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Topic：Issues and international trends towards the community-based integrated care system in Japan

＜Review＞

# Challenges and opportunities in the development of the community-based integrated care system in Japan: Significance of social capital within community-based integrated care system

Takako TSUTSUI

Research Managing Director, National Institute of Public Health

**Abstract**

In April 2005, the cabinet council formulated basic policies for the reactivation of communities in Japan through the Local Revitalization Act. The council, while promoting the implementation of social networks and investing in human resources, stipulated the need to stimulate the social capital inherent to each community. Meanwhile, the Ministry of Education, Culture, Sports, Sciences and Technology (MEXT) as well as the Ministry of Economy, Trade and Industry (METI) also examined the possibility of supporting social capital. It was at the same time that the long-term care insurance system was reformed.

This reform promoted the implementation of a "community-based integrated care system," but no mention was made of social capital. However, as the design of the system was a task delegated to each local government and considering that some governments put social capital at the core of the system, some leave it out of consideration, and some others try to cultivate a social capital adapted to the Japanese situation, significant differences between local governments in the design of the system can be expected.

The diffusion of a concept such as social capital, which describes various dimensions outside market mechanisms and monetary exchanges, probably had some influence on the design of community-based integrated care systems.

The purpose of this paper is to determine what definition and conception of social capital could be relevant for the management and implementation of community-based integrated care systems. The current state of research in the United States and in Japan is also summarized, and the reasons explaining the growing interest in social capital from the World Bank and the OECD are clarified.

***keywords:*** community-based integrated care system, social capital, local government, community

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## Ⅰ. Introduction

The Social Policy Bureau of the Cabinet Office examined the relationship between social capital and civil activities and tried to grasp social capital quantitatively [1]. In recent years, research institutes from various ministries have also started to conduct research on social capital.

In April 2005, the cabinet council formulated basic policies [2] for the reactivation of communities in Japan through the Local Revitalization Act. The council, while promoting the implementation of social networks and investing in human resources, stipulated the need to stimulate the social capital inherent to each community. Various reasons could explain this decision. For example, the shift towards an information-based society and the aging of the population have led to the fear that citizens may be less and less inclined to transcend their respective social positions to actively help each other. Moreover, based on the view that fostering and strengthening relations

2-3-6 Minami, Wako, Saitama, 351-0197, Japan.
Tel: 048-458-6111
Fax: 048-458-6715
E-mail: tsutsui@niph.go.jp

between people within a community will lead to a more fulfilled and peaceful life, the tasks of increasing the social capital and resolving various policy issues started to be seen as two faces of the same coin and as related processes that needed to be addressed.

The Ministry of Education, Culture, Sports, Science and Technology (MEXT), in the "Research paper on the future information technology strategy [3]" of March 2005, described the conditions for building a society that values lifelong learning and stated that: "It is necessary to implement measures for lifelong learning according to the new concept of public sphere with the three different levels mentioned below. By implementing such measures, it seems possible to increase social capital".

The Ministry of Economy, Trade and Industry (METI), in the chapter "Paradigm of the manufacturing industry in harmony with the twenty first century [4]" of the "National manufacturing strategy" report of November 2005, described a socio-economic system for relations between companies and argued for the need to accumulate, in this relational space, a social capital for human networks that supported trustful relationships.

The Cabinet Secretary also published a paper in February 2006 entitled "Public policies for the revitalization of communities [5]" (revision). The first paragraph ("Promoting networks and developing human resources") of chapter one ("Promoting and supporting innovations and wisdom") describes local companies, educational institutions, public institutions, and various organizations as leaders for the promotion of communities. These various organizations include non-profit organizations (NPOs) created for a specific purpose, such as welfare or urban development, as well as all the associations involved with community activities. The paper recommends reactivating those organizations, clarifying the purpose of each leader within the community, and planning a system of goals to achieve within a given period and according to a common theme important to the community. With this paper, the Cabinet Secretary clearly considered the function of mutual help within a community as social capital.

Reports from the two ministries mentioned previously also suggested the need to improve and accumulate social capital. METI, when speaking of accumulating social capital, clearly believes that social capital can be grasped quantitatively. However, MEXT suggests, through expressions such as "improvement of social capital," that it is a functional capability.

Those documents from the ministries and from the Cabinet Secretary show how the term "social capital" can be understood and used differently, even on the same governmental level.

This lack of a clear definition and the ambiguous use of the words did not stop MEXT from using widely, along with the mass media and politicians, the catchphrase "a new public sphere" as if it were a completely different and new area of social security.

After the 1990s, the Ministry of Health, Labour and Welfare (MHLW) recognized the need [6] to change the traditional local community by introducing community healthcare and community welfare through the implementation of the Long-Term Care Insurance System in 2000. This system was designed to allow elderly persons in need of care to live and stay longer at home and was used as a trump card that could substitute for the old system of self-care and mutual help.

However, the Long-Term Care Insurance Act was revised in 2006 to create a system that not only simply focuses on home care but on community care by implementing community-based integrated care centers and building new living environments. Because this revision and the interest from the ministries towards social capital started at the same period, it seems likely that the improvement or the accumulation of social capital was also evoked when the community-based integrated care system was designed.

However, as the system was designed to be a task delegated to each local government and considering that some governments put social capital at the core of the system, some leave it out of consideration, and some others try to encourage a form of social capital that has been adapted to the Japanese situation, significant differences can be seen between local governments.

The purpose of this paper is to investigate the meaning that social capital may have in the context of a community-based integrated care system. In the process, after revealing a fallacy that tends to occur in research on social capital, this paper also suggests a new way of considering social capital that may be more relevant when designing and managing a community-based integrated care system.

## Ⅱ. Worldwide growing interest in social capital and current state of research in Japan

### 1. Context behind the growing interest in social capital

Since 2000, the growing worldwide interest in social capital (including in Japan, where it has been acknowledged as part of "a new public sphere") has been clearly linked with a notable decline of the United States. The economic crisis that followed the terrorist attacks on the United States as well as the shift in the industrial structure seriously deteriorated the public service spirit and the faith of the middle class in social stability. This explains the need

for a major overhaul in the United States.

This decline in the United States that led to the growing interest in social capital goes along with a decline in social democracy and of the welfare state in many European countries.

The deterioration of social capital in America started after the oil shock of the 1970s and the large-scale downsizing strategies of companies. These events weakened the middle class, which is at the core of social capital, and subsequently led to the deterioration of local communities.

Social capital can be seen as a favorable means to increase the public service spirit and to dispel distrust towards the market, or as "a concept that includes various dimensions outside market mechanisms and monetary exchanges that influence economic performance [7]". The important part here is that the economy is influenced by elements outside the market.

According to Sato Hiroshi, those elements outside the market became the center of attention for the following reason: "As globalization and the gap between rich and poor kept expanding, even the World Bank, as a lending financial institution, had to be involved in not only economic but also social development and poverty reduction plans. However, in order to expand the role of the institution without entirely reforming its organizational principles, 'it was necessary to demonstrate that social development could contribute to economic development […] and to make that possible, social capital seemed to be the most appropriate concept [8].'"

This explanation originally applied to the World Bank but is also valid when trying to explain the growing interest in social capital in general: the context behind this growing interest is the failure of policies promoting an almighty market and structural adjustment policies.

**2. Current state of research on social capital in Japan**

Japan has taken examples from the United States in many disciplines on a conceptual and theoretical level, including in areas of social sciences such as economics, development studies, politics, and policy sciences [9, 10].

In recent years, some experimental studies have also been conducted in Japan [1, 11]. The Cabinet Office conducted two generic surveys on social capital entitled: "Social capital: creating a virtuous circle of rich relationships and civic activities (2003) [1]" and "Research paper on social capital and the revitalization of communities (2005) [12]".

Much research focuses on the relationship between social capital and the health of the population. In the field of public health and social epidemiology, a particular interest has been shown in social capital, which is already acknowledged as one of the social factors influencing health conditions [13, 14]. The hypothesis according to which health conditions are positively influenced by social capital is frequently tested on a national and local level through various indicators [15, 18].

In Japan also, research results show that residents of communities with a high social capital are more likely to be healthy [19, 20]. These studies discuss how indicators such as "trust", "interpersonal relations" and "social inclusion" have a spillover effect and influence each other. Those three indicators have been combined and used as proxies to estimate the social capital of each municipality of Japan. The standardization and the calculation of those indicators on a local level revealed the correlation between them and confirmed the spillover effect between their component elements [1, 12].

As an attempt to understand why Japanese people had the longest life expectancy in the world, Ichiro Kawachi compared Japan and the United States and found that even though the United States was above Japan in terms of gross domestic product (GDP), rate of healthcare expenditures over GDP, disposable income, house size, smoking rate, alcohol consumption rate, and hereditary components, Japanese people still had a longer life expectancy than Americans. After hypothesizing that the reason could be that there is more economic disparity in the United States and that Japan has a higher level of social cohesion in the workplace and in communities, research was conducted to prove empirically that people living in communities with high social capital and low economic disparity were more likely to be healthy [21, 22].

Similarly, Kondo has been carrying out group research and has conducted a series of surveys since 2003 with 32,891 elderly persons in 15 municipalities (in three different prefectures but mainly in Aichi prefecture) through self-reported questionnaires sent by mail and investigating: "Subjective feelings of healthiness", "Drinking and smoking history", "Length of education", "Equivalent outcome", "Existence or non-existence of a disease currently treated", "Administrated medication", "Fall history", "Force of mastication", "BMI", "Auditory disorders", "Visual impairment", "Elimination disorders", "Tendency to depression", "Sleep-related information", "Average walking hours per day", "Frequency of going out", "Relationship with friends", "Social Support", "Social integration", "Work", "Engagement in domestic work" and "Proxies of social capital" (including questions such as: "Do you trust people in general?"). The results from this study also indicated that people in communities with high social capital are more likely to be healthy [14, 23, 24].

Moreover, the possibility of introducing the concept of

social capital in the field of community healthcare and especially in health promotion activities involving residents has been debated [25] because the comprehension of the nature and quantity of social capital that may enhance coordination between various organizations is crucial for those activities. From a similar point of view, it has been pointed out that grasping the quantity of social capital in communities is beneficial for health promotion activities [26].

In the field of health promotion activities involving residents, the activities of searching for a leader in the community, promoting collaboration between organizations and building trustful relationships within networks are now described in terms of assessment and development of social capital. This shift has allowed for former community healthcare activities conducted for example by public health nurses to be considered as activities for the development of social capital and has led to greater public recognition of those activities.

The meaning and importance of those activities used to be hard to grasp and communicate, but using the concept of social capital helped to describe outcomes in a new way [27] and revealed the formerly tacit competence of people and public health nurses working in the community. From this point, social capital started to evolve as a sort of omnipotent tool.

The importation of indicators of social capital in the field of public health in Japan made it possible to take into consideration various public health activities already conducted and their results. This means that the use of those indicators was just an attempt to make apparent the outcomes for this type of activity.

Most of the research mentioned above came to the conclusion that people in communities with a high social capital show better health performance. Thus, those studies revealed a correlation between some health indicators and the civic culture underpinning communities, currently rephrased as “social capital”.

Putnam’s research on social capital was originally based on civil society and the civic culture of modern European countries. Thus, the method used to grasp social capital may not apply directly in the Japanese context.

However, even though the civic culture and the social communities may be different in Japan, recent research on Japan has still been able to measure, at least partially, the same social mechanisms (networks, norms, trust) that Putnam aims to measure and which are supposed to increase the efficiency of society and the collaboration between people.

Currently, many studies are still at the stage of establishing relationships between health indicators and indicators of social capital. Thus, very few studies are focusing on how to improve or accumulate social capital.

It may also be interesting to discuss the quality of social capital in future research in Japan.

## Ⅲ. Relationship between social capital and community-based integrated care

The fact that the Cabinet Office chose to support comprehensive studies on social capital tends to prove that, in Japan also, social capital was created to overcome the failure of policies promoting an almighty market and structural adjustment policies.

Bourdieu defines three forms of capital: economical, social and cultural. Moreover, he suggests that economic capital is at the root of the two other types of capital. He also argues that labor time is the key to convert one form of capital to another. To make this transformation, it is necessary to take into consideration both the labor time accumulated in the form of capital and the labor time needed to shift from one type to another. For example, to convert economic capital to social capital, it is necessary to produce unpaid work such as “paying attention, taking care, and being thoughtful”. Even though this may be considered as a loss from a strictly economic point of view, social exchange theory considers it as a long-term and profitable investment.

The theory of Bourdieu seems relevant to explain the type of social capital that the MHLW is trying to promote in the community-based integrated care system. According to this theory, it can be said that the long-term care insurance system has succeeded in transforming unpaid work such as the “taking care” part of “paying attention, taking care, and being thoughtful” activities to paid work, or economic capital, by creating a market for this activity.

The remaining “paying attention and being thoughtful” activities, which clearly used to belong to social capital before 2006, are also being converted to economic capital through the implementation of “housekeeping and daily life assistance services”.

The time when the MHLW had to take a position on the community-based integrated care system coincided with requests from many researchers and citizens’ organizations to cover those services by long-term care insurance [28]. The decision made by Japan to transform some social capital to economic capital was greatly influenced by the decision to respond or not respond to this request.

However, the MHLW did not make a long-term and profitable “investment” as defined by Bourdieu. Ever since Putnam’s work was reported, there has been no doubt that the bond between individuals and between groups, within a family or a community, and which is built on trust,

networks, and social connections (which defines social capital) is a social resource. The relevance of this resource for economic output is also undeniable.

Social capital used to be considered as a precious and invisible resource in Japan, but recent research and governmental surveys are clearly trying to make this resource more apparent. Even though a full understanding of social capital is probably not possible or even relevant, implementing such a concept has enabled greater recognition of the value of social capital.

The MHLW introduced the concept of community-based integrated care when planning the paradigm shift from "care by society" to "care by community" [29]. In other words, it was used to described the shift from a system where care is provided by the entire society to a system that allows care to be provided at a local level.

However, it is important to distinguish "community-based care" from the "community-based care system" that the government implemented and whose main purpose is to enable users to remain at home (in the community) by providing medical treatment and care services.

Reports on community-based care published in 2008 [30] and 2009 [31] describe four levels of care provision (self-care, mutual care, social solidarity care and governmental care) along with the slogan: "From care by society to care by community". These reports emphasize the idea that formal and informal care provided through the long-term care insurance system (social solidarity care) have replaced or supplemented the informal care (mutual care) provided in communities through networks or by family members.

Originally, the four levels of care provision (self-care, mutual care, social solidarity care and governmental care) were designed based on the principle of subsidiarity, which underpinned citizens' groups in modern Europe and consist in taking decisions at the smallest level possible and allowing intervention from a higher level only when it was not possible to do otherwise. In other words, this principle specifies the role and order of intervention of individuals, associations and regional policies.

However, no order of intervention was specified for the four levels of care designed by Japan, especially for mutual care and social solidarity care, which just happen to be between self-care and governmental care (public assistance) [32].

Currently, the coordination and management of those two levels of care are important topics in the development of the community-based integrated care system in Japan. Concretely, not only the capacity of mutual care of the community and the capacity of social solidarity care of the long term-care insurance have been reviewed, but the operation manual (March 2003) for community-based integrated care centers states that: "it is necessary to design a community-based integrated care system that enables an organized management of the various social resources, formal and informal, of the community" [33]. A fallacy that generally occurs is to consider those informal social resources as social capital and thus to consider a community-based integrated care system as a structured social capital system.

However, even though social capital undeniably plays a key role in the smooth running of the system, the community-based integrated care system only integrates medical treatment and other care services and is called as such because of the way it is provided, that is, within a community. Nevertheless, social capital is crucial because it is, as Uzawa would say, the "soft part" created by smooth human relationships that allows the "hard part", that is "the social common capital", to be used efficiently.

Bourdieu noticed in regard to groups of experts that the owners of the means of production only need economic capital to obtain machines, but to use them they must have access to embodied cultural capital, either in person or by proxies such as engineers. As those executives and engineers are not the possessors of the means of production and only sell the services of making the machines work, they can be classified among the dominated groups. However, they can also be classified among the dominant group because they draw their profits from the use of a particular form of capital, that is, their cultural capital. From this, Bourdieu makes the interesting observation that the collective strength of the holders of cultural capital would tend to increase along with the cultural capital incorporated in the means of production.

If this principle applies to the smooth human relationships incorporated with social capital, then one issue that research on social capital should deal with is finding out if there are techniques that could increase this fluidity and whether there are groups of specialists who actually possess those techniques.

## Ⅳ. Conclusion

From an international point of view, the community-based integrated care system developed in Japan is an attempt to bring together integrated care and community-based care [32]. Incentives through the long-term care and medical fee system already promoted collaboration between healthcare facilities and community-based long-term care services, and the new reform of the system in 2012 will reinforce this integration of care.

Many studies conducted in advanced countries that have tried to assess the efficiency of integrated care systems

have pointed out the fragmentation of care systems and the lack of integration between primary care (private practitioners) and secondary care (hospitals). Recent studies naturally consider communication between involved parties as an important criterion [34] that is greatly influenced by the quantity of social capital.

Another field on which many studies focus on is the analysis of networks between individuals. Basically, such studies are an attempt to measure the link and relationships between people and organizations.

Specifically, those studies are trying to reveal who is speaking to whom and who isn't, who is at the center of the network, who is deciding the agenda, if people are banding together or not, and if there is cohesion or "cracks" in the network. For example, the studies by Wiktorowicz [35] and Holmesland [36] measure the degree of social interaction and investigate the possibility of estimating the value of networks and social capital.

The importance of social, economic and environmental factors has been recognized since the 1970s, and current approaches taken in studies on social capital are quite diverse [37, 38]. It has been suggested that social factors that have an impact on those factors, including political measures (for example, housing allowances, means of transport, home-delivered meals), may have an even greater impact on health than healthcare systems, individual decisions and lifestyles [39].

Concretely, evidence from organizations involved in public health suggests that low-income individuals and families have a lower life expectancy, regardless of the cause, and are at higher risk for mental, social and physical issues than people in high-income communities [39, 40]. There is little doubt that this evidence triggered the growing interest in social capital.

This was the justification that specialists from the medical field needed in order to plead for more support to be given to individuals and communities–support that transcends the framework of medical and clinical services. Measuring social capital was the means that could allow the efficiency of this new type of support to be estimated.

Thus, when considering the significance of social capital in the community-based integrated care system, it is crucial that the Cabinet Office and other researcher remember this fact and avoid the mistake of assuming that communities in Japan can substitute for mutual help and are some sort of *gemeinschaft*, in which mutual help is supposedly very active.

Communities in Japan are certainly imbued with a civic culture in a modern European sense and, fortunately, some active members of the community have developed a real "habit of heart". This social capital is now needed by the community-based integrated care system of Japan and thus, it is necessary to investigate methods to accumulate and use this precious resource without waste.

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**抄録**

2005（平成17）年4月，地域再生法に基づく，地域再生基本方針が閣議決定され，地域再生のためのひとづくり・人材ネットワークづくりの促進の中で，地域固有のソーシャル・キャピタルを活性化することが明記され，経済産業省，文部化科学省でもソーシャル・キャピタルの検討がなされ，時期を同じくして，介護保険制度の改正もなされた．

この介護保険法の改正では，「地域包括ケアシステム」の創設が謳われたが，ここにソーシャル・キャピタルが言及されることはなかった．しかし，地域包括ケアシステムの構築は，各自治体が実施する事業であることから，このシステムを構築する際に，日本的な意味でソーシャル・キャピタルを意識した自治体と本来の意味でのソーシャル・キャピタルを基礎として実行した自治体と，全くこれを考慮しなかった自治体では，そのシステムの有り様は大きく異なったものと予想される．

すなわち，ソーシャル・キャピタルを市場メカニズムの外から，あるいは貨幣価値の交換関係以外の側面から影響を与える個々の機能を言い表す概念として用いたことは，「地域包括ケアシステム」の構築には，少なからず影響を与えたことが予想される．

このような背景をふまえ，本稿では，今後の地域包括ケアシステムの整備や運営において，このソーシャル・キャピタルをどのように定義し，これを，どのように考えていくべきかを論述した．また現在のソーシャル・キャピタル研究の現状について，アメリカや日本の状況をまとめ，とくに国際機関である世界銀行やOECDがソーシャル・キャピタルに関心をもった理由についても言及した．