

# **Community-based Integrated Care in Japan —Suggestions for developing countries from cases in Japan—**

**July 2022**

**Japan International Cooperation  
Agency  
(JICA)**

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## Preface

The aging of the population is a global trend, not only in developed countries, but also in developing countries. It is estimated that in the about 30 years from 2019 to 2050, the global population aged 65 and over will double from 700 million to 1.55 billion, and the percentage of the population will increase from 9% to 16% (World Population Prospects 2019: Highlights).

Japan is experiencing more rapid aging of the population than in Western countries, entering a super-aged society ahead of the rest of the world. The Japan International Cooperation Agency (JICA) has taken advantage of the experience and lessons learned by Japan as it has responded to these rapid changes in population structure to implement technical cooperation in the field of measures for aging societies, mainly in Thailand so far and developing countries in the Asian region. In recent years, the need for support in this field has been increasing as populations age in various countries, and interest is also increasing in Latin America and elsewhere, in addition to Asia.

Based on such circumstances, this Working Paper focuses on “Community-based Integrated Care” as one of the important concepts in current measures for the aging society in Japan and has been created for the purpose of policy formulation and on-site reference mainly for developing countries. First, after reviewing the background and history of Japan’s Community-based Integrated Care System in Chapter 1, and the concepts and mechanisms in Chapter 2, Chapter 3 will look at practical examples of Community-based Integrated Care in three regions in Japan (Komagane City, Nagano, Fujisawa City, Kanagawa, and Higashiomi City, Shiga). Chapter 4 will then consider how to promote Community-based Integrated Care based on these practical examples, and Chapter 5 will summarize recommendations for the context of developing countries.

Today, there are a variety of measures for aging societies in developing countries, and while cases from Japan cannot be uniformly applied, it is hoped that this Working Paper will promote a deeper understanding of Community-based Integrated Care and the development of measures and efforts tailored to the systems and culture of each country.



**Preface**

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# Chapter 1. Historical and Institutional Background of “the Community-based Integrated Care System”

This Chapter will describe the historical and institutional background that led to the promotion of a Community-based Integrated Care System in Japan, and will outline the Long-Term Care Insurance and subsequent issues associated with the implementation of Long-Term Care Insurance and the requirements of a Community-based Integrated Care System, from the perspective of the transition of older people’s health and welfare measures that accompanied the changes in socio-economic conditions from the 1950s to 2000.

## 1.1. Trends in Health and Welfare Measures for Older Adults in Japan

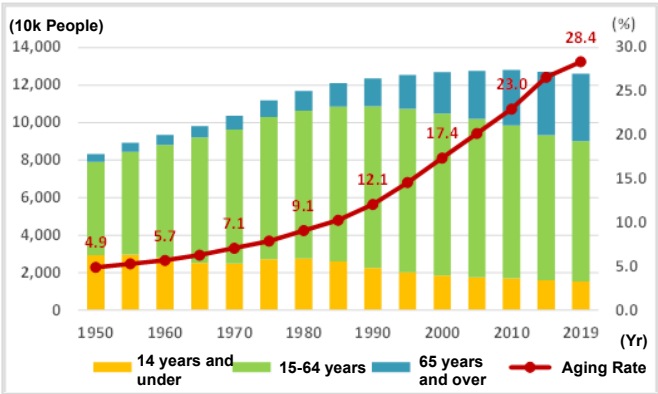
As the aging of society progressed rapidly in Japan, there was an urgent need to improve the legal system for health and welfare for older people, and various measures have been developed. The demographics and social background will be described below along with particularly the transition to the introduction of the Long-term Care Insurance regarding Japan’s health and welfare measures for older people.

### 1.1.1 1950s-1960s: Achievements of UHC and the beginning of measures for older adults

#### (1) Socio-economic and public health conditions

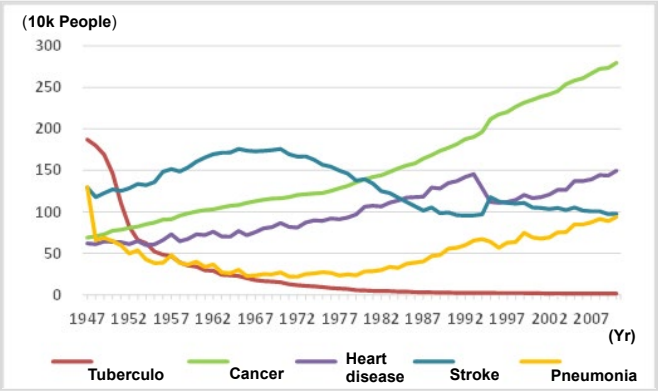
Fig. 1-1 shows the population composition and transition of the aging rate from 1950 to the present. From 1955 to the 1960s, Japan experienced dramatic economic growth under the formation of a demographic dividend due to the decline in young population (14 years or younger) and an increase in the working-age population (15-64 years old). This high economic growth brought changes to the industrial structure from what had been mainly primary industry to secondary and tertiary industries, and also led to an outflow of much of the rural workforce into big cities, promoting nuclear family households in urban areas.

Also, with respect to health and hygiene, the average life expectancy in 1947 of both men and women was in their 50s, and by 1965 this had been extended to 67.74 years for men and



Source: Created based on the 2020 MHLW White Paper

Fig. 1-1 Trend in Population Composition and Aging Rate



Source: Created based on the 2011 MHLW White Paper

Fig. 1-2 Trend in Mortality Rates by Major Cause of Death

72.92 years for women<sup>1</sup>. One of the factors in this was the change in disease structure from infectious diseases to chronic diseases. Fig. 1-2 shows the trend in mortality rate by main cause of death from postwar to modern times. Tuberculosis was the highest cause of death until 1950, but improvements in the hygienic environment and nutritional conditions and advances in medicine reduced infectious diseases so that from 1951 to 1980 stroke became the leading cause of death, followed by cancer in second place.

## **(2) Enactment of the Welfare Act for the Elderly**

Until this time, older people's welfare policies had mainly targeted those in financial distress as part of efforts to alleviate poverty, but as the population composition, socio-economic environment, and family structures changed, it became necessary to implement measures responding to mental and physical difficulties common to older adults. The "Welfare Act for the Elderly" was enacted in 1963 as a measure to widely promote the welfare of older adults.

Under the Welfare Act for the Elderly, specific measures were outlined such as the creation of special nursing homes, providing legal standing to the visiting caregiver program, and the conducting of health check-up services. With respect to institution-based services, until this point admission had been limited to persons in financial distress, but special nursing homes were established, as facilities that older persons in need of long-term care could enter regardless of their financial situation. On the other hand, given that the number of older people requiring long-term care exceeded the capacity of facilities, this resulted in priority being given to those with low income in urgent need of care, and due to the need for an income test this was not always a system which was easy to access. By the late 1960s, the serious state of bedridden older people became clear and gradually long-term care for older adults came to be recognized as a universal need.

## **(3) Achievement of universal insurance and universal pension**

In 1961, Japan attained universal coverage of social health insurance and pension insurance programs. Until then, social health insurance and pension programs were mainly developed for employees and civil servants, and even as of the mid-1950s about one-third of citizens was not covered by health insurance programs, mainly those that were agriculture, forestry and fisheries workers, self-employed, and micro-enterprise employees, and their families. Informal sector workers and non-workers did not have a pension program. Under these circumstances, with the need for enhanced social security, coverage of health insurance and pension insurance was expanded to every citizen<sup>2</sup> at the relatively early stage of economic development.

Also, in parallel with the enhancement of the health insurance, there was also an enhancement of the system to provide the medical care, with the number of hospital beds mainly in private hospitals increasing about 2.7 times in the 30 years from 1955.

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<sup>1</sup> 2011 MHLW White Paper

<sup>2</sup> However, persons receiving welfare benefits are excluded from applying for National Health Insurance, as medical care is provided for most of them through the medical assistance of welfare public assistance.

## **1.1.2 1970s: Improving income security and medical access for older people**

### **(1) Social background**

In 1970, with an aging rate of 7.1%, Japan became an “aging society.” It should be noted, however, that the level of aging was not uniform nationwide, but was different between urban and rural areas. The age structure in urban areas was relatively young, due to the influx of mainly young people from rural areas, and the aging rate in Saitama, Kanagawa and Chiba prefectures in 1979 was in the range of 5-6%. On the other hand, in rural areas, where the population had flowed from, the aging of the population was already progressing significantly, reaching the 13% level in Shimane and Kochi prefectures<sup>3</sup>.

In addition, the total fertility rate was at the level of about 2.0 or higher until the early 1970s but fell below 2.0 from 1975 and has continued to decline. The causes can be considered the declining marriage rate of young people due to the increased rate of social advancement, and adjustments to childbirth intervals<sup>4</sup>.

In terms of trends for older people’s households in the 1970s, with an increase of nuclear families under the high economic growth, the number of three-generation households declined relatively, and households with only a couple (where at least one of the couple was 65 years or over), and single-person households increased<sup>5</sup>.

### **(2) Free medical care for older people**

As mentioned above, universal health insurance coverage was achieved in 1961, but while this was applicable to all citizens, there was an institutional disparity in the differing copayment rates depending on the program in which a person was enrolled. Since older people often have multiple illnesses, medical expenses were an economic burden for them, who did not necessarily have high incomes. In 1973, the Welfare Act for the Elderly was revised in response to this, implementing free medical care for the older persons. Under this system, persons aged 70 or more had out-of-pocket medical expenses paid by public funds from the national and local governments. This resulted in older people’s visits to doctors no longer being suppressed for financial reasons, improving access to medical services.

### **(3) Enhanced income security with the revision of the pension program**

With respect to income security for the older people, the legal basis for the Employee’s Pension Insurance and National Pension Insurance were both revised in 1973<sup>6</sup>. To maintain real benefits against inflation, an indexation was introduced to revise the amounts of benefits in line with inflation when inflation rises by more than 5%. In addition, a re-evaluation of the standard remuneration that forms the basis for the calculation of Employee’s Health Insurance benefits ensured that benefits reflected increases in wage levels associated with economic growth. National Pension benefits were also raised significantly. In spite of severe economic fluctuations due to the oil crisis and rapid inflation in 1973, such revisions led to pension benefit levels

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<sup>3</sup> 1980 MHLW White Paper

<sup>4</sup> 1980 MHLW White Paper

<sup>5</sup> 1980 MHLW White Paper

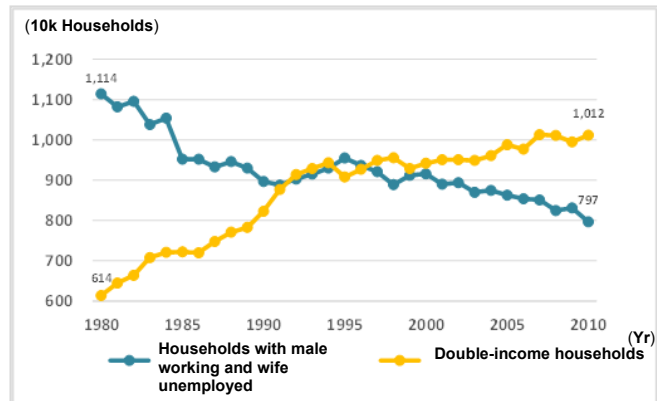
<sup>6</sup> See the column for more information on the pension system.

improving significantly.

### 1.1.3 1980s: Review of the medical care system for older people

#### (1) Social background

In the 1980s there was a change to working style of each household. Fig. 1-3 shows the trend in single income households and double-income households since 1980. As of 1980, single income households were the mainstream, accounting for 1.8 times the number of double-income households. However, double-income households increased throughout the 1980s. Until then, women were mainly responsible for long-term care and child-rearing in the home, but as social advancement progressed roles in the home also changed, resulting in growing needs for the “socialization of care” to support long-term care by society.



Source: Created based on the 2011 MHLW White Paper

Fig. 1-3 Trend in the Number of Double-income Households

The increased demand for the socialization of care, coupled with the free medical care policy for older persons since 1973, led to an increase in “social hospitalization”<sup>7</sup>. Fig. 1-4 shows the hospitalization rate per 100,000 population by age group. Since the introduction of free medical care policy for older people, only the hospitalization rate for persons aged 65 or over continued to rise throughout the 1980s.

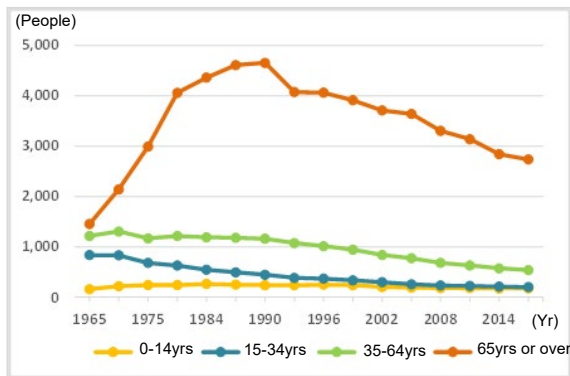
In addition, Fig. 1-5 shows the outpatient consultation rate per 100,000 population by age group. As with the case of hospitalization, the outpatient consultation rate for persons aged 65 or over rose significantly in 1975. While access to medical services to older persons improved, an issue of over-prescription of medicines and excessive examinations arose.

Also, since 1981 a change was observed in mortality rate by cause of death (Fig. 1-2). Mortality from strokes, which had previously been the leading cause of death, declined, and from 1981 to the present mortality from cancer has been rising.

#### (2) Enactment of the Health and Medical Services Act for the Elderly

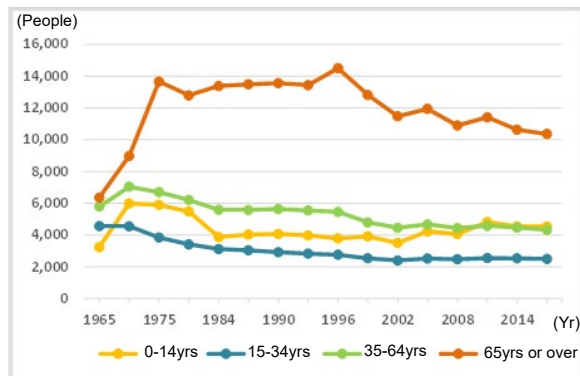
After the introduction of free medical services for older people, as mentioned above, the hospitalization and consultation rates increased significantly and medical expenditure for older people have also increased

<sup>7</sup> Hospitalization in medical institutions as an alternative to long-term care based on patient and family circumstances despite the low need medically for treatment or nursing care.



Source: Created based on MHLW Patient Survey

Fig. 1-4 Trend in Hospitalization Rate by Age Group (per 100,000 population)



Source: Created based on MHLW Patient Survey

Fig. 1-5 Trend in Outpatient Consultation Rate by Age Group (per 100,000 population)

sharply. The medical expenditure for older people inflated about 5.7 times from 428.9 billion yen in 1973 to 2,428.1 billion yen in 1981<sup>8</sup>, putting pressure on the finances of the National Health Insurance Program which had a particularly significant share of older population in the covered population. Also, with the change in disease structure with a focus on chronic diseases such as cancer, heart disease and stroke etc., the importance of prevention and early detection, in addition to the treatment of illness, increased, and the “Health and Medical Services Act for the Elderly” was enacted in 1982 with the purpose of ensuring the health of older people through comprehensive health care.

The Health and Medical Services Act for the Elderly abolished the free medical care program for older persons, reinstating the copayment of patients aged 70 years and over, encouraging self-care and proper consultations for staying healthy. The Act also specified the provision of health programs for people aged 40 years and over, from prevention, to treatment, rehabilitation, and home medical care.

### (3) Establishment of health service facilities for the aged (Intermediate facilities)

In this way, with increased needs for integrated services toward a return to home through coordinated health and welfare services, not medical-focused services such as social hospitalization, the Health and Medical Services Act for the Elderly was revised in 1986 and “Health Service Facilities for the Aged” were established as intermediate facilities between hospitals and home. Health service facilities for the aged provide services focused on nursing care and long-term care, and functional training, for older people whose medical conditions are relatively stable. Health service facilities for the aged differ from special nursing homes for older persons under the government’s rationing system<sup>9</sup>, in that there are no income tests for admission and individuals can select their facility and receive contracted services. The creation of these intermediate facilities reduced excessive medication and began to provide medical care aimed at guidance for daily life.

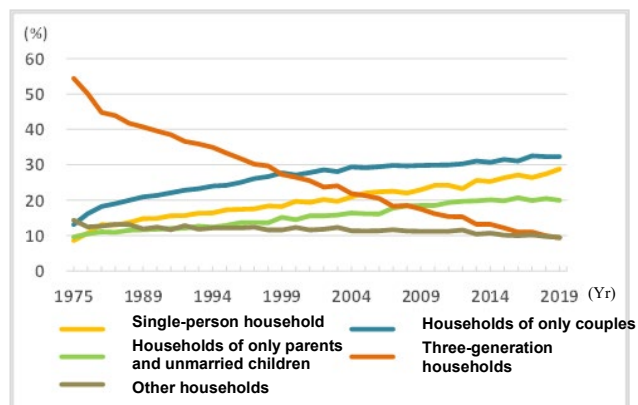
<sup>8</sup> 2015 Report on the State of the Medical Care System for Elderly in the Latter Stage of Life

<sup>9</sup> Shifted to a contract system with the introduction of the Long-Term Care Insurance in 2000.

## 1.1.4 1990s: Development of infrastructure for health and welfare of older people

### (1) Social background

In 1994, 24 years after the start of the “aging society” in 1970, Japan reached an aging rate of 14.1%, becoming an “aged society.” Since reaching its peak in 1995, the working-age population began to decline, and the young population also declined. Also, against a background of the “1.57 shock” in which the total fertility rate hit a record low of 1.57 in 1989, measures against the declining birthrate and legal systems for child-rearing support were promoted from 1990.



Source: Created based on MHLW Comprehensive Survey of Living Conditions

Fig. 1-6 Trend in the Structure of Households with Older People

In terms of social aspects, the number of double-income households increasing since the 1980s surpassed the number of single income households in 1997 and has continued to increase since (Fig. 1-3). Also, Fig. 1-6 shows the trend in the structure of households with older people. While there was a significant decline in the percentage of older people living in three-generation households, single-person households and households of only couples were on the rise through the 1980s and the 1990s.

### (2) Introduction of the Gold Plan and the New Gold Plan

As measures for home medicine and home care began to unfold from the 1980s, the “Ten-Year Strategy to Promote Health Care and Welfare for the Elderly (Gold Plan)” was formulated in 1989. The Gold Plan established goals for the 10 years from 1990 for home and community-based and institution-based services, with particular attention to the promotion of home and community-based services.

In addition, the Welfare Act for the Elderly was revised in 1990. This established a system in which the responsibility for implementing welfare services for older adults were unified with municipalities and municipalities and prefectures were mandated to create older people’s health and welfare plans. This reform made municipalities, which are the closest to residents, to provide home and community-based and institution-based welfare services in a unified and planned manner.

Five years after the formulation of the Gold Plan, in 1994, the “New Ten-Year Strategy to Promote Health Care and Welfare for the Elderly (New Gold Plan)” was formulated, revising the plan for the latter half of the original plan. The New Gold Plan was aimed at the further enhancement of long-term care infrastructure ahead of the enactment of the Long-Term Care Insurance Act.

### (3) Enactment of the Long-Term Care Insurance Act

As mentioned above, in the 1990s there was a rapid development of infrastructure for health and welfare



for older adults, with a focus around the Gold Plan. On the other hand, socially, the situation around the support of older people in need of care by the families was becoming more and more difficult, and long-term care for older adults came to be seen not as a special issue but as a universal one. In 1997, the “Long-Term Care Insurance Act” was enacted, and the Long-Term Care Insurance came into effect from April 2000, as a mechanism for supporting the long-term care of older people by all citizens, considering older adults to be equal members of society.

For the enforcement of the Long-Term Care Insurance, the “Direction of Health and Welfare Policies for the Elderly over the Next Five Years (Gold Plan 21)” was formulated, as a continuation of the 1999 New Gold Plan. In addition to the development of care service infrastructure, the aim was to create a participatory society where older adults stayed healthy and had a sense of purpose, ensuring their dignity and supporting their independence by promoting both frailty prevention and everyday living support etc.

## **1.2. Long-Term Care Insurance**

As mentioned in 2.1, the background behind the introduction of the Long-Term Insurance was the major impact of social changes, not only with the increase in the number of older adults requiring long-term care due to the increase in the older population, but also the decline in the long-term care functions of families due to changes to family forms such as nuclear families and an increase in double-income households etc. The issue of long-term care for older adults had become a universal need, and a mechanism was required for support by society as a whole.

In addition, until then long-term care for older adults had been carried out with tax revenue under the two systems of the welfare system and health insurance system, but there were issues such as facilities and services under the welfare system being decided by municipalities, and being generally difficult to access due to income tests, and the issue of the medical system not meeting its true purpose due to social hospitalization etc. Thus, there was a need to reorganize “welfare for older people” and “health for older people” as the Long-Term Care Insurance to make health, medical care and welfare related long-term care services universally available. Below, the purposes and basic philosophy of the Long-Term Care Insurance, and its operating mechanism will be outlined.

### **1.2.1 Purpose and Basic Philosophy**

The Long-Term Care Insurance Act specifies that the purpose of this system is to “provide necessary health care services and welfare service benefits” for people in need of long-term nursing care to “maintain dignity and independence according to their abilities in their daily lives.”

The three basic concepts of Long-Term Care Insurance are “self-support,” “user-oriented,” and “methodology of social insurance.” As described under the purpose of the system, Long-Term Care Insurance goes well beyond simply taking care of the immediate needs of older adults requiring long-term care, but rather is based on the philosophy of “self-support” of older adults. In addition, the concept of “user-oriented”

is realized by the comprehensive and efficient provision of appropriate health and welfare services from a variety of providers, based on the choices of the user, and based on the physical and mental condition of the user and their living settings. Also, it is a social-insurance based program based on the philosophy of national solidarity. The relationship between the benefits and contributions is clear, which ensures objectivity and fairness.

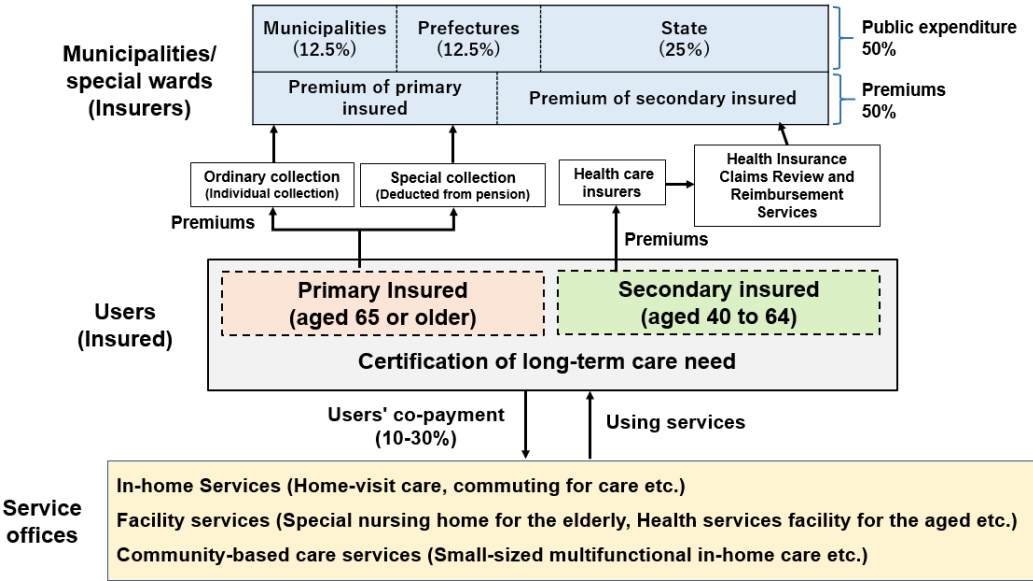
**1.2.2 Structure of the Long-Term Care Insurance**

Table 1-1 shows the outline of the Long-Term Care Insurance, and Fig. 1-7 shows the operating mechanism.

Table 1-1 Outline of the Long-Term Care Insurance

Financial Resources	Premiums (50%), tax (50%)		
Insurers	Municipalities, special wards (Tokyo 23 Wards)		
Insured	Primary insured	Secondary insured	
	Eligible persons	Persons aged 65 or older	Health Insurance subscribers between 40 and 64 years old
	Eligibility for benefits	People requiring long-term care (bedridden, or in a condition requiring long-term care due to dementia etc.) People requiring support support is needed for daily life)	Persons requiring support or long-term care due to specific disease caused by aging
Collection of premiums	Collection by municipalities (Persons with a certain amount of pension have pension deducted)	Collection by health insurers with health insurance premiums	
Benefits	Long-term care benefits and prevention benefits (Benefit in kind. Reimbursements are sent to service providers for users.)		
User Co-pay	10-30% co-pay, depending on income		

Source: Created based on MHLW materials



Source: Created based on MHLW materials

Fig. 1-7 Long-Term Care Insurance Operating Mechanism

## **(1) Financial Resources**

Financial resources are made up of 50% transfer from national/local governments (tax) and 50% premiums, and the breakdown of the government transfer is 25% from the national government, 12.5% from prefectures, and 12.5% from municipalities. 5% of the 25% borne by the national government is used for risk adjustment among municipalities with different income and aging levels. By doing this, the burden of insurance premiums are not too high for municipalities in which the percentage of persons aged 75 or over are higher or residents' income levels are lower than in other municipalities.

## **(2) Insurers**

The insurers of the Long-Term Care Insurance are municipalities (1,718 municipalities nationwide) and special wards (23 Tokyo wards). Insurers carry out the work of certifying the requirement for long-term care, providing insurance benefits, and imposing and collecting the premiums of primary insured.

## **(3) Insured**

The insured are divided into "primary insured" and "secondary insured," where those aged 65 and over are classified as "primary insured" and medical insurance subscribers aged between 40 and 64 are "secondary insured." The requirements for receiving benefits and method of collecting premiums differ for primary and secondary insured.

Primary insured receive support or long-term care when it is required. Secondary insured are able to receive required support or nursing care only for 16 specific diseases caused by aging.

In terms of the collection of insurance premiums, they are collected by municipalities for primary insured. In principle this is deducted from pension payments, and if the pension received is less than a certain amount it is collected separately. Premiums for secondary insured are collected from the medical insurer together with medical insurance premiums.

## **(4) Certification of long-term care need**

To receive benefits, the need for long-term care or support is to be certified, and applications for this are made to municipalities. When a municipality receives an application for certification of the need for long-term care or support from a resident, they send out a certification investigator to perform a certification investigation (primary decision), and following this, a secondary decision is made by a Long-Term Care Certification Examination Committee of outside members established by the municipality. The degree of care required is classified, from mildness, as Support Required 1 – Support Required 2, and Long-Term Care Required 1 – Long-Term Care Required 5.

## **(5) Use of services**

Table 1-2 shows the types of long-term care services. Long-term care insurance services can be "long-term care benefits" for those certified as needing long-term care, or "prevention benefits" for those certified as needing support. Prevention benefits are paid for the purpose of preventing the worsening of conditions until they require long-term care.

Table 1-2 Types of Services

	Designated and supervised by prefectures, government-designated cities and core cities	Designated and supervised by municipalities
Long-Term Care Benefits	<p>[In-home services]</p> <ul style="list-style-type: none"> <li>• Home-visit care services (home-visit care services, Home-visit bathing services, Home-visit nursing cares, Home-visit rehabilitations, etc.)</li> <li>• Commuting for care (Commuting for nursing care, Commuting rehabilitation services)</li> <li>• Short-term stay services</li> <li>• Lending welfare equipment</li> <li>• Provision of specific welfare equipment, etc.</li> </ul> <p>[Facility services]</p> <ul style="list-style-type: none"> <li>• Welfare facilities for the elderly requiring long-term care</li> <li>• Health care facilities for the elderly requiring long-term care</li> <li>• Sanatorium type medical care facilities for the elderly requiring care</li> <li>• Integrated Facility for Medical and Long-term Care</li> </ul>	<p>[Community-based long-term care services]</p> <ul style="list-style-type: none"> <li>• Small-scale multifunctional in-home and community-based care</li> <li>• Community-based commuting for care</li> <li>• Night time home-visit care</li> <li>• Commuting care for elderly with dementia</li> <li>• Care in communal living for elderly with dementia (group homes)</li> <li>• Care for elderly in community-based specific facilities</li> <li>• Care for elderly requiring long-term care in small-scale nursing care institutions facilities</li> <li>• Regular visiting/on demand home-visit long-term/nursing care</li> <li>• Combined multiple service (multi-functional long-term care in a small group home and home-visit nursing)</li> </ul> <p>[Home care support (Care plan creation, Care management)]</p>
Prevention Benefits	<p>[Preventive services]</p> <ul style="list-style-type: none"> <li>• Home-visit care services (Preventive home-visit bathing care, Preventive home-visit care, Preventive home-visit rehabilitation, etc.)</li> <li>• Commuting for care (Preventive home-visit rehabilitation)</li> <li>• Short-term stay services</li> <li>• Lending preventive welfare equipment</li> <li>• Provision of specific preventive welfare equipment, etc.</li> </ul>	<p>[Community-based preventive services]</p> <ul style="list-style-type: none"> <li>• Preventive commuting care for elderly with dementia</li> <li>• Preventive small-scale multifunctional in-home and community-based care</li> <li>• Preventive care in communal living for elderly with dementia ((group homes)</li> </ul> <p>[Nursing care prevention support]</p>

Source: Created based on MHLW materials

When using these services, care management is provided by a care manager. Care managers create a care plan which combines the long-term care insurance services suitable for each user, and then coordinates communication with relevant organizations. Care plans are reviewed on a regular basis according to the condition and wishes of users.

Out-of-pocket expenses to users for long-term care insurance services are limited to 10-30% of the cost of the service according to the user's income. For those aged 65 or over that earn a certain level of income or higher, they pay 20%, and for those aged 65 or over whose income level is equivalent to that of working generation, they pay 30%.

### 1.3 Implementation of the Long-Term Care Insurance and the development of a Community-based Integrated Care System

The Long-Term Care Insurance, which was introduced in 2000 as a mechanism to support the long-term care of older adults by all of society, changes the provision of long-term care within society by enabling users to choose comprehensive health, medical and welfare services. The following highlights the impacts and challenges after the implementation of this Long-Term Care Insurance, based on the circumstances from the start until the revision of the law 5 years later. It also explains the background and policy direction that sought

the Community-based Integrated Care System.

### 1.3.1 Health and welfare for older people following the implementation of Long-Term Care Insurance

#### (1) Issues arising from the implementation of the Long-Term Care Insurance

By shifting from a government's rationing to an individual's contract, it became easier to use long-term care services, without having to submit to a government income test etc. However, various issues have begun to arise in the operation of this system.

Due to users being able to select their own long-term care services, the number of people certified as needing long-term care has been rising year after year. Fig. 1-8 shows the trend in the number of people certified as needing long-term care over 5 years, and here a particular increase can be observed in people with mild conditions (support required, long-term care required 1). Support required increased 2.2 times in 5 years, and long-term care required doubled.

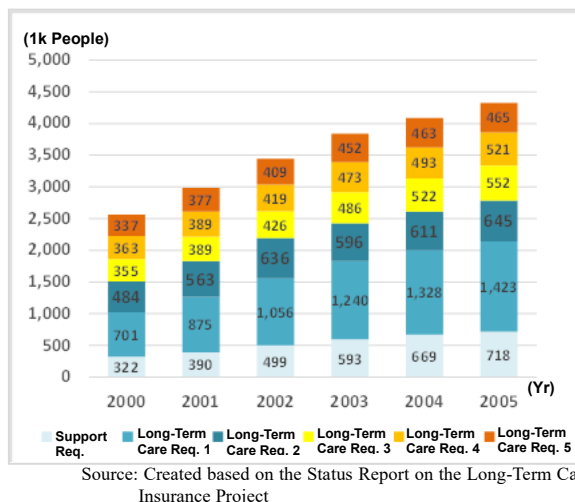
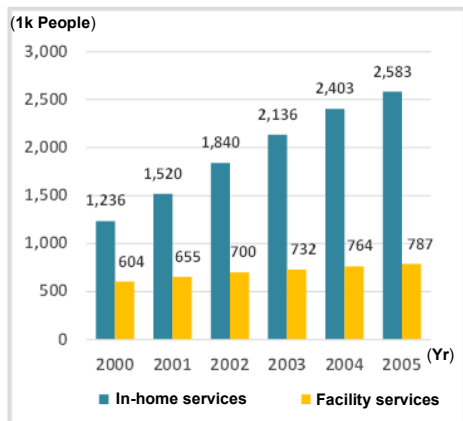


Fig. 1-8 Trend in the Number of People Certified as Needing Long-Term Care

On the other hand, in comparison with people with moderate to severe conditions (long-term care required 2 and above), it is also clear that the proportion of those with mild conditions whose degree of long-term care required improved was low. While the aim of the Long-Term Care Insurance is to provide preventive benefits to people with support required to prevent them from becoming classified as long-term care required, the fact is that this has not been the effect.

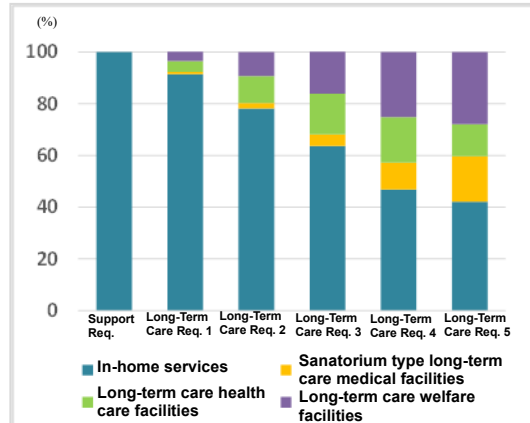
In addition, of long-term care services offered at home and in institutions, the number of users of home services in particular have increased significantly (Fig. 1-9), and looking at the breakdown of these users, many of these users of home services have mild conditions, while the majority of those with serious conditions use institution-based services (Fig. 1-10). According to a survey conducted by the Cabinet Office regarding the type of housing of those that need long-term care, about 60% of older persons wished to continue living at home, while fewer than 20% wished to enter a facility. These things show that services under the Long-Term Care Insurance have been unable to support people in their own homes, and thus have been unable to provide older adults with the lives that they wish<sup>10</sup>.

<sup>10</sup> Elderly Long-Term Care Study Group Report "Towards the Establishment of Elderly Long-Term Care –Care to Support the Dignity of the Elderly in 2015" (2003)



Source: Created based on the Status Report on the Long-Term Care Insurance Project

Fig. 1-9 Trend in the Number of Beneficiaries by Service Type (Monthly Average)

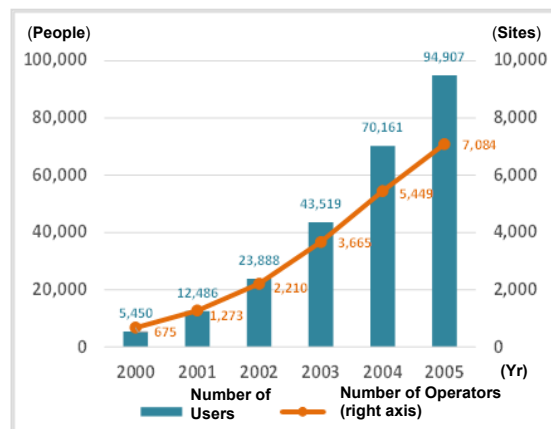


Source: Created based on "Elderly Long-Term Care 2015"

Fig. 1-10 Service Usage by Degree of Care Required (April 2003)

An analysis of the results of certifications of the need for long-term care also revealed that the effects of dementia were observed in about half of people needing long-term care<sup>11</sup>. Fig. 1-11 shows the trend in the number of users and providers of daily living care in communal living for persons with dementia (group homes), and both increased rapidly over 5 years, and that the need to care for older adults with dementia are increasing. Dementia care is also a central issue for older people's long-term care from the perspective of maintaining dignity, and it is clear that further studies are needed in the future.

In addition, care management was also introduced in the Long-Term Care Insurance, with care managers to provide long-term care services in a planned manner to suit each individual, but there are many diverse issues faced by older persons and it is difficult to resolve all of these within the scope of services under long-term care insurance. Therefore, it became clear that there was a need not only for support under the Long-Term Care Insurance arranged by care managers, but also to consider various ways in which older adult's living could be supported within the community.



Source: Created based on the Survey of Long-Term Care Service Facilities and Operators

Fig. 1-11 Trend in the Number of Users and Providers of Daily Living Care in Communal Living for Older Adults with Dementia

## (2) Changes in social values

The aging of the population, as well as increases in chronic illnesses such as cancer and heart disease, and dementia, and an increase in the number of older persons living alone have brought changes not only to long-term care, but also to medical thinking and health values.

<sup>11</sup> Elderly Long-Term Care Study Group Report "Towards the Establishment of Elderly Long-Term Care –Care to Support the Dignity of the Elderly in 2015" (2003)

In the past, the focus of medical treatment had been “curing” disease and a “hospital-based model” medical care system was adopted which aimed for treatment/lifesaving, recovery, and rehabilitation in individual hospitals. However, with many older people having multiple chronic diseases for a long time, it is important that patients living with illnesses are “supported” by medical care, and that the patients also place importance on prevention and on working to maintain and improve day-to-day health. The aim was to realize a “community-based model” of providing medical care which takes advantage of the characteristics of hospitals and clinics and shares their functions to support the lives of patients in the community and to guarantee needed medical care in cooperation with the entire community<sup>12</sup>. Also, the values of patients with respect to health emphasize not only the curing of illnesses, but also how to secure and improve the quality of life while living with illness.

### **1.3.2 In search of a community-based integrated care system**

As described in 2.3.1, further challenges related to the health and welfare of older adults have emerged since the introduction of Long-Term Care Insurance. As many older people wish to continue to live in the communities to which they are accustomed, each individual has their own challenges, from those living with dementia, to those severe cases requiring long-term care and those living alone etc., and it is difficult to meet all the needs of older persons with just services under the Long-Term Care Insurance alone. It also became clear that services under the Long-Term Care Insurance alone were insufficient for maintaining and improving physical and mental health. An integrated approach was required to realize life in the community where older adults could be watched over and supported by the community and could make their own efforts to maintain health and prevent their conditions from becoming serious. Below, the perspectives sought by a community-based integrated care system and the issues behind such an approach will be described.

#### **(1) Collaboration of various regional resources**

Older people have a diverse range of living needs, from the illnesses they have to the level of physical independence, forms of families and ways of life. Communities contain many resources and actors that support older people’s living, including governments and medical institutions, long-term care service providers, NGOs and volunteers, etc., but there was no coordination system in place for such resources, and they were fragmented. For services related to medical and long-term care and everyday living support to be provided in a continuous and integrated manner, it was necessary to encourage the cooperation of all community resources from the perspective of the life of older people themselves.

#### **(2) Enhancement of self-support and mutual support**

While the preventive benefits of the Long-Term Care Insurance are aimed at improving the care-dependence level through the use of its services, this was not fully effective, and the number of older adults that need mild support/long-term care were increasing. It is important for older people themselves to work on promoting health and preventing frailty, and to reduce the period for which they will require long-term

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<sup>12</sup> Interim Report of the National Commission on Social Security Second Subcommittee (Service guarantees (Medical, Long-term Care, Welfare)) (2008)

care as much as they can. In addition, as the number of healthy older people in a community increase, the older people themselves build a support system in which they are active participants. By enhancing self-support and mutual support along with institutionalized mutual assistance services such as long-term care insurance and medical insurance etc., this can be expected to enhance the effectiveness of each.

**(3) Realizing dignified lives**

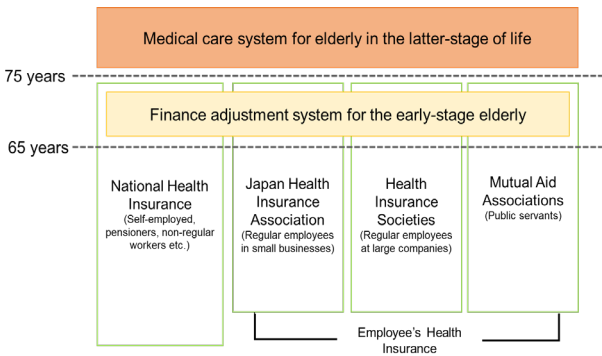
As specified in the Long-Term Care Insurance Act, the basic philosophy behind long-term care is maintaining the dignity of older persons. Even when older persons require long-term care, it is important that they are still able to continue to live life in their own way and to make their own decisions. In the support of older people, it is a requirement that experts and non-experts such as local volunteers etc. support the decision-making of the older person that they support, and that they respect their decisions. This makes it possible for older people to live with dignity.

**(4) Initiatives based on local characteristics**

The aging of communities differs in characteristics between urban and rural areas, and even between rural areas, and in the future the differences between communities are only expected to grow. Also, the generation that is about to become the older population are expected to have even more diverse needs, having experienced the period of high economic growth, and having diverse values. As the characteristics of various communities and the image of older persons diversify, there is a need to develop measures that are suited to those communities and to the individuality of the residents that make up those communities.

**Column – Japan’s Medical Insurance System**

As shown in Fig. 1-12, the structure of Japan’s medical care insurance system can be roughly divided into various employment-based programs for employees, the area-based National Health Insurance for the informal population, and the medical care program for persons aged 75 years or over. There is also a risk adjustment scheme for the early-stage older people, which sharing the burden of medical expenses for people aged between 65 and 74 among the National Health Insurance and Employee’s Health Insurance programs. This was introduced to eliminate an imbalance in the burden between health care insurers arising from the aging of people insured under National Health Insurance as those that had moved from employee’s health insurance programs to National Health Insurance after their retirement.



Source: Created based on MHLW materials

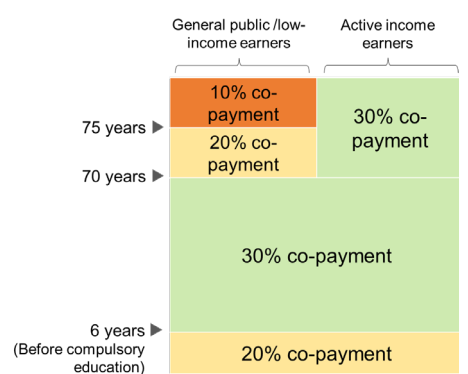
Fig. 1-12 Structure of Social Health Insurance System



The social health insurance system is the foundation for providing medical services to all citizens. The enrollment and contribution is obligatory. When receiving medical services, citizens can choose any medical institution (“free access”) and the benefit package is the same for everyone regardless of their health insurance programs.

Fig. 1-13 shows the patient’s co-payment of medical expenses. It is 20% for children under the age of 6 who have not begun compulsory education and is 30% for those aged 6 to 69 years. For those aged 70 to 74 the copayment is basically 20%, but active income earners pay 30%.

People 75 years or over basically pay 10%, but here too active income earners pay 30%.

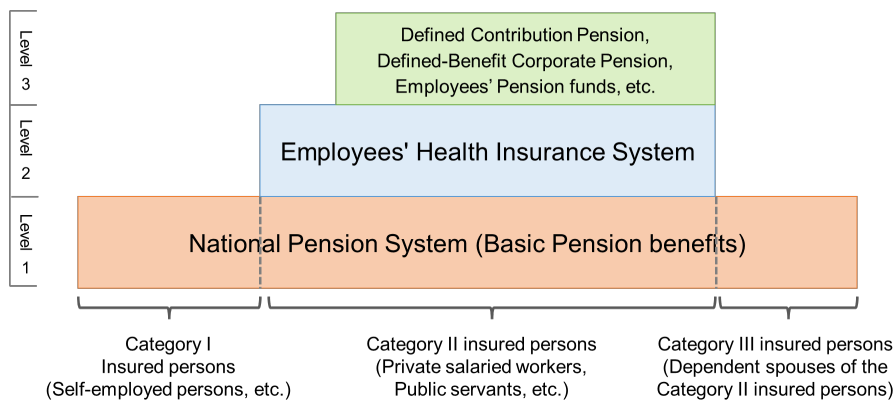


Source: Created based on MHLW materials

Fig. 1-13 Percentage of Partial Burden of Medical Expenses (Patient’s Co-pay)

### Column – Japan’s Pension System

Fig. 1-14 shows the structure of Japan’s public pension insurance system. Japan’s public pension insurance system is a “three tier” system, where the first tier is the National Pension program in which everyone enrolls (basic pension), the second tier is the Employee’s Pension program which insures salaried workers and other employees, and the third tier is private pensions that people can voluntarily join. The purpose of the first tier, the National Pension program, is to guarantee a minimum basic income required for living in old age, and all residents of Japan between the age of 20 and 59 must enroll.



Source: Created based on MHLW materials

Fig. 1-14 Structure of the Pension Insurance System

This pension insurance system is outlined in Table 1-3. The insured under the National Pension program are divided into three categories: primary insured, secondary insured and tertiary insured. The primary insured include mainly the self-employed, farmers and the unemployed etc. The premium amount is fixed. The secondary insured are people that work for a company under the Employee’s Health Insurance

program, sharing premiums 50-50 between the employer and the employee. The tertiary insured are dependent spouses of the secondary insured, and premiums are borne by the pension program in which the spouse is enrolled. In all cases, the benefits of old-age pensions are in principle paid from 65 years, but this can be brought forward to the age of 60 or deferred until 70.

The operation of this system adopts a pay-as-you-go system that provides pensions for the current recipients with funding from premiums paid by the current contributors, and in addition to premiums, funding is also provided from the transfer from the national government and the investment income from reserve funds.

Table 1-3 Outline of the Pension Insurance System

Financing system	Pay-as-you-go		
Source of Funds	Premiums, government transfer, reserve funds		
Insured	Primary insured	Secondary insured	Tertiary insured
Targets	Persons between the age of 20 and 59 residing in Japan who are not secondary or tertiary insured (self-employed, farmers, unemployed etc.)	Insured under the Employee's Pension program, and members of mutual aid associations (private sector salaried workers, civil servants)	Dependent spouse of secondary insured, between the age of 20 and 59
Insurance premium	Fixed amount.	Shared 50-50 by employer and employee. Premiums proportional to salary/wage.	No premiums (borne by spouse's pension program).
Benefits	In principle, 65 years or over, although may be possible to receive in advance from 60 years or to defer until 70 years.		

Source: Created based on MHLW materials

### Column – Japan's Public Assistance program

The public assistance program is a national government's program guaranteeing the constitutional right that "all people shall have the right to maintain the minimum standards of wholesome and cultured living (Right to a minimum standard of living)." Japanese citizens have the right to receive protection indiscriminately and equally for needs in living to the extent that they meet the criteria set out in the Public Assistance Act.

Public assistance is provided on the basis of a person in need not being able to live without it, after exhausting all available assets, working ability and benefits from other programs (pensions, allowances etc.) within their household as well as dependencies and assistance between parents and children etc. Therefore, to receive payment a means test is necessary.

The public assistance program is funded by the national government and by prefectures and municipalities. The proportion of funding from the prefecture and municipality depends on whether there is a welfare office in the place of residence or municipality of the person requiring assistance.

Regarding the relationship between public assistance and long-term care insurance, even if a person is

receiving public assistance, the people aged 65 or over and the people enrolled in social health insurance programs between the age of 40 and 64 are insured under long-term care insurance. If insured under long-term care insurance, the co-pay amount of long-term care insurance (10% of the cost of services) is paid as benefits from the public assistance program (“long-term care assistance”). People who are not covered by the Long-Term Care Insurance because they are not enrolled in social health insurance programs can receive long-term care services under the public assistance program as long-term care benefits<sup>13</sup>.

Regarding the relationship between public assistance and social health insurance program, recipients of public assistance are excluded from the National Health Insurance program. Therefore, most medical care for recipients of public assistance is provided by the public assistance program as “medical care assistance benefits,” and the full amount of all medical expenses are paid from the public assistance program.

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<sup>13</sup> Recipients of public assistance are excluded from the National Health Insurance, so the majority of them do not have medical care insurance and are provided long-term care assistance.



# Chapter 2. Concepts and Mechanisms of Japan’s “Community-based Integrated Care System”

In the previous Chapter, the background to the idea of Community-based Integrated Care System in Japan was articulated, such as the changes to health and welfare measures for older people and associated social changes since the 1950s, and the issues that emerged from the implementation of the long-term care insurance in 2000. This Chapter will give an overview of policy developments for the Community-based Integrated Care System and will define the system, before describing the concepts and mechanisms of Community-based Integrated Care. Finally, the roles of the Community-based Integrated Care will be introduced, from the perspective of an older adult.

## 2.1. What is the Community-based Integrated Care System?

### 2.1.1 Development of the Community-based Integrated Care System

As mentioned in Chapter 1, since the start of the long-term care insurance in 2000, while many older adults wished to live in their own communities, it became clear that services under the long-term care insurance alone would not be able to make it possible for them to continue to live at home. Also, with an increasing number of older adults having dementia or living alone etc., the challenges facing each older person became more diverse and complicated. In response to this, the decision was made to try to establish a “Community-based Integrated Care System” as a mechanism to provide integrated services in cooperation between health, medical, long-term care and welfare services so that older adults can continue to live in the communities with which they are accustomed.



The first official government document to mention a “Community-based Integrated Care System” was the report of the Elderly Long-Term Care Study Group,<sup>14</sup> “Towards the Establishment of Elderly Long-Term Care and Care to Support the Dignity of the Elderly in 2015,” which was published in 2003. This report established that there was a challenge in continuing living at home, and it presented the idea of a community-based integrated care system.

Following this, the Community-based Integrated Care System was clearly positioned under the Long-Term Care Insurance Act and other related laws, as shown in Fig. 2-1. Also, for health service provision, there was a transition from the “hospital-centered model”, which aimed at complete recovery from illnesses, to the

<sup>14</sup> A Study Group of experts appointed by the Director-General of Health and Welfare Bureau for the Elderly of the MHLW in 2003.

“community-based model”, which maintains and supports life in the community while coexisting with illness. That prompted the development of a medical care provision for the community-based integrated care system. The Community-based Integrated Care System was initially built targeting the year 2025 where the baby boomer generation would be 75 years or over, but now it is required to establish a system that realizes an inclusive and symbiotic community for a diversified and pluralistic society looking ahead to 2040 when the junior baby boomers will reach the age of 65.

### 2.1.2 Definition of the Community-based Integrated Care System

The Ministry of Health, Labor and Welfare defines the Community-based Integrated Care System as follows:

*“A system providing integrated support and services in the community to maintain the dignity of elderly people and support their independence, so that they can continue to live, to the extent possible, in their own way in the communities to which they are accustomed to the end of their lives.”<sup>15</sup>*

\*Parenthesis added

The Community-based Integrated Care System consists of the five elements of housing, medical care, long-term care, preventive care, and daily living support, with the basic concept being to provide these things in an integrated manner to be available within everyday living areas (community-based). Furthermore, this mechanism was intended to be built based on community characteristics and community independence and autonomy, and the management of this process is assumed by local governments (municipalities).

## 2.2. Concepts of the Community-based Integrated Care System

The concepts behind the Community-based Integrated Care System of five elements, four forms of support, integrated care focused on the individual and rooted in the community, and community management, will be described below.

### 2.2.1 Concepts of the Community-based Integrated Care System (1): 5 Elements

The Community-based Integrated Care System consists of the five elements of housing, medical care, long-term care, preventive care, and daily living support. By providing these elements in an interrelated and integrated manner, it can be possible to support living at home.

Table 2-1 Five Elements of the Community-based Integrated Care System

<b>Housing</b>	<ul style="list-style-type: none"> <li>- Housing as the foundation of living</li> <li>- Living that suits the wishes and financial resources of an individual</li> <li>- Living environment for older adults in which they have privacy and full dignity is preserved</li> </ul>	
<b>Medical care</b>	<ul style="list-style-type: none"> <li>- Hospitals providing acute phase care, recovery phase care and rehabilitation as well as general practitioners providing primary care.</li> <li>- Strong cooperation among medical service providers of different ownership and functions.</li> </ul>	Provide together with life support as needed

<sup>15</sup> “Community-based Integrated Care System” on the MHLW website ([https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/hukushi\\_kaigo/kaigo\\_koureisha/chiiki-houkatsu/](https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/hukushi_kaigo/kaigo_koureisha/chiiki-houkatsu/)) (Accessed: May 15, 2021)

<b>Long-term care</b>	- Home- and community-based services such as home visit care, home nursing care and outpatient care etc., as well as services at institution-based care including long-term care welfare facilities for the elderly
<b>Preventive care</b>	- Prevent (delay) frailty and care-dependence as much as possible and even when such care is needed, prevent deterioration as much as possible - Not only individual guidance from professionals, but also resident led activities such as exercises classes etc. that encourage social participation
<b>Daily living support</b>	- Various daily living support services such as security, meals, and shopping etc. - Variety of support as service options as well as a broad range of informal support such as neighbors calling on them and watching out for them, with a diverse array of actors involved

Source: Created with reference to the Report of the Community-based Integrated Care Study Group (March 2013)

Also, in addition to the above elements, “the choices of an individual older person and the attitude of her/him and her/his family” are an important support element of the Community-based Integrated Care. Older adults themselves selecting and determining their own way of life and lifestyle is fundamental, and a mechanism and support structure is needed. This shows the importance of common understanding and shared attitude of an older person and her/his their family towards the kind of life they want to live and how they want to face end of life issues when they need care.

### 2.2.2 Concepts of the Community-based Integrated Care System (2): 4 forms of support

The four forms of support, self-support, mutual support, social solidarity support and governmental support, are the concepts behind how the above-mentioned 5 elements are supported in the community.

Table 2-2 Self-support, Mutual Support, Social Solidarity Support and Governmental Support

<b>Self-support</b>	Efforts of the individual and family living together Includes self-care and the purchase of market services on one’s own
<b>Mutual support</b>	Relatives, friends, and neighbors etc. helping each other Includes the activities of support groups, volunteers (including paid) and resident organizations etc.
<b>Social solidarity support</b>	Benefits and services under social insurance programs such as medical services, pension benefits, long-term care benefits, etc. Burdens shared by peers (insured) who share risks
<b>Governmental support</b>	Tax-based welfare services and public assistance

Source: Created based on MHLW materials

As shown in Fig. 2-2, the Community-based Integrated Care System is a system that combines four support functions, and which is built based on balancing the resources that support the community with inter-relationships. By combining these things, it is possible to complement each other for the support needed for living in community.

It is necessary to keep in mind that the sharing of roles between self-support, mutual support, social solidarity support and governmental support changes depending on the era and community. For example, in the past in Japan, long-term care for older persons was meant to be family members’ role, and the roles

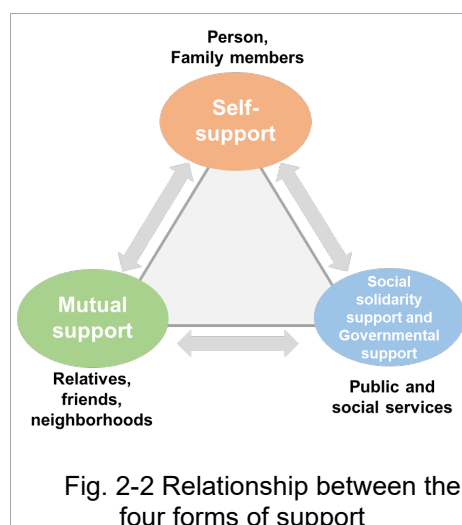


Fig. 2-2 Relationship between the four forms of support

of mutual support and governmental support were relatively small. With an increase of nuclear families and advancement of women's social participation, there came a need to socialized external long-term care, which meant a shift from self-support and mutual support to social solidarity support or governmental support. Services under the Long-Term Care Insurance became to play a large part in long-term care for older adults.

The role sharing of self-support and mutual support also differs depending on the community. In other words, since the social background of the era and the characteristics of communities differ, roles of the four forms of support need to be considered and created by the citizens within each community.

### **2.2.3 Concepts of the Community-based Integrated Care System (3):**

#### **“Community- based Care” x “Integrated Care”**

The core concepts of the Community-based Integrated Care System that Japan is aiming for include community-based care that expresses care which is community specific and rooted in the community, and integrated care which aims for the integrated provision of medical and long-term care services.

#### **(1) Community-based care**

Community-based care refers to the provision of necessary care and support, including housing, medical care, long-term care, preventive care, and daily living support, within the living area of older persons by a variety of both formal and informal actors. Here, community is defined as “the area of daily living in which necessary services are provided, within a distance of about 30 minutes.” The aim is to provide care within the area of daily living and not in locations that are far away from home, so that a person can continue to live in the community with which they are accustomed.

#### **(2) Integrated Care**

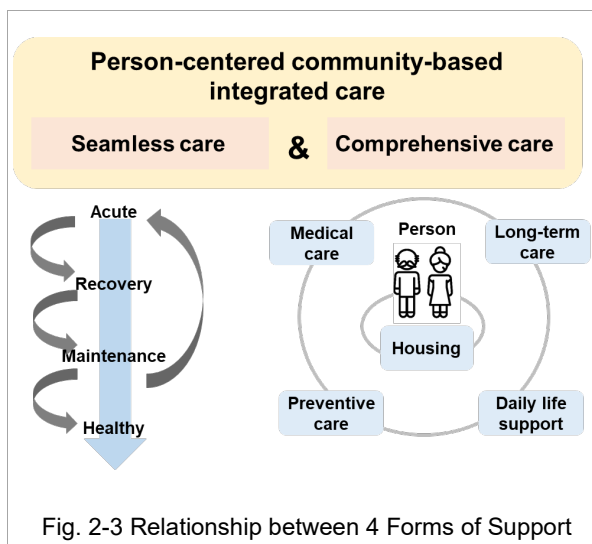
From the start of the Long-Term Care Insurance, one of the challenges in older people continuing to live at home in their own communities was the fragmented nature of local resources to support their living, and it was noted that this system of cooperation was not sufficiently established. Even when there were resources within a community, since these had existed separately and independently, it was difficult to provide continuous and integrated support based on the needs of each older individual. For this reason, it was not possible to establish continued living within the community. To deal with this, the aim of the Community-based Integrated Care System was to build a unified service provision system by bringing together medical and long-term care in particular.



The important thing about integrated care is considering and providing care with the individual at the core. From the perspective of the individual, it is necessary that care not be intermittent, or in other words that care is provided seamlessly.

As shown in Fig. 2-3, integrated care has two aspects: “Seamless care” and “Comprehensive care”.

Seamless care refers to the functional integration in the fields of medical and long-term care during the acute, recovery and maintenance phases, providing team care through multidisciplinary collaboration with a focus on the condition, needs and wishes of the individual. This also meant strengthening cooperation between medical and long-term care service providers and connecting hospitals and communities with continuous services. From the acute phase through the recovery and maintenance phases, the locations and professionals providing the care will also change. Even so, it is essential that there is collaboration between stakeholders and organizations to provide seamless care.



Even so, it is essential that there is collaboration between stakeholders and organizations to provide seamless care.

Comprehensive care means that in addition to medical and long-term care, all the various community resources such as housing, preventive care, and daily living support necessary for living at home are provided in an integrated and unified manner. That is, while a variety of actors as community resources including governments, medical institutions, long-term care service providers, NGOs and volunteers etc. provide care, comprehensive care can only be provided when there is a system that integrates all these actors. The fact that this system integration includes not only formal services such as medical and long-term care insurance services, but also informal support in the form of community support (mutual support) is said to be characteristic to Japan.

#### 2.2.4 Concepts of the Community-based Integrated Care System (4): Community management

In building a Community-based Integrated Care System, the process requires management. In Japan, this is referred to as community management, and is led by municipalities, who are the insurers of long-term care insurance. This means that there will be an attempt to build a Community-based Integrated Care System that suits the characteristics of each community.

It has been shown to be important in community management that the local stakeholders share goals and a way of thinking about what kind of community they want to create, based on the local conditions, needs, issues and available resources. It is also necessary in order to achieve the goals of the community to manage the process of identifying and developing local resources related to the 5 elements of the Community-based

Integrated Care System, based on self-support, mutual support, social solidarity support and governmental support, and to manage how these will be combined and will cooperate in a balanced manner.

This ends the description of the outline of Japan's Community-based Integrated Care System. Fig. 2-4 shows an illustration of the system based on these concepts.

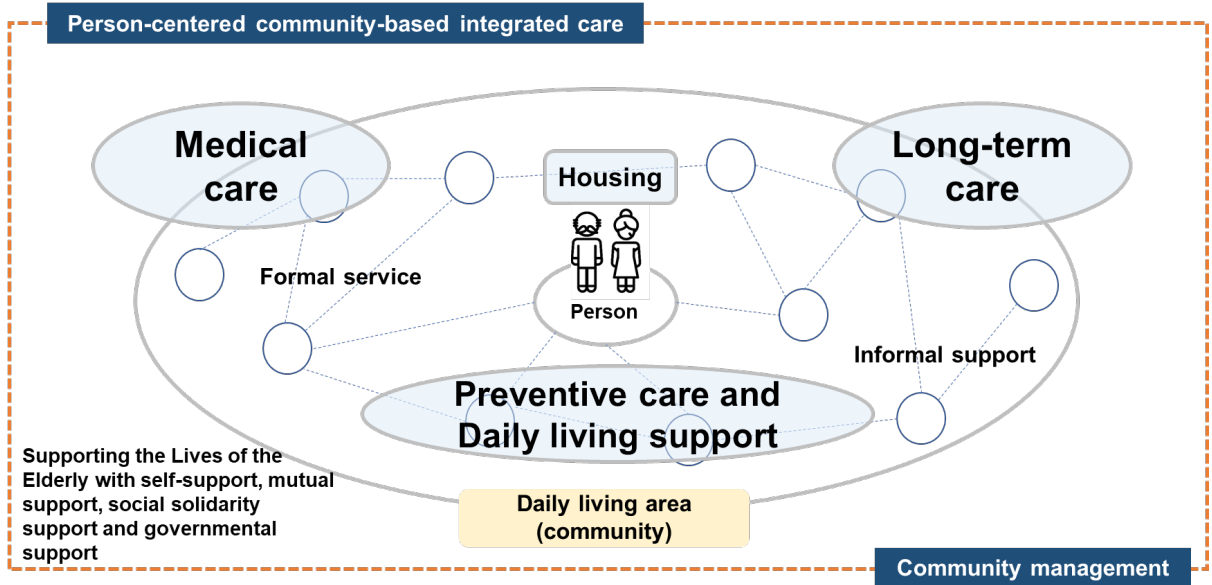


Fig. 2-4 Japan's Community-based Integrated Care System

### 2.3. Mechanism of the Community-based Integrated Care System

This section will describe the specific method of building the Community-based Integrated Care System.

#### 2.3.1 Mechanisms of the Community-based Integrated Care System (1): Roles of the National Government, Prefectures, and Municipalities

As decentralization has been promoted in Japan, many of the work and authority related to social welfare, including in the fields of old-age, disabilities, and child welfare, have been delegated back to municipalities, the most basic level of self-governing units. The authority of municipalities as the insurer of long-term care insurance has also been strengthened. In this sense, municipalities have been in charge of the building of Community-based Integrated Care Systems, with the national and prefectural governments providing backup mechanisms.

Below, the roles of the national, prefectural, and municipal governments in building the Community-based Integrated Care System will be outlined.

##### (1) Role of the National Government

In addition to the formulation of laws and regulations and the presenting of policy measures related to health and welfare for older people, the national government also provides financial support to municipalities for long-term care services. The national government also holds Councils and Study Groups and implements model projects etc., formulating guidelines and directives and tools etc. for promoting community-based integrated care, and works to address disparities between local governments.

For example, the national government has provided the “Community-based Integrated Care ‘Visualization’ System” website as an analytical tool for municipalities and prefectures to conduct community management. This information system centralizes various information related to the building of Community-based Integrated Care Systems, including information related to long-term care insurance, making it able to be obtained in an easy-to-read form using graphs etc.

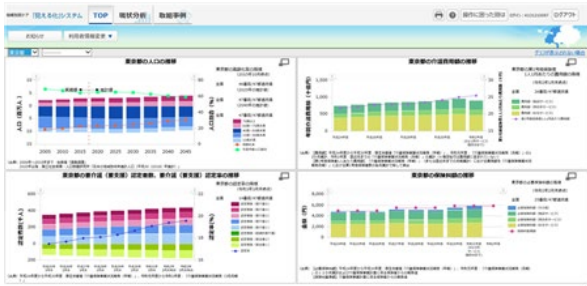


Fig. 2-5 “Community-based Integrated Care ‘Visualization’ System” Website

##### (2) Role of Prefectures

Prefectures also have a supporting role in the efforts of municipalities in building Community-based Integrated Care Systems. “Support Plan for Long-term Care Insurance Implementation” and “Regional Medical Care Plan” etc. are formulated based on the circumstances and issues of each prefecture, and policy measures and medium to long-term strategies are presented. In addition, the community management of municipalities is supported through implementing training for municipalities, providing technical advice and implementing model projects in the region etc. Municipalities vary in size, but for those in particular with a

small population and weak financial base, it is often the case that one staff member is in charge of all tasks related to health and welfare for older people, so logistical support from the prefecture is important.

In addition, the prefecture is primarily responsible for ensuring health service provision in its area. To realize the construction of a Community-based Integrated Care System, it is a requirement to work in collaboration with municipalities to develop home medical care and strengthen cooperation in long-term care services that meet the needs of older persons in the community. In this regard, prefectures were instructed by the national government from 2015 that the concept of community medical care was being formulated, and they have been formulating and promoting action plans to realize this, while considering the ideal form for this medical care system based on estimated needs for medical care in 2025.

### **(3) Role of Municipalities**

#### **◆ Formulate plans**

Regarding health and welfare for older people, municipalities are legally required to formulate “Municipal Elderly Welfare Plans” based on the Welfare Act for the Elderly and “Municipal Long-Term Care Insurance Implementation Plans” based on the Long-Term Care Insurance Act every three years. These plans set out the goals and measures, program implementation plans and service provision systems etc. for health and welfare for older people, including long-term care insurance. In addition, since 2015 the national government has positioned long-term care insurance implementation plans as “Community-based Integrated Care Plans,” strengthening efforts for the building and promotion of a Community-based Integrated Care System. These plans are created consistently with the “Prefectural Elderly Welfare Plans” and “Prefectural Support Plan for Long-Term Care Insurance Implementation” which are also legally required.

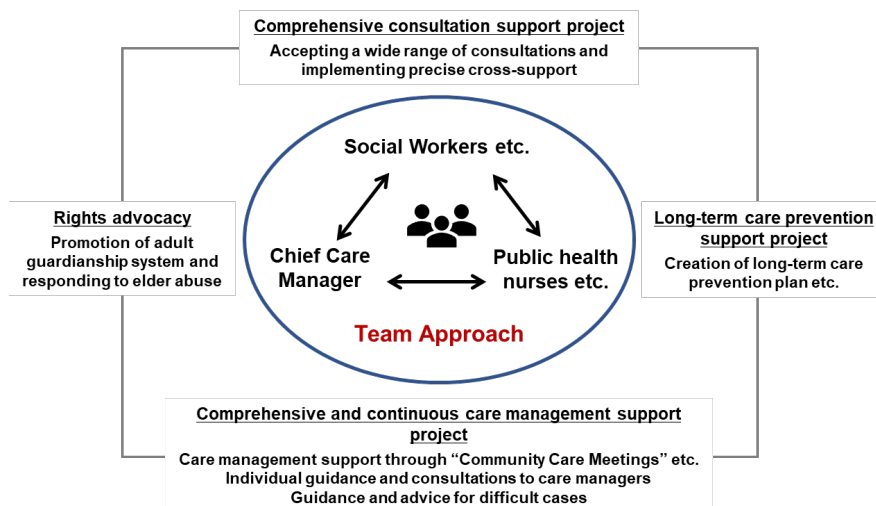
#### **◆ Establishment and operation of Community-based Integrated Support Centers**

Community-based Integrated Support Centers are the core office of Community-based Integrated Care Systems and are established by municipalities and either operated directly or outsourced. The number of these centers and their target areas are determined by municipalities considering consistency with daily living areas. As of April 2020, these were installed in 5,221 locations nationwide<sup>16</sup>.

As shown in Fig. 2-6, in addition to being responsible for creating a cooperative system between relevant parties and institutions, these centers provide comprehensive consultations and advocacy for older people in the community and implement long-term care prevention support activities, as well as supporting community care meetings and care managers, providing comprehensive and continuous care management support. Public health nurses, social workers and chief care managers are placed in these centers.

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<sup>16</sup> “Community-based Integrated Care System” on the MHLW website  
([https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/hukushi\\_kaigo/kaigo\\_koureisha/chiiki-houkatsu/](https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/hukushi_kaigo/kaigo_koureisha/chiiki-houkatsu/))  
(Accessed: June 1, 2020)



Source: Created based on MHLW materials

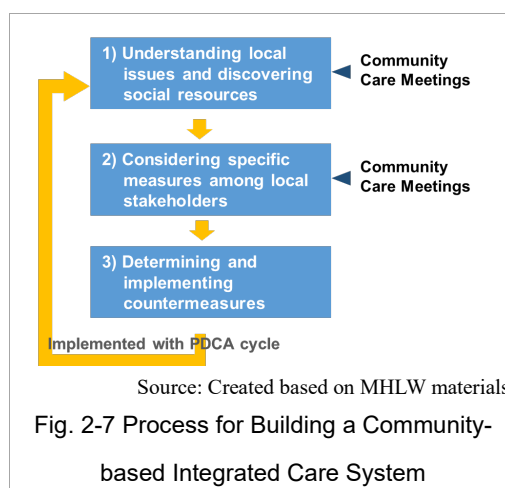
Fig. 2-6 Role of Community-based Integrated Support Centers

### 2.3.2 Mechanisms of the Community-based Integrated Care System (2): Community Management

As introduced under the concepts, the management of building Community-based Integrated Care Systems, that is, community management, is led by municipalities, which are the basic administrative units. The specific methods of community management are described below.

#### (1) Building Community-based Integrated Care Systems Utilizing the PDCA Cycle

Municipalities are given guidance as shown in Fig. 2-7 from the Ministry of Health, Labor and Welfare for the process of building a Community-based Integrated Care System. Given that the population structures, community resources and social environment etc. all differ depending on the community, first, it is important to “(1) understand the conditions in the community,” and then based on the community issues and resources that become clear from this, “(2) consider specific measures” and “(3) implement these based on the formulated plan.” This process operates under the PDCA cycle.



Source: Created based on MHLW materials

Fig. 2-7 Process for Building a Community-based Integrated Care System

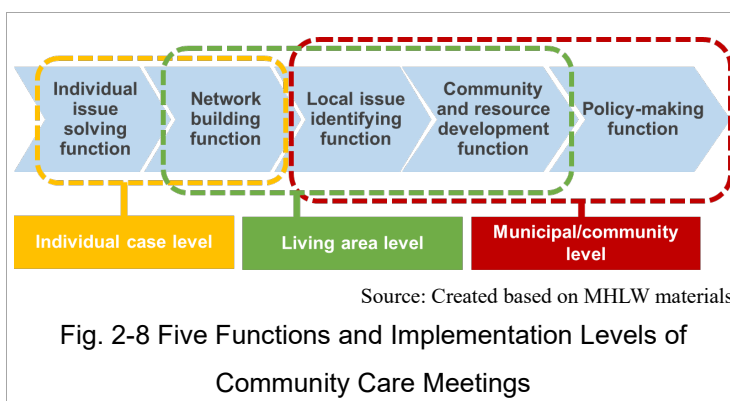
Also, within this PDCA cycle, what is important is clarifying the answer to the question of “What kind of community do you want to create?”, sharing this with the community, and setting specific evaluation indicators to work towards achieving it. For municipalities, these solutions are expected to be clear within the “Long-term Care Insurance Implementation Plans” mentioned above<sup>17</sup>.

<sup>17</sup> However, in reality the evaluation is that “many municipal plans do not set specific goals or means of achieving them in the building of a

## (2) Utilization of Community Care Meetings

“Community Care Meetings” are utilized as part of the PDCA cycle process for building a Community-based Integrated Care System. This is a mechanism for promoting both the enhancement of support for individual older adults and to improve the social infrastructure that supports them, and the holding of these Community Care Meetings is prescribed within the Long-Term Care Insurance Act. By supporting individual cases through multidisciplinary collaboration, these meetings have the functions of not only building a community support network, but also discovering community issues, developing community resources, and formulating necessary policy.

As shown in Fig. 2-8, Community Care Meetings have five functions, and depending on the function and the cases being considered, these can be established at each level of individual cases, daily life areas, and municipalities. Municipalities use these meetings and encourage the collaboration of all relevant parties to deal with individual issues and to develop systems for the entire community.



### 2.3.3 Mechanisms of the Community-based Integrated Care System (3): Seamless Care

In the provision of seamless care, various specialized institutions and professionals are involved such as in medical care, nursing care, rehabilitation, long-term care, dentistry, and medication, etc. To promote cooperation between these various institutions and professionals, it is necessary to have a shared awareness of the issues, to set goals, to smoothly share information, and to have a clear role-sharing. The following is a list of methods taken to promote the provision of seamless care.

#### (1) Community Collaborative Critical Pathway

The community collaborative critical pathway is generally referred to as the community collaborative pathway. With respect to what the critical pathway is, this is an idea that began to be introduced in US industry in the 1950s and was also partially introduced into Japanese medical institutions in the 1990s, as a medical treatment plan developed as a means of providing quality medical care in an efficient, safe, and proper manner. The community collaborative critical pathway in Japan is the creation of a medical treatment plan for moving from acute hospital care to recovery hospital care and then back home as soon as possible, and this is used and shared by all medical institutions in providing medical treatment, so that patients can receive medical care without worry, with the presenting and explaining of the medical treatment that they will receive in

Community-based Integrated Care System, but merely reorganize existing programs and activities around the five (structural) elements (of Community-based Integrated Care)” and “there are few examples in which there are verifiably objective outcome indicators set for the evaluation of achievements.” (Reference material: Community-based Integrated Care Study Group (March 2016), “Community-based Integrated Care Systems and Community Management,” p. 18)

advance, including the roles of the multiple medical institutions that will be involved in their treatment.

Today, these pathways are shared by parties involved in medical and long-term care within communities, and this is used as a tool for building cooperative systems between medical institutions and organizations related to medical and long-term care as overall medical care plans from the start of treatment to living at home, to help quickly return to home after going through the processes of acute to recovery hospitalization (rehabilitation hospitals). By creating a medical treatment plan from the acute phase to returning to home, using this to clarify the roles of related institutions and professionals, and sharing this information, a mechanism is created to support patients by a team of multiple professionals at different service providers. With such a mechanism, patients can receive consistent and seamless treatment (Fig. 2-9).

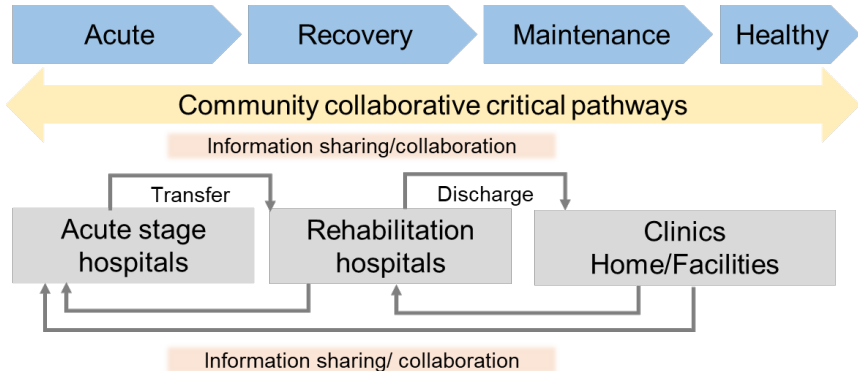


Fig. 2-9 Community Collaborative Critical Pathway

**(2) Hospitalization and Discharge Support<sup>18</sup>**

Seamless support is promoted, including at the time of hospitalization and discharge, so that even if a person gets sick and is hospitalized, they will be able to continue to live their lives in a familiar community after discharge. The mechanism under the social health insurance to realize this used to be the add-on reimbursement payment for discharge support. That has been changed to be for admission and discharge support now. Admission and discharge support is provided mainly for those patients<sup>19</sup> that are expected to have difficulty in leaving hospital. More specifically, interviews are carried out with patients and their families from the early stages prior to hospitalization to check living conditions and medical and welfare service usage, providing an orientation about hospitalized life and screening patients that may have difficulty with discharge. By doing this it is possible to understand issues with discharge at an early stage and by sharing this information among different professionals a systematic response to discharge can be developed.

Also, as part of discharge support, discharge support nurses (staff) can be placed in the ward, collaboration with local medical institutions and care managers, and multidisciplinary conferences are promoted. Also, to support the smooth transition to home care, add-on reimburse payment is made for home visits by nurses

<sup>18</sup> MHLW MHLW Health Insurance Bureau, Medical Economics Division “Outline of Medical Fee Revisions 2018 – Medical Department I” (May 2018) (<https://www.mhlw.go.jp/file/06-Seisakujouhou-12400000-Hokenkyoku/0000198532.pdf>) (Accessed: June 11, 2021)

<sup>19</sup> People living in poverty, people who require a reorganization of their lifestyle after hospitalization due to a decline in ADL compared to prior to hospitalization, people who are not in a good environment for receiving adequate care, and people who are repeatedly hospitalized and discharged etc.

immediately after discharge. With these measures, it is expected that discharge can be supported, looking ahead to returning and continuing to live at home.

**(3) Home medical care and long-term care cooperation promotion program<sup>20</sup>**

For older people that need both medical care and long-term care to continue living at home, starting with those that have chronic illnesses, there needs to be cooperation between medical and long-term care service providers in the community so that home medical and long-term care need to be provided in an integrated manner. To promote such a cooperation, the Long-Term Care Insurance Act sets out the “home-based medical and long-term care collaboration promotion program” to be implemented nationwide.

Fig. 2-19 outlines this project. Under the coordination of municipalities, a consultation desk is set up at a local doctors’ association etc. as a base for supporting collaborative home-based medical and long-term care, and in cooperation with Community-based Integrated Support Centers a collaborative system of related organizations within the community is constructed. Related organizations include hospitals and clinics for home-based care, home care nurse providers, pharmacies and long-term care service providers etc. Centered around this base, these related

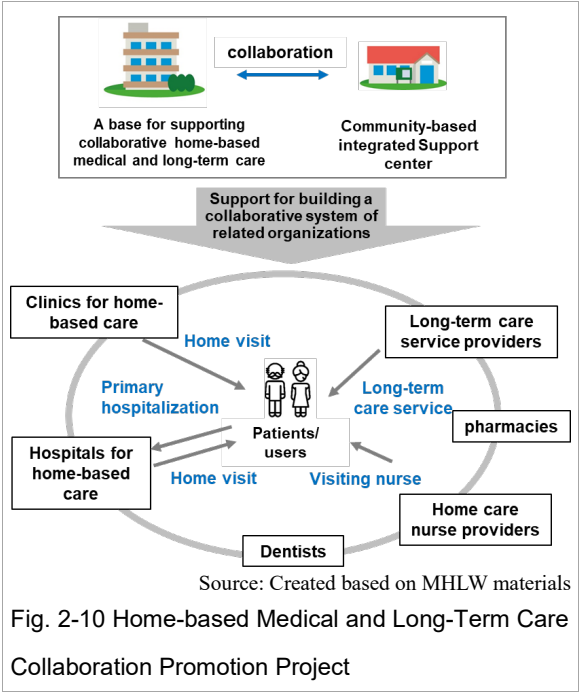


Fig. 2-10 Home-based Medical and Long-Term Care Collaboration Promotion Project

organizations gather to discuss issues in multidisciplinary collaboration, providing a home-based medical care service that can respond 24 hours a day to establish a system that provides home-based medical and long-term care services in an integrated manner.

**2.3.4 Mechanisms of the Community-based Integrated Care System (4): Comprehensive Care**

To realize the provision of comprehensive care including housing, medical care, long-term care, preventive care and daily living support, various formal and informal community resources need to be connected and their cooperation needs to be encouraged. There is also a need to develop resources if certain resources are insufficient. The following initiatives are for these purposes.

**(1) Daily Living Support System Development Program<sup>21</sup>**

The number of older persons that live alone and require only mild long-term care but still need support is

<sup>20</sup> MHLW Health and Welfare Bureau for the Elderly, Division of the Health for the Elderly “Home-based Medical and Long-Term Care Collaboration Promotion Project Handbook Ver. 3” (September 2020) (<https://www.mhlw.go.jp/content/12400000/0006666660.pdf>) (Accessed: June 11, 2021)

<sup>21</sup> MHLW Health and Welfare Bureau for the Elderly, Promotion Division “Basic Concepts of Integrated Long-Term Care Prevention and



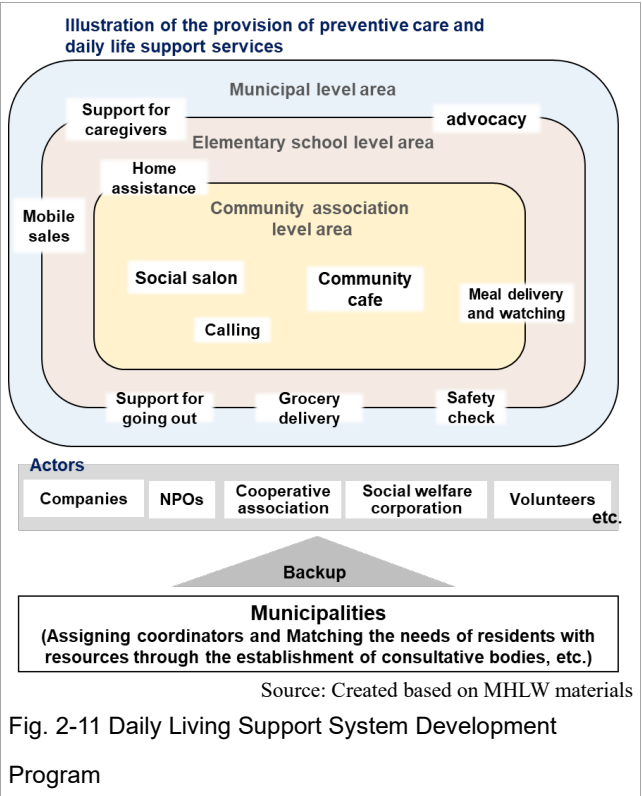
increasing, along with the need for frailty prevention and daily living support. Formal services by specialists are insufficient to fully support these frailty prevention and various daily living needs, so the participation of various actors including community residents, volunteers, NPOs, and private companies etc. is required. Also, from the perspective of prevention, it is important to be able to continue to do the activities that the individual wishes to do, and to continue to interact with the community, so there is a need for various opportunities for social participation in the community. Given this situation, municipalities have implemented “Daily Living Support System Development Programs.” These programs are also known as “community creation” which support the community with various actors.

As shown in Fig. 2-11, calling on older people, assisting them with housework, delivering meals and watching over and checking on their safety are all activities that are required for frailty prevention and daily living support. These activities are backed up by municipalities to ensure that they are provided by various actors in the community. The placement of “living support coordinators” and the establishment of “consultative bodies” are ways in which these various actors can be connected and can create a supportive community.

◆ Living Support Coordinators

Living support coordinators, also known as “community support promoters,” work inside communities to encourage the collaboration of various stakeholders and organizations and play a role in promoting the enhancement of resident-led activities in which older adults participate and various other services. More specifically, they develop resources by creating services that are lacking and training support workers etc., build networks between stakeholders, and match community resources and services with the needs of older adults.

As an example of these initiatives, holding exercise classes and cooking classes etc. to provide opportunities for residents to interact with each other and train older volunteers, giving them purpose. There are also examples of package delivery and meal delivery providers that watch over older adults and establish an emergency contact system.



Daily Life Support Project\*  
 (https://www.mhlw.go.jp/file/06-Seisakujouhou-12300000-Roukenkyoku/0000192996.pdf) (Accessed: June 11, 2021)

#### ◆ Consultative Bodies

The establishment of Consultative Bodies is prescribed as a platform for the collaboration of community residents and related parties to promote community development. These are teams in which stakeholders work together towards community development. Consultative bodies are expected to include living support coordinators at their core, with members including local residents, Residents' Association members, local organizations such as senior citizens' clubs and local merchants' associations, NPOs and private companies etc. The geographical scope of consultative bodies can be of two, the entire city (layer 1) and daily living areas (layer 2) according to local community conditions. Activities of these consultative bodies vary, but can include considering systems to watch older adults, and the management of resident-led living support activities or gathering places (salons etc.).

#### **(2) Individual Community Care Meetings**

The Community Care Meetings held by Community-based Integrated Support Centers are called "Individual Community Care Meetings," where there is collaboration between multiple disciplines such as medical care and long-term care to consider support for individual cases and work to solve problems. Development of care manager's practical skills are expected through the meeting by examining individual cases.

In the examination of individual cases at Community Care Meetings, it is not just about coordinating long-term care services, but by bringing various stakeholders together such as medical and long-term care specialists, as well as social workers, community welfare officers and residents' association representatives etc., consideration is given to comprehensive care including social participation and daily living support.

## 2.4. Role of Community-based Integrated Care System from the Perspective of Life Stages

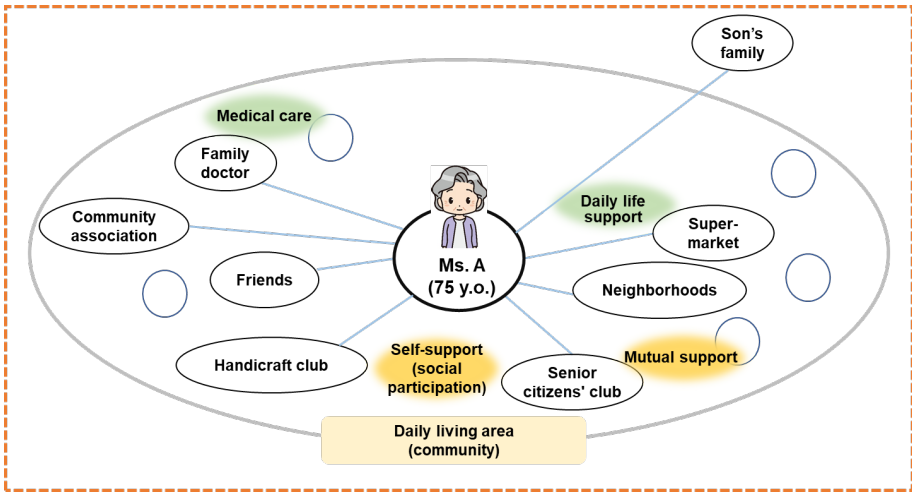
Here, based on the content so far, we will describe the community living of an older person (Ms. A), who lives in a community where a Community-based Integrated Care System is promoted.

### (1) Ms. A, 75 years

- Widowed, lives alone in her own home for many years.
- Has one son who married and lives two hours away by car.
- Makes regular visits to a clinic because of her high blood pressure.
- Does her own housework, including shopping, cooking, and cleaning etc.
- For household chores that are difficult to take care of on her own, such as replacing light bulbs or removing heavy garbage etc., she asks her son's childhood friend who lives next door for help. Also, for large shops, she uses the nearby supermarket's delivery service.
- Teaches a handicraft club at the senior citizens' club to which she belongs, using her own skills at handicraft.
- Has many friends that live in her community and enjoys getting together with them for tea and to go on trips.
- Discussed moving to live with her son and his wife but Ms. A wanted to continue living in the community where she has lived for many years.

At 75 years, Ms. A has connections with various people in the community and lives her own life. She is also active socially, enjoying time with friends, and serving as an instructor in a handicraft group etc. As a result, she maintains her physical and mental health (self-support).

Also, what she can't do for herself, she is able to get help for by asking a friend in the neighborhood (mutual support). In addition, although she lives alone, she can do so without any problems, getting the daily living support that she needs by utilizing supermarket services etc.



**(2) Ms. A, 83 years**

- Two years ago, she fell from the stairs while on a trip and broke her hip. She was hospitalized in a secondary medical institution for treatment and rehabilitation for about 3 weeks.
- This triggered weakness in her legs, making it difficult to cook for herself, so she often buys ready-prepared meals. The inside of the house is not adequately cleaned. She has also stopped participating in her favorite handicrafts group and attending tea parties with her friends.
- Symptoms of dementia are also beginning to appear, with her not knowing where her home is when she goes out etc., and her son and his wife, her friends, and acquaintances in the neighborhood worry about Ms. A.

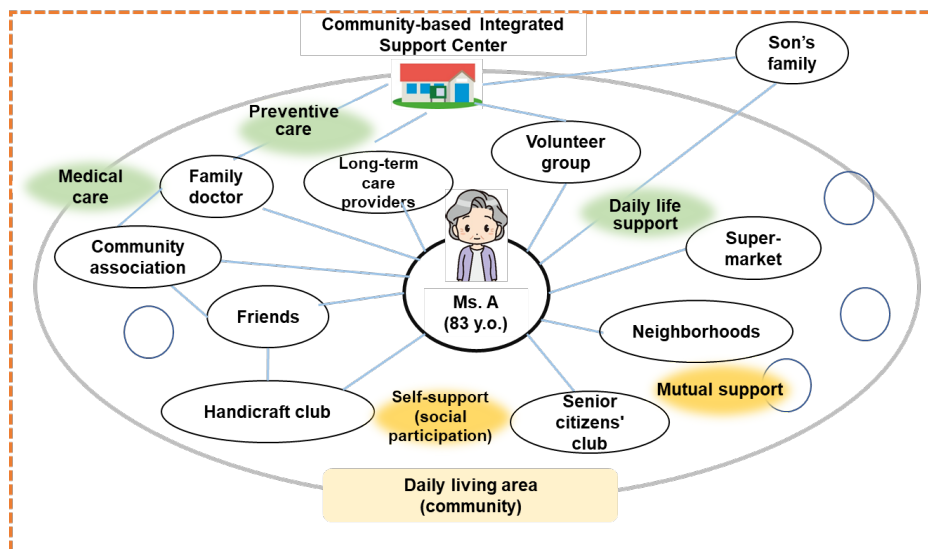


- Ms. A's son has consulted with the Community-based Integrated Support Center in Ms. A's area. A care manager formulated a preventive care plan, which includes weekly visits to a day service center for functional training.
- Also, at the introduction of the Community-based Integrated Support Center, she is called in on and has meals delivered by a community volunteer group.
- A friend from her handicraft group that is aware of her situation comes to her home to pick her up, and takes her to the handicraft group, so that opportunities to go out are increasing little by little.

Due to the deterioration of her mental and physical functions the opportunities to go out are reduced, and some housework becomes difficult, which makes living independently more difficult, but after consulting with the Community-based Integrated Support Center various community resources have become involved with Ms. A including connecting with community volunteer group, and Ms. A is able to return more and more to her own life.

With the coordination of the care manager, she has begun going to a day service for preventive activities and she has regained greater motivation to participate in society. Also, with the support of friends, she has rejoined the handicraft group activities, leading to further motivation from being able to contribute to the community as a handicraft instructor.

Even with symptoms of dementia, it is still possible to live with peace of mind with the support of a watchful volunteer group.

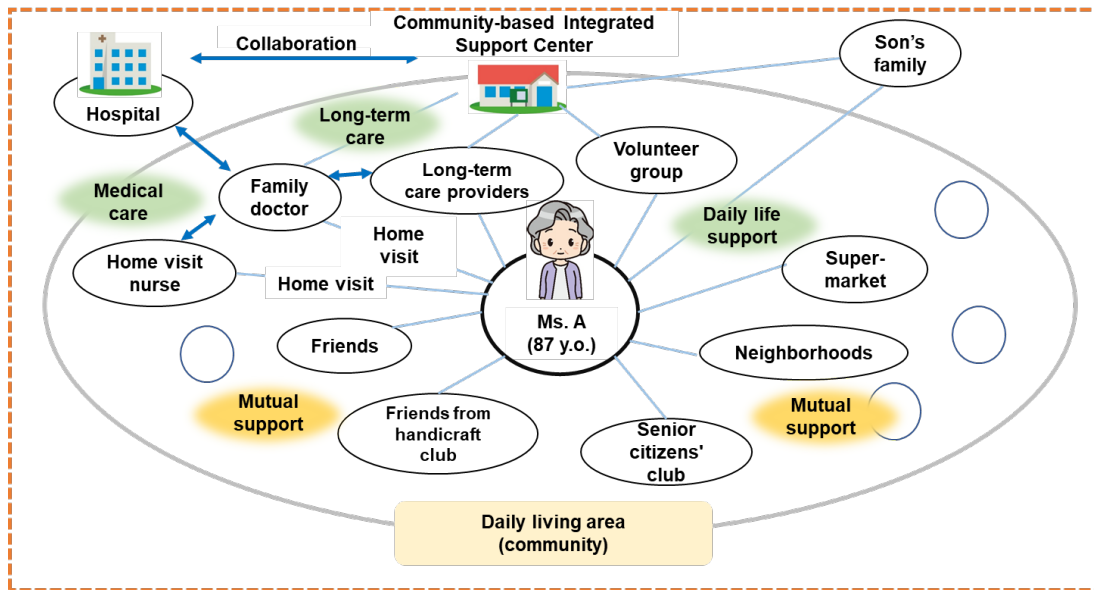


### (3) Ms. A, 87 years

- Two years ago, she has a cold which triggered pneumonia, for which she was hospitalized. Since then, she has had similar symptoms twice and has been repeatedly hospitalized and discharged.
- The degree of long-term care required has advanced and she spends most of her time at home. She is able to go for short walks, take meals and go to the toilet on her own.
- In collaboration with a secondary medical institution, home-visit nursing station and long-term care service provider, the care manager of the Community-based Integrated Support Center coordinates the necessary care for Ms. A, including home-visit nursing and bathing etc.
- She is still called on and received meals and shopping support from a volunteer group.
- She is visited by friends, members of her handicraft group, and her grandson, and while going out is limited she still has connections with people.
- Ms. A herself and her son's family are discussing with her doctor how she would like to spend her final days.

She has had repeated hospitalization due to pneumonia, but with the collaboration of the secondary medical institution in which she was hospitalized, as well as the Community-based Integrated Support Center, and the clinic, long-term care service provider and home-visit nursing station in the community where she lives, Ms. A is provided seamless care from hospitalization to discharge and living back at home.

Also, along with the coordination of the Community-based Integrated Support Center care manager, members of the volunteer group that have been involved with Ms. A for many years continue to provide support for parts of her daily life. In addition, Ms. A is able to live the life that she wants in connection with people that she loves, such as friends and neighbors etc.



### Chapter 3. Practicing Community-based Integrated Care <sup>22</sup> in Japan: Three Cases

This Chapter will introduce efforts in the three following areas as examples of the provision of integrated medical care and long-term care, and the implementation of comprehensive living support services under the Community-based Integrated Care System developed in Japan. In extracting practical cases, areas were selected that may have useful implications for developing countries in terms of respective area’s characteristics in providing medical care, long-term care, and living support services.

- ◆ Komagane City, Nagano: Case of self-management support for stroke patients
- ◆ Fujisawa City, Kanagawa: Cases in an urban area
- ◆ Higashiomi City, Shiga: Cases in a rural area

In addition, in putting together these cases, a literature research and interview survey were conducted. The subjects of the interview survey are shown in Table 3-1.

Table 3-1 Subjects of Interview Survey

	Area	Name of Institution/Organization	Name	Interview Date
1	Komagane City	Komagane City Office Community Health Division Prevention Care Section	HAMA, Tatsuya	Feb 5, 2021
2	Fujisawa City	Grundtvig Co., Ltd.	Representative Director SUGAHARA, Kensuke	Feb 24, 2021
3		Aoi Care Co., Ltd.	Representative Director KATO, Tadasuke	Mar 24, 2021
4		Fujisawa City Welfare Department Community Symbiotic Society Promotion Office	SATO, Yasutomo ISHIDA, Daisuke	Apr 13, 2021
5	Higashiomi City	Higashiomi City Eigenji Clinic	Director HANATO, Takashi	Feb 19, 2021

<sup>22</sup> In this paper, all care provided under the Community-based Integrated Care System is referred to as “Community-based Integrated Care.”

Outline of Surveyed Municipalities (Data from the same year is used to compare the three cases (differ from figures within the text))

	Item	Komagane City	Fujisawa City	Higashiomi City
Basic Information	Area*1	165.86 km <sup>2</sup>	69.57 km <sup>2</sup>	388.37 km <sup>2</sup>
	Total population (2015)*1	32,759	423,894	114,180
Older population	Population density*1	197.5	6,093.1	294
	Population 65 or over (2015)*1	9,564	99,195	28,095
	Aging rate (2015)*1	29.2%	23.4%	24.6%
	Number of older persons' couple households (ratio) (2015)*1	1,371 households (11.1%)	17,508 households (9.7%)	3,563 households (8.8%)
	Number of single older person's households (ratio) (2015)*1	1,176 households (9.5%)	18,205 households (10.1%)	3,339 households (8.2%)
Long-term Care	Number of people certified as needing support/long-term care (as of end August 2020)*2	1,393	19,620	4,720
	Certification rate (as of end August 2020)*2	14.1%	18.4%	15.7%
Medical Care	Monthly insurance benefits expenditure per primary insured (June 2020)	23,283 yen	19,400 yen	19,791 yen
	Number of hospitals (per 100,000 people)*3	9.1	3.3	6.1
	Number of general clinics (per 100,000 people)*3	96.7	89.2	63.7
	Number of doctors (per 100,000 people)*4	213.8	196.0	158.9

Sources: \*1 Ministry of Internal Affairs and Communications, "Census" (2015)

\*2 MHLW "Long-Term Care Insurance Project Status Report" Monthly Report

\*3 MHLW "Medical Facility (Dynamic) Survey" and Ministry of Internal Affairs and Communications "Population, Vital Statistics and Household Number Survey based on Basic Resident Register"

\*4 MHLW "Survey of Doctors, Dentists and Pharmacists" and Ministry of Internal Affairs and Communications "Population, Vital Statistics and Household Number Survey based on Basic Resident Register"



### **3.1. Self-Management Support to Prevent the Recurrence of Strokes in Komagane City, Nagano – Realizing Integrated Care through Self-Management Support**

Komagane City in Nagano is a small provincial town with a population of 30,000, surrounded by abundant nature, and is famous as a tourist destination. Like other regional towns, the population has been on a downward trend since 2008, and the birthrate is declining and the population aging<sup>23</sup> rapidly. In terms of Community-based Integrated Care in Komagane City, there is an example of medical institutions and local government collaborating to provide seamless care in the implementation of self-management for stroke patients themselves to prevent recurrence.

#### **3.1.1 Outline of municipalities**

##### **(1) Basic information**

Komagane City is located in the southern part of Nagano prefecture and is in an area surround by natural beauty with the Southern Alps mountains to the east and the Central Alps to the west. It has a thriving tourist industry with abundant tourism resources and sees more than 1.2 million tourists visit every year. Its largest industry is manufacturing. The city is also actively engaged in international exchange, with the Japan Overseas Cooperative Association (JOCA) headquarters and the JICA Komagane Training Center.

##### **(2) Population statistics**

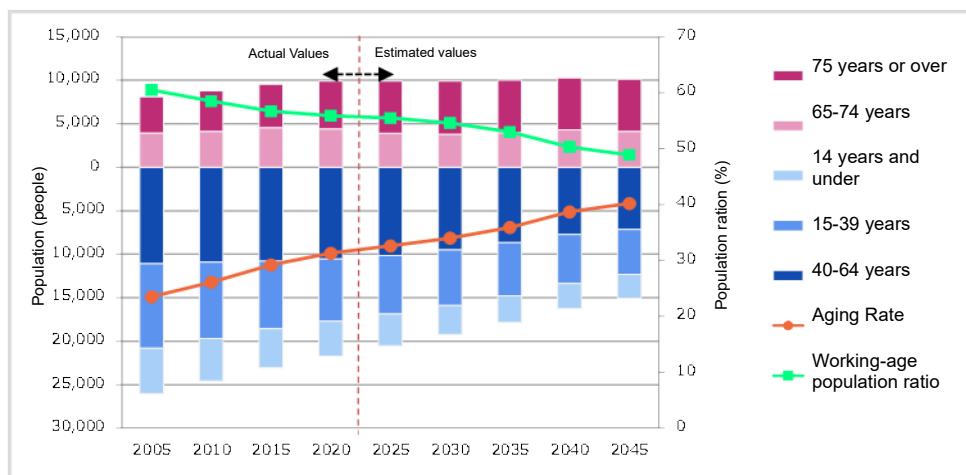
The total population as of 2019 was 32,197, with 13,171 households, of which there were 9,939 elderly people aged 65 or over and 5,503 aged 75 or over, for an aging rate of 30.9%<sup>24</sup>. The city's population has been on a downward trend since 2008, and according to the results of future population estimation the population will continue to decline in this way and is expected to fall below 30,000 (29,091) in 2030<sup>25</sup>. As shown in Fig. 3-1, the young population (0-14 years) and working-age population (15-64 years) also continue to decline in parallel with the population decline, but since the older population has not changed as much the aging rate is expected to exceed 40% by 2045.

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<sup>23</sup> Komagane City Urban Planning Master Plan (2014)  
([https://www.city.komagane.nagano.jp/gyosei/shiseijoho/toshikeikaku\\_keikan/toshikeikaku/2360.html](https://www.city.komagane.nagano.jp/gyosei/shiseijoho/toshikeikaku_keikan/toshikeikaku/2360.html))  
(Accessed: May 10, 2021)

<sup>24</sup> Komagane City Statistics (2019 edition)  
(<https://www.city.komagane.nagano.jp/soshikiichiran/kikakushinkoka/shoshikataisakukakari/2/1/2781.html>)  
(Accessed: May 10, 2021)

<sup>25</sup> Komagane City Urban Planning Master Plan (2014)



Source: MHLW Community-Based Integrated Care Visualization System

Fig. 3-1 Trend in Komagane City Population

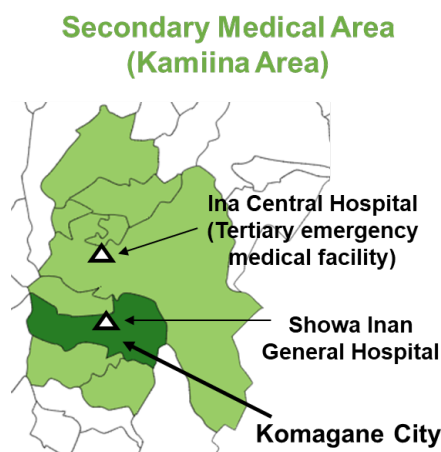
### (3) Current state of the older population

In 2019 the aging rate of Komagane City was 30.9%, which is higher than the national average (28.4%). As of the end of July 2019, there were 1,403 people needing support or long-term care (number of certified persons), accounting for 14.2% of the older population (certified rate). In the future, as the population aged 85 or over increases, the number of people certified as needing long-term care is also expected to increase<sup>26</sup>. In addition, 1,155 people, or 11.8% of the older population, live alone (as of 2018) and this percentage is also increasing year by year<sup>27</sup>.

### (4) Medical service provision and daily living areas

As shown in Fig. 3-2, the Kamiina secondary medical area in which Komagane City is located consists of 8 municipalities. The Ina Central Hospital in Ina City is responsible for tertiary emergencies.

The Showa Inan General Hospital located in Komagane City is a hospital owned by a cooperative of four municipality governments. This hospital has a total of 300 beds, including 233 acute care beds and a 35 recovery beds, and from October 2017 a Community-based Integrated care Ward<sup>28</sup> with 32 beds was also



Source: Created based on "Nagano Community Medical Care Concept"

Fig. 3-2 Kamiina Secondary Medical Area and Core Hospitals

<sup>26</sup> Komagane City (March 2021) "Komagane City Elderly Welfare Plan/8<sup>th</sup> Long-term Care Insurance Business Plan (Draft)" (<https://www.city.komagane.nagano.jp/material/files/group/3/hukusikeikaku,kaigohokennziguoukeikaku.pdf>) (Accessed: May 10, 2021)

<sup>27</sup> Komagane City Statistics (2019 edition)

<sup>28</sup> Community-based Integrated Care Wards are wards that provide rehabilitation according to medical conditions so that patients in stable medical condition after acute treatment who can be discharged from hospital are able to return home with confidence.

opened<sup>29</sup>.

In terms of daily living areas, Komagane City is divided into three areas, to the north, south and east, and each is overseen by a Community-based Integrated Support Center under the direct management of the city.

### **3.1.2 Outline of activities**

#### **(1) Background and recognition of issues**

From 2010, the city set up a forum for discussions with medical professionals toward the formulation of a vision for long-term care for dementia and has studied what kind of system can be created within the community. This has resulted in the creation of fertile soil for both the city and medical professionals to consider what community they should create.

For the causes of needing care in the city's long-term care insurance, dementia ranked first (30%), followed by stroke (20%). The stroke mortality rate was about 1.5 times the national average, and there were many cases of recurrence within a year after discharge. Through an analysis of this situation by the city's long-term care insurance staff, it was recognized as an issue, and this was then shared with citizens and medical and long-term care and welfare service providers. It was then decided to work on this issue as a national research project.

90% of the city's emergency patients are transported to the Showa Inan General Hospital, the most common diseases being brain diseases. City officials already had a face-to-face relationship with the director of the Showa Inan General Hospital, and after sharing an awareness of the above issue cooperation was obtained to implement the research project. For the year between October 2014 and September 2015 there were 224 stroke cases at the hospital, and of these, there was a high number of 46 recurrences (20.5%), and of these 46 cases it was confirmed that 14 of them (30.4%) recurred within 1 year. It also became clear that with recurrence the degree of care required was also more severe<sup>30</sup>.

In this way, based on this actual data from the hospital, officials from the hospital were positive towards working on this project. Until this point, the hospital had thought that "treatment is over when people are discharged," but by showing them the data that the large number of cases of recurrence and readmission after discharge, this thinking changed to considering whether something could be done during hospitalization to prevent recurrence. They started thinking that it may be possible to prevent recurrence by sharing information necessary to prevent recurrence with the patient and family while they were hospitalized and by providing support in the form of discussions even after discharge.

In response to this, Komagane City decided to implement a project to improve the self-management skills

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<sup>29</sup> Showa Inan General Hospital New Reform Plan (FY 2017-2020)(<http://www.sihp.jp/download/kaikaku-plan/kaikaku-p-end.pdf>) (Accessed: May 10, 2021)

<sup>30</sup> Tataka Tsutsui (2019) "Deepening the Community-based Integrated Care System: Change management using the integrated care theory," Chuohoki Publishing Co., Ltd.

of patients hospitalized and discharged due to stroke.

**(2) Details of the project and results**

A self-management support system was developed for use from hospitalization to discharge and living back at home, for government and medical institutions to collaborate to prevent the recurrence of stroke in patients. This is a system that supports the self-management of the patient with the cooperation of the municipality, hospital, accompanying service providers (Community-based Integrated Support Center and Care Manager), internal medicine/attending doctor, the patient and their family.

Through this self-management project, the number of patients with recurrence and readmission decreased. As of the end of September 2017, of the 8 people that participated in the model project, only one patient had a recurrence or readmission 8-21 months after discharge. In 2018, 9 patients received self-management support, and all of them have been able to continue to live at home.

**Column – Self-management**

The purpose of self-management is to minimize the impact on mental and physical condition and functionality from chronic illness, and self-management efforts include symptom management, illness treatment, responding to the physical and mental effects of symptoms peculiar to the chronic disease, and lifestyle improvements. Also, self-management carried out by the patient and medical professionals together.

(Reference: Tsutui and Higashino (2015) “Establishment of ‘Self-management Support’ as part of Japan’s Community-based Integrated Care System”, Management and Information: Bulletin of the School of Management and Information, University of Shizuoka 27(2), 27-35, 2015-03)

**3.1.3 Details of activities**

Table 3-2 shows the self-management support implementation process. This is a simplified version of the self-management support implementation process created by Komagane City as part of the research project, and it clarifies the roles of each stakeholder at each stage from the time of admission. This makes it possible for stakeholders to share the goals and process of self-management support.

**Table 3-2 Self-Management Support Implementation Process**

	<b>At Admission</b>	<b>During Hospitalization</b>	<b>Before Discharge</b>		<b>After Discharge</b>
Hospital	<ul style="list-style-type: none"> <li>Explain the risk of recurrence and the need for self-management</li> </ul>	<ul style="list-style-type: none"> <li>Provide information for discussion with the accompanying professional</li> </ul>	<ul style="list-style-type: none"> <li>Give necessary advice about the plan</li> </ul>	Discharge Conference	
Municipality (Chief Care Manager)	<ul style="list-style-type: none"> <li>Creation of list of project targets</li> <li>Determination of an accompanying professional</li> </ul>	<ul style="list-style-type: none"> <li>Coordinate date for the accompanying professional to gather information with hospital</li> </ul>	<ul style="list-style-type: none"> <li>Support plan creation</li> </ul>		
Accompanying professional (Care Manager)		<ul style="list-style-type: none"> <li>Use the “Information sharing table” to collect information</li> </ul>	<ul style="list-style-type: none"> <li>Create SM plan (draft)</li> </ul>		<ul style="list-style-type: none"> <li>Check the self-management checklist and health</li> </ul>

→ Currently home-visiting nurse		from the hospital team • Use the “Medical condition self-checklist” to gather information from the patient (family)		management table once a month • Report the results to the attending doctor and city officials
Internal Medicine Doctor			• Give necessary advice about the plan	• Receive report from the accompanying professional and provide the patient with necessary advice
Patient/Family		• Respond to discussion with the accompanying professional	• Express opinions in creating the plan	• Respond to questions from the accompanying professional once a month

Source: Created based on TSUTSUI Tataka (2019) “Deepening the Community-based Integrated Care System”

The specific activities of each step are detailed below.

### (1) Promoting Understanding of the Risk of Recurrence and Self-Management

At the time of admission, the risk of recurrence and the need for self-management are explained to the patient. The nurse in charge of the ward provides preventive education to the patient and motivates the patient to perform self-management after discharge. The patient is encouraged to understand the importance of self-management, being told of the high risk of recurrence. By showing actual data of the rate of recurrence etc., the patient and their family can be convinced of these facts.

### (2) Self-management plan creation

During hospitalization, an accompanying professional collects necessary information from the hospital and the patient and creates a self-management plan based on the intentions of the patient herself/himself. Table 3-3 shows an example of a self-management plan.

Table 3-3 Example of a Self-management Plan (75 years/male)

	Period (discharge to 1 month later)	Mostly kept	Kept about half the time	Not really kept
Medical care	Attend examination on designated date.			
Taking medication	Take medication as prescribed.			
Blood pressure	Measure and record blood pressure in the morning and evening.			
Exercise	Target number of steps per day of 8,000.*			
Meals	Reduce the amount of miso soup by half as prior to hospitalization. Stop pouring soy sauce on dishes.			

\*A fitness tracker is lent out, with wireless communication function throughout the city.

Start using the fitness tracker as soon as it's ready while still in the hospital.

The fitness tracker uploads data to reading terminals installed at medical institutions and public facilities etc. by the city.

Uploaded data can be checked by city officials on a dedicated site.

### **(3) Discharge support**

Hospital officials and the accompanying professional hold a discharge conference where the self-management plan is shared among relevant parties and the content of the post-discharge goals and support policy are confirmed.

In 2016, the hospital established an “Office of Medical and Long-term Care Collaboration” as a mechanism to provide smoother discharge support, and a city coordinator is in place to receive applications for long-term care insurance benefits while patients are still hospitalized. Until this, the patient’s family had to receive guidance on applying for long-term care insurance benefits from a medical social worker at the time of discharge and then go to city hall to apply, but patient information could not be shared between the medical social worker and city hall, so the burden on the patient’s family was heavy. By establishing an Office of Medical and Long-term Care Collaboration within the hospital, consultations for certification and scheduling of certification surveys could be conducted in the hospital, and the hospital and government could work together to consider necessary support. These efforts were also realized through the self-management support project.

### **(4) Self-management companion support**

After discharge, the accompanying professional visits to conduct an interview and follow-up guidance 4 times a year (1, 3, 6 and 12 months later). Initially, the care manager served as an accompanying professional as a welfare professional, but there is currently a system where home-visit nurses act as an accompanying professional to provide guidance and conduct interviews. The background for this was the fact that self-management of medication and exercise to control blood pressure, and meals etc. often require medical follow-up, so the need for accompanying professional to be medical professionals was recognized.

Also, case conferences are held at the hospital once a month, in which the accompanying professional (home-visit nurse etc.), ward chief, Deputy Nursing Director, registered dietitian, physical therapist, social worker and government representative participate, where the execution of self-management plans are monitored and accompanying support is considered.

## **3.1.4 Achievements and future developments for Community-based Integrated Care in Komagane City**

### **(1) Achievements**

As mentioned above, an achievement in the reduction of stroke patients suffering recurrence or readmission was observed. In addition to these direct results, through the series of efforts above, it can be said that another achievement was the fact that integrated medical and long-term support for stroke patients was provided. The progress in the level of coordination and collaboration between core medical institutions, long-term care providers and government officials around support for self-management from the time of admission to discharge, and then return to life after discharge, was another achievement.

## **(2) Future developments**

Based on the results of taking up strokes and establishing a self-management support system in a single clinical department, the introduction of similar initiatives is also being considered for other diseases. For example, there is a recognized issue with the high readmission rate of heart failure.

The establishment of a health improvement and prevention consultation desk is also being considered for a private sector fitness club. A place was needed where residents can easily drop by and have health consultations, and exercise to improve their health, but the current health center doesn't play this role well as it is an administrative contact. Therefore, based on the experience of establishing a medical and long-term care collaboration office in a hospital, a city consultation desk is planned to be set up in a fitness club to be opened in the future. A system will be established to support health consultations and health promotion by placing public health nurses, nutritionists and staff that can provide exercise guidance. This will create an environment in which hospital assessments (appropriate amount of exercise after discharge etc.) can be put into practice.

### **3.1.5 Key points from this case**

In the case of Komagane City, through self-management support for stroke patients, “seamless care” has been realized from acute to recovery care, and then returning to life at home. It also suggested the importance of promoting self-support, that is, the ability of individuals to perform self-management, in promoting community-based integrated care. The following is a consideration of what efforts and initiatives in this case are used to develop a community-based integrated care system.

#### **(1) Factors contributing to the realization of seamless care**

The first factor that contributed to the realization of seamless care was the “shared awareness of the problem and vision” of stakeholders. With the formulation of the vision for long-term care of dementia in 2010, the municipal government took the opportunity to have discussions with medical professionals. These efforts helped government officials to take the view that to promote measures appropriate to the community it was important to learn about the current state of that community from people who knew it well. Conventionally, the role of city administrators was to emphasize the implementation of national government policies, but since this they came to gather the thoughts and issues of various parties within the community and consider together with those relevant parties how best to solve them. Through such efforts, a common understanding was fostered between the city and people involved with respect to community issues and ideals, and a foundation for collaboration was established. Because of this foundation, when efforts were made to take on the challenge of preventing the recurrence of strokes, collaboration between the city and relevant parties was smooth and a collaborative approach to medical and long-term care (seamless care) was promoted.

Next, it can be said that the “organizational integration of government and medical institutions” was another effective factor for the realization of seamless care. By establishing an administrative contact for medical and long-term care collaboration inside the core hospital and placing a city coordinator there, patients

became able to receive seamless service from “medical care” to “long-term care.” By physically integrating these organizations, hospitals and government became able to consider support for patients with a common understanding, promoting cooperation.

As seen above, this case was an example of a municipal government managing the process of building a community-based integrated care system, and the role played by the government in realizing seamless care was a significant one. Government worked with stakeholders and built the foundation in terms of sharing the vision and organizational integration, but then, rather than the government simply taking a unilateral position in designing the process it was important that it encouraged dialogue and coordinated collaboration between stakeholders.

## **(2) Mechanisms to enhance self-management skills**

For older adults with chronic illnesses, including strokes, to continue living in their communities while maintaining their physical and mental health, it is important to improve their self-management abilities. In the case of Komagane City, the effort was made to improve self-management abilities by empowering each patient and providing self-management support with an accompanying professional.

Collaborative systems were strengthened so that the professionals engaged in each stage from admission, to hospitalization, discharge and return to living at home would have a shared understanding of the patient through monthly case conferences, so that they could each serve as a companion for the purposes of self-management. Companion self-management support is provided with preventive guidance while hospitalized, then through regular interview guidance by hospital and government officials after discharge. In addition, having the patient set themselves goals to prevent recurrence with a “self-management plan” was an important factor in increasing their involvement and awareness of self-management.

Efforts were also made to utilize community resources in promoting self-support. It was recognized through the self-management support project that the environment of community living after the discharge of stroke patients was not sufficient to support self-management. This role could be taken by city health centers, but because this is an administrative contact it is currently difficult to get operating proactively.

Thus, by setting up a city consultation desk in a private sector fitness club, city officials are able to promote cooperation for health counseling from professionals and health improvement. In this way, by considering the use of community resources more broadly, not only older person related ones, it is possible to enhance the community infrastructure to support older adults at the same time.



## **3.2. Creating a Community to Support Older People in Living their Own Lives in Fujisawa City, Kanagawa – Realizing a Community Symbiotic Society in which Residents Connect with and Support One Another**

Fujisawa City in Kanagawa prefecture is a city that was developed as a commuter town for Tokyo and has a population of about 440,000 people. It has residential areas spread throughout the city, and many tourists visit the southern area which borders Sagami Bay. Like other urban areas, it has substantial medical care and long-term care resources, but as the community becomes more diluted, the isolation of local residents such as older persons, child-rearing generations and people living in poverty has become an issue. In response to this, Fujisawa city has been working on the development of a community-based integrated care system for all generations and all subjects. New support measures for the community are also being developed through pioneering efforts at long-term care facilities to develop communities in which older people can live the lives that they want to live.

### **3.2.1 Outline of municipality**

#### **(1) Basic information**

Fujisawa city is located in the central part of southern Kanagawa prefecture, about 50 kilometers from Tokyo, and faces Sagami Bay to the south. It has developed as a commuter town because of the convenience of being about 1 hour by train from central Tokyo. Many factories were attracted there during the high economic growth period of the 1950s to 1970s, and large-scale housing complexes were built, significantly increasing the population. Even today it is a popular and comfortable city to live in with its large commercial facilities and everything necessary for everyday life, as well as its rich natural environment.

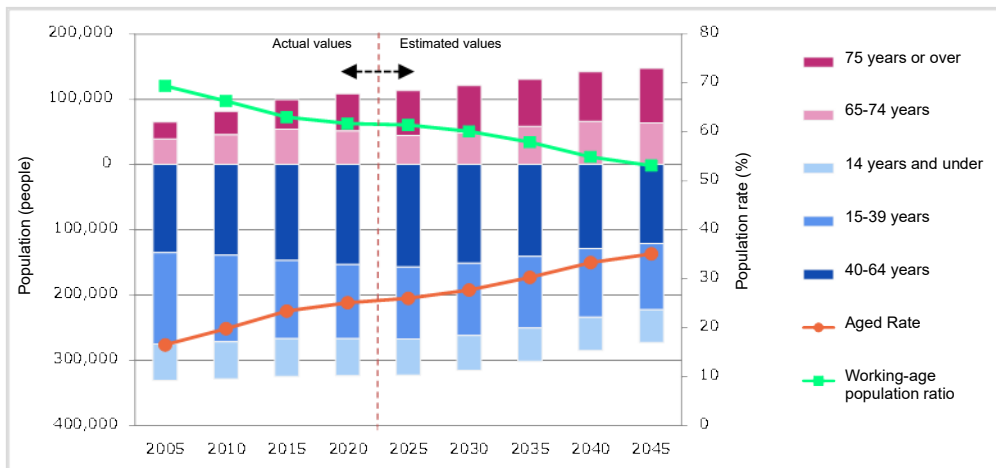
#### **(2) Population statistics**

The total population as of May 2021 was 440,911, and this is increasing every year. In the future it is expected to peak in 2030 (444,068 people) before it is expected to decline. There are 206,013 households (2.14 people per household) and the older population aged 65 or over is 107,827, with an aging rate of 24.46%<sup>31</sup>. As shown in Fig. 3-3, the population will continue to age, reaching an aging rate of 30.5% in 2035, 33.3% in 2040 and expected to exceed 35% in 2045, when about 1 in 3 people will be older adult. On the other hand, the working-age population is expected to decline about 7% by about 32,000 people between 2020 and 2040, and the resulting serious shortage of workers is a concern. The number of single-person households, including older persons and unmarried, is also increasing, and is expected to peak at around 199,000 households in 2040<sup>32</sup>.

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<sup>31</sup> Fujisawa City website (<https://www.city.fujisawa.kanagawa.jp/kourei-s/shise/toke/jinko/kore.html>) (Accessed: May 10, 2021)

<sup>32</sup> Fujisawa City (2021) “Fujisawa Municipal Administration Comprehensive Guidelines 2024 – Transition to Sustainable Urban Development by 2040”



Source: MHLW Community-Based Integrated Care Visualization System

Fig. 3-3 Trend in Fujisawa City Population

### (3) Current state of the older population

The older population aged 65 or over is increasing year by year. In 2013 the aging rate exceeded 21% and as of May 2021 it was 24.46%, so that 1 in 4 people were older adult. The number of people needing support and long-term care (number of certified persons) is also increasing year by year along with the number of older people and as of the end of August 2020 this numbered 19,620 people. This trend is expected to continue increasing in the future. The number of persons aged 70 or over that are living alone is also increasing, and as of October 2020 more than 10% of the older population live alone. Also, the number of people recognized as having dementia as of the end of September 2020 was 11,341, and this too is increasing year by year<sup>33</sup>.

Looking at the aging rates for each of the 13 administrative districts, there are differences in population structures depending on the area, from a little under 20% to more than 30%.

### (4) Daily living areas

As shown in Fig. 3-4, the terrain of Fujisawa City is elongated north to south, and the city is divided into 13 living areas (35 elementary school districts and 19 junior high school districts). There are 1-2 Community-based Integrated Support Centers (Iki-Iki Support Centers) located in living area, for a total of 19 locations throughout the city.



Fig. 3-4 Fujisawa City's 13 Districts (Living Areas)

<sup>33</sup> Fujisawa City (2021) "Iki-Iki Longevity Plan Fujisawa 2023"

### **3.2.2 Outline of activities**

#### **(1) Background and recognition of issues**

Against a backdrop of urbanization and nuclear families etc., and as community ties diminish, the existence of people that are isolated from their communities and are not able to properly deal with life's problems is becoming prominent. In a survey conducted by Fujisawa City on its citizens, it was even clear that there was an increase in people without connections to their community, with an increase in double-income households and a decline in participation rates in local governments and neighborhood associations. There were also many people expressing opinions such as "there is no one nearby that I can discuss things with," "there is nowhere to get together with people," and "I don't know anyone else in the community." As community ties weaken in this way, when it comes to people suffering from dementia or in a condition needing long-term care it can be difficult to continue living in the community to which they are accustomed. The challenges facing people in the community are also becoming more diversified and complex, such as poor living conditions, tiredness of childcare or long-term care, and the recent "8050 problem," in which parents in their 80s support their children in their 50s who are being a shut-in to their homes, etc., so it is becoming more and more difficult to solve the problem by responding to just as one target population, older adults, children, or persons with disabilities.

As for the support for older adults, the problem of separating older adults more and more from the community the more support services there are is being recognized. Commuting for outpatient rehabilitation and daycare can tend to become the center of life, diminishing relationships with neighbors, and with meal delivery services as well there are situations where there are no opportunities to leave home, causing isolation to progress. If older people become more dislocated from their local communities in this way, there is an increased risk for them in continuing to live at home when dementia or long-term care conditions worsen. The same is true if they are no longer able to rely on their family for nursing care and daily living support. In addition, in interviews for this survey with service providers, many noted a one-way perspective of older people saying that they were "being taken care of," leaving an awareness of the issue of the dignity and will of the individual being a second thought.

#### **(2) Details of activities and results**

##### **○ Fujisawa City (municipal government)**

In response to the above situation, in 2015 Fujisawa City began building a "Fujisawa-style Community-based Integrated Care System" for all generations, targeting everyone. The city is developing measures aimed at a community where not just older adults but everyone from children to older adults, people with disabilities, and people living in poverty etc., can live in the community in which they are accustomed, living the kind of life they want to live. In April 2021, organization reforms saw the organization of the "Community Symbiotic Society Promotion Office," which collaborated with the "Older People Support Division" to promote a

Community-based Integrated Care System targeted at older people, to advance efforts towards the realization of a community symbiotic society.

○ **“Aoi Care” long-term care facility**

Aoi Care is developing a long-term care service to support the community living of older adults consisting of small-sized multifunctional home- and community-based care, daycare services and a group home business (see the Column below for details about these services). This is characterized by developing these services in a form that is open to the community to help older adults play a more active role in the community. Aoi Care facilities are not just for older adults but are places where local residents such as children and child-raising families etc. can gather and interact. Also, by focusing on independent activities by older adults, including people with dementia, the degree of long-term care need can be maintained and improved.

○ **“Grundtvig” long-term care facility**

Grundtvig provides services such as home-visit nursing stations<sup>34</sup> and small-sized multifunctional home and community-based care. By developing those services in vacant housing complexes with the aim of “making the community into one big family,” these are places where not only older adults, but a diverse range of generations can gather and interact. Through these connections with people, older people are supported in continuing to live their own lives the way that want to.

Column – “Daycare Services,” “Group Homes,” and “Small-sized Multifunctional Home- and Community-based Care”<sup>35</sup>

○ **Daycare Services (Outpatient daycare)**

With the aims of maintaining and improving mental and physical function and reducing the burden on families, older people go from their homes to the facility on day trips to receive assistance with bathing and meals, and to receive functional training. Various activity programs are available for users to enjoy themselves during the day.

○ **Group Homes**

Facilities for communal living with support from professional staff, with small groups of about 5 to 9 people suffering from dementia. Support is provided to live in a homely environment with as independent a life as possible to delay the symptoms and progress of dementia.

○ **Small-sized Multifunctional Home- and Community-based Care**

Single long-term care facility open 24 hours a day, 365 days a year providing daycare services, home-visit care and short stays so that clients can continue to live at home even if they need long-term care. The “small-sized multifunctional home- and community-based care” developed by Grundtvig offers the three services above, as well as a home-visit nursing service.

<sup>34</sup> Visiting user homes, conducting medical procedures based on doctor’s instructions, managing medical devices, and preventing and treating bedsores etc.

<sup>35</sup> See WAM NET website (<https://www.wam.go.jp/content/wamnet/pcpub/kaigo/handbook/service/>) (Accessed: June 15, 2021)

**3.2.3 Details of activities**

**(1) Fujisawa City**

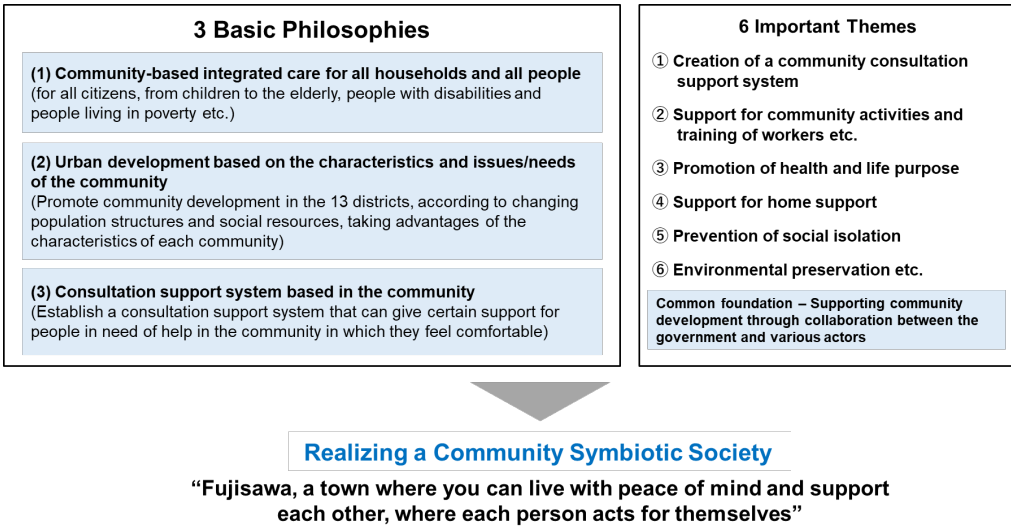
**1) Promotion of a Fujisawa-style community-based integrated care system**

**○ Initiatives to realize a community symbiotic society**

In the Community Welfare Plan<sup>36</sup> (the current plan runs from 2021 to 2026), the city notes that the future that they are aiming for with community-based welfare is “the city of Fujisawa where each person supports one another and feels at ease living there,” and this promotes measures aimed at realizing a “community symbiotic society” based on the development of a supportive community. Progress on this plan is managed using the PDCA cycle, by which goals are set to be achieved by each measure, and measures and activities are regularly evaluated and reviewed.

As specific initiatives both inside and outside of government towards the realization of this community symbiotic society, the development of a Fujisawa-style community-based integrated care system is being promoted, targeting all generations. So that everyone can continue to live with ease in their own way in a community in which they are accustomed and taking advantage of the characteristics of each of its 13 districts, efforts are being advanced for each governmental department and agency to collaborate with citizens and groups and organizations active in the community to solve issues related to community life.

The basic philosophy and priority themes of the Fujisawa-style community-based integrated care system are shown in Fig. 3-5.



Source: Created based on the “Fujisawa City Community Welfare Plan 2026”

Fig. 3-5 Basic Philosophy and Priority Themes of the Fujisawa-style Community-based Integrated Care System

Under the recognition that the promotion of the community-based integrated care system is something that

<sup>36</sup> According to the Social Welfare Act, prefectures and municipalities are obliged to make an effort to formulate this plan.

needs to be worked on with a long-term perspective, the city has set goals for 2020, 2025 and 2040, and has created a roadmap to reach these goals and promote these measures.

**○ Promotion of community development in areas close to residents**

Community development is promoted in each of the 13 districts where there are living areas, according to the characteristics and needs of each district. As the foundation to promote the Fujisawa-style community-based integrated care system, community social workers have been placed in each community to support consultations and to develop the community. Also, Councils are established in each of the 13 districts, which are run by the Living Support Coordinator<sup>37</sup> and a Fujisawa city official. This is a platform for community stakeholders to gather and discuss local issues and solutions. In this way, the government is able to get involved in the community, promoting face-to-face relationships with relevant people and institutions and promoting resident-led activities.

The above is a new role for government which goes beyond the conventional provision of welfare services. Through such efforts, there has been a shift from the idea of “supporting older people” to the idea of creating a community through the collaboration of all parties that goes beyond “supporters” and “people receiving support” regardless of the generation or target population.

**(2) “Community verandah” project**

A project is being developed with the support of the city to promote mutual assistance in the community, by creating places for multi-generational exchange at 35 locations around the city (as of April 2021) where anyone, including older adults, people with disabilities and children etc. can feel free to drop by. The city supports the launch and operation of diverse groups of residents such as neighborhood associations and volunteer groups etc. who work on various initiatives.

“Community verandahs” are places to restore the connections between community residents, and where the child-rearing generation can learn from older people who have already raised their children, and children who live away from their grandparents can have opportunities to interact with older people. Also, for older adults, it is an opportunity to have a role in the community and to participate in society, contributing their own special skills to the activities of the community verandah. This can also be said to be an initiative that revitalizes informal support.

**Column – Case of an Older Adult Participating in the Community Verandah Project<sup>38</sup>**  
75-year-old Ms. A had nothing to do during the day, so she tended to stay at home. Then, her care manager introduced her to participate in community verandah activities. Initially she was just in the position of participating in activities (receiving support), but she wondered if she could make use of her special skill with calligraphy and became active as an instructor. This is a good example of how the wall between

<sup>37</sup> Living Support Coordinators have been installed in the City Social Welfare Council and 4 Regional Support Centers around the city. Community Social Workers also serve on the City Social Welfare Council.

<sup>38</sup> From interview with the Fujisawa City Welfare Department Community Symbiotic Society Promotion Office (April 13, 2021).

“supported and supportive” can naturally be removed where community residents come together and interact. This feeling of being useful in a familiar place is needed and important both for the individual as well as the community.

### **(3) Long-term care facility “Aoi Care”**

Aoi Care Co., Ltd. operates a small-sized multifunctional home- and community-based care facility, daycare service and group home in the Mutsuai district of Fujisawa city. The company’s Representative Director, Tadasuke Kato, launched Aoi Care in 2011 based on his experience working at a nursing home for the elderly, with the idea of realizing within the community support for the independence (autonomy) of older adults, as seen in the long-term care insurance, and not just providing one-sided care. The following two points represent the practical support that Aoi Care provides to older adults.

#### **1) Support for the independent activities of older adults**

At Aoi Care, rather than just taking care of older persons, emphasis is placed on each person having a role and supporting their activities so that they can act independently. Assessments are made to check the client’s work history and past experience, to understand what they can do and are good at, or in other words, their strengths. In addition, they find out “what can be done with Ms. A” and “what Ms. A can do,” and then prepare an environment to make this possible. The person who prunes the facility garden was a gardener, the person that runs the facility’s candy store used to run a candy store, but they are also users of long-term care services, including for dementia. The clients also participate in community cleanup activities etc. and are actively engaged in efforts to contribute to the community.

As mentioned above, Aoi Care provides care so that the strengths of older adults can be utilized and they can act independently, it doesn’t just seek to “look after them.” This can be said to be an effort to transform older people from people receiving long-term care to people that contribute to the local community. As a result of these efforts, the degree of long-term care need of users has been maintained, and some people have even improved<sup>39</sup>.

#### **2) Creating a comfortable place for everyone**

For older people to not have to live in a special location but to continue living in their own communities, connections with people in the community are important. Also, it is necessary to spread throughout the community the idea that long-term care and welfare are not special, but just a part of life. Based on this recognition, Representative Director Kato has removed the walls around the Aoi Care facility to make it open to the community, so that people in the community can pass through freely, and the facility was designed to be a school route and playground for children. There are also a candy store, cafeteria, calligraphy classrooms and free spaces where diverse people from all generations can gather. By creating a comfortable environment for everyone, many people can naturally come together, and exchange is born.

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<sup>39</sup> Care Style website “Can it be done anywhere? Breaking down the rumored Shonan model ‘Aio Care’” (<https://carestyle.jp/article/986/#i-4>) (Accessed: May 14, 2021)

Through such efforts, for example by a child spending time and growing up around a lady with dementia, when that child become an adult, they will not see dementia as out of the ordinary but will simply regard it as part of life. Also, but being able to connect with other people in the community, a system of support for older adults with dementia in the community is being created, little by little. These efforts of Aoi Care are creating a community where older people can continue to live the life they want to live in their own community. In addition, while support for older adults was the starting point, Aoi Care is creating a platform not only for older people but also as an environment in which diverse people from the community, including children and people with disabilities, can interact. In these days in which community-based welfare is the theme in Japan, this is an initiative that is truly building a community symbiotic society.

#### **(4) Long-term care facility “Grundtvig”**

Representative Director Kensuke Sugahara, from his experience coordinating support for areas affected by the Great East Japan Earthquake, realized the need to create communities that were always helping each other so that they wouldn’t have as much trouble when something bad happened, and in 2015 he launched Grundtvig Co., Ltd. Based on the concept of “making the community into one big family,” small-sized multifunctional home- and community-based care etc. are being developed using vacant apartments in housing complexes. The following two points represent the practice of Grundtvig.

##### **1) Initiatives to “make the community into one big family”**

Grundtvig is located in the Shonan Oba district of Fujisawa City, operating a small-sized multifunctional home- and community-based care provider utilizing an apartment of a 10-story rental housing complex (about 240 units). In addition to care establishments, there is also a community space in the housing complex, and vacant rooms rented as employee dormitories, and about 10 staff including nurses and physiotherapists live as residents of the housing complex.

When the business started in 2015, the aging rate of the housing complex was as high as 90%, and there was almost no connection with people in the community. Given this, the long-term care facility was opened to the community and activities were developed where anyone could easily stop by and participate. As children with disabilities, and children on their way home from school stop by to play, and other residents stop by, multi-generational exchanges between residents are being born. Also, the staff of Grundtvig that live in the housing complex also serve as officers of the residents’ association and participate in residents’ association and disaster prevention activities etc., working with others in the community to revitalize the community. Events centered around disaster prevention are a common issue for local residents and such events are being implemented continuously, as a starting point to benefiting multiple generations.

Through such efforts, Grundtvig is providing support that connects people within the community of a housing complex, so that they can develop face-to-face relationships with each other. This is a form of community development where all the residents of the housing complex become one big family that supports one another, including older people using Grundtvig. Also, by involving people from the community with



their diverse values and ways of thinking, the practice of community welfare and care can also become social education for the community, including children, learning values and practices from each other.

## **2) Providing personalized care**

At Grundtvig, emphasis is placed on restoring mental and physical function so that people can live the life they want in the community they want to live in. For example, a man in his 80s was told by his doctor that he shouldn't swim in a pool, but he still really wanted to go to the pool that he loved. The staff at Grundtvig understood his feelings and prepared to accompany him to the pool, with a shared understanding of the risks. When people are able to do what they want, it gives them motivation to live, and this motivation can be linked to improvements in mental and physical functions. All the staff share these values and provide personalized care.

Representative Director Sugahara notes that risks need to be managed from the four aspects of a person, their body, their mind, their society, and their culture. In Japan, there is a tendency to think only about physical and mental care, but it is necessary to consider total care for an individual that includes connections with society and that person's cultural activities. At Grundtvig, since care is thought about in terms of the individual, support is provided for life in the community in the way that each person wishes it.

### **3.2.4 Achievements and future developments of community-based integrated care from Fujisawa City, Aoi Care and Grundtvig**

About 5 years has passed since 2015, when Fujisawa city promoted the "Fujisawa-style community-based integrated care system." From interviews, it was found that the philosophy and way of thinking about the community-based integrated care system had begun to penetrate into citizens and stakeholders. Thanks to the coming together of stakeholders, including local residents, and government at the daily living area level and their repeated efforts to confirm community issues and consider measures to solve them. Also, through the community verandah project, it was confirmed that people in the community connected with each other and functioned to provide informal support. Fujisawa city intends to continue its efforts in community-based integrated care by building on this foundation towards the future aging of the city in 2040.

The efforts of Aoi Care and Grundtvig to support independence were also a realization of the ideal way for the community-based integrated care system to operate, providing an example for other long-term care providers and related organizations. A model has been presented in which the onus on deciding how to care for older people has been shifted to older persons themselves, where communities can be developed in which older people have connections and can continue living the way they want to live. Through such community development, as well as the provision of personalized care, the motivation of older adults to live has been improved, leading to the maintenance and improvement of their physical and mental conditions. Mr. Kato of Aoi Care noted that he wanted to aim for a society in which older adults are supported not by social security but by a society that cares for each other. One of these efforts is the running of a multi-generational apartment complex where young and old people support one another. At Grundtvig, the meeting place at the housing

complex is planned to be renovated and turned into a cafeteria operated by people in the community. The purpose is to create a space where even more residents can connect together. Also, in addition to the housing complex, a business open to neighboring areas will be developed, and there are plans to expand and create a community that supports one another.

### **3.2.5 Key points from these cases**

The efforts of Aoi Care and Grundtvig in Fujisawa showed how the establishment of places where diverse residents could gather and interact and where connections in the community were promoted could activate self-support and mutual support. This creates informal support, which is an important element in the realization of “comprehensive care rooted in the community.” The practical experience of Aoi Care and Grundtvig present important suggestions of the ideal way to “provide care that is centered on the individual.” Consideration is given below to how the approaches of these cases worked to “focus on the individual” and provide “comprehensive care rooted in the community.”

#### **(1) Practice of care centered on the individual**

These cases (Aoi Care and Grundtvig) showed that through the practice of care focused on the individual it is possible to realize a dignified and independent life even for people that have dementia or need long-term care. When care is personalized, rather than seeing older people as someone to be cared, there is an emphasis on supporting them in acting independently with a focus on what they are good at from their life history and experience, and what they enjoy. Also, by providing care that isn’t fixed on the purposes of long-term care or rehabilitation but is closer to the person’s wishes, this can support them in an independent way of life. The provision of this kind of care leads to motivation to live and social participation, and also has a positive effect on physical and mental condition.

These cases also emphasized efforts to create social roles, starting from the independent activities of the individual. By creating connections with the community and opportunities for that person to contribute what they are capable of to the community, it is possible for them to continue living the life they want to live within that community.

#### **(2) Efforts to realize comprehensive care rooted in the community**

The realization of comprehensive care rooted in the community, which is one of the concepts of the community-based integrated care system, needs to not just involve formal services but also needs to be connected with informal support. For residents with various life issues to continue living in communities without being cut off, there needs to be connections in the community that are working to provide informal support. Community solidarity is important, especially in an emergency such as an earthquake. Since Fujisawa is an urban area, there has been a particularly remarkable decline in community solidarity, and weakening of connections between residents. In such a situation, the efforts introduced in this case were a form of community building, if communities can be considered a small part of the community where daily life takes place, such as in elementary school districts and housing complexes. By providing a place where

anyone can easily get together, a diverse group of people from the community took the opportunity to interact and connections between people were made. In these activities, relationships that support one another were fostered, where each person can play a role without the need to fix roles as “supporting side” and “supported side.”

Also, recognizing the importance of restoring community ties to community-based integrated care, the government has worked together with certain organizations to develop a community that supports one another, playing an important role in activating connections and mutual support. Given that it is not easy for residents in the community to naturally connect with one another in urban areas, it is essential, as we saw in this case, for the government to pay attention to informal support and to be proactive in work to revitalize these communities to promote community-based integrated care.

Furthermore, the rebuilding of connections between people seen in these cases was not just a result of efforts with older people, but also involved various other people from the community including children, people with disabilities and people of child-rearing age, leading to the realization of a community symbiotic society which goes beyond the concept of community-based integrated care for older people. As communities become more diluted and the nuclear family becomes more dominant, children are having fewer opportunities to interact with diverse people such as people with dementia and people with disabilities etc. By providing opportunities as part of daily life to engage and interact with diverse people, including older people, an understanding of the community symbiotic society will be fostered. Efforts such as this with a consciousness of social education are important elements in the realization of community-based integrated care and a community symbiotic society.

### **3.3. Community Medical Collaboration Network and Whole Community Care in Higashiomi City, Shiga**

Higashiomi City, Shiga prefecture, is located almost in the center of the prefecture and is a rural city with abundant nature on the east side of Lake Biwa. It has a population of about 110,000. In the Higashiomi area they follow the “good for everyone” spirit of the Omi merchant’s old family motto of “good for sellers, good for buyers, good for the community,” and based on this spirit of good for everyone, “Good for Everyone Study Groups” was launched with a philosophy for “good for patients, good for institutions and good for the community.” Through the face-to-face relationships formed by this study group, Higashiomi City is currently working towards the realization of “whole community care,” whereby the lives of everyone in the community is supported by community connections.

#### **3.3.1 Outline of municipality**

##### **(1) Basic information**

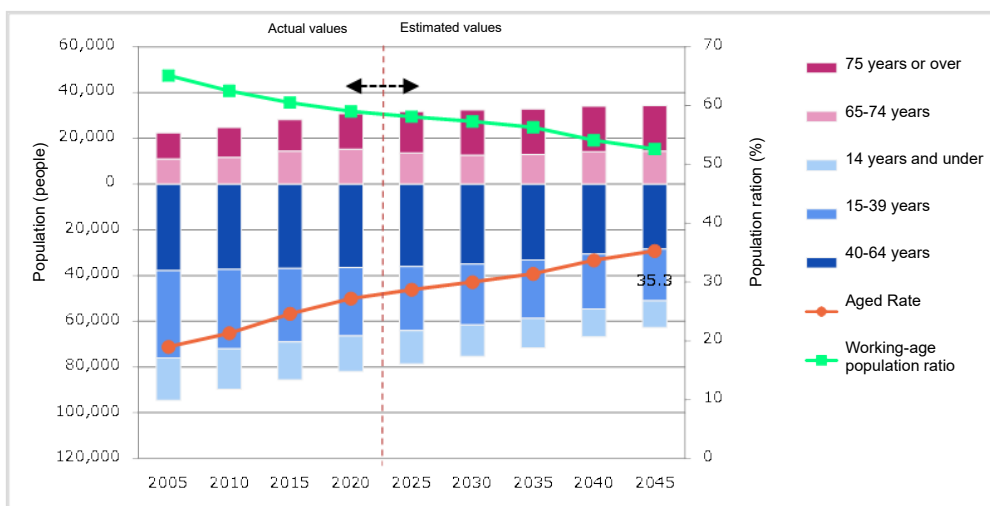
Higashiomi City is located in the center of Shiga prefecture, with Lake Biwa to the west, Echi River through the center of the city, and the Hino River flowing to the southwest, making it an area rich in water and greenery. The eastern part of the city is occupied by forests, and agriculture, forestry and mining industries are thriving there. Since ancient times this has been a crossroads and has prospered as a market town and commercial city. From such a historical and cultural background, the spirit of “good for everyone” of the Omi merchants has been nurtured and handed down to the present day.

##### **(2) Population statistics**

Regarding the demographics of Higashiomi, the total population began to decline from 2009, and the populations of young people (0-14 years) and working-age people (15-64 years) continue to decline<sup>40</sup>. On the other hand, as shown in Fig. 3-6, the older population has continued to increase year after year. The aging rate of Higashiomi in 2045 is estimated to be 35.3%, and while this is lower than the national average (36.8%), it is still higher than the prefecture average (34.3%). In particular, from 2025, the population aged 75 or over is expected to significantly exceed the early-stage old population.

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<sup>40</sup> 7<sup>th</sup> Higashiomi City Elderly Health and Welfare Plan and Long-term Care Insurance Plan (2018)



Source: MHLW Community-Based Integrated Care Visualization System

Fig. 3-6 Trend in Higashiomi City Population

### (3) Current state of the older population

Regarding the current state of older people in Higashiomi city, as of the end of January 2021 there were 4,740 people certified as needing support or long-term care (number of certified persons), accounting for 15.7% of the older population (certification rate). Of these, nearly 70% of the total are mild (support required, long-term care required 1-2), and this is increasing year by year<sup>41</sup>.

In terms of the trend of older people's households living alone or as couples only (where one is 65 or over), the increase has been remarkable with the percentage of these households within the total number of older people's households accounting for 25.4% in 2000 and 43.7% in 2015, a rise of 18.3 points. Also, looking at older adults living alone in 2015 by gender, females made up two-thirds<sup>42</sup>.

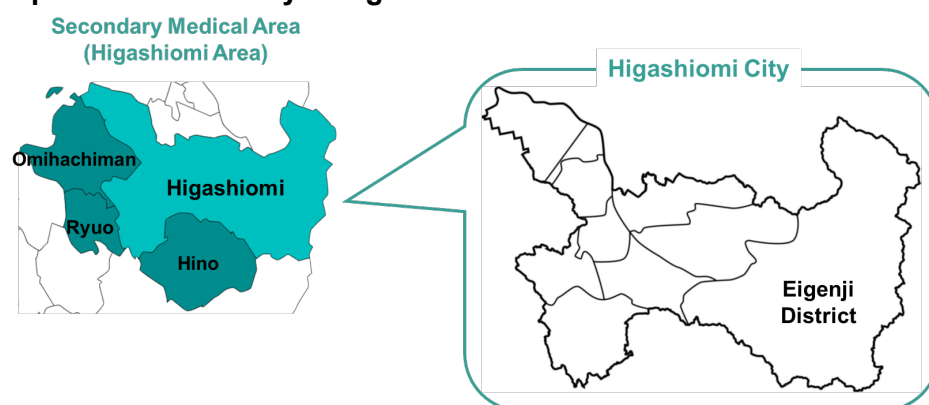
Regarding the employment status of older people, 24.1% are engaged in some kind of work. By industry, half work in tertiary industries, while about 20% work in each of primary and secondary industries<sup>43</sup>.

<sup>41</sup> MHLW Community-Based Integrated Care Visualization System

<sup>42</sup> 7th Higashiomi City Elderly Health and Welfare Plan and Long-term Care Insurance Plan

<sup>43</sup> 7th Higashiomi City Elderly Health and Welfare Plan and Long-term Care Insurance Plan

#### (4) Medical service provision and daily living areas



Source: Created based on Shiga Prefecture Health and Medical Care Plan, Higashiomi City Elderly Health and Welfare Plan and Long-term Care Insurance Plan

Fig. 3-7 Locations of Higashiomi City and Eigenji District

Fig. 3-7 shows the locations of Higashiomi City and Eigenji District. Within the medical service provision system, Higashiomi City is included within the “Higashiomi Area” of Shiga prefecture’s Secondary Medical Area. The Higashiomi Area consists of 2 cities, Higashiomi and Omihachiman, and 2 towns, Ryuo and Hino, and Higashiomi City has the largest area.

The medical and long-term care resources of Higashiomi Area and Higashiomi City are shown in Table 3-4. In terms of medical resources, the number of medical facilities and beds per 100,000 population for the entire Higashiomi Area are below the national average, but the number of hospitals in Higashiomi City is the same as the national average and the number of hospital beds is above the national average. On the other hand, with respect to the number of doctors, Higashiomi City is well below the national average, so it cannot be said that medical resources are abundant. The level of long-term care resources is also higher in Higashiomi City than the Higashiomi Area, but they are still lower than the national average.

Table 3-4 State of Medical and Long-term Care Resources in Higashiomi Area and Higashiomi City

Resources			Higashiomi City	Higashiomi Area	Nationwide
Medical resources	Number of facilities* <sup>1</sup>	Hospitals	6.13	4.79	6.47
		General clinics	49.92	52.65	68.94
	Number of beds* <sup>1</sup>	Hospitals	1,256.79	1,092.26	1,185.40
		General clinics	32.40	32.25	68.38
	Number of doctors* <sup>1</sup>		155.02	186.68	244.11
Long-term care	Number of long-term care facilities* <sup>2</sup>		12.52	11.82	12.40
	Number admitted (admission type facilities)* <sup>2</sup>		70.19	68.83	76.41
	Number of long-term care staff (full-time equivalent)* <sup>2</sup>		64.90	62.69	74.70

\*1: Number of facilities/beds/personnel per 100,000 population

\*2: Number of facilities/capacity/personnel per 1,000 aged 75 or over

Source: Japan Medical Association Community Medical Information System

As shown in Fig. 3-7, the Eigenji district of Higashiomi city is one of the 13 daily living areas in the city. Of the daily living areas, it is located in the easternmost side away from the city, in an area occupied mostly by forests where depopulation is progressing. As of 2017, the total population of the Eigenji district was 5,408 people, and the aging rate was 34.91%, the highest among the daily living areas.

### **3.3.2 Outline of initiatives**

#### **(1) Background and recognition of issues**

In 2007, following the 2006 revision to the Medical Care Act, the “Higashiomi Community Medical Collaboration Network Study Group (Good for Everyone Study Group)” was launched in the Higashiomi Secondary Medical Area to build a medical collaboration system which covered from inpatient medical care to home medical care. The issue at the time was that as patients transitioned from inpatient to home care, although there was a certain degree of collaboration in place within hospitals or between hospitals, there was not a good level of collaboration between hospitals and the relevant organizations that were involved in home care. In particular, while conference sheets and manuals etc. were shared and utilized within hospitals, they were not being used for rehabilitation or medication management after discharge, and there were no community rules for collaboration. In addition, as collaboration systems between hospitals were becoming more complex, it was difficult to follow the condition of patients after discharge with only one-way communication.

Thus, in the “Good for Everyone Study Group” that was launched within the Secondary Medical Area, community alliances and critical pathways were created for the typical case of stroke, for the flow from acute to recovery, maintenance and home life phases, and medical and long-term care related stakeholders began to work to develop face-to-face relationships.

Following this, with the idea of forming a network that took advantage of community characteristics in even more familiar living areas, the “‘Community-level’ Good for Everyone Study Group” was formed. “Team Eigenji,” which is active in the Eigenji District of Higashiomi City initially held case meetings at the Eigenji clinic, but as an outgrowth of this is now positioned as a “‘Community-Level’ Good for Everyone Study Group”.

Through medical care activities in the community, it was realized that just intervening medically in the “illnesses” of patients would not provide support for the patient’s life, and that it was important that the community play some kind of social role in relation to health, and the connection was made between professional services and community activity.

#### **(2) Details of initiatives**

To promote community medical collaboration in the Higashiomi community, a “Good for Everyone Study Group” was launched as a unit of the Secondary Medical Area, and community collaboration and critical pathways were created using stroke as a model case. Since then, this Good for Everyone Study Group has

held meetings once a month with various stakeholders involved in medical and long-term care within the area, holding study sessions, case studies and information sharing on the themes each time and building face-to-face relationships.

In the Eigenji District of Higashiomi City, “Team Eigenji” was active in the “‘Community-level’ Good for Everyone Study Group.” Team Eigenji consists of medical and long-term care professionals and government, as well as all kinds of people from the community such as police officers and firefighters, commercial and industrial associations, temples, social workers/child welfare officers, citizen groups and residents etc. These community stakeholders are working on “whole community care” through mutual support by meeting regularly, exchanging information, and doing what each person can do.

### **(3) Results and achievements**

As a result of operating the community collaborative critical pathway for strokes as created through the Good for Everyone Study Group, the average length of stays for stroke in acute and recovery care hospitals in the Higashiomi Medical Area was reduced<sup>44</sup>. In particular, in acute care hospitals, the average length of stay in 2008 was 42 days, but in 2012 this had been shortened to 27.8 days. Furthermore, by shortening the length of hospital stay, beds were freed up for accepting emergency patients, meaning that the emergency transportation rate for stroke patients (including those suspected of stroke) to acute care hospitals in the area improved from 64.2% in 2007 to 85.5% in 2014.

As a result of the activities of Team Eigenji, while prior to 2000 there had been no end-of-life care cases at home, currently about half of people in the community are able to live in the community until the end.

#### **3.3.3 Details of activities**

##### **(1) Good for Everyone Study Group**

The Good for Everyone Study Group has been active for 14 years, since its inception in 2007. At the time of its launch, the Shiga Prefecture Higashiomi Health Office was the main entity holding study meetings, but with the 100<sup>th</sup> study group in 2016, the NPO Good for Everyone Study Group was launched, and this has been managing the study groups.

Regarding the content of its activities, it started by taking up the case of strokes and considered the creation of community collaboration critical pathways so that seamless services could be developed as functional differentiation and collaborative systems of stakeholder organizations in response to the 2006 revision of the Medical Care Act. The details of the main activities to provide this seamless care are described below.

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<sup>44</sup> Excludes facility providing both emergency medical and rehabilitation care services (1 location).



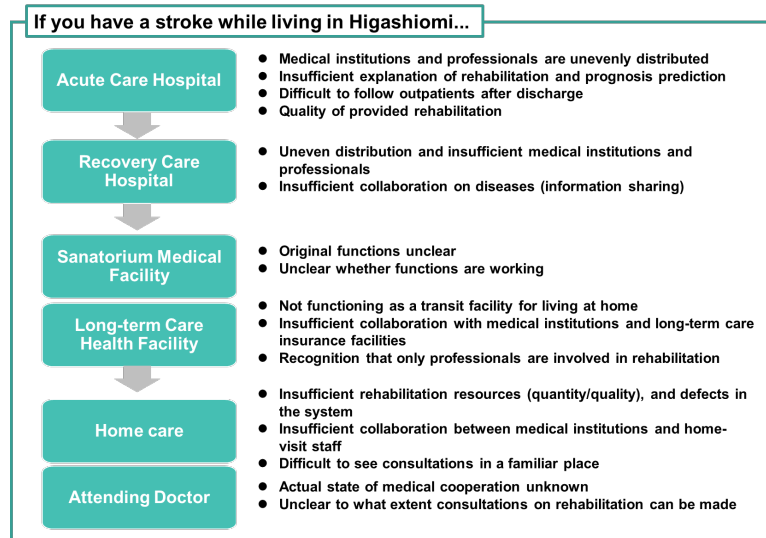
# 1) Creating community collaboration critical pathways

Unlike the in-hospital critical pathways created by each medical institution, the creation of community collaboration critical pathways involves capturing community medical and welfare resources from a wide area perspective and requires consideration of the collaborative systems while taking into account the life and culture of the community. For this reason, the prefecture’s local health office played the primary role of gathering together stakeholders in medical and long-term care in the Higashiomi Area and holding study meetings to learn about actual conditions (study groups began to be held regularly every month, to be later known as the Good for Everyone Study Group).

At the study group, they started by understanding the actual state of stakeholders engaged in the series of services from hospitalization to returning home for stroke cases, and the issues are set out in Fig. 3-8. The main issues included the uneven distribution of medical institutions and medical professionals in acute and recovery care hospitals, the need

to clarify the functions and positioning of medical treatment hospitals and health services facilities for elderly, the insufficient collaboration between facilities throughout the entire community, and a lack of understanding of rehabilitation leading to no collaboration between medical care and rehabilitation.

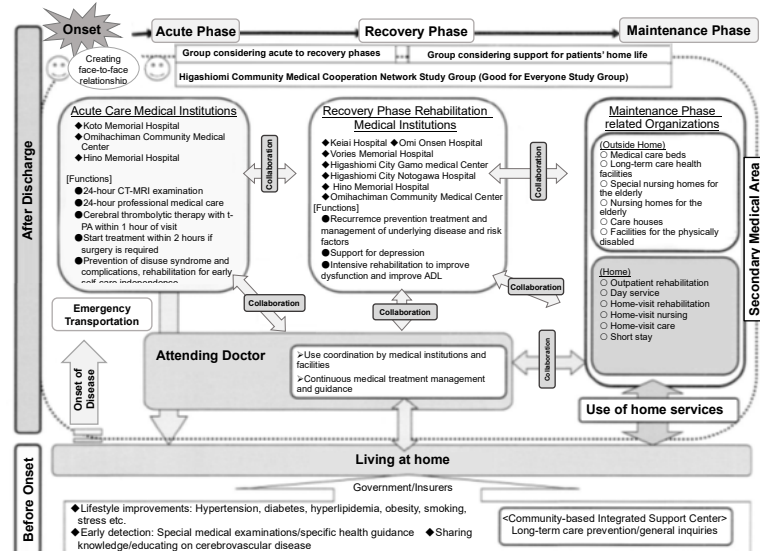
Such community medical issues were shared with the study group, and while exchanging opinions the



Source: Created based on Michie Takeuchi (2008) “Current State and Issues in Community Collaboration Critical Pathways for Strokes”

Fig. 3-8 Actual State of Community Cooperation in Stroke Cases

the need



Source: Michie Takeuchi (2008) Current State and Issues in Community Collaboration Critical Pathways for Strokes

Fig. 3-9 Illustration of Community Medical Collaboration System for Strokes

functions of each of acute, recovery and maintenance care hospitals were clarified, and their roles were separated. As a result, the illustration (Fig. 3-9) of the collaboration system of related organizations leading to life at home was shared and a format was created for the community collaboration pathways.

After this, about 50 people from relevant organizations gathered once a month to discuss issues, reviewing the trial community collaboration critical pathway and making repeated corrections before it officially came into operation.

## **2) Sharing patient information using “Good for Everyone Notebooks”**

The Good for Everyone Study Group has created the community collaboration critical pathways, as well as the “Good for Everyone Notebook.” Good for Everyone Notebooks are held by the patients that are transitioning from acute care hospitals to home medical care and long-term care, using the community collaboration critical pathway and patients bring this notebook with them when they receive medical care at a medical institution or long-term care services, and the notebook is filled in by the medical institution or long-term care service provider. This makes it possible for all medical care and long-term care professionals that interact with the patient to know and share all the information about what kinds of treatments and rehabilitation the patient received in the transition back to living at home, what kinds of medication they are taking, and what other illnesses they have etc.

## **3) Creating face-to-face relationships**

In the Higashiomi Area, various ideas are being worked on within the Good for Everyone Study Group which holds meetings once a month for medical and long-term care professionals to develop face-to-face relationships. Generally, in building face-to-face relationships within these professions, the upstream and downstream awareness of medical institutions from acute care to recovery care to maintenance care, and the upper and lower awareness of doctors and co-medical staff become the bottleneck, but flat relationships are being built with the following efforts.

- ◆ Everyone starts with a self-introduction

At the start of the study meeting, people introduce themselves to help people remember their faces. When the study meeting had been held more than 50 times, regular members had developed a face-to-face relationship, so since then only first-time participants have been introduced.

- ◆ Meetings are held in a circle

Rather than participants lining up side by side to listen to a lecture from a podium, they sit in a circle, giving all participants the opportunity to speak.

In addition, the study meeting has been held continuously once a month since its inception 14 years ago in 2007. On average, more than 100 people participate each time, and they continue to build face-to-face relationships. The following ideas have been incorporated to increase the motivation to continue to participate.

- ◆ Times are strictly adhered to

So that participation in the study group is not a burden, the principle of strictly adhering to the time is followed, for one two-hour meeting per month. No matter how well the discussion is going, try to finish it in 2 hours.

◆ Venues are rotated

At the beginning of the study group, Prefecture's local health office was the venue, but after this, it was decided to rotate among participant's venues. Cases are introduced and shared from the facility holding the meeting, and this has good effect in motivating the presenters of that facility.

◆ There are things to learn and gain

By participating in the study group, connections are made with various people and there are new things to learn and discover. It is important that the study group is seen as an opportunity for participants to learn.

## **(2) Team Eigenji (Community-Level Good for Everyone Study Group)**

Team Eigenji, which is positioned as the "Community-Level Good for Everyone Study Group," developed out of individual case meetings held at Eigenji Clinic in Higashiomi, and it has reached its current form by widely inviting community stakeholders and not just those in the medical profession. Team Eigenji is working to realize whole community care which connects visible services with invisible connections, recognizing the need for there to be invisible (informal) connections in the community that support their lives while providing the visible (formal) services of medical and long-term care necessary for older adults to live in the community .

## 1) Multi-discipline study groups in the community

Team Eigenji gathers medical and long-term care professionals who play the role of institutionalized social solidarity support and various community stakeholders who play the role of mutual support (commercial and industrial associations, community revitalization groups, public welfare officers, and residents' associations etc.) to hold regular study sessions. Originally only the medical profession held case meetings about patients, but this has developed into multi-disciplinary study sessions which connect people involved in mutual support with medical professionals in the position of social solidarity support, from the realization that it is not medical treatment alone that supports patient's lives.

At Team Eigenji, importance is placed on filling the gap between mutual support and institutionalized social solidarity support, and discussions are held with various professions on familiar community challenges and various community activities are planned. For example, to support an isolated individual with no connections with the community, necessary support methods are considered such as

obtaining information from mobile food stalls that know the residents and connecting with the government etc. Also, the role of the police is not just to protect older adults staying at home or those that are wandering around lost, but also to connect them with appropriate services as supported by community networks.

Team Eigenji is working on the following as devices to encourage the continued participation and activity of people in the community.

### ◆ Create relationships where you can share fun things

At Team Eigenji, rather than mandating “we want you to do xx,” work has the purpose of “let’s do something fun.” Overcoming community issues one by one and sharing joy with each other increases motivation to participate in activities.

### ◆ Start with what you and I can do

For familiar issues in the community, start with what each person can do and try to allow everyone to participate so that activities will continue, and people will enjoy it. Also, it is important to create opportunities for activity, because there are things that people can do even if they have dementia or weak legs.

### ◆ Don't start with the goal, develop the community through dialogue

At Team Eigenji, rather than setting goals first and filling in what is lacking in the community, dialogue is



Source: Materials provided by Team Eigenji

Fig. 3-10 Team Eigenji Connections

repeated with the parties and stakeholders, thinking together what kind of community each person wants to live in, and then working together to develop such a community. For familiar issues, repeatedly work to do what you can and the uniqueness of the community will evolve into activities.

## **2) Reporting to the Good for Everyone Study Group, expansion to other communities**

So that the initiatives and good practice of Team Eigenji can be used as reference for other Community-Level Good for Everyone Study Groups, they are actively reported and shared with the Good for Everyone Study Group. At the Good for Everyone Study Group at the Secondary Medical Area level, many were of the opinion that they didn't know what was going on in the community or how to get started with activities in their community, and the activities of Team Eigenji has been useful for expansion into other communities.

### **3.3.4 Achievements in Community-based Integrated Care and future developments in Higashiomi City**

#### **(1) Achievements**

As a specific result of the efforts of the Good for Everyone Study Group, as mentioned in 4.3.2 (3), improvements have been observed in shortening the average length of stay at hospital and improving the admission rate of emergency patients within the area, and patients have been able to move sooner to rehabilitation and then return to living at home. Also, the face-to-face relationships built in the Secondary Medical Area have led to the revitalization of activities of the Community-level Good for Everyone Study Group (Team Eigenji) developed in the community. In the Eigenji District, the number of people receiving end-of-life care at home is increasing, fostering community ties as people are able to continue living in their familiar communities.

#### **(2) Future developments**

The Good for Everyone Study Group is accepting a wide range of participation from the local community, not limited to participants from government and the medical and long-term care profession, and the network is further expanding. Also, the examples of initiatives and experiences of the Community-level Good for Everyone Study Group have been expanded to other communities through the Good for Everyone Study Group, and it is expected that this will continue to raise the community strength throughout the entire Higashiomi area and eventually the entire prefecture.

### **3.3.5 Key points from this case**

Looking at the initiatives and achievements in Higashiomi City from the perspective of the concepts of the Community-based Integrated Care, the multidisciplinary human resource network formed through the Good for Everyone Study Group and the collaboration tools of the critical pathways have realized the provision of seamless care, and the efforts of Team Eigenji to fill the gap between mutual support and institutionalized social solidarity support, and the social participation of each citizen has realized comprehensive care. Below, consideration is given to how the initiatives of the Good for Everyone Study Group and Team Eigenji have worked to realize this community-based integrated care.

## **(1) Initiatives for the provision of seamless care**

For the creation of pathways and community collaboration critical pathways as collaboration tools to realize seamless care between acute, recovery, maintenance and home living phases, the creation of face-to-face relationships through repeated study groups and the sharing of information between medical and long-term care professionals with a focus on the patient with Good for Everyone notebooks are all important elements of community-based integrated care.

Building a collaborative system began with looking at the actual conditions of the institutions responsible for medical and long-term care, and then understanding each other's fields of specialty and characteristics as to what can be done at each hospital, to smoothly clarify functions and share roles among the medical institutions in the community. Also, with regard to the collaboration system, the already operating critical pathways between medical institutions were applied, and by setting the ultimate goal after discharge as living back at home, a concrete image was formed. The community collaboration critical pathways created in this way play an important role as the basis for providing seamless care to patients.

In addition, as with the community collaboration critical pathways, the Good for Everyone Notebooks were also an important tool. These are owned by the patient and are used for healthcare professionals and long-term care workers to write down necessary information about patient care from their respective professional perspectives, and by sharing this information between those parties it is possible to provide care which is centered on the individual.

In addition to the tools that make such a collaboration system work, the building of face-to-face relationships between these care professionals is also of great significance. While respecting the specialized functions of medical institutions in acute, recovery and maintenance phases, and the specialized expertise of professionals in medical and long-term care, a stronger collaboration system can be realized by building a flat relationship in which opinions can be freely exchanged.

## **(2) Initiatives to realize comprehensive care in the community**

Various services are needed to support the lives of older adults in the community, including medical care, long-term care, preventive care, daily living support and housing etc., and these services are provided by various actors. Thus, given the fragmented nature of services in the community, community members in the Eigenji District working in the medical and long-term care professions gathered together to form the platform Team Eigenji to build a network of various service providers. This network serves as the foundation for the provision of comprehensive care. By working together, Team Eigenji are able to quickly capture information needed to support an older adult and consider and exchange opinions among professionals and non-professionals as to what can be done. As a result, comprehensive care is provided by combining necessary professional services with informal support in the community.

Furthermore, the method in which Team Eigenji operates is by repeated dialogue from the perspective of older adults to support their way of life. There are hundreds of different views and perspectives on where

people want to live and how they want to live when they get old. At Team Eigenji, the opinions of all are respected and extracted through dialogue.

Also, within this dialogue, it has been learned that even for older adults who need support, there are some things that they just like to do their own way, and some people find meaning from participating in society. Team Eigenji supports what each individual can and wants to do and creates opportunities for social participation, fostering the transition from a relationship of “supporter and supported” to “mutual support.”





## **Chapter 4. Discussion on the promotion of community-based integrated care system with practical examples**

This Chapter will discuss below what value can be derived from the building of a community-based integrated care system and what the requirements are for realizing this value, based on the practical examples from the three communities introduced in Chapter 4.

### **4.1. Value realized through community-based integrated care system**

From the practical cases of Komagane City, Fujisawa City and Higashiomi City, the following two values were realized through the creation and promotion of community-based integrated care system. The following ways of life for older adults have been made feasible.

#### **◆ Continuing to live in the community with which they are accustomed (aging-in-place)**

As the aging of society progresses, it will be a challenge for society to make it possible to continue to live in the community in which people are accustomed even if people need long-term care, have dementia, or live alone. The creation of an integrated system that aims for such a society is underway in each community in Japan, to provide comprehensive care including medical and long-term care, as well as long-term care prevention and daily living support, in a form that is firmly rooted in the community.

In each of the 3 communities introduced in the practical cases, the results of older adults being able to continue to live at home were confirmed.

In Komagane City, accompanied self-management is provided and the self-management abilities of stroke patients is strengthened as an initiative to promote self-support by empowering the patients. These efforts lead to the maintenance of good health and improved motivation to live, reducing recurrences and readmission for older patients that received self-management support and allowing them to continue to live at home.

In Fujisawa, they are attempting to rebuild the connections between people through government and long-term care service providers, as the mutual support functions of communities decline as a characteristic of urban life. By establishing a place for diverse people in the community to interact, each person devise ways to participate and play a role, fostering relationships that support each other. These connections between people in the community promote the social participation of the elderly (self-support), and also function as informal support when help is needed, supporting the community life of older people.

In Higashiomi City, by developing community collaboration critical pathways, both the patient themselves and medical and long-term care workers can see a path for care with a view to living at home, shortening the average stay of patients in hospital, and making it possible to transition to patients returning home sooner. Also, in the Eigenji District, medical and long-term care professionals and non-professionals from the community work together to build a community in which supporting relationships are cultivated between

people, making it possible for people to continue to live their lives until the end in the communities to which they are accustomed.

Thus, through the various efforts realized under the community-based integrated care system, people have been empowered to continue to live their lives until the end in the communities to which they are accustomed, while being supported by the various people in the lives such as family, friends, and neighbors.

#### ◆ Dignified and self-determined lives (dignity and autonomy)

In everyday living in familiar communities, the dignity and autonomy of each older adults is valued. Here autonomy means “determining for yourself what kind of life you want to live.” As people age, even if their physical function and cognitive function declines, they can still maintain dignity and live their own lives, making everyday decisions for themselves and having a role in society by interacting with people in the community. Such care and the way of the communities is explored in the three communities through their activities.

In the practice of self-management support in Komagane City, medical professionals do not unilaterally tell patients how they would perform their self-management, but rather the patients themselves are involved in the planning and execution processes, setting their own goals to prevent recurrence. This has not only raised their awareness of self-management, but also led to them having ownership over their own life and way of life.

At “Aoi Care” and “Grundtvig” in Fujisawa, support is provided so that each individual could act autonomously, focusing on what they like and what they are good at, so that they can get close to the life that each of them wants to live. Also, social roles are emphasized in connections with society. In this way, care is provided in a way that led to a way of life that makes each elderly person feel like themselves, realizing a dignified and self-realized life.

At Team Eigenji in Higashiomi City, emphasis is placed on dialogue between the parties involved in providing support. The team confirms with the individual their desires of where they want to live when they are elderly and what they want to do when they can no longer eat, and then they consider what can be done for them. By this method, people are supported by their surroundings and can continue to live in dignity and autonomy.

## **4.2. Key points of creating and promoting a community-based integrated care system to realize those values**

The important points for promoting community-based integrated care systems that made the above two values possible will now be discussed based on the practical cases of the three communities.

The following efforts have realized “continued life the way you want to live, in the community to which you are accustomed.”

## **(1) Support for the individual (centered on the individual)**

For older people to be able to live the life they want to live, it is important to respect their wishes and to support them so that they can act autonomously. At Aoi Care there are many older adults with dementia using the facility, but they are given assessments of what they like and what they are good at from their life history, and instead of just taking care of them their independence is supported by preparing an environment in which they can do “what they can do” and “what they want to do”. In this way, by providing care based on the wishes of the individual, each person is able to realize the life that they want to live. Similarly, at Grundtvig, they take on the challenge of providing personalized care. By considering the needs of people in terms of the four aspects of body, mind, society and culture, the care needed by each individual is considered and support is provided in the community for the life they want. Team Eigenji in Higashiomi City also provide care according to the wishes of the individual, after repeated dialogue with the person, and this results in self-actualization and the life that they wanted.

## **(2) Enhancement of self-support and mutual support**

The support needs for older adults to continue to live in the community are diverse, and in addition to medical and long-term care services, preventive activities to maintain physical and mental health and prevent deterioration, and daily living support such as calling in on them and shopping are also indispensable. In the case studies, governments and professionals focus on this point and made efforts to enhance self-support and mutual support.

In preventive activities, it is important that each individual works to support themselves with self-care of their illness and maintaining their own physical and mental health. In the case of Komagane City, self-support is strengthened by providing companion support by professionals for self-management from the time of admission at hospital. In terms of daily living support, informal support plays a major role in mutual support, and not just formal services.

In an urban area like Fujisawa City where there has been a particularly significant decline in community solidarity, government and long-term care establishments are working to create connections between people in small community units such as elementary school districts and housing complexes. Through such efforts, relationships of mutual support are fostered, making it possible for elderly people to continue living in those communities.

It is also important that self-support and mutual support are reciprocal and enriched. In supporting the maintenance of physical and mental health and independence, having individuals get opportunities to participate in society starting with the things that they want to do leads to motivation to live and strengthens the self-support of that individual. Also, social participation leads to connections in the community, which builds relationships of mutual support. In addition, through these connections with people and the community, roles are held in mutually supportive relationships, giving people the opportunity to contribute, and this in turn increases the motivation to participate further in society, strengthening self-support.

In the “community verandah” project mentioned above in Fujisawa city, activities that are participated in to create opportunities to get out allow interaction with people in the community, and in doing so roles are found that make use of the characteristics of each person and this gives them opportunities to contribute to the community. This in turn leads to ongoing participation in activities and enhances self-support.

### **(3) Collaboration between various local actors**

For older adults to continue living at home, with their various daily living needs, in addition to medical and long-term care, it is essential that a diverse range of organizations and stakeholders in the community be involved in the daily living of the elderly person, including supermarkets, police etc. Thus, in the practical cases in the three communities a platform was formed for various stakeholders to gather. On these platforms, dialogue between the relevant parties is emphasized, and by continuing this dialogue face-to-face relationships is established for flat relationships that transcend profession and roles.

For example, in Komagane City, with the formulation of a long-term care vision for dementia, the government proactively established opportunities for discussions among relevant parties and by continuing this a common understanding of community issues and a shared vision of the community was fostered.

Also, in Team Eigenji in Higashiomi City, participation in regular meetings is invited from not only medical and long-term care professionals but various stakeholders such as police officers and commerce and industry associations etc., as well as members of the community, and face-to-face relationships are built as a result. By doing this, seamless care is realized through the collaboration between professionals, and comprehensive care is provided through collaborations between professionals and non-professionals. In this way, by having various stakeholders engage in dialogue and build face-to-face relationships, it becomes possible for them to collaborate under a common vision, providing comprehensive care to support older people in continuing to live at home.

In addition, to ensure the continuation and sustainability of community-based integrated care efforts, with the collaboration of various actors, it is important to respect ideas of the institutions and individuals involved and ensure that each has autonomy in participating.

At the time of its inception, the Good for Everybody Study Group in Higashiomi area was a government-led initiative, but by establishing such devices as providing opportunities to learn through the study group, rotating venues, and giving everyone an opportunity to speak, each person was able to participate with autonomy. As a result, the Study Group now continues with the participants taking the initiative.

### **(4) Efforts according to community characteristics**

The environments surrounding older people differ from community to community, and the challenges and available resources are not the same. The understanding of self-support and mutual support, and values may also differ from community to community. Therefore, for older people to be able to continue to live at home, care needs to be provided in an integrated manner, including housing, medical care, long-term care,

preventive care and daily living support, but the methods by which this care is provided and the communities capable of providing such care differ from community to community. In all three cases, rather than seeking to have perfect care provided in the community first and then make up for what is lacking, they have repeated discussions with relevant parties and community stakeholders about familiar issues, and then develop their communities while thinking about and sharing the way they want the community to be. With this process, it is possible to make use of the diverse resources and people, and strengths within the community and to build a care system that suit the community.

For example, Team Eigenji in Higashiomi City doesn't look at what the community doesn't have, and see this as an issue, but rather at what it does have, and think about how they can make use of it, and then works to develop a community through repeated dialogue with community stakeholders with the purpose of "doing fun things." By doing this, activities are continuously being developed, utilizing the strengths and characteristics of the community.

Based on the points in (1) to (4) above, Fig. 4-1 (following page) shows the community that is realized with its enhanced functions as a result of establishing a community-based integrated care system.

Through a community-based integrated care system that rather than being fragmented medical care and long-term care and community resources focused on being "focused on the individual," "enhancing self-support and mutual support," "collaborating with various community actors," and "efforts based on the characteristics of the community," it is possible to create a system that provides care from the perspectives of supporting independence and providing daily living support and preventive care with a focus on the individual. By deploying these things into the daily living areas of older adults, it is possible to provide integrated care focused on the individual and rooted in the community, so that older adults can continue living in the communities with which they are accustomed.

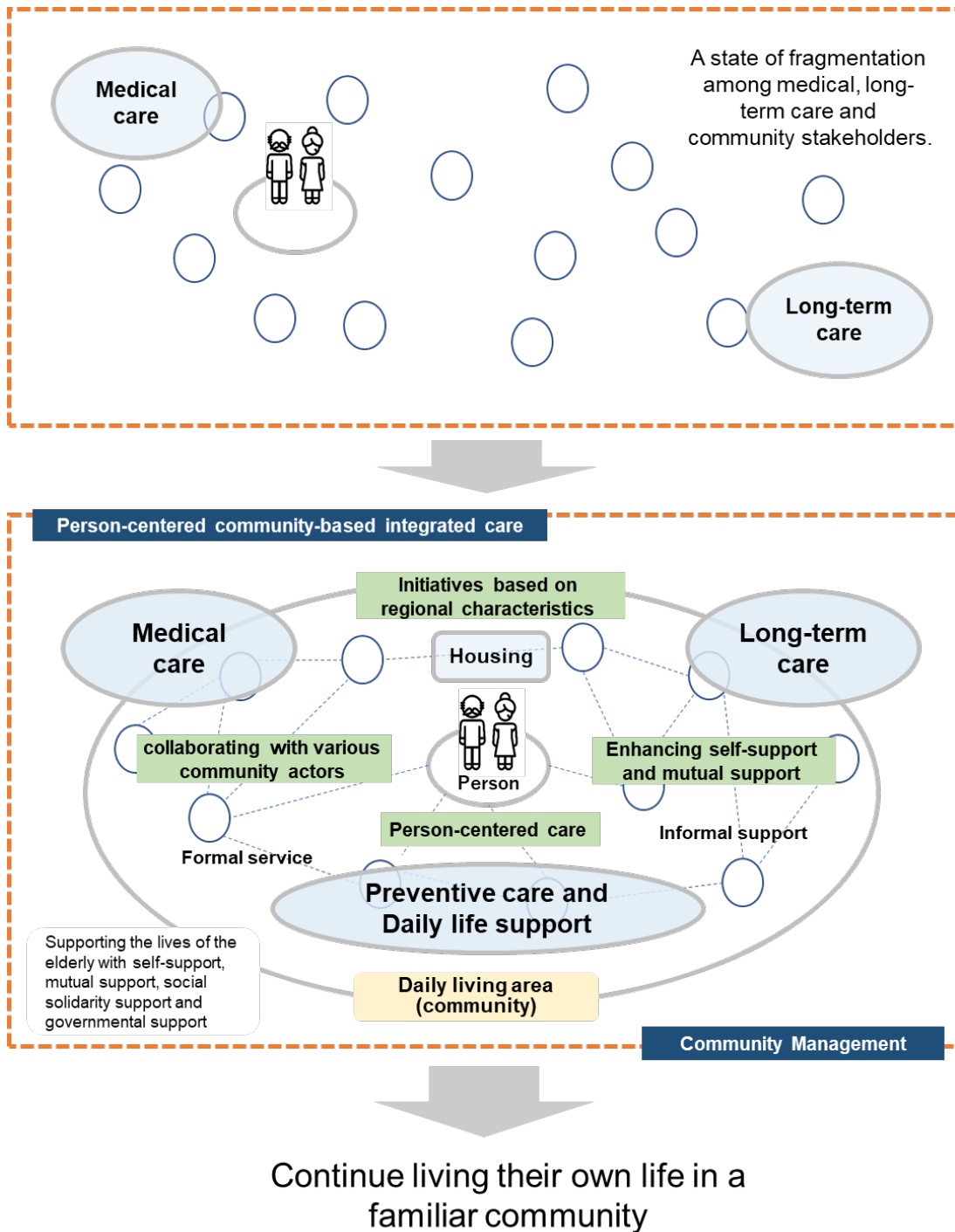


Fig. 4-1 Community Targets by Community-based Integrated Care

### 4.3. Further possibilities of the community-based integrated care system

#### (1) Community-based integrated care system as an evolving process

Community-based integrated care systems are a mechanism for providing housing, medical care, long-term care, preventive care and daily living support in an integrated manner, and the aim is that this system be constructed by 2025. However, there is no single idea for this and no perfect format. As we have seen in each

of the cases presented, each community has its own challenges, and to improve the community requires the participation in community development of government officials, medical and long-term care providers, people in the community, and then the individual that has the challenges, with each person doing what they can. In this way, communities are shaped by the involvement of people, and change shape according to the needs of the time and the community's resources.

Community-based integrated care systems are a mechanism that will continue to evolve as each individual thinks about and works on the ideal way of living life the way they want. By continuing to use this mechanism, residents will further connect, develop, and expand the communities that are built as a result. As long as the progress from this process continues, it will be able to be inherited from one generation to the next.

## **(2) Towards the realization of a community symbiotic society**

The opportunity to build community-based long-term care systems came from a review of the long-term care insurance and the need for comprehensive support for the lives of older persons in each community, based on the conditions of that community. As mentioned above, efforts towards building a community-based integrated care system differ for each community, but while the development processes may differ, they continue to evolve within each community.

For example, in Komagane City, collaboration is underway with the organized integration of various service providers, such as government and medical institutions, and government and private companies etc. In Fujisawa, the targets of the community-based integrated care system are expanded to everyone in the community, encouraging exchanges between the generations, from children to older adults. Also, in Higashiomi City, diverse community resources have been created along with supportive relationships to support the elderly.

This evolution is also consistent with the idea of a “community symbiotic society” that Japan is aiming for by 2040.

*“The thinking behind the development of the community symbiotic society goes beyond the framework of institutions and fields and the conventional relationships of ‘supporting side’ and ‘supported side’ as a way of thinking about communities and society in an inclusive manner where people are connected to each other and to society, and each person has a purpose and a role and lives in a way that supports each other<sup>45</sup>*

By 2040, the older population will increase even further, and many older persons will live in communities. Also, older people that are living in 2040 will witness the problems of a super-aged society, and older people of the modern time will have many diverse values having experienced the development of ICT (information and communications technologies) and changes to the community.

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<sup>45</sup> Final Report of the “Study Group on Comprehensive Support and the Participation and Collaboration of Various Parties towards a Community Symbiotic Society”

There will also be a variety of health conditions and living environments, depending on the individual. With such diversity of people, the society in which we will live will be pluralistic, and in such a pluralistic society it is important to include everyone in dealing with all kinds of values and challenges that they will have. This process of inclusion, will lead to the realization of a “community symbiotic society” where all people can live together in the community.

In the cases that have been introduced, the efforts made to build and promote a community-based integrated care system have been practiced as inclusive communities including all people, regardless of age, profession, or disability etc. This has fostered “mutual support” which goes beyond roles such as “supporting side” and “supported side.” These are efforts that lead to a “mutually supportive” society in which all people, whether older adults, people with disabilities, or children etc., have connections in society and create purpose in life together. The community-based integrated care system will further develop as part of this process of evolution.



# Chapter 5. Suggestions for Developing Countries (Recommendations)

In this Chapter, after examining the current conditions and issues in developing countries from the perspective of community-based integrated care, suggestions will be presented from the experience of building community-based integrated care systems and promoting them in each community in Japan, for developing countries with aging populations.

## 5.1. Current state of developing countries as seen from the perspective of community-based integrated care

The current state of aging in developing countries, particularly in Southeast Asia and Latin America, will show significant progress into the future. In these developing countries, the state of aging and socio-cultural background differs but from the perspective of building a community-based integrated care system there are some commonalities in the current state and issues, and in their strengths. These will be summarized below.

### (1) Current conditions and issues in developing countries

Table 5-1 shows the current conditions and issues in developing countries related to the building of community-based integrated care systems, organized from the perspectives of formal services and community/society.

Table 5-1 Current Conditions and Issues in Developing Countries

Current Conditions and Issues	
Formal Services	<ul style="list-style-type: none"> <li>- Social security programs on health and income security etc. tend to be immature, fragile or fragmented (there are issues such as financial aspects, benefits package, and population coverage, etc.)</li> <li>- “Supportive medical care” is underdeveloped for changing disease structures from infectious disease to chronic disease (there are low priorities in the fields of recovery medical care and home medical care, rehabilitation and long-term care, and a lack of resources)</li> <li>- There are insufficient efforts of preventive activities (self-management and healthy behavior)</li> </ul>
Community/Society	<ul style="list-style-type: none"> <li>- Due to the social advancement of nuclear families and women, etc., in some areas the socialization of long-term care is required.</li> <li>- Traditional values are diminishing, and mutual support is declining in urban areas</li> <li>- There is discrimination and prejudice against older people (ageism)</li> </ul>

○ Formal services

In terms of formal services, in many countries the social security programs on health and income security, etc., tend to be immature or vulnerable, and even where programs have been introduced there are issues with financial aspects and benefits, and coverage rates etc. As a result, there is insufficient medical services if you get older or sick and insufficient income support when work is difficult due to physical or mental deterioration,

and life itself can be difficult to live especially in the absence of reliable relatives. According to the World Health Organization (WHO) World Report on Ageing and Health<sup>46</sup>, in a survey of people aged 60 or over, as reasons for not having access to health services about 60% of respondents from low-income and middle-income nations mentioned “unable to pay for medical expenses.” As can be seen from these results, for older people with growing medical needs this lack of medical and income insurance can be a serious problem. In addition, there is also the issue that these formal services are typically spread across a wide range of ministries and agencies, so that their operation is fragmented<sup>47</sup>.

In addition, in developing countries as in developed nations, the disease structure is changing from infectious diseases to chronic diseases, but the priorities on fields such as recovery medical care and home medical care, rehabilitation, and long-term care are low and there is a lack of resources, such that the transition to medical care that supports everyday living while people are sick has not progressed. In the “Global Strategy and Action Plan on Ageing and Health” adopted by the WHO General Assembly in 2016<sup>48</sup>, Strategic Objective 3 is “Aligning health systems to the needs of older populations,” noting that the existing systems focusing on for acute illnesses cannot sufficiently respond to the needs of older persons.

Furthermore, as the number of patients with chronic diseases increase, the importance of self-management for relieving the symptoms of chronic illness has been noted. It is essential to work on preventive care by managing their own health and illnesses, so that even if they have chronic illnesses, they can maintain their physical and mental health and continue to live and prevent the worsening of physical and mental conditions as much as possible. Such self-management support measures have been introduced in some developed nations such as the UK, but as ageing progresses in the future the number of patients with chronic illnesses will increase and in developing countries the importance of these things will increase more and more<sup>49</sup>. Also, regarding the prevention of chronic diseases, the WHO Report (2015) states the need for measures to prevent the outbreak of chronic diseases and for healthy behavior to delay such diseases.

## ○ Community/society

Not only in Japan, but also developing countries are undergoing major changes in communities. Particularly in urban areas in Asia, nuclear families are becoming more common as the migration of young people from rural areas to urban areas also increases due to the progress of urbanization. With such changes to society and family structure, and the social advancement of women who have previously been in charge of long-term care within families, the care system functions of traditional families can have been weakened.

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<sup>46</sup> WHO (2015) World Report on Ageing and Health. p.91

<sup>47</sup> For example, in Thailand, the social insurance system is operated by the Social Security Office of the Ministry of Labour, social welfare is operated by the Ministry of Social Development and Human Security, public health is operated by the Ministry of Public Health, and the National Medical Insurance is operated by the independent administrative agency of the National Health Security Office. (Reference: MHLW “2020 Overseas Status Report” <https://www.mhlw.go.jp/wp/hakusyo/kaigai/21/dl/t2-04.pdf>) (Accessed: June 11, 2021)

<sup>48</sup> WHO (2017) Global Strategy and Action Plan on Ageing and Health (<https://www.niagaraknowledgeexchange.com/wp-content/uploads/sites/2/2018/08/WHO-GSAP-2017.pdf>) (Accessed: June 11, 2021)

<sup>49</sup> See Takako Tsutsui (2019) “Deepening the Community-based Integrated Care System: Change management using integrated care theory” p.354-356 about self-management support.

As a result, while the population of people in need of long-term care due to aging is increasing, it has become difficult for families to meet long-term care needs and in some communities the socialization of long-term care is required<sup>50</sup>.

In response to such issues, in the WHO “Global Strategy and Action Plan on Ageing and Health,” Strategic Objective 4 is “Developing sustainable and equitable systems for long-term care,” which promotes the creation of systems of collaboration between older adults and their families, communities and public or private long-term care providers etc.

Also, based on the social changes mentioned above, particularly in urban areas where the inflow and outflow of populations is most intense, it can be assumed from the experience of Japan that this will lead to a diminishing of traditional values of these communities and a further decline in mutual support.

Furthermore, in the WHO 2016 “Global Strategy and Action Plan on Ageing and Health,” ageism is mentioned as an obstacle to the implementation of the strategy and plan<sup>51</sup>. Ageism refers to prejudice and stereotypes about age, and also organized policies or activities in the form of discrimination, prejudiced attitudes, discriminatory practices and stereotyping based on it, and it can take various forms. As the population ages, rather than simply dispelling discrimination and stereotypes against older persons and seeing them as a burden on society, it is necessary to create societies in which each older adult plays an active role as a member of society.

Because of ageism, the social participation of older persons is also assumed to be limited. As active aging is promoted, it will be important to promote efforts to get elderly people to have roles in society and to have opportunities to participate in society.

## **(2) Strengths of developing countries**

Up to this point, the current condition and challenges of developing countries in terms of the progress of aging have been highlighted, but there are also many points that can be seen as strengths in promoting community-based integrated care. While the functions of mutual support are declining with the influx of population into urban areas due to industrialization, in more traditional rural communities there are still many areas where a strong sense of solidarity with family and neighbors remains, based on territorial connection, religion and ethnic ties. In such areas in particular, regular religious events such as meetings and festivals are held, based in temples and churches. Also, depending on the religion, Buddhism has the concept of “paying offerings” and Christianity has the teaching of “love your neighbor,” and so in many countries giving to others and caring for others is natural, and the relationship of mutual support has already taken root as a religious value.

Due to such strong connections between residents, groups such as health volunteers, older adults volunteers,

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<sup>50</sup> These changes to the community are also mentioned in WHO Report (2015) p.12

<sup>51</sup> WHO (2021) Global report on ageism (<https://www.who.int/publications/i/item/9789240016866>) (Accessed: June 11, 2021)

or mother's groups etc. tend to be organized within communities, and this can also be of use within the health system.

For example, in Thailand, there are about 1 million health volunteers nationwide as workers in primary health care. Those registered as health volunteers with the Ministry of Public Health have allowances paid for transportation etc. and carry out health promotion activities and home visit care in their communities.

Also, in Vietnam, "multi-generational self-support clubs" have been organized nationwide with the support of HelpAge International, providing health checks and home care for older adults in need of support<sup>52</sup>. The independent activities of these residents are also important resources in promoting community-based integrated care.

On the other hand, regarding medical care provision systems, while Japan's system is private-sector-driven in which more than 80% of hospitals and more than 90% of clinics are private<sup>53</sup>, developing countries' systems are mostly dominated by the central government or local governments. This dominance of the government sector in health systems can be a strength in promoting community-based integrated care.

Unlike Japan, where each medical facility has its own management policies and must therefore by definition be fragmented, in developing countries it is easier to institutionally reflect the policies of national and local governments in the operation of medical facilities, meaning that governance is likely to work when developing collaboration between medical institutions. In addition, the fact that community primary medical institutions not only treat residents but are also responsible for health management and disease prevention is a great strength when providing "healing and supportive medical care" to the community.

This describes some of the current conditions and issues, and the strengths of developing countries in relation to aging, but on the other hand, the socio-economic conditions and social security system development status, as well as the disease structure and socio-cultural backgrounds for these countries vary, so efforts to develop community-based integrated care systems need to take into account an analysis of the current issues and needs of each country as well as community characteristics.

## **5.2. Suggestions for developing countries**

As could be seen above, there are various issues in developing countries relating to aging, but on the other hand there are also still relationships of mutual support in communities and many other areas of strength for the promotion of community-based integrated care. In the future, as aging further progresses, it will be necessary to leverage these strengths and overcome the challenges to continue working on the realization of a society in which older adults can live the lives they want to live with dignity.

In this regard, there are suggestions that can be presented to developing countries from the experience of

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<sup>52</sup> HelpAge International website (<https://ageingasia.org/ageing-population-vietnam/>) (Accessed: June 11, 2021)

<sup>53</sup> MHLW 2019 Medical Facility Survey

Japan in the development of community-based integrated care. Also, in some communities in developing countries they are facing the same decline in community ties in urban areas and growing need for the socialization of long-term care as Japan also experienced, and Japan's experience in responding to these social changes through the promotion of community-based integrated care systems may be useful in developing countries.

Given all of this, the following suggestions for developing countries have been summarized as recommendations based on the considerations from the three practical case studies presented above and Japan's own experience.

### **(1) Designing comprehensive older adults care policies and programs from a long-term perspective**

In general, it is a common social norm in developing countries that caring older adults is mainly a family role, and government support for older people is mainly centered on medical care. Aside from this, for older adults with no relatives, they are provided with institutional care as a remedy when families and the community are unable to support them.

On the other hand, due to changes in social conditions, there are many communities in which the functions of traditional familial care systems are weakening. From the experience of Japan, as nuclear families and the advancement of women into society progress, it will eventually be the case that caring for older adults with families alone will be difficult. Given this, governments in developing countries will need to design policies and programs with a long-term perspective to respond to the future aging of their societies.

As outlined in Chapter 2, from the 1950s to the 1990s, Japan developed medical-centered measures such as increasing the quantity of health service provision to respond to the rapid progress of aging in society. However, as a result, care needs other than medical care also came to be handled at hospitals, and "social hospitalization" became a problem.

Also, before the introduction of the long-term care insurance, measures to support older people's daily living were divided into "welfare" and "health care," resulting in fragmented services. Care at hospitals and facilities that were disconnected from the community and fragmented care were far from the lives of older people in the communities that they were familiar with, and this hindered the dignity and autonomy of older people. At the same time, responding to the daily living needs of older people with chronic illnesses by health service provision system focusing on curative care was also financially inefficient and caused unnecessary financial pressure. Such policy development centered on medical care from the Japanese experience is also at risk of being followed by developing countries.

It is important to predict trends in aging and social conditions with a long-term perspective and to consider from the perspectives of guaranteeing the rights of older adults and from financial aspects, and not just medical, how comprehensive care such as long-term care and living support etc. will look, and how it will

be provided to older adults.

## **(2) Designing communities where older adults can live with dignity (Transition to the social model)**

To support the dignified lives of older adults, it is important to provide not only basic needs such as food, clothing, and shelter, but to also provide an environment in which the wishes of the individual will be respected, and to provide care based on the life that the person themselves want to live. For these purposes, it is necessary to support as much as possible continued life in familiar communities, in connection with familiar people such as family and friends.

In developing countries, the families that traditionally supported the lives of older adults are declining, and the number of single or couple-only households among older people's households is increasing. Also, the services of related organizations for older people (medical institutions, municipal welfare departments etc.) are often fragmented and often have inadequate perspective on comprehensive care focused on the life of older adults. Thus, this alone is not expected to be sufficient to support their living.

As the number of single or couple only households among older people's households is increasing in Japan, it was found that there was a limit to what professional medical and long-term care services could do to support them with declining physical function and cognitive ability in continuing to live in their communities.

In the end, for older people to be able to live with dignity until the end of their lives in their own communities it requires not only professional medical and long-term care services, but a recognition of the essential nature of the will to live (self-support) that comes from living the life you want, and connections and supporting relationships (mutual support) with people in the community, as these services are made use of in daily life.

For example, in the case of Higashiomi City, the provision of medical and long-term care services in the communities in which older people live, and self-support with an emphasis on the autonomy of the individual and mutual support from the community, showed that it is possible to provide a considerably dignified life for an older adult. However, to foster such self-support and mutual support, there need to be changes in communities and society, or that is, a change to the social model.

In the practical cases of Grundtvig and Aoi Care in Fujisawa City, by opening up activities related to long-term care services to the public, connections with diverse people are made, making a difference in the community. By engaging with diverse people, including older people, a change takes place in the values of people in the community with respect to the aging and illnesses, and the social relationship previously based on "supporter and supported" also changes. In such a community, older adults can to live with peace of mind in supportive relationships, with their self-determination and wishes respected.

In the case of Komagane City, the local government, a hospital and professional organizations worked together and changed the way they provide care, empowering older persons and increasing their motivation

for self-management, resulting in older people's continuing living at home.

In developing countries, as the family care system is weakening, while it can be difficult for older people to be able to continue living in their communities, on the other hand there is still a strong sense of community solidarity and mutual support functions due to traditional values, which are also a great strength. Taking advantage of such strengths for designing community-based integrated care that nurture self-support and mutual-support will be particularly important perspectives for realizing the dignified life of older adults.

### **(3) Working on community development as an evolving process**

In all three of the case studies, they develop the community through the promotion of the community-based integrated care. In particular, based on the participation and dialogue with various stakeholders, visions are shared between community stakeholders, government, professionals and residents, and community issues and solutions are considered, bringing changes to the community through their efforts to solve these issues. This is a part of changing the traditional communities, but it isn't the case that from prior to the creation of these systems a perfect form has already been determined. Those models were actually created by following a democratic and evolving process.

Stakeholders all come together towards the wishes of older adults to continue living at home and continue enjoying their favorite hobbies and worked towards realizing this. This results in the building of flat relationships between people, who are really enjoying their work. However, this process of community development requires leadership to manage it, and if properly managed these so-called new community models will naturally develop.

Also, when building a new model in such communities, it is important to focus on what you already have and on tangible and intangible values. In the case of Komagane City, a private fitness club is tried to promote self-management within the community. In this way, it can be effective to capture and use resources that are widely available in the community rather than just being limited to the fields of medical care and welfare. Also, from the experience of the "community verandah" in Fujisawa as a place for multi-generational exchange, this made it easier to settle and make sustainable activities based around the "neighborhood association" as a body of the traditional community. In developing countries, since there are various activities that will have already been attempted with the solidarity of residents, activities based on this foundation are also likely to be effective.

In any developing nation and its communities, changes in economic and social conditions can be significant and it is necessary to respond to the diverse and complex issue of aging against such a backdrop. Therefore, it is necessary to create communities where older people can live their lives with dignity based on the conditions and needs, issues and resources of any particular community or era. The experiences of Japan mentioned above are sure to be a good reference for working on the development of communities in developing countries to respond to the challenges of aging.

#### **(4) Seeing older people not as people that need to be supported by others, but as supporters of themselves and others**

As disease structures in developing countries transition from infectious diseases to non-infectious diseases and as the treatment period is expected to be prolonged, it will be important to actively incorporate efforts for self-support, including self-management and prevention. On the other hand, depending on the country, there may be little consciousness of self-management or preventive activities, and these may not have been actively attempted at either public or individual levels. For older people with reduced physical function, in some cases when the family and society fail to understand the idea of aiming for physical and mental independence by using the remaining functions, and as a result this can lead to a further decline in mental and physical function. It is important to work to break down ageism and to empower older adults and support their autonomy in life, increasing their motivation to live, which in turn maximizes the effectiveness of professional services including medical treatment.

When thinking about the empowerment and self-support of older persons, their initiative is important. In terms of self-support, the concept of autonomy to “decide your own life for yourself” and “live your own life” are important elements. In the case of Komagane City, when individual older adults take charge of their own medical management, this raises their consciousness of self-support to maintain their physical and mental health and prevent the deterioration of illness, and this has a positive impact on health. In the case of Grundtvig in Fujisawa City and Team Eigenji in Higashiomi City, the decisions of the individual as to what they want to do are also supported, and the individual is cared by supporting the realization of their wishes. Such care empowers the individual and increases their motivation to live.

In addition to the perspective of self-support, it is also important to include older adults as one of the actors involved in thinking about solutions to community problems, including problems that they face themselves. By addressing a particular challenge rather than seeing older adults as the problem, older adults are able to play an active role and find fulfillment. The empowerment of older people is essential to this. In the case of Fujisawa City, older people are contributing actors in the development of the community and there is a focus on what each person can do and what role they can play in the community. In the efforts of Team Eigenji in Higashiomi City, they also support what the individual can do and wants to do, even for an older adult in need of support, and they created opportunities for social participation.

Thus, contrary to ageism, it can be said that the main point in supporting the dignified and autonomous lives of older adults lies in changing perceptions and breaking away from the stereotypes that older people “can’t” or that they “need support” and seem like a problem and transitioning to the perception that older people can be “supporters” both of themselves and of others.

#### **(5) Creating a mechanism of providing medical care that aims for returning to live at home and continuing to live at home**

Many of the diseases that affect older people are characterized by requiring continuous medical management, and when rehabilitation after receiving acute care at a higher medical institution or follow-ups



after discharge are insufficient the risk of readmission or being bedridden is high. In developing countries, often when a person suffers worsening lifestyle related diseases or falls etc., requiring inpatient treatment, the patient is discharged and sent home without mindfulness of home life and rehabilitation or service coordination. Also, after discharge, they are often not managed properly by a medical professional and the medical guidance provided to the patients or their family is often lacking, and in some cases, they remain bedridden after discharge from hospital.

As seen from the efforts to provide seamless care in Japan, keeping in mind life after discharge from the time of admission and through the coordination of medical care and services (community collaboration critical pathways and hospitalization support), the integration of medical management and life is improved, leading to a reduced risk of readmission or becoming bedridden. Also, as in Komagane City and Higashiomi City, it can also be effective to focus on the problematic disease and increase the integration of medical management and daily life.

In many developing countries in which the government is responsible for most of the healthcare delivery to older adults, community public medical institutions are often responsible not only for the treatment of residents, but also for their health management. This is favorable for providing consistent medical care from the hospital to the home. There is a need to focus on these strengths and to design a medical care provision system that makes it possible to provide seamless care through the acute, recovery and maintenance phases, with the aims of returning to home life and continuing to live at home.

## **(6) Designing administrative systems consistent with the community-based integrated care**

The administrative systems in developing countries vary from country to country. In some countries, decentralization is promoted but there are also cases which local governments are not clearly provided with the authority they need, including over the use of the budget, to respond to community needs. Also, for example when medical services are provided by the central government and social services are provided by local governments, the levels of the implementing bodies for medical and social services often differ. In Japan, the various authorities for implementing systems related to older adults' care used to be dispersed among levels of government<sup>54</sup>, and when there were multiple programs for the same purpose<sup>55</sup>, this served as a hindrance to the delivery of integrated service. In designing administrative systems, this point should be in mind. Also, given that the conditions of older adults and communities and the ideas of people within communities differ by the community, it is recommended to have administrative systems that can respond to differing priorities in each community.

It is also important that the community-based integrated care is not just limited to older people but that it is oriented to an inclusive society. In the experience of Japan, programs and budgets are strictly separated for

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<sup>54</sup> The levels of administrative organization were different in Japan prior to 1990, with facility services overseen by prefectures and home-based services overseen by municipalities.

<sup>55</sup> Until the introduction of the long-term care insurance in 2000, even where the content of the service was the same medical care was provided by medical insurance and welfare was provided by the social welfare system, making it a complicated system for users.

each target person, and this can be a hindrance when dealing with cross-targets. It is useful to design programs so that they can respond flexibly to cross-disciplinary needs, regardless of the target.

**(7) Additional point to remember when promoting community-based integrated care**

Finally, here is another key point to remember when building and promoting a community-based integrated care.

It should be noted that when aiming for a society in which older people are able to live with dignity in their own communities, there are limitations to the approach of building and promoting a community-based integrated care on its own. As mentioned in 6.1 (1) on the current conditions and issues, in many countries medical and income security are immature or vulnerable, and health care and income security are an essential part of realizing a dignified life. When creating and promoting a community-based integrated care, its foundation is the development of basic public services. It is also particularly important to train the professionals that support the lives of patients with chronic diseases, in at-home medical care and rehabilitation. They are an important part of the foundation of community-based integrated care.



