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Sustainability of Social Prescribing in Japan

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Contents

- Social Prescribing in Japan
  - The integrated care systems for older people
  - Further partnerships between medical sector and welfare sector and local community with the concept of social prescribing

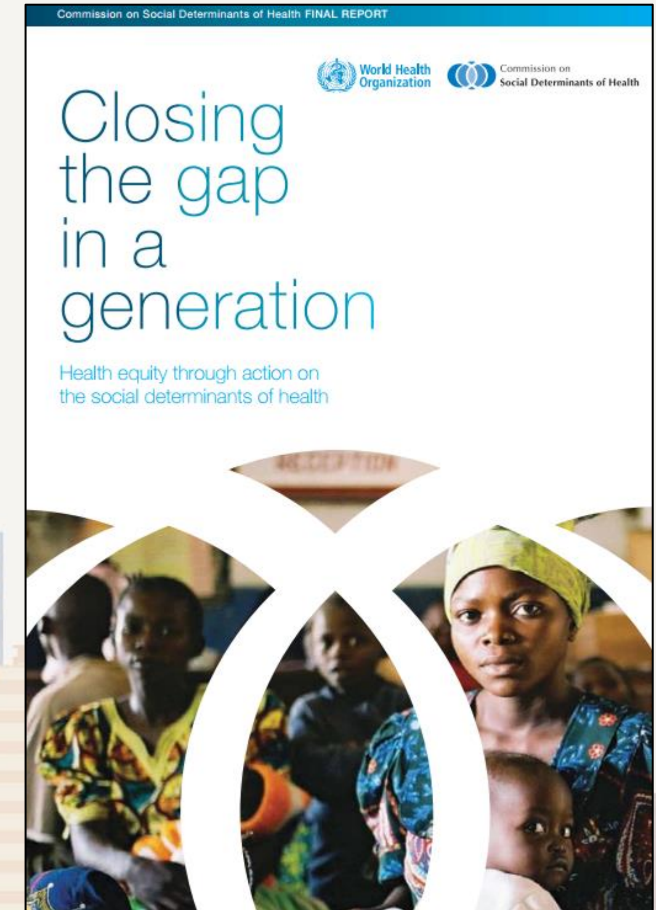
- Making it sustainable
  - Possible policy options
  - Issues in building a system of social prescribing

Three recommendations by the WHO Commission on Social Determinants of Health (2008)

1. **Improve daily living conditions**
2. **Strengthen governance**

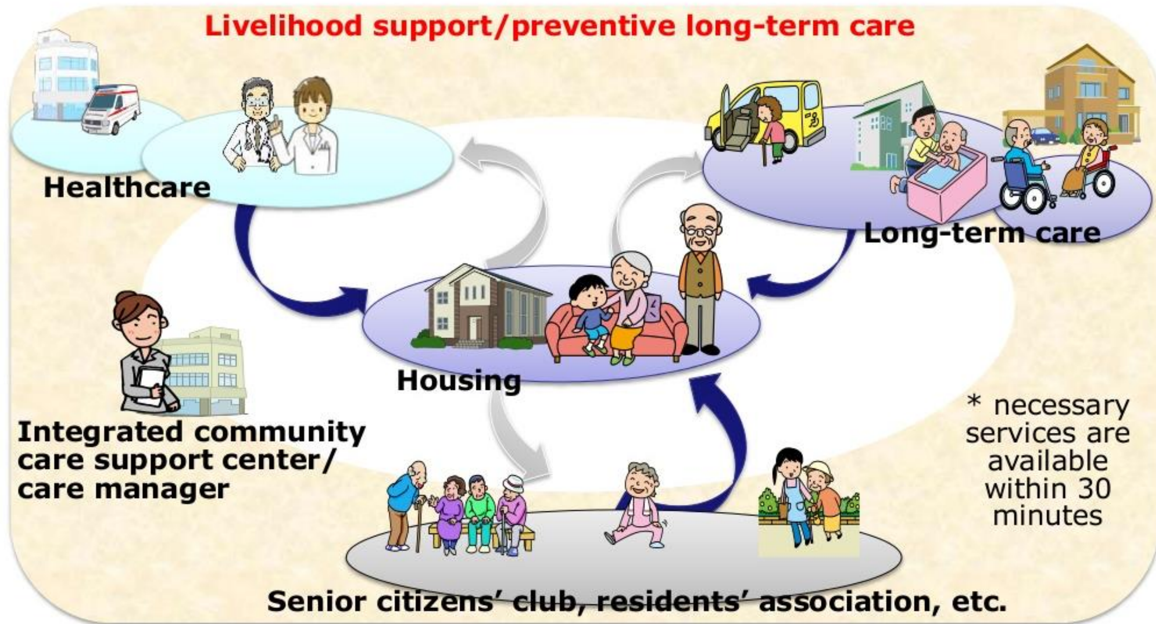
   To tackle the inequitable distribution of power, money, and resources
3. **Health Equity Assessment**

   Measure and understand the problem and assess the impact of action



Community-based Integrated Care System:

Japan's current community organizing strategy for Healthy ageing



Promoting partnerships among care providers, citizens, and community resources

Lessons from the field

Community-based care for healthy ageing: lessons from Japan

Junko Saito,[a] Maho Haseda,[a] Airi Amemiya,[a] Daisuke Takagi,[a] Katsunori Kondo[b] & Naoki Kondo[a]

Problem The measures for long-term care prevention that the Japanese government had introduced in 2006 were unsuccessful because of the failures to identify high-risk individuals and to enrol enough participants in the community prevention programme.

Approach The Japanese government shifted its primary strategy from a high-risk strategy to a community-based population strategy in 2015, by reforming the Long-term Care Insurance Act. This act is focusing on community-based care and social determinants of health. The Act and the government's plans for long-term care prevention are inspired by a social participation intervention called *ikoino saron*, that is gathering salons for people older than 65 years. These salons, managed by local volunteers, are held once or twice a month in communal spaces within walking distance of community members' homes and have a low participation fee. At the gatherings, older people can meet and interact with others through enjoyable, relaxing and sometimes educational programmes.

Local setting Japan has the world's largest ageing population, with 27.7% (35.2 million/126.7 million) of people older than 65 years.

Relevant changes Studies have shown that participation in the salons was associated with a halved incidence in long-term care needs and about one-third reduction in the risk of dementia onset. Evidence also suggests that financially vulnerable older adults were more likely to participate in such interventions. In 2017, 86.5% (1506/1741) of the Japanese municipalities had implemented the salons.

Lessons learnt Integrated care for long-term care prevention should consider interventions targeting the whole community in addition to high-risk individuals.

Abstracts in عربي, 中文, Français, Русский and Español at the end of each article.

Introduction

Japan has the world's largest ageing population. In 2017, 27.7% (35.2 million/126.7 million) of people living in Japan were older than 65 years. Over the years, the Japanese government has reformed its policies to respond to the need of the ageing population and to prevent long-term care. In 2006, the government implemented measures aimed to identify frail or semi-frail older adults (that is, 65 years or older) and provide early preventive care programmes for functional decline, to delay dependence on long-term care. The measures consisted of identifying older people with disability risks, by screening them, mainly at regular health check-ups, using a validated one-page questionnaire (Kihon checklist).[1] Identified high-risk individuals were subsequently referred to free community prevention programmes.

However, the measures failed to identify high-risk individuals and participation in community programmes was low. Based on available evidence, the government estimated that approximately 5% of the total older population was at risk, and therefore should be the target of preventive care. However, in 2014, by the ninth year of strategy implementation, only 0.8% (267 654/32 824 841) of older adults had joined the community prevention programme.[2] This result was due to the low participation in the screening process for functional difficulties: only 34.8% (11 408 862/32 824 841) of older people participated, a lower percentage than that for regular health check-ups (41.5% for 65–74-year-old people).[2] Although supportive evidence is not available, we speculate that physical and environmental barriers and the lack of support to overcome these barriers, such as incentives and transportation, may explain the low participation. The low screening participation could also increase inequities in preventive service provision.

A community-based survey identified that the proportion of socially disadvantaged people undergoing health check-ups was low.[3] Moreover, the screening programme created ethical debates because the Japanese government categorized the older adults identified as frail as "special elderly" (*tokutei kouretsha*). Some researchers and policy-makers were concerned about potential labelling and stigmatization, and in 2010, the government changed the name to "target individuals for secondary prevention programmes" (*niji-yobou taishousha*).

The low participation in the community prevention programmes resulted in limited attributable impact. In theory, even if the government succeeded in providing the programme to all eligible persons, these only represented 5% of the total older population. However, work on disease prevention, suggests that the distribution of disease and risk is generally a continuum, without an exact boundary between the normal and abnormal and that people developing a disease could be identified as normal in a screening programme.[4] In Japan, half of those who developed functional decline did not belong to the high-risk or special elderly group before their functional decline started.[5] The government recognized the issues associated to the secondary prevention measure, that is, difficulties in maintaining participants' motivation and high discontinuance rates and hence revised its policies for preventing long-term care.[6]

Here we describe the country's current strategy and we focus on a social participation intervention called *ikoino saron*, that is, salons where older people can gather.

Current strategy

In response to the increasing awareness on health inequality, the second term of the National Health Promotion Movement:

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570 *Bull World Health Organ* 2019;97:570–574 | doi: http://dx.doi.org/10.2471/BLT.18.223057

Lessons from Japan

*Failure of high-risk strategy by health professionals

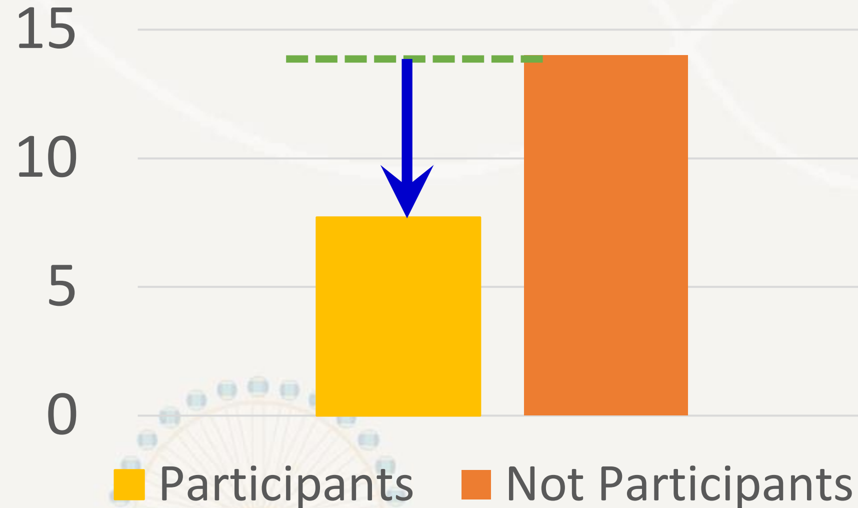
*Successful shift to population strategy: community building approach with local citizens)

Saito J, Haseda M, Amemiya A, Takagi D, Kondo K, Kondo N*. Community-based care for healthy ageing: lessons from Japan. ***Bull World Health Organ*** 2019;97:570-4.

"Kayoinoba" 通いの場

Making community "salons" (social gathering places) prevent functional disability

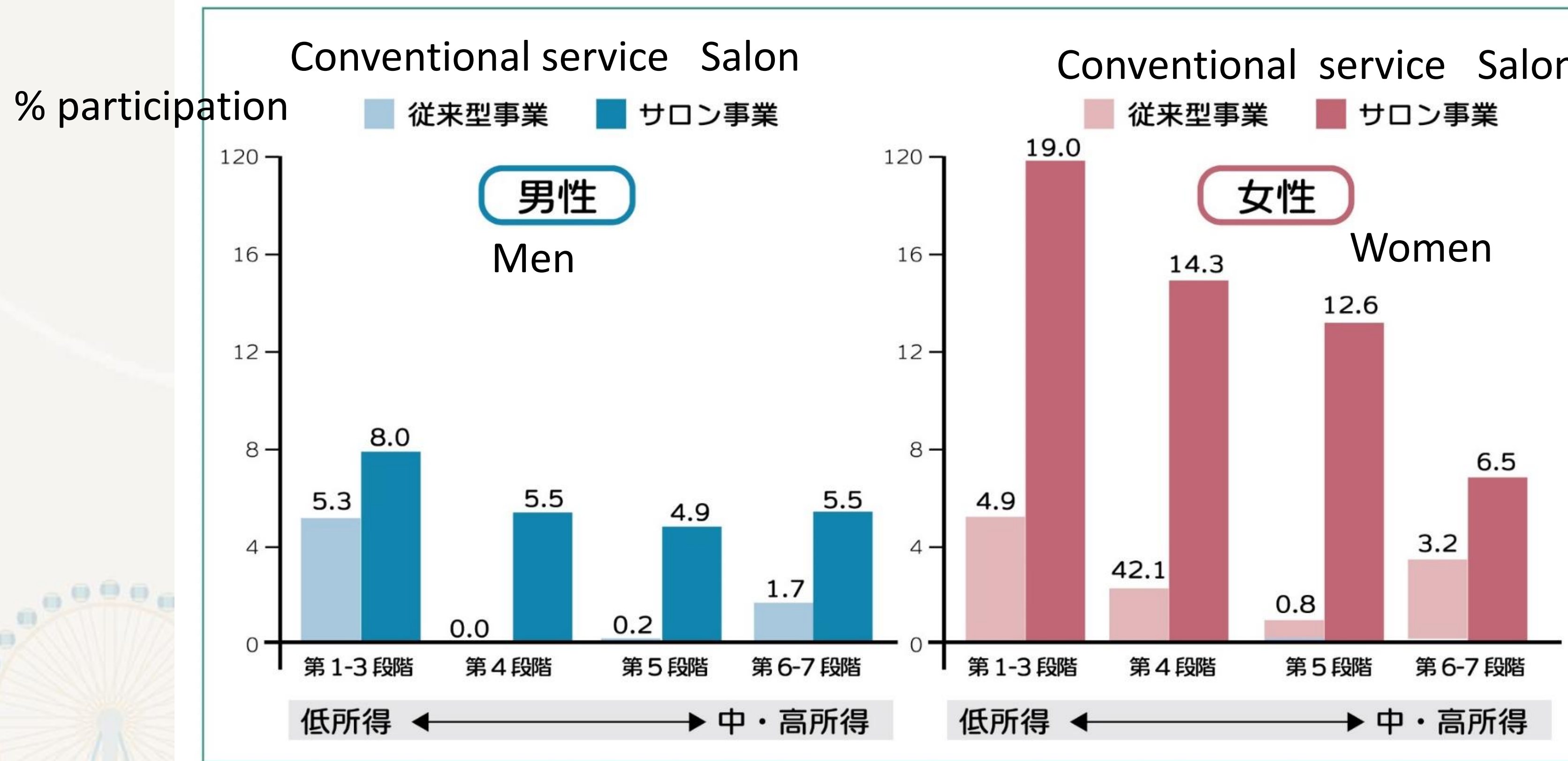
Establishing "community salons" in towns where older people can interact with each other may reduce the rate of people requiring nursing care by half.



Hikichi, H., Kondo, N., Kondo, K., et al. Effect of community intervention program promoting social interactions on functional disability prevention for older adults: propensity score matching and instrumental variable analyses, JAGES Taketoyo study. **Journal of Epidemiology and Community Health 2014** doi: 10.1136/jech-2014-205345

Japan Gerontological Evaluation Study
AGES

Low income people are more likely to go to the salon

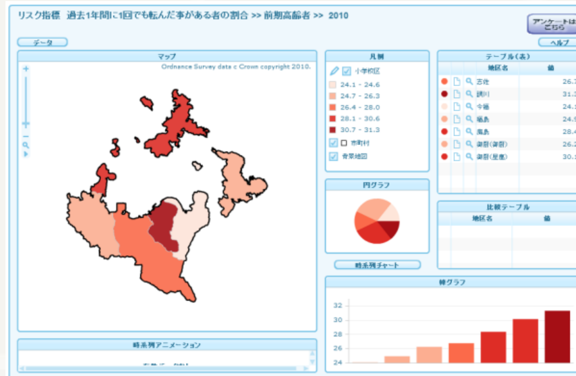


平井寛・近藤克則（2010）季刊社会保障研究，46(3): 249-263

Income Low high Income Low high

Success in a rural town: Matsu-ura city

Visualized health data → **Share in the community meetings**



Triggered residents' action

"Oh.. there are many people living-alone who have difficulty in shopping!"

New community activity launched

"Oyorimasse" (just drop by) salon: lunchtime social gathering for those living alone

Activity continued & expanded

Mobile shop is back!

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Do the Community-based Integrated Care Systems work?

(Haseda et al, Soc Sci Med 2019; Health Place, 2022)

Intervention: 16 municipalities
Providing community diagnosis data **AND supporting health sectors on how to utilize it**

Control: 16 municipalities
providing community diagnosis data

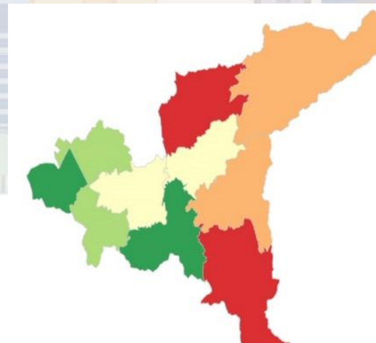
Assist them in organizing intersectoral meetings on aging policies

Support to utilize community health data with local people's groups

Community diagnosis sheet

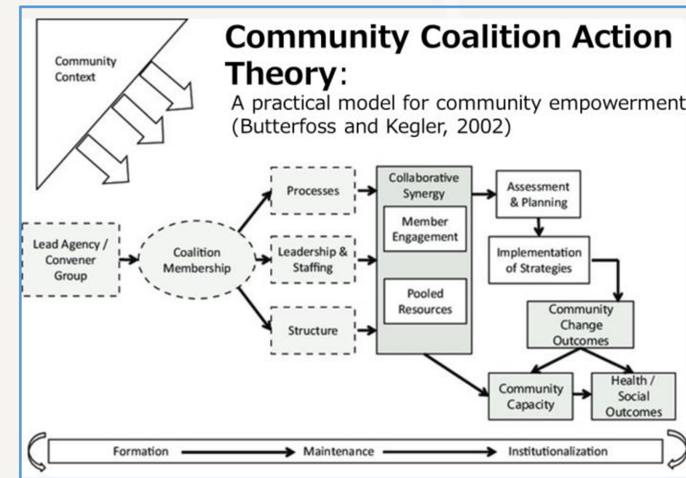
地 域 診 断 書

Social & health risks maps



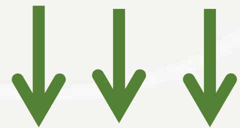
Hypothesis

based on Community Coalition Action Theory



Support agency

Support



Health Sector

Coalition

Local people

Other sectors

Organizations in the community

Skills for policy planning, leadership, assessment, and partnership **building**

Collaborative synergy:
Member engagement, pooled resources

Community capacity

Healthy actions & health equity

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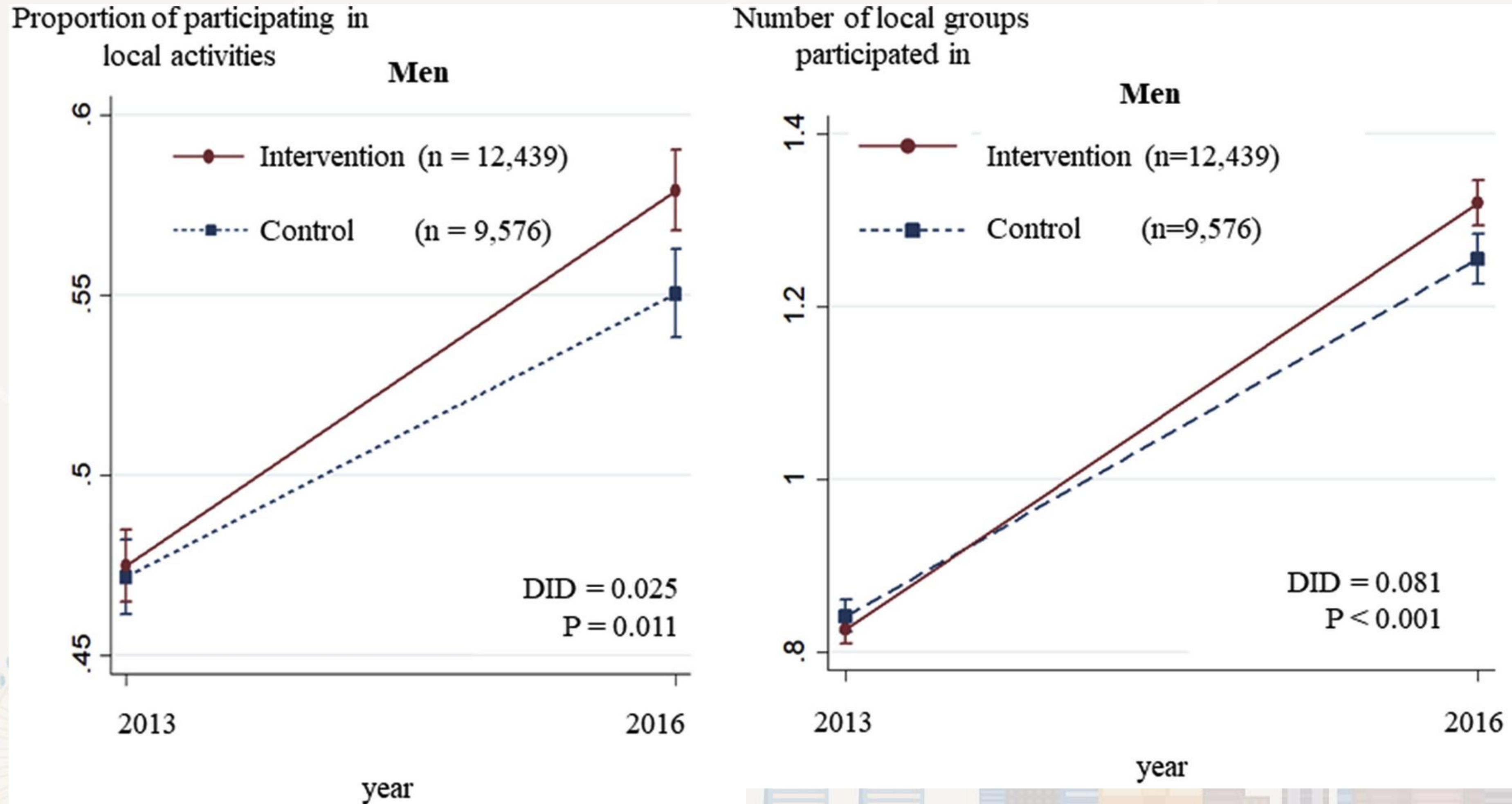
Change in Social Participation: difference-in-differences regression



No difference among women. The effects are remarkable for leisure activities and neighborhood associations

Weighted by the inverse probability of being in the intervention group, using propensity scores calculated with municipality characteristics at baseline

Haseda et al, SSM, 2019

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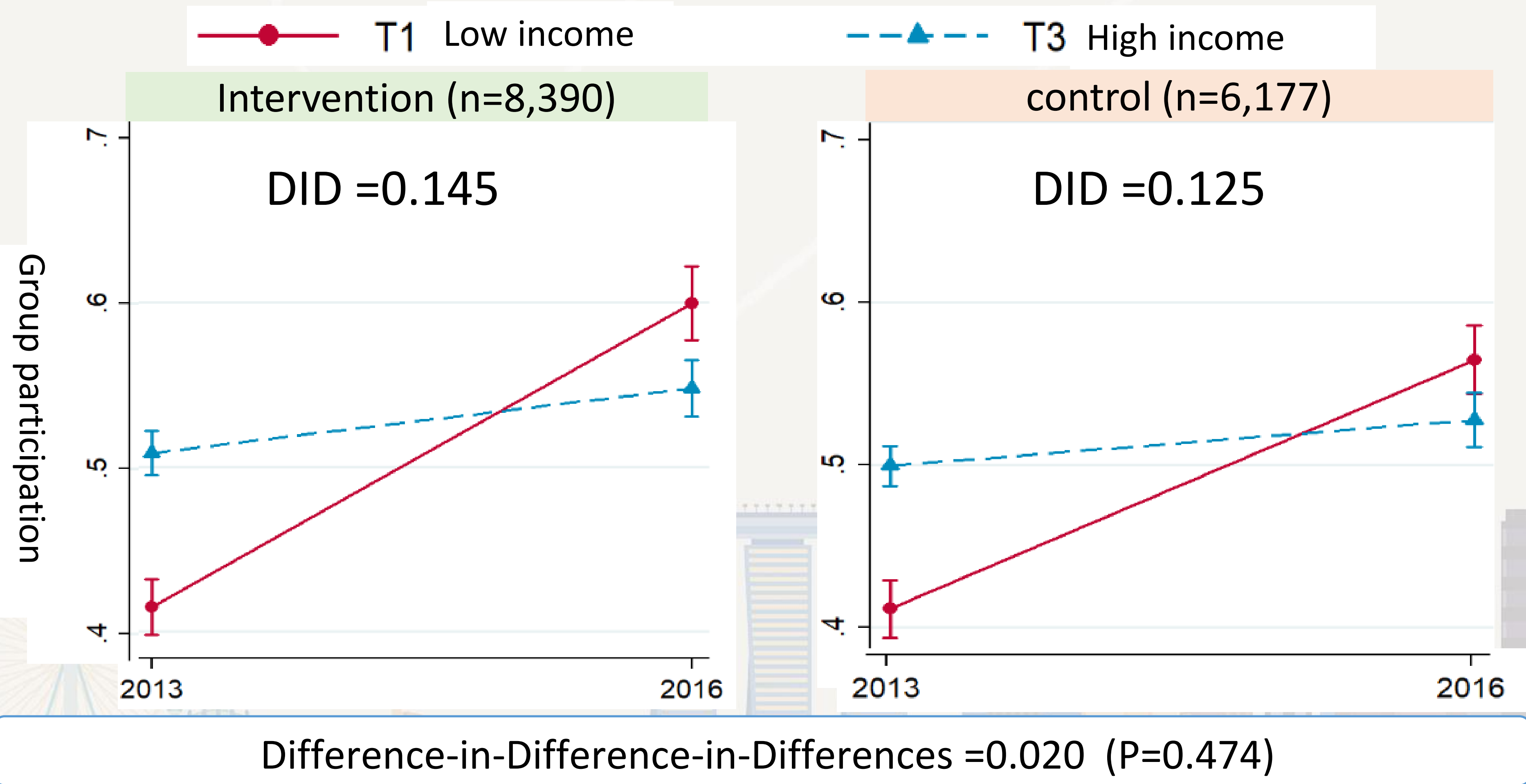
Results by income in men

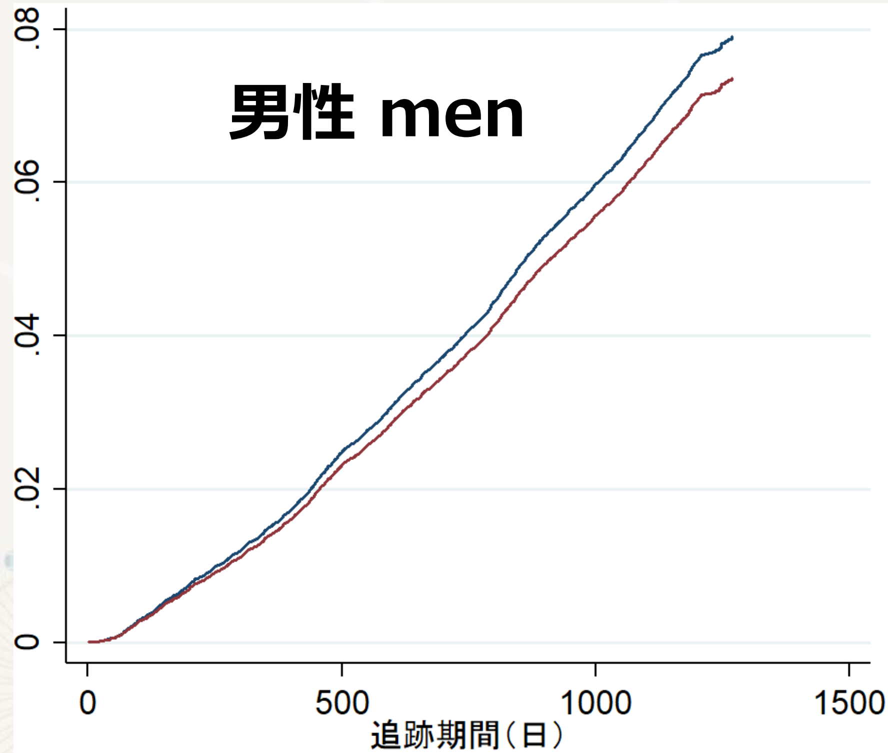


No statistical difference by income levels

Mortality also reduced in interventions areas

Intervention   Control

Cumulative mortality



Adjusted Hazard ration =0.90
(95%CI: 0.84-0.96)

Haseda et al, Health&Place 2022

Mortality by income, men

Intervention — Control

Low income (n=9,910)

High income (n=15,621)

No interaction on income x intervention

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Policy actions on Community-based Integrated Care

- Impact assessment and financial incentive programs by the Ministry, 2018-
  - Community Integrated Care Centre, municipalities, and Prefectures reports action indicators
  - Government provide refund in proportion to the performance summary score
  - 40 billion yen (3-400 million dollar) provided
  - Reforming the indicators every year
- Mandatory healthcare support for welfare recipients for municipalities, 2021-
  - Cross-sectoral collaboration activated (welfare sector x health sector)

Two mechanisms for cross-sectorial actions

Medical& Long-term Care

多職種連携
Inter-professional partnerships

b/w hospital care, home care, long-term care, etc

Community care/ welfare protection

地域包括ケア　Community –Based Integrated Care Systems
地域共生社会　Inclusive Community Creation

A wide-range collaborations including local citizens BUT weak participation of medical care sector

Can "Social Prescribing" overcome this divide?

Domestic trends in Social Prescribing

2018 The Japanese Association for Primary Care “Views and Action Guidelines on Health Disparities." Introducing Social Prescribing.

2019 Japan Medical Association, "Training of Family Physicians" workshop Lecture on "Social Prescribing for Family Physicians".

2020 Study session on social prescribing at the Diet members voluntary meeting for social security reform, of the Liberal Democratic Party. Recommended promotion of social prescribing.

Social prescribing was introduced in the "Basic Policies for Economic and Fiscal Management and Reform“ by LDP (the ruling party)

2021 Establishment of Minister for Loneliness and Isolation

The model project for social prescribing started at seven Prefectural Health Insurance Associations

2022 Increased budget for the social prescribing model projects

2023 (Wrapping up the model projects with some further policy suggestions)

Minister of Health & researcher’s cross-talk on social prescribing on a popular economics Journal

Definitions in Japan

- “Activities to link patients with social issues that may cause health problems or hinder treatment with non-medical social resources that can solve those social issues, starting from medical institutions, etc., and to create opportunities for care together with patients" (Nishioka & Kondo, Medical Care and Society 2020).
- “Efforts by family doctors, etc. to pay attention to the social issues of their patients and collaborate with local resources” (Cabinet Office, 2021).

Case repots on voluntary (unpaid) hospital-based social prescribing activities

Author, year	Target	Description
Ito, 2010	Homeless, isolation, financial difficulty	Financial counselling, application for welfare protection, job hunting support, etc.
Fukuba, 2015	Single-parent household	Childcare support, introducing support network
Fukuba, 2017	Financial difficulty	SDH medical record, food bank, low-cost care certification,
Yamanaka, 2011	homeless	Collaboration with NGOs, providing clothing
Tsuka, 2013	Living alone	Introducing group meetings at apartment complex
Nishiyama, 2013	Living alone older adults	Preventing isolated death, introducing community health room, introducing group activities
Funakoshi, 2013	Home care, dementia patients	Introducing group activities,

A tool was developed for screening patients: Measuring Poverty and Isolation in Clinical Practice

1. この1年で、家計の支払い（税金、保険料、通信費、電気代、クレジットカードなど）に困ったことはありますか。
2. この1年間に、給与や年金の支給日前に、暮らしに困ることがありましたか。
3. 友人・知人と連絡する機会はどのくらいありますか（連絡方法は電話、メール、手紙など何でも構いません）。
4. 家族や親戚と連絡する機会はどのくらいありますか（連絡方法は電話、メール、手紙など何でも構いません）。

Poverty Assessment Scale (Nishioka, Kondo, et al., 2019)

1. In the past year, have you had any problems paying your household bills (e.g., taxes, insurance premiums, communication expenses, electricity bills, credit cards)?
2. During the past year, did you have any difficulties in living before receiving your salary or annual deposit?
3. How often do you contact your friends and acquaintances (by phone, e-mail, letter, etc.)?
4. How often do you have contact with your family and relatives (by phone, email, letter, etc.)?

Nishioka D., Ueno E., Funakoshi M., Saito M., Kondo N. Development of a Patient Impoverishment Assessment Scale for Use in Medical Institutions. Japanese Journal of Public Health 67. 2020

From the model projects:
For a better information sharing

"social issues" section was added to "Patient Information Form"

診　療　情　報　提　供　書

紹介先医療機関等
担当医（担当者）　　　（科）　　　殿

年　月　日

紹介元医療機関（所在地）　（　）
電話番号　（　）

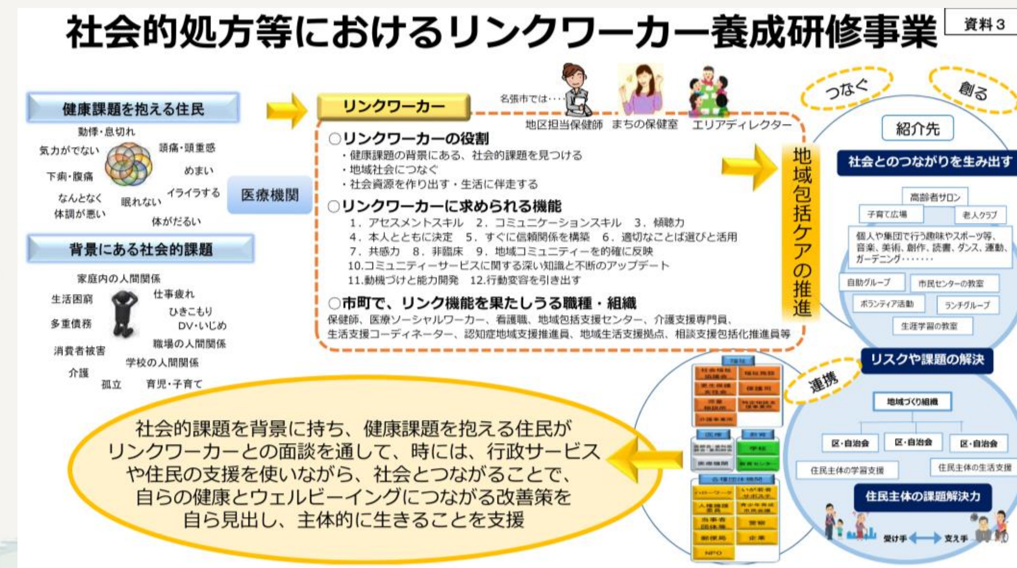
医師氏名　　印

患者氏名：	性　別：　男　・　女
生年月日：　年　月　日（　歳）	職　業：
住　所：	TEL：
傷　病　名	
紹　介　目　的	
既往歴・家族歴	
症状経過・検査結果	
治療経過	
現在の処方	
生活上の課題（生活環境、経済状況、家族関係など）	
備　考	

1．必要がある場合は、続紙に記載して添付すること。
2．必要がある場合は、画像フィルム、検査記録、SDH問診シート等を添付すること。

From the model projects:
Human recourse development: Link worker training sessions

Nabari city & Yabu city: big advocates of social prescribing



Attracts young-generation family physicians

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Actions from various sectors

- “Cultural Prescribing” project by Tokyo University of the Arts & National Museum
- Kosugi-yu（小杉湯）, long-established public bat begins social prescribing (awarded by the Tokyo metropolitan gov.

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Issues in building a system of social prescribing

- **What is the incentive structure that rewards those who takes cost for social prescribing?**
- **How to avoid the adverse effects of inappropriate "medicalization" and institutionalization?**
- **Social prescribing as culture or the systems? How do people and organizations move and create value cycles?**
  - Regulations: mandatory?
  - Incentives: financial or non-financial?
  - Leave to the free market
- **Where are the channels of institutionalization and what to install?**
  - **Insurers: H**ealth checkups and health guidance: social risk assessment and response for the target population
  - **Long-term care insurance:** benefits and service provision based on social function assessment (isolation, loneliness, etc.)
  - **Medical care (physician):** direct reimbursement to social prescribing actions? →Criticism is strong.
  - **Medical institutions:** benefits for certified medical institutions
  - **Welfare policies**: Health assessment and strengthening of response
- **Who is needed? How to secure the human resources?**