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Helena Erjanti (ed.)

# REFURBISHING ELDERLY CARE

## Strategy of Cost Efficiency in Theory and Practice



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A•60**

# **Refurbishing Elderly Care Strategy of Cost Efficiency in Theory and Practice**

**Helena Erjanti (ed.)**

2007 Vantaa

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ISSN 1458-7211  
ISBN 978-951-799-119-3

Edita Prima Oy, Helsinki 2007

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# Foreword

## **Overhauling Elderly Care – the Strategy of Cost Efficiency in Theory and Practice**

The Second Finland-Sendai Seminar, held in September 2006, formed part of a cooperation agreement made between Tohoku Fukushi University, Helsinki School of Economics, Laurea University of Applied Sciences and the cities of Espoo, Vantaa and Sendai for developing services for senior citizens through a shared research and development programme. The agreement was made in Sendai on 22 May 2006. The First Finland-Sendai Seminar was held in March 2006. In it, experts from Tohoku Fukushi University, Helsinki School of Economics and Laurea University of Applied Sciences, as well as employment sector experts from Japan and Finland, presented innovations created in their countries for meeting the increased demand for services for the elderly. The seminar held in September 2006 continued on the themes developed in the previous seminar, accentuating the cost efficiency and profitability of health and social services.

In Finland, most services for senior citizens are produced by the public sector. The acquisition of nursing, care, rehabilitation and other similar services from the private sector is already very common in Finland and will most likely increase in the future. Networking know-how can be useful for clarifying the operating models of service providers and increasing cost efficiency. For example, the gross cost of senior services in Finland is now over EUR 1.7 billion per year; as the number of elderly citizens doubles within the next 30 years, the cost will also double if the current service structure and operating models are followed. At the same time, opportunities for public funding will decrease. Developments in Japan are following a similar pattern. The creation of more functional and efficient operating models for the consolidation of public service production and the acquisition of nursing, care, rehabilitation and other services from private providers can for its part reduce the gap between increased demand and decreased funding in Finland and Japan.

This publication contains the presentations held during the Second Finland-Sendai Seminar in September 2006, discussing the total cost efficiency and profitability of health and social services in Japan and Finland. Comparative data will help both countries develop the effectiveness and cost efficiency of services. This publication compiles 16 presentations that shed light on the future challenges regarding costs and profitability faced by services for the elderly in Finland and Japan. It focuses on the cost structure, cost correlation and production of health and social services for the elderly in the public and private sectors, and on data for analysis and research. The publication also includes the preliminary results of the Active research and development project, based on the agreement mentioned above, which aims at developing services for senior citizens. This publication forms part of Laurea University of Applied Sciences' publication series.

Special thanks are due to Dr. Koki Hagino, Rector of Tohoku Fukushi University; Dr. Eero Kasanen, Rector of Helsinki School of Economics; and Dr. Pentti Rauhala, President of Laurea University of Applied Sciences, for their efforts in coordinating of research and development work. Thanks are also due to the members of the steering group, Dr. Koichi Ogasawa, Dr. Kristian Möller, Dr. Juha Metso, Dr. Jaakko Valvanne, Mayor Ossi Savolainen and Dr. Tiina Mäki, as well as to the steering group of the Second Finland-Sendai Seminar and all other organisers, for their contributions to a successful seminar. Special thanks also to the experts who made presentations at the seminar and for contributing to this publication. Finally, I would like to thank all of the seminar's financial supporters, as well as Marketta Kokkonen, Mayor of the City of Espoo, and Juhani Paa-janen, Mayor of the City of Vantaa, for promoting the agreement.

Vantaa, 2007

Helena Erjanti

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*Koichi Ogasawara*

# **New Way to Cost and Profitability of Health and Social Services**

*-Japanese Experience of 5 Years and the Next Research Task-*

This article is a part of research results funded by the Ministry of Education and Science Academic Frontier Project, JSPS Research Grant, Nissei Foundation and Insurance Japan Foundation.

## **Abstract**

In April 2006, the reformed Long-term Care Act was comprehensively in force. The legislation was enacted in 1997 as one of the most crucial parts of so-called Welfare Reform and put in force in April 2000. 5 years experiment of marketization of the elderly care services has definitively showed the idea that care service provision system needs more effectiveness for clients QOL and improved cost performance in socio-managerial view point, not through the pass of enhancing competitiveness and short-range improvement of cost performance, but through the another pass of creating a integrated critical pass system and networking of social capitals for optimizing consisting services provision. The experience suggests that the long-term care system, whatever it is for the elderly only as is in Japan or of multiple services for the elderly, disabled, as well as the patients as is in Finland or other neighbor EU nations, is in the process of convergence toward integration and networking solution, so that intensive research on the elemental structure and functional mechanism of the integration/networking solution is keen to built a future model of integration and networking solution.

## Introduction

During the course of so called Welfare Reform, the first watershed legislative package was enacted in 1990, where total 8 pieces of welfare legislations, headed by the Elderly Welfare Act, were restructured. Emergence of the concept “care service” in a series of legislations is of historical importance in the sense that it creates dualism in social service into social work on the one hand and care service on the other. This introduction emergence of the concept in public policy on social service was closely linked with the policy of deregulation of service provision for the private sector, a kind of welfare mix policy, in order to enhance activities of the private care providers and extension of care service market.

“Care service” at this particular legislative reform means care service for older persons and infancy service for the children under the age of primary school. “Care service” represents generalization and universalisation of those service needs. “Care service” also includes the trend towards communization of the service provision system, so that clients and their families are afforded to use services on their needs within the inhabitance.

The dualism in social service has prompted a division of social work and care work. In other words, division between ADL oriented care services and mental support/social integration oriented social services has been prompted even by the legislation on the vocational qualifications in 1987, where social worker and care worker are defined as a different types of expert and ranked in ladder within higher education system. “Care service” also implied division of work in between nursing and caring to specify roles and functions into each qualification related unit.

The enactment of the Long-term Care Act in 1997, and the full implementation in 2000, highlighted the divided structure of care, cure, and social work services in a way that it put the division in the form of legal institutional structure with creating the types of services rewarded by each individual insurance payment packages. The Act of 5 years validity was due to be reviewed in 2005. Second term of the Act was started partly from October 2005, but fully from April 2006. There is a visible jump from the first phase to the second of the legal system in its approach to the elderly care.

The jump is from deregulatory-market model oriented approach to networking-model approach, from individualistic consuming approach to community-solution

model approach, and the elderly care specified approach to the more universal security of the care service approach. This paper is to, firstly, describe the reasons for the jump, secondly to find the structure of the reformed care system, and thirdly to focus on the policy move towards community based networking of sub-systems of multi-disciplinal medical/social service provision.

## **5 years of the first Long-term Care Act**

### ***a. Long-term Care System as the Social Infrastructure***

Japanese long-term care system was institutionalized and in action in April 2000. It carries three distinguished aspects from comparative point of view. Firstly, it was framed as a social insurance system with 50-50 budgetary contributions of the population above 40 years old and of the central and each provincial governments respectably. It is therefore the system of impartial and universal insurance to afford care service socially for the person who has the need to be cared and is assessed as being in need.

Secondly and nevertheless, it provides quasi-market system by deregulating care business in the care service provision process. Though the role of care-manager was introduced, care provision under the system is on the policy assumption that care services are able to be customized, so that every care qualified workers can perform services in the same way and therefore increasing number of care service providers may contribute to the policy target of securing universality and impartiality in care services provision.

Thirdly, the first Long-term Care Act targeted only such category of population who lost capability of daily life self-support to be in need for the care only because of aging, though there included exceptions of particular diseases. Care for the disabled and handicapped people and long-term patients is not consolidated in the care Act.

### ***b. 5 years in practice***

5 years of the first Long-term Care Act has witnessed, as showed in Table 1, some 17% increase in the elderly population to raise the elderly population ratio from 21.65% in April 2000 to 25.24% in June 2005 when the legislative reform process begun.

The number of the elderly people who is assessed as care service needy has been increased by 91% from 2.18 million in April 2000 to 4.17 million in June 2005. Accordingly, care service users receiving any kind of care service either as home care or as facility care has been raised up by 121%. Raise in home care was so drastic as have about 2.5 times increase in 5 years.

### population over 65

○ **3.6 million increase (17% up)**

	April 2000	April 2003	June 2005
number of 65 +	21,65	23,98	25,24

### assessed as service client

○ **2 million increase(91% up)**

	April 2000	April 2003	June 2005
number of the assessed	2,18	3,48	4,17

### care service receiver

○ **home care 159% up, facility care 50% up, 121% up in total**

	April 2000	April 2001	April 2002	June 2005
Home care	0,97	1,42	1,72	2,51
Facility care	0,52	0,65	0,69	0,78
Total	1,49	2,07	2,41	3,29

Table 1. Increases in elderly population, assessed clients, and service users.

Data: Ministry of Health, Labour and Welfare.

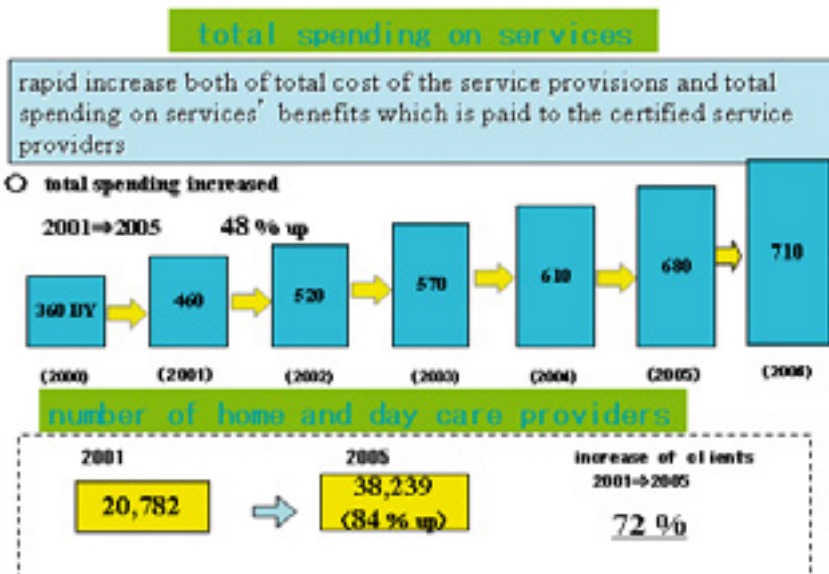


Table 2. Total spending on long-term care service. Data: Ministry of Health, Labour and Welfare

Table 2 shows that total spending on the long-term care services provision by the annual budgetary base has increased by about 1.7 times in the 2005 budgetary year and almost doubled in the 2006 against the 2000 by real volume. Comparison of the budget size between the fiscal year of 2001 which is the first budget based on the real cost performance and 2005 informs us 48% increase had happened. An estimation by the Ministry of Health, Labour and Welfare even tells that size of the budget will be 1200 billion yen in the year of 2015 and 1900 billion yen in the 2025.

On the other hand, number of the service providers increased by 84% in between 2001 and 2005 thanks to the deregulation, while the increase of real service users less increased by 72% during the same 5 years.

Table 2 clearly informs us that the total care service providers increased by 84%, with 72% increase of the users and only 48% increase in the total budgets, during 5 years. Therefore, 5 years experience of the Long-term Care Service Act brings the following results to our Japanese care service system.

care service providers of smaller size in business quantity and care human resources increase, which also links to the lower profitability and lower quality of services small number of rather large scale of providers emerged, which is not really private capital oriented provider, but mainly such providers as rooted in the

special welfare service corporation of legal entity and as originated or substantially linked with the medical-care service corporation.

## **Distinctive shift from facility oriented care to home/residentiality centered care**

On the other hand, 5 years experience also brings us new evidences. It comes to be confirmed that about a half of the causes for being cared in total is from any kind of dementia. About 80% of the causes for being cared in facility care is also from dementia. It is also evident that relatively less serious ranks of care service users has been drastically increased during the last 5 years, so that about a half of the service recipients under the Act is actually categorized into the lowest and second lowest ranks of severity of care need out of 6 ranks in total. Survey on the spending structure of the insurance fund also suggests that there is a clear trend towards dependency on facility care service within the clients who are categorized into the 2 lowest ranks of severity, whereas there is a good amount of ratio of clients in the two heaviest ranks who try to stay at home with receiving home helping and home nursing service together with daycare and other related services.

These evidences show the fact that such system as focusing on the free-choice-contract oriented service provision and as enhancing competitive service provision has been escalating the increased demand for the easily usable services and the increased gap in the real cost spending between to those who need publicly managed integrated and continuous service package and to those who chose single unit of service as one of the selective conveniences. Much use of public resources on choice by the category of people who have less need for the care services and less increase of the packaged care services in including use of facility care by the people who have serious need to be supported publicly implies the fact that micro-rationality of free-choice and contractual use of care services is not always coherent with total rationality of the system of care provision, so that certain initiative for controlling the care service provision comprehensively may necessary for securing the stability and continuity of the care service provision system.

These evidences also show the fact that optimality of the functional mechanism of long-term care of itself should be restructured from that of initially designed. The care service system should necessitated for more preventive service package, more dementia targeted, more multidisciplinary, more community integrated, and more accessible by the elderly and their families in serious need.

## **Restructuring of the Framework for the Long-term Care**

Reforming the Long-term Care Act, therefore, contained two dimensions: redesigning the framework of care system and restructuring the functional process of the care.

The redesigning of the framework is in two holds: change in the basic idea and in the structural composition. The first stage of the Act is based on the idea that the care service is a kind of goods having nature of customizability, being priced per unit, accountability, and availability by free selection and consuming contract. Therefore, there should not be much artificial control on the boundary in pre-active/preventive and post-active/supportive care. Neither should there be much social intervention in the decision making process of the clients and families for the service use as well as in the ruling relations between causes and types of services of the care. As a result, the structural composition of the care is simple in that what the policy did is preparing legally providable service menu, setting the maximum of insurance budget for each individual 6 ranks of care need, equipping the process from application through assessment to the termination of care services, with requiring in principle every clients 10% self payment of the service prices. It is basically for service users' choice and responsibility to find the most suitable service selection. "Care-manager" was newly institutionalized not as an independent expertise, but as agent for the client. Client was able to draw his/her care plan by self-management.

The Long-term Care Act amended has introduced the idea of "community complex care" (chiiki-hokatsu-kea) as the alternative framework. "Community complex care" is a system of multi-expertise corporation to perform client-oriented comprehensive and continuous care. It consists both of physical, mental, and social care services and of preventive/proactive services consistently, and also consists both of specialized services of cure, care, and rehabilitation and of socially afforded voluntary activities. The Community Complex Care Centre is to be located one in each junior high school area where at least one each registered medical/community nurse, registered care manager and registered social worker is allocated, which is expected to work as a team, to perform as community care management centre, and to provide preventive/proactive services.

Registered care manager allocated in the Centre is administratively appointed bet élan and is expected such role as a super care manager who has discretion to navigate performances of each individual registered care manager employed by care service providers and to coordinate good environment of care management.



## Reformed Service Provision Complex

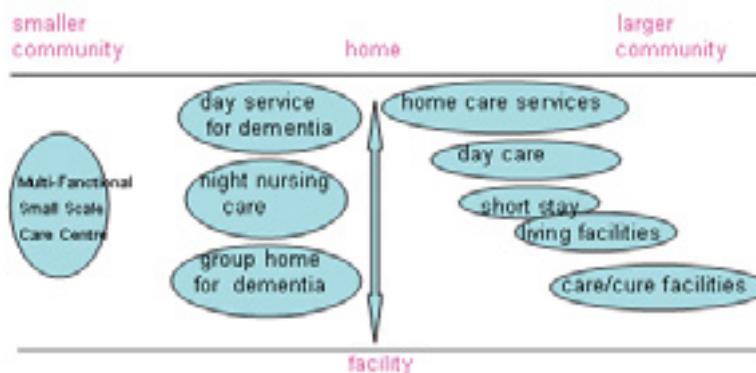


Table 3. Care Service Complex. Source: Ministry of Health, Labour and Welfare, with the author's translation and arrangement.

Table 3 is a map of the community care service complex location under the management of the Community Complex Care Centre. Table 4 shows the concept and structure of the multi-Functional Small Scale Community Care Centre, which has a compact multi care functions, especially for the dementia elderly. In comparison, Finnish model of service integration is mapped in Table 5.

## Multi-functional community based care

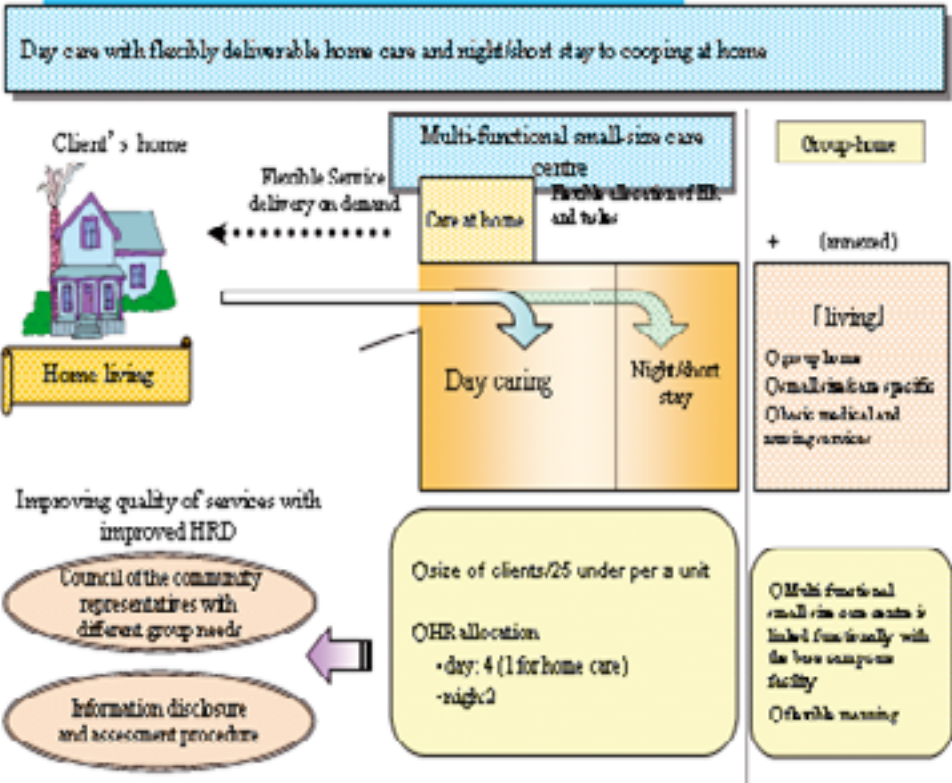


Table 4. Multi-functional Small Scale Care Community Centre.. Source: Ministry of Health, Labour and Welfare, with the author's translation and arrangement.

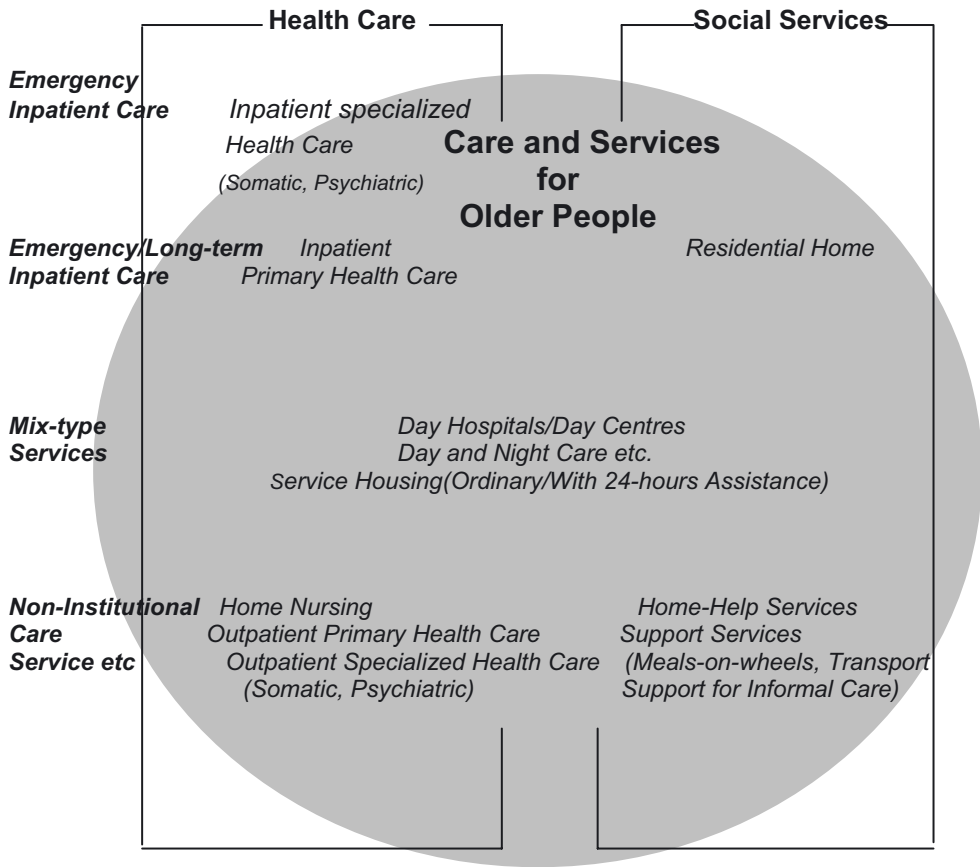


Table 5. *Integrated Social/Health Service Model in Finland. Source: STAKES, Care and Services for Older People 2002, Gummerus Kirjapaino Oy, 2003, p.22, with the author's arrangement*

It is easy to understand that the new framework contains an idea of multi-lateral networking, not just only a series of bi-lateral relations, in differently designed care services for the purpose of rationalizing the inefficiencies the previous framework experienced. The new framework also contains an idea of leanism by small-sizing and communalizing care services provision complex. The attachment of the medical centre of comprehensive health care functions to the Multi-functional Small Scale Care Community Centre is coherent with reconstruction of the medical system, the other side of the elderly care reform.

Comparing the new framework with the Finnish model, we see a certain convergence, except that the Finnish system covers other categories of clients than older people and unification between cure and care is more matured.

The system of administrative navigation by the local government to the registered service providers is also introduced in order to improve quality of services and to standardize social requirement to the providers.

As to reform of functional structure, the target of care service of itself has been renewed from that of supporting self-independency to preserve humanity-oriented QOL. In other words, focus on improving the client's living environment and social relations and on coping continuously with the client's somatic and psychiatric fluctuations in life course becomes the main concern of the care system. Such group of care functions as supporting self-independency in ability of daily life is integrated relevantly into the QOL based care structure. The core change is in the care-management system. Development of skills of assessing needs and complaints, skills of communication with deferent types of clients, family members and experts, skills of managing team care, and also skills of monitoring the process and effect are to be strengthened though the more systematic vocational training, navigation from super care-manager, and re-registration process in every 5 years.

## **Concurrency with the Medical System Reform**

The reforming process of the long-term care system has been in concurrency with the 5th medical system reform. This is the most fundamental in the medical care service provision system in that it introduced the idea of "community critical-pass" as the method of integration of medical/co-medical care resources as well as integration of medical and social service resources at community sphere.

The idea of community based comprehensive medical service of itself has a long history of practice, especially in those underpopulated regions, as an alternative move to the hierarchical division of roles and specialization of clinical medicine. Practice of cooperation between medical/co-medical and care services has also long been practiced mainly by the initiative of influential leaders in the medical side, with formulating several sub-types. The legal reform means inclusion of these matured ideas and evidences from the practice into the legal framework. The policy recognizes these as costless and community-autonomous service provision system.

## Image of the New Medical Plan

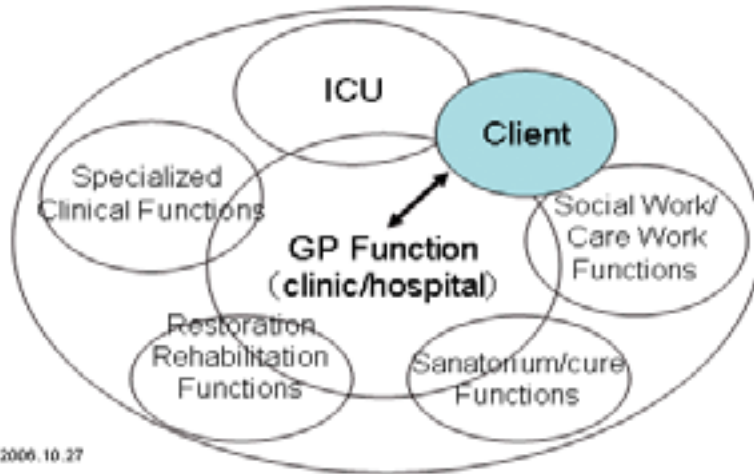


Table 6. Image of the New Medical Plan. Source: a presentation PPT of Professor Yumi Kato, Tohoku Bunka Gakuen. University at community critical pass project, Tohoku Fukushima University, with the authour's translation

As Table 6 shows, the new system is expected to operate by the core role of General Practitioner type of function by the individual clinic or hospital near client's daily living. This is not new in European system of medical service, but quite new in Japan where the medicare system is set on the principle of clients' at-will selection of medical facilities. The table also shows that the community critical pass should be planed in each clinical subject, by allocating the specialized clinical medicine functions. From the long-term care point of view, vascular disease is particularly targeted.

# Reform in Sanatorium System

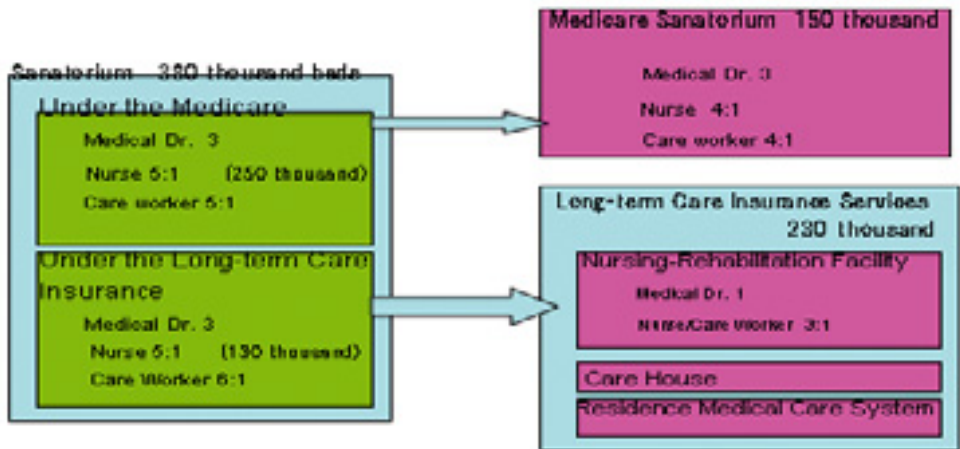


Table 7. Reform in Sanatorium System

# Residence Medical Care System

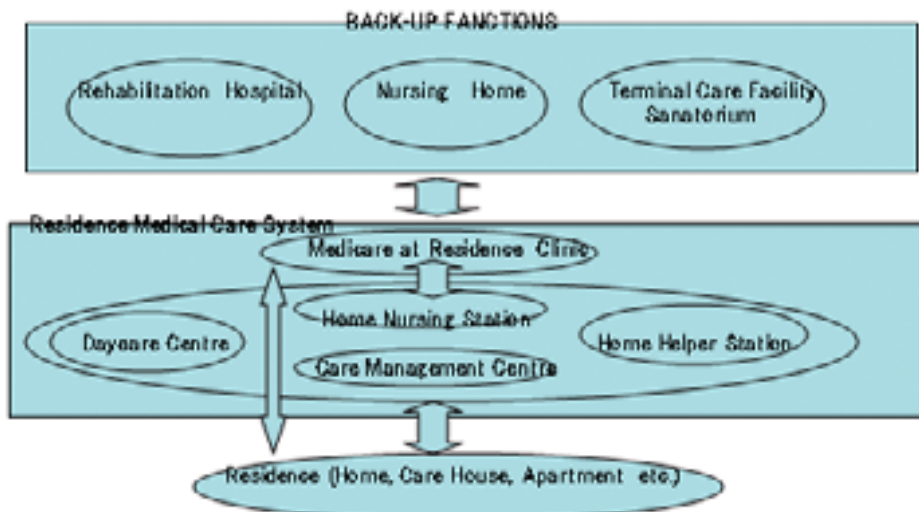


Table 8. Residence Medical Care System allows indicate corporate and provide/receive relations of information, knowledge, and services.

Table 7 shows the structural reform by the second Long-term Care Act in sanatorium service system. Within the same total capacity of bedding, about 60% of the capacity is separated from hospitals to communize into the residential medical care system suggested in Table 8 or other two types of care facilities which locate in the community care network as mapped in Tables 3 and 4. About 40% is reformed more medical service intensive sanatorium system by improving the allocation ratio of the nurse and care workers.

The sanatorium system has institutionalized by the first Long-term Care Act. Both medicare and LTC Insurance were applicable practically by the medical doctors' decision. The result is that almost 80% of the patients living in the sanatorium has no or little need for the medical treatments, whereas the patients needed in the medical treatments were scattered in the sanatorium under the coverage of LTC Insurance. The reform, therefore, has two objects: firstly, transferring non-or-less-medicine targeted clients to the LTC Insurance coverage, and, secondly, strengthening the medical sanatorium substantially as the function of restoration process.

## **Community-based Comprehensive Care: an ideal type**

Communization of the social services is also in the process in other policy areas, especially in the services for the handicapped and supports for the single mothers. "Community" as a functional networking and communization of the social services are now the keyword for the social policy reform. It is the community that is functionally defined and implies networking type of way of functioning (Baidi and Ogasawara 2005). Therefore, it is differently conceptualized community from that in the argument of "care-by-community" or "new public".

The community as a functional complex of medical, co-medical and social services is a kind of process of each client's case pass within the framework of comprehensive team care which is describable in a map of Table 9. This is a community of multi-experts corporation and of continuous pass management. Therefore, we have to define a kind of controlling mechanism to preserve its comprehensiveness and continuity. This is also a community of enhancing tripartite merits: higher managerial performance to each individual service provider, closer mutual benefits of acquiring knowledge and developing creativity for each participatory service expert, and most crucially actualize improved QOL and utility to the client. Controlling mechanism should have self-contained de-

vice of face-to-face adjustment and of multiple commitment to the adjustment with non-cursive procedure.

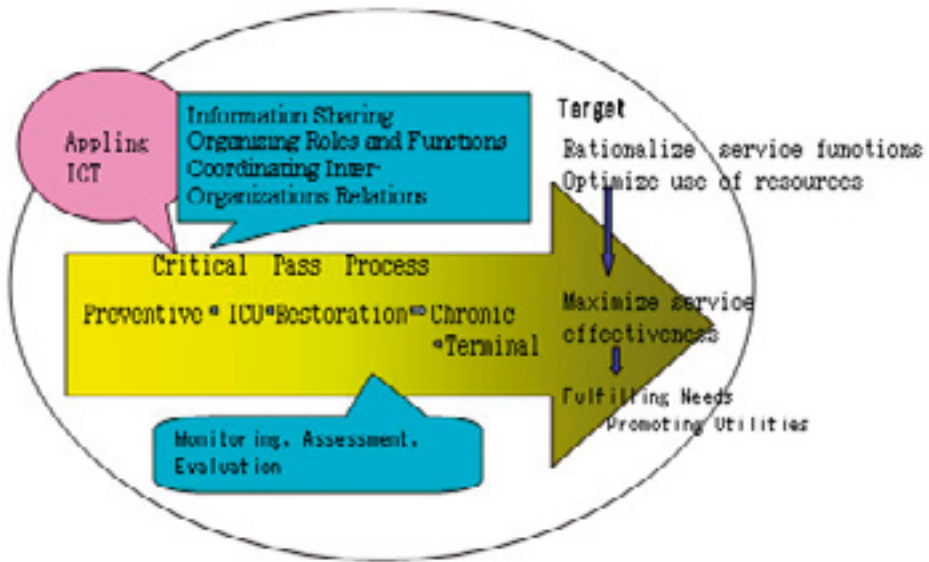


Table 9. Conceptual model of Community Client Pass Network

## Solution System and Social Capital

Previous argument of community based corporation, at least in Japanese welfare studies' context, has tried to create policy administration oriented conceptualization. Central to the subjective notion is administrative organs or institutionalized organizations. Concept has always been designed on the base of authoritative relations of service provision. Reform of the concept has also targeted the more efficiency of the system management. Solutions have tended to be either vertically controllable one or market-initiative oriented de-regulation. At



the stage of welfare state in the industrial society logically ranged in a nation economy, model of vertically control of welfare resource distribution has been justifiable because of the stability of the policy target and monetary resources spendable in the administration of redistribution. However, this pattern of conceptualization is no more valid in our current debate, where the target and method of medical/social services is more individually specified, more commoditized in the process of life living, and more non-monetarised.

If we are able to define the welfare system as a system for providing fairness in social opportunities for one's own wellness in life through one's own way and efforts, the system should have consolidated structure of four different sub-systems of distributing indispensable resources. Characterizing those four by the definitions of the mode of resource distribution, the intermediate media of distribution, and the relativeness of sharing distribution respectively; sub-system 1 is family characterised by self-support, love, and intimateness, sub-system 2 is association by mutual-benefit, solidarity, and partnership, no matter whether stake holding relation is selective like company or the membership is not optionable like neighborhood society, sub-system 3 is the government by redistribution, political power, and publicity, and sub-system 4 is the market economy by exchange, money, and materialism (Fijimura 12001 p.14) . In contemporary society, role of company and non profit organization becomes crucial in sub-system 2, optionability of membership or stake holding relationship becomes stronger because of fluidity in residency.

The régime called the welfare state has been a kind of posture or milieu architected of those four sub-systems, in that posture people runs their life on their given conditions. Academic interpretation of the welfare state has weighted sub-system 3 nevertheless(in major Japanese publication, Tokyo University Institute of Social Science 1984-1985 ; Institute of Social Development1992 ; Shinkawa 1993 ; 2006 Part 1 ; Takekawa 1999). Sub-systems other than government have been located as supplementary functional dimension of analysis to the active and interventionistic function of the government to the private autonomous social spheres in the ordinary welfare state studies. The distribution of resources through governmental functions should be based on the public norm of eliminating poverty and disadvantages in social opportunities. It is differently arranged from other 3 sub-systems which have their functional principles on the private autonomy and voluntarism. There is the factor of authoritative adjustment of various social merits and targets. governmental function. The reason for the welfare state studies to have put priority on the governmental function is not the fact that it is the 20 century' historically particular form of distributing welfare re-

sources, but the logic that, seeing the universalisation of the welfare state régime, explanation on the paradigm of legitimacy, degree and range of the public responsibility, and their form of institutionalization is the central pass to assess the dynamism of social development process and historical phase of the post world War II international structure. The analysis has provided us a great knowledge on the comparative types of the regime, the theory of divergence or convergence (Kasza 2006, Schoppa 2006) and the non-European modelisation of the welfare state (Takekawa and Lee 2006).

Transferring from industrial society to the knowledge society and changing in the social mode of distribution/sharing welfare resources, the welfare resource provision system is shifting from the sub-system 3 centred to the networking fluidity in between the sub-systems and various elements of sub-systems. The key factors of analysis is shifting from capital/physical work/vertically controlled division of work mode to the individual/knowledge creativity/horizontally coordinated network of roles mode. The shift is also from organizationally accumulation of skills and know-hows to the individually necessitated nexus of creativity; from justice-based distribution to the fairness in the accessibility to knowledge/information/merits; from applicability and transferability oriented way of value add to the creativity and net participatory way of value add (Westlund 2006, 10).

Facing the shift, the way to support or actualize humanistic quality of life becomes more dependent on the social nurture of enriching relationality of individuals or purpose specific local entities. The theory of social capital has certain variations: P. Bourdeu recognize social capital as a kind of resource acquired by the intercourse in between individuals or groups and JS Coleman see social capital as an structural entity in between or intra networks and groups, whereas Westlund 2006 defines social capital “social, non-formalized networks that are created, maintained and used by the networks’ modes/actors in order to distribute norms, values, performances and other social attributes and characteristics, but also emerge as a result of actors sharing some of these attributes”(Westlund 2006, 8). Despite of the differentials in the conceptualization or of the effort of consolidating varieties, the elementary factors used in the social capital conceptualization may be attractive as a indicators in defining the network.

Table 10 shows the key indicators and contents and indispensability for defining network with comparison of bilateral relation.

		x=dispensable	=partly or incompletely necessary	o=indispensable
indicators	contents		relation	net-work
Norm	Value sharing		x	o
Key resource	Knowledge/information			o
Range of the market	Non-nation wide (global/local)			o
Core discipline	Knowledge creation			o
Owner of capital	Individual/purpose-specific group			o
Key issue	Accessibility and right to knowledge			o
Managerial discipline	Horizontal integration			o
Dependency	Organization needs individual of knowledge/information		x	o
Care capital	Creativity		x	o
Infrastructure	Digital net infra			o

Table 10. Application of the key indicators in social capital to definition of network

Relationship between organizations/groups, typically between companies, is normally have a shape of contract relationship, where each individual organization is supposed to be an right-duty performer on the monetary relation. The fact that even strong mutual commitment relations ever existed in Japanese keiretsu relation has restructured by the keen needs for cost cutting and global allocation. Therefore, it is rather utopian sense to say the relations are based on the value sharing.

We may hypothesize that if certain social capital relation contains those indicators as individual-centered attachmentality, horizontal integration, individual-oriented knowledge and information distribution, creativity and applicability of knowledge, open accessibility to knowledge and information, publicity of merit

distribution, and secession from the political governability, i.e., secession from dependency to the institutionalism and administrative initiative.

## **Conclusion**

Community integrated care is the certainly policy target in providing social resources for the care. It is also logically justifiable as a system of creating corporately and distributing flexibly knowledge based care resources in post-industrial phase of social norm. "Network" is the concept justifying the system and enhancing strategically social transition in the methodology of care service creation and distribution. The previous type of division of work oriented relations in the care service provision may be substituted by the more individual and human resource oriented networking. Vocational qualifications should not be interpreted as a hierarchical job structure, but is to be re-interpreted as a horizontally integratable specialised roles which are accountable by the knowledge each individual qualification holder has.

As a social system, network should contain mechanism for operation, continuity, and self-adjustment. Within the range of the indicators suggested in Table 9, this mechanism may have variations, and variations may be driven by the local circumstance of certain particularities of factors. Finding these variations and driving factors is the task for the case studies.

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*Hisakuni Saito*

## **Care and Buddhism - Another Viewpoint on the Concept of Caring**

### **Introduction**

The nursing-care insurance system in Japan is formulated on the assumption that modern Japanese are individuals produced by modern Western communities. It is doubtful whether such individualism is applicable in Japanese communities. In the past, a characteristic feature of the lifestyle of most of the aged in Japan was their putting a consistent priority on interpersonal relations between others, without asserting their own rights or position. They realized that their social position in the community would decrease, and, in fact, a main hope was not to become a burden for their families. Today, we are often disappointed to see senior citizens in homes for the aged not expressing their views or demanding their rights, but silently accepting their situation. However, we must remember that until recently, most Japanese lived out their lives without the need to make large decisions about their lives and living situations. Is it not a kind of cruelty to abruptly demand self-decision and self-responsibility from them in the twilight of their lives?

In the nursing-care field it is said that we must have respect for the dignity of the aged. In Japan that dignity was traditionally maintained through an understanding of their practical usefulness to the community/family through their manpower for labor, wisdom & experience, ability to coordinate groups of people, and so on. Moreover, in the Japanese tradition seniors took a central role in memorial services, and by telling stories about the deceased, they create a connection between the living and those who passed before. In passing away themselves, they would become guardians, constantly looking over the family to protect them. These perceptions retained the dignity of aged members of the family and community. Family memorial services installing the deceased family member as a guardian are an institution that continues even today. But in our current modernization, perception of the practical usefulness of our aged members is being

lost, and even the traditional ceremonies/institutions are undergoing changes (Shinmura 1991).

The traditional Japanese idea of respecting the aged is related to Confucianism, but this respect does not develop automatically. According to the teaching of Confucius, we have natural feelings of love and respect for those nearest to us - mothers, children, and other near relatives. However, training and conscious discipline are necessary to amplify and apply these feelings to the extended family, region and country. And this process was considered part of study and learning in Confucianism (Zhou 1993).

As mentioned before, the idea of respect for the aged is based on a weak foundation and, nowadays, in fact that dignity seems to be steadily decreasing. In such a situation, there are calls for changing our basis for value from “doing” to “being”. Instead of valuing a person for what s/he does (his/her usefulness), we would value him/her for just being there. This is especially important in the education of people involved in caring profession.

As Mr. Hiroi said in his book about caring, the concept of caring is in conflict with modern science. He illustrated how the concept of caring is in conflict with modern science as follows:

SCIENCE	CARE
1. Isolating and Manipulating subject and controlling nature	1. Sympathy and “ togetherness” with the subject in a friendly atmosphere
2. Experimental and Evidential rationality ( Induction)	2. Importance of individuality and subjectivity of each subject

Figure 1. Science and Care (Hiroi 1997. p.167)

As we see, a scientific approach typically involves isolating and manipulating subjects and controlling nature. And science is based on experimental and evidential rationality. In contrast, the features of care are sympathy and togetherness with subjects in a friendly atmosphere. And the individuality and subjective experience/viewpoint of each subject is important.

And Mr. Hiroi argues that medical treatment as a science must change to “medical caring” in treatment of the aged. In their case, the biological body-functionality irrevocably erodes. Established medical treatment for younger people can be harmful for the aged. Forcible, invasive treatment can reduce quality of life. In this situation, in contrast to the medical model, a living caring medicine model is key (Hiroi 1997). Even in pursuit of a caring model, there is potential for a kind of paradox. Caring professionals are conducting research to establish norms and writing manuals with the goal of increasing the quality of caring. But this scientific approach, while aimed at promoting care, can itself stand in contrast to true caring. We discuss how to develop experts in the field. But at its core, the central subject this debate should not be how to develop individual experts; it is more important to improve general human abilities. The quality of caring depends on every caring staff and his/her ability, knowledge of human nature, and creation of trusting interpersonal relations. Another proper subject of this discussion is how to educate and imbue staff on-site with a spirit of respect for others and a consciousness of their value. Recent scandals involving cruelty by caring staff highlight the need for this.

## **Buddhism and caring**

Up to this point, I have offered a general view of actual problems, but now I will share some thoughts on care from a viewpoint of Buddhism. First, I will explain the Buddhist view of human life, then look at examples of ideal caring by Buddha, and go on to examine Bodhisattva, as a practitioner and upholder of dignity for every single human. Finally, I would like to present thoughts of the founder of Nihon-Sōtōshū Dōgen about the practice of care. In this way, it is possible to gain another view of caring, apart from the Western frame.

## **Buddhism’s view of life**

At first I would illustrate the concept of human life and suffering in Buddhism. Buddhism looks on the craving deep inside of humans. This craving is called the “thirst ( ā)” or “unknowable ( avidyā).” Thirst is an inevitable desire of



living beings and is so fundamental that we can refer it as an impulse for existence. In this sense it is called thirst. This craving is so deep and fundamental that we do not even recognize it. In that sense it is called unknowable desire. This craving constitutes the Self which imagines that a fixed and substantial “ I “ exists on its own, without relationship to others. In this way we form the normal, unquestioned cognitive frame in which we perceive our Self at the centre, confronting the outer world around us. Our Self sets itself apart from all other things, existing without relation to them, and evaluating them according to its own standards (Haya 1999). We thus have come to value people based on how useful or useless they are. These are all foolish delusions, resulting from the dominance of craving. We don't recognize this, and are excessively attached to that fixed and substantial Self, the only way we can conceive of existing. This is why we suffer when we confront a constantly changing reality. One who notices her own craving deep inside and sees that this can only lead to damaging herself, is thus lead back to repairing inter- and intra-personal relationships, and to an enriched life-style of significance. This is the object Buddhists. To realize this object, relationships with others are vital. Although these relationships benefit others, as well, in the process of exploring and getting over your own desire, they form a kind of self-care. This relationship between your self and others is called “ Engi” (praṭīyasamutpāda, interrelationship) in Buddhism. This means also that you understand yourself here and now and the other people in your environment. How does this Buddhist viewpoint relate to our subject today, the problems of care?

## **Buddha's caring**

At first, I would like to discuss about Buddha's caring.

*“Before long, alas, will this body lie on the earth, despised, bereft of consciousness, useless like a burnt fagot.” ( Dhammapada 3.19)*

This is a phrase of an early Buddhist's sutra. An annotation indicates that that these words were given from Buddha to a Bhikkhu, the elder Tissa. The context is that Tissa had a swelling on his body, this grew till his bones could not stand up alone. His comrades (Bhikkhu) did not help him and he lay on the ground, on the verge of death. Buddha saw him, soaked his cloth in hot water, washed his body, let him take a bath and finally he lay him down on a sheet with clean and dried cloths. Tissa, who was cleaned in heart and body, saw the master with a fresh feeling. At that time said Buddha those phrase to him.

With that, Tissa reached the completion of his training and died peaceful and satisfied. The annotation explained it like this: He got ill, he did not know when his life would end, no one helped him and he was lying in his own excrement. This would be the saddest way to die. Originally in the tradition of the Bhikkhu, it was usual to train alone, so this situation has some reality. Buddha tended to Tissa's body and environment. Buddha made Tissa comfortable in his last moments. Then Buddha told him explicitly that the time for his end had come. Thereby, Tissa understood his situation and could prepare his mind for death.

Basic needs:	Clothes, cleanliness
Spiritual support:	Get close to each other, caring
Self-realization:	Acceptance of death and end of life

Figure 2. Buddha's care

Here you can see the visualization of care: Satisfying of basic needs, getting close to each other and helping one to accept his own situation (to die). Moreover, Buddha understood Tissa's whole mental situation and provided here an ideal of terminal care.

An anecdote of Kisā Gotāmi

*“Good, you came here. To get medicine, go to the edge of town and go in every house. You have to get the spore of a white poppy from a house without any past deaths.” (Therī Ghā tā , 213)*

Kisā Gotamī was born in a poor house. She married into a family which disdained her because of her poor origin. Change came when her son was born. She was respected, now, as a mother. But one day, her son died in his most beautiful time. She carried the corpse around her town and begged: “ Please, give my son medicine.” People saw her and laughed: “ I haven't seen any medi-

cine for dead.” But she continues to walk without sensing the people’s laughter. One person thought that possibly Buddha could help her and said: “ Woman. The only one person who knows a medicine for your son is Buddha. Go to him and ask.” At these words she went to Buddha and asked him for medicine. Then Buddha said: “ Good, you came here. To get medicine, go to the edge of town and go in every house. You have to get the spore of a white poppy from a house without any past deaths.”

Satisfied with these words, she went to town and begged for a poppy, but nowhere was there a house without any past deaths. She now understood that world is full of mutability and we all die eventually . Then, she buried her son in a graveyard and returned to Buddha. He asked: “ Did you get the poppy?” “ The Poppy is no longer important for me and it’s over. Please, give me peace of mind.” Kisā answered. Then Buddha taught her, she became a Bhikkhunī ( female Bhikkhu) and obtained a state of nirvana ( perfect peace).

In this anecdote, you can see Buddha’s special kind of caring. This way of caring is the most effective, in another words, the only way to care for her. It was impossible to solve her problem with talk and reasoning. Her problem was that she could not accept the facts. Her relationships to herself and her environment had been destroyed she could not return to her previous situation. Buddha’s reaction was not just an example of his rich wit; he reacted in this way so she could rehabilitate herself and overcome her difficulties. He solved not only her problem with her dead son, but he led her also to solve her fundamental problems, including the perceived shame of her origins.

In Buddha’s teachings, there is not the one almighty God. Instead, he teaches us to look inside ourselves and find absolute peace of mind. Meditation has great meaning in this process of searching/watching. Basically, if you watch your heart, everything in the world, including yourself, will change. But our cognition usually seeks a fixed definition for everything, and this is one of our problems. The simple act of grasping/defining things in words itself, is to commit the mistake of fixing them. This cognitive path also causes troubles in accepting new ideas. Monitoring your own mind is the process by which you rectify the gap between one’s own cognition and reality. Gotamī’s wanderings to get medicine for her dead child involved her trouble with acceptance. It is important that Buddha’s care lead her to accept a reality that can change at any time.

Stories about Buddha, especially stories from the early phase of Buddhism, are less involved with superhuman, charismatic and supernatural elements, and there many stories on the human level. A special one is “ Mahaparinibbāna

suttanta” I won’t go deeply into it here, but it is a sutra with stories of Buddha up to his death. It is written that Buddha, in his aged phase, was traveling with his follower Ānanda. This story inspires us to meditate on the aged, who will die and need care, but also on the carer. This text is used in training for terminal-care, nursing and several other circles of learning (Fujiwara 2000).

## **Mayeroff’s concept of caring and Buddha**

The writer of *On Caring*, Milton Mayeroff, said as follows: to care for another person, in the most significant sense, is to help him grow and actualize himself. Through caring for certain others, by serving them through caring, a man lives the meaning of his own life (Mayeroff 1971). In the anecdotes, the character of a carer is seen in the person of Buddha. But Buddha himself had already gained comprehension/enlightenment, so his character was Buddhistically completed. That is why, there is not an element of mutual growth in the special case of Buddha.

You could say that Buddha’s care was just a charity-activity, a self-promoting realizing of his ideology, and of his religious ambitions to be in authority over others. But these elements cannot be found and this impresses even more the reader. In “Mahāparinibbhana suttanta” there are pictures of him when aged, afflicted by rotten food and complaining of his thirst, although he had completed his character Buddhistically. By thinking about care, you can find many points in these stories. As Mayeroff said, the mission for Buddha was to live out the true meaning of his own life.

### ***Hesitation***

It is necessary to add one more anecdote: After completion of his character he went on a missionary journey, but he hesitated.

*“ I should not explain it, now. This law is difficult to understand for people who live under greed and anger.” (Vinaya, Mahāvagga, I, 5, 1-13)*

If the enlightened Buddha had ended under the Bodhitree, he would have ended as an unknown saint but, through his missionary activity, Buddhism was born. This start of missionary activity is very important in thinking about Buddhism. He did not travel only to announce his teachings. He stood up to relieve suffering people. His own problem was to solve the fundamental agony of life, at first, for

himself. But it would not be necessary to help others if this is only for himself ( Haya 1999 , Miyamoto 2004).

His hesitation was related to his worry that people would not understand him. But he could not just leave these people under the suffering so he turned to activity. You can say that Buddha found his meaning in life in the relief of others. There is often hesitation until one reaches the stage of living real life. Buddha reached his purpose in life, under the Bodhitree. But he felt that even this was not enough. After hesitation, he decided to make a life of believing in others, relating to them and relieving them from agony.

## **Concept of Bodhisattva**

Now, I would like to speak about Bodhisattva, the practitioner of Mahayana-Buddhism. This is relevant for many people when considering the concept of caring in today's world. In Mahayana Buddhism a Bodhisattva is a being who seeks enlightenment through the altruistic practice of relieving the suffering of other beings - a task for which he postpones his own enlightenment. His practice is the embodiment of compassion and kindness. The way of Bodhisattva begins with two processes. The first is to arouse the Bodhicitta, and the second is to take the Bodhisattva vow. Bodhicitta means the thought of enlightenment. To arouse the Bodhicitta is to have the thought of getting enlightenment. It is an intention of getting enlightenment. Moreover, this Bodhicitta is the will for awakening, living with self-awareness and practicing self-completion. The vow of Bodhisattva includes the intention of salvaging all living things as a central point. Here you can see the concept of "other." Before the rise of Mahayana-Buddhism, there was not any clear concept of "other" in Buddhism (Okayama 2005).

Now, Bodhisattva could relieve others through compassion and kindness. And the Bodhisattva does not need to be a monk. Secular Bodhisattvas appeared (Williams 2005). The rise of Bodhicitta doesn't require a religious view. It can be explained in a worldly way. It is to have the self-awareness to make your own life good. And it is to an orientation toward relationship with others. It could be said that the exploration and realization of your own life in the practice of relationship with others would be the life-style of a Bodhisattva. People concerned with caring, should have the self-awareness that they are not only contributing to a better life for others, but to their own betterment, as well. Then their career can become a great challenge with promise of significant benefit for others and themselves. Moreover, it is explained that salvaging/helping others through practice

of compassion and kindness is supported by emptiness (śūnyatā). “Emptiness” is a central concept of Mahayana-Buddhism. It is difficult to explain, but it relates to withholding value judgment. Man discriminates and judges the value of things, but a Bodhisattva excludes these considerations. He doesn’t have the mindset of asking who is more valuable than another.

## **Bodhisattva Shishyobo**

(The four ways a Bodhisattva acts to benefit human beings)

1. Fuse (Almsgiving)
2. Aigo (Loving words)
3. Rigyo (Beneficial actions)
4. Doji (Identification with those who are to be helped)

For a Bodhisattva, there are four teachings which have to be practiced. These are called Shishyobo, the four ways to benefit others. The four points of Shishyobo are Fuse, Aigo, Rigyo and Doji. Fuse means almsgiving. Aigo means loving words. Rigyo means beneficial actions. Doji means identification with those who are to be helped. I think these are very significant not only for Bodhisattva practice, but also for people involved in caring. The founder of the Japanese Sotoshu sect, Dogen, made his own interpretation of these<sup>1</sup>. Dogen gave Fuse a very wide meaning. Its original meaning is offering.

At first, he explained Fuse as not to covet something. The act of Fuse is to give something, and this requires that the desire of ownership be given up. Next, he said that a king, even one who rules over all the world must not covet the position of being a great ruler. He also said that anything offered as Fuse (money, material objects, teaching, kindness, etc.) is valid. The size, price or one’s ownership of something does not matter, its inherent importance is obtained through the act of offering. In this way, the common, traditional meaning of Fuse was surpassed and the significance of any type or act of offering is realized. This has profound implications for our relationships to ourselves and with others throughout the world.

“ Aigo” the second teaching of Bodhisattva Shishyobo, means that you have to talk to people with affectionate feeling, as you would with a baby. This is much more than simple praise. Acting with the character of Aigo will lead to its growth within you. A loving heart comes out of this affection and Aigo develops from such a loving heart. This has the power to change the world.

“ Rigyo,” the third teaching, means that you don’t fight against someone else gaining and advantage. You understand that your advantage and other’s advantage are not in conflict. You and others should gain mutual advantage. This is relevant, not only between people, but to our attitudes toward all of life, including the natural world around us.

“ Doji” means to abandon the distinction between yourself and others. You care for the property, feelings, and lives of others as if they were yours. You make no essential distinctions between yourself and others. You identify with others and yourself. Dogen said that as you treat others with peace and kindness, you are able to understand and sympathize with them, as with yourself. I think that this is an important point in our relationships and in caring for each other.

## **Conclusions**

In his younger years, Buddha already perceived birth, aging and diseases as facts of life. But most people, as they grow old, begin anew to think about their meaning of life, the value of their life and how significant it was. By reflecting on their past, they see things in a new light and will unavoidably develop in doubts and insecurity. In senescence, people are losing the things in which they had grounded their life. As they look for a substitute, the meaning of their being becomes more and more problematic. Their own liberty decreases and changes come to relations with others. In this context, the aged have to confront aging, disease and death. From a Buddhist view, the problem is that they cannot control changes in their consciousness although there are changes in reality. Buddhism teaches that attachment blinds one. It is not strange that it is the cause of distress and agony. We all have various distresses but these are caused by ourselves and will disappear as we change ourselves.

Furthermore, Buddha’s awareness is deeper. You should not just change yourself to get away from distresses and agonies. You should lead yourself to a better life by observing your life deeply and understanding that life is ruled by desire.

In Buddhism, our view of human beings and the world are in the nature of relationship between past, present and future. It is possible to change yourself by the attitude of your own mind and the way of your will. There is also a connection to others and relationship is in the nature of every being. By influencing others, you change yourself, and influences from others also change you.

To feel the reality of the relations between all things, and have this living inside you will lead you to feel the real support of others and give you the power to support others through understanding of others in truly human relationships. We must look at the reality of life and see that we must live fully every single moment. And with every single change to yourself, your environment or obstacles you face, you understand these realities and accepting them. This is the viewpoint of Buddhism. Moreover, this is the picturing of the ideal carer's way of life in Buddha's and Bodhisattva's path. Additionally, it is full of suggestions for what a care giver's career is.

If I had to enumerate its differences from a Western view of caring, the first point would be that it is not anthropocentric and egocentric. In the Western view of caring, it is assumed that the cared-for are self-completed and caring is practiced with egocentric and anthropocentric elements. In Buddhism, everyone and everything are related to each other and the focus is constantly changing. This means that rather than constantly viewing the situation from one's own, fixed vantage point, our viewpoint is mobile, thus allowing realization of wider consciousness and caring. The second point of major difference is that in Buddhism the abandonment of desires is closely related to any capacity for relationship and caring for others. Including and interpretation of Buddhism in how we view caring is quite new. But it may offer help in getting through the impasses of anthropocentrism, individualism and rationalism that we are dealing with now.

This article was originally presented on 19<sup>th</sup> September 2006 at the second FSS in Helsinki.

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*Nozomu Shimazu*

# **A Discussion about the Network of Health and Social Care by Some Organization Theories**

## **Discussion of Some Theories Explaining Network**

### ***(1) The resource dependence theory***

The inter-organizational studies have accumulated much useful theories. Among those, it is said that the most leading theory is the resource dependence theory. This theory is based on the following premise<sup>2</sup>. The organization cannot carry out self-fulfillment. In order for the organization to continue, it is necessary to obtain required resources from the outside. So, inter-organizational relationship is formed in order to obtain resources required for an organization. An organization is going to hold its autonomy and avoids the dependence to other organizations. And a business enterprise is going to raise a partner's dependence. This theory explains competition of a business enterprise and the relationship of cooperation in this way. This theory is leading for explaining the inter-organizational relationship of the business enterprise based on a market.

Probably, it will not be suitable to explain the network of health and social care. For a business enterprise, winning competition and surviving it will prove the justification of the activity of the organization. However, for the organization of health and social care, winning competition is not proving the justification. For

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<sup>2</sup> Pfeffer, J., Salancik, G.: *The External Control of Organization*, Harper and Row, 1978

the organization of health and social care, achieving the function in the community shows the justification of organization activities. In the hospital management index which the Ministry of Health, Labour and Welfare of Japan define, importance is set up in order of functionality, profitability, and productivity in the financial results of management analysis.

The organization of health and social care is firstly asked for exhibiting the function in the community. Therefore, it can be said that the resource dependence theory which considers that other organizations are the targets for control is not suitable to analyze the network of health and social care.

## ***(2) The institutional theory***

Next, we will discuss the institutional theory. Institutional theory considers that an organization is the subsistence embedded in sociocultural institution environment. Institutional environment is a various rule and a requisition and the organization can get justification by accepting it. According to this theory, if a certain organization follows the value, the norm, and the style of action which is spread, it will be considered that the organization has received dominant culture. As a result, the organization gains justification.

This theory regards the focus of inter-organizational relationship not as the issue over resources but as an issue over justification. The moot point of this theory is considering that an organization and an individual are passive existence to environmental pressure. As a result, a positive influence of an organization and an individual is treated lightly. Although there are such moot points, the institutional theory can explain well the inter-organizational relationship strongly influenced by the institution by a governmental policy and professionals group like health and social care.

Moreover, this theory does not regard institutional relationship as a domination relation like the resource dependence theory. Therefore, it is thought that this institutional theory is suitable for analyzing the network of health and social care. However, this theory will not be able to explain well the case that is making the network of health and social care voluntarily. Then, the theory can explain the point that a network is generated voluntarily will be required.

## ***(3) The social network analysis theory***

Social network analysis theory explains inter-organizational relationship as follows. The multiple links between business enterprises is spread around the mar-

ket which is a domain of an economic activity. In the link, information, norm, knowledge, etc. related to transactions exist. To the business enterprises, the network between organizations offers the meaning of information and the context, and has a function which solves the matter of the uncertainty in a market. The following five things are among the links seen in the network between such firms<sup>3</sup>.

1. "Resource exchange" about goods or services.
2. "Information exchange" by communication
3. "Power relations" generated from a non-symmetric exchange
4. "Boundary penetration" by the activity adjusted in order to attain the common purpose.
5. "Sentimental attachments" which raises common sense of solidarity and induces feeling of duty.

The institutional theory regards an organization as a passive subsistence as stated previously, but the social network analysis theory sees an organization as what builds up inter-organizational relationship positively.

This theory is based on the structuralism that a network structure specifies the act of an organization or a person. This theory does not mention that the act of an organization or a person specifies a network structure. Then, another theory explaining the influence which the act of an organization or a person has on a network structure will be needed.

#### ***(4) The Knowledge creation theory***

So far, the organization theory has treated the knowledge as articulable one which exists in the form so it can be transferred. This is the knowledge which can be expressed in a manual, digital data, etc. However, Nonaka<sup>4</sup> and Badaracco<sup>5</sup> pointed out about the importance of tacit knowledge as well as the importance of such articulable knowledge. Since tacit knowledge is the individual knowledge connected with a specific situation, it is difficult to tell others separate from the situation. On the other hand, articulable knowledge is explicit and is the knowledge which can be transferred with a logical language. Thus, after dividing knowledge into such two dimensions, knowledge creation is explained as a dy-

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<sup>3</sup> Knoke, D.,: *Changing Organizations*, Westview, 2001, 65-66

<sup>4</sup> Nonaka, I., and Takeuchi, H.: *The Knowledge—Creating Company*, Oxford University Press, 1995

<sup>5</sup> Badaracco, J.: *The Knowledge Link*: Harvard Business School Press, 1990

dynamic mutual conversion process of these two types of knowledge. An important point is that obtaining of tacit knowledge cannot separate from a specific situation. Badaracco calls this tacit knowledge which exists in the situation as "embedded knowledge". And he says that the purpose that an organization makes relationship with other organization is to create new knowledge through obtain and a transfer of embedded knowledge. An organization will improve through the process.

Since such knowledge is dispersed among different organizations, it is necessary for an organization to make relationship with other organizations. According to this theory, in case of health and social care organization, new knowledge will be created when some health and social care organizations are organized as a knowledge sharing network. This theory can explain that the behavior of the actor who seeks after new knowledge forms a network. However, since this theory regards the motive for an organization to make a network, as an organization winning competition, it will have the same problem as the resource dependence theory seen previously.

### **(5) The Networking theory**

Finally I will take up a networking theory. Networking theory takes the point of view in which an actor's behavior sets a network structure<sup>6</sup>. In this theory, the motivation for people to make a network, the rule made there, the function of communication, etc. concludes that it works on a network structure. Kaneko calls "community" the network done in this way. And he says that a matter unsolvable in the market or the hierarchy organization will be able to solvable in the community as social capital. It is called "community solution"<sup>7</sup>. The sphere where such community solution is suitable is human service which treats the matter of the way of life of persons, such as medical care, nursing, social care and education. In future society, community solution plays a big role along with the market solution or the hierarchy solution. And the field where community solution is performed is community as a network.

In order for the network of this type to work well, the three elements are required that is a "rule", a "role", and a "tool". The rule is the norm made voluntarily, the roll is achieving the mission assigned voluntarily, and the tool is the instruments for communication. Thus, in this theory, they think that the reason organizations

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<sup>6</sup> Lipnack, J., and Stamps, J.: *Networking*, Ron Bernstein Agency Inc., 1982

<sup>7</sup> Kaneko, I., *Community Solution*, Iwanami(Tokyo, Japan),2002: (Japanese literature)

make networks are not for winning competition with other organizations. In such a point, I think that it will be effective to use this "networking theory" with "institutional theory", a "social network analysis theory", and "knowledge creation theory" as a theory which analyzes the network of a health and social care. The feature of four theories considered being effective in explaining the network of a health and social care is as in the next table 1.

	Pay attention to a network actor	Pay attention to a network structure	Pay attention to other elements	The purpose of making a network
The resource dependence theory	yes			Obtaining of required resources
Institutional theory			yes (external environment)	Alignment to institution
Social network analysis theory		yes		Does not specify
Knowledge creation theory	yes	yes		Self grows
Networking theory	yes			Solution of a common issue

Table.1 Comparison of the theories about a network

Next, I will discuss some subjects seen in a health and social care network using the concepts of these theories.

## Hypothetical Explanation of Network of Health and Social Care in Japan

### *(1) Who makes a network and make it with what motivation.*

From the point of an actor's behavior, I will see the issue who makes the network of health and social care. Why is the network of a care made in a certain community, and isn't it made in a certain community? In Japan, although the example which has grappled with it in advanced is seen, as long as I have seen, it is characteristic that the network has been made by medical doctors. This could be interpreted as follows. The more the autonomy accepted socially is high as professionals like a medical doctor, the more its limit can be recognized by them. As a result, they take action of depending on other professionals for the part which

cannot have responsibility. This may be able to be called "dependence of autonomy" paradox. In this way, it is possible that the network of health and social care where the care is taken over to many others is formed.

The thing which I would like to emphasize here is not that only medical doctors can make a network. I would like to mention that whether should not only medicals doctor but each occupation being provided with ability with the true autonomy as professionals, and then networks will spread.

Institutional environment is thought as another possibility of the subject which makes a network. It is thought that institutional theory explains this phenomenon. Like the organization of a health and social care, the organization strongly influenced by institutional or a policy shows an alignment tendency. Institutional theory considers that institutional environment, that is, a custom, a norm, an agreement, etc. affect the trend of such alignment. Now, because the network of a health and social care is going to be politically advanced in Japan, such a institutional view is needed when analyzing the phenomenon.

## **(2) Network functional requirements - Rule, Role, Tool**

Next, after a network is made, what are the requirements to work a network? Kaneko considers that they are "rule", "role", and "tool."<sup>8</sup> The rule is kinds of norms which network members make for maintain the network. Or it may be better to say that a gathering of people who share recognition that the necessity for rules and to be protected is a network. Next, since a member reaches some agreement, not a hierarchy but the role which assigned voluntarily is needed. This is a role. If it says in another way, a network will be a system in which the governance by a spontaneous role is settled. And another thing called a tool will be needed which is an instrument for pulling out the function of a rule and a role to the maximum extent. The feature of network communication is neither a finite procedure (routine) like a hierarchy organization, and nor based on the only scale of a price like a market<sup>9</sup>. It is made by communication by a network participant's relationship. The tool is the utilizable means for such a purpose of communication. Tools are the conference as an occasion of communication by facing, the telephone and E-mail as a means of communication, specifications of a product and service, etc. Information may be joined by using these. For such

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<sup>8</sup> Kaneko, op. cit.

<sup>9</sup> Powell WW. "Neither market nor hierarchy: network forms of organization", in *Research in Organizational Behavior*, B. Staw. L.L Cummings. Ed.12:295-336, 1990.JAI.

communication of information, sharing of information becomes a precondition. Therefore, the subject of a tool leads to making the rule of sharing information in the following stage. Thus a network develops spirally.

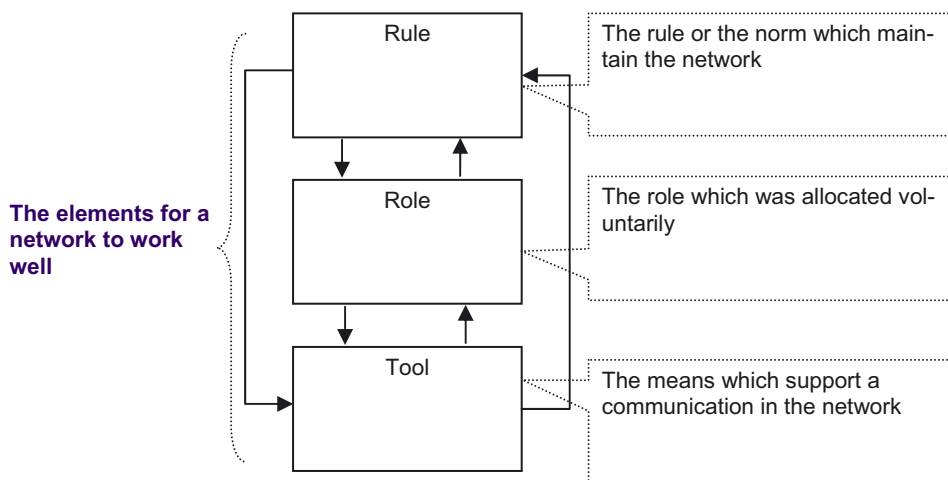


Figure 1. Rule Role and Tool, the elements for a network to work well

For the example of the network of a care, it is a rule that the norm of attending joint care conference positively is voluntarily. And it is a roll to propose from a special standpoint in care conference according to the rule. In order for everybody to understand information in common at the conference, the tool as an objective standard like a care management system is needed. Furthermore, based on such a standard, a tool like the institutional critical (or clinical) path may come to be used.

Here, I paid attention by the networking theory to the side that an actor's behavior specified a network structure. On the other hand, from the point of view of the social network analysis theory, there is outcome of research that the closed



structures of network are the important conditions which establish the norm of the actor in a network<sup>10</sup>.

### **(3) Why is it important taking face to face communication?**

Generally, in the network of the health and social care, the study meeting, the informal meeting, etc. are often held. It is often pointed out that it is important taking face to face communication. What meaning have this kind of communication for a network theory? Knowledge creation theory divides knowledge into two kinds, tacit knowledge and articulable knowledge. And they consider that leading to new knowledge creation comes out through sharing the tacit knowledge which cannot fully be expressed verbally. Since such tacit knowledge is the knowledge embedded at the field, Badaracco calls tacit knowledge "embedded knowledge." On the other hand, since articulable knowledge can be transmitted between individuals and organizations, it is called "migratory knowledge"<sup>11</sup> Moreover, Wenger noted that the craftsmen who are not necessarily together from usually is making a loose community and teaching them mutually, and growing up in continuous relationship. He called such a system "the community of practice"<sup>12</sup>. Badaracco paid attention to the process for making the network. So he called the relationship between organizations as "the knowledge link". On the other hand, Wenger paid attention to the core of the network.

If we see with the concept of "the knowledge link" and "the community of practice", what kind of issue is there in the network of a care? For example, the holding frequency of care conference, the percentage of attendance of the persons concerned, and the time required per subject, there is considerable variation by the regions. If it interprets from the viewpoint of knowledge creation theory, it can be thought that the existence of the network of the knowledge link and the existence of the community of practice will be concerned that there is such variation.

### **(4) The strong ties and the weak ties.**

Finally, I will see the influence which a network structure has on an actor's behavior from the viewpoint of a network analysis theory. This theory is accumulating rich researches until now. Among those, for the network of a health and so-

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<sup>10</sup> Colman, J., "Social Capital in Creation of Human Capital", *American Journal of Sociology*, 94, 95-120, 1998

<sup>11</sup> Badaracco, op. cit.

<sup>12</sup> Wenger, E., McDermott, R., W. Snyder: *Cultivating Communities of Practice*, Harvard Business School Press, 2002

cial care, the research on strength and weakness of ties exist in a network is considered to give a rich suggestion. Granovetter surveyed the relation between an information provider and a person who changed his job. Investigation showed that the information from those who have weak relationship which do not have much contact brought about useful job information. This is well known as a paradox of "the strength of weak ties."<sup>13</sup> On the other hand, there is also a research which paid attention to the effect of the strength ties.

Moreover, there is also research on the relation between the strength of ties and trust. According to these researches, a strong tie makes an exclusive network. And since reciprocity is performed on the whole in this, an emotionally commitment increases among members. And since the trust based on good intentions grows up and information exchange is performed closely, the transfer between organizations of tacit knowledge progresses easily. On the other hand, since the weak tie forms the open network, the confidential relation to the capability which can be evaluated objective is easier to be built than a commitment deep in emotionally. Therefore, in an open network, since result-oriented information exchange is performed, the transfer of articulable knowledge goes easily. Thus, the issue of network openness is greatly related to trust, knowledge creation, a knowledge transfer, etc. between network members. This issue will become a big subject of research in the future.

This research was supported by The Mitsubishi Foundation (social welfare research fund2006 No.18)

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*Hiroo Hagino, Yoon Youngsoo, Katsuyuki Doi, Tadanobu Endo*

# **Medical & Health & Welfare Care network as the “BA (Place)” to Create Knowledge, Case in Japan**

## **Introduction**

As we have discussed for two years, we now confront common problems. One is rapid progress of aged society. Japan and Finland are the top two of the world in the speed of aging, and this phenomenon created problems of quantity. In addition, both Japan and Finland have developed economically recently. As a result, the national life style of both countries has changed dramatically. So the demands for Medical & Health & Welfare services are also changing so much. We have to solve the problem of quality at the same time.

Nevertheless, it will be impossible for both countries to maintain their growth rate as previous time. To the worse, we will require downward revision. So we have to innovate both Quantity & Quality measure. High quality but efficient method, High cost performance method is required. These are our common backgrounds with which we had started.

## **Japanese Situation: Backwardness of Medical & Health & Welfare Network**

Japanese “Long Term Care Insurance” (LTCI) system has started from 2000 as the method to support socialized elderly care. At this period, LTCI defined the aim of care as “promotion of self-support”. And various cares were reduced to each action so as to make standard model for LTCI. Care work was recognized with Taylor systems. To say more, care worker was thought to be like a part-time job worker of Mac Donald. But this system has made problems in quantity and quality. There are more clients who need care, more clients who live alone or

only with couple and more clients who are suffering from dementia than we had expected.

So we have made LTCI reform in 2005 based on the changes from “care” model to progressive “care + preventive care” model, from “physical care” model to “physical care + dementia care” model and from “live with family” model to “live with family+ single” model. And one of key points of this reform (key point to solve these problems) is “Community-based care”.

Japanese care trend is moving from in-facility care to home care. This change inevitably requires correspondences to diversity. For this correspondence, we have to be innovative. We need new paradigm which makes this possible. To satisfy the new elderly (high educated, rich and sensitive to various their rights, existing monetary resources will not be enough. “Knowledge” which can correspond to diversity and can make high cost performance will also be core resource. We have to change our presumption.

To be innovative in Medical & Health & Welfare care services, network among Medical & Health & Welfare actors is essential to improve not only efficiency but also efficacy. By establishing various value networks, new values and knowledge will be made and this improves efficiency and efficacy. As Mr. Doi appealed, networking is now being required in front line of care. But there has not been enough networks in practice. This is one reasons of Japanese social welfare providing system’s inefficiency and ineffectiveness. In Japan, either medical network itself (Hospital-Clinic network etc.) is not enough.

One big obstacle which disturbs this network is “sectionalism”. There are two dimensions of sectionalism. One is sectionalism in governmental sector itself (like bureaucratic sectionalism). The other is occupational sectionalism which comes from bureaucratic sectionalism. In Japan, there is a tendency that “Each bureau has more priority than Ministry”. If the section is different even though in the same ministry, it is very difficult to collaborate. This is bureaucratic sectionalism. And the other one is sectionalism of facilities and professionals. Japanese facilities and occupations are managed by each bureaucratic section. Difference of section connects to difference of system. System difference of each occupation, facilities and etc also makes sectionalism in each field. So each social and public resource was isolated. Medical & Health & Welfare efficient collaboration has been difficult for this reason. New method to overcome this situation is actually requested.

## Needs for Network

One method for this request will be network. To be innovative, we need to make network beyond these sectionalisms. To improve efficiency and efficacy, to achieve high cost performance, corporation among the same kind of actors is not enough. We should concentrate various kinds of actors to make chemical reaction in network.

If the network is constructed in Medical & Health & Welfare care service, if we can prepare “BA (place)” where various kinds of actors can gather, our personal, facility-limited or occupational-limited knowledge will be “Socialized”,

”Externalized”, ”Combined” and ”Internalized”. Such knowledge will can be core resources to solve our problems. This will contribute the level up of quality and improve efficacy and effectiveness.

I will pick up four advanced Japanese cases. They are Japanese advanced trial for community-based care (But they may not be advanced cases as compared with Finland.)

## Classification of 4 Cases in Japan

I will introduce 4 Japanese network cases in Medical & Health & Welfare care.

- 1) Ex Onomichi (Hiroshima pref.)
- 2) EX Mitsugi (Hiroshima pref.)
- 3) Miyagi Hospice care network (Miyagi pref.)
- 4) SMILE Net Miyagi consortium(Miyagi pref.)

I will classify these 4 networks according to three factors. The first factor is their “Communication tools”. Many actors who participate in each network communicate by their common communication tools. This factor will show with what incidents each network links their actors. The second factor is their “Actors”. We will be able to classify the nature of network by what kind of actors participate in the network. The third factor is the “Reward” of network. We also may classify by this factor as in the chart below. We can also classify with the factor of “nature of network” etc. But I will simplify to these three factors this time.

Case/Factor	<i>Communication Tool</i>	<i>Actor</i>	<i>Reward</i>
<i>Ex-Onomichi</i>	Expectation	Professionals	Mutuality
<i>Ex-Mitsugi</i>	Expectation	Professionals/ Local government/Citizen	Mutuality/ Monetary
<i>Miyagi System</i>	Expectation	Professionals/ Local government/Citizen	Mutuality
<i>SMILE NET Consortium</i>	Expectation	Professionals/Company	Mutuality/ Monetary

Concerning the factor of “Communication tool”, every network is unified with their “Expectation” in these cases. Each actor joins network to realize their expectations. In many cases, actors of Medical & Health & Welfare network have tendency to join and communicate with their expectations. They share their philosophy and collaborate to realize their common expectations. But the context which each actor includes in their expectation is different. So we will need to verify these expectations one by one in details at another research.

I will classify four networks with the rest two factors case by case in the next paragraph.

## Features of Onomichi System

- Enforcement of “family doctor function” and multidisciplinary collaboration through “**care conference**”
- With the initiative of medical association, in “**BA**”(care conference) health & welfare professionals (including dentists)
- Abundant knowledge assets as social capital
- Networking of multidisciplinary small scale professionals (similar to *corporatism*)
- participation of caseworker or volunteer leader

### Case of “Onomichi medical association system community-based care”

Onomichi city is a typical Japanese middle scale city of 90,000 people. But in Onomichi, the aging ratio was higher than other average Japanese local city. Medical doctors of Onomichi were anxious about management of coming aged society. As there has not been so many large hospitals and nursing homes in Onomichi, they tried to establish regional collaboration and home care system with initiative of Onomichi medical association (led by charismatic Dr. Katayama). Under the initiative of Dr. Katayama, Onomichi medical association (not local government) started to establish community based care network for the elderly.

Their philosophy was CGA (Comprehensive Geriatric Assessment). In 1994 they tried to enforce family doctor functions to realize the philosophy of CGA. And they learned that to enforce CGA, team-care is inevitable. They hoped to provide progressive geriatric care by the team with multidisciplinary collaboration.



They held so many research meetings and came to the conclusion that it was impossible to care the elderly with only medical actors. Fortunately, in Onomichi, social capital as knowledge assets has been equipped. Onomichi medical association has held "Hatsukakai" with tradition of 100years (drinking section meeting) every month. Each time, almost half members participate in this meeting. So they have already had informal intimate human relationship among medical doctors. That could be the basement of close partnership among medical doctors. This was advantage.

Onomichi medical association begged to other actors to cooperate with medical doctors to care the elderly at home. So this network's premise actors were professionals. Various professionals joined this network for mutuality, to reduce each actor's effort by care in community. By establishing this network, they could get rewards of mutuality and make impossible to possible (sustainable care at home). Various actors ( hospital doctor, family doctor, nurse, visiting nurse, dentist, hygienist, SW, OT/PT/ST, care manager, welfare instruments lease provider, transportation, volunteer etc.), sometimes over 20 kinds of actors collaborate to support one client. In such way, they established holistic client oriented Medical & Health & Welfare care provision system with comprehensive and organic collaboration in the community. They made network of multidisciplinary small scale professionals and service providers. This model may be similar to corporatism in a sense.

They have revised their system after Swedish, Danish, Canadian system. This system is one alternative for urban community-based care model.

The essence of Onomichi model was enforcement of "family doctoral functions" and "multidisciplinary collaboration" through "care conference as BA(place)". In "BA" (care conference), Medical & Health & Welfare professionals (including dentists) got together. Care conference plays core roll in this system as a place of knowledge creation.

Onomichi-system care conference is held in almost all cases even though it is light case. In Japan medical doctors seldom participate in care conference. But in Onomichi, 97% of family doctor has experience to participate. There are some key points for this. In principle care conference is held in family doctor's clinic for their convenience. And as a coordinator, care manager adjusts all the actors thoroughly in advance. In addition, Onomichi medical association prepared a standard care conference model. So average time of care conference is only within 15 minutes. It makes it possible to held periodically and continuously in all cases. This makes close partnership of many actors. Medical doctor can get

many information from other actors and can order effectively. Seamless care becomes possible. And other actors also can have multiple viewpoints and find new antidotes through this BA.

Merits of Onomichi style Care conference are like this: 1) efficient and effective resource provision, 2) security and confidence of clients, 3) effective share and communication of information, 4) improvement of quality and specialty of each actor, 5) preventive effect. The core of these merits is care conference as BA.

It makes adequate resource provision possible through many multidisciplinary advice and information share. Gathering so many professionals to support clients makes mental effect for clients. It improves efficiency and effect. For example it reduced useless call for care providers in Onomichi.

## **Case of “Mitsugi general public Hospital”**

Ex-Mitsugi town (with 8100 people) is a stereotype Japanese under populated area with poor health and welfare resource. Private sectors could not afford to make network with existing resource. They have to produce social recourses from the beginning. This situation made local government a main actor of this network. This may be one alternative for rural community based care network.

At first, “Mitsugi public general hospital” took importance on Neurosurgery and Cancer. But even though they had relieved patients, within 2,3years many patients came back to hospital with the situation of bed-in. They were suffering with many pressure ulcers and dementia This bed-in have been made by the lack of adequate health and welfare home care. We may say it “artificial bed-in”. With only medical care (only by hospital) it was impossible to stop making this artificial bed-in of the elderly. Mitsugi general Hospital leaded by Dr. Ymaguchi had started various delivery Medical & Health & Welfare with various kind of teams. They tried to supply really useful home care service. Communication tool of this network was expectation of solving this “artificial bed-in” problem.

But bureaucratic sectionalism disturbed efficient solution. Medical & Health & Welfare care had been managed by different sections in local government. It could be possible only through close collaboration of public hospital, health section and welfare section of local government with the initiative of local government (establishment of “public health & welfare center”). But in many local municipalities, this is still very difficult. By integrating the function of hospital (medical care) and local administration (health section and another welfare section), needed multidisciplinary visiting team care, could be provided. This solution was

possible only by unified Medical & Health & Welfare care provision with public large hospital and local government. This integration created BA (“public health & welfare center”) where various actors (not only professionals but also civil servants, statesman and citizens) meet. And they think that citizen participation is also very important to make this system efficient and effective. Without improvement of resident’s consciousness, home care can not be effective and efficient. So they expanded this network to citizen. This will be same as Finnish local administrative system reform.

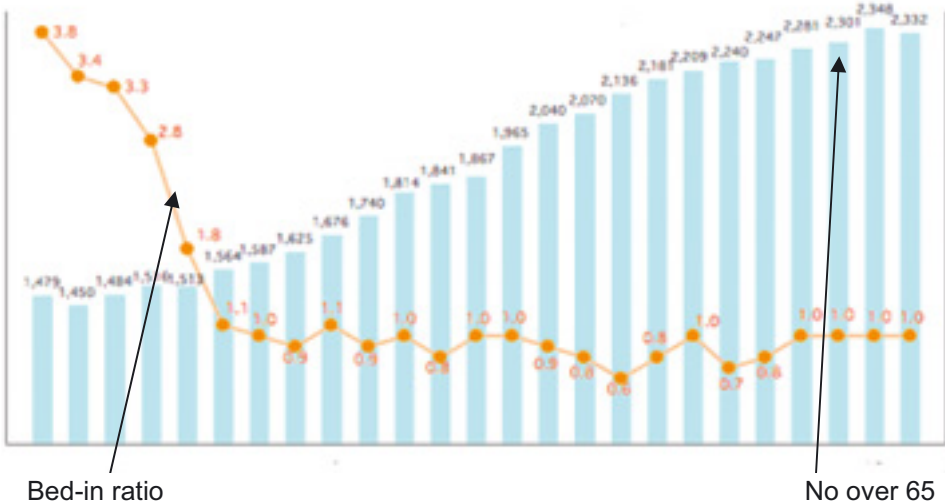
In this system, like Onomichi, periodical (every Monday ) care conference also plays very important roll as “BA”. Through care conference, information and philosophy was shared even without ICT technology. Many actors gather in this “BA” and make multiplier effect.

Not only “public health & welfare center” but also care conference is an important BA.



Concept Map of Mitsugi general public hospital.

Orange circle is “Mitsugi general public hospital”. They provide acute care, rehabilitation, sanatorium, hospice hospital function and center of dementia. The green circle is “local governmental health and Welfare” resource. In Mitsugi, local governmental health and welfare section locate in” Mitsugi general public Hospital”. So corporation is very easy without bureaucratic sectionalism. Yellow circle is welfare resources of local government. They have facility-care complex (Nursing Care Home etc.) and also various stations to support home care. And in this network, care conference takes central part in each case.



As a result of this network, we can see visible merits. Not only the improvement of Medical & Health & Welfare care (rewards of mutuality), but also monetary reward for actors could be seen.

Before community-based comprehensive care (hybrid of Medical & Health & Welfare care) was provided, bed-in ratio of Mitsugi was double of national average (mainly by artificial bed-in). It is almost impossible to recover from bed-in, but it is possible to prevent artificial bed-in. This was the reward for professionals of this network. After 10 years of community based care, in Mitsugi bed-in ratio has become one-third of national average because average life expectancy of bed-in people are 3.5 years in Japan. As a result of artificial bed-in prevention, they could get this result. And in additional to this, by providing useful team

home care service, shift from facility care to home care became possible. Many elderly could return their home. The cost of home care is much cheaper than facility care. So local government can save these expenses. As a result, in this area, medical expense per person decreased even though aging ratio has risen. Community based care made other merits further more.

The hospital-in span of the elderly has been shortened, so medical fee cost has improved. So hospital has changed to the black. In addition, as the expansion of hospital function, the number of staff has increased. So employment for inhabitants has grown. And also population of town has increased by settlement of staff and their family. This phenomenon also brought increase of daytime population by patients and their family. So residential consumption has raised. To say more, some patients has moved in this town with family to take community-based care. By these effects, decrease of population is not so serious and the liveliness of town is raising.

Now previous ex-Onomichi city and ex-Mitsugi town are integrated into one (new) Onomichi city. Both systems are advanced networks of Medical & Health & Welfare care. Their common points are like this. Provision of team care by multidisciplinary collaboration was realized in this 2 case. In this collaboration, care conference plays very important roll as “BA”. Seamless Community-based care among Medical & Health & Welfare care was merged. We could see Value net here in common.

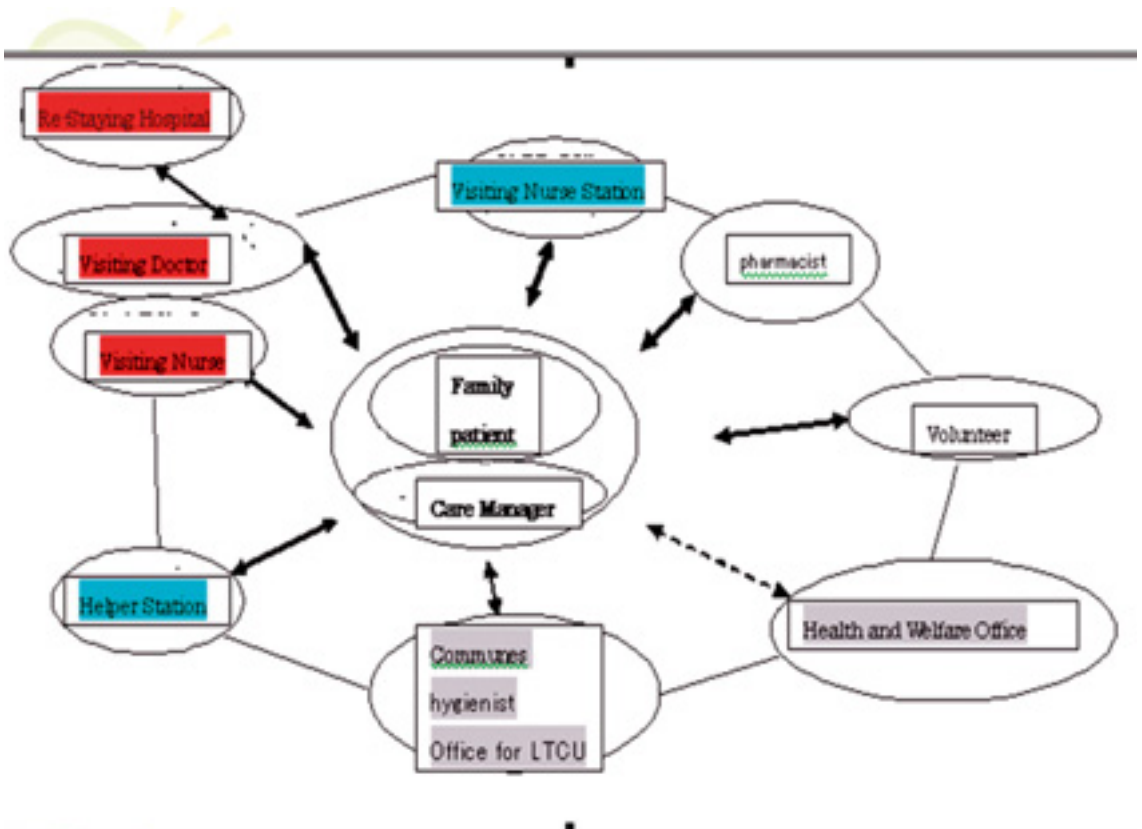
And their difference comes from their presumption of resources. Ex-Onomichi was urban area with some social resources, so they can establish network with existing resources. But ex-Mitsugiwas was in rural area with poor social resources, so local government has to produce resources himself. This was the origin of the difference in some factors.

### ***Case of “Miyagi Home Hospice care network (Miyagi system)”***

These next 2 cases in Miyagi are still pilot cases. One has started five years ago and the other just started from 2007. As community-based care progress in Onomichi and Mitsugi, both community has started the same new attempts. That is “Palliative care”, “Terminal care” and “Hospice Care”. This is the last goal of life and also the goal of community-based care. In our Miyagi pref. this kind of advanced network has just launched.

Miyagi prefecture (with 2.4million people) locates in Northern-east part of Japan. According to the “Research on terminal care” by Japanese Ministry of Health& Labor , with no limitation, 60% of Japanese hopes to stay at home in their termi-

nal. But only 12% of Japanese actually died at home. There are some obstacles which prevent granting their last hope to receive their own decline at home.



*Concept map of Miyagi Home Hospice care network*

What prevents people from granting their last hope is the fact that alleviation of throbbing pain and general health care are thought to be taken in only hospitals. Actually there are few family doctors who have these skills. The second one is anxious of clients and family. Many Japanese disgust to be burden for their fam-

ily. On the other hand, their family prejudices that home hospice care is not adequate environment for clients. The third one is costs of clients. Home hospice care is more expensive than facility hospice. Application of LTCI and Medical insurance for home hospice care is complicate. The forth is incomprehension to hospice care. Home hospice care may be the cause of social isolation for clients and irrational reproach for family. Without these problems, many people want to die at home.

In case of "Miyagi hospice care network", local government took initiative and made network with various actors to realize this hope. The communication tool of this network is expectation of removing these obstacles above by making network. But I have to say in advance once more that this "Miyagi hospice care network" has started only 5 years before, and this project's annual budget is only thirty-five thousand € with very small project and now on trial and error.

This system started with existing prefecture health center's medical network by initiative of Miyagi prefecture office. During 1994-6, some patients of Miyagi Prefecture Cancer Center asked to die at home. So cancer center's staff asked health center to support patients and center. With try and error, they collaborated to support them. Based on these cases, in 1997 prefecture office entrusted research and study of home hospice care to Miyagi Prefecture Cancer Center. Based on the result of research, in 2001 Miyagi prefecture office regulated home hospice care network all over its area with basement of seven prefecture health centers. As existing health center network was not enough at all for home hospice care, they expanded it to various actors. They added special health care actors for cancer (inc. pharmacy etc) and welfare care actors (such as home helper, MSW and etc) and citizen volunteer.

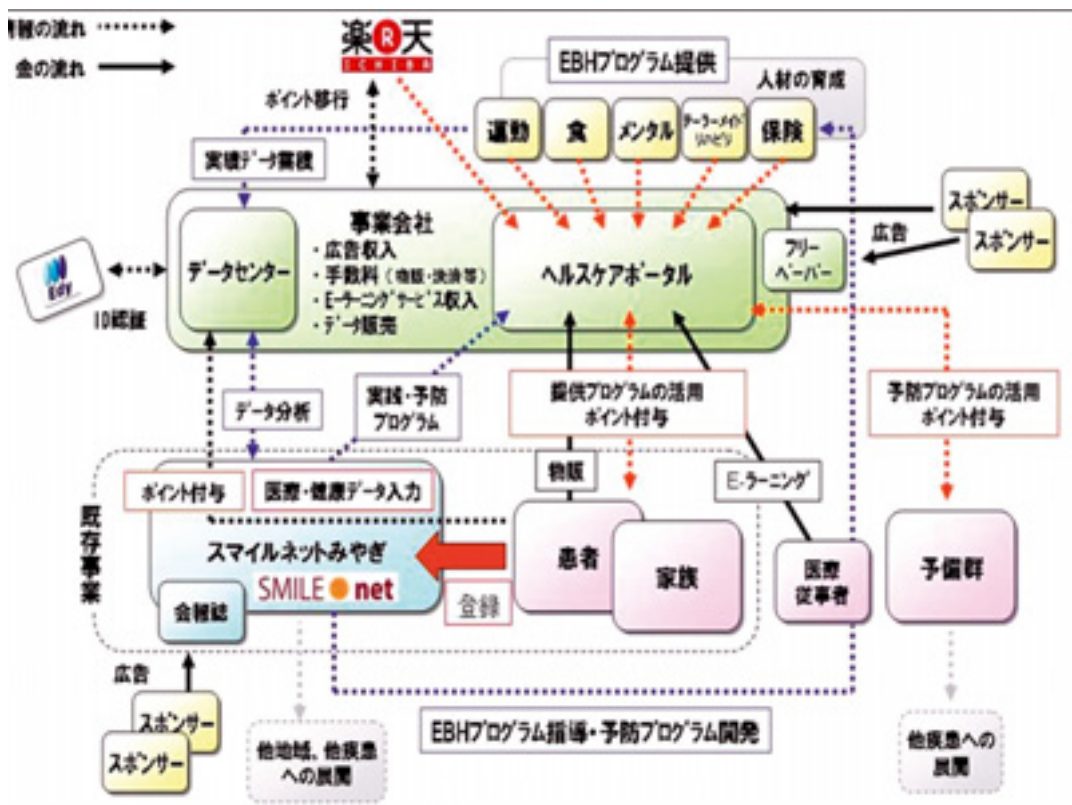
They made one integrated organization "Miyagi Home Hospice Care network" which covers all prefecture area. Community Health section of prefecture office supports broad wide affairs such as preparing network to promote home hospice care (support of local board establishment etc), unified training of professionals, PR, enlightenment (for both professionals and citizens). Owing to public administration's participation, the interests of citizen increased. As a result, broad networking became possible. Governmental participation is very effective in the field of PR and enlightenment. PR and enlightenment will contribute to prevention and efficiency.

Off course there are so many problems on this network. Firstly, by the nature of hospice care, it is very difficult to find index to estimate the effect. Now we are using death at home ratio, but we are not confident this is the best. Secondly,



this care is a very personal one, so it is difficult to evaluate quality, estimate its effectiveness and efficiency, and make a standard model. Thirdly, we are very lack of training expert nurse with specialty. Fourthly from principle of religious separation, utilization of religion (ex. spiritual care) is not sufficient. Fifthly there still remains a regional deviation for home hospice care.

On the systematizing process into all prefecture area, we have to remove several factors. Many original members of home hospice care dropped on this process. We may have to certify the details so as to we can clarify what factors which had been removed on regularizing is essential for home hospice care.



Case of “SMILE-NET MIYAGI consortium” (stroke network in Miyagi pref.)

In establishing “SMILE-NET MIYAGI:Stroke-net in Miyagi Local E-communications”, existing medical network of Tohoku University was basement.



Stroke is No3 cause of death in Japan. Miyagi prefecture locates Northeast district of Japan and has salty meal custom. So there are more patients in Northeast district. Stroke is not only No3 death cause, but also No1 cause of handicap in Japan. Medical doctors in Miyagi have seeking how to measure this problem.

Medical doctors of Tohoku University and its groups made "Miyagi Stroke Research Conference" (members are acute hospital/rehabilitation hospital/sanatorium type wards /nursing care home with rehabilitation etc.). This conference was a network of Medical & Welfare care on single disease. This network had developed "MS Net: Miyagi Stroke Net". "MS NET" is a network to support prompt home return with ICT technology.

Their communication tool is expectation of improving QOL of clients through immediate home return. Various facilities and professionals try to establish smooth collaboration for this aim. In this network, first main actors are professionals and their first reward was improvement of client's QOL. SMILE Net Miyagi consortium was founded on existing medical network of this "MS Net: Miyagi".

But in this network, reward for hospital side (lightening the business of doctors, improvement of sickbed-occupational ratio) was also included. But this network was difficult to maintain for some reasons. For example, there were few incentives for other actors (non-group member of Tohoku Univ. etc) to join this network. And it had only weak financial backgrounds. So they tried to expand this network to profit companies. They designed business platform. SMILE-NET was designed under this process.

A medical instrument company (profit companies) described this business model. So monetary reward (off course, not "only" nor "direct"). It placed existing medical network in core of this network. Its scope is health service and rehabilitation with ICT technology. And another ICT profit company who has professional baseball team in Miyagi participated in this network with a kind of its mileage program. METI (Ministry of Economy, Trade and Industry) selected this consortium as "Support project of service industry creation" in 2007.

Core part of this business model is ME&I portal. Originally this portal was a provision system of on-demand video programs and other function. They tried to use this portal to improve amenity in hospital. By making this consortium, new values of various health care soft (inter-net, e-mail, facility guide, CV of stuff/doctor, meal request, e-case record check etc.) was created for this portal terminal. This portal is profitable for improvement of both medical environment

and amenity in hospital. And further more, information service of community based care and conditioning service of rehabilitation will be added.

This model's key point is to provide incentives for clients to register their health data by providing "super point: a kind of mileage program"). As this point makes clients conscious of their health, the same function as residential participation, it also creates preventive effect. Medical actors can get much useful information through this network and they can provide useful prescription for clients. This mileage points are provided by Edy Card ( electrical money ) , and one-to-one market reveals there.

In this network, business cost will be managed by advertisement of sponsor companies. This advertisement is attractive for sponsor because this advertisement is delivered for specific clients who have needs. This type of advertisement is so effective and economical. And to the more, inpatients in hospitals have too much free time on their hands. So click ratio is very high. This will realize No-cost for clients and hospital. Through this business platform, SMILE NET may establish sustainable and WIN-WIN relations. By establishing BA where various actors meet, not only the reward of mutuality, but also currency reward may be produced in this network.

### ***Conclusion***

These four networks in Japan is a trial for High cost performance in Medical & Health & Welfare care. By establishing networks as BA, by making value creating network, we may achieve effective and efficient methods. To be innovative in this field, to establish this kind of multidisciplinary network, we should classify advanced cases by factors and through this process we should establish typology of Medical & Health & Welfare care.

***Hiroo Hagino, Yoon Youngsoo, Katsuyuki Doi, Tadanobu Endo***

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This work was carried out in the Kansei Fukushi Research Center of Tohoku Fukushi University, Sendai, Japan, supported by "Academic Frontiers" Project for Private Universities: matching fund subsidy from the Ministry of Education, Culture, Sports, Science and Technology (2003 ~ 2007).

*Tsuyoshi Koyama*

## **Coping at Home / Caring TV**

### ***Background***

Ever since the establishment of the Comprehensive Care Center for the Aged Kobushi-en in 1982, I have been engaged in creating support services to facilitate for the elderly to continue living at home. From 1995, I established home help service for 24 hours a day throughout the year.

On the other hand, directions towards independent living at home, that was one of the main objectives of the long-term care insurance enforced in 2000, did not readily progress. In these circumstances, I received in 2003 a state appointment for a two years' period to conduct a future-oriented research project, for studying services that would guarantee all day around safe home living. The concrete result of this project was the development of an at-home nurse call (support call) system, which was a two-way communication system with picture screen phones at both sides.

### ***The system of support call***

The model of Japanese support call system at night is similar to the one being carried out in Sweden, but we developed a call system consisting of a picture screen phone and a mobile telephone with a picture screen. The reason for this was that we wanted to provide the users security mainly in the midnight time zone by confirming their situation not only by sound contact, but also by visual contact. In addition, confirmation by picture as well as by sound was regarded important in a city of a population of 200000-300000, to guarantee each user a safe home living also at night time.

The advantage of the support call system using picture screen phone is that both user and service provider can have mutual communication while seeing each other's faces and confirming the situation, which provides a high level of security and information exchange. Another advantage is that the service provider need not just wait but can answer the call while performing her continuous

duties. In this way, this support call system in the community corresponds to the usual nurse call system at night time duty in institutions.

### ***Method of Usage***

- ① Home help staff have a mobile telephone with a picture screen and the user has a screen phone in the home.
- ② The user calls with a pendant button when necessary, and talks in the screen phone. Both user and home help staff can see each other's face on their phone's screen.
- ③ When necessary, contact from the helper side can be also made.
- ④ There is no operator waiting for calls, but home help staff can receive calls directly and communicate with user while working elsewhere.
- ⑤ Depending on the situation of the caller, home help staff can cooperate with other services.

### ***Problem***

There are basic problems of this system, some of which are as follows, but there are also other unresolved problems too.

- ① Difficult for home help staff to answer calls while driving a car.
- ② During bathing help, it is difficult for home help staff to hear alarm phone bell.
- ③ When all the helpers are busy, the alarm call cannot be answered.
- ④ Dealing with emergencies is difficult.
- ⑤ Weak electric waves depending on place.

No picture of user will be transmitted if he/she is not in front of the in-built camera of the screen phone.

One unresolved problem is the paying method of accumulated charges by every use. In other words, due to this accumulated payment method of conventional home help, it will be too expensive to continue receiving all day around care for 365 days, making some users unable to receive all the care they need.

Although the night time care system that was officially approved as a result of the long-term care insurance revision, made it possible to introduce the all day around support call system, and although the fixed amount paying system for the call is being evaluated, the accumulated paying method is still in use. Therefore, discussions for a fixed amount paying system in future will be necessary.

However, from the fact that users of multi-functional small-scale home care, a service that was introduced at the same time as night time home care after the revision of long-term care insurance, can receive different services for a fixed amount, it seems that, in poorly populated small areas, offering similar services to those offered for a fixed amount to users of multi-functional small-scale home care is a good alternative. Of course it goes without saying that multi-functional small-scale home care service users use the support call service.

This system proves to be suitable in the present Japanese conditions not only in urban regions but also in mountainous and in depopulated areas.

***Tsuyoshi Koyama***

*Tsuneo Okuma*

# **Sendai City Policy for Health and Welfare**

## **1. Introduction to Sendai City**

Sendai City was established by a local feudal lord in 1601 as a castle town. Modern Japan is divided into seven regions, of which Sendai city belongs to the second most northern region, known as “Tohoku.” The city is situated in the center of Miyagi Prefecture, one of six prefectures in the region. The population of Miyagi Prefecture is 2.36 million, and 44%, 1.02 million, live in Sendai city. Sendai has an area of 788 km<sup>2</sup>, and is the political and economic center of the Tohoku region. Looking at its industrial structure, however, production from manufacturing industry has declined and now its main industry is led by consumption and distribution. The ratio of the elderly population aged 65 and over is 16.3%, lower than 19.9%, the national average, and 19.3% for the entire Miyagi Prefecture.

In the political structure of Sendai city, the city assembly, comprising 60 councilors, functions as the decision-making body, and an elected mayor functions as president of the executive body. Within the administration there are bureaus supervised directly by the mayor, as well as those independently run as public enterprises.

## **2. Outline of Policies for the Health and Welfare of the Elderly**

Public health and welfare is the responsibility of the Public Health and Welfare Bureau and the Child Future Bureau. The Child Future Bureau was recently established to develop policies concerning the younger generation, who will contribute to the future of the region. As a member of a ward office, I would like to

introduce the Public Health and Welfare Bureau, which covers projects for the elderly, the topic of this report. The bureau has three departments. Policies for the elderly are the responsibility of the National Health Insurance and Senior Citizens Department, including the Senior Citizens Planning Section. There are also other sections that are involved with policies for the elderly, for example, the Public Health and Sanitation Department promotes care prevention for the independent elderly.

The city is divided into five administrative wards, in each of which a ward office acts as a point of contact to provide services for citizens. Aoba ward office, to which I belong, is one such office, and is located in the city center where 281,000 people live, representing 27% of the population of the city.

Each ward office also has three departments. Most of the services of the Public Health and Welfare Bureau and Child Future Bureau are delivered by the Public Health and Welfare Center of the ward office. In each center, there are six sections, and among these, services for the elderly are handled by the Disabled and Senior Citizens Welfare Section and the Public Health Section.

Seen from the financial viewpoint, the health and welfare budget is a part of our general account of 110.296 billion yen. Due to the effects of the decrease in the entire budget because of the severe financial condition of the city administration, the health and welfare budget was reduced by 3.4 billion yen from the previous year. This also slightly decreased the budget for projects related to services for the elderly. The budget for care service provision is not included in this budget as it is a part of the special account.

The proportion of the health and welfare budget in the general account has been increasing each year, and this year is 27%, representing a 1% rise on the previous year. In the past, the public works budget, which is essential for developing the urban infrastructure, was the biggest. Over the last few years, however, the health and welfare budget has been allocated the largest portion. Within the health and welfare budget, the elderly health care and welfare budget is 19.625 billion yen, representing 17.8%. This is less than child health and welfare or social aid out of all the budget items.

I will discuss revenue later in the introduction to the status of local government in Japan, but here let me say that in spite of the delay in tax reforms for transfer of tax revenue sources to local governments, 30.9% of revenue comes from the national and prefectural governments, upper organs of administration, and two-thirds from the municipality.

Besides the general account, the city has a special account. Nursing care is run through the Long-Term Care Insurance System as social security, and accounts for 22% or 41 billion yen of the total 186.4 billion yen for the special account. Elderly medical care insurance expenses of 70 billion yen are also included in the special account—a proportion of 37.6%. Altogether the elderly care-related budget totals 111 billion yen, or 60% of the special account. In addition, the National Health Insurance budget includes medical care for the elderly.

The city of Sendai, as an insurer, runs Long-Term Care Insurance finance as a part of its social security system. Since the Long-Term Care Insurance System was established by the national government, according to a breakdown of cost, the national government burden is a quarter, that of prefecture and city, the insurer, is one-eighth for each; therefore, a half of the cost is covered by the public sector. The rest is covered by the insured—the citizens. “Category 1” insured people are 65 and older who are eligible to receive long-term care benefits mainly, and “Category 2” insured are those aged between 40 and 64.

I would like to explain the keywords we associate with our elderly health care and social welfare plan. The keywords for our basic goal are the “independence and dignity” of the elderly.

Japan experienced magnificent regeneration and a high economic growth rate after World War II. The elderly of today are proud of having led this growth, so only economic independence has been their prior concern. That’s why we have to encourage them to now direct their concerns towards mental and physical independence.

There are four major issues: The purpose of life means mental independence. Extending longevity with good health is physical independence. Promotion of care in the community is a part of community development, which the present elderly have not been so good at. Improving the quality of services means to improve environment and living circumstances for carers.

Our basic viewpoint includes realizing physical and mental independence by respecting individual dignity. For collaboration and utilizing social resources, it is necessary for the private and non-profit sectors to identify their roles and responsibilities. We would like to promote regional community development, which is, as I mentioned earlier, the most challenging issue for the present elderly.

We are carrying out measures in coordination with other related projects, such as the “Citizens Health Promotion Plan,” with targets relating to their health throughout unlimited life stages. The term of our elderly health and welfare plan



is three years, from 2006 to 2008. Based on the achievements of this plan, we intend to draft a strategy for the following three years, 2009 to 2012.

To describe the situation of the elderly in Sendai, I would like to utilize some data again: the trend of the aging population rate, the conditions of the elderly at home, and the increase in the number of elderly who require care.

The transition in the elderly population rate shows that a sharp increase is expected after 2004. This is a reflection of the high birth rate after 1945, the year WWII ended. In Japan, people often say on various occasions that the post war period is not over yet. This means that various kinds of its effects are still being observed today. In this sense, the increase in the numbers of the elderly is among them. The number of households that include elderly members is increasing, although this does not mean that single elderly households are also increasing rapidly.

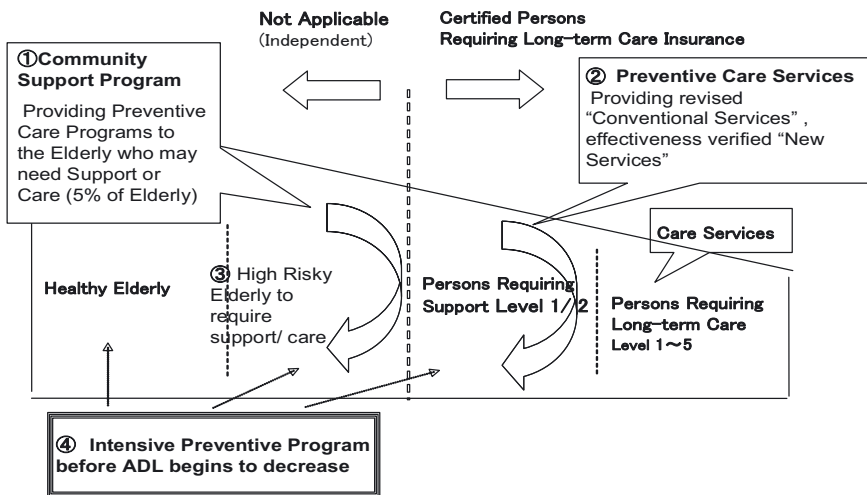
As the rate of elderly increases, a growth in the number of elderly who require care is also predicted. With the effect of our care prevention projects, which I will explain later, our estimates are based on the hope that these projects can slow down the number of elderly requiring care. Therefore I am keenly aware of the necessity to commit to care prevention activities.

Sendai city focuses on care prevention. The city introduces care prevention measures intensively at the point when daily living ability starts deteriorating, which is called “operating at the brink.”

In this “operation” three programs are run: (1) An in-community support program, the target for which are those elderly that are expected to need support or care in the future. For this segment, physical and mental support is provided. (2) Our care prevention services also target the elderly who need partial support or care. Programs to slow down the deterioration of ability are offered instead of daily living support services. (3) The third program is to identify elderly expected to need support or care as the “specified elderly,” and then establish a care prevention plan and actively intervene.

# Prevention Oriented Systems

## Prevention Care Services / Community Support Program



### 3. Relationship between National and Local Governments and Challenges to Local Government's Decision-Making

In the field of policies for the elderly that I have explained, the national government specifies the details and requires local governments to enforce them. It might be difficult to find difference in projects outlined earlier, among local governments with the same size of population, so we have to be more concerned about planning projects based on the actual situation.

This is the case not only for measures for the elderly. According to Japanese laws, ordinances governing local governments can be enacted within the national laws. In terms of financing, the national government specifies how a large part of the health and welfare budget explained previously is to be expended.

Delegation from the central government to local governments has been discussed; but still most of the national government's administrative work is operated by local government as entrusted services.

It may take time, while balancing the transfer of tax revenue and power, but I think an appropriate relationship between national and local governments will develop. An ideal local government would carry out measures appropriate to the

actual needs through sound knowledge of its own area. Transfer of taxation power is essential to create such a local government.

It is also necessary to clarify the roles and responsibilities of local government. For this, the legislation system itself has to be reviewed. Regarding their relationship with the entire prefecture, people in Sendai need to be aware that they are also residents of Miyagi Prefecture.

By the way, comparing the tax burden with other countries, although the year of data is not common, the proportion of overall tax burden to the gross national income of Japan is 23%, as low as the US. Unfortunately I don't have data for Finland. Tax in Sweden is 47.9%, more than double that of Japan. If a heavy tax burden can promote measures for the elderly with the trust of the government, we would like to learn from their experience.

In conclusion, I would like to mention the environment of collaboration between industry, academia, and the public sector. As the power of local government is limited in Japan, in decision-making measures, proven academic results and evidence are essential. It seems disadvantage to create values, however, this means how much we expect steady research results.

Transparency in planning, designing, and ordering processes will ensure free competition and this will also contribute to maintaining accuracy in specifications and cost awareness.

From the viewpoint of industry, the ability to plan based on estimated return on investment will meet the principles of the market, and thus collaboration with the public sector is essential.

It might seem a little odd if I mention the viewpoint of the university, but in Japan—and throughout the world, the status of universities has been changing—especially in terms of the management of a university, where financial aspects have become increasingly important in addition to human resource management. Under such circumstances, we understand that the balance between practical research, which can usually be easily funded, and interdisciplinary research, for which direct applications are not particularly obvious, can be a sensitive issue. I believe that this project is being run by Tohoku Fukushi University with national funding. As a viewpoint of the city of Sendai, I hope the results of the project will contribute to even more effective policy management.

***Tsuneo Okuma***

## **Measurement and research of productive efficiency in health and elderly care**

The concept of productive efficiency deals with productivity: the relationship between inputs and outputs, with a unit's productivity considered in relation to the best possible productivity. Inputs factors in economic analyses of health care services are usually classified as labour, capital and supplies. The most important category is labour, which constitutes some 65-75% of total running costs. Physicians' costs are usually 10-15% of the total labour costs. Measuring the output of health care services is particularly challenging. The intermediate outputs of health services are typically visits to physicians, laboratory tests, surgical procedures and bed days. Final outputs include episodes of care and all of an individual patient's episodes for example during a year (patient treated). In determining and measuring the outputs of health care, it is essential to take into account the patient case mix. The case-mix adjusted outputs are usually determined by using the patient classification systems as DRGs (Diagnosis Related Groups) in hospital care and RUGs (Resource Utilisation Groups) in elderly care.

CHESS (The Centre for Health Economics at Stakes) has experience of measuring productivity in hospital care and institutional care for the elderly. VATT (the Government Institute for Economic Research) focuses on measuring productivity differences in primary care, especially between health centres.

The productivity of hospitals and health centres has been measured since 1988. An extensive hospital benchmarking project was launched jointly by six hospital districts and Stakes in 1997 in the form of a pilot study, and extended in 1998 to include all districts (all public hospitals). The aim was to develop methods for measuring and comparing productivity in hospital care at hospital, speciality and

patient group levels from the provider's perspective. Later, methods were also developed for measuring productivity from the population's perspective (Junnila 2005). Also international comparisons of hospital cost efficiency were developed in the Nordic countries, especially between Finland and Norway (Linna et al. 2006).

The productivity of institutional care for the elderly has been measured as a part of the "Benchmarking and the Implementation of the RAI (Resident Assessment Instrument) System in Elderly Care" project since 2000. The project was launched in 2000 on the initiative of Stakes and the Chydenius Institute in collaboration with the staff of private and public serviced housing facilities and residential homes, and with public health centre wards. The project was initiated in three municipalities with 92 participating wards, representing 2,276 beds. In 2004, there were 282 participating wards from 26 municipalities, with 7,032 beds. This represents 20% of all patients in long-term institutional care in health centres and residential homes in Finland (Noro et al. 2005).

## **Development of productivity in health and elderly care**

Case-mix adjusted hospital productivity increased during the years of economic decline 1991-1993 (Linna 1998). In recent years the trend in hospital productivity has been decreasing. Between 1998 and 2002 productivity fell by an average of 0.7% a year, especially in 2000-2002. This decline was caused by an increase in the number of staff, unaccompanied by any corresponding increase in output. This may also mean that the high productivity of earlier years stemmed from the limited staffing at the time (Linna and Häkkinen 2004). However, in international comparisons, Finnish hospitals have been found to be more efficient than for example Norwegian ones. In 1999, the average level of cost efficiency was 17-25% lower in Norwegian hospitals than in Finnish ones (Linna et al. 2006).

In health centres, productivity changes have followed the general economic trends. In other words, when economic trends were positive, the productivity of health centres was negative, and vice versa. From 1997 to 2003 the average productivity declined by 13.7%. Productivity changes were measured as a ratio of key services produced (e.g. visits to physicians) and real operating costs. Case-mix adjusted output data were not available (Räty et al. 2005).

The productivity of institutional elderly care declined by 7% in 2000-2003. In other words, the ratio between the resources used and the number of produced inpatient days diminished. The average productive inefficiency of the ward was approximately 20%. This implies that the average ward used a fifth more per-

sonnel and capital resources to produce the same amount of case-mix adjusted inpatient days as the most efficient ward. The study also demonstrated a trade-off between productive efficiency and the quality of care. High productive efficiency at ward level was mainly associated with quality indicators that reflected passivating and non-rehabilitating care or the outcomes of such practices. Moreover, a low level of personnel and capital resourcing was associated with high productive efficiency. However, the results show that the connection between quality and productivity efficiency was not especially strong. Small changes in the quality of care do not necessarily have a major impact on productivity efficiency, and vice versa (Laine et al. 2005).

### **Future research challenges: including effectiveness in productivity analysis**

CHESS began developing a population-based cost effectiveness approach in 1998, using acute myocardial infarctions as an initial disease group. Later the project expanded to become the PERFECT (Performance, Effectiveness and Cost of Treatment Episodes) project, which aims to develop indicators based on register data that can be used to compare and evaluate the effectiveness, quality and cost effectiveness of specialist care across regions, hospitals and population groups. The focus of the project will be on selected disease groups with sufficient significance in terms of costs and burden of illness. In 2006, the project included seven disease groups: 1) acute myocardial infarctions; 2) hip fractures; 3) breast cancer; 4) hip and knee replacements; 5) very low birth-weight infants; 6) schizophrenia; and 7) strokes.

***Hennamari Mikkola***

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*Rolf Myhrman*

# **Total Cost and Profitability of Health and Social Services: Challenges and Future Visions in Finland**

## **Strategies for Social Protection 2015**

The Ministry of Social Affairs and Health will take initiatives to increase awareness of health and social welfare in all areas of society. The operations will be based on the guidelines issued under the Welfare 2015 programme and the Health 2015 public health programme. Our vision for 2015 is for Finland to be a socially and economically sustainable, efficient and dynamic society. The well-being of our society will be rooted in the maintenance of work ability and general functional capacity combined with individual initiative. It is envisaged that in 2015 the health differences between population groups will have been reduced, the general functional capacity of the population will have improved, and older people will not need care until a more advanced age.

Preventive work will have taken on a more prominent role in the various functions of society and as part of the service system.

The quality, availability and effectiveness of services will have been improved.

### ***Cost and quality in health care***

On the level of production, productivity refers to the relationship between output and resources. However, measuring productivity without regard to quality or value is a risky foundation for a wise policy; the effectiveness of political operations must be evaluated through objectives, resources and impact. In the social policy-making process, objectives are set and the resources needed for attaining the objectives are targeted. The decision concerning division of resources between prevention, primary health care and specialised care is an example of this



so-called political allocation. The impact of objectives can be monitored with the aid of indicators describing the implementation of objectives.

The target of achieving simultaneous improvements in cost and quality in health care has arisen for several reasons. In Figure 1, the productivity frontier incorporates all available best practices in terms of process protocols, technologies, drugs, and other aspects of care (and it is clear that many health care services lie far from the frontier). Catching up and moving to the frontier will allow providers to deliver current outcomes at lower costs, to improve outcomes at the same cost, or, in many cases, to attain better outcomes at lower costs.

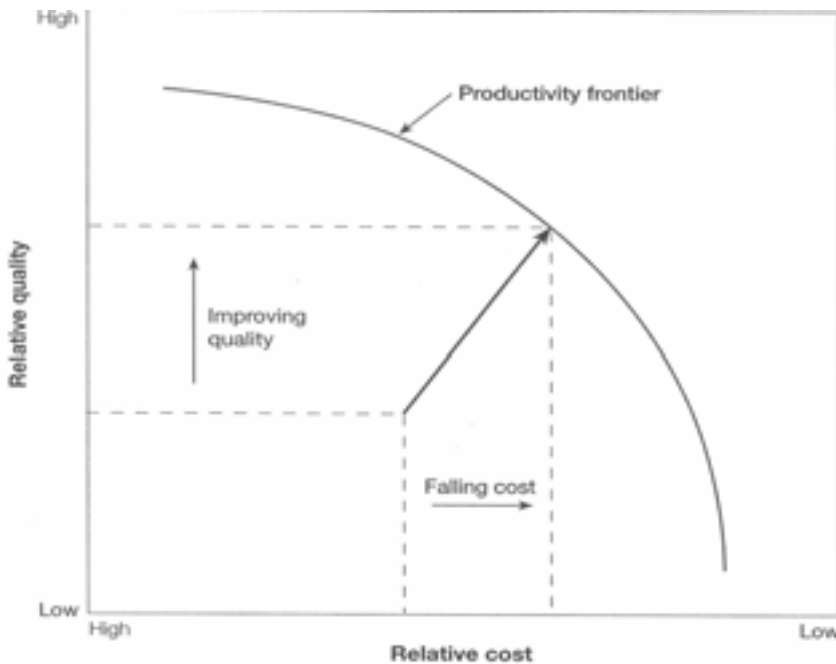


Figure 1. Productivity frontier: operational effectiveness versus strategic positioning

## Concepts and definitions of productivity

### *Misleading facts*

According to the productivity concept of national finances, the productivity of the public sector has declined in recent years. Many studies have also shown that the productivity of both specialised medical care and health centres has decreased recently.

	Expenditure <sup>1</sup> 2003 EUR billion	2000	2001	2002	2003	2004
		productivity change %				
<i>State</i>	9.9					
Total productivity		-0.7	2.8	-1.4	-2.1	0.0
<i>Joint municipal authorities</i>	12.6					..
Health care centres	2.6	-0.9	-3.4	-3.7	-3	..
Specialised care	3.6	..	-2.2	0.1	-0.3	..
Institutional elderly care	1.2	..	-6.4	-0.5	-0.5	..
Total productivity of municipalities		-1.8	-2.5	-3.2	-1.5	..
Educational services	5.5	-1.3	-1.5	-3.4	-0.9	..
Comprehensive school	3.2	-2.2	-1.6	-3.7	-0.3	..
Upper secondary school	0.5	-2.9	-2.9	-5.7	-1.6	..
Vocational school	0.4	1.0	1.8	-4.0	-3.4	..
Library services	0.3	-0.5	-0.5	0.3	-0.5	..
Social services	6.8	-2.7	-4.5	-3.2	-2.3	..
Children's day care	2.0	-2.8	-3.8	-3.6	-1.4	..

<sup>1</sup>State expenditure according to state accountancy, municipal operating costs from municipal accountancy.

Table 1. Development of productivity of services provided by the state and joint municipal authorities. Source: Economic Review 2005, Ministry of Finance

In studies, productivity is measured as the volume of output achieved with a given sum of money. The activities measured include operations, visits to the doctor or treatment episodes. In the comparison, an attempt is made to standardise factors such as the patients' age structure and how demanding the treatment is. If there are large differences in costs per unit between different production units, the units shown to have inefficient cost management should consider whether their production methods are rational, or whether resources

are being correctly targeted. The method is well suited to the evaluation of unit cost efficiency.

Productivity figures of this kind are suitable for the assessment of *economic efficiency*, when measuring output per resources, i.e. the costs per unit of the activity. Unit costs have been used as an indicator of productivity. Measured thus, the result has invariably been the weakening of productivity during the period under study. However, this method does not tell very much about the quality of operations.

### ***Productivity level***

#### **Measuring productivity in health care**

**Allocative efficiency** = efficient grouping of resources (e.g. geographically or operationally)

**Economic efficiency** = output per resources, output cost per unit

**Technical efficiency or yield** = output per production unit (e.g. surgeries per team or theatre)

**Quality** = correspondence between objectives/recommendations and performance

**Benefit** = the impact of resource use on population health

In addition to the productivity assessments mentioned above it is necessary to look at the realisation of the goals of social and health care services.

The objective of social and health care is to reduce social problems and the burden caused by illness, injury or disability, and to improve and maintain the well-being, state of health and functional ability of the population.

The extent to which output promotes health and alleviates suffering among clients describes the impact or quality of each activity. Social and health care productivity indicators do not for instance explain how the efficiency of social protection has increased as clients are increasingly being treated in the community instead of in institutional care. However, evaluations should give an idea of how well our health care system is working.

The measurement of the productivity of social and health services, and public services in general, is divided into two categories:

1. measuring the impact of the activity, i.e. doing "the right things"
2. evaluating whether the activities are implemented as efficiently as possible

Restricting the scope of study to just one of the two does not provide a full picture of the functional ability of the service structure. The aim should thus be that ***the right things are done as efficiently as possible***.

Measuring productivity often involves a number of technical problems, which make it hard to assess the development of productivity. For example, the quality of health services is much more difficult to measure compared to market production. An efficient health care system provides services without unnecessary delays, and it has an impact on people's well-being and health. There are few statistical or research data available on how these factors have evolved over time or how they vary between health centres, and it has therefore not been possible to take them into account in productivity calculations. In addition, it seems that as of at least 1999, the episode productivity of hospitals is to a large extent explained by the development of real wages in specialised care (Figure 2).

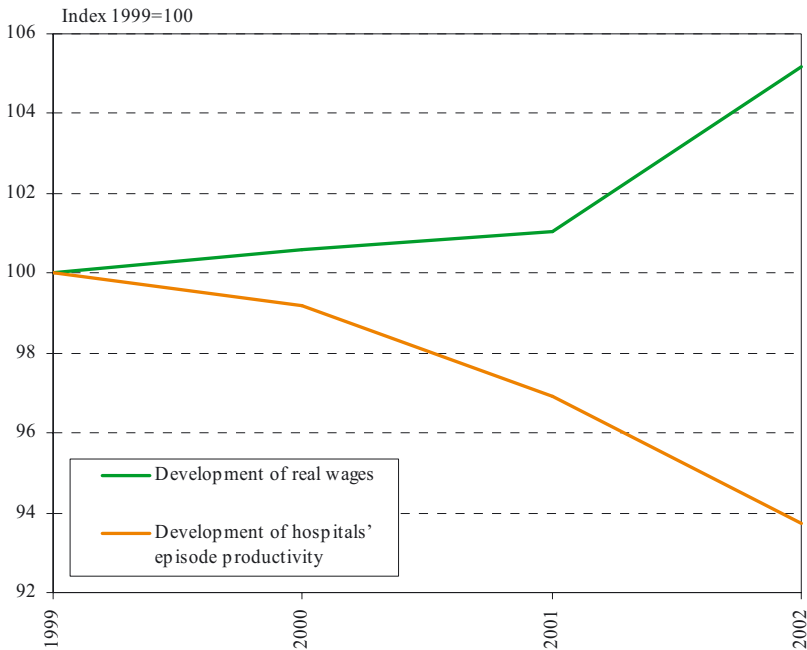


Figure 1. Development of hospital productivity and development of real wages in specialised care, 1999–2002

If a (service) firm operating in the commercial market measures its operations without taking into account quality, only output, it will soon get into trouble, because clients can assess the quality of its products. Insufficient measuring may thus easily lead to incorrect policy recommendations.

At Helsinki University Central Hospital, for example, neurology is the weakest speciality measured in terms of episode productivity, although the prognosis of brain infarction patients has improved at HUCH, and 80 per cent of patients manage without expensive further treatment. Meanwhile, mortality has fallen lower than anywhere else in Finland. However, the improvement of the quality of treatment is not taken into account in productivity indicators, such as episode productivity.

### ***Impact***

The impact of activities on patients and the economic efficiency of activities help the production unit to target resources for different lines of operation. The assessment is based on the needs of the institution's (hospital's) clients. When the scope of study is expanded to cover the entire population in the area, decision on resource allocation – e.g. between outpatient care and institutional care – must be made on political level.

Political decision-makers mostly get information about the benefits of health care through the efficiency and impact indicators mentioned above. Based on these, they set targets and allocate resources for health care. The question is whether the resources are targeted on a national and/or municipal level so that the benefit for the entire population in the area is maximised.

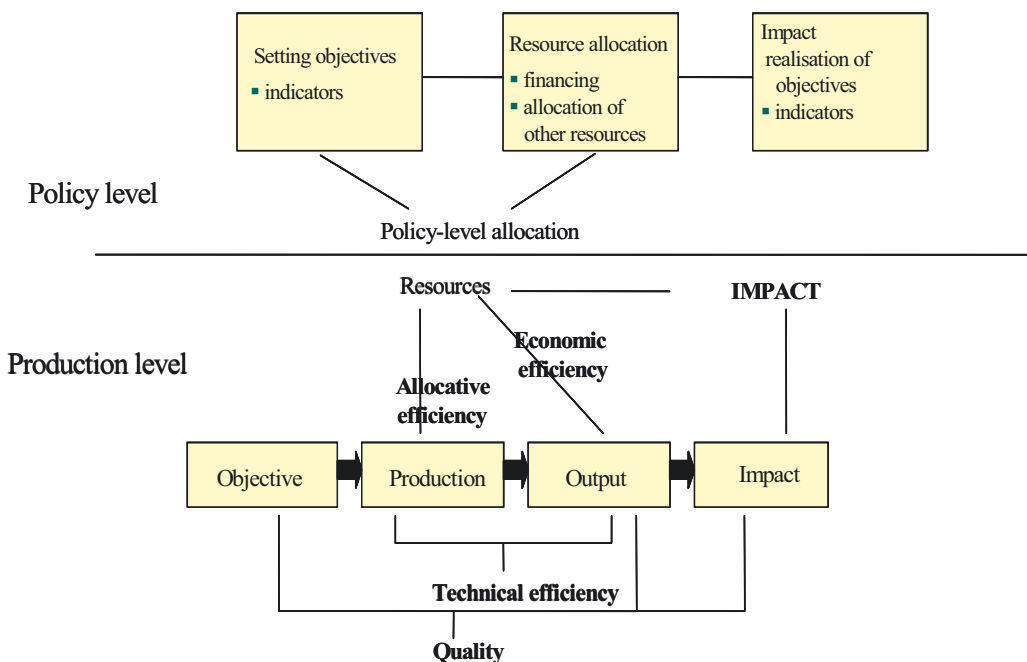


Figure 2. The health policy-making process and types of production level efficiency

## Political level

### *Allocation*

On a political level, resources are allocated on the basis of estimated population health benefits. This is thus a question of political allocation, with political priorities. Political-level allocative efficiency is sought for example by making decisions concerning resource allocation between prevention, primary health care and specialised care. Attempts to reach allocative efficiency can also be made on geographical and operational levels. An example of this is the ongoing municipal and service structure reform project. The level of allocation may be defined by the technology used; for example, the regional centralisation of expensive magnetic imaging equipment is sensible, while cheaper X-ray equipment may be placed in every health care centre. On a production level, allocative efficiency refers to the efficient grouping of resources aimed at optimising the production process.

When assessing the productivity of the entire health care system, the following aspects must be taken into consideration: how resources are allocated, what their operative efficiency is, how processes are managed, how well objectives and performance meet, and what impact the use of resources has on population health.

## **Well-functioning services**

The aim is to ensure equal availability, quality and sufficiency of municipal services in accordance with population needs, with a reasonable tax and payment burden.

The most important impact goal of social and health care services is the improvement of the availability and quality of services. In years to come, this will call especially for securing the sufficiency of staff and sustainable financing of the services.

Municipalities will be encouraged to step up their cooperation with the third sector and to benefit from their expertise in reinforcing and establishing preventive action, rehabilitation and civic activities. The resources of older people who are healthy and fit will be actively welcomed in voluntary activity in various sectors of society. Attention will also focus on the differences in functional capacity between the sexes.

### ***Future need for social and health care services***

Figure 4 shows average age-group-specific social and health care service expenditure in 2004. It is noteworthy that expenditure varies considerably between municipalities and regions. In addition, age-group-specific expenditure is constantly changing, and the boundary between social services and health care is porous, particularly in elderly care. The expenditure on older age groups – e.g. those aged 80–84 in relation to those aged 30–34 – is fourfold in health care services as well as in medicines and services covered by health insurance. In the case of social services, the corresponding difference is twentyfold.

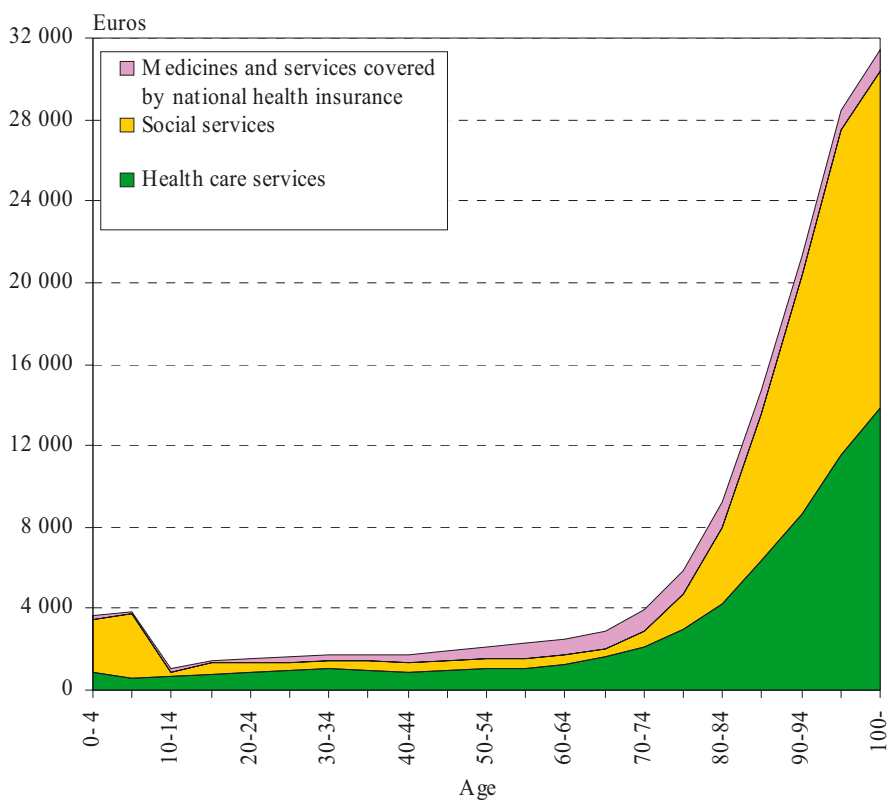


Figure 3. Age-group-specific social and health care expenditure (including user fees and health insurance co-payments by beneficiaries), according to type of benefit in 2004, EUR per person

Social and health service expenditure can be estimated to rise in the 2020s and 2030s, as the number of very elderly people increases markedly. On the other hand, it must be taken into account that according to several studies, the rise in the number of the aged has not so far led and will not lead to a corresponding rise in expenditure. The OECD assessment report on health care in Finland also states that technological changes will continue to be the factor with the biggest impact on health care service demand in the future. It is likely that public health will continue to improve in the future, and the elderly will be able to cope independently longer than before. In addition to improved health and functional abil-



ity among the elderly, the service needs caused by population changes may be alleviated by many other factors as well.

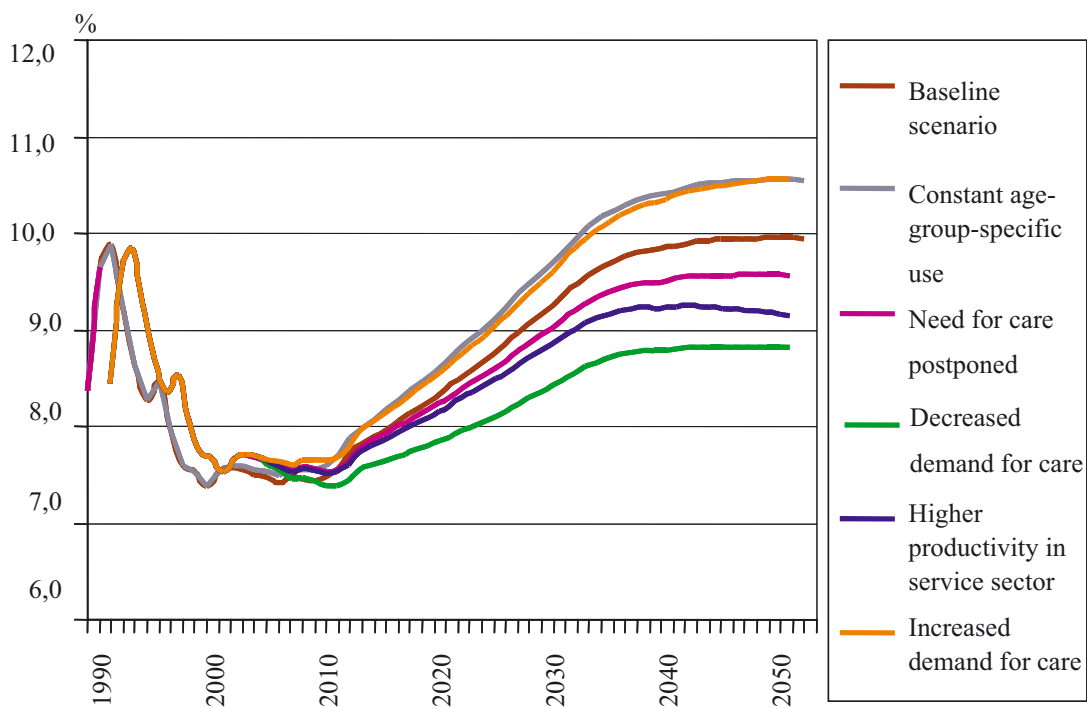


Figure 4. The GDP ratio of municipal social welfare and health care expenditure, 1990-2050, per cent

Trends in expenditure can also be significantly influenced by service provision solutions such as the adoption of new, more efficient operation and care methods, making use of technological advances, and reforming service and production structures. In health care services, supply also creates demand, which is why supply has a decisive impact on future costs.

## Health care financing

### *Null sum game*

The financing of Finnish health care is a combination of municipal and state funding, user fees and the private health care service sector supported by health insurance<sup>14</sup>. The Finland's Slot Machine Association is a significant participant in the funding of care services for the disabled and elderly<sup>15</sup> and in youth work. Decisions on health care legislation and the financing of health services have been made gradually over the years.

Public financing makes up about three quarters of the total funding of health care expenditure, while the remaining quarter comes from private sources. From the beginning of the last decade, the share of private financing has grown by about five percentage points. This has mainly occurred through a rise in the financing share of households. The 19 per cent financing share of households is among the highest in the EU. Within the public sector, the government's financing share has been halved, from 36 percent in the beginning of the 1990s to 18 percent in 2003. During that same time, the financing share of municipalities has increased by nearly eight percentage points, and that of the Social Insurance Institution of Finland (SII) by about six percentage points.

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<sup>14</sup> The way services are arranged, their extent or content is not defined in legislation; assessment and implementation is left to the municipalities.

<sup>15</sup> The financing streams are considerably more complex than presented here, especially in the case of services for the elderly, including e.g. various investment and operation subsidies.

Year	Central-government	Municipalities	SII	<i><b>Public financing, total</b></i>	Employers	Relief funds	Private insurance	Households	<i><b>Private financing, total</b></i>
1980	38.2	28.9	12.4	<b>79.6</b>	1.2	0.6	0.8	17.8	<b>20.4</b>
1985	34.0	34.7	10.2	<b>78.9</b>	1.3	0.7	1.2	18.0	<b>21.1</b>
1990	35.6	34.7	10.6	<b>80.9</b>	1.4	0.5	1.7	15.6	<b>19.2</b>
1995	28.4	33.8	13.4	<b>75.6</b>	1.5	0.4	2.0	20.5	<b>24.4</b>
1996	24.1	37.8	13.9	<b>75.8</b>	1.6	0.5	1.9	20.3	<b>24.2</b>
1997	20.6	41.2	14.2	<b>76.0</b>	1.6	0.5	2.2	19.7	<b>23.9</b>
1998	18.9	42.5	14.8	<b>76.2</b>	1.7	0.5	2.2	19.4	<b>23.7</b>
1999	18.0	42.4	14.9	<b>75.3</b>	1.7	0.5	2.2	20.3	<b>24.7</b>
2000	17.6	42.2	15.4	<b>75.2</b>	1.9	0.5	2.1	20.4	<b>24.9</b>
2001	17.1	42.8	15.6	<b>75.5</b>	1.9	0.5	2.0	19.7	<b>24.1</b>
2002	16.9	43.3	16.1	<b>76.3</b>	1.9	0.5	1.9	19.4	<b>23.7</b>
2003	17.6	42.4	16.5	<b>76.5</b>	2.0	0.4	2.0	19.0	<b>23.5</b>

Table 2. Financing shares of total health care expenditure, 1980–2003 \*includes 5.2 per cent central government financing support. Source: National Research and Development Centre for Welfare and Health, “Health Care Expenditure and Financing in 2003”. Statistical Summary 4/2005.

A system with separate financing channels calls for good coordination of the service system from the viewpoint of care, costs and the client. If coordination of the service system is insufficient, problems are encountered in 1) the transfer of costs to other operators; 2) a lack of coordination of service provision; and 3) an increase in service provision costs and 4) user fees.

Municipalities can steer streams of clients between the public and private sector by prioritising their service supply. Particularly in long-term elderly care, the division between outpatient care and institutional care changes financing responsibilities, and municipalities have made use of this possibility to transfer costs to be paid by the Social Insurance Institution and clients.

The division of medication costs is also a key problem in the multichannel system. In outpatient care, the patient is responsible for covering the cost of medicines jointly with the Social Insurance Institution, whereas in institutional care, medications are included in the fixed price of care. By transferring patients to

outpatient care, the municipality can transfer these costs to be paid by the client and the Social Insurance Institution. At the same time, the patient's status changes in terms of social protection.

Queuing costs are a significant negative effect caused by the poor coordination of the health insurance system and public health care services. Municipalities and health care districts do not have a direct interest in affecting the costs caused by queuing, such as sickness allowances and medication costs in outpatient care.

Queues have not traditionally been a problem in countries with an output-based financing system. Queues are mainly a feature of countries where hospitals receive a lump sum agreed in advance. It is thought that queues may lessen productivity, as hospital staff must devote more time to queue management at the expense of actual patient work. A slight, although not statistically significant correlation has been detected in Finland between poor productivity and patient queues (Järvelin 2004). On the other hand, waiting times may decrease both the supply and the demand of services. Particularly in the case of non-urgent public services, queues may actually be well-motivated, as they curb excessive demand.

As a whole, the current financing system encourages the arrangement and implementation of services based on each operator's starting premises. The situation has led to quarrels about who should pay for care, a deterioration of the concept of comprehensive client care and problems in regulating the amount and structure of financing.<sup>16</sup>

### ***Challenge to find win-win solution.***

***Rolf Myhrman***

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<sup>16</sup> The OECD discussed factors related to the multi-channel structure of our health care system in its report assessing Finnish health care.

# Private, Public or Public-Private Mix of Health Care in Finland and Japan

## Introduction

For years, proponents of privatisation have argued that private firms respond to competitive market pressures and provide high-quality services at lower costs. Too often the public decision on privatisation is treated as an either/or decision. However, “you don’t always get what you pay for”, as Sclar (2001) puts it. The real global dilemma is that there is nothing inherently superior in the private sector provision of goods and services, because if the private sector is always effective, then why do about 80% of all businesses fail? The pursuit of efficiency in health care has become a central aim of policy-makers. However, they need to be assured that expenditure is in line with the citizens’ interests when many sources of finance, such as tax revenues, are under acute pressure (Bozeman 2006; Jacobs et al. 2006).

Forms of privatization and the cases where public services are more efficient than private ones are not usually known. In many cases, it is also unclear where the decisions for or against the reforms of health care services stem from. In both Japan and Finland, political decision-makers are unwilling to increase the amount of taxes in order to solve the problems of aging. On the other hand, costs in both countries are so high that they cannot be met just with financial resources. However, the either/or logic, i.e. the logic of bad/good service, is too often used to argue for a reform of health care services. The comparisons of public and private services do not support the logic, and even citizens do not necessarily prefer services based on it.

Instead, emerging hybrid forms of service provision in health care try to follow the idea of “both/and” (Faerman et al. 2001; Arendt 1958). Nevertheless, underlying libertarian and egalitarian ideologies seem to be embedded in these hybrid forms (e.g. public-private partnerships). In practice, “fostering entrepreneurship in health care” all too often means highlighting the fact that freedom of choice is

good in itself, and that individuals are the best judges of their own welfare (Williamson 2005). At the same time, not all members of society have the right to basic services, and society is not even allowed to determine what these basic services are. This paradox is very hard to overcome and heavily affects how we judge reality (Vuori & Kingsley 1999). In the health care sector it means answering questions such as how can we simultaneously increase the technical efficiency of care and the effectiveness of treatments, even in preventive care.

## **Citizens' preferences and the challenges of Finnish and Japanese social and health care**

This paper forms part of a large empirical and theoretical study conducted in Finland, the UK and USA, as well as a few other countries (e.g. Japan) between 2004 and 2008. It is mostly funded by the Academy of Finland. The main idea of this presentation is to describe the citizens' preferences in Finland with regard to public and private health care services. The description is based on survey data (2006) from five cities in Finland (N= 2,799) In addition, we present a few ideas on comparing public and private health care systems between Japan and Finland (Vuori & Merviö 2006).

The paradoxes described above led us to ask the following questions: How can we get rid of the "either/or" decisions in providing health services? How can we combine the strengths of libertarian and egalitarian ideologies in order to construct value-free public-private partnerships in health care (cf. "avoiding cream-skimming")? Can we analyse clearly whether the citizens' choices of public and private health care are determined by their diseases, insurances or other preferences? How can proponents of the public or private sector dramatically overcome their ideological conflicts? Answering these questions should be start with basic concepts such as efficiency. Proponents of the public sector (i.e. the public interest) will always define efficiency in terms of preventive health care, while proponents of entrepreneurship will stress the importance of technical efficiency (process management, cost efficiency, etc.). In reality, the effectiveness of health care needs the optimisation of public-private interests at the macro level and solid analyses of citizens' preferences at the micro level.

Social transformations in post-war Japan have had a great impact on the elderly. Traditional inter-generational interactions and familial and kinship-based reciprocities are being challenged by the post-modernisation processes – hence government policies that attempt to address the problems are mostly in vain (see Thang 2002). For the first time in Japanese history, in late 2005, the number of

people aged 90 or over topped one million, with 25.53 million people aged 65 or above and more than 23,000 centenarians. There was also a very low birth rate (1.29) (MHLW 2005). If we look the statistics of Finland, we are right behind Japan, but our citizens are not aging quite as fast as the Japanese. In both countries, the familial burden of caring for an aging population has increased, but in Japan the trend is even worse for many reasons. Because the amount of elderly people is going to be very high in Finland, we are trying to solve the problem by following in the footsteps of Denmark. Specifically, it means that hospitals will provide fewer services for the elderly than before, with the expectations that the elderly will stay at home longer. The services that they need the most will be provided in their homes by municipalities or private social and health care organisations. However, there is still resistance to change on this front, and, in spite of citizens' preferences, services are provided by public health care, especially university hospitals. This is because in Finland, the elderly have been taken care of by municipalities and the public sector in general for years.

Interestingly, in Japan the problems and solutions are very similar in some ways. Given the problematic constellation of demographic transitions and the issues related to familial care, the establishment of a long-term care insurance (Kaigo Hoken) as a prompt policy response was welcomed – many nationwide surveys in the last decade have indicated that an overwhelming majority (more than 70%) of respondents support the move towards a new type of elderly care. More importantly, these surveys highlighted the readiness of people to receive elderly care from the community (Lai 2006).

However, in both countries new forms of service provision cannot solve the aging problem if there are not enough professional care givers available. For example, it is estimated that to secure nursing homes for 2% of the elderly population in 2020, existing facilities would have to be staffed with 210,000 more workers, against the backdrop of a diminishing workforce in Japan. Therefore, increasing labour would not be the answer to aging problem, even if we had the necessary resources.

Constrained by the demographic transition, the aging population and a diminishing workforce, the Japanese and Finnish socioeconomic systems will become dependent on an influx of labour and the outsourcing of services. However, both countries will have huge problems in recruiting for example nurses, with an especially problematic situation in Japan. For instance, in 2005 there were some 1.3 million working nurses in Japan, but another 700,000 were needed considering the total number of hospital beds, work shifts, parent leave and other forms of leave. In Finland, some 100,000-120,000 nurses will retire between 2010 and

2015. The number may not seem very high, but in relation to the increasing cost of health care, it is not an easy problem to handle. In both countries it is very difficult to hire enough nurses, and all other developed countries globally face exactly the same problem. There are not and will not be enough the migrant workers available, although for both countries, the importing elderly care workers seems inevitable. There is also the fact that immigrants have huge problems with adopting new ways of life and cultural values in both of these countries (e.g. in terms of language).

In addition, there is a new generation of young women and men who are not willing to care for their parents or to become nurses. At the same time, citizens do not understand how much healthy living habits can decrease the costs of health care. Finns have had always problems with dietary habits, and the Western lifestyle has also become popular in Japan. In the future, the Japanese will also suffer from new diseases due to poor diets.

So what should we do? In both countries, policy-makers should look at the complexity of delivering services for citizens with the “both/and” logic. In other words, services should be provided by public-private partnerships (Vuori 2006). Finns do not believe that public service is the only solution for delivering health care services. On the contrary, based on our survey they seem to believe that in future, services should be delivered by public-private partnerships rather than by public or private organisations alone (see Table below.) If this is the right reform, the next question is: How can we find the best way of delivering services in different areas of social and health care? This is the question which our research project will strive to answer, because policy-makers need to be assured that health care expenditures are in line with citizens’ preferences.

*In your opinion, to what extent should public and private health care be responsible for providing health services? (sector)*

Responsible for providing health services	Employed in the public sector	Employed in the private sector	Others (Unemployed, students, pensioner etc.)
Public health care should carry main responsibility	53 %	38 %	52 %
Private health care should carry main responsibility	1 %	2 %	1 %
Both equally responsible	46 %	60 %	47 %
Total	100 %, n= 561	100 %, n= 752	100 %, n= 1176



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# Preventive services for the elderly

## Abstract

Various methods have been applied to postponing disability. The Preventive Services for the Elderly (EEVA) project in the City of Espoo, Finland, aims to employ targeted experiments to develop permanent preventive services and operational models that are customer-friendly, functional and economical. Successful and well-established services will be adopted after careful evaluation of the project in 2007.

## Introduction

The preservation of functional capacity and quality of life is the goal of preventive gerontology. In Finnish geriatrics, the importance of prevention has been addressed since the early 1990s (Tilvis and Valvanne 1993).

Social and health care policies in many Western countries aim to enhance the possibility of elderly citizens living as long as possible in their own homes, thus minimising permanent institutionalisation. This is a common aim in Japan and Finland, where the number of senior citizens is rapidly increasing. Susumu Fujiwara has presented the development and promotion of a system for reducing the need for nursing care (Fujiwara 2006). This article describes the background and implementation of a set of new preventive services in the City of Espoo (Finland).

The functional capacity of the elderly deteriorates gradually as a consequence of chronic degenerative diseases and aging (Reuben and Solomon 1989). Initially, difficulties arise in the advanced activities of daily life (e.g. driving a car, gardening, organising social events). Next, the instrumental activities of daily life are affected (e.g. shopping, cleaning, phoning, using money). Finally, difficulties arise in the basic activities of daily life (e.g. walking in a room, getting dressed, hygiene, eating). Acute social problems and medical incidents often take place dur-

ing the functional decline before dependency increases so much that permanent long-term institutional care is needed (Figure 1).

Preventive measures can roughly be divided into early and late interventions, as shown in Figure 1. Early interventions include both primary and secondary preventive measures, while late interventions, which belong to tertiary prevention, consist of measures used in the care of acute and chronic diseases.

The proportion of the population aged 75 years or above is 3.9% in Espoo, the second largest city in Finland. The annual increase in the number of elderly citizens (75+) is around 4%. Thus, preventing premature disability in the aged population is one of the main aims of the care system for the elderly. The central idea behind organising services for senior citizens in Espoo is to offer high-quality services at each stage of the deteriorating functional capacity of an individual (Figure 2).

The currently senior services in the City of Espoo are mainly targeted at those whose ability to function has already reduced. Traditionally, services come under one of three elements which are: 1) home care; 2) geriatric outpatient and hospital care; and 3) long-term care in serviced accommodation and institutions. Until 2005, the only preventive services for the early stage were activities at the senior service centres. Flu vaccines were given annually at local health centres, but without any common strategy.

### **Preventive Services for the Elderly (EEVA) development and pilot project 2005–2007**

The aim of the Policy for the Elderly in Espoo (2002) is to promote health and quality of life of aging citizens by supporting their physical, mental and social well-being, independence, self-reliance and safety in their living environment.

The design of the Preventive Services for the Elderly (EEVA) development and pilot project began in winter 2004 on the basis of an initiative submitted to the city council proposing the founding of an advice clinic for the elderly in Espoo. The project was launched as a response to the initiative. Active members of the senior council were also invited to the steering group of the project.

Based on a multidisciplinary gerontological approach, the Preventive Services for the Elderly (EEVA) project aims to apply targeted experiments to developing permanent preventive services and operational models that are customer-friendly, functional and economical. Other important aspects are creating social networks for seniors and formulating new cooperation models for various operators. One of the objectives of the EEVA project is create partnerships and de-

velop innovations. Key partners include local residents, other municipal services and Laurea University of Applied Sciences.

During the planning of the project it was decided not only to pilot an advice clinic but to cover the whole spectrum from population-level activities to targeted customer-group-specific experiments (Figure 3). The services were based on research evidence and good practices (e.g. Valvanne 2005). The established sub-projects are described briefly in Table 1.

The aim of the EEVA project is to enhance the quality of life of senior citizens by activating and empowering them. The main messages of the project to the aged are collected in Table 2.

At the time of writing, the project has been in operation for two years. It has received positive feedback from users of the preventive services and from the public. During January 2007, there was a web-based survey regarding the importance of the preventive services offered by the project. Preliminary results showed that 80-90% of respondents believe that all services are important except Caring TV, which is seen as important by less than half of the respondents. The general attitude towards service models based on new technology appears to be fairly sceptical, even if the services are well accepted by the users themselves.

Networking and close cooperation with Section of Education and Culture in Espoo and Laurea University of Applied Sciences have generated new ideas for how to promote the social and mental well-being of seniors. One example is that Laurea and other social and welfare organisations together have made the target groups of Caring TV broader (Piirainen and Raji 2006). Collective events, such as scientific lectures and cultural performances have also been organised. In December 2006, the city council decided to offer free admission to public fitness clubs for citizens aged 70 years above. The Recreation Department of the Section of Education and Culture will plan how to realise this budget reform in practice, in close cooperation with the EEVA project.

The project and its results will be internally evaluated during the spring of 2007. Successful and well-established operational models and services will be adopted in Espoo following the project's conclusion. In order to fully cover the needs of senior citizens, the organisation of services for the elderly in the City of Espoo should include a preventive service unit (Figure 4). Models and services developed during the project may also be applied to other Finnish municipalities.

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For more information, visit [www.espoo.fi](http://www.espoo.fi): → In English → Home → Our services → Social and Health Services → Health Services → Preventive Services for the Elderly

**Table 1. The subprojects of the Preventive Services for the Elderly (EEVA) project**

**Vaccination, Nutrition and Physical Activity Campaigns**

Planning and implementing population-level health promotion functions in cooperation with a variety of operators.

**65+ Service Guidance**

Supporting life management after retirement and exploring ideas with pensioners.

**Senior Advice**

Guidance and information about elderly services provided by the municipal, private and third sector available to local residents, employees and partners by phone or at the advice point.

**Rehabilitation Advice Centre**

A drop-in facility helping elderly clients living at home to explore solutions to support their functional capacity, well-being and empowerment.

**Screenings and Health Examinations**

Developing a model for screenings and health examinations that can be used by health and social service employees to assess the functional capacity of the elderly.

**Balance Clinic and Hip Protectors**

Preventing falls and hip fractures among high-risk groups as part of geriatric outpatient services.

**Caring TV**

Promoting well-being with the help of a two-way TV connection in cooperation with family carers of the elderly, the City of Espoo, Laurea University of Applied Sciences and TDC-Song.

**Table 2. The main messages of the EEVA project to senior citizens**

Don't forget:

- Physical activity and good nutrition maintain and promote your functional capacity.
- Keeping mentally and socially active reduces your risk of memory problems.
- Include muscle strength and balance exercises in your daily routine.
- Vaccination reduces the risk of influenza.
- Giving up smoking is always a good idea – even when you are older!

Join in! Doing things together improves the quality of your life!

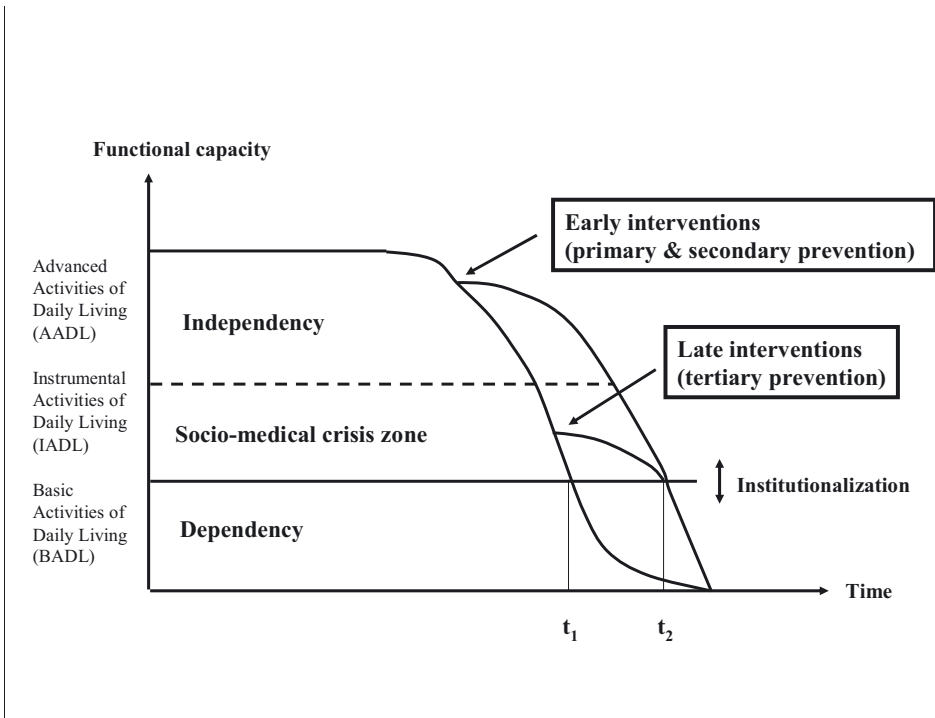


Figure 1. Postponing dependency with early and late interventions at individual level (modified from Bergmann 1982).

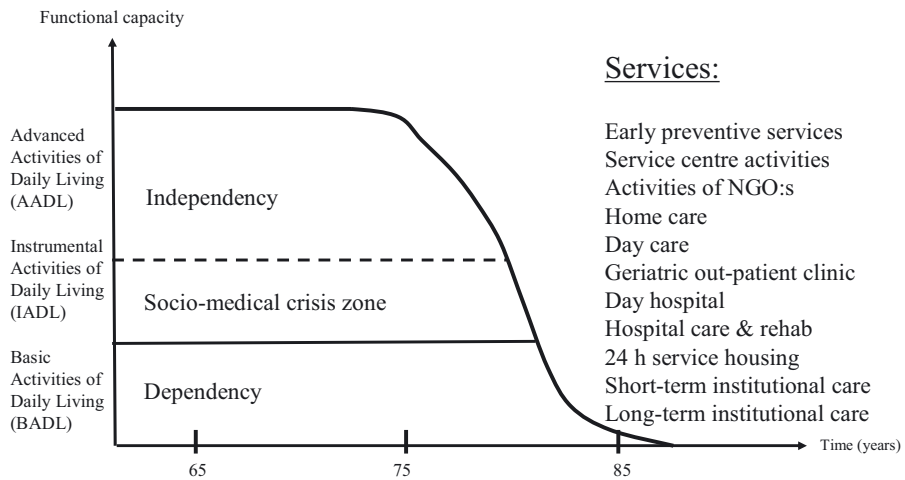


Figure 2. Functional capacity and services for the elderly in the City of Espoo. The services are aligned to the declining functional capacity of senior citizens, to meet their changing needs.



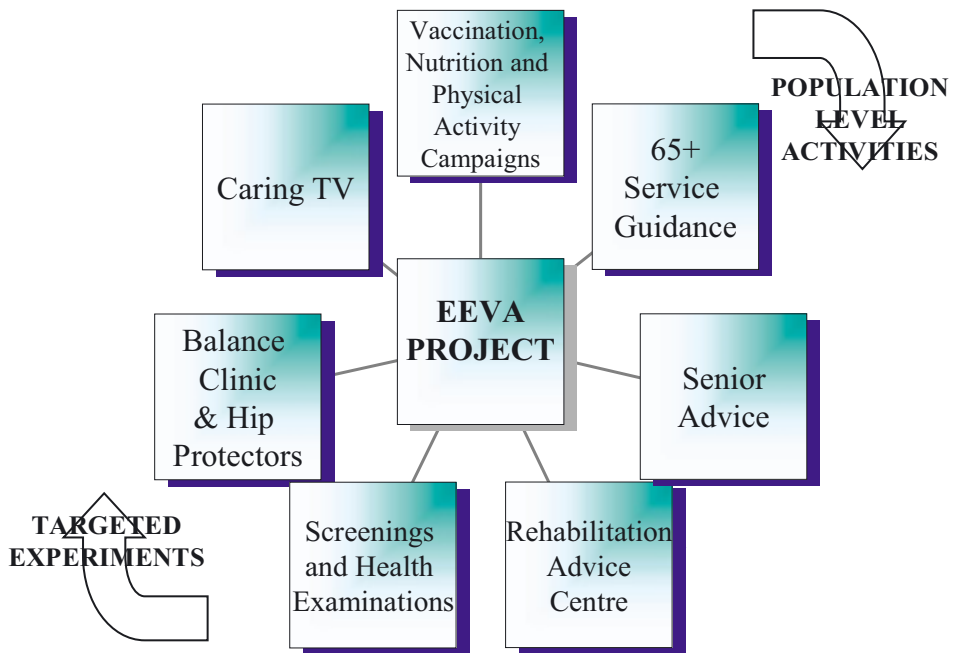


Figure 3. The subprojects of the EEVA project cover the whole spectrum, from population-level activities to strictly targeted experiments

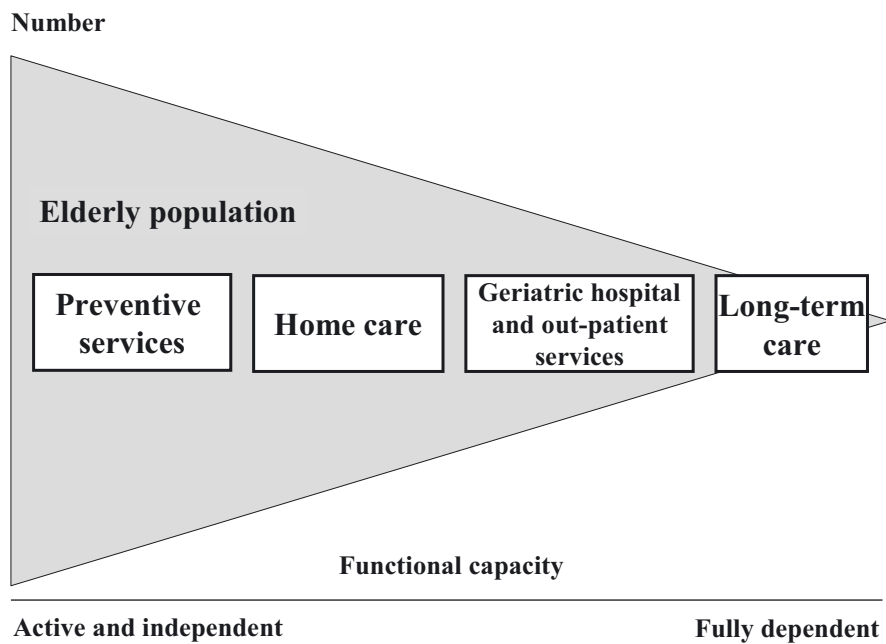


Figure 4. Future organisation of services for the elderly in the City of Espoo

# **Value-Creating Networks within Elderly Care: Research Plan and Status of the ActiveNet Project in Finland**

## **Prologue**

The Finnish-Japanese Active project focuses on research and development in elderly care. In this paper we will introduce the research plan and status of ActiveNet, which is one of the subprojects of the Active collaboration.

ActiveNet focuses on studying value-creating networks within elderly care both in Finland and in Japan. The subproject is jointly managed and conducted by research teams from the Helsinki School of Economics (HSE), directed by Professor Kristian Möller, and from the Tohoku Fukushi University (TFU), directed by Professor Koichi Ogasawara. We are greatly indebted to Professor Ogasawara and his Japanese research team for their invaluable contribution to this paper through their strong involvement in designing the original ActiveNet research plan.

In this paper our purpose is to present and discuss the project as it is seen from the Finnish perspective. We will start with brief introductions to the background, conceptual basis and research goals of the project (Sections 2, 3, and 4). Thereafter, we will present the methodological approach of the study as well as the Finnish case studies (Sections 5 and 6).

## **Background and research gap**

Industrialized countries worldwide are faced with considerable challenges due to the rapid ageing of population. This is true especially in Finland and in Japan. Unless we improve the current structuring of social and health care services, we are facing decreases in the amount and quality of wellbeing services as well as

increases in spending on these services. New innovations in terms of technologies, service structures, and processes are needed for us to maintain, or even improve, the current status of elderly wellbeing services.

Research on value-creating business networks shows that networked value creation can lead to improvements in various types of value-producing activities. Numerous studies show that the successful development, production, and delivery of products and services in rapidly growing global markets, especially in the ICT sector, require cooperation and joint efforts of multiple parties, including producers, customers and various institutions (Doz et al. 2001; Möller et al. 2005; Powell et al. 2005).

Based on these findings we propose that it is possible to improve service quality and cost-efficiency through networked value-creation also in the field of wellbeing services. This requires that these services are developed in and provided through networks of different actors (including e.g. public-private collaboration), wherein each actor has different qualities and competencies jointly advancing the common cause.

Network forms of service development and production are, indeed, also emerging in the field of wellbeing services (e.g. Kivisaari and Saranummi 2006, Pitta and Laric 2004, Glendinning 2003). This development is relatively new, however, and there is considerably little empirical evidence and conceptual understanding of these new modes of service production and their management. The ActiveNet study focuses on this highly topical issue.

## **Value-creating networks in the field of wellbeing services**

In this section we will take a brief look at two conceptualizations of how we approach studying different types of wellbeing networks. These two frameworks thus outline the starting points to this study.

Firstly, value-creating networks in the field of wellbeing services may be conceptually and practically categorized into three basic types. These include (1) networks providing medical or health care services, (2) networks providing welfare or social care services, and (3) social networks binding care service providers together with their clients and the clients' families (Ogasawara 2004; Ogasawara and Hirano 2004; Shimazu 2005). Basically, the difference between these three types of networks relates to the type of value they produce for their end-customers. Type 1 produces value in terms of medical care relating to clients' physical or mental health. Type 2 provides value beyond mere medically-

oriented care, including e.g. welfare services such as house cleaning, food delivery, and income support. Finally, type 3 provides comprehensive, wide-ranging wellbeing values through a community-based and client-centered approach.

These three types of value-creation are at least conceptually distinguishable from each other. However, in practice we can often witness mixed types of networks. We presume, nevertheless, that these three types of networks are based on fundamentally different logics of value creation, thus providing a good starting point to understanding and studying different value-creation network types within wellbeing services.

Secondly, based on recent work on business networks within the Finnish-Japanese Active-project (Möller, Järvensivu, Rajala 2006) as well as elsewhere (Möller et al. 2005), we argue that networks pursuing different type of value, namely efficiency or effectiveness (Pfeffer and Salancik 1978), require different types of management, coordination, and organizing. This point is illustrated in Figure 1 describing the classification of health care value-systems into three basic modes based on their underlying value-production logic.

# Health Care Value Systems

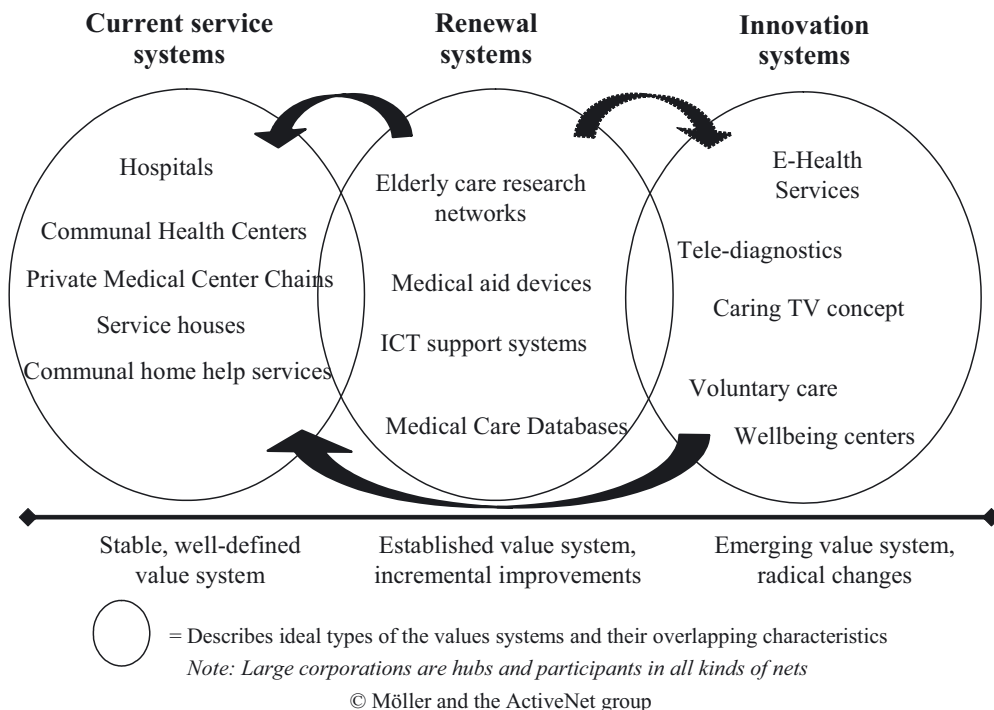


Figure 1. Value-system continuum: Three basic types of wellbeing service systems (modified from Möller, Rajala and Svahn, 2005; Möller and Svahn, 2003)

The left-hand side in Figure 1 (current service systems) describes mature and relatively stable value-creation systems that are organized to produce well-defined services, including e.g. those provided by hospitals, communal health centers, and private medical centre chains, and aim at processual efficiency.

The renewal of these efficiency-seeking network modes takes place through renewal projects located in the middle section of Figure 1 (renewal systems). These are multiparty project networks where different experts (e.g. hospital representatives, information system providers, consultants, etc.) collaborate for renewing the efficiency-seeking service systems by developing and implementing new technologies, service processes, and organizational changes.

Finally, the right-hand side of Figure 1 (innovation systems) describes such emerging networks that create radically new technological and/or service inno-

vations, such as e-health services, tele-diagnostics, and tele-care. The development of these radical innovations requires deep collaboration between various highly specialized parties. These networks are characterized by high uncertainty concerning future developments. In time, having become fully specified and taken into operation, these radical innovations may be adopted by the more established renewal and/or efficiency-seeking systems.

The two frameworks presented above thus provide the starting points to the ActiveNet project. We will therefore study (1) different combinations of medical, welfare and community-based networks as well as (2) different types and combinations of efficiency-, renewal-, and innovation-seeking wellbeing networks.

## **Research questions and expected contribution**

The overall objective of the ActiveNet subproject is to study value-creation networks in the field of wellbeing services for the elderly. Special attention is paid to innovation networks, because theoretical knowledge of this area is underdeveloped compared to efficiency-seeking networks (Möller et al. 2005).

Key research questions of this study are:

- What kind of networked social and health care services can be identified in Finland and in Japan, and what kind of actors they include and how are they organized?
- What are the key benefits and challenges (required resources and capabilities, e.g. IT systems) of the identified networks?
- What are the key elements (e.g. resources and capabilities, roles, processes) of high quality, effective, and efficient social and health care networks?
- How can different actors (e.g. service providers, institutional and governmental actors) manage the construction and coordination of these networks?

Through these research questions we aim to contribute both theoretically and practically into the field of elderly wellbeing services in Finland and in Japan. The contribution relates to producing theoretical as well as practical models for understanding different types of wellbeing networks and their management.

## **Research methodology**

In terms of research methodology, this study is a multiple case study resting on interview and documentary data. We chose the case study method because it fits well to studying networks and because it is well suited to providing answers

to open-ended research questions such as in this study (Halinen and Törnroos 2004; Yin 2003).

Since the research questions of this study are fairly open-ended, we will need not only theory-driven empirical analysis but also data-driven investigation into the study context. Therefore, this study follows neither strictly deductive nor inductive reasoning, but abductive reasoning, which is a combination of theory- and data-driven research approaches (Dubois and Gadde 2002).

In this section we will briefly introduce our methodological premises. We start with a description of the case study method and the abductive approach. We then briefly discuss the processes of case selection, data collection, and data analysis. Finally, we will summarize the methodological discussion with a brief description of the research process.

## **The case study method**

Case studies have been commonly and successfully used in research focusing on networks (e.g. Halinen and Törnroos 2004; Welch 2000). Case studies are suitable for exploring networks, because they can capture the dynamics of different network contexts and provide a many-sided view of a study object (Halinen and Törnroos 2004; Easton 1995; Eisenhardt 1989).

In the context of network research, a case strategy can be defined as an intensive study of one or a few networks, where multiple sources of evidence (e.g. interview and documentary material) are used to develop a holistic description of the network(s) and where a network refers to a set of actors connected to each other for the purpose of producing value (e.g. Halinen and Törnroos 2004).

Moreover, the aim of case studies in general is to acquire a deep understanding of the nature, significance, and functioning of one or a few cases, and to report on this understanding thoroughly, carefully, and credibly to academic as well as other audiences (Lukka and Kasanen 1993). The case method is therefore suitable to finding answers to open-ended research questions such as in the current study.

A common argument against case studies is that they provide little basis for scientific generalization (Yin 2003, 10; Lukka and Kasanen 1993). This concerns especially single-case analysis. To address this concern, Eisenhardt (1989) has introduced a case study process resting on multiple-case analysis, which allows the researcher to draw more generalizable theoretical conclusions as compared to single-case analysis.



Dyer and Wilkins (1991), however, have criticized Eisenhardt's theory-building method. They see the method as paradoxical because, although its purpose is theory generation, yet it includes many of the attributes of hypotheses testing. While Dyer and Wilkins do not think that Eisenhardt's approach is necessarily wrong, they do believe it is limited in important ways because it neglects some of the strengths of classic, in-depth case studies.

The strength of in-depth case studies is that a careful study of just one, specific case enables the researcher to discover new theoretical aspects and question old ones. Conversely, multiple-case studies may lead to rather superficial case descriptions, offering less ground for theory generation. Single-case studies can, therefore, provide a deeper level of contextual insight and understanding than multiple-case studies. (Dyer and Wilkins 1991; Halinen and Törnroos 2004.)

To sum up, single- and multiple-case studies have their own strengths and weaknesses. The choice of using either one depends on the nature of the knowledge that is sought. In this study we have chosen a multiple-case approach, as we believe that a single case would not adequately reveal the full richness of all the different types of wellbeing networks that we theoretically presume based on our conceptual basis (see Section 3).

## **Abduction as a research approach**

Abduction is an approach to knowledge production that combines induction (i.e. data-driven theory generation) and deduction (i.e. theory-driven testing of hypotheses). Abduction relies, on the one hand, more on theory than induction, which improves the explanatory power of case studies. On the other hand, it allows a less theory-driven research process than deduction, thereby enabling also data-driven theory generation. (Dubois and Gadde 2002.)

Dubois and Gadde (2002) suggest that case studies focusing on both assessing prior theories and generating new theory, such as in this study, can follow the process of "systematic combining". Systematic combining is an application of the abductive process. As a research process, it moves between the empirical and a model world in a constant dialogue between the two. Moreover, systematic combining involves matching theory with reality (i.e. going back and forth between theory, data sources, and analysis), and directing and redirecting the theoretical and empirical investigation of the study based on the ongoing findings.

In this study we will follow the process of systematic combining. We will use the initial conceptual frameworks described in Section 3 as our starting points to the study. They will thus be our preliminary guides in data collection, analysis, and drawing theoretical conclusions. In the meanwhile, though, we will not hold the frameworks constant, but they are themselves under constant development and remodeling, too.

## Case selection

Case studies aiming simultaneously at theory generation and the assessment of prior theory, such as the current study, will benefit from selecting and analyzing cases which (1) are in some ways typical examples of the types of networks studied, so that they have the potential to reveal some typical aspects of the reality, but (2) which also have some *atypical* characteristics, so that they have the potential to reveal something new and even unexpected regarding the research questions (see e.g. Yin 2003).

We used the following aspects as selection criteria for our study cases:

- The cases should clearly represent networked service production and/or innovation as opposed to hierarchical or market-based service production/innovation
  - In other words, we wanted to select such *typical* cases of wellbeing services where networking is an inherent mode of organizing for both efficiency-seeking, renewal, and innovation-seeking tasks
- The case networks should produce or have potential to produce exceptionally high quality wellbeing services in terms of either efficiency- or innovation-search
  - In other words, we wanted to select such *atypical* cases which would potentially reveal something new or even unexpected about how to *improve* current modes of organizing; therefore we did not want to just replicate what we already know about the current forms of networking in wellbeing services
- Our cases should represent different types of networks, namely (1) efficiency-seeking, (2) renewal, and (3) innovation-seeking networks
  - Here we wanted to ensure that we would be able to assess and extend our initial conceptual frameworks relating to the operations and management of different types of value-creation within the wellbeing sector

Based on these criteria we selected five Finnish cases for a closer study. These cases will be described briefly in Section 6.

## Data collection

Case analysis in this study is grounded on two data sources: interviews and documentary material. Interview data will form the core data, and documentary data will have a more supportive role.

As our research process is abductive, our data collection procedure is fairly open-ended and non-restrictive. We will collect interview and documentary data on a wide range of issues relating to our research questions. We will also try to keep our minds open to any unexpected data that we may come across during the research process. These unexpected data may then potentially lead us to new research directions and towards new, potentially significant research findings, we hope.

Although we strive to remain open to a wide range of data, we will nevertheless approach all of our interviews through the following basic discussion themes/questions:

- What are the main value-creation tasks of the case network in question?
  - What kind of basic, efficiency-seeking operations does the network do?
  - What kind of renewal- or innovation-seeking goals does the network strive at?
- Who are the main actors in these efficiency-, renewal-, and innovation-seeking networks, and what are their roles and responsibilities?
- What kind of critical events, challenges, or difficulties have these networks encountered?
- What has been done to overcome these critical events, challenges and difficulties?

Through these basic discussion themes we will be able to (1) produce a description of the main aspects of each case (their tasks, structures, and processes), (2) assess their main challenges (critical events and difficulties), and, ultimately, (3) make conclusions on how to manage or coordinate these networks.

The sampling of the interviews will follow a “snowball” sampling logic. In other words, we will first start the interviews with such network actors that are known to be highly influential within their networks. We will then ask from these informants about whom we should interview next, and then proceed to interview these new informants. And these new informants will again lead us to new informants, and so on.

The challenge in snowball sampling is to know exactly when to stop searching for new informants, because any organizational or social network is, at least in theory, limitless. This means that if we did not have any stopping-rules for the sampling we might end up interviewing altogether hundreds of people.

Our particular challenge here is to know when our interview data “saturates”. Hence, to set some limits to the number of interviews, we have decided upon two stopping-rules for the interviews. Firstly, we will determine if a potential new informant possesses an influential or otherwise significant role within the network with regard to contributing to the network’s tasks. Secondly, we will determine if it is likely that the informant can contribute any new information that is essential to our study. Only if the answer to both of these questions is yes, we will proceed with the interview. Through this decision process the group of informants for each case study will eventually limit itself, or “saturate”.

With regard to interviewing itself, our interviewing style is based on the “active interviewing” approach proposed by Holstein and Gubrium (1997; 1995). Traditionally, interviewing is often seen as a search-and-discovery mission, concerned with maximizing the flow of valid and reliable information that resides inside the informant’s mind, minimizing any distortions of what the informant knows, and controlling the interview process to eliminate possible sources of bias, error, and misunderstanding.

However, “active interviewing” treats the interview as a social encounter in which knowledge is jointly constructed by the interviewer and the informant. The interview is not regarded as “merely a neutral conduit or source of distortion, but is instead a site of, and occasion for, producing reportable knowledge itself” (Holstein and Gubrium 1997, 114). In active interviewing, both the interviewer and the interviewee are active discussants, and knowledge is constructed collaboratively between them. Hence, meaning is not simply transported through the informant’s replies. Rather, meaning is actively assembled in the interview encounter through a dialogue.

This interviewing style allows us to get deeper into the subjective meanings of the research subjects, and to gain an insight into how the informants have differ-

ent and sometimes even conflicting opinions of and perspectives to the study context. We believe that these possible contradictions will then reveal essential new aspects to networking, as we will not focus on “maximizing the flow of valid and reliable information that resides in the informant’s mind”, or on the “unbiased” version of the reality.

Regarding the documentary material, we will collect a wide-ranging database of available information on each case. We will actively search for data on each study case through (1) searching the internet for any case-related information, (2) asking the informants for documents that they regard as being essentially related to their daily work or the network’s operations, and (3), as we come to contact with the informants’ working environment (e.g. the informants’ workplace), we will look around for any interesting documents that might relate to the case. There are no stopping rules for collecting documentary material; vice versa, we will not decide beforehand which piece of information will be useful, but we will collect all material available.

## **Data analysis**

In data analysis we will follow the classic steps of qualitative analysis (Miles and Huberman 1994, 9): (1) interpreting and coding the data, (2) categorizing and thematizing, (3) finding patterns and making preliminary conclusions, (4) generalizing conclusions within the data, and (5) confronting the generalizations with pre-existing knowledge. We will use a qualitative data analysis program (NVivo 7) to facilitate data analysis, although we acknowledge that the analysis could well be done also without computer assistance.

Our first task in data analysis is to describe each case. This involves describing different aspects and characteristics of each case, such as what does the network try to achieve, what are its main value-creating tasks, who are the main actors of the network, what are their roles within the network, how are different resources and activities connected to each other in the network, etc.

Secondly, we will describe the critical events of each case. If possible, we will do this through a historical analysis of each case. This means that we will try to describe how the case networks have evolved through time, and what have been the critical events in this development. Here we are interested in asking questions such as what are the critical events of each case, why are these events regarded as critical, what are the potential causes of each critical event, what have the actors done to overcome the challenges or difficulties involved with the criti-

cal events, etc. These descriptions will give us tools to understand the networks' key challenges and how these challenges may be overcome.

Finally, grounded on the above descriptive phases, we will generate conclusions on how to possibly manage the case networks and what kind of managerial capabilities are needed therein. The conclusions will include frameworks, models, and even normative guidelines regarding (1) the key characteristics of different efficiency-, renewal-, and innovation-seeking networks in elderly care, (2) the key challenges of these networks vis-à-vis their characteristics, and (3) how to manage each network type.

## Research process

To summarize the methodological discussion, this study is a multiple-case study of different types of wellbeing networks and it follows an abductive research process (see Figure 2). In other words, the study will progress through a multiple-case analysis involving a constant dialogue between various theoretical models and empirical investigations.

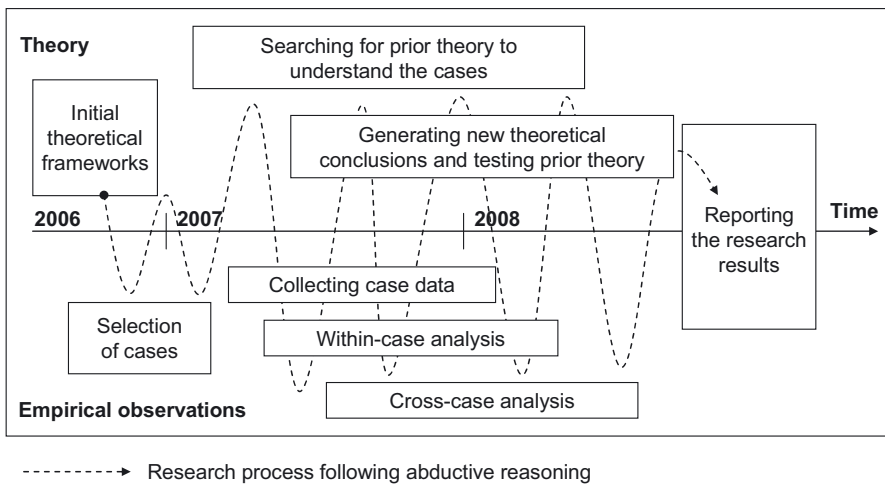


Figure 2. Research process

As can be seen from Figure 2, we have already started the study in 2006 with some initial theoretical frameworks relating to different types of wellbeing networks and their management. These frameworks were briefly described in Section 3 of this paper. Next, during 2006 and in the beginning of 2007, we selected some case networks for a closer review. Throughout 2007 and also in 2008 we expect to collect empirical data on the cases and conduct within- and cross-case analysis; this will be done concurrently with searching for and assessing existing theoretical models that may help to understand and analyze the empirical cases. We will report on the study continuously throughout the study process, and a summarizing, all-inclusive final report of the project should be published by the end of 2008 or at the beginning of 2009.

## **Empirical data: Cases from Finland**

In the previous sections we have presented the background, conceptual basis, research questions, and methodology of the ActiveNet research project. In this section we will briefly introduce our five study cases from Finland. The cases are:

- 1 Home care service provisioning network(s) in the Tikkurila area of the city of Vantaa, Finland. (This is an efficiency-seeking network case, but includes also many aspects of renewal networks.)
- 2 Home care service provisioning network(s) in the city of Espoo, Finland. (This is an efficiency-seeking network case, but includes also many aspects of renewal networks.)
- 3 Seamless transferring of patients from an acute hospital to home care and/or long-term care in the city of Helsinki, Finland. (This is clearly an efficiency-seeking network case, but includes also some aspects of renewal networks.)
- 4 The Well Life Center (WLC) R&D-center located in the city of Espoo, Finland. WLC is run by Laurea University of Applied Sciences and it focuses on R&D activities through multidimensional collaboration between public, private and other partners. (This is clearly an innovation-seeking network case, but includes also some connections to renewal and efficiency-seeking networks.)
- 5 The Finnish Wellbeing Center (FWBC) located in the city of Sendai, Japan. FWBC is a Finnish style elderly care facility built in collaboration between Finnish and Japanese partners. FWBC is also closely connected to its R&D center, located next to the FWBC facility. The R&D-center focuses on elderly care innovation through public-private collaboration. (This is an innovation-

seeking network case, but includes also many connections to renewal and efficiency-seeking networks.)

These five study cases represent different types of wellbeing networks vis-à-vis our theoretical conceptualizations. Cases 1, 2 and 3, for instance, are good examples of networks where medical and social care provisioning is mixed in complex collaboration between public and private actors as well as patients and their families. Cases 1 and 2 are closer to comprehensive care networks as compared to case 3 which is closer to a medical care network.

With regard to the conceptual framework by Möller et al. (see Figure 1), cases 1, 2 and 3 locate at the left end of the value-system continuum. The main purpose of these case networks is to provide services to clients as efficiently as possible. However, they also include some activities that aim at renewing the current operative systems; thus, these cases embody also activities that resemble renewal networks.

Cases 4 and 5 are more clearly innovation networks. The task of these case networks is to create innovations that radically change the current systems of value-production in the wellbeing sector. Both of the cases offer a mix of medical and social care services, with also some aspects of community-based care. In case 4, for instance, public and private actors as well as patients and their families come together to innovate around care technologies, services, and processes. In case 5, Finnish and Japanese partners have united their know-how to create a new type of elderly care concept and facility previously unseen in the Japanese context.

Although cases 4 and 5 are networks seeking more or less radical innovations, they are not completely isolated from renewal- and efficiency-type networks. In case 4, for example, the new technological innovations created at WLC, such as the Caring-TV, must be operable also in real-life, efficiency-seeking contexts. In case 5, now that the innovative FWBC facility has started its operations, the focus within the facility has turned from innovation-search to the search of also efficiency in providing care services for the clients of the facility.

All in all, the Finnish research team of the ActiveNet project focuses on studying the five cases introduced briefly above. These five cases will provide, we hope, multiple opportunities in both generating new understanding on as well as assessing existing theories of different types of wellbeing networks and their management.



## Epilogue: Invitation for an open dialogue

In this paper we have introduced the research plan and status of the ActiveNet project. As we have described, the project is still in progress and we have a lot of work ahead. Therefore, we welcome all kinds of comments, suggestions, ideas, and proposals for research collaboration. We may be contacted at timo.jarvensivu@hse.fi (Dr. Timo Järvensivu, Researcher, Helsinki School of Economics).

***Timo Järvensivu***

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*Pirjo Havukainen*

# **Teacher in Regional Development: the Senior Trainer Programme as an Activator of Senior Citizens**

## **Abstract**

The Senior Trainer Programme helps to diversify the university of applied sciences' regional development work and offers alternative ways of action for citizens who have reached the third age. One part of the programme is the training of volunteer coordinators and group leaders. The purpose is to increase senior citizens' competence in and readiness for volunteer work. The Senior Trainer Programme includes training, research and, in its later stages, joint projects with Laurea's students and senior trainers.

## **1 Introduction**

The purpose of this article is to introduce the Senior Trainer Programme, whose activities include training coordinators and team leaders for volunteer work. In addition, the Senior Trainer Programme includes research and, at later stages, various types of volunteer action. The purpose of the programme is to offer an option for citizens who have reached the third age.

The third age is usually defined as the period beginning with retirement, when many people have the opportunity to fulfil their personal wishes and goals (cf. Laslett 1989). The third age can be seen as a stage that is connected to a certain situation in life or as a turning point, rather than as a specific chronological age. Target-oriented actions and consequent life management are emphasised in the third age. Some people try to build their lives according to the model with which they are familiar from working life, by taking part in activities such as training or volunteer work (Muhonen & Ojala 2004).

This is the situation to which the Senior Trainer Programme responds. Third age citizens have plenty of life and work experience, as well as know-how. Their experience can be put to good use through volunteer work. In Finland, the proportion of senior citizens who take part in third sector organisations is one of the highest in the EU. Just over half of all 60-year-olds take part in the activities of charities and municipalities (Vaarama et al. 1999). Approximately 28% of 65- to 74-year-old men and women, 24% of 75-year-old men and 15% of 75-year-old women have reported participation in volunteer work. They are active in OAPs' associations, religious organisations, local councils and social and health care organisations (Koskinen 2004).

The members of Finland's baby boom generations (born 1945-1950), potential volunteer workers, have plenty of know-how. They are well represented in various groups of society (Koskinen 2004). Of the group, 29% have a university education, 39% a secondary education and 32% an elementary education (Koskinen 2004; cf. also Tiisanoja 2002). In addition existing competence, they need special volunteering skills. The ageing population is growing, which will probably lead to an increase in the number of volunteers, so the need for coordination, guidance and management of volunteers increases.

When they retire, ageing citizens lose some of their work-related contacts. Other groups are needed to fill in these spaces and to create networks of contacts. Belonging to a group can be seen as resource-enhancing social capital. Volunteers and senior trainers can form such groups. It could be said that people have social capital as long as they have social relationships (Heikkinen 2000). Social capital is created through interaction based on trust and reciprocity.

## **2 The Starting Points of the Senior Trainer-programme**

The Senior Trainer Programme and the instruction of senior trainers was organised by Laurea University of Applied Sciences and the volunteer work support unit of the City of Vantaa's Social Affairs and Health Unit. The basic idea came from Germany, where a similar programme was organised as a three-year development programme funded by the German state. The purpose of the programme in Germany was to use the know-how of elderly citizens and to increase their knowledge, which was seen as a social capital and resource. The programme, which was organised in 16 federal states, included training, research and various projects. It resulted in the launch of a national Senior Trainer Teaching Programme (Braun et al. 2004; Burmeister et al. 2005; Burmeister 2006.)

The purpose of the Finnish project is to diversify the know-how of senior citizens and increase their readiness for volunteer work. The Senior Trainer Programme includes training, research and, in its later stages, joint projects with Laurea's students and senior trainers. The idea of the Senior Trainer Programme is to actively put to use the know-how of its senior participants. The purpose of the training is to analyse the know-how gathered during one's lifetime and to use it for maintaining and advancing one's own and others' wellbeing.

### **3 Instruction of Senior Trainers**

#### ***Curriculum***

The Senior Trainer Programme curriculum was designed in line with the German curriculum. During the training, the roles of volunteer work coordinator and group leader are built in cooperation between programme participants and teachers. The curriculum consists of eight modules, of which one includes a practical placement in a volunteer organisation and/or getting to know different types of volunteer work. The content of the modules was as follows: 1) Orientation to the Senior Trainer Programme and its content; 2) Example from the German Senior Trainer Programme: "senior citizens as experts"; 3) Life stories and future challenges for senior trainers; 4) Finnish volunteer work, examples of senior trainers in volunteer work; 5) Belonging to and leading a group; preparation for the practical placement; 6) Practical placement; 7) Evaluating practical experiences; own future as a senior trainer; 8) Final and assessment seminar – own well-being as a senior trainer.

The Senior Trainer Programme has been carried out once. Lecturing, team work, reflective discussions and different types of assignments were used as teaching methods. Team work and reflective discussions were seen to be methods that promoted learning. The group acted as a unit that empowered others; a group in which social capital increased. According to Siitonen (1999), especially knowledge, trust in one's own skills and self-confidence can be realised in reflective discussions and inner dialogue in this process. Empowered senior trainers found their voices. Empowerment changes the way the senior trainers perceive their actions (cf. Robinson 1994; Siitonen 1999).

The importance of experiences, personal involvement and partnerships is emphasised in the instruction of senior trainers. Work backgrounds, professional know-how, life experiences, contact with volun-

teer work and training motivation are the starting points for learning to be a senior trainer. Learning arises through cooperation, with group members sharing their experiences. This way the students' experiences are conveyed to promote the group's learning (e.g. Kumpulainen 2002). Teachers act mainly as instructors and impulse-givers.

### ***Participants***

Seven women and three men took part in the first senior training group. The ages of the participants ranged between 56 and 58. The participants were either retired or receiving an early retirement pension. Almost all participants had experience of volunteer work. In terms of professional backgrounds, there were teachers, nurses, secretaries and other administrative employees. Their motivation for taking part in the programme was the desire to find meaningful activities after retirement and new ways of helping others. Laurea teachers, a planning officer from the volunteer work support unit of the City of Vantaa's Social Affairs and Health Unit, Professor Burmeister from the Neubrandenburg University of Applied Sciences in Germany, and a group of volunteers. The Senior Trainer Programme also offered learning opportunities for Laurea students who participated in planning the programme, as assistants during training sessions, and helping with research. In future, students will work in joint projects with senior trainers. New senior trainers are also being trained.

## **4 Conclusions**

Growing old is a phenomenon that affects the whole of society. As the baby boom generations mature, Finland's aging population has started to be seen as an opportunity and a resource rather than an encumbrance. People are healthier than before when they retire. Those who have reached the third age have free time and more of them are willing to use their time for meaningful and planned activities that add content to their lives. Retiring workers also have plenty of know-how and skills they gained during their working lives. However, there has not been enough thought at the societal and national levels as to how to make use of and support the aging population's resources and their roles as active citizens (e.g. Koskinen 2004).

For their part, Laurea University of Applied Sciences and the volunteer work support unit of the City of Vantaa's Social Affairs and Health Unit have started to respond to this challenge, training senior trainers in volunteer coordination and group leadership activities. Volunteering is a natural form of action for Finns after

retiring. Although there are plenty of aged volunteer workers, coordination of volunteer work also requires skilled volunteers.

One aim of the Senior Trainer Programme was to diversify Laurea's regional development work. Volunteer workers, lecturers at the university of applied sciences, students and municipal sector employees work together for the well-being of the region. In addition to its regional and social significance, the Senior Trainer Programme also empowers individuals. Social ties and relationships created in the training generate social capital, which increases the individual's and the community's well-being.

An article on the project was published in Finnish in the KeVer online magazine, issue 4/2006.

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## **The Peng Model® in the Finnish Health Care Database**

In addition to being a tool for cost effectiveness analysis, the Peng model aims to identify other beneficial aspects related to the project under investigation. Such benefits are characterised as direct, indirect or more difficult to evaluate (obscure). Peng analysis can also be used to determine the monetary value in euros of the human aspects of a project for the patient, for health service providers and for society. The resulting net benefit and net benefit ratio describe the cost effectiveness of the investment. Peng was developed in Sweden and has been applied to many municipal and private investment enterprises, mostly in the area of IT investments. The most direct benefits are gained in relation to costs, through the identification of the most valuable investments.

In Finland, the first application of Peng analysis took place in relation to the health care database of the Hyvinkää health care district. The outcome was the conclusion that the use of a digital database outweighed conventional methods by producing benefits that exceeded direct and risk elimination costs by a factor of 5.17. In the first year, the total cost of the digital database was EUR 826,270. The saving in terms of just radiography processes was EUR 4,276,886, not including processes such as laboratory, operation room or ward care operations.

A brainstorming group is a key element for creating savings. The group should consist of five to eight people. In the case of Hyvinkää, the group had 10 members. These members knew the processes well and some of them were able to evaluate the benefits in financial terms. The calculated benefits for the patient were EUR 404,000, for the health service providers they were EUR 670,280, and for the society EUR 3,202,606.

The outcome of the Peng analysis was that the direct benefits were EUR 200,000 less than costs and expenses (EUR 826,270), but that the total benefits (direct, indirect and obscure) were 5.17 times higher than costs. It is recommended that the investment should be reassessed if costs exceed direct bene-

fits. In Hyvinkää, retaining the old system would have resulted in increased expenses. The Peng analysis should be repeated as soon as the new regional IT system has been in use for at least six months.

To conclude, the significance of the Peng model is increased by the fact that it produces information on a wider spectrum of investment-related factors than conventional cost-effectiveness analysis tools. Peng creates a more human viewpoint for determining the value of investments. For those involved in the Peng analysis, it is a new discreet analysis tool with a modern and determined viewpoint. For municipal officials it provides a better base for making decisions and structured objectives, an opportunity to focus on the most important benefits, improved possibilities for following up projects.

***Mervi Lepistö***

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# Case study of a Japanese elderly care provider

## Abstract

This paper describes the operations of a Japanese elderly care provider operating in the city of Sendai. Data for this paper were collected during a research trip to Sendai in July 2006. This study was part of the research whose objective is to compare the operations of a Finnish and a Japanese elderly care provider in order to identify good practices. The research focused on business management and the case company's operations were examined from four perspectives – those of the customer, business processes, finance, and learning and growth. The last perspective is associated with the company's human resource management. The research methods used in this empirical study were interviews and observation. This paper presents the findings concerning the processes and financial perspectives of the Japanese case company.

Further analyses and final research outcomes will be presented in a final report.

## Introduction

There are two types of care facilities in Japan: large rehabilitation-oriented facilities and daily support facilities. The case company is an elderly care home that particularly focuses on daily support services. The business idea of the company could be condensed as offering accommodation, medical, rehabilitation and support services for the elderly on a long or short time scale. It is a provider of elderly care services operating in the city of Sendai.

The company is part of the Tohoku Fukushi-kai Medical Corporation, which was established by Tohoku Fukushi University in 1998. The health care facility for the aged was opened in 2000 and offers rehabilitation services ranging from accommodation to day care and home visits. Full-time residents are provided with

a single or twin room with en suite bathroom and a wheelchair support mechanism. The facility also includes dental and oral hygiene care. As an additional service the company leases assistive equipment for the better maintenance of physical and mental care.

The company's services can be roughly divided into two categories: long-term care services and home care services. Home care services include short-stay, day care and home helper services, which can be further divided into two categories: home helper services operating via a Nurse Station and home helper services operating via a Home Helper Station. At the moment the emphasis is increasingly on offering rehabilitation services, which are also the area of the company's future growth. The company's service structure is presented in the figure below.

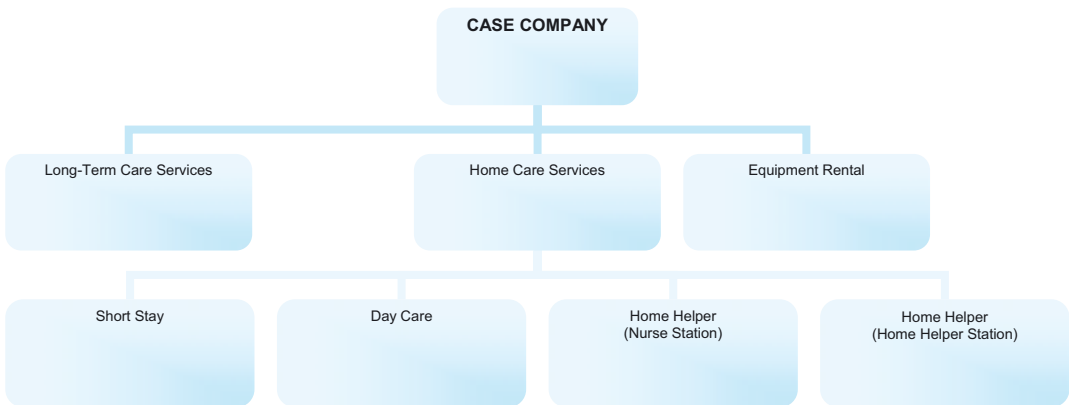


Figure 1. Company's service structure

Home Helper services which operate through the Nurse Station are for customers who need rehabilitation or medical treatment or are likely to become bedridden due to disease or injury. Meanwhile, the Home Helper Station was introduced more recently and it handles home helper services that concentrate on preventive care as their own unit. The users of these services are elderly citizens who will use the company's other services in the future, but who are currently in a good enough state of health to survive on their own without rehabilitation services or medical treatment. These services are provided in the customers' own homes. The services have two functions: promoting the customers' emotional state by providing company, and maintaining their physical condition by giving them easy tasks. The aim of the service is to retain the customers' in-

dependence for as long as possible. This new service area is strategically very important for the company, as it can strengthen the connection with the elderly before they are in need of the company's inpatient services.

## **Implications of Kaigo Hoken**

The main implications of Japan's long-term care insurance, Kaigo Hoken, for the company's business concern quality control and financing. Quality control by Kaigo Hoken covers three aspects: human resources, equipment and learning methods. Service providers can only receive the maximum income from Kaigo Hoken if they fulfil the criteria for these aspects in all care units. The situation of the company in question is very good, since its human resources exceed the criteria and it is doing well in other aspects as well.

In addition, Kaigo Hoken has a maximum coverage level of 100 customers at service need grading Level 5, who stay 365 days per year. Facilities that are bigger than this do not receive any additional income from Kaigo Hoken. Kaigo Hoken also regulates the prices of services, which are therefore fixed.

Since the maximum coverage of Kaigo Hoken is fixed, service providers need to seek alternative sources of income. As a solution, the company has introduced room rates. The cost of a personal room is JPY 3000 per day, which is an additional fee that the customers pay themselves. The managing director believes that despite this additional fee, customers will want to use the company's services because of their quality. Thus, the quality of the services is a very important way to distinguish the company from its competitors.

Kaigo Hoken also decrees that the qualified Care Manager should plan the treatment and care alone. However, in this company, the care staff who deliver the care and are therefore in touch with the customers, participate in the planning process. This is considered to be vital, as the care personnel know the customers better than anyone.

## **Strategy of the company**

In the company, the driving force behind all decision-making and action is the creating customer satisfaction. The company is one of the first elderly care facilities in Japan to concentrate on satisfying the individual needs of each customer. Due to cultural and historical factors, elderly care facilities have previously been more focused on the needs of a group. Thus, a business model that focuses on

individual needs is strategically one of the most remarkable differentiating factors of the company.

Rehabilitation services are strategically very important for the company. This is due to the fact that Kaigo Hoken increasingly stresses the importance of preventive care and rehabilitation in order to restore and enhance elderly citizens' independence and ability to live at home for as long as possible. These are the services that are given the most support by Kaigo Hoken. The case company's managing director believes that rehabilitation services are also the most important reason for customers to choose the company as their service provider. Thus, these services are vital for the company as it strives to distinguish itself from its competitors.

In addition to rehabilitation services, the managing director lists as competitive advantages the effective utilisation of the Care Plan (introduced later in more detail), and the company's human resources, whose number exceeds that of most of its competitors. The company's linkage to Tohoku Fukushi University can also be seen as an advantage when properly handled.

Being related to Tohoku Fukushi University, the company has outsourced its R&D to the university. The Clinical Art program is one example of the cooperation between the company and Tohoku Fukushi University. Students are an important resource when it comes to recruiting future employees and interns for the company. Ideas for new services are found through dialogue with the company's suppliers and other partners, utilising the company's networks.

Networking with the local community, partners and suppliers is seen as very important in the company. The company is trying to create an advanced network of local businesses and caregivers who know their current or potential customers. By cooperating with this network, the company can find ideas for new services and for the improvement of its operations. One example of this is how the company was able to reduce the total cost of diapers by observing the suggestions of diaper producers as to how the products could be used more efficiently. Networks are also used as a recruiting channel in order to find the most competent employees.

The company's strategy is to position itself in the market as a desirable service provider through high price, high quality and distinctive human resources. This goal-oriented market position is presented in the figure below. However, an accurate representation of the situation compared to competitors is not possible to make based on current research results.

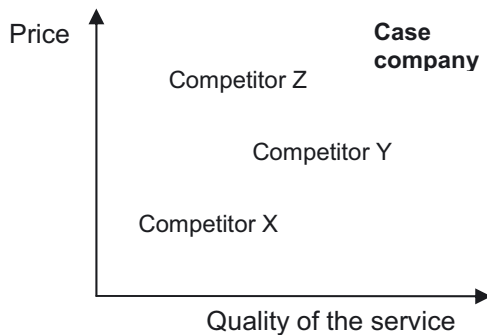


Figure 2. Company's objective

The company's objective is to stand out from its competitors through its human resources, in that it aims to have more care personnel than the others. In practice it directs the income gained from the additional room fees to increasing the number of personnel. By doing so, the managing director believes that the company can clearly show its customers that the additional money they pay compared to other service providers is used to improve their living environment and to promote their well-being. Thus, inputs into human resources are used as a way to create added value for customers.

The company's strategy for increasing its profits is to acquire more customers and to provide better quality. The introduction of new services is important for acquiring new customers and creating the critical mass the company needs to cover its expenses, as income from Kaigo Hoken can be expected to decrease. However, it has to be said that strategic management is given less attention in the company, while the main driver behind decision-making is customer satisfaction and customer acquisition. Sometimes other variables, such as costs, receive less attention. Apart from the obvious benefits of focusing on customer satisfaction and customer acquisition, this approach seems to have some downsides, such as a lack of real strategic focus.

## Key processes of the company

The company's services are divided into separate units that concentrate on different services. Each unit operates in a slightly different way and therefore processes vary by unit. However, the company has standardised a few key processes such as the process of building and updating the Care Plan.



## Process of planning care

The process of care planning or building the Care Plan is one of the company's key processes. Through it, the company finds out what the customers and their families want and need. Success in this process is very important in order to create customer satisfaction, which is the company's most important objective. Based on the interviews, the company's care planning process can be described as follows.

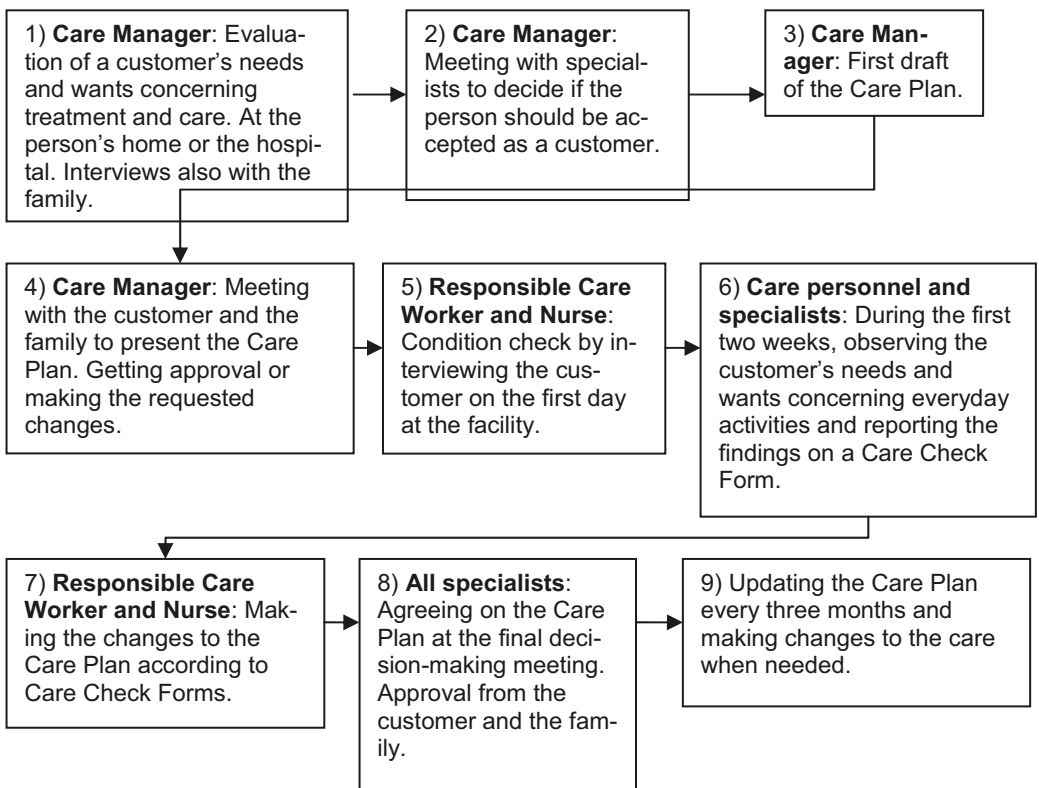


Figure 3. Company's care planning process

What is exceptional about the process of building the Care Plan and updating the plan compared to other service providers in Japan, is that all the specialists

and responsible care workers participate in the process. According to the regulations of Kaigo Hoken, this process ought to be conducted by the Care Manager alone. Through this practice, the company strives to ensure the suitability and quality of the care. In addition to the exchange of information between professionals, another very good aspect of the process is that the customers and their families participate actively, which can be assumed to have a positive impact on customer satisfaction.

The Care Plan plays a key role as an information tool as well as a quality control tool. The plan is very comprehensive, covering all the necessary aspects of care and being updated every three months. In addition, the care personnel react to any problems or shortages that arise, making immediate changes and reporting on them on the Daily Reporting Form. Infection and materials manuals are also used as quality control tools.

### ***Process of reacting to faults***

The feedback and solution process usually follows the pattern presented below. Roughly speaking, there are two ways: the management way and the staff way. In the first way, someone from the management team receives the feedback and provides staff with guidelines for action. In the staff way, the staff receive the feedback and, depending on the urgency of the situation, act right away or consult the management team first.

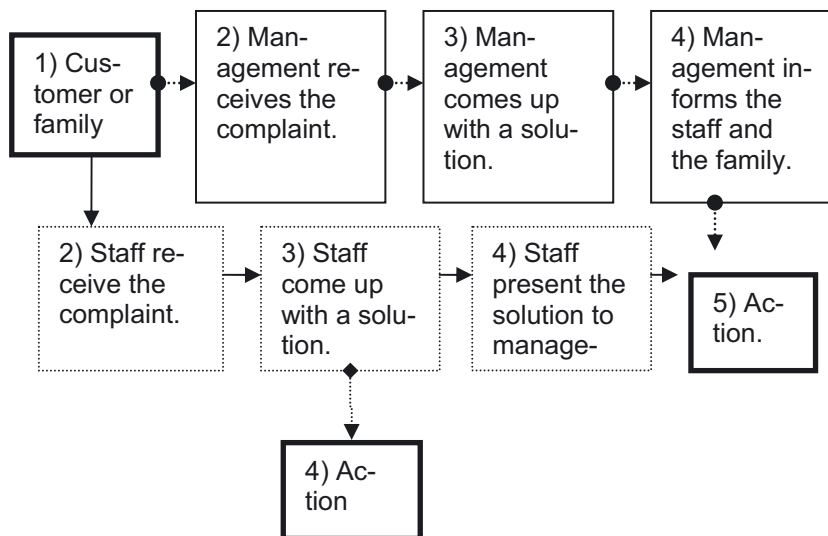


Figure 4. Feedback process

The company has authorised its employees to react to problems when they occur, fixing problems using their own judgement, sometimes without consulting their superiors. This reduces reaction times and can be seen as a form of the so-called Just In Time philosophy. However, as there are no common codes of conduct for problematic situations and employees can come up with solutions of their own, it can be difficult to ensure a consistent quality of service. The company's solution to this challenge is that when problems or complaints occur, the solutions are always made public, presented for example on a notice board in the staff corridor. In this way the company strives to make everyone aware of potential faults and their practical solutions, so that staff will know how to react as quickly as possible to problems and also how to avoid them. This practice is one way of controlling the quality of service.

### **Information flows**

The processes of sharing and exchanging information in the company are not simple, but they are interesting due to their thoroughness and diversity. There are many channels for sharing information between employees, care workers and specialists: an information board, Daily Reporting Forms, the Care Plan, meetings and everyday face-to-face communication. Daily Reporting Forms are filled after each shift so that people coming in for the next shift have the necessary information for conducting their work successfully, especially in terms of

giving the right care for the customers. The company has clearly acknowledged the fact that employees need up-to-date information, not only to perform their jobs well but also to keep them motivated. However, all the information is on paper and it is very time-consuming to write the reports and find the necessary information. IT tools could be used to make the sharing and finding of information more efficient.

### ***Quality control***

The process of controlling the quality of the service may lack standardization and have some flaws when it comes to measuring customer satisfaction, but it also has very good features. Everyone is authorised to monitor the quality of service, which is measured mainly by customer satisfaction attributes and the improvement of physical and mental conditions. Quality is controlled quite comprehensively in the company, as in addition to constant observation conducted by care workers, monitoring is also carried out by a Nurse Captain, a Nutrition Specialist, a Doctor and other specialists on a daily basis. More thorough controls are carried out every three months when the Care Plan is updated. Each employee pays attention to different aspects of the service, so all the aspects of quality are covered. Such empowerment motivates all the employees to promote quality and work towards it, which results in satisfied customers. However, as quality control is internal and conducted by the same employees who take care of the customers, it affects the reliability of the results reached through the interviews conducted by the staff.

### **Financial issues**

Cost management is not used as a management tool in the company. Costs are calculated on a company level, but not on a unit- or customer-specific level. The lack of cost management is acknowledged in the company, but at the moment the expense of introducing new cost management practices or programs is considered to exceed the potential benefits.

At the moment, the situation is financially very challenging, and the company is striving to acquire new customers and find new profitable services that could create additional income. The managing director emphasises the fact that the operating environment is highly challenging for every service provider and that the problems experienced are due to the disadvantageous regulations of Kaigo Hoken. However, the introduction of cost management practices could offer a tool for identifying unprofitable functions or services, and for further actions to be

taken to cut costs and increase profitability. Cost management practices are also useful when determining whether new services are worth offering or not, although this decision is naturally also affected by other factors, such as strategic objectives.

## **Conclusions**

The Care Plan as a unifying tool for managing all the aspects of care, and the versatile use of the plan offer an interesting benchmarking target. The process of planning care (or building the Care Plan) was especially interesting. Through the participation of all the professionals from different fields of expertise and the care workers who are in close everyday contact with the customers, the company tries to optimise the provision of services and to ensure customer satisfaction. This is an important part of its strategy for differentiation from competitors.

The processes of sharing and exchanging information in the company are interesting due to their thoroughness and diversity. However, all the information is on paper and it is very time consuming to write the reports and find the necessary information, which takes up excessive human resources. These resources could be directed to providing care to customers and, particularly, to increasing the number of care workers, which is believed by the management to have a positive impact on customer satisfaction. IT tools could make the sharing and finding of information more efficient.

The company's financial situation is very challenging. As the company cannot change the operating environment determined by Kaigo Hoken, it should seek other ways to improve its finances. The introduction of cost management practices could offer a tool for identifying unprofitable functions or services, and for further actions to be taken to cut costs and increase profitability.

## ***Ainokaisa Kuisma***

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Interviews conducted in the Japanese case company during a research trip to Sendai in July 2006.

*Hannu Pirnes*

## **The Concept of Services for the Elderly and their Present State**

In the elderly care sector in most Western countries, cost and productivity aspects are becoming topical due to the decline in financing possibilities for public services, concurrent with increasing demand. While public financing resources for elderly care services will decline rather than increase from the present level, the gap between demand and supply of welfare services will rapidly widen. The development of a more efficient and better working service concept will delay this disadvantageous trend. An interesting assumption is that productivity improvement in the welfare sector can be traced from business theories rather than from traditional health care issues. This specific aspect was a motivating factor for the establishment of this research and development project.

The aim of the Active project is to develop new elderly care services on a broad basis by combining Japanese and Finnish research know-how and practical experiences of elderly care development in both countries. The Active research and development network combines the resources of Laurea University of Applied Sciences, the Helsinki School of Economics, Tohoku Fukushi University, the City of Espoo, the City of Vantaa, Tohoku Fukushi Corporation and development-oriented, leading companies. The Active project covers a whole long chain of activities beginning with basic research and extending up to various practical operations. In the Active network, researchers, municipal and business professionals, as well as students collaborate to find and develop innovative models for elderly care. The success of the project largely hinges on how well we succeed in encouraging all participants to devote their resources to achieve the common objectives.

The Active project provides an umbrella for individual subprojects, which all support our shared objective of developing better elderly care services with lower costs. The aim of the Active project is to be one of the leading R&D projects of its kind. This means that we are interested in all new openings in the field of elderly care that support our Active objectives. We are also interested in all poten-

tial capable, skilled persons and organisations that share our motives and are willing to commit to our research and development objectives.

Learning by Developing (LbD) is a method we have successfully used in the search for innovative ideas in the improvement of present elderly care services. According to the LbD principle, students study specific narrow areas in the field of elderly care, analyse the present situation through up-to-date theoretical issues and, as a conclusion, try to construct a new, improved service model. We have also engaged several students to conduct their Bachelor's or Master's theses within the Active project. Our experiences of students' innovativeness in the search for new solutions have been especially encouraging. Many valuable new openings and ideas in our Active project have been originally produced by students who are simultaneously taking their ordinary studies. The new Learning by Developing method, in which ordinary study modules are combined with development tasks, provides an interesting approach for finding and analysing weaknesses in existing systems, producing innovative ideas and development proposals and, above all, offering a larger research capacity for use in our Active research & development project.

Contradictory marketing orientations in elderly care systems, combined with the largely distinct cultural characteristics of Finland and Japan set a great challenge for our research. Without examining the details of elderly care systems in Finland and Japan, it is essential to understand the main features, similarities and differences of the two countries' systems. In Finland, the public sector plays a commanding role in the organisation of elderly care services, partly due to the corresponding significant share of public financing. Municipalities have various and even contradictory roles in elderly care services; at the same time as they themselves produce the services, they also buy competing ones from the private sector. The Japanese long-term care insurance system, Kaigo Hogen, makes the Japanese elderly care system more market-oriented than the corresponding Finnish system. The Japanese system covers all people aged over 65, as well as younger patients with chronic diseases. The Kaigo Hogen system is financed through insurance payments in which the share of public financing plays a dominant role. The major difference between the Japanese elderly care system and the corresponding Finnish system lies in customer orientation. In the Japanese system, an elderly person is a genuine customer, entitled to buy services from the best possible supplier. In the Finnish system, the municipality provides services, and if an elderly citizen is not satisfied with given services, the only alternatives are to go without or, should the person be wealthy enough, to buy services from the private sector without public support. However, already at this

stage we are strongly convinced that despite the different circumstances in Japan and Finland, the research and development cooperation in the field of elderly care will be a great success in the long term.

Most important in our Active project is that we succeed in being open to all new ideas, all the time. We have already identified several new openings for our Active project, of which the development of new business models for private elderly care provides is one of the most topical at this stage. Currently, private companies in the Finnish elderly care sector typically have problems in running their business profitably, due to the complex roles of the customer and supplier, and also because the working capital load is too heavy in relation to turnover. By developing better and more profitable business models for private service enterprises, we can help to close the gap between rapidly booming demand and slowly increasing supply.

We believe that despite its complexity and difficulty, the Active research context may lead to significant results. With the aid of the Learning by Developing educational method, we have succeeded in creating a useful and extensive research platform which provides more research volume while simultaneously improving the students' learning and motivation. The future is likely to provide great challenges for us. It is now our job to learn to utilise and put into practice the numerous potentials latent in our Active research and development platform.

***Hannu Pirnes***



## **Networks and the Activenet**

### **Definition of networks and networking in the ActiveNet project**

Information networks have created new kinds of networking opportunities. This has led to the idea that networking is primarily communication via information networks. However, there are also other kinds of networks. Above all, networks include interpersonal activities like in the ActiveNet project, which is discussed in this article. It is an interactive project whose communicative nature is highlighted. The network's partners' – Tohoku Fukushi University, Helsinki School of Economics, Laurea University of Applied Sciences and the cities of Espoo, Sendai and Vantaa – common interest is to combine their welfare, business and technology know-how to generate international innovations that improve the life of senior citizens (cf. Stoker 1997; Niinikangas & Näätäsaari 2000). According to Latour (1996), a network is formed of knots, which have as many dimensions as they have connections with other knots within the network. This raises the question of whether there is a connection between the parts mentioned or not. Aro (1998) considers the most essential aspect of networks to be how tight and well-bonded it is. What is central is the distances between the knots and the strength and number of bonds between the knots. According to Linnamaa and Sotarauta (2001), networking represents the growing importance of mutual, non-hierarchical interdependence and increased dependence between the participants.

Networking can be compared to partnership. Partnerships are about taking part in something, about commitment, commonly agreed and understood goals, and considered and directed local practices. Partnerships are always both discursive and practical (Luostarinen and Hyyryläinen 2000). When a partnership is developed, local and regional social and partnership capital is created. These are the creative resources for different situations of action.

According to Linnamaa (1998), when networking as a concept is connected to development, as in the case of the cities of Espoo, Vantaa and Sendai, it can be described as a network of regional developers. It is created by the most central actors, which with their own actions and cooperation influence the areas' development and have a functioning connection between them. In regional development, networks are often seen as a symbol of successful operations. However, Linnamaa and Sotarauta (2001) note that networking is not an indication good cooperation and does not guarantee it. According to them, networking is one way to organise cooperation. They consider the rigidity of institutions and organisations, the expiry of networks and neglect for the development of network functionality as obstacles to the ideal model of networking. Awareness of these problems can increase the functionality of networks. The challenge faced by the Active network is to avoid the problems described above. The Active network is clearly defined as a network that only includes defined partners and that functions within the flexible structures of participating higher education institutions and city councils' social and health care units.

## **ActiveNet project and open networks**

Typical features of open networks are spontaneous, fast information flow and an open exchange of information. Functions are based on equality and these networks do not necessarily have leaders. They emphasise cooperation instead of hierarchy and competition (Aro 1998). According to Julkunen (1992) networks are not predictable and legally secure if they bar people. When networks connect people from different fields, they create interfaces that enable new thinking and innovations. Within each organisation, networking improves entity control. According to Ståhl and Grönroos (1999), a networked organisation must not be directed from the top down but through delegation of power. These aspects of open networks seem to be well represented in the pilot project involving Tohoku Fukushi University, the Helsinki School of Economics, Laurea University of Applied Sciences and the cities of Espoo, Sendai and Vantaa.

An ideal example of an open network is the development of the Linux operating system, where the starting point was a base created by one person, to which all those who were interested could make additions, developing the original model further. Each volunteer was motivated by the idea of creating an even better operating system. In this way the input of each volunteer was a guarantee for developing the network and the volunteers could get a more advanced and functional version of the operation system for themselves. The results of open net-

working have been amazing. The network aiming for developing the areas of Espoo, Vantaa and Sendai could be conceived to adapt the idea of Linux development, functioning as successfully. The people working in the area could freely have their say in open information networks and write down their initiatives, which others in the same area could develop further. In this way, regional development could take place gradually, by solving one problem at a time as creative solutions are created in open networks.

The University of Aachen in Germany, the University of Leuven in Belgium and the University of Eindhoven in the Netherlands have realised the importance of networking in a similar way to the network created by Tohoku Fukushi University, Helsinki School of Economics and Laurea University of Applied Sciences, applying their know-how to improving the competitiveness of Europe in relation to India and China. Similar networks include Silicon Valley and the Research Triangle in the United States, the Öresund Science Region in Denmark and Sweden, the New Horseshoe in Canada, the Valencia Knowledge Corridor in Spain, Sophia Antipolia in France and the Beijing Science Cities in China.

The ActiveNet project is a good start when thinking about forming a similar research and development network connecting the welfare, business and technology know-how of the cities of Espoo, Vantaa and Sendai in order to improve their welfare and social cohesion. The areas covered by the ActiveNet project are similar in size to those covered by the European, Asian and American examples.

## **Partnerships and the ActiveNet project**

Partnerships are an important decision and a competitive principle of action. Cooperation is seen as one of the most important social innovations in society. The idea of dividing cooperation into separate tasks is seen as a key to continuous development. Partnership is a justified way of action when dealing with complex problems which need new creative solutions. Most often, significant reforms require extensive know-how, cooperation between sectors and diverse partnerships. This is the goal of the networking project of Tohoku Fukushi University, Helsinki School of Economics, Laurea University of Applied Sciences and the cities of Espoo, Vantaa and Sendai.

Central to the pilot project is the process of networking. In the network pilot project, the participants have created new alliances and adopted new ways of ac-

tion. The higher education institutions Tohoku Fukushi University, Helsinki School of Economics and Laurea University of Applied Sciences, and the cities of Espoo, Vantaa and Sendai are put side by side and various types of practices and experiences are compared actively. The project forms a multilayered intercultural process, whose effects go out in various directions. Creating a partnership requires making choices based on values. Decisions on which ways of thinking and action should be kept and which abandoned have to be made.

According to Wisserhof's (1997) model, a space of action for partnership is built through the alteration of three systems: the cognitive, the social and the regional system. Socio-psychological, institutional and regional alteration processes take place in partnerships. Creating a partnership discourse is part of the sociopsychological process; the aim is to increase partnership capital. The ActiveNet project has already achieved the results described above.

The idea of partnership can be described as follows: it involves equality, accepting the delegation of power and sitting down for negotiations as partners. Negotiations are open and communicative and aim at finding a way to create a good life for the elderly by developing welfare services. It is also important to create an overall picture of the situation of services aimed at the elderly, as well as of local welfare services and the opportunities they have. Furthermore, it is crucial to define the common good, how to create new views and strategies, and how to exchange creativity, knowledge, experience and other resources that benefit all partners. All in all, the question of negotiating as partners is about building mutual understanding (cf. Pursiainen 1997). Partnership is both a practice and an attitude.

In the ActiveNet project, trust was built gradually through meetings and seminars. When there are two different cultures at play, such as the Japanese and the Finnish cultures here, extra emphasis is needed for building trust that bridges differences. It can be said that a good level of trust has been achieved and that the networks have functioned smoothly, generating new ideas and topics for research and development and for the growing market of welfare services for the elderly.

International competitiveness of regions and interest towards promoting welfare services through partnerships can be increased by creating national and international networks between different areas, as in this effort between higher education institutions and cities in Finland and Japan, which are all aligned with welfare technology and promoting the well-being of the elderly. If the institutes and regions can create new kinds of networks leading to innovations, this can gener-

ate regional development and international competitiveness, helping Finland and Japan to succeed globally.

**Helena Erjanti**

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This publication contains the presentations held during the Second Finland-Sendai Seminar in September 2006, discussing the total cost efficiency and profitability of health and social services in Japan and Finland. Comparative data will help both countries develop the effectiveness and cost efficiency of services. This publication compiles 16 presentations that shed light on the future challenges regarding costs and profitability faced by services for the elderly in Finland and Japan. It focuses on the cost structure, cost correlation and production of health and social services for the elderly in the public and private sectors, and on data for analysis and research. The publication also includes the preliminary results of the Active research and development project, which aims at developing services for senior citizens.

ISSN 1458-7211  
ISBN 978 951-799-199-3



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