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Social Innovation Diffusion through Communities of Practice

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I. Introduction

Social innovation is needed to solve numerous social problems or issues caused by the super-aged society in Japan. There are many social problems to be solved worldwide, such as medical care, social welfare, and air pollution. These problems are escalating and have become increasingly serious. Mair (2010) noted that these problems are created because institutions and organizations strive to satisfy other perceived social needs.

Japan is currently a super-aged society. A white paper on the aging society published by the Cabinet Office, Government of Japan in 2015 reported that the population aging rate, which indicates the proportion of the elderly population, was 25.1%. The white paper states that the proportion of the elderly population is increasing every year, and is likely to reach approximately 40% by 2050. Examples of social problems caused by a super-aged society include escalating medical costs, care for elderly adults with dementia, and abuse and neglect of the elderly. In fact, The Ministry of Health, Labour, and Welfare (MHLW) in Japan state that "The number of persons with dementia will have increased from 2.8 million at present to 4.7 million. In urban areas, the population will have remained stable, but the popu-

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lation of those aged 75 or older will have rapidly increased. In rural areas, the population of those aged 75 or older will have gradually increased, but the total population itself will have decreased." These are serious and complex problems.

MHLW revised a public nursing care insurance system in April 2015 to uphold a policy that had in place "The Integrated Community Care System" in Japan. The MHLW in Japan defines The Integrated Community Care System as one that provides housing, medical care, long-term care, prevention services, and livelihood support in an integrated manner in communities. This system aims to enable elderly people to continue living in their hometowns. I consider this system an example of social innovation. However, the MHLW enforces the implementation of The Integrated Community Care System, and as such, it cannot work efficiently. As the government enforced this care system across Japan, each local government does not know how to properly implement it. Consequently, it leads to further social problems or issues. Therefore, I think that the creation and diffusion of new social innovation is necessary for the effective functioning of the system.

It is difficult for the government or a single organization to address these social problems or issues, because of their complexity and diversity. According to Wei-Skillern et al. (2007), "the resources that any single organization brings to bear on a social problem are often dwarfed by their magnitude and complexity." Therefore, many researchers suggest the importance of collaboration between multiple organizations (Wei-Skillern et al., 2007) and the creation and diffusion of social innovation (Nicholls and Murdock, 2011; Nicholls et al., 2015; Mulgan et al., 2007; Mulgan, 2006, etc.). Mulgan et al. (2007) define social innovation as "new ideas that meet social needs. It refers to innovative activities and services that are motivated by the goal of meeting social needs." As examples of social innovation, they highlight new models of public health, organic foods, and pedagogical models of childcare. Phills et al. (2008) add microfinance and fair-trade as social innovations, while Brown and Wyatt (2010) describe mosquito net distribution in Africa to reduce the incidence of malaria.

The purpose of this paper is to consider the mechanisms of the diffusion of social innovation through a variety of communities of practice (Lave and Wenger, 1991). There are two research questions. The first addresses how communities of practice are formed beyond the boundaries of organizations and different professions. The second question addresses how social innovation diffuses through these various communities of practice.

II. Theoretical Background

Research on social innovation has increased since 2007. However, there are only a

few academic research achievements thus far compared to those in business innovation studies. Mulgan et al. (2007) emphasize that "many social innovations have progressed from margin to the mainstream, and much of the most important innovation of the next few decades is set to follow patterns of social innovation, rather than innovation patterns developed in sectors such as information technology or insurance." As Mulgan (2006) asserts, "business innovation is generally motivated by profit maximization and diffused through organizations that are primarily motivated by profit maximization." An important addition to what he states about business innovation is that it is created within the organization. On the other hand, social innovation is open innovation created through collaboration between multiple organizations, which should importantly address unmet social needs. Christensen et al. (2006) referred to disruptive innovation for social change as catalytic innovation. They indicated that "in a region where social needs exist, innovative business models are built and present social problems solved by providing services."

The process of social innovation remains under-researched. Typical research on the process of social innovation includes that of Mulgan (2006) and Mulgan et al. (2007), which described the four-phase process of social innovation [Figure-1] as follows: (1) Generating ideas by understanding needs and identifying potential solutions: "An idea of a need that is not being met, coupled with an idea of how it could be met." (2) Developing, prototyping, and piloting ideas "involves taking a promising idea and testing it in practice." (3) Assessing, scaling up, and diffusing good ideas "comes when an idea proves itself in practice and can then be grown, replicated, adapted, or franchised." (4) Learning and evolving: "Innovations continue to change, for example, learning and adaptation transform ideas into forms that may be very different from the expectations of the pioneers." The first and second phases constitute the creation process of social innovation, while the third and fourth phases encompass the diffusion process. Rogers (1995) shows that diffusion is the process by which an innovation is communicated through certain channels over time among members of a social system. Katz et al. (1963) characterized the process of diffusion as the (1) acceptance, (2) over time, (3) of some specific item—an idea or practice, (4) by individuals, groups, or other adopting units, linked (5) to specific channels of communication, (6) to a social structure, and (7) to a given system of values or culture.

Mulgan (2006) noted that in social organizations, the acceleration of social innovation is supported by practitioner networks, allies in politics, strong civic organizations, and the support of progressive foundations and philanthropists. However, he did not describe in detail how these factors accelerate social innovation. I consider practitioner networks the most important of these factors. In the field of elderly care, various types of professional practitioners collaborate to develop professional com-

munities. Once they recognize and accept social innovations, these diffuse among professional communities. Therefore, I focus on practitioner networks in terms of a variety of practitioner communities of practice. As such, the purpose of this paper is to clarify the mechanisms of social innovation diffusion with specific focus on the third phase of Mulgan's social innovation process.

III. Methods

This paper is a case study (Eisenhardt, 1898; Yin, 2008; Eisenhardt and Graebner, 2007) on "learning therapy" created by Kumon[1)]. Founded in 1958, Kumon is an educational service company in Japan that provides education materials and services for children. The company franchises preparatory schools in 49 countries around the world, and considers that the joy of developing one's own ability through learning is not limited to children. Kumon strives to energize and contribute to the local community through education.

In 2004, Kumon founded a new business division, namely the Center of Learning Therapy (KLT). Learning therapy was developed by the Kumon Institute of Education in Osaka, Japan in conjunction with Professor Ryuta KAWASHIMA of the Smart Aging International Research Center at TOHOKU University. It is a proven method for dramatically impacting the quality of life for seniors living with dementia. Professor KAWASHIMA is a brain scientist and medical doctor. About 15 years ago, he became renowned in Japan for jointly developing a brain training game and program for adults in collaboration with a large Japanese game company.

Learning therapy was first introduced in 2004, and has been implemented by more than 1,600 nursing facilities across Japan. Kumon defines learning therapy as an innovative, non-pharmacological treatment that has been shown to improve the symptoms of memory loss among elderly adults with dementia. Many changes have been observed in these seniors; for example, they smile more frequently, communicate with others, and are energized to learn. Local governments have also implemented learning therapy programs. I consider learning therapy to be an example of social innovation, which has been successful in the first stage of social innovation diffusion. The reason I consider it as such is because modern medical research can do very little to stop the progress of dementia with pharmacological treatment.

The analytical method used in this paper is a qualitative analysis of interview surveys, observational research, and secondary data. Secondary data was collected from various sources including KLT press releases, the company's homepage, news-

1) I received the generous support from of Mr. Otake, Mr. Ito, and Mr. Arimura at the Center of Learning Therapy in Kumon on for the interview surveys and observational researches.

paper accounts, and magazine articles. Furthermore, I conducted interviews with the president, vice president, public relations officer, leaders of each unit, and managers of each KLT area from May 2014 to June 2016. In addition, I conducted observational research by attending workshops and study meetings on learning therapy throughout Japan from May 2014 to June 2016.

IV. Case Study

Learning therapy was developed through collaboration between industry, government, and university. In this collaboration, industries included Kumon and the nursing facility of a social welfare corporation, government collaboration was through a grant from the Japan Science and Technology Agency, and the university was TOHOKU University. Learning therapy has extended to the United States as well, where Eliza Jennings nursing home became the first location in the country to offer it. At Eliza Jennings, "learning therapy involves a caregiver trained to work with two older adults by engaging them in simple arithmetic, writing and reading exercises, and some communication for 30 minutes."

KLT's major pillar of business is providing learning therapy in assisted-living facilities for seniors to stop the progress of dementia or prevent progression to dementia. In addition, KLT provides learning therapy to local governments and public organizations. Since 2004, the number of Japanese nursing facilities and local governments introducing learning therapy continues to gradually increase [Figure-2] [Figure-3]. In 2004, approximately 20 nursing homes had implemented the therapy. This number has now grown to more than 1,600. Briefly, the spread of learning therapy has continued across Japan.

Many non-pharmacological treatments are available for dementia patients other than learning therapy, such as oral care, light exercise, and music therapy. While these have a longer history than learning therapy, they are not as developed and dispersed in Japan. Moreover, the Japanese nursing care industry is complicated. The nursing care and welfare fields are characterized by collaborations between various professions including doctors, nurses, pharmacists, caseworkers, care workers, and care managers. Corporate involvement is also diverse, for example by joint-stock companies, non-profit organizations, social welfare corporations, and healthcare corporations. Specialized types of elderly nursing homes are low cost and offer deathwatch services. Group homes target people with dementia. While anyone can transfer to a paid nursing home, fees for services provided are very expensive and many homes are operated by joint-stock companies. Therefore, multiple and complex boundaries exist between organizations in nursing care and social welfare in Japan. It is difficult to diffuse social innovation across various organizations in the medical,

nursing care, and welfare fields. Ferlie et al. (2005) conducted two qualitative studies in the health care sector in the UK to trace eight purposefully selected innovations, theorizing that multi-professionalization shapes the "non-spread" (non-diffusion) of innovation. The researchers explain that "social and cognitive boundaries between different professions delay spread, as individual professionals operate within uni-disciplinary communities of practice." Their new theory explains barriers to the diffusion of innovation in multi-professional organizations in health care and other settings. However, why has KLT learning therapy diffused across Japan?

It is difficult for Japanese nursing care facilities to decide whether to introduce KLT learning therapy. Generally, nursing care insurance covers nursing care services provided in facilities for elderly people. However, the KLT learning therapy is not covered by this insurance. Therefore, even if nursing facilities choose to provide learning therapy alongside high-quality nursing care services to their users, they cannot earn the nursing care benefit. Major problems facing Japanese nursing facilities include a shortage of human resources, lack of communication among staff, and inefficient management. Under these circumstances, introducing learning therapy is a major liability for many Japanese nursing facilities. Why then do nursing facilities introduce learning therapy? Does KLT have effective operating activities? Is it the strength of the Kumon brand? The nursing facilities that introduce KLT learning therapy hope to deliver better care for seniors, and are conducting the therapy on limited resources. I believe that KLT's actions and activities are examples of social entrepreneurship. Moreover, I think that the actions and activities of the nursing facilities introducing KLT learning therapy are also examples of social entrepreneurship. Austin et al. (2006) define social entrepreneurship as "innovative, social value-creating activities that can occur within or across the nonprofit, business, or government sector."

Diffusion of KLT learning therapy initially began as related to the science of the brain, because it can potentially stop the progress of dementia. A few years later, the positive impact of learning therapy was demonstrated in enhancing the operational efficiency of nursing facilities and increasing the motivation of staff. For example, nursing facilities increased business productivity, reduced employee turnover, and worked in close cooperation with various professions. This result is attractive for nursing facilities facing human resources challenges. Most recently, an increasing number of nursing facilities are introducing KLT learning therapy after finding value in these results.

V. Analyses and Findings

A key factor in the continuous spread of KLT learning therapy across Japan is the

formation of networks between the nursing facilities introducing it, which have gradually developed into a variety of communities of practice [Figure-4]. These networks and communities of practice are evident countrywide. Most nursing facilities introducing KLT learning therapy contemplate "how to achieve better care for elderly people with dementia through learning therapy." Thus, they developed regional networks to learn about each other and their evolution through KLT's practical learning therapy. How do these communities of practice form across Japan? Has KLT played a central role in forming communities of practice? Actually, these activities represent independent efforts by nursing facilities introducing learning therapy. The conditions of communities of practice differ regionally, and as such, each has distinctive characteristics. KLT plays the role of a catalyst to form communities of practice.

The first communities of practice emerged around seven years ago in Ehime Prefecture, when while a certain nursing facility in Ehime made great efforts to introduce learning therapy to users, it could not do so effectively. This facility has constantly struggled. The facility then consulted KLT staff, who suggested observing those nursing facilities effectively providing the therapy. Subsequently, they toured a superior facility in Fukuoka through the intermediation of KLT, recognizing the strong need to learn from each other. Consequently, this facility became a leader and formed communities of practice in Ehime. Their members are nursing facilities introducing KLT learning therapy. A few years later, these communities of practice have spread to Hokkaido, Ooita, Fukuoka, Shiga, and so on. Members belonging to each community of practice meet regularly to share information and learn from each other. Most recently, in addition to sharing information on learning therapy, they also voice concerns regarding their facilities. A KLT staff member provides support in terms of effectively transferring members' knowledge between facilities and by coordinating their communities of practice.

Nursing facilities are increasingly crowded. There are many institutional barriers and boundaries between facilities providing nursing care services. There are also councils based on the functional category of nursing care services. However, in the past, interaction across various boundaries of nursing facilities have been limited. KLT achieved this interaction based on providing learning therapy across various nursing facilities offering different nursing care services. As a result, in some regions, it is in the process of changing people's perspectives on elderly nursing care. Furthermore, more nursing facilities are currently considering introducing KLT learning therapy.

VI. Conclusions

In this paper, I attempted to consider the mechanisms of social innovation diffusion through a case study on Kumon. I consider the key concepts of social innovation diffusion through a variety of communities of practice to be inter-organizational trust and identity between organizations. The mechanisms of social innovation diffusion through a variety of communities of practice are summarized for the case of Kumon below.

The mechanisms of forming communities of practice based on KLT learning therapy follow. The nursing facilities introducing learning therapy recognized the need to share their best practices and transfer their knowledge between many types of nursing facilities to effectively use the therapy to care for elderly people with dementia. Subsequently, social entrepreneurs developed communities of practice based on KLT learning therapy in some regions. KLT plays the role of coordinator of these communities of practice. Second, I describe the mechanisms of social innovation diffusion after building communities of practice based on KLT learning therapy. Nursing facilities introducing learning therapy developed a trusted relationship with each other through communities of practice based on learning therapy in each region. These promote knowledge transfer or information sharing between facilities. Perceiving their communities of practice to be beneficial further promotes inter-organizational trust. Moreover, they created a new identity for learning therapy that is more than the identity of belonging to their facilities. As a result, they have enhanced their relationship of trust with each other through their communities of practice, and have become the moving force for enriching the quality of care in regions by increasing the number of nursing facilities that have introduced learning therapy. I consider this social entrepreneurship.

After the activities of communities of practice based on learning therapy became more active, they participated in other communities of practice for geriatric care in their regions. Consequently, they expanded their activities to include participation in regular meetings held by medical doctors, clinical nurses, and care workers in regions, as well as participation in community events. These activities are their autonomous actions. Because of these activities, nursing facilities not providing KLT learning therapy also experienced it, and have come to view the nursing facilities introducing learning therapy with KLT's staff, developing a new relationship of mutual trust. They have made the decision to introduce learning therapy, and continue to participate in communities of practice based on it. Furthermore, they forged an identity for learning therapy and contributed to recruiting new members for communities of practice. I think social innovation is diffusing as a consequence of these cycles.

Scant attention has focused on the mechanisms of social innovation diffusion. However, demonstrating these mechanisms in terms of communities of practice is a significant contribution of this paper. A challenge for the future is to further explore the mechanisms in multiple cases.

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Eliza Jennings Website
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Ministry of Health, Labour and Welfare Website
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SAIDO Learning Website
http://saidolearning.com/

Appendixes

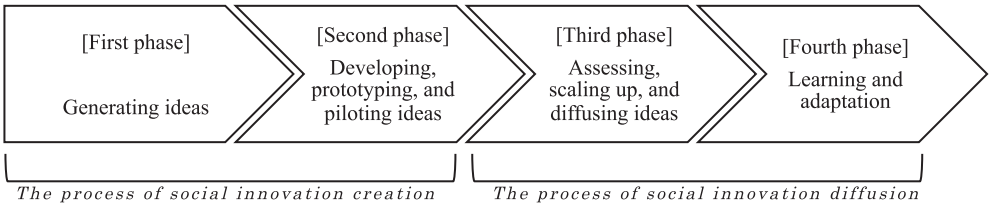

Figure-1 The social innovation process (Mulgan, 2006; Mulgan et al., 2007)

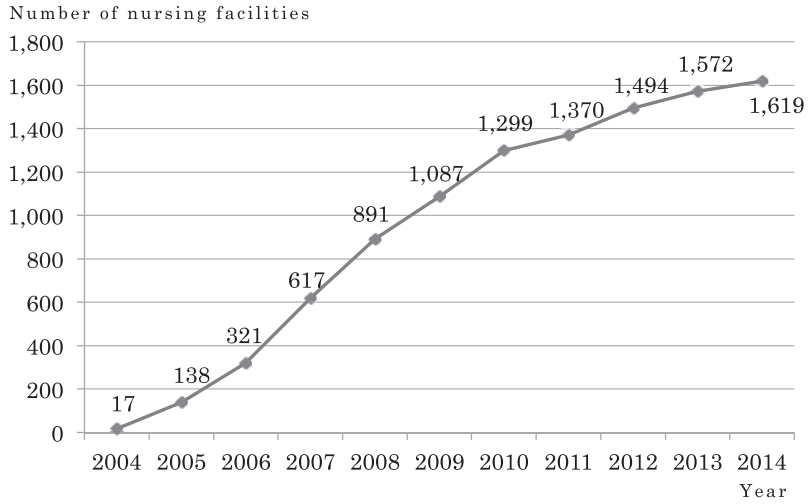

Figure-2 Status of diffusion of learning therapy in nursing facilities

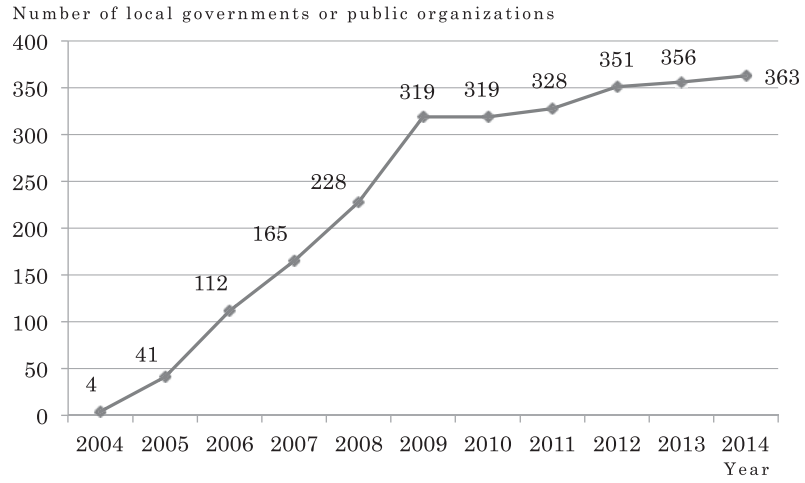

Figure-3 Status of diffusion of learning therapy in local governments

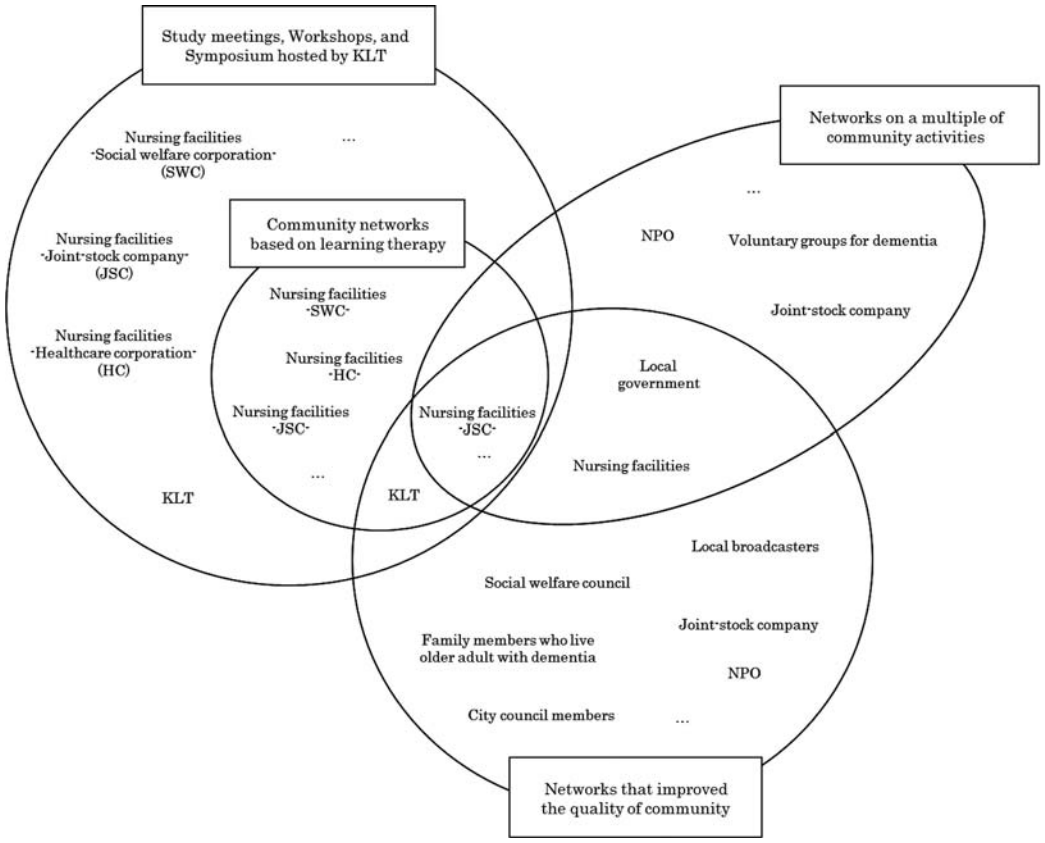

Figure-4 Communities of practice based on KLT learning therapy