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How did Japanese "Community-Based Integrated Care System" Function during the COVID-19 Pandemic?

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Abstract

On January 16, 2020, the first case of the novel coronavirus infection (COVID-19) was identified in Japan. Subsequently, the number of infection cases increased, leading to the first declaration of the state of emergency in Tokyo, Kanagawa, Saitama, Chiba, Osaka, Hyogo, and Fukuoka on April 7, 2020. On April 16, 2020, the declaration was extended nationwide. The state of emergency was lifted on May 14; however, this did not apply to metropolitan areas. On May 25, the state of emergency was lifted across Japan, after one and a half months of its initial imposition.

Keywords: COVID-19; Infection; Healthcare; Care providers

Introduction

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On April 16, 2020, the declaration was extended nationwide [1].

The state of emergency was lifted on May 14; however, this did not apply to metropolitan areas.

On May 25, the state of emergency was lifted across Japan, after one and a half months of its initial imposition.

Unlike lockdown measures typically imposed by governments in Western countries, Japan's declaration of the state of emergency did not force people to stay home.

During this period, elementary, junior high, and high schools were temporarily closed, and universities were requested to provide courses online.

Restaurants were asked to close or reduce their service hours. Companies were advised to reduce their commuting workforce by 80% and increase their online work at home.

These requests by the government, however, are not obligations punishable by law. Nevertheless, Japanese people accepted the government's request because of the fear of infection at that time.

In Japan, the declaration of the state of emergency was announced thrice during the pandemic, with the second one effective from early January to mid-February, and the third from May to June (Figure 1).

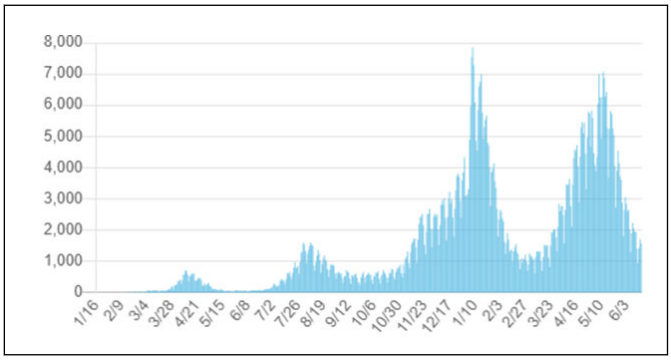

Figure 1: *Number of patients in Japan who were infected by COVID-19.*

The Japanese government aims to establish a "Community-based Integrated Care System" across Japan by 2025, the year in which the postwar baby boomers turn 75 years old. The "Community-based Integrated Care System" will enable elderly people to utilize necessary healthcare and long-term care services within 30 minutes from home, thereby providing comprehensive care services at the community level and facilitating the elderly to live at home until the end of their lives. In implementing the "Community-based Integrated Care System," the establishment of a sound and improved elderly care services provided under the Long-Term Care Insurance (LTCI) system and the healthcare services under the Health Care Insurance (HCI) system are essential, but local communities are also expected to carry out care prevention functions through voluntary activities of the residents.

The author has been studying co-operative healthcare and elderly care practices in Japan for ten years. Health and eldercare co-operatives in Japan are not only limited to healthcare providers and elderly care services, but also include influential promoters of health and care prevention initiatives at the community level. At the 4th Transforming Care Conference held in Copenhagen in 2019, the author reported the analysis of a questionnaire survey in 2017

targeting hospitals and long-term care service providers. Staff working at hospitals and long-term care services run by the co-operatives was observed to have a high level of work satisfaction, which is closely related to their daily communication with patients, service users, and volunteers [2]. This demonstrates the presence of a "co-production" structure embedded within the system, where the service users and professionals work as a "co-producer" of healthcare and long-term care. Through the analysis, the effect of "co-production" in providing quality healthcare and nursing care was verified (ibid.).

This study outlines the status of long-term care services for elderly people in Japan during the spread of COVID-19, or more precisely, around the first declaration of the state of emergency. Furthermore, it examines how co-operative healthcare and elderly care services deal with the infection to see how "co-production" functions during the pandemic. The analysis of actual healthcare and elderly care practices by co-operatives during the pandemic may help verify the possible benefits to society created by "co-production" in terms of elderly care and healthcare services. This study focuses on the realities of nursing care for the elderly during the first declaration of the state of emergency in the spring of 2020.

In this paper, Chapter 2 outlines the co-operatives providing healthcare and long-term care services and reflects how these co-operatives are running the "Community-based Integrated Care System" through the analysis of a quantitative survey conducted by the author. Chapter 3 explains elderly care under the state of emergency, declared in April 2020. Chapter 4 outlines the interview research and also demonstrates the characteristics of "Minami Iryoh Seikyo" (Minami Health Co-op) as an example of Japanese Health and eldercare co-operatives. Chapter 5 describes a case of "Community-based Integrated Care System" organized by a health and eldercare co-operative during the COVID-19 pandemic. The interview targeted the Minami Health Co-op, an organization active in the southern area of Nagoya City. The Minami Health Co-op is one of the organizations that contributed to our quantitative research in 2016-2017. Chapter 6 presents the conclusion of this paper.

Literature Review

Healthcare and long-term care by Co-operatives in Japan

The concept of "co-production" has been discussed since the 1970s has been inherited by the field of civil society research or third sector research. Service quality can be improved by identifying the bureaucratism in public services and by users who participate in the production process of public services. "Co-production" refers to co-operative work by which public service providers, users, and citizens contribute to the provision of public services. In recent years, "co-production," which is different from its primary meaning, has been used in many scenarios. To clarify these differences, the Public Administration Regime (PAR) by categorizing it into four types: traditional public administration, new public management, new public governance, and communitarian [3]. The traditional public administration regime assumes that everyone will be treated equally, and public services will be provided by public servants. Service quality is determined by bureaucratic standards, and the policies made by professionals are emphasized. The new public management regime is based on public choice theory and pursues efficiency and lower costs to provide public service. This concept manifests against a background of criticism for inefficiency of the traditional public administration, promotes the commercialization of public service, and tries to increase the productivity of the public sector. New public governance is based on network theory and shares the responsibility of public service provision among various actors. The root of this concept is participatory democracy or neo-corporatism. A public service is operated through a network or partnership, and the third sector and social enterprises play critical roles. A citizen is defined as a co-producer of public services. The communitarian regime is based on a combination of theories: market, community, volunteer, and charity. Citizens are responsible for producing the services they need. Because service provision takes many shapes and ways, it is difficult to continuously provide high-quality services.

The role played by citizens/users and professional staff. New public governance is based on the idea of establishing a partnership between citizens and the government, where citizens are considered co-producers of public services. New public governance emphasizes collaboration and negotiation between partners, regardless of whether they are public, private, or nonprofit. User participation and mutual dialog between service users and staff replaces professionalism or competition as the main guarantee of service quality.

Health and eldercare co-operatives in Japan

There are two common types of co-operatives. There are producers' co-operatives where a producer (provider) is a member and consumers' co-operatives where a consumer (user) is a member. Although co-operatives comprising medical doctors as producers' co-operatives exist in other countries, the Japanese co-operative is different because it consists of local residents (users) and professionals (providers), with both parties being capital investors, sharing equal rights, and defined as operators.

There are two different groups of healthcare and eldercare co-operatives: the National Welfare Federation of Agricultural Co-operatives and the Japanese Health and Welfare Co-operative Federation. Both co-operatives provide health care and eldercare and are expected to build the "Community-based Integrated Care System." Around 5% of healthcare services and 3% of elderly care are provided by these two co-operative organizations as third-sector organizations in Japan.

The idea of co-operation in Japan came from Europe at the beginning of the 20th century. The first healthcare co-operative in Japan started in a small village called Aohara-mura in 1919 (JA Zenkoren website). The residents of this farming community did not have a doctor, so they opened a clinic by financing and recruiting a doctor. Similarly, in Tokyo, a co-operative clinic was opened and provided health care for those who were poor and in need. It can be said that co-operatives focused on providing universal health care for all. The Japanese healthcare system was premised on a free market in 1874. This system was different from European countries, where the government set up healthcare institutions.

"Co-Producer" of health care and eldercare

According to a previous research, 70% of municipalities highlighted several challenges in the co-production of healthcare and eldercare, such as "not knowing how to encourage and motivate residents to work as volunteers" and "it is quite difficult to coordinate among professionals and organizations." About half of the "Community General Support Centers" that are expected to function as a hub for "Community-based Integrated Care Systems," argue

about financial issues such as "they do not have enough manpower although they have many operations and tasks". The majority of the "Community-based Integrated Care System" should be categorized as per the "communitarian regime". The role of citizens (volunteers users/patients) might be "enforced" housekeeping provider in this regime or users might be passive beneficiary without participation.

However, the "Community-based Integrated Care System" managed by the co-operative health and eldercare is different from the public sector-managed system. They have several channels to talk about their ideas and opinions for providers and professionals. They are active in investing or donating for funding providers' health and eldercare work. Many users also feel that their voices are heard, which means that there exists a well-established venue where volunteers and users can express their views and ideas. It is also important to note that it is not just about being able to voice their opinions but knowing that their voices are being paid heed to. Organizations of co-operatives seem to maintain an active dialog between stakeholders. Volunteers, users/patients, and professionals talked to each other more than at public hospitals, and citizens (volunteers and users/patients) are satisfied with the service quality of the co-operatives.

Health and eldercare co-operatives contribute to their communities in other ways. Co-operatives contribute to the elderly by promoting health and preventing health issues. They provide not only health and eldercare services but also impart other social values. A community-based integrated care system created by co-operatives should categorize the new public governance regime [4]. Citizens are co-producers of health and eldercare, and professionals of co-operatives are collaborative in nature. Users' and volunteers' participation leads to mutual dialog and collaboration with the staff.

Elderly care under the declaration of the state of emergency in spring 2020

The number of COVID-19 positive people at the peak of each subsequent wave surpassed that of the first wave. While the number in the first wave is not statistically significant, the real number would have been much larger than the official figure, considering the fact that PCR testing in Japan was less compared to other countries. The Ministry of Health, Labour and Welfare reports the number of people who tested positive and the number of people who passed away due to COVID-19. However, they do not offer a detailed breakdown of the figures, such as the death toll in long-term care facilities. Kyodo News Service conducted a survey targeting municipalities to determine the infection status in long-term care facilities until May 8, 2020 [5]. According to the survey results, 700 people (474 users and 226 care workers) were infected with COVID-19, of which 79 patients died. In home care services, 238 people (164 users and 74 care workers) were infected, of which 9 succumbed to the disease.

The survey reported that the ratio of long-term care facility users in the overall COVID-19 death toll was 14% in Japan, which was significantly lower than that in other countries. For example, a considerable number of nursing care facility users passed away due to infection in New York, US, and Lombardia Region, Italy, where nursing care facilities accounted for about a third of the overall death toll by the spring of 2020.

As a reason behind the low COVID-19 death ratio in long-term care facilities in Japan, identified five characteristics of long-term care facilities in Japan as contributing factors. First, only a limited number of elderly people are admitted to care facilities. Second, the care facilities are small in terms of size. An American study focusing on nursing homes considered facility size to be a significant risk factor for death. Third, the organizing bodies of long-term care facilities in Japan, which are mainly social welfare corporations, closely follow administrative instructions. During the first wave of COVID-19, the MHLW was quick to issue instructions to long-term care facilities as early as January 31, with a directive to deal with COVID-19. This eventually led to the temporary closure of long-term care facilities by the end of February [6]. Fourth, an infection management framework was established, which is an obligation for all long-term care facilities in Japan. Each long-term care facility in Japan has committees for almost all major infections, which are tasked with preparing infection control manuals and constantly checking the implementation status and effects of infection control measures. Finally, the fifth factor is the high education level of the staff, unambiguous personnel requirements, and eligibility requirements within the facilities.

Government policy

During the first state of emergency, the Ministry of Health, Labour and Welfare positioned long-term care services for elderly people as an essential service equivalent to healthcare and requested long-term care facilities and home care service providers to remain open. However, according to the law, day care services and short-stay services are subject to the business closure request of the prefectural government. Despite this, there has been no such request made on day services or short-stay services. Some home care service providers voluntarily suspended their business to prevent the spread of infection from infected individuals or individuals in close contact with the infected. In the case of short stay or day care service providers, the law requires them to procure alternate services when they are closed. To respond to this need, the staff of the providers visited service users' homes to provide visiting care services.

There was a payout of a special fixed-rate benefit at 100,000 yen (750 euros) per person in May. Initially, the program was for low-income people, but it was later expanded to include the entire population in Japan to ensure that the cash reaches people as soon as possible.

Service users and their families

As mentioned above, long-term care services were provided during the state of emergency, but the users refrained from using the services for the fear of contracting COVID-19. In many cases, it was the family members who stopped their elderly parents from using the services. In addition, during the state of emergency, many workers were encouraged by their employers to work from home and were therefore able to look after the elderly at home. That said, the arrangement forced working family members to bear a significant burden as care providers while working. At the same time, the conditions of the elderly people staying home worsened in terms of frailty, typically manifesting as deteriorating ambulatory function and destabilized mental condition.

Staff

The workload of frontline long-term care service staff increased due to the infection countermeasures. Staff members with small children had to spend more time looking after their children at home because of school closures. Some staff slept at the facilities or in their cars after work to avoid accidental infection spread to their family members.

Because Japan was not well-equipped to conduct PCR tests effectively, healthcare workers and elderly care workers could not voluntarily receive PCR tests to reduce their concerns for possible infection. Local public health centers were responsible for the management of PCR tests, but they only allowed individuals to undergo PCR tests after they had a fever for four days. In addition, local public health centers determined who was eligible to take the PCR test and limited the eligibility to those who had fever and were suspected of the infection or individuals in close contact with the infected.

In June 2020, the government decided to pay a "special bonus" to workers in healthcare services, elderly care services, and welfare services for people with disabilities. This "special bonus" was for care workers, both full time and part time, who worked for at least ten days after the first infection case in the prefecture they work in. They were given 200,000 yen (for each of those who handled infected individuals or individuals in close contact with the infected) and 50,000 yen for the other staff through their employers. In the nursing care sector, only a few were granted 200,000 yen, while most of the workforce received 50,000 yen (about 375 Euros) each. In addition to the special bonus, the low average salary of the nursing care staff came to light. While the average monthly salary of ordinary laborers is 350,000 yen (about 2625 Euros), elderly care staff's average salary is 220,000 (about 9200 Euros) [7]. Owing to elementary and junior high school closures, there were home care workers who had no other choice but to take days off to look after their children, which resulted in a further reduction in their salary.

Care providers

After the declaration of the state of emergency, the number of home care services going bankrupt increased. Home care service providers (specialized in home care services, day services, among others) in Japan are typically small businesses, of which 60% are run privately, and 66% of home care services and 70% of day services are run by commercial companies (2020). Care service providers receive long-term care premiums based on the volume of services provided in the LTCI system. For these companies, a decrease in the number of service users is a severe blow to their finances. Furthermore, day service providers often provide services in small spaces, where sufficient social distance is impossible if all users visit their facilities at once. For this reason, service providers with limited space had to reduce the user headcount per day. If there were any infected cases among the users or staff, they had to close the business.

In an effort to support home care service providers, the government relaxed the conditions of the long-term care premium and provided preferred lending schemes; however, smaller businesses had no savings to keep their operations running. Bigger business operators succeeded the users of the bankrupt day services, with which they increased the user base and stabilized their businesses.

How did health and welfare co-operatives work during the pandemic?

The aim of this research is to clarify how health and welfare co-operatives worked during the COVID-19 pandemic in the spring of 2020. The subject of this research, Minami Health Co-op, is one of the co-operatives that participated in our quantitative research in 2017. The interview research was conducted on July 7, 2020, at the Minami Health Co-op. There were four interviewees-a standing director of the Minami Health Co-op, a consultant of the Minami Health Co-op Board of Directors, the Head of the Community Support Center in the hospital, and the head of the long-term care service for the elderly. The interviewees were asked to talk about events that occurred in the provision of health care and long-term care for elderly people by the Minami Health Co-op during the first state of emergency declaration from February 2020 (when COVID-19 was spreading in Japan) to July 2020. The interviewees were also asked to talk about the reactions and actions of the staff members and local residents (co-operative members, service users and their families, local residents) in response to these events.

Minami health co-op as user-owned health and eldercare

A health care and eldercare co-operative is a co-operative that provides health care and long-term care for elderly people. A total of 108 co-ops are members of the Japanese Health and Welfare Co-operative Federation, and they own hospitals in 75 locations (12,300 hospital beds) and have 1000 long-term care services (2019). The Minami Health Co-op is part of the Minami Health Co-op's Hospital in the southern part of Nagoya City. In 2010, the location of Minami Health Co-op's Hospital was moved to its current location. The Minami Health Co-op Hospital has 26 departments and 313 beds. It is not designated as a medical institution for infectious diseases and does not have beds, especially for patients infected with COVID-19.

Co-op members who were local residents outlaid two billion yen as an "investment" for the cost of the ten billion yen (7.5 million Euros) total construction cost. This means that Minami Health Co-op's Hospital is a user-and resident-owned hospital.

The activities of the Minami Health Co-op began as a result of the damage inflicted by the Ise Bay typhoon of 1959. In this region in the south of Nagoya City, three-hundred thousand residents suffered damage and five thousand residents were killed by the typhoon. Two years later, in 1961, the local residents founded a health care co-operative and began a small clinic because they felt the necessity of health care closer to the residents. When the universal healthcare insurance system began in 1961 in Japan, the Minami Health Co-op developed greatly as a regional healthcare institution in the high economic growth period from the 1960s to the 1970s.

The current business of the Minami Health Co-op is wide-ranging, from health care and long-term care to housing for elderly people. In the healthcare division, as well as the Minami Health Co-op Hospital, there are also two other small hospitals, five local clinics, and a dental clinic. These places are operated based on the national HCI system. Further, in the long-term care division, the co-operative operates nearly all home care services included in the national LTCI system, including group living for elderly people with dementia, home care services for long-term care facilities, and service housing for elderly people.

The Minami Health Co-op is active and comprises approximately 100,000 members in southern Nagoya City and the surrounding municipalities. Nearly 80% of the residents are co-operative members in the area of Minami Health Co-ops' Hospital, and it can be said that the health care and long-term care are operated by the local residents.

"Investment" by local residents

The fact that local residents themselves contribute money to create necessary long-term care services is also a characteristic of healthcare

co-operatives. Local residents contributed two billion yen to the total construction cost of the Minami Health Co-op's Hospital, which amounted to ten billion yen, as mentioned above. The Minami Health Co-op collects approximately three billion yen (2.3 mil Euros) in annual contributions from its members, and this equates to each member contributing about forty thousand yen (300 Euros). Contributions are refunded when a member leaves the organization. There are also elderly members who contribute one thousand yen (7.5 Euros) each month when they are hospitalized.

Health and eldercare co-operatives, including Minami Health Co-op, hold annual meetings of member representatives from May to June every year. At the meetings, they report activities that have been carried out over the year, announce the project plan for the year to come, and aim to build a consensus among the members. This highlights the democratic management of health and eldercare.

"HAN" (a small group, the Minami health Co-op local organization

The Minami Health Co-op has 100,000 members. In southern Nagoya City and surrounding cities, there are 130 branches, which are activity bases. There exist as many as 1,800 "HAN" groups, which are organizations that conduct activities at the neighborhood level (2020). The "HAN" groups, in particular, are noteworthy, when we consider health and eldercare co-ops. If three neighbors or friends come together, they can register as a "HAN" group. Activities conducted by "HAN" groups are called "HANKAI," or HAN meetings, and fifteen thousand HAN meetings were conducted in the year 2019. There are various HAN activities such as physical exercises for health promotion, lunch meetings, and history study meetings. Thus, HAN meetings demonstrated their effectiveness during the COVID-19 crisis.

Service users and residents create health care and elderly care

During its history, Minami Health Co-op conducted the "Build a long-term care provider for each block" and "Let's find one thousand staff members" campaigns. As part of the "Build a long-term care provider for each block" campaign, co-operative members who are local residents think about what kind of long-term care service is necessary for the area in which they live. They look for places and plans to gather funds for construction. Through this campaign, the Minami Health Co-op has successfully found former factories and old private houses, and started long-term care services such as group living for elderly people with dementia, day care services, and short-term stay care services in their community.

As part of the "Let's all work together to find one thousand staff members" campaign, co-operative local members try to find doctors, nurses, care workers, and other healthcare workers among their friends and neighbors, who are not working due to retirement or some other reason.

A shortage of health care and elderly care staff is serious; however, owing to this movement, over two thousand staff members have been found for the Minami Health Co-op during the last ten years. In particular, the campaign has led to the employment of over 100 care workers. It is said that staff members found through local networks are less likely to leave their jobs and more likely to be suited to it than staff members recruited by private human resource agencies.

"Co-production" during the COVID-19 pandemic at Minami health Co-op

The Minami Health Co-op confirmed its "Policy to respond to the COVID-19" at the member representatives annual meeting held on June 28, 2020. The response policy comprises the following seven items:

- Co-operate with the municipalities and local people, and take good care of the elderly, the sick, those infected with COVID-19, and their families.
- Co-operate with those around us and put effort into carrying out prevention activities.
- Continue health care, long-term care, welfare services, housing, and other businesses of Minami Health Co-op, while putting the safety of the staff, patients, and users first.
- Minami Health Co-op businesses should also care for people who show symptoms of COVID-19 infection.
- Use the "Help-each-other sheet" ("Otagai-sama sheet") and expand the network of trust in the region. With respect to things we can do, actualize actions one by one.
- Share information about infections in the community.
- These activities shall be continued until the national or local government issues a declaration of safety.

An interesting point was that staff members working in the areas of health care and long-term care (doctors, nurses, care workers, etc.) and local residents (co-operative members, service users, and their families) spoke with each other with respect to health care and long-term care in the COVID-19 pandemic, and formulated a shared policy. It is noteworthy that the COVID-19 pandemic response was also not led by specialists, and that local residents took an active part in the response as service users. This response policy was created after the first state of emergency declaration, but the policy can also be seen in the health care and long-term care provided by the Minami Health Co-op, which was observed at the time of the pandemic. Rather than describing this response policy as something that was suddenly formulated due to the COVID-19 pandemic, it can be described as something that followed as an extension of co-operative member activities.

Response to a COVID-positive patient in the hospital

It was confirmed that a female patient in her seventies admitted to the hospital from a long-term care facility for pneumonia one week prior had tested positive for COVID-19 on the evening of February 29. The patient's condition was critical, and she needed an artificial ventilator. The number of people who tested positive in Aichi Prefecture, where the Minami Health Co-op worked, was still only twenty-nine at that time. Seven specialists, including a nurse authorized to manage infection, established an infection control team. Pneumonia inpatients were at a high risk of infection, so they were all moved to private wards. Forty-two people, including eight doctors and twenty-eight nurses who had worked in the ward where the female patient had been, were instructed to stay at home. Next, a press conference was held at 11:30 pm on the same day, and efforts were made to share accurate information with the local community. Because the Minami Health Co-op's Hospital was not a designated medical institution for infectious diseases, it did not have the facilities to accept patients suffering from infectious diseases. There was still no response in terms of patients suffering from infectious diseases on a nationwide scale, so information regarding suitable responses was

unavailable, and everything had to be decided by the organization. However, it must be mentioned that they let the society know that they were experiencing a state of emergency that same day, a response typical of Minami Health Co-op, which always discusses the importance of sharing information.

Two more inpatients were confirmed as positive cases, and these two were also inpatients who had come from the same long-term care facility as the first patient. Among workplace confusion caused by experiencing the situation for the first time, in order to share information between staff members, patients, and local people, staff members of the community support center in the hospital issued a newsletter daily and distributed it to staff members and patients, trying to share information from inside and outside the hospital.

Voluntary movements

The local members of the Minami Health Co-op discussed what they could do in the emergency state. They were not medical professionals, so they were not permitted to enter the hospital. They imagined that both the patients and staff members in the hospital would feel uneasy, and decided to send 300 cards with messages on them to all the patients in the hospital. Further, so that the patients and staff members could relax, even if just a little, about twenty co-operative members held a dance performance at three o'clock in the afternoon, at the hospital. Smiling faces could be seen through ward windows. In addition, a trolley sales service was started in the hospital based on the idea of a local member. Ice-cream, candy, coffee, and so on were sold in response to requests from inpatients. Since outpatients were not accepted at that time, staff members in the outpatient care areas participated in the trolley sales service.

Response to home care services

At the end of February 2020, users were found positive at three day care service providers in Nagoya City. As a result, day care providers in a part of Nagoya City were ordered by the Mayor to suspend business for two weeks. A request was made for home care to be continued even if there was a high-risk contact (i.e., being exposed to a person who tested positive for COVID-19).

During these two weeks, study sessions on infection control aimed at staff members engaged in home care were held in the Minami Health Co-op home care service division. Staff members working in home care services, in particular, had little knowledge of infection prevention. Usually, home care workers do not wear uniforms, and instead wear aprons while they work. They did not change their aprons before visiting the next person they cared for. However, in the midst of the COVID-19 crisis, it was necessary to change aprons each time they visited the home of a person utilizing their care services. Disposable aprons are worn as a matter of course in health care, and it was decided that they would be worn by home care workers as well. Further, the home care workers used paper towels in the course of their work, but rather than using those from the care utilizers' homes, they used the ones they took from their office. Gloves and goggles had never been used in home care; however, in order to protect themselves from the COVID-19 infection and not let the people who utilized the care become infected, the home care workers utilized their own originality and ingenuity to prepare "hygiene kits" which they used at work. They were able to invite Minami Health Co-op Hospital nurses who specialized in infection at the study meetings, and the nurses were also able to respond to the anxiety of the care staff members. Study meetings that nurses were invited to were held repeatedly, and this was effective in eliminating the anxiety of the care staff members.

Care managers and those responsible for the home care service providers were able to check the safety of elderly people who utilized LTCI services. However, the percentage of elderly people was about 15% of the total number of elderly people, and nobody, including government authorities, could fully understand the conditions of the lives of elderly people living alone. They felt that no one, except local residents, could understand the troubles of the elderly people who lived in the local community.

Response of long-term care facility and service housing for elderly people

At the long-term care facility, no visitors from outside were allowed in. In response to norovirus and influenza, the facility closed its doors to the public when the number of infected people increased, so the same method was followed. There is a palliative care ward at Minami Health Co-op's Hospital. Most of the patients occupying the 15 beds in the palliative care ward were aged, terminal cancer patients. These patients usually spend leisure time with their families or volunteers; however, with the state emergency declaration in force, meetings with family and visitors were restricted. The staff members who worked there imagined how hard it would be to spend your precious remaining time alone, and in particular worried about how infection prevention measures should be for elderly people who require nursing care. Eventually, it has become possible for patients in the palliative ward to meet their family for approximately 10 minutes a day. The suggestion has come from patients' families and volunteers who work for them except the declaration, and the staff and the hospital accepted it.

The response to COVID-19 at the serviced housing for elderly people was quite different. Serviced housing for the elderly is regular housing, and those who live there are independent. Therefore, meetings with outsiders and outings cannot be prohibited, as they can be in other long-term care facilities. The Minami Health Co-op planned a study meeting for elderly residents. These meetings gave them opportunities to learn that it is important to protect them against the risk of infection.

Face mask-making and distribution

The Minami Health Co-op has a mutual help network system that connects staff members who work in health care and long-term care services with local residents. The Community Support Center (Chiiki Sasae-ai Center) involves health care, long-term care services, and residents in the local community.

Japan faced a serious mask shortage from February to June of 2020. Hospitals, long-term care facilities, and home care service providers also lacked surgical masks. A serious situation occurred in which a doctor at a university hospital could only use one surgical mask per week.

Prime Minister Abe stated that surgical masks would be sent out to medical institutions, and two cloth masks would be distributed to each household to counteract the mask shortage at a press conference in April 2020. A total of 26 billion yen (197 million Euros) was spent on distributing cloth masks to each household. However, the masks were distributed to each household in June, and by then people were already able to buy masks at shops. Furthermore, the distributed cloth masks were small, and they were not very effective in preventing infection.

The public and mass media criticized the government's response to the lack of face masks, which is a symbolic topic demonstrating the slowness of action on the part of administrative agencies in times of an emergency, thus proving their lack of insight into the general public's lives.

Discussion

Staff members who worked at long-term care facilities felt very glad and said, "We've been using the same mask for a week-we'd like a new one." Local residents who heard the requests of the staff members through their Community Support Center and felt the seriousness of the mask shortage began making masks themselves, using old clothes. First, they delivered handmade masks to care workers in long-term care facilities and home care providers. They then distributed masks to the elderly people in the neighborhood. Local residents were able to ascertain the safety of the elderly by delivering masks to the neighborhood, and they put elderly people who had become unwell in contact with Minami Health Co-op's Hospital or their Community Support Center [8]. At the time, there were many people who feared infection and hesitated to visit other people; however, distributing masks created opportunities for people to talk with others in their neighborhood as well. The face mask is a reasonable tool for elderly people in the community to communicate with each other.

Study sessions (HANKAI) to prevent infection

While the first state of the emergency declaration was in effect, many volunteer activities were suspended all over Japan. During this period, people were asked to reduce their contact with other people by 80%. Elementary and junior high schools were closed, and even in the workplace, people were asked to work remotely from their homes. Further, volunteer activities often utilize public facilities, and the fact that their use was prohibited also had an impact on them.

However, Minami Health Co-op members found that there were many elderly people who were worried about spending time alone at home, and looked for ways to restart their activities as much as possible. When distributing masks in the neighborhood, they came across elderly people who were troubled because they were unable to go shopping, and met other elderly people who had deteriorated physically because they did not go out for a long time. They thought that if the situation continued this way, the healthy life of many elderly people could not be maintained.

Local members decided to start study sessions at home for small groups of people, and they invited health care specialists who worked at the Minami Health Co-op. Local members acquired knowledge about preventing infection through the study sessions. "Worry correctly" is the slogan of the people of the Minami Health Co-op, and this means protecting yourself by obtaining correct information. The concept "Worry correctly" means that people should be careful regarding COVID-19, but also have the correct knowledge.

The habit of holding small-group study sessions has taken root in the co-operative society movement, and these sessions are termed "HANKAI." "HANKAI" demonstrated their effectiveness in a number of areas during the COVID-19 crisis [9]. Study sessions were held for acquiring correct knowledge about how to prevent infection. "HANKAI in a green park" was a movement to encourage people to talk while seated on park benches, in order to keep social distance, and "Walking HANKAI" was introduced to alleviate the lack of exercise that had come into being.

Further, everyone was eligible to receive a grant of 100,000 yen (750 Euros) each as a special fixed-sum grant project in May 2020 [10]. As government application forms are difficult for the elderly to fill out, local members started "HANKAI" for elderly people to fill out the application forms and invited care managers in Minami Health Co-op's eldercare to act as supporters [11]. "HANKAI" was also an opportunity for the professional staff of Minami Health Co-op to fully understand the troubles of the local residents. It also provided opportunities for both the service users to get to know each other and other locals and professionals in health care and eldercare.

Conclusion

The "Community-based Integrated Care System" aims to be established in Japan by 2025. Long-term care services are provided based on the public LTCI, and health care is provided based on the public Health Care Insurance present. The Japanese government expects neighborhoods to play critical roles such as confirming safety within the community.

The network between health and eldercare providers does not work well in the top-down model of the "Community-based Integrated Care System." Co-production of healthcare and eldercare between users and professionals cannot be seen in such systems. However, health and eldercare co-operatives that have a bottom-up mechanism show the possibility of service co-production between local residents and professionals. The dialog between stakeholders (e.g., service users, residents, professionals, volunteers) is much more efficient within the co-operatives, and they have a system of voice in their decision-making process according to our survey in 2016-2017. There is a possibility that local residents become "co-producers" of health and eldercare in their community, along with professionals.

The purpose of this paper is to clarify how health and eldercare worked during the COVID-19 pandemic. How did health and eldercare co-operatives contribute toward the "Community-based Integrated Care System"? According to a private survey, 700 people (474 users and 226 care workers) were infected with COVID-19, of which 79 users passed away. In the home care service, 238 people (164 users and 74 care workers) were infected, of which 9 users succumbed to the disease. The number of infected patients in Japan was not as significant in the first wave of the COVID-19 pandemic in spring 2020, compared to European countries and the United States. The survey indicated that 14% of the infected patients who passed away were older adults who stayed in eldercare facilities.

One of the reasons older adults staying in eldercare facilities were not as affected was because the Ministry of Health, Labour and Welfare provided information to all eldercare facilities in the early stage of the pandemic. Long-term care facilities are strictly regulated to have their own infection management framework. Unambiguous personnel requirements and eligibility requirements within facilities are also regulated. Eldercare in facilities in Japan is characterized by top-down management by the central government, which has led to fewer victims in emergencies.

Home care providers are not protected by the government, unlike long-term care facilities. There were few infected patients in home care; however, a number of home care providers and day care services were closed because of financial difficulties. Approximately 60–70%

of home care and day care service providers are for-profit organizations; however, they have a small scale of business. The number of users further decreased during the pandemic because elderly users were afraid of contracting infection. This situation put pressure on the management of long-term care providers.

This paper presents an example of the Minami Health Co-op as a co-production of eldercare during the COVID-19 pandemic. During their annual conference in 2020, Minami Health Co-op proposed the slogan "infected patients should be protected." Professionals often visited communities to determine the importance of correct infection control. Local members and residents delivered the newsletter and had small meetings with professionals to study infection control.

Local members started to make handmade cloth masks and deliver them to care workers. They also started making face masks for elderly people in the community. If they found sick elderly people who lived alone, they asked for help from professionals in Minami Health Co-op's hospitals or social workers in the Community Support Center. The municipalities asked volunteers to stop their activities during the state of emergency. However, a kind of co-production of health and eldercare has continued in the bottom-up type of "Community-based Integrated Care System even during this period," as demonstrated by the Minami Health Co-op.

This relationship prevented the deterioration of the long-term care business of the Minami Health Co-op. As elderly people continued to use home care and day services, they could maintain their daily routines. The presence of local residents contributed to easing the feeling of loneliness among care workers and other professionals, and there were few employees who left their jobs. This research shows that the function of co-production between professionals and local residents was beneficial to them even during the pandemic.

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