The reason that hospital A initiated a volunteer program was to qualify for certification from the Japan Council for Quality Health Care (2). In 1997, the Council informed hospital A that it did not have any volunteer groups. In response, the hospital decided to bring in a small group of volunteers. The hospital advertised they were recruiting volunteers who would be willing to provide support for hospital nurses and their patients. This advertisement was placed in the rural paper and a small number applied.

Following this, the hospital received acknowledgment of a retrial (Ver.4) (3) for certification in 2003 and 2004. Hospital A became eligible to obtain an official certification (No.GB12-2) (4). Subsequent to having organized the first volunteer group "Group T", the volunteer coordinator, a nurse in a top management position, brought in a second volunteer group of regional elders "Group K". When I met them in 2006, Group T then had 17 official members and about six of the 17 were regularly active; Group K had 19 members with 12 of them regularly active. A third volunteer group consisted of young students from two high schools and one junior college. Most of the time, they visited the hospital largely at random times during summer or winter holidays, each about two weeks, every year. There were between 2 to 6 students from each of the three schools. These volunteers constituted Group S.

The interval of their activities was as follows:
- Group T : Every day or every second day for 2 to 3 hours in the morning or afternoon.
- Group K : Every other Wednesday for a few hours
- Group S : Every day for 2 to 3 hours each morning or afternoon for two weeks during summer and/or winter holidays

Their typical gender and age was as follows:
- Group T : Predominantly female, aged 40 to 60
- Group K : Predominantly male, aged mid 50s to late 70s
- Group S : All female students; some belonged to a volunteer school club
Some of the volunteer activities of each group were accepted (adopted) and some others were not (non conformance), see (b) below.

(a) Activities Adopted by Hospital A: Group Activities
Groups T, K, S: materials (e.g. making patient gowns, cutting newspapers or cloths cleaning)

Groups T, K, S: Preparing or ordering materials for nurses (e.g. folding gauze)
Groups T, S: flower caring for the hospital grounds (e.g. mowing the lawn, caring for the flower beds)
Groups K: Adjusting wheelchairs
Groups T, S: Assisting patients (e.g. guiding clients coming into the hospital, walking with patients who are blind or otherwise need assistance, pushing wheelchairs)

Groups T: Helping other volunteers (e.g. mentoring and observing student volunteers and helping new volunteers)
Groups T, S: Planning special activities and running errands (e.g. birthday parties or seasonal activities such as Christmas events) and running errands and taking messages to and from rooms, patients, wards

Groups T, K: Meetings with hospital staff

(b) Non conformance activities:
   1. Any activities that require the hospital to prepare or to buy materials.
   2. Any activities that require the nurses to support volunteers.
   3. Some activities wherein volunteers communicate directly with patients and offer some service.

(c) Requests of volunteers from hospital staff: Group Requests
Groups T, K, S: Report the date, numbers of volunteers each day and details of the content of their activities to the hospital.
Groups T, K: Constant activities
Groups K: Prepare for activities by volunteers themselves
Groups K, S: Activities are truly profitable for the patients, not only for volunteers

(d) Declining activities
In hospital A, some of the activities of volunteers were considered of marginal value to the patients or to the medical work involved, and some of the activities were permitted or maintained over time.
6. Discussion

The activities of Groups T and K are held in striking contrast to one another. This may result from the different composition of the two groups. Group T members are middle-aged housewives, while Group K consists mostly of much older retired men. Differences between the attributes of the members of such diverse groups give each group its individual character.

Members of Group T are very humble in their dealings with nurses and other hospital staff and always try to ascertain what the hospital expects of them and how they should behave within the hospital setting. They usually communicate very well with nurses and always take care not to disturb them while giving them support. They are sensitive, versatile, flexible, and anticipatory. As a result, they tend to repress their own actions.

Many members of Group K may not be as sensitive to expected behavior in a hospital setting as those in Group T. For example, when members of Group K require materials for performing their volunteer tasks, they often ask the busy nurses for help or support with preparations. Thus, Group K members may seem more stubborn and ignorant of their duties as volunteers or of what the hospital expects of them. They often appear demanding, seemingly to be requesting assistance with their own ideas for volunteer activities. When they demand something, it would seem in their view, that their position overrides the needs of the nurses and/or the hospital. Thus the demands of Group K place increased workload on the nurses as they seem not to only to have to provide regular care for patients, but also to have to attend to the needs of these volunteers. The more the members of Group K work for patients, the more the nurses’ work increases. As a result, many nurses become annoyed with Group K members; some report that the volunteer activities of Group K are "just a burden."

Additionally, since students compose Group S membership, its activities also require the attention and support of the nurses. Since their attendance and activities are irregular, they are difficult to plan for and hard to depend on as any regular service for the patients or the hospital in general.

The following summarizes the difficulties in expanding the volunteer activities of each group:

1) Group T cannot act appropriately because they worry too much about their activities disturbing the work of the professionals in the hospital. They fail to initiate or to perform proactively for fear of being out of step with their volunteer roles.

2) Group K cannot be evaluated properly because their actions are too far removed from the hospital structure and may or may not have direct impact on the patients.

3) Group S is guided by both teachers and nurses and, thus, their activities are dependent on these individuals leading them.
Presently, all three groups of volunteers in hospital A experience trouble because of their varying kinds of dependence on the hospital structure. If each group was able to act independently of the medical staff and have their roles restructured, each group’s problems might decrease.

The members in Group T, for example, could plan and perform their duties more freely on behalf of the patients so as not to bother the nurses. The members of Group K could deal with financial or practical difficulties by performing in accordance with their own ideas without the support of the nurses or the hospital funds. Nurses then would be free from spending time and caring for volunteers. Also, if the activities of Group K were independent, evaluations could be more neutral with only significant activities needing evaluation, and these could remain as constant services. The point is that volunteer groups cannot, at present, act in the hospital independently. Ensuring autonomy for volunteer groups should solve this complex situation.

7. Rural Governments as Policy Makers

In the Canadian case, they have had success in estimating which volunteer activities are truly helpful for people and institutions. Once they judge that a certain activity is, in fact, helpful, rural governments can support it with sufficient funds. Such authority might be placed in their hands to endorse volunteer activities or even give permission for fund-raising to support helpful activities. In the same way, if they judge that certain volunteer activities aren’t helpful, they can withdraw their support. Rural governments can take the role of estimating which volunteer activities are actually needed and worthwhile.

8. Conclusion

Japanese hospital volunteers may not always be fully active for various reasons. The specific reasons across all hospitals are still not clear. On the one hand, it could be due to government inefficiency and insufficient mobilization of volunteers into hospitals. On the other hand, it may not be the fault of the local, prefectural, or national government.
The placement of hospital volunteers usually requires a political lobby of some sort, unless the government clearly states that there should be some kind of volunteerism to help cover medical costs. If such funds have been decreased, then the medical system must demand compensation to act as a replacement to seek ways to lower costs and at the same time maintain the level of service, i.e. volunteers.

The money that government would normally give to fund volunteers could be much less than the funds saved by downsizing hospitals. While the government remains eager to place volunteers into hospitals, hospitals are often unable to realize their full value. Hospitals are still not ready to use them to their fullest extent. The gap between recognizing the true value of volunteers and their actual use and between what governments expect and what hospitals actually experience, evidences a less than successful mobilization of this type of volunteerism in Japan.

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1 Doulas are people who give additional care to a woman in labor.
2 Japan Council for Quality Health Care 日本医療機能評価機構
3 Nowadays, every hospital has to get certain certification from the Japan Council for Quality Health Care in order to receive budget subsidiary aid from the government.
4 Official certification (No.GB12-2) 病院機能評価（No.GB12-2）

Postscript
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