



International Comparative Social Enterprise Models

## Social Enterprise in Japan: The Field of Health and Social Services

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## PREFACE AND ACKNOWLEDGEMENTS

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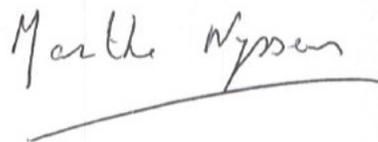
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## INTRODUCTION

In Japan, there is neither a common definition of social enterprises (hereafter referred to as SE) nor a public policy to promote them. In the last decade, the Ministry of Economy, Trade and Industry (METI) hosted a study group on community businesses, then another one on social businesses, but no consistent efforts to promote them have been made. In the academic domain, some researchers have shown interest in the emerging SE and introduced discourses from other industrialized countries, but there is very little communication among them to create a common understanding or make joint efforts to put SE on the public policy agenda. Some researchers are influenced by the North-American social entrepreneur school while the others adhere to the European EMES school, but it was just a few years ago that exchange began between them.

This does not mean there is no such phenomenon or no need for SE; a variety of practices of SE are emerging and there exist crying needs for them in the post-welfare state to cope with the increase in precarious employment and unemployment, financial difficulty in maintaining health and social services, social exclusion of disadvantaged groups and collapsing communities in both the economic and social contexts.

We can distinguish between three types of SE, which are often overlapping:

- social service provision SE, which provide health care, elderly/child care, care for the disabled, education and related services;
- work integration SE (WISE), which provide jobs for disadvantaged people excluded from ordinary labor markets;
- community development SE, which provide various services based on community needs in order to enhance local economies.

This paper will focus on SE in health and social service provision. It will give an overview of health and long-term care services in Japan, list types of service providers and compare them in light of EMES indicators. Then, it will identify health co-operatives in urban areas and *Koseiren* (agricultural co-operative federations) in rural areas as typical SE models, and explain their characteristics (mission, target groups, governance and resources) and institutional trajectories.

## 1. OVERVIEW OF HEALTH AND SOCIAL SERVICE PROVISION IN JAPAN

The Japanese health care system is characterized by the compulsory medical insurance system, weakly coordinated medical institutions on the supply side and consumer's free access on the demand side. Universal coverage under the public medical insurance system was accomplished in 1961. The entire nation is covered by one of public medical insurance schemes for workers, government employees, teachers, self-employed, the elderly etc. Most of these schemes have accumulated enormous deficits due to their obligatory contribution to finance the health services for the elderly in a rapidly aging society. This is what the government has tried but failed to solve over the past decades, often coming to deadlocks due to the power of vested interests. The insurance companies have launched private medical insurance policies to offer supplemental coverage (e.g. cancer insurance).

The supply side ranges from hospitals to community clinics (general practitioners). These medical institutions are all designated as not-for-profit entities by the Medical Service Act. There is a growing gap between oversupply in large cities and undersupply in remote areas, while the declining number of obstetrics and pediatrics departments causes problems for consumer access, even in large cities. The service providers have weak liaisons with each other, which sometimes causes failures to accept emergency patients. There is a strong tendency towards horizontal and vertical integration through the formation of hospital chains and so-called “medico-welfare complexes” which integrate medical and long term care services in the same groups. Such trends spur the commercialization of medical and social services.

The demand side of medical services is characterized by consumers’ free access to medical institutions. They can visit any hospitals or clinics but a coordinated care delivery system from primary care to more advanced care has yet to be established. This situation has resulted in heavy congestion in some large hospitals, where outpatients receive “a 3-minute diagnosis after waiting for 3 hours”. Consumers have little information with which to choose hospitals/clinics, as providers are not permitted to advertise and very little comparative information is available. The fee-for-service payment system has led to the excessive use of examination and medication, which might increase medical costs and cause side effects. The patients have to pay the extra costs for services not covered by medical insurance, e.g. advanced medicine, partially covered hospital rooms, and so on. Health promotion to prevent diseases is not covered by medical insurance.

The elderly social care system evolved in a quite different institutional framework, in which the national and local governments have the main responsibility to provide necessary relief to indigents, children requiring protection, fatherless families, elderly people with handicaps and people with disabilities, and to support their living and self-sufficiency. So-called “social hospitalization” had been criticized for enhancing costs and causing beds to remain occupied longer than necessary; indeed, elderly patients tended to stay in expensive hospitals even when they no longer needed medical care. But during the 1990s the system underwent drastic changes, from selective services based on administrative decision to universal services based on user’s choice, which have been summarized as follows<sup>1</sup>:

- Generalization of welfare services: changing from special and selective services for the poor to more general and universal services, available to anybody who needs the services, regardless of their income.
- User-oriented mechanisms and improved service quality: changing from a system in which administrative offices decide and provide certain services, to a user-oriented system where users can select and use the services they desire.
- Municipality-centered mechanism: shifting from the national agency-driven centralized administrative work for welfare to the community-based efforts for welfare services to meet the local needs.
- Normalization: increasing in-home services to support the elderly living at home and in their local communities, to be supplemented by quantitative expansion of in-facility services.
- Multi-dimensional system for providing services: shifting from “limited” providers, such as municipalities, social welfare corporations and social welfare councils, to involving other entities, such as private companies, non-profit organizations, volunteers, etc.

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<sup>1</sup> Ministry of Health, Labor and Welfare (MHLW), *Annual Report on Health and Welfare 1998-1999*.

- Co-operation among health promotion, medical care and social care providers: changing from separated services to integrated services based on collaboration among those service providers to support elderly and handicapped people.

The public long-term care insurance (LTCI) system was launched in April 2000 by totally reorganizing the existing elderly care system in combination with related medical services. It aimed to offer a large part of conventional welfare services through the mechanism of social insurance that covers the entire nation. Municipalities were designated as the insurers that would operate the public long-term care insurance system, and expected to take leadership in creating business plans for long-term care in their jurisdictions and developing infrastructure for care services based on these plans. This system was meant to replace the tax-based bureaucratic service assignment for the poorer social strata with insurance-based individual choice for all citizens so that they could maintain their human dignity by choosing the care services that they require.<sup>2</sup> It opened up competition among various types of service providers—not only the existing social welfare corporations, but also a number of for-profit companies, co-operatives, and nonprofits that have entered into the provision of home-based elderly care services.

## 2. ORGANIZATIONAL FORMS OF HEALTH AND SOCIAL SERVICE PROVIDERS

### 2.1. Health service providers

The Medical Service Act of 1948 provides the regulatory framework for health service providers. The MHLW publishes annual statistics on health services and distinguishes 29 types of health service providers, which are classified in the following 6 categories:

- state;
- public-interest institutions;
- social insurance institutions;
- medical corporations;
- individuals;
- others.

The “state” includes MHLW, state universities and other state-related organizations. “Public-interest institutions” are hospitals and clinics operated by prefectures, municipalities and other organizations designated by the Minister of Health, Labor and Welfare (Art. 31, Medical Service Act). They include the Japanese Red Cross, *Saiseikai* Imperial Gift Foundation, and *JA Koseiren*<sup>3</sup>. “Social insurance institutions” are those that operate the public pension and health insurance schemes. “Medical corporations” (MC) are founded with the governor’s approval as associations or foundations operating hospitals, clinics, and elderly health care facilities (Art.

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<sup>2</sup> Those who require long-term care (e.g. bedridden patients, patients with dementia, etc.) can benefit from the insurance, provided they are given certification by municipalities after screening judgments based on the doctor’s opinions. Benefits are determined corresponding to the level of care required, which is assessed according to a seven-level scale. The insured make contracts with service providers on the basis of a long-term care service plan established by “care managers”. The benefits are provided mostly in kind, and the user’s co-payment is fixed at 10% of the cost of the insured services, with an upper limit.

<sup>3</sup> JA stands for “Japan agricultural co-operative”.

39 and 44, Medical Service Act). They are basically legal entities owned and run by doctors, and dominant in hospitals (66%) and clinics (37%). They are not seen as typical nonprofits since residual assets are allowed to be distributed among shareholders and their corporation tax rate is identical to that of conventional companies. The revised Act in 2006 abolished medical corporations with equities (having claim rights for residual assets) in order to strengthen their nonprofit status and created social medical corporations (SMC) to intensify services in the public interest (for example services in remote areas, emergency for children, etc.). Most general practitioners worked as "individuals" until the introduction in 1985 of a new form called "single doctor medical corporations", which separated medical and household accounts; from then on, many GPs adopted this new form, which now constitutes 80% of MCs. "Others" include all other types of institutions, such as social welfare corporations (SWC), public interest corporations (PIC), health co-operatives and public limited companies (PLC). There are very few PLCs; an example hereof is the Toyota Memorial Hospital, which had been built to serve Toyota's employees but was subsequently opened to the public. The MHLW statistics show the evolution in the number of hospitals and clinics<sup>4</sup> distributed according to their founding entity (Table 1 and 2).

**Table 1: Number of hospitals, distributed by founding entity**

Year Founding entity	1980	1990	1999	2005	2011
State	457	399	370	294	274
Public institution	1,367	1,371	1,368	1,362	1,258
Social insurance provider	140	136	131	129	121
Medical corporation	3,038	4,245	5,299	5,695	5,712
Individual	3,460	3,081	1,281	677	373
Others	762	864	837	869	867
<b>Total</b>	<b>9,224</b>	<b>10,096</b>	<b>9,286</b>	<b>9,026</b>	<b>8,605</b>

Source: MHLW statistics, 2011

**Table 2: Number of clinics, distributed by founding entity**

Year Founding entity	1980	1990	1999	2005	2011
State	838	487	578	633	585
Public institution	3,539	3,842	4,224	3,964	3,632
Social insurance provider	777	805	848	750	581
Medical corporation	753	8,025	22,680	30,941	36,859
Individual	66,447	60,731	53,973	50,693	46,227
Others	5,555	6,962	9,197	10,461	11,663
<b>Total</b>	<b>77,909</b>	<b>80,852</b>	<b>91,500</b>	<b>97,442</b>	<b>99,574</b>

Source: MHLW statistics, 2011

<sup>4</sup> According to the Medical Service Act, hospitals have more than 20 beds for hospitalization while clinics have less than 19 beds.

## 2.2. Social service providers

The Social Welfare Act of 1951 stipulates general principles of social service and its providers, while the Long-Term Care Insurance Act (LTCI Act) of 1998 provides for rules to be observed by insurers and providers of elderly care services. "Social welfare corporations" (SWCs) are founded with the governor's permission as associations or foundations operating a range of social services for the elderly, children, the handicapped, etc. They are often seen as typical QUANGO since they enjoy a wide range of tax concessions and public subsidies for constructing facilities. The provision of residential social services such as nursing homes for the elderly is limited to governments and SWC (Art. 2 and 60, Social Welfare Act), whereas non-residential elderly services were opened to other providers, both for-profit and non-profit, under the LTCI Act of 1998. As a result, SWC's share in home-based services had drastically dropped, while they maintained their dominant position in running nursing homes. "Medical corporations" (MCs) have retained a large share in medicine-related services, while private firms have gained the lion's share of home-based services. Specified nonprofit organizations (NPOs) and co-operatives entered into the service provision sector in 2000, but their share is still rather limited (see tables 3 and 4).

**Table 3: Share of residential care facilities under the LTCI System**

Providers	Municipalities	Public bodies	Social welfare corp.	Medical corp.	Public interest corp.	Others
Facilities						
Long-term care nursing facility	7.4	0.2	92.3			
Long-term care health facility	4.5	2.0	15.6	74.3	2.7	1.0
Medical long-term care nursing sanatorium	4.8	1.1	1.1	81.9	12.7	8.4

Source: MHLW statistics, 2011

**Table 4: Share of home-based services facilities under the LTCI System**

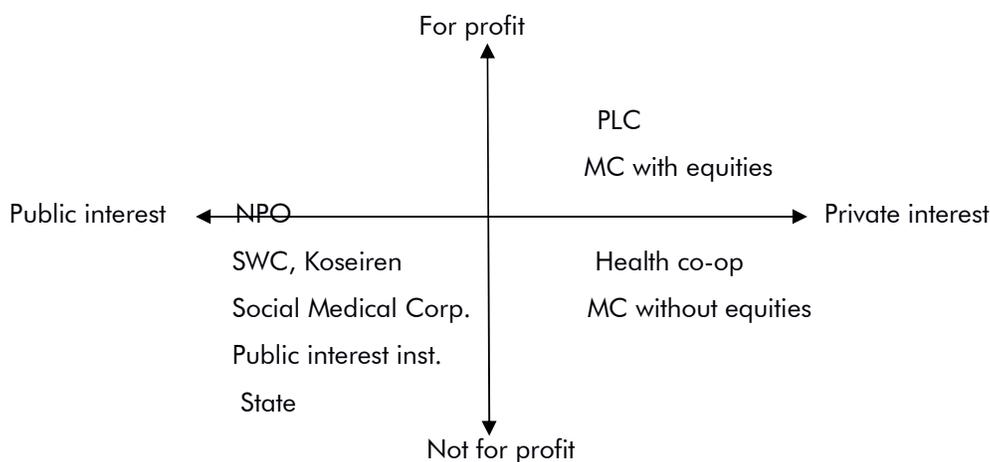
Providers	Municipalities	Public bodies	Social welfare corp.	Medical corp.	Public interest corp.	Co-ops	Private firms	NPOs	Others
Facilities									
Home helper	0.5		23.9	6.5	1.1	3.0	58.6	5.6	0.7
Visit bath	0.5		42.8	1.6	0.8	0.8	52.5	0.8	0.1
Visiting nurse	3.4	3.1	8.5	39.4	16.7	3.5	26.8	1.6	0.4
Day care	1.1		36.9	7.5	1.1	1.8	46.4	5.1	0.6
Day rehabilitation	2.8	1.5	9.5	77.2	3.2		0.1		6.1
Short stay	3.0		84.5	3.8	0.1	0.4	8.3	0.4	0.1
Short nursing	4.1	1.8	11.4	77.1	2.9				2.7
Group home	0.1		23.7	18.0	0.4	0.4	52.3	4.8	0.2
Rental equipment	0.1		2.8	1.4	0.4	3.4	91.6	0.7	0.6
Care planning	1.3		29.4	18.6	2.9	2.8	40.6	3.5	0.8

Source: MHLW statistics, 2011

### 3. COMPARISON OF SERVICE PROVIDERS IN LIGHT OF EMES INDICATORS

There exists a variety of organizational forms of health and social service providers. This is a result of piecemeal institutional evolution which catered to specific needs while the taxation regime became increasingly complex. These service providers are located on a public interest (wellbeing of the general public) vs. private interest (wellbeing of a particular person) axis and for-profit vs. not-for-profit axis (Figure 1). Amongst third sector organizations, SWC and Koseiren are located closer to the public sector while MC with equities are much closer to PLC. Health co-ops are located in-between since they have nonprofit characteristics, i.e. constraint of dividend distribution while they are legally allowed to distribute residual assets, although most of them have bylaws which prohibit this.

**Figure 1: Public interest and not-for profit dimensions of organizational forms**



**Table 5: Organizational forms of health care & long-term care service providers**

	SWC	MC	NPO	Health co-op	Koseiren	PLC
<b>Governing law</b>	Social Welfare Act	Medical Service Act	Specified NPO Act	Consumer Co-op Act	Agricultural Co-op Act	Company Act
<b>Regulating agency</b>	MHLW	MHLW	Cabinet office	MHLW	MAFF	Ministries in charge
<b>Distribution of dividends</b>	Not allowed	Not allowed	Not allowed	Not allowed	Not allowed	Allowed
<b>Distribution of residual assets</b>	Transferred to public bodies etc.	Distributed to share holders	Transferred to public bodies etc.	Distributed to share holders	Transferred to public bodies etc.	Distributed to share holders
<b>Corporation tax (rate)</b>	Taxed on trading income* (19%)	Taxed on whole income (25.5%)	Taxed on trading income* (25.5%)	Taxed on whole income (19%)	Taxed on trading income* (19%)	Taxed on whole income (25.5%)

\* Not taxed for main activities for public interest.

In order to evaluate their organizational forms, health co-ops and *Koseiren* are compared with dominant MCs in light of EMES indicators (Table 6). While the three organizations meet all economic project indicators, since they are business entities that earn income by providing services, they display a wide discrepancy in social mission indicators. The social mission of MCs is not clearly stated in most cases and they can distribute residual assets among founders-shareholders; moreover, these initiatives generally come from doctors, and very rarely from other citizens. Both types of co-operative (health co-op and *Koseiren*) have higher scores in this regard. As far as governance-related indicators are concerned, user participation is very strong in health co-ops, while MCs have no channels for user participation. The three forms have high degrees of autonomy and democratic decision-making, based on the principle of “one person, one vote.”

**Table 6: Comparison of service providers in light of EMES indicators**

Indicators		MC	Health co-op	<i>Koseiren</i>
Economic project	Continuous production	***	***	***
	Some paid work	***	***	***
	Economic risk	***	***	***
Social mission	Explicit social aim	?	***	***
	Limited profit distribution	*	**	***
	Citizens' initiative	*	***	**
Governance	High degree of autonomy	***	***	***
	Participatory nature	*	***	**
	Decision-making not based on capital ownership	***	***	***

Attributes are shown by number of asterisks, from strong (\*\*\*) to weak (\*).

The characteristics of these forms are also clarified in light of the EMES understanding of SE (Table 7). Defourny and Nyssens (2006) argue that SEs are characterized by hybridity: they are multiple-goal and multi-stakeholder organizations, relying on a mix of various resources. In the case of MCs, the social aim, other than service provision, is not explicit; by contrast, co-operatives have explicit social aims: user empowerment, improved access to health care services and community building. MCs only have two types of stakeholder (medical professionals and clients), while co-operatives have members (users and investors) who play an important role in the governance and daily operations. As far as resources are concerned, the remuneration for services reimbursed by the health insurance system and patient copayments constitute a major source of income for the three types of service provider; co-operatives can also often count on volunteer help.

Table 7: Comparison of service providers in light of EMES understanding

Service providers	MC	Health Co-op	Koseiren
<b>Indicators</b>			
<b>Multiple goals</b>	?	Empowering users through learning/ check up Community building	Securing farmers' access to health care services in rural areas Community building
<b>Multiple stakeholders</b>	Users (patients) Professionals	Public (community) Users (patients) Investors (members) Professionals	Public (community) Users (patients) Investors (agricultural co-ops) Professionals
<b>Multiple resources</b>	Remuneration for services Copayment	Remuneration for services Copayment Volunteers	Remuneration for services Copayment

On the basis of such a comparison, the author identified health co-ops and *Koseiren* as typical SE models and will hereafter concentrate on describing the characteristics and trajectories of these models.

## 4. FEATURES OF THE HEALTH CO-OP MODEL AND THE *KOSEIREN* MODEL

### 4.1. Health co-op model

#### 4.1.1. Social mission

Health co-ops have a social mission: enhancing people's health in entire communities through delivering services and encouraging consumer participation. Being highly specialized, health and social services are characterized by prevailing asymmetric information, resulting in doctors' domination; users are placed in the disadvantageous position when it comes to tapping information and making decision on health care. In the event of consumers not being satisfied with diagnosis or treatments, their response tends to be exit rather than voice. Health co-ops have sought to promote consumer participation in health and social services through implementing a "Charter of Patient's Rights" as a guideline to be followed by patients and professionals.<sup>5</sup> It was formulated through active participation of multiple stakeholders, crystallizing health co-op's views on health care. It goes beyond informed consent,<sup>6</sup> stating that each patient who suffers disease or illness has the following rights and responsibility:

<sup>5</sup> The Charter was adopted on May 11<sup>th</sup>, 1991, at the Annual Meeting of the HCA.

<sup>6</sup> Informed consent is generally understood as a concept of interaction to promote patient's rights, but it can be a one-way communication from doctors to patients, as seen in the term "explanation and consent", a translation used by the Japanese Medical Association.

- a) Right to be informed of disease, medical care plan and drugs
- b) Right to determine a suitable medical care plan
- c) Right to patient's privacy
- d) Right to learn about their disease, prevention and treatment
- e) Right to receive necessary and optimum medical service at any time
- f) Responsibility to participate and co-operate

The Charter emphasizes patients' right to be informed, to learn and to exercise self-determination. To this end, co-ops started disclosing case records to patients to share information about treatment and medication, and provided them with various opportunities to learn about health so that they can have the capacity to make the right decision on suitable medical care plans. Some co-ops started organizing member volunteers into "simulated patients groups" aiming to improve communication between users and providers, while others are trying out "medical care by multi-professional teams" to enhance the quality of services by enabling collaboration among different treatment departments and various specialists (nurses, X-ray examiners, therapists etc.), placing patients at the center of the process. Thus they seek to bring about openness and democracy in the industry, which tends to be closed and authoritarian.

The other aspect of health co-op's mission is to build "healthy communities" through providing integrated services for health education, medical treatments and long-term care. This reflects the holistic view of health as displayed in the concept of health promotion.<sup>7</sup> There has been a longing to integrate health education, medical care and long-term care in order to address the changing patterns of diseases from acute/contagious ones to chronic ones, generate better-coordinated services for the beneficiaries and reduce overall costs. But such a goal is not easily achieved, mainly due to institutional and functional reasons. In order to attain the goal of building healthy communities, health co-ops have increased their involvement in the provision of long-term care, as a natural extension of health education and medical care, where they have accumulated experience and know-how. To this end, they have made substantial investments in training personnel and building facilities for long-term care. As a result, they are now the second largest long-term care providers in Japan. In addition, health co-ops often map out the local needs and resources, analyze health-related problems and possible solutions, and coordinate integrated provision of prevention, health and social care services. However, given their limited financial and technical capacity, it may not be realistic for health co-ops to provide all kinds of such services. Co-ops, therefore, function best in collaboration with other organizations, including municipal health centers, social welfare corporations, worker co-ops and volunteer groups, while also advising and partnering with local authorities.

#### **4.1.2. Target groups**

Health co-ops serve urban populations who have a wide choice of doctors. The majority of co-op members are healthy consumers who want to be prepared for health risks (diseases or accidents) and want to lead healthy lives. In this regard, health co-ops are different from organizations exclusively composed of patients. At the same time, medical professionals,

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<sup>7</sup> Health promotion has been defined by the World Health Organization's (WHO) 2005 Bangkok Charter for Health Promotion in a Globalized World as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health". The primary means of health promotion occur through developing health-related public policy that addresses the prerequisites of health such as income, housing, food security, employment, and working conditions.

including doctors, nurses, technicians and pharmacists are also involved as members of health co-operatives. In this regard, health co-ops are multi-stakeholder membership organizations involving both service users and providers. According to the statistics for 2010, out of 2.75 million members, nearly 1% were persons employed by the health cooperatives themselves, including administrative staff. Health co-ops seek to create a synergistic effect by involving different stakeholders working together in the same organizations to attain common goals, i.e. promotion, maintenance, and recovery of users' health. It is expected that users can help providers offer better services by committing themselves to the health care process, while providers can help users to establish positive attitudes in maintaining health and tackling diseases. This mutually reinforcing process can be seen as co-production.

Health co-ops have made various efforts to enhance users' capacity for health promotion through the training and self-monitoring of members. Co-op members are encouraged to attend lectures, take correspondence courses and enroll in "health colleges" organized at the local, regional and national levels so that they may become co-operative "hoken iin" ("health advisors"), who then lead voluntary activities within *Han* groups.<sup>8</sup> Members in *Han* groups, with the initial assistance of nurses and health advisors, learn how to monitor their own health conditions by taking blood pressure, measuring the sugar and salt content in urine, measuring fat content, and checking teeth, using simple devices such as manometers and test papers. Such activities are conducive to an enhancement of users' consciousness about their own health and can lead to changes in their dietary life. If irregularities are detected through these self-monitored tests, members then make appointments to see doctors at health co-ops. These self-monitoring activities have proved to be effective for the early detection and treatment of illness. Such voluntary activities for preventive purposes have evolved into more comprehensive health promotion activities. Since 1997, a campaign known as the "Seven Habits for Health" has been promoted by co-ops as one of their user sensitizing programs.<sup>9</sup> The intent of the program is to change consumer's daily habits and remove elements that can lead to disease and illness. These programs are designed and promoted by health advisors, while professionals support them in the form of classes for dietary life, physical training, dental hygiene counseling, etc. These initiatives are highly valued by municipalities and often considered to be a part of official health promotion programs (Kawasaki 2007; Kurimoto 2013).

How to improve access to health care for the increasing number of people who are excluded from services due to unemployment and low income under the economic downturn is an issue that attracts a wide social concern. The overhaul of the entire health insurance system is required, but it will take time due to the number of conflicting interests. Under such circumstances, health co-ops have made a variety of efforts. Their social workers counsel needy people on how to apply for the reduction of/exemption from the national health

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<sup>8</sup> Every year, some 10,000 members attend correspondence courses. Co-op schools, volunteer schools, home-helper training courses and culture courses are organized by primary co-ops. "Health colleges" are organized to give 20-30 hours of lectures to volunteering members on the basic knowledge on health care. "*Han*" groups are voluntary small neighborhood gatherings which undertake various member activities.

<sup>9</sup> The seven habits in daily life promoted by health co-ops include: (1) to get sufficient sleep (7-8 hours); (2) to avoid overwork and take enough rest; (3) to avoid smoking; (4) to avoid excessive drinking; (5) to continue moderate exercise regularly; (6) to have a balanced diet with low salt/fat; (7) To eat regularly, including breakfast, and to avoid snacks. The eighth habit, namely "to brush teeth morning and night", was added in 2005.

insurance (*Kokuho*) premium, public assistance as a last resort, and so on. Health co-ops are also offering, at their own expense, “free or low-cost care” for low-income groups.<sup>10</sup>

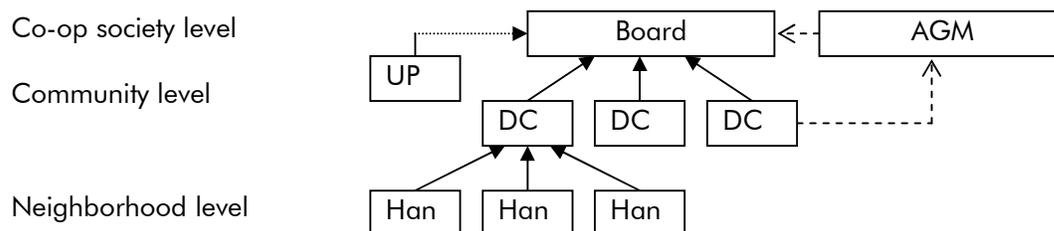
### 4.1.3. Governance model

Health co-ops' membership composition leads to a user-dominant board of directors. In health co-ops in 2008, there were 1,943 lay board members representing users (72.4%), compared to 739 paid board members representing providers. In the case of the largest health co-op, namely the Saitama Medical Co-op, in Saitama Prefecture, 23 board members (21 housewives and 2 retired men) represent users, while 10 board members (3 doctors, a nurse and 6 executive directors) represent providers. Co-op chairpersons are medical doctors in many cases; in some co-ops, they are professors, lawyers, etc. Having medical professionals on boards may give them disproportionately large power over other board members, which may raise problems in governing co-ops in a democratic manner. The chairpersons are, however, well informed on co-operative values and principles and make efforts to be responsive to users' voices. Executive directors are expected to function as stewards or trustees, bringing different interests together in health co-ops, and there is less inclination toward managerial dominance than in many retail co-ops. As Ohno (2008) points out, health co-ops can provide a model for multi-stakeholder governance of medical institutions, even though they still have to solve potential tensions or conflicts between the management logic and professional logic, or between the stewardship governance model and the democratic model. In order to empower users in the process of health promotion and medical care, health co-ops have created a number of intermediary organs between the board and the membership, which aim to encourage users to participate in the governance of the organizations. At the grassroots level, user members are encouraged to learn about health promotion in *Han* groups, which meet regularly at members' houses. Over 300,000 co-op members belong to 27,000 *Han* groups. This means that nearly 11.5% of members belong to *Han* groups, which involve 11.1 members on average. On average they meet 2.9 times a year to undertake various activities such as self-health monitoring, learning to cook with less salt, and physical exercising, and promote mutual help among increasingly isolated city dwellers, especially elderly people. In addition, district committees are organized in school districts to promote members' activities and create networks with other organizations within communities, while user panels and opinion boxes are attached to hospitals and clinics to reflect users' opinions about the running of these facilities. These intermediary organs often elect delegates to the Annual General Meeting or transmit members' voices to the board (Figure 2).

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<sup>10</sup> 134 hospitals and clinics of 45 health co-ops offered free or low-cost care in 2012. It accounted for about 18% of such service provision, which is a much larger share than co-op's share in health care provision (estimated at around 1%).

**Figure 2: Structure for governance and member participation**



DC: District Committees

UP: Users' Panel attached to hospitals/clinics

—> Communication/reporting

---> Electing delegates / board members

.....> Advice

#### 4.1.4. Multiple resources

Health co-ops depend on multiple financial and human resources. In principle, there is no difference between health co-ops and other medical institutions in financing health and social care: their major source of income are the compensation redeemed by the compulsory health insurance scheme and long-term care insurances and patient's co-payment. Health insurance covers 70-90% of incurred medical care costs while long-term care insurance covers 90% of long-term care costs. In both cases, taxes are included to sustain social insurance schemes for the elderly. The patient's co-payment for medical care has been increased from 10% of costs to 30% over four decades. In addition, most hospitals charge extra fees to patients who want to stay in hospital rooms with fewer beds instead of the standard six beds. This system was introduced to bolster hospitals' revenue, and it was generally accepted by patients who valued privacy and amenity; however, except for a few cases, most health co-ops did not apply this system because of their egalitarian stance.

Health co-ops have mobilized human resources through professional members' active commitment and user members' voluntary contribution. Needless to say, the qualified professionals are the most important resource in the industry. So health co-ops have made a variety of efforts to recruit and retain committed doctors, nurses and other medical professionals. To this end, they have organized regular courses on co-operative values and principles, conducted training on professional skills at various levels, accepted medical students and interns as trainees (possibly leading to future employment of these trainees within the co-op), and promoted the Center for Family Medicine Development in order to ensure that doctors obtain professional skills as family doctors, act as gatekeepers of health care in communities and accomplish the co-op's mission.

Members' voluntary contributions have played a crucial role in recruiting new members, raising members' share capital, and governing co-ops. They are encouraged to take part in the membership drive and raise funds when co-ops build new facilities such as hospitals, clinics and facilities for elderly care. The lay board members, AGM delegates and health advisors play pivotal roles in promoting members' activities and education, while co-op staff assigned as member relations officers (organizers) coordinate members' activities. Member volunteers undertake various activities for disseminating information, acting as simulated

patients, and doing non-core activities to assist the co-op's operations. They often contribute to organizing co-op festivals and local health check campaigns.

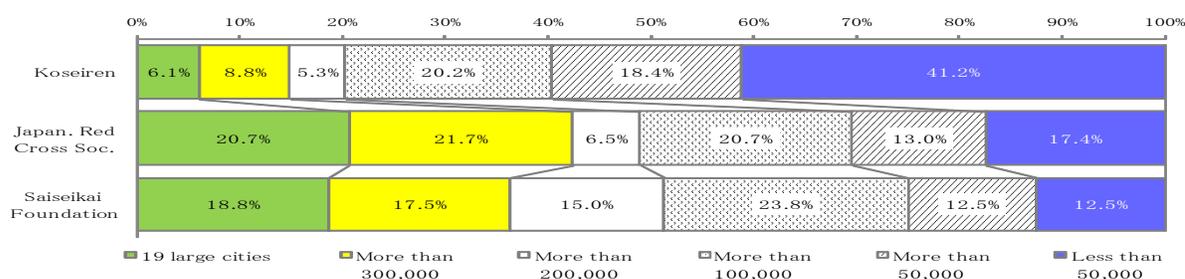
## 4.2. Koseiren model

### 4.2.1. Social mission

Koseiren's mission is to secure access to health and social services in rural and remote areas where very few alternatives exist. The modern medical system in Japan was built on general practitioners since the end of 19th century, when most medical institutions were concentrated in urban areas, while the bulk of the rural population lacked access to health care, especially in the period following the economic recession after World War I. In doctorless villages, sick people had to travel to urban areas, which required both time and money, or wait to die. With neither health insurance nor public assistance, contracting a disease literally meant falling into poverty for farmers, who had to sell land and property, or even their daughters. Under such circumstances, agricultural co-ops proposed to create medical service co-ops under the Industrial Co-operative Act of 1900. The first co-op clinic was opened in Shimane Prefecture in 1919; it aimed to provide health services at reduced costs.

After the Second World War agricultural co-operatives founded *Koseiren* as specialist organizations for the health care of farmers. Many *Koseiren* operate in sparsely populated and remote areas. For instance 47 out of 114 *Koseiren* hospitals operate in areas with fewer than 50,000 inhabitants, and 20 of these hospitals are the sole hospitals operating in their municipality. Figure 3 clearly shows the importance of *Koseiren* in sparsely populated areas. The services that *Koseiren* provide within small communities are outstanding in comparison with those provided by other public interest institutions. Designated by the Ministry as core hospitals for medical care in remote areas, they provide a range of support services through dispatching and training of doctors, travelling clinics and health promotion activities. Most *Koseiren* hospitals provide emergency medicine and disaster relief (see Table 8). They also maintain pediatrics, obstetrics and gynecology departments as indispensable infrastructure in rural areas. Since they provide services for the general public, some *Koseiren* hospitals/clinics have been converted into municipal ones and vice versa.

Figure 3: Koseiren—serving small local communities



Source: JA Fact Book 2013.

**Table 8: Public-interest hospitals as of March 31, 2011**

	Total number of hospitals	Core hospitals in remote areas	Hospitals accepting clinical trainees	Hospitals for emergency medicine	Hospitals for disaster relief
<i>Koseiren</i>	114	22	83	104	34
Japanese Red Cross Soc.	92	15	81	87	61
<i>Saiseikai</i> Foundation <sup>11</sup>	79	7	66	69	24

Source: JA Fact Book 2013.

#### 4.2.2. Target groups

The main target groups are farmers who have been exposed to a variety of health risks such as chronic diseases caused by unbalanced diets, long hours of hard work, and acute diseases or injuries associated with the use of agricultural chemicals and machinery. In the past, the severe health risks in rural areas and the short supply of health care services had not been adequately addressed. In 1945, Dr. Toshikazu Wakatsuki, Director of Saku General Hospital, Nagano *Koseiren*, became very interested in the lack of health care in doctorless villages and started health promotion activities for farmers with the motto “prevention is better than treatment”. He organized campaigns to enlighten farmers through drama performances and conducted health check-ups for villagers on the spot. Following successful campaigns, such practices have become widely accepted and have spread throughout the country since around 1970. Dr. Wakatsuki also conducted field studies of farmers' lives and established the concept of potential diseases largely caused by their ignorance and the fact that they delay in consulting a doctor, which led to the Asian model of rural medicine.<sup>12</sup> Based on the 12th National Agricultural Co-op Congress resolution to establish activities to protect farmers' life and health (Basic Plan for Life), adopted in 1970, *Koseiren* implemented nationwide life planning and health promotion activities for farmer-members.<sup>13</sup> Today *Koseiren* conducts a variety of activities to improve rural populations' access to health services. They provide health services not only in hospitals/clinics and rural check-up centers, but also through 18 mobile clinics for remote areas and 204 health check-up vehicles, equipped with X-ray imaging machines. In 2011, more than 3.2 million rural residents received regular annual health screenings, and 490,000 of these rural residents received comprehensive medical checkups. The results of these check-ups are fed back to communities, which examine how to meet the diversified health needs of local residents. In addition, health education is regularly conducted through health seminars, consultations for healthier diet and exercises for maintaining physical ability. It can thus be said that *Koseiren* seek to build community-based health and social care.

In 2008 Nagano *Koseiren* conducted a community outreach program through visiting doctors/nurses, and it developed a Community Care Network together with local GPs, social

<sup>11</sup> *Saiseikai* Foundation was created by the gift of Emperor Meiji and other donations in 1911 to provide health care for the needy people. It was authorized as SWC in 1952.

<sup>12</sup> Based on these practices and studies, Dr. Wakatsuki founded the Japanese Association of Rural Medicine in 1952 and helped to set up the International Association of Agricultural Medicine in 1961.

<sup>13</sup> *Koseiren* took the initiative to set up the Foundation for Preventing Hypertension and Stroke in 1963 (one year later, this foundation was renamed the Foundation of Preventive Medicine for Adult Disease).

care workers and other professionals in the area, aiming to create coordinated care delivery in communities, including terminal care at home.

### **4.2.3. Governance model**

*Koseiren* federations are specialist organizations providing health and social care for agricultural co-op members. They are secondary organizations, owned and controlled by primary multi-purpose agricultural co-ops in each prefecture and affiliated with the National Welfare Federation of Agricultural Co-ops (*Zenkoren*). As a part of the wider JA system (*Keitou*), they collaborate with agricultural co-ops in many areas, ranging from the organization of periodical health check-ups and health and diet promotion for farmers, to the training of care-givers for farmers and their wives, and procurement of produce such as raw materials for hospital diet.

The smaller *Koseiren* generally choose a unitary board system, while 20 out of 34 *Koseiren* have a dual board system, consisting of a supervisory board and an executive board. In the dual board system, the supervisory board is composed of non-executives (5 to 16 members) who are elected as representatives of primary co-ops in the general meeting; they are in most cases chairpersons of agricultural co-ops. The supervisory board is responsible for making decisions on important matters, and appointing executive board members. The executive board is basically composed of executives (3 to 6 members) who are entrusted with the day-to-day business operations. There are a few cases in which doctors have been elected to the executive board. Such a dual board system was introduced to secure professional management while reflecting the collective interests of farmers. *Koseiren* have internal auditors (2 to 5 members) elected by the general meetings and they receive an external audit by the JA's National Audit Organization. In such a structure, individual co-op members are linked only in an indirect manner while a majority of medical professionals are not involved in governance. There exist some users' councils to reflect users' voice to the administration of the medical institutions.

### **4.2.4. Multiple resources**

As far as financial resources are concerned, there is no difference between *Koseiren* and other medical institutions. *Koseiren* are financed by repayment from health insurance providers and patients' copayment; *qua* public interest medical institutions, they also often receive public subsidies for operations and construction of facilities. The subsidies granted to *Koseiren* amounted to JPY 18.8 billion in 2012. The National Federation is concerned with the difficulty of maintaining some remote hospitals that are permanently in the red, mainly due to depopulation. *Koseiren* make annual financial plans in which they have to balance expenditure with income.

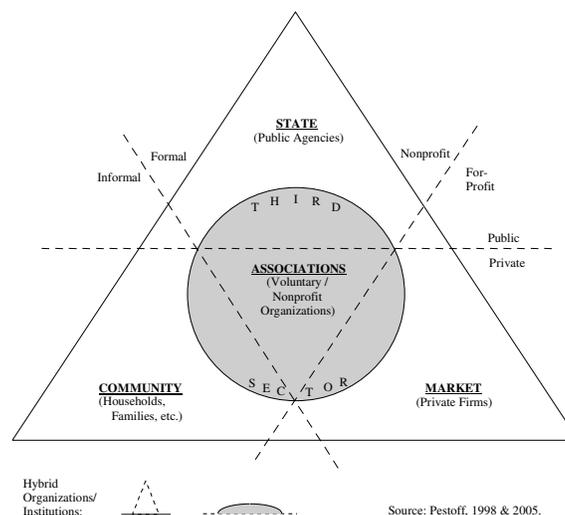
The direct involvement of volunteers is rather limited in comparison with what is the case in health co-ops, but some agricultural co-ops encourage member volunteers to help patients in *Koseiren* hospitals and clinics.

### 4.3. How to locate health co-op model and *Koseiren* model in the “welfare triangle”

In Pestoff’s welfare triangle (see figure 4), there are arched parts where the third sector overlaps with the state, market and community sectors. Health co-ops are located in the overlapping part between the third sector and community sector since they seek to address the health problems in the whole community so that people can lead a healthy life. As mentioned before, their mission is to build “healthy communities” through providing integrated services for health education, medical treatment and long-term care, reflecting the holistic view on health promotion in communities. To this end, *Han* groups are operating as neighborhood organizations for mutual help while district committees promote member’s activities and create networks with other organizations within communities.

On the other hand, *Koseiren* sit in the overlapping part between the third sector and state sector, on the ground that they are usually assigned special responsibilities *qua* public medical institutions serving remote areas, providing emergency medicine and disaster relief. Therefore they can take over the management of public hospitals as a public-private partnership while their hospitals can be transferred to the latter, as has often happened. They are also located in the overlapping part between the third sector and community sector, since they are providing the infrastructure for health care in rural communities.

**Figure 4: The third Sector in the welfare triangle**



## 5. INSTITUTIONAL TRAJECTORY OF HEALTH CO-OPS AND *KOSEIREN*

### 5.1. Health co-op model

The origin of health co-ops dates back to 1948, when the Consumer Co-operative Act was enacted, although there were some forerunners before World War II. Indeed, medical service co-operatives had been set up in urban areas under the Industrial Co-operative Act, while so-called “proletarian clinics” had been created to cater to the working class who did not have access to medical care. These clinics had been formed by conscientious doctors who saw the

need to serve the unprivileged people at that time, but they lacked the democratic organizational basis typical of co-operatives.

The Consumer Co-operative Act created the institutional framework to constitute medical institutions on a democratic basis that enabled popular participation. It has been only a tool to allow general consumers to manage health care while it allowed non-members to use services on the ground of the public interest nature of medicine (Medical Service Act) and doctors' obligation to see patients (Medical Practitioners Act). Many health co-ops were set up in accordance with provisions of the Act from the outset, while others resulted from the transformation of general practitioners as individual operators, medical service co-ops or medical corporations. Some co-ops were created as a result of the separation of existing multipurpose consumer co-ops (Hino 2005).

In 1957, the HCA (Health Co-operative Association) was set up by twelve health co-ops to coordinate their activities as a national sectorial organization of the Japanese Consumers' Co-operative Union (JCCU). The HCA's policy originally stated that their mission was to strengthen services for patients and members, which were simply seen as beneficiaries. However, during the 1960s, many co-ops started organizing *Han* groups among members, encouraging members' health check-up activities and tackling diseases caused by air/water pollution. Accordingly, in 1969 the HCA adopted a policy to encourage members' health promotion activities, seeing *Han* groups as the way to ensure active member participation.

In 1988 the HCA adopted its first five-year plan, which included the task of establishing a charter for patients' rights. It is noteworthy that not only medical professionals but also patients and user members took an active part in the process of drafting this charter. In 1991, the "Health Co-ops' Charter for Patients' Rights" was adopted to facilitate users' self-determination pertaining to health care. In 1992 the HCA took the initiative to hold the first International Health Co-operative Forum in conjunction with the ICA Tokyo Congress, which led to the formation of the International Health Co-operative Organization. In 2000, health co-ops entered into elderly care provision, in accordance with the LTCI Act, and rapidly expanded facilities and human resources. The HCA promoted health co-ops' involvement in elderly care and adopted the "Health Co-ops' Guidelines for Long-term Care" in 2005, after a series of member consultations. In 2007, the Consumer Co-operative Act underwent a drastic amendment: health care and welfare services were for the first time cited as types of activities, and a cap on non-member business was introduced (it cannot exceed the amount of member business). Then in 2010, the HeW Co-op (Japanese Health and Welfare Co-operative Federation) was created, separating from the JCCU. In 2013, a "Charter" and "Guidelines" were integrated in "Health & Welfare Co-ops' Charter for Lives". As such, the institutional trajectory of health co-ops was largely influenced by the initiative of federal bodies rather than by the legal framework within which they operated.

## 5.2. *Koseiren* model

In the early 20th century, medical service co-operatives were created in rural areas under the Industrial Co-operative Act, despite strong resistance by doctors' associations, which insisted on the profession's monopoly in health care<sup>14</sup>. By 1940, 153 agricultural co-ops operated medical services, covering 5.4 million people. During World War II, all agricultural co-ops were integrated into the state apparatus, but more rural hospitals and clinics were built to help

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<sup>14</sup> They argued that only doctors could run medical institutions.

maintain health care provision for the farmers, who constituted a major “reservoir” of soldiers. After agricultural co-ops were reorganized based on the Agricultural Co-op Act of 1947, *Koseiren* federations were set up to take over co-op hospitals and clinics which had been operating since pre-war days. In this process, most agricultural co-ops faced financial difficulties due to the negative legacy and hyperinflation around that time, and some *Koseiren* were liquidated. For example, the Iwate Prefecture *Koseiren* was dissolved, while its facilities and medical personnel were taken over by local governments in 1950. Then in 1947-1948, *Koseiren* received public subsidies under the Act for Reconstruction and Promotion of Agricultural Co-ops, and their financial situation began to stabilize. The Agricultural Co-op Act allowed non-member business up to 20% of the total turnover, but this threshold was extended to 40% in 1951 and 100% in 1965. In 1951, *Koseiren* federations were designated as public-interest medical institutions by the Minister for Health and Welfare, according to Art. 31 of the Medical Service Act. This means that they cannot pay out dividends nor distribute their residual assets, which rightly belong to the State, local governments or other *Koseiren* when they are dissolved. In return they are entitled to public subsidies and tax exemptions. They were exempted from the corporation tax on health care services in 1984 and on elderly care in 1998. They were also allowed to operate their own nursing homes in 2007 and now operate six homes. As such, their status of public-interest medical institutions has been intensified in a consistent way, while their characteristics as mutual organizations have been somewhat diluted.

## CONCLUSION

In heavily regulated markets, co-operatives provide better access to health care by empowering urban consumers through learning and participation and by offering a variety of health and social services to farmers in rural areas. At the same time, however, a number of barriers to users' access to health care still exist; such barriers include poor coordination in the provision of quality health care and the growing number of people excluded from care due to economic reasons.

Health co-ops seek to create a local network for health promotion, medical treatment and long-term care, operating a network of clinics and hospitals, nursing homes or service houses, and even fitness centers. Recently, they took an initiative to establish professional primary care to promote quality and effective health care centered on users' families and communities. Based on the pioneering practices of family medicine by the Tokyo Hokuto Medical Co-op, HCA set up in 2005 the Center for Family Medicine Development (CFMD) to conduct residency and fellowship programs and R&D for family medicine.

*Koseiren* federations have built a network of seamless provision of health and social care, ranging from health promotion in communities to primary care at clinics, secondary care at hospitals, including emergency and rehabilitation, long-term care at home and in facilities, through to terminal care. Saku General Hospital of Nagano *Koseiren* has played a pivotal role in creating a typical Integrated Healthcare Network in the rural areas (Matsuyama 2014).

Health co-ops and *Koseiren* are attracting growing interest as unique social service provider SE models. They are often referred to as practical models empowering consumers and farmers, and their experiences are disseminated in the health and social service industry at home and abroad. They deserve more focused research based on theoretical frameworks and empirical fact findings.

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