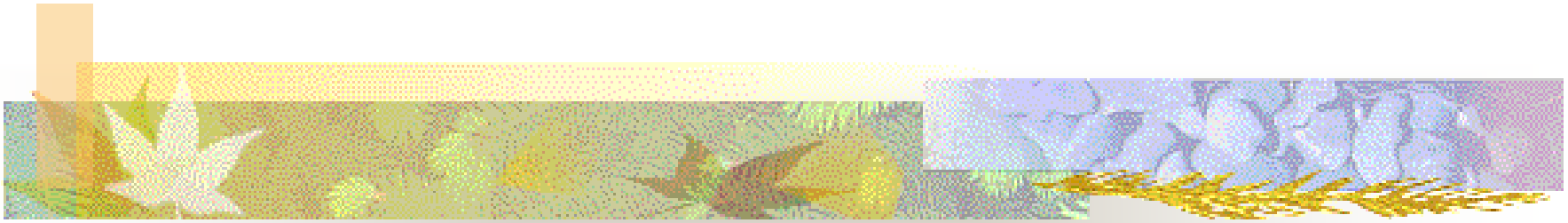
Why and how health co-operatives can contribute to health promotion and integrated community care in the rapidly ageing society?



Pellervo/University of Helsinki Seminar on November 25, 2016

Akira Kurimoto, @Hosei University, Tokyo

Plan of presentation

- Institutional framework of health and elderly care
- Institutional framework of co-operatives
- Context of Social Policy Reform for the Elderly
- Who provide health and elderly care
- Brief history of health-related co-ops
- Mission and business of health co-ops
- Member participation to health promotion
- Coordination for integrated community care
- Minami Medical Co-op’s Case
- Conclusion

Institutional framework of health and elderly care

- Types of health care system

	UK, IT	FI	DE	JP	US
Delivery (%public)	Public	Public	Public	Private	Private
	Nearly all	Nearly all	ca.90%	ca.20%	ca.25%
Finance (source)	Public	Public	Public	Public	Private
	Tax	Mixed	Insurance	Mixed	

- Most of EU member states deliver care thru public institutions while JP and US rely on private delivery.
- The costs are financed either thru tax or social insurance premiums while private insurance has been dominant in the US except for Medicare, Medicaid etc.

Institutional framework of health and elderly care

- Japanese health/elderly care system at a crossroad
- Welfare regimes (Gosta Esping-Andersen)
  - Social democratic: universal coverage
  - Conservative: dependence to families (women)
  - Liberal: deregulation, partly mix billing
- Models of providing public goods (Jurian le Grand)
  - Trusting professionals: doctor's associations
  - Command and control: MHLW (NHS, managed care)
  - Voice: health co-ops (NHS foundation)
  - Choice (quasi-market): public health insurance, LTCI

Institutional framework of health and elderly care

- Main laws pertaining to health and elderly care

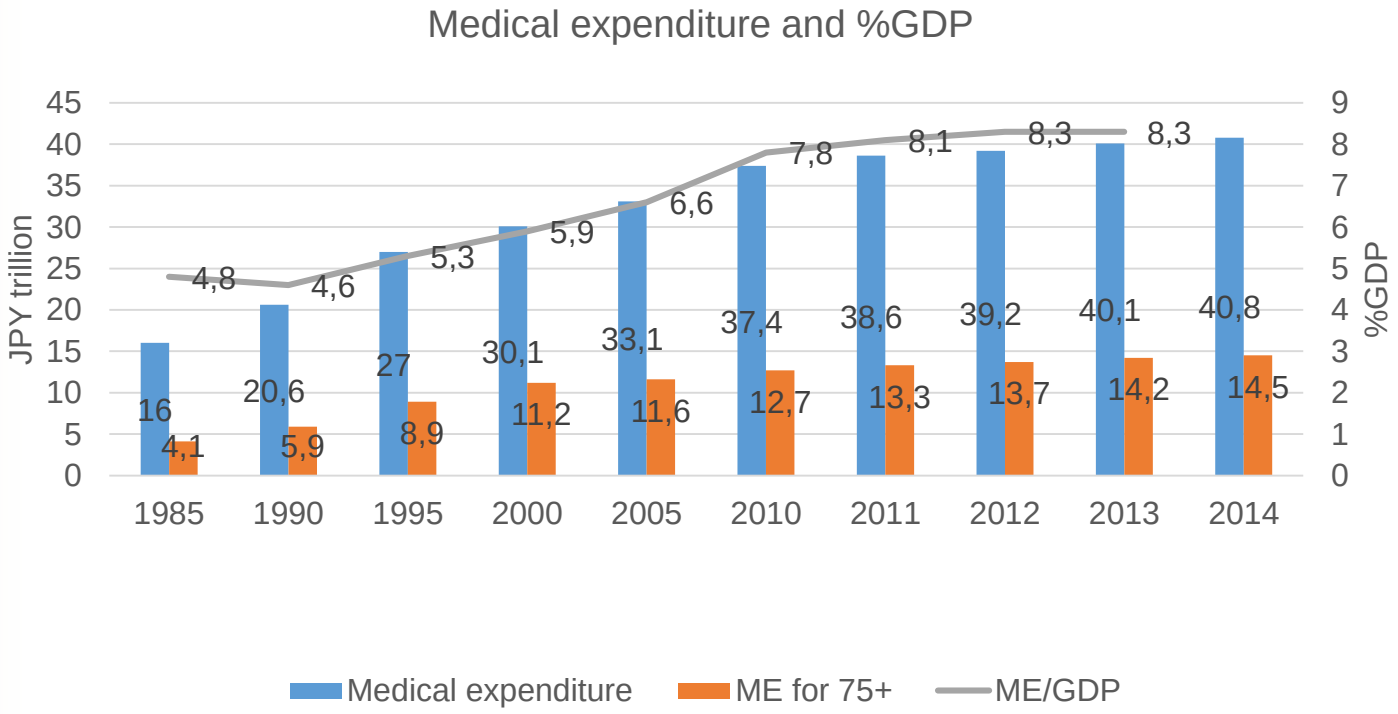
	Health care	Elderly care
Delivery of services	1948 **Medical Service Act** 1948 Medical Practitioners Act 1948 Act on Public Health Nurses, Midwives and Nurses 1960 Pharmaceutical Affairs Act 1982 Elderly Health Care Act 1994 Community Health Care Act	1951 Social Welfare Service Act 1963 Elderly Social Welfare Act 1987 Social & Care Worker Act 2000 **Social Welfare Act**
Finance of services	1922 Health Insurance Act 1958 National Health Insurance Act 2008 Health Insurance Act for Latter-stage Elderly	1997 Long-term Care Insurance Act 2014 Act to Promote Securing Integrated Health and Elderly Care in Communities

Institutional framework of health and elderly care

- Health care
  - Universal health care accomplished in 1961
  - Delivery: free access, weak coordination
  - Finance: insurance + tax + co-payment (30%)
  - 8 health insurance schemes merged to 4+”old old”
  - Success of universal care but how to contain costs
- Elderly care
  - Universal long-term care launched in 2000
  - Delivery: from public institutions to mixed entities
  - Finance: insurance + tax + co-payment (10%)
  - Success of LTCI but how to contain rising costs

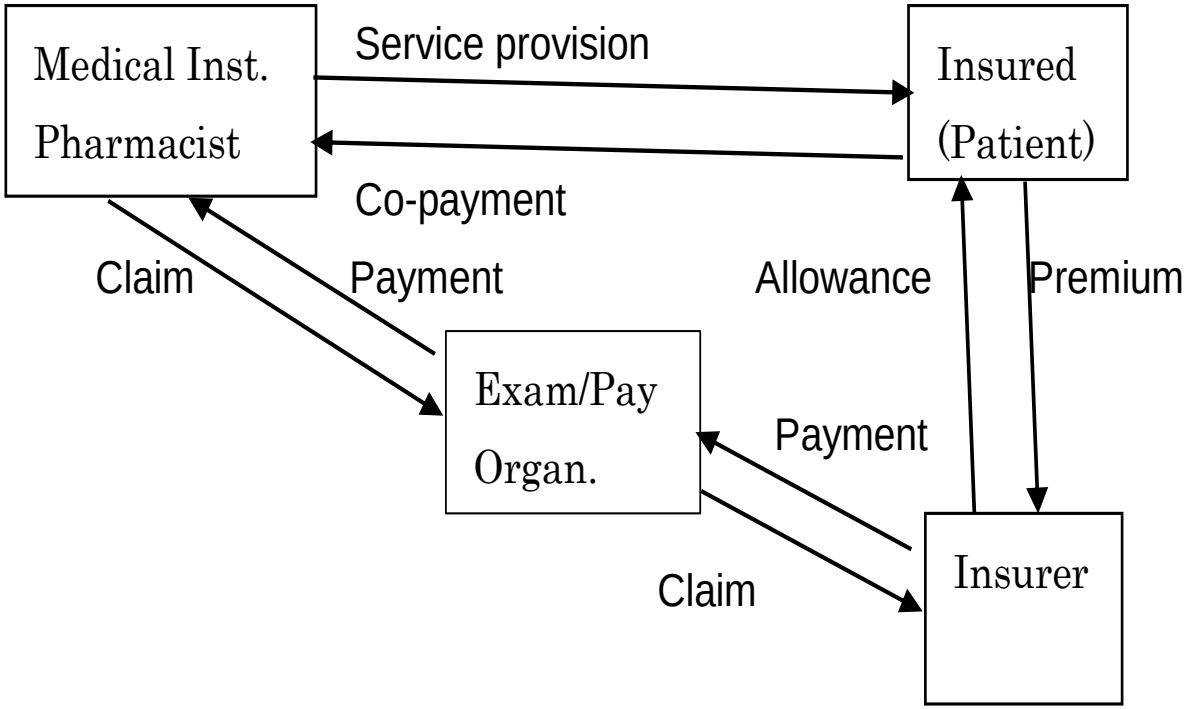
Institutional framework of health and elderly care

- Ever increasing medical expenditure



Institutional framework of health and elderly care

Health insurance scheme



Institutional framework of co-operatives

- Separate legislations and supervisory ministries
- JA *Koseiren* (Prefectural welfare federation of JA co-ops)
  - Agricultural Co-operative Act (ACA, 1947)
  - “Medical care services” in Article 10, ACA
  - Non-member trade allowed to the extent of 100% of member’s
  - Status of public medical institution (asset lock when dissolving)
  - No corporation tax for medical business (CTA annex 2)
- Health co-ops
  - Consumer Co-operative Act (CCA, 1948)
  - “Medical care services” in Article 10, CCA
  - Non-member trade allowed to the extent of 100%
  - Non-distribution constraint (no dividend, no patronage refund)
  - Lower corporation tax as co-operatives (CTA annex 3)

Institutional framework of co-operatives

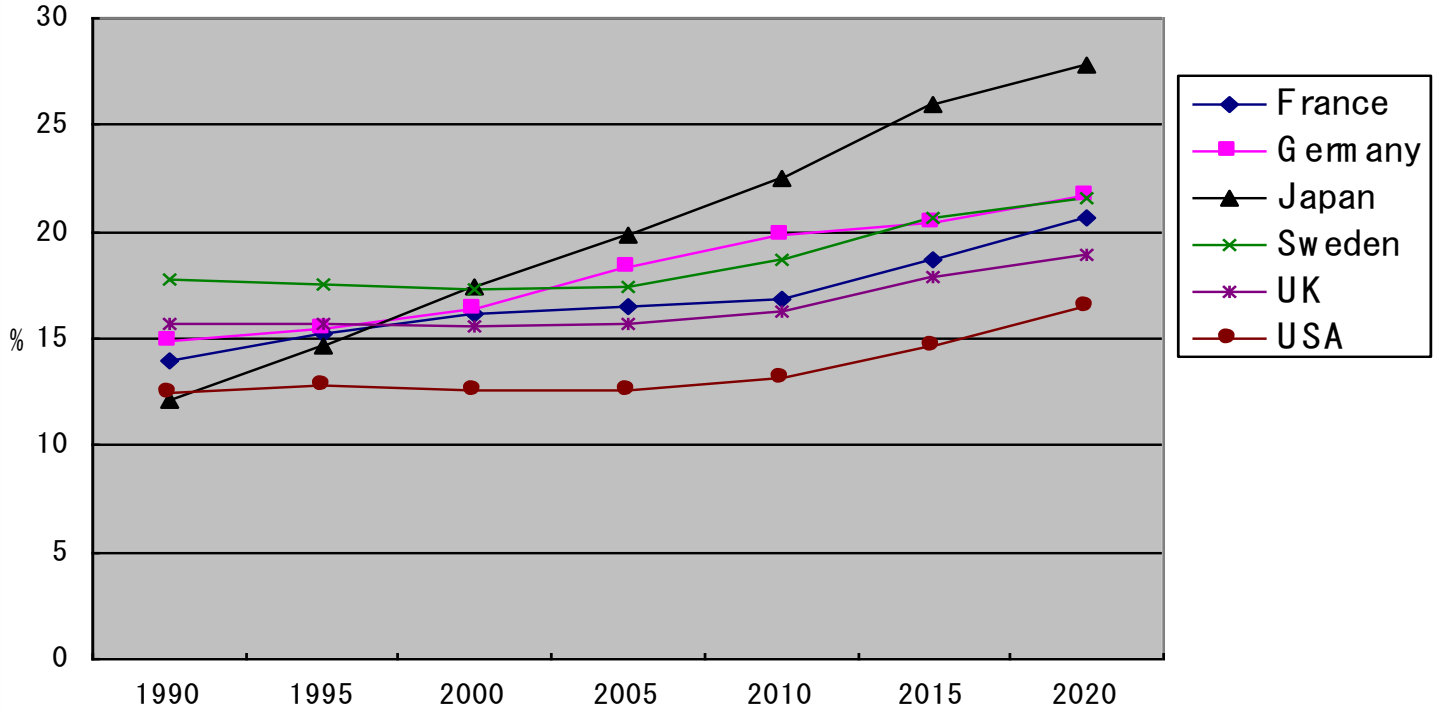
- JA *Koseiren*
  - 47 out of 114 *Koseiren* hospitals operate in areas with less than 50,000 inhabitants while 20 of them are the sole hospitals operating in such municipalities.
  - They provide a variety of support through dispatching and training of doctors, travelling clinics and health promotion activities for farmers.
  - Since they provide most of services for the general public, some *Koseiren* hospitals/clinics have been converted into municipal ones and vice versa.
  - *Koseiren* might be transformed to social medical corporations based on provisions of amended ACA.

Institutional framework of co-operatives

- Health co-ops
  - User-owned entities according to UN classification (1997)
  - Health Co-op Association (HCA) summarizes characteristics of health co-ops;
    - It is a medical institution primarily composed of healthy people (99%).
    - It places emphasis on health promotion and institutions to secure it.
    - It has medical facilities that secure user's participation in health care.
    - It has *Han* groups where members can participate as a principal.

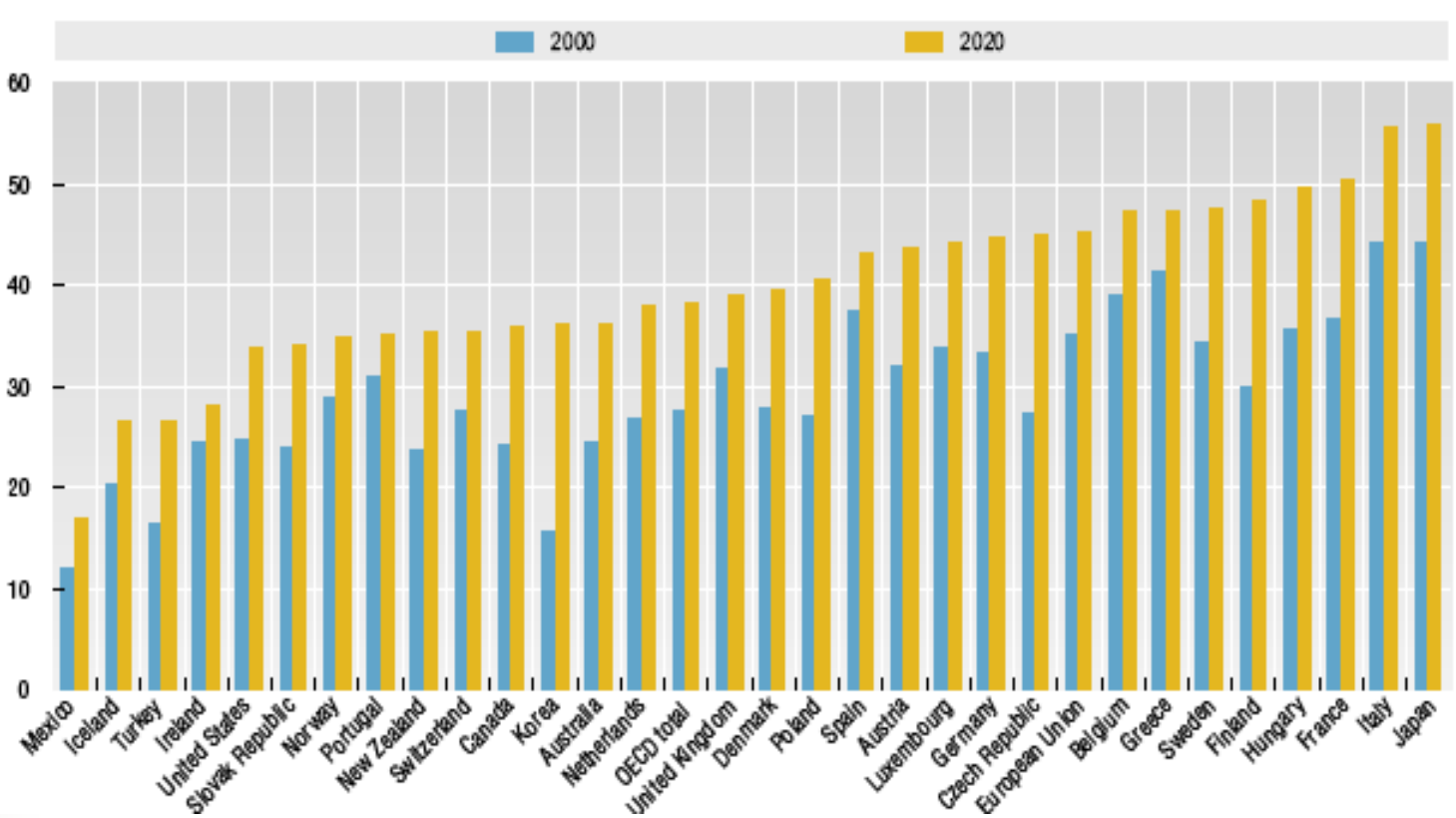
Context of Social Policy Reform for the Elderly

- Ratio of the population aged 65+ to the total population

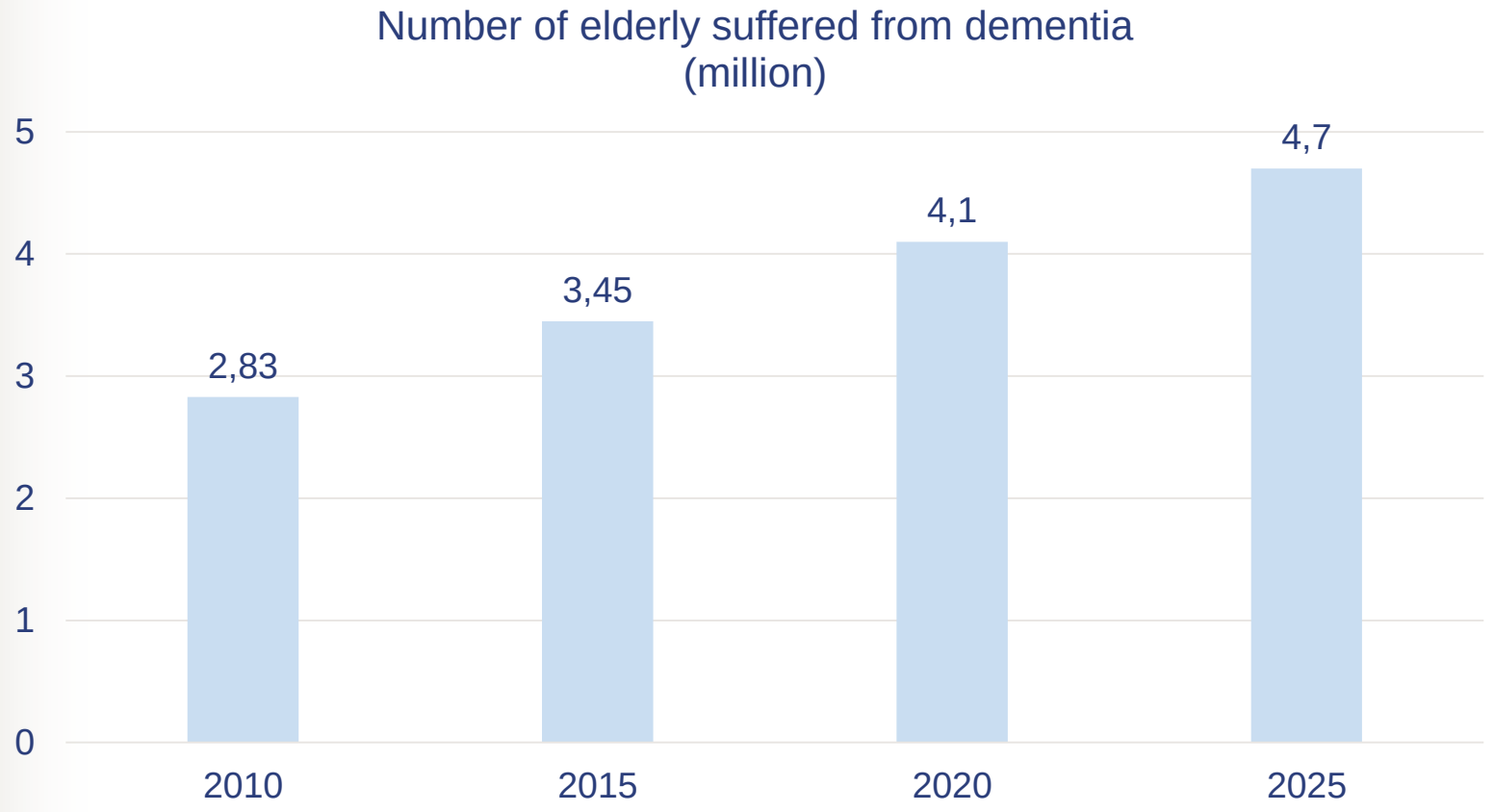


Context of Social Policy Reform for the Elderly

Ratio of the population aged 65+ to the labor force



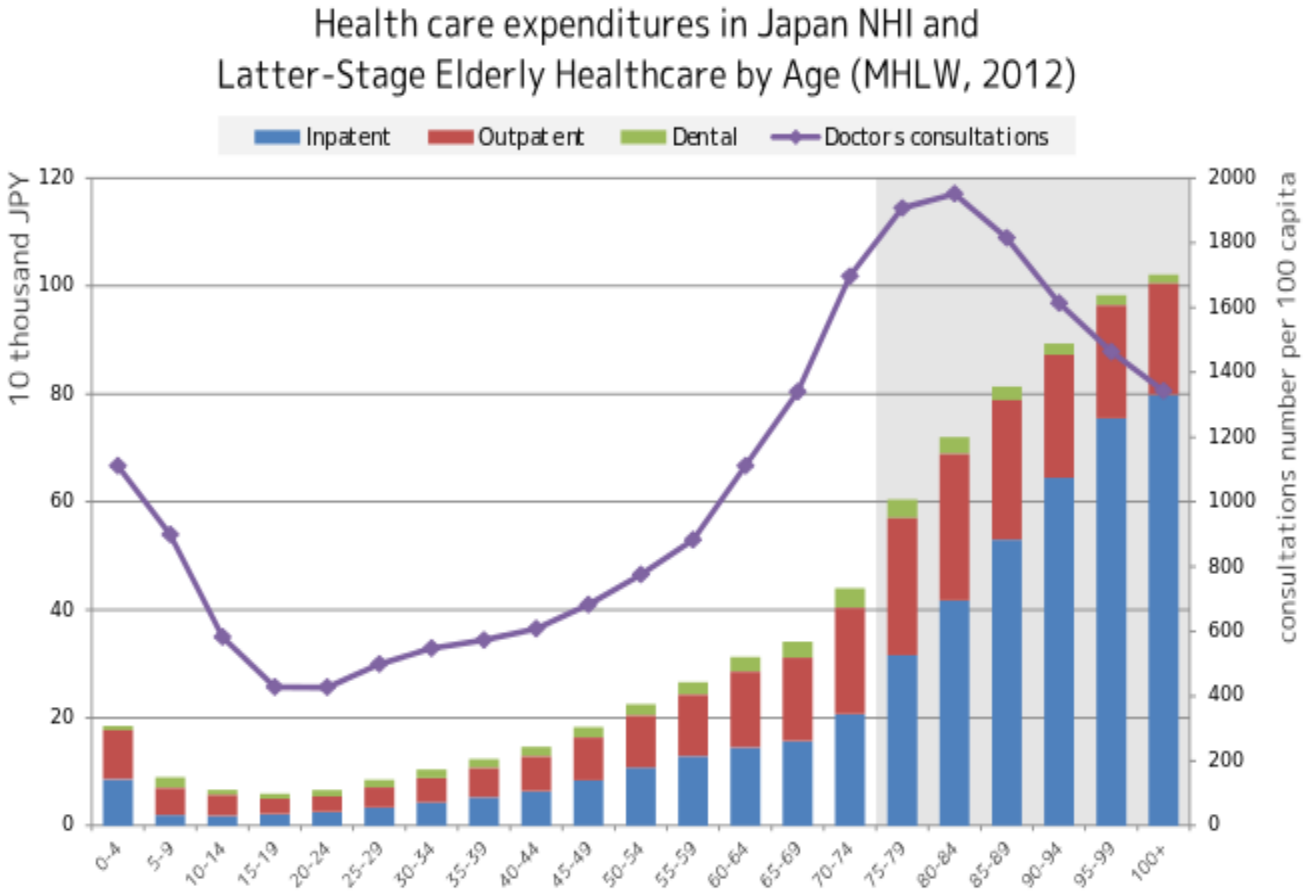
Context of Social Policy Reform for the Elderly



Context of Social Policy Reform for the Elderly

- Efforts to contain medical expenditure
  - Increase patient's co-payments from 10 %(1981) , 20% (1997) to 30% (2003)
  - Policies to contain ME thru lowering insurance payment and reducing number of doctors/beds since 80s caused negative effects described as "health care collapse"
  - Introduction of medical insurance system for latter-stage elderly aged 75+ in 2008 financed by tax (50%), transfer from other insurers (40%) and co-payment (10%)
  - But medical expenditure increases JPY 1 trillion p.a. due to aging population and advanced medicine

Context of Social Policy Reform for the Elderly



Context of Social Policy Reform for the Elderly

- To secure efficient/quality health care in the communities
- Reporting functions of hospitals and formation of Community Health Care Visions (2014-)
  - Medical institutions have an obligation to report their current and future direction of medical care functions (for acute, recovery or chronic phases) to prefectural govts.
  - Prefectures formulate Community Health Care Visions which include total estimates of medical care demands in each secondary area for medical service providing system.
- Repositioning of clinics with beds
- Home medical care and liaison with long-term care

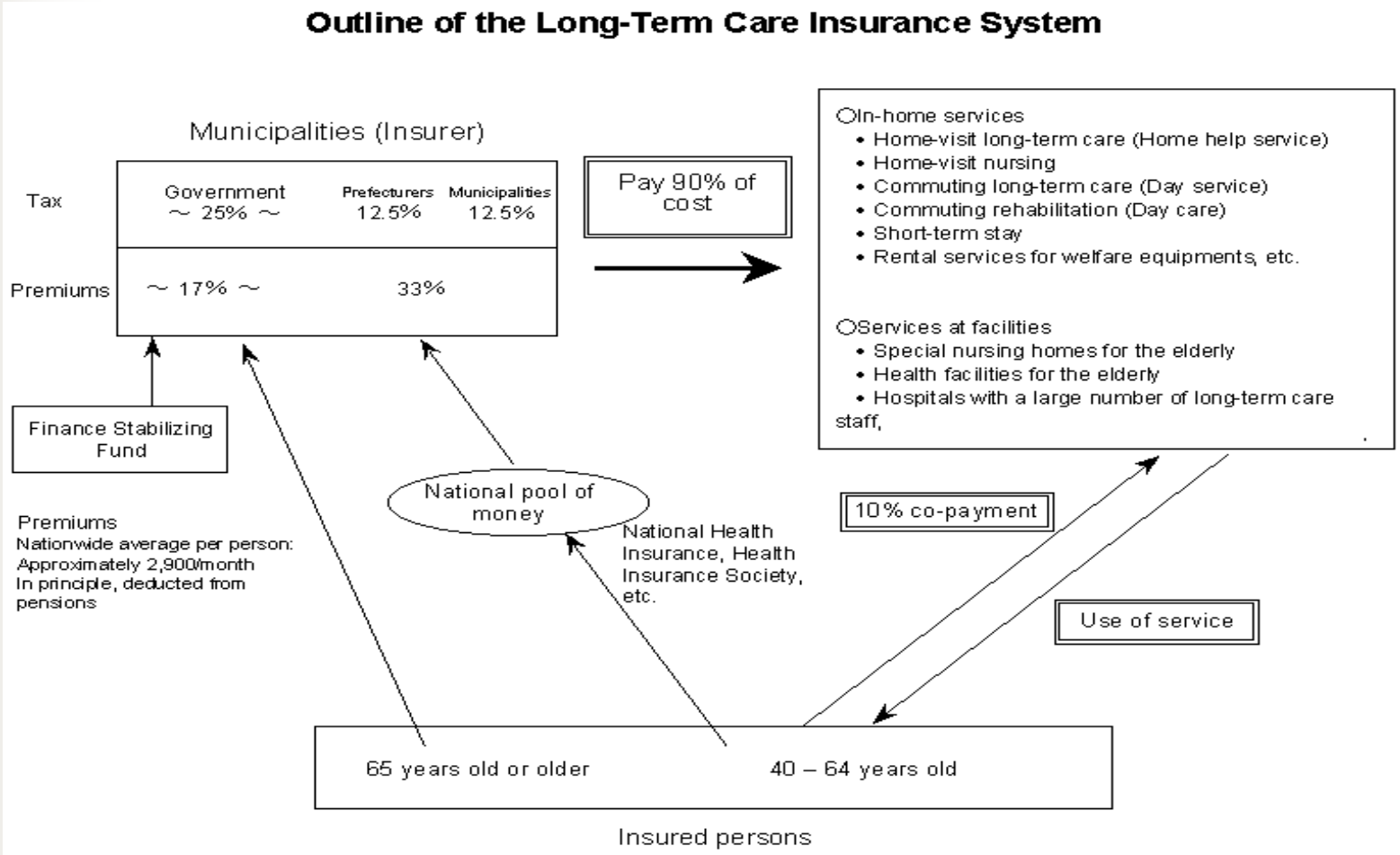
Context of Social Policy Reform for the Elderly

- **Quasi-market Reform in Social Welfare Policy**
  - In the 1970's the generous social welfare policy was introduced but soon faced setbacks after the oil shocks.
  - Discourse on "Japan-style welfare society" relying on traditional care by family members (women) was also abandoned.
  - In 1990, the revised social welfare laws enabled municipalities to outsource in-home services to non-public providers.
  - In 1995, the Social Security System Council recommended restructuring of the whole social welfare system.
  - Long-term Care Insurance (LTCI) Act took effect in 2000 allowing non-public providers to enter the welfare business.

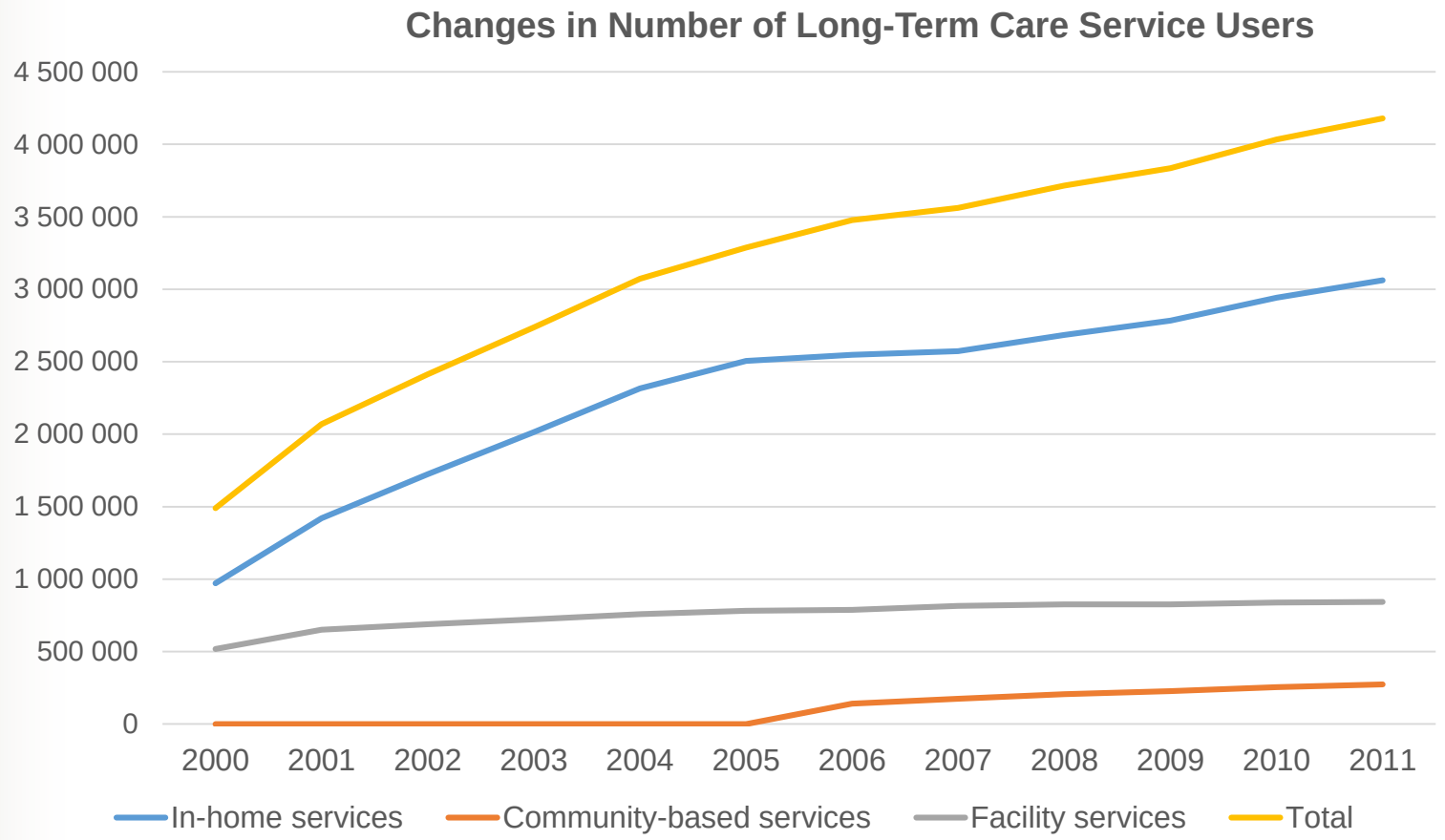
Context of Social Policy Reform for the Elderly

- **Underlying Principles of Reform**
  - Generalization of welfare services
  - User-oriented mechanism and improved service quality
  - Municipality centered mechanism
  - Normalization by improving in-home services
  - Multi-dimensional system for providing services
  - Co-operation among health promotion, medical care and social care

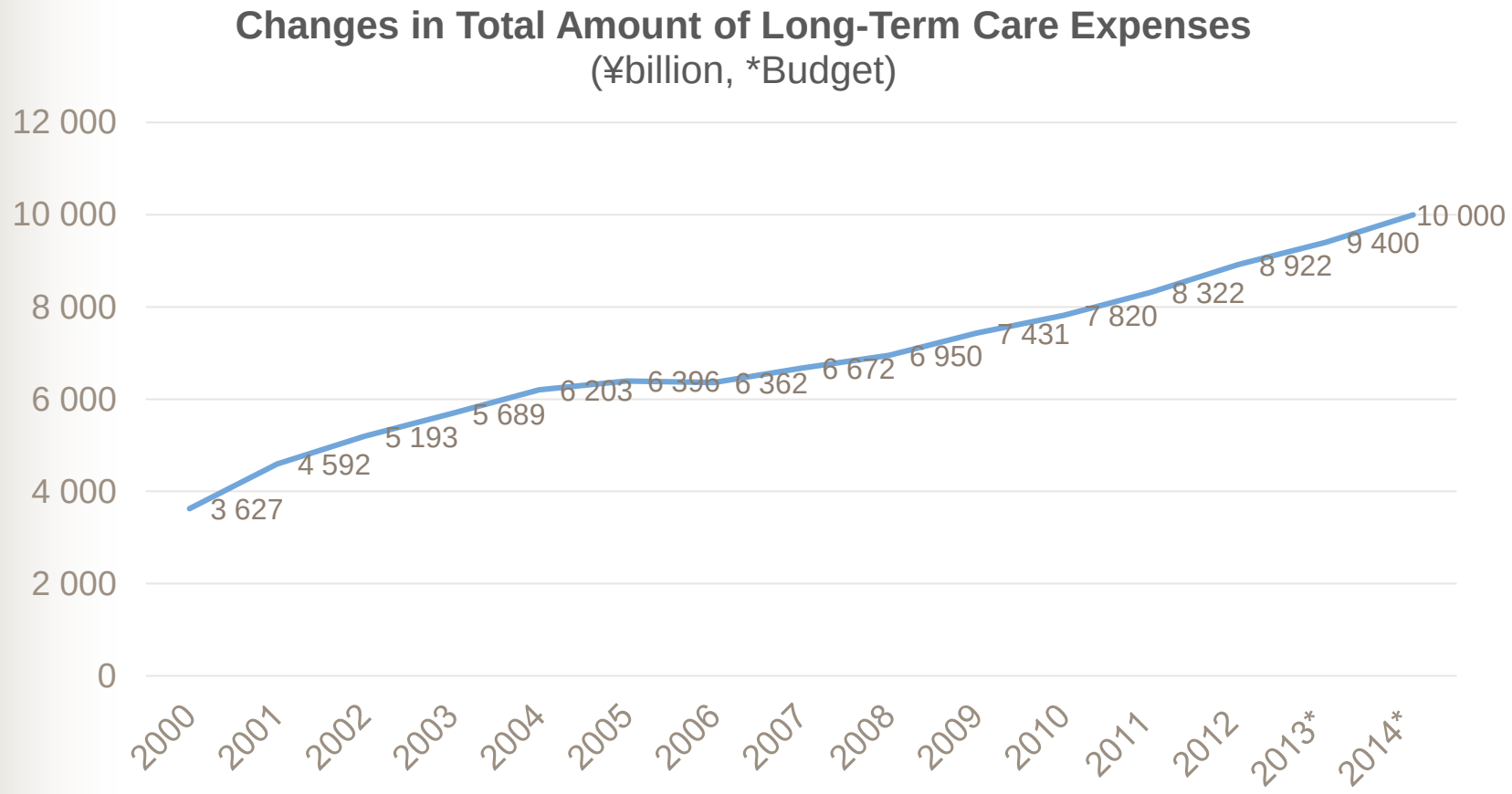
Context of Social Policy Reform for the Elderly



Context of Social Policy Reform for the Elderly



Context of Social Policy Reform for the Elderly



Context of Social Policy Reform for the Elderly

- **Questioned sustainability of LTCI system**
  - Sharp increase of care service providers and facilities.
  - The certified persons: 2.2 →5.8 million during 2000-2013.
  - LTCI service users : 1.5 →4.2 million during 2000-2011.
  - The overall cost: JPY 3.6 T → JPY 10.1 T during 2000-2015.
  - The number of elderly with dementia who needs care is estimated to grow from 2.8 million (9.5% of 65+) to 4.7 million (12.8%) during 2010-2025.
  - The revised LTCI Acts introduced reforms prioritizing preventive care provision and charging hotel costs in 2005.
  - MHLW introduced the idea of the Integrated Community Care (ICC) in 2011.

Context of Social Policy Reform for the Elderly

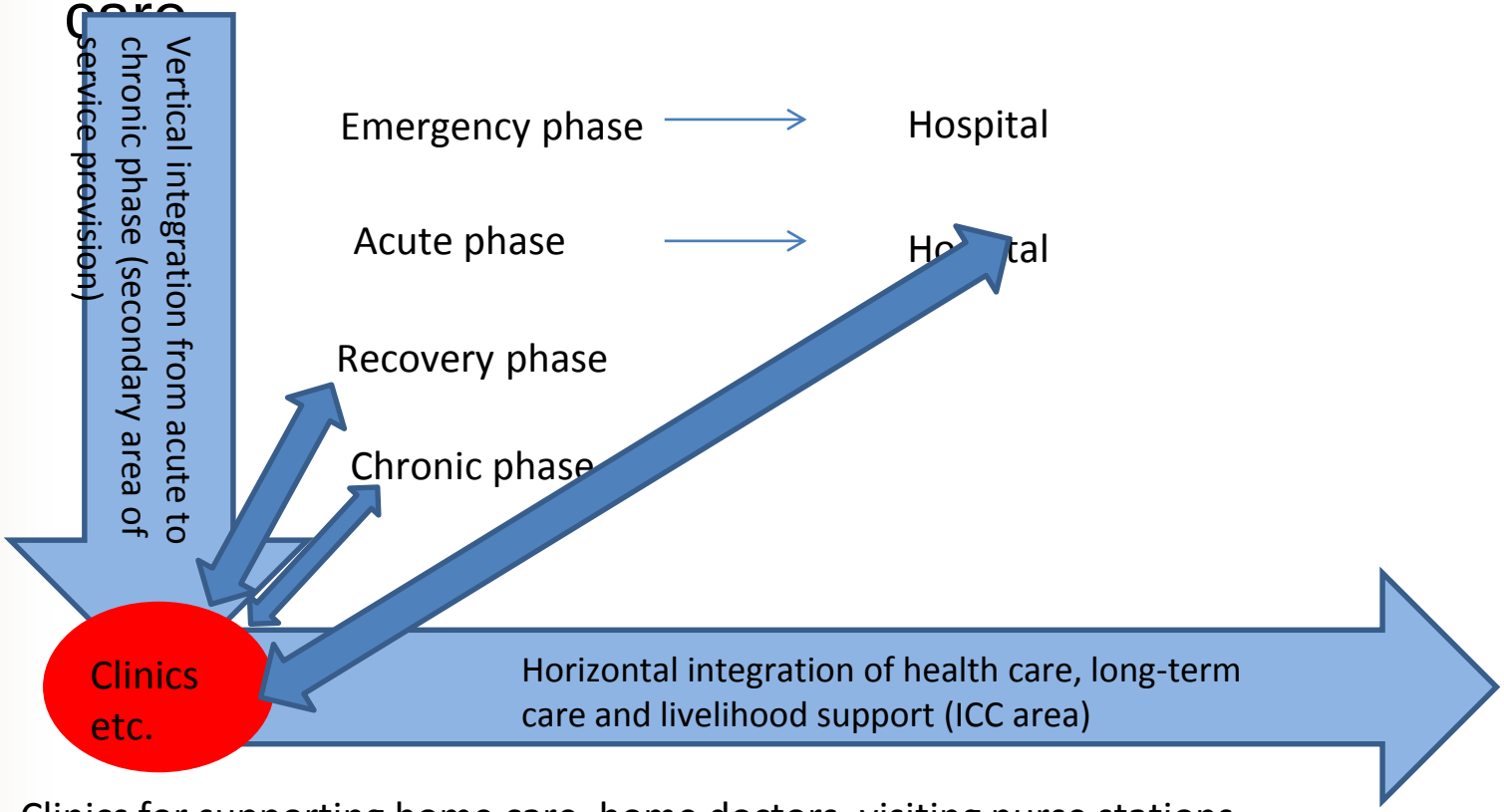
- MHLW seeks to build “integrated community care (ICC) system” by 2025 when the baby boomer generation turns 75 years old threshold.
- ICC is a network of entities that provides following services in an integrated manner in communities.
  - Housing
  - Medical care
  - Long-term care
  - Prevention services
  - Livelihood support
- ICC assumes an approximate range of a junior high school district as a space of network.

Context of Social Policy Reform for the Elderly

- Act to Promote Securing Integrated Health and Elderly Care in Communities (ICC Act) passed in 2014.
- ICC aims to enable people to continue to live in their home towns to the end of their lives with a sense of security once they are in severe need of long-term care.
- ICC needs to be created by municipalities based on independent and original ideas of the community concerned and according to its characteristics.
- ICC intends to reduce public expenditure and address to the elderly in urban areas while it is based on disparity in the municipalities and burden of service providers.
- MHLW encourages public/private initiatives for ICC.

Context of Social Policy Reform for the Elderly

- Image of clinics linking hospital care and home care



Clinics for supporting home care, home doctors, visiting nurse stations
Source: HeW CO-OP Japan

Who provide health and elderly care

- Types of service providers

	Health care	Elderly care	
		Facility-based care	Home/commu-nity-based care
Public sector	✔	✔	✔
Social Welfare Corp.		✔	✔
Medical Corp.	✔	✔	✔
Other nonprofits			✔
Co-operatives	✔	✔	✔
For profits			✔
Individual GPs	✔		

Who provide health and elderly care

- Types of service providers
  - Public sector includes state (prefectures, municipalities), public-interest institutions (Japan Red Cross, *Saiseikai, Koseiren*) and social insurance institutions.
  - Nonprofit sector includes social welfare corporations (SWCs), medical corporations (MCs) and others NPOs.
  - Co-operatives include agricultural co-ops (*Koseiren*), consumer co-ops (health co-ops) , fishery co-ops, SME co-ops and worker co-ops (elderly co-ops).
  - For profit sector is allowed to engage in long-term care but not in health care with a few exceptions.

Who provide health and elderly care

- Increased competition among elderly care providers under LTCI
  - Public sector retreating from service provisions while focusing on regulator's role.
  - SWCs (incorporated under Social Welfare Act) and MCs (incorporated under Medical Service Act) maintaining its share in services in facilities while grass-root NPOs expanding services in homes and communities.
  - Co-operative sector holding minor shares while running special nursing homes as SWCs.
  - For-profit sector making aggressive expansion in home-based care focusing on services generating higher profits.

Who provide health and elderly care

- Reform of SWCs and MCs
- SWCs founded as Quango
  - SWCs founded as sole agents for special nursing homes
  - Landlords contributing lands while benefitting from public grants for construction and no corporation tax
  - Dominantly family business with very little innovation
  - Amended law (2015) requesting improved governance and transparency, contribution to public benefits
- MCs founded as corporate form for doctors
  - A bulk of hospitals (60%) and clinics (30%)
  - Corporate form for doctors with few constraints
  - Same tax rate as conventional businesses
  - Amended law (2007) requesting stronger non-distribution constraint and public interests (Social Medical Corp.)

Who provide health and elderly care

- **Number of hospitals by founders (MHLW statistics)**

	1981	1990	1999	2005	2015
State	457	399	370	294	329
Public institutions	1,367	1,371	1,368	1,362	1,227
Social insurance providers	140	136	131	129	55
Medical corporations	3,038	4,245	5,299	5,695	5,737
Individuals	3,460	3,081	1,281	677	266
Others	762	864	837	869	866
Total	9,224	10,096	9,286	9,026	8,480

Who provide health and elderly care

- Number of clinics by founders (MHLW statistics)

	1981	1990	1999	2005	2015
State	838	487	578	633	541
Public institutions	3,539	3,842	4,224	3,964	3,583
Social insurance providers	777	805	848	581	497
Medical corporations	753	8,025	22,680	36,859	40,220
Individuals	66,447	60,731	53,973	50,693	43,324
Others	5,555	6,962	9,197	10,461	12,830
Total	77,909	80,852	91,500	97,442	100,995

Who provide health and elderly care

Share of number of service providers designated under the LTCI system (2014)

	Types of services	Municipalities	Public bodies	SWCs	MCs	PICs	NPOs	Co-ops	PLCs
In-home Services	Home help	0.3		19.1	6.2	1.2	5.4	2.5	64.4
	Home-visit bathing	0.4		39.9	2.0	0.9	0.4	0.8	55.5
	Home-visit nursing	2.6	2.5	7.4	32.5	10.0	1.8	2.6	40.3
	Day service	0.7		27.7	6.4	0.7	4.3	1.5	58.4
	Day rehabilitation	3.0	1.3	9.1	77.2	2.6			0.1
	Short-term stay	2.4		82.6	3.6	0.1	0.5	0.4	10.4
	Rental specific equipment			2.6	1.4	0.3	0.6	1.9	92.6
Community-based Services	Regular/on demand home-visit			29.2	17.1	1.0	2.0	2.0	48.0
	Outpatient care for dementia	0.6		46.3	12.1	0.9	5.9	1.5	32.5
	Group home for dementia patients	0.1		24.1	17.0	0.4	4.6	0.5	53.1
Facility Services	Special elderly nursing home	5.9	0.1	93.9					
	Health facility for the elderly	4.4	1.8	15.6	74.3	2.8			
	Sanatorium type facilities	5.1	1.0	0.9	82.7	2.6			

Who provide health and elderly care

Typology of Co-operative Providers of the Elderly Care

Types of co-ops	Home help	Visiting nurse	Day service	Leasing equip-ment	In-home care planning
Consumer co-op	136		32	33	101
Agricultural co-op	376		109	173	227
Health co-op	156	251			59
Koseiren		112			131
Elderly co-op	98		36	6	32
SME co-op	113		36	28	36
Fishery co-op	2		1	3	
Total	881	363	214	218	586
Co-op's share	4.2%	0.6%	1.5%	2.7%	2.1%

Brief history of health-related co-ops

- Industrial Co-operative Act (1900) provided for multi-purpose co-op societies for credit, supply, marketing and services.
- The first co-op clinic was opened by a rural co-op in Aoharamura, Shimane Prefecture in 1919 aiming to provide health services to farmers at reduced costs.
- Tokyo Medical Co-op set up by Dr. Inazo Nitobe and Dr. Toyohiko Kagawa as the first medical service society in 1932.
- There had been strong resistance from doctor's associations to co-operative health care.
- *Koseiren* federations were founded based on ACA since 1948 and designated as the public medical institution by the Ministry of Health and Welfare in 1951.

Brief history of health-related co-ops

- Health co-ops were founded based on the CCA since 1948 with four patterns
  - Constitution of medical co-ops from the outset (ex. Tottori Medical Co-op).
  - Transformation from the GPs (ex. Tsugaru Health Co-op transformed from GP Tsugawa Clinic).
  - Transformation from other corporations including medical service societies or medical corporations (ex. Tokyo Medical Co-op)
  - Separation from existing multipurpose consumer co-ops (ex. Tone Health Co-op separated from Gunma Worker's Consumer Co-op, Tokyo Northern Medical Co-op from Workers Club Consumer Co-op)

Brief history of health-related co-ops

- In 1957, the Health Co-operative Association (HCA) was set up by 12 medical co-ops to coordinate their activities at the national level as a specialized organization of the Japanese Consumers' Co-operative Union (JCCU).
- HCA sent medical mission to rescue typhoon victims in 1959.
- HCA started publishing the monthly journal in 1977.
- HCA promoted member activities for health learning and self-check in *Han* groups and branches.
- In 1991 HCA adopt *the Charter of the Patient's Rights* to facilitate user's self-determination pertaining to medical care.
- In 2010, the Japanese Health and Welfare Co-op Federation (HeW CO-OP Japan) was founded separating from the JCCU.

Mission and business of health co-ops

- Health co-op's mission is to enhance people's health in entire communities through delivering services and encouraging consumer participation in health care.
- Being highly specialized, health care is characterized by prevailing asymmetric information resulting in doctors' domination while users are placed in the disadvantageous position in tapping information/making decision on health care.
- In case consumers are not satisfied with diagnosis or treatments, they tend to exit rather than voice. Health co-ops have sought to promote consumer participation in the health care through implementing 'Charter of Patient's Rights' as a guideline to be followed by users and providers.

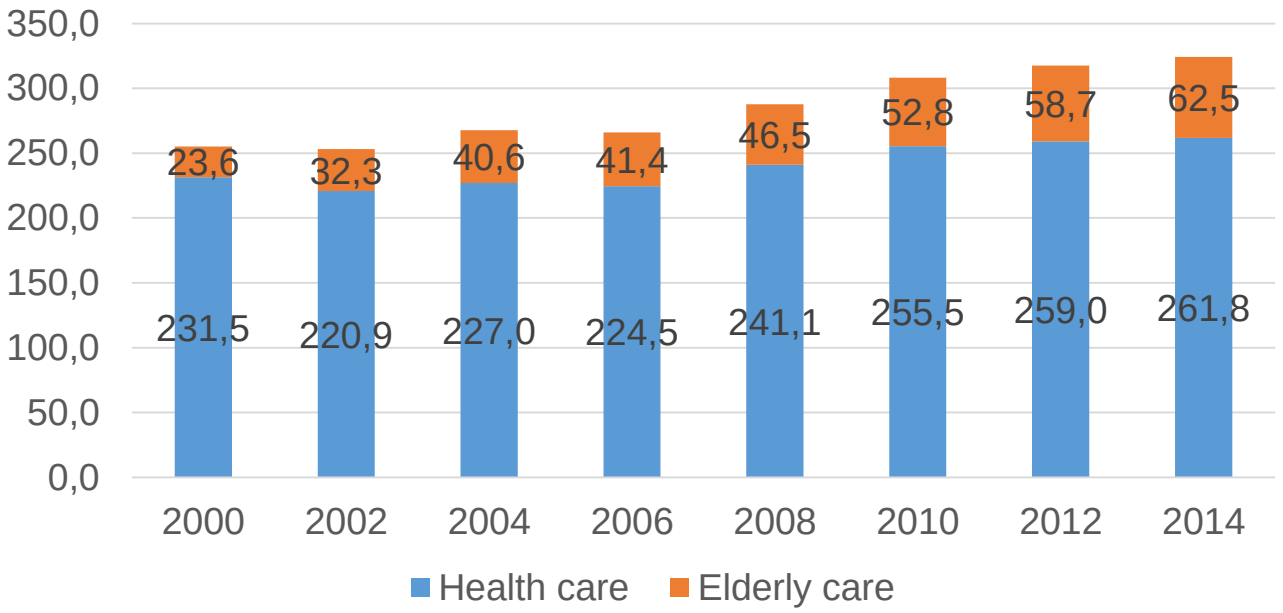
Mission and business of health co-ops

- **Health co-op's Charter of Patient's Rights adopted in 1991**
  - Right to be informed of diseases, medical care plan and drugs
  - Right to determine suitable medical care plan
  - Right to patient's privacy
  - Right to learn about their own disease, prevention and treatment
  - Right to receive necessary and optimum medical service at any time
  - Responsibility to participation and co-operation

(It was updated as "Health co-op's Charter for Lives in 2013.)

Mission and business of health co-ops

- **Turnover of health co-ops (JPY billion)**



Mission and business of health co-ops

- **Health Co-op's service facilities**

	1980	1985	1990	1995	2000	2005	2010	2014
Hospitals	63	75	82	79	81	77	77	76
Medical/dental clinics	126	169	176	234	280	311	349	344
Facility services						48	72	71
Community-based services						22	87	175
In-home services						512	462	466

Mission and business of health co-ops

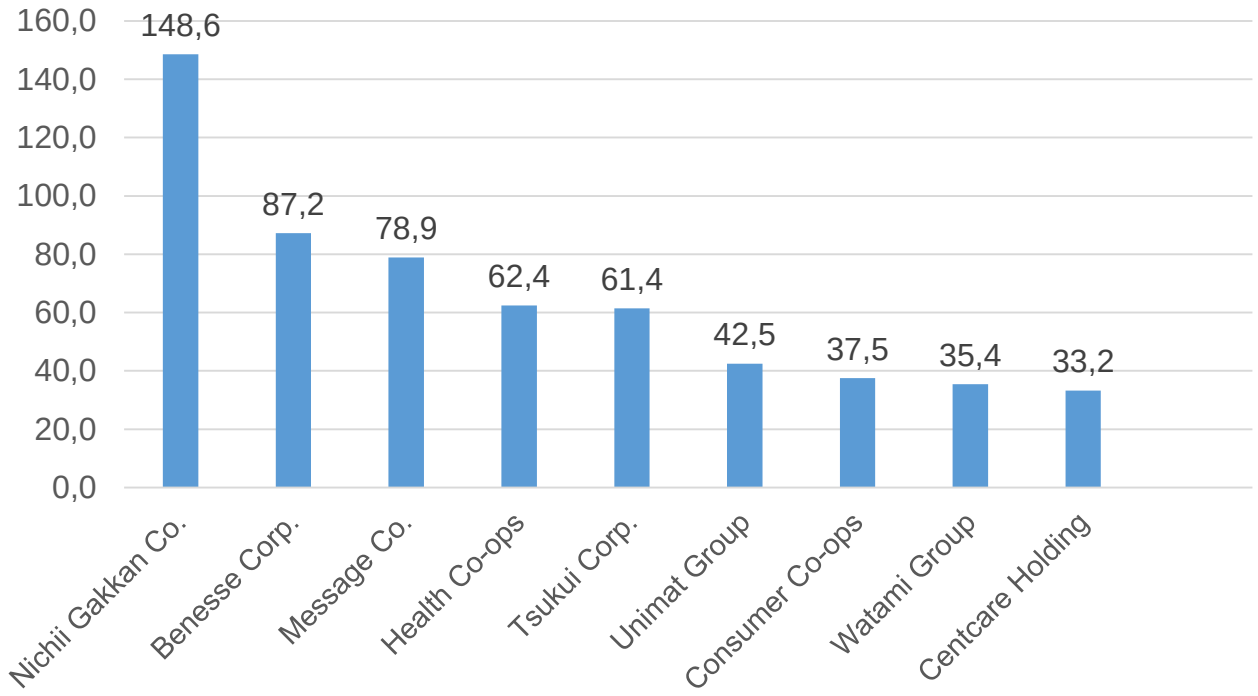
- **Health Co-op's health care facilities (2015)**
  - 75 hospitals with12,113 beds
    - 16 hospitals with more than 200 beds
    - 43 hospitals with 100-200 beds
    - 16 hospitals with less than 100 beds
  - 267 health clinics
  - 70 dental clinics
  - 187 visiting nurse stations
  - Other facilities include health check-up centers, fitness centers etc.

Mission and business of health co-ops

- **Health Co-op's elderly care business**
  - Since 2000 health co-ops increased their involvement in the LTCI as a natural extension of health promotion/care.
  - They rapidly invested in long-term care business (facility-based, home-based and community-based) and recruited /trained care workers.
  - Business for the elderly care includes nursing homes, health facilities for the elderly, home helper stations, day care centers, rehabilitation centers, service houses, group homes for dementia people etc.
  - They became the fourth largest long-term care providers.

Mission and business of health co-ops

The turnover of major providers of elderly care business in 2014
(in JPY billion)



Mission and business of health co-ops

- Varied orientation to meet different community needs
  - Health promotion in the communities. Many health co-ops are affiliated with the Japan Network of Health Promoting Hospitals & Health Services（J-HPH). WHO will make HPH recognition.
  - Higher functions of hospitals accredited by Japan Council for Quality Health Care (evaluating patient-centered care, quality/ safety assurance, quality medical practice and governance).
  - R&D for training specialist home doctors. HeW CO-OP set up the Centre for Family Medicine Development.
  - Emphasis on elderly care liaising with health care. This leads to the Integrated Community Care (ICC).
  - Access of lower income patients to provide services at no/lower co-payment based on the Social Welfare Act (with no insurance reimbursement but some tax benefits).

Member participation to health promotion

- **Health co-op's multi-stakeholder membership**
  - Health co-ops are classified as user-owned by the UN survey (1997) as 99% of members are users.
  - 2.9 million members join 110 co-ops in 40 prefectures.
  - A majority of members' age seems to be 60+.
  - Members raise share capital to help co-ops to invest in health and long-term care facilities (JPY28,000 p.c.)
  - Most of members are healthy and wish to maintain their health while self-help groups of patients are organized.
  - Medical and social service professionals are also allowed membership. 35,875 employees including doctors, nurses, care workers join health co-ops as members.

Member participation to health promotion

- **Health Co-op's Health Promotion**
  - Health co-ops promoted co-op member's learning about health promotion in '*Han*' groups and provided lectures, 'health colleges' or correspondence courses.
  - They encouraged member's self-monitoring of health conditions in '*Han*' groups thru;
    - Measuring blood pressure, sugar or salt contents in urine, fat content etc. using simple devises.
    - Keeping records and going to see doctors if irregularity was found (e.g. hypertension, high sugar contents).
  - They trained voluntary 'health advisors' as a driving force for health promotion activities (ca. 15,400 members).

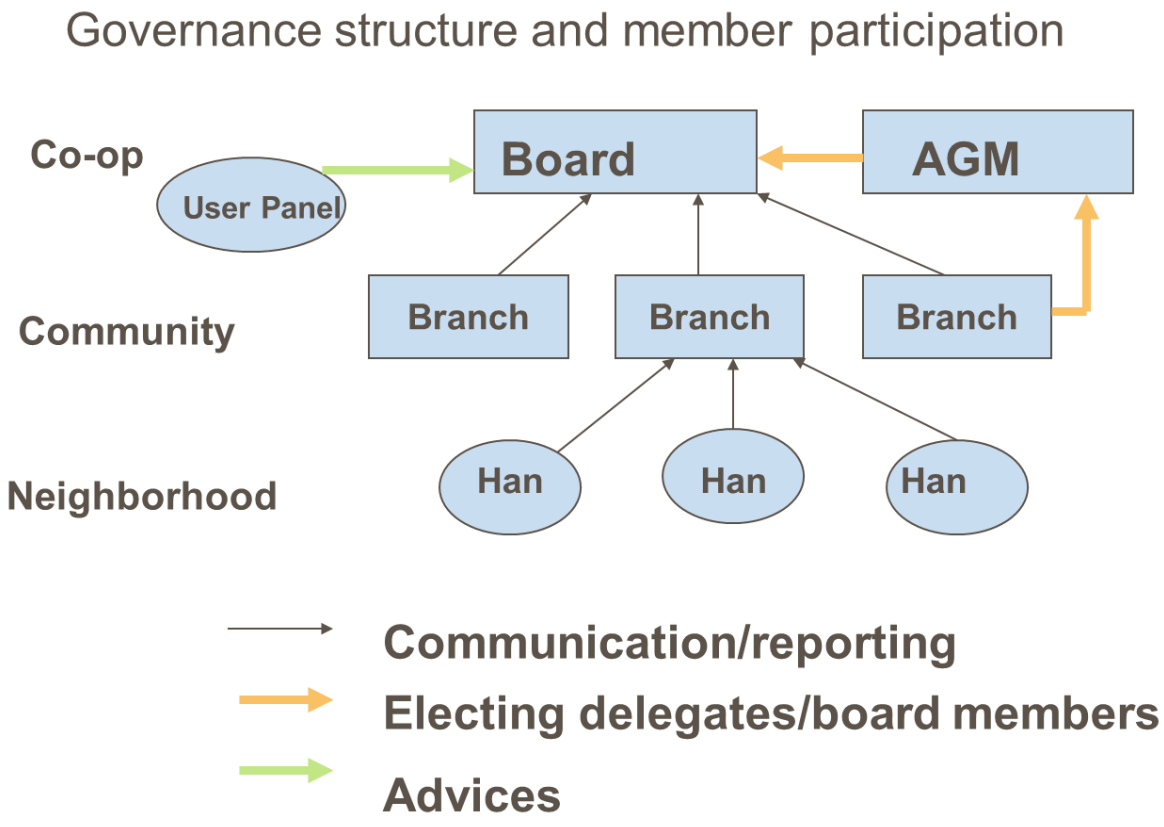
Member participation to health promotion

- **Health Co-op's Health Promotion**
  - They promoted '8 habits of daily life' (good sleeping, no smoking, no excess drinking, exercise, balanced diet, teeth brushing etc.) and '2 criteria for health' (maintaining adequate weight and blood pressure) to keep good health.
  - Members are encouraged to make 'my commitment for good health' and implement it individually or collectively.
  - The campaign to reduce salt consumption in dietary life is undertaken aiming to lower risks of circulatory diseases.
  - These activities are conducted in line with the WHO's Active ageing program for age-friendly environments and highly evaluated by the WHO.

Member participation to health promotion

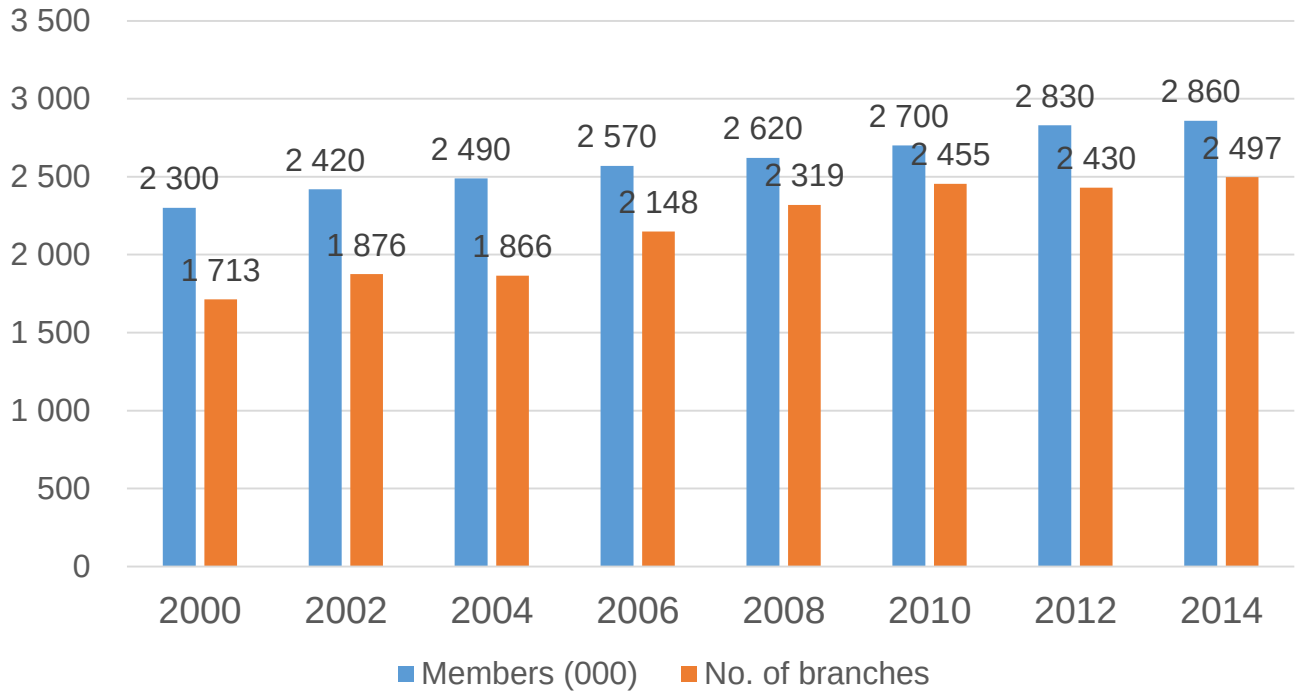
- **Health Co-op's Health Promotion**
  - Health promotion activities have been coordinated by branch committees and voluntary health advisors.
  - These activities are combined with comprehensive medical examination and professional health care at co-op's medical institutions.
  - Health co-ops promoted medical check-up by making full use of municipalities' health promotion schemes and offering lower fees for optional examinations so that even people of poorer social strata could take part.
  - Such initiatives resulted in the higher intake of health check-ups of members compared with national average and the increased usage of health co-op's services.

Member participation to health promotion

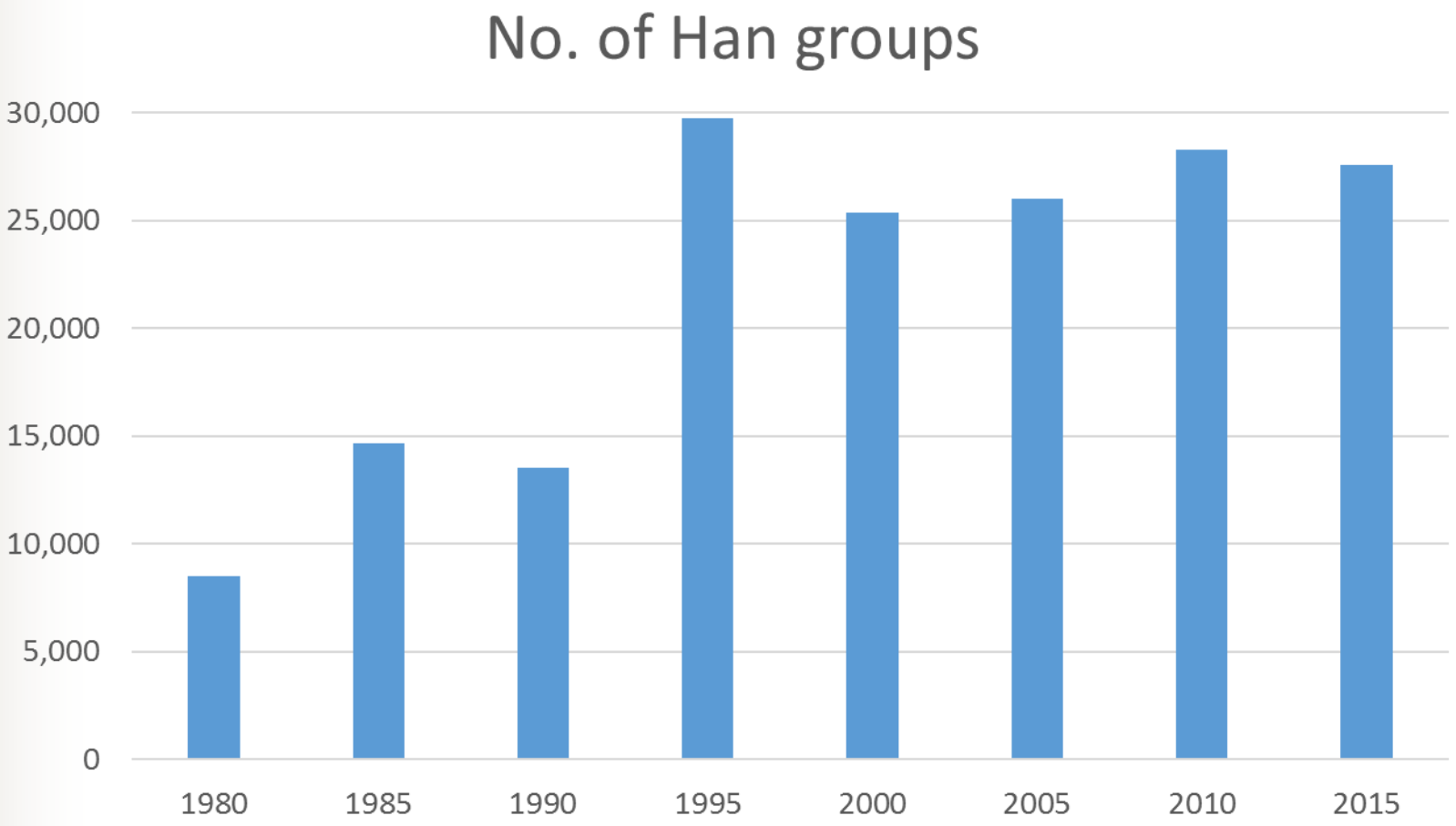


Member participation to health promotion

- **Number of health co-op members and branches**



Member participation to health promotion



Coordination for integrated community care

- Health co-op's initiatives to build ICC networks.
  - Strong needs to integrate health promotion, medical care and long-term care, addressing the changing patterns of diseases from acute/contagious ones to chronic ones.
  - But it was not easy to achieve such an integration because of functional and institutional reasons.
  - Health co-ops have campaigned to create healthy communities thru a network of health promotion, medical care and long-term care to provide better-coordinated seamless services for beneficiaries since the 1990s.
  - Such initiative is resonant with official policy for the Integrated Community Care (ICC).

Coordination for integrated community care

- Health co-op's initiatives to build ICC networks.
  - HeW CO-OP decided to create its own model of ICC to build communities where anyone can live with security thru linking businesses and member's activities (for medical care, long-term care, food and housing) to implement its Charter for Lives in 2014.
  - It proposed three challenges to build the ICC model.
    - To draw 'liaison map' aiming at making local needs/resources visible at branch level as a basic tool to build the network for the ICC.
    - To set up gathering sites where local residents can easily drop in and communicate to make friends and seek counsels on health.
    - To set up health co-op's branches at elementary/junior high school districts as focal points of promoting the ICC.

Coordination for integrated community care

- Health co-op's initiatives to build ICC networks.
  - A variety of initiatives are being made to identify local needs, mobilize co-op's resources and liaising with other institutions/groups in the communities.
  - Some co-ops intensified roles of visiting nurses and rehabilitation hospitals to facilitate service provision in the communities while others invested in service houses or multi-generation houses to promote care at home.
  - Minami Medical Co-op in Nagoya has built a network of housing, medical care, long-term care, prevention and livelihood support. It was designated as a model of ICC by the Ministry of Health, Labor and Welfare.

Minami Medical Co-op's Case

- Origin: Minami Medical Co-op was founded in 1961 by 308 health workers and local residents who volunteered to serve victims severely affected by Isewan Typhoon that killed more than 5,000 lives in 1959.
- Location: Southern part of Aichi Prefecture (Nagoya)
- Membership: 75,800 in 2014
- Employee: 823 incl. 83 doctors, 317 nurses, 123 care workers etc. who are also members.
- Turnover: JPY 10,364 million (9,206 million for medical care, 1,072 million for social service)
- Facilities: 37 (2 hospitals, 10 clinics, 5 visiting nurse stations, health facility for elderly, group homes, service houses etc.)

Minami Medical Co-op's Case

- Co-op clinics tackled with air pollution-related illness (asthma etc.) in the heavy industrial zones during 1960s-1970s.
- The general hospital was opened in 1976.
- Visiting nurse stations were built during 1996-1998.
- When LTCI system started in 2000, Co-op entered the elderly care as a natural extension and made substantial investment in facilities such as group homes, day service centers.
- "Co-op villages" clustering long-term care facilities and multi-generation flats were opened in 2005 and 2009.
- The health facility for the elderly was built in 2008.
- The central hospital was renovated in 2010.
- The nursing home cum service houses was built in 2015 .

Minami Medical Co-op's Case

- Minami Medical Co-op's businesses/member activities in light of ICC

Functions	Co-operative businesses	Member activities
Housing	1 nursing home/service house 2 multi-generation flats	1 volunteer group for chatting and cooking
Medical care	1 general hospital 1 rehabilitation hospital 10 medical/dental clinics 1 maternity center 5 visiting nurse stations	12 volunteer groups for helping daycare, chatting, transportation, cooking, hobbies, gardening, etc.
Long-term care	1 health facility for elderly 9 short-stay/day care centers 9 group /small multi-function homes 7 home-helpers stations	3 volunteer groups for helping daycare, chatting and transportation
Preventive services	1 health checkup center 1 fitness club	1,137 *Han* groups Volunteers
Livelihood support	Home helpers Children day care centers	85 branches "Mutual help sheets" Dementia supporters

Minami Medical Co-op's Case

- Co-op's coordinated health and elderly care services
  - Medical care and long-term care facilities are closely linked, often in the same premises, forming health-welfare clusters.
  - General hospital provides emergency medical services 24 hours all year-round and operates centers for health checkup, fitness, midwifery and hospice care as well.
  - The other hospital is specialized in rehabilitation care.
  - Visiting nurse stations attached to clinics offer care at home.
  - The health facility for the elderly helps patient to return homes.
  - Two "villages" consist of group/small multifunctional homes attached to multi-generation flats.
  - The nursing home cum service house is closely linked with group/small multifunctional homes, a day care center etc.

Minami Medical Co-op's Case

- Co-op's member participation to health promotion
  - Members are involved in various activities to enhance their QOL and build healthy communities.
  - Members conduct health learning/checkup activities in *Han* groups. They go to meet doctors, when abnormality is found.
  - Members take part in branch committees and user panels.
  - Active members even assist co-op in finding premises for group homes and raising funds to finance these facilities.
  - Members take part in planning of health/elderly care facilities. When the renovation of a general hospital was planned in 2006, "1,000 members' consultation" was organized. In total, 45 planning sessions were held and 5,400 members took part to planning process in 10 working groups.

Minami Medical Co-op's Case

- Co-op's efforts for community building
  - Co-op businesses and member activities contribute to building healthy communities in collaboration with local institutions/groups.
  - Co-op staff and members often consult to solve problem faced by local residents thru "mutual help sheets" that are filled to identify the troubles in health and daily life and find solutions.
  - Active members take part in volunteer groups and learn to become dementia supporters to help local residents in need.
  - Co-op contributes to build a network for improved quality of health/long-term care and helps local residents to nurture a sense of community thru mutual help and altruistic activities.

Conclusion

- Health co-ops presents a unique model of social innovation combining health promotion, medical care and long-term care.
- Minami Medical Co-op's efforts for community building is recognized as a model of the Integrated Community Care.
  - Co-op builds a network of living centered on hospitals by encouraging mutual helps in the communities.
  - Co-op not only operates facilities for health promotion, health care and elderly care but also extends activities to improve daily life of residents.
- But the coordination mechanism of health and long-term care enabling normalization that helps the elderly to receive a mix of optimal cares and live an active life with dignity in communities requires to be elaborated in depth.