The "Community-based Integrated Care System" and Discourse Ethics – From the Viewpoint of Autonomy and Solidarity –

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Abstract

Since the establishment of the Long-term Care Insurance System in 2000, the promotion of the Community-based Integrated Care System has been promoted. The policy of the Long-term Care Insurance System sets in-home care services before reducing the economic burden in this country. However, this idea is not used in the latest report. The policy that individuals requiring care and terminal-stage patients be sent into a large-scale accommodation in a depopulated area and live there until they die, is not adopted because of the belief or philosophy of the foundation of respect for dignity.

In this study, I discuss the problems of the core concepts of the community-based integrated care system; we reconsider these problems from the standpoint of discourse ethics, which considers autonomy and solidarity as equal fundamental principles.

Keywords: The Community-based Integrated Care System, Community Care Service, Autonomy, Solidarity, Discourse Ethics

Introduction

Japan is ahead of other countries in the super-aging and declining birthrate society, and various problems are being discussed in relation to this. Among them, the most urgent issues that need to be addressed with a medium- to long-term perspective are medical and long-term care issues, or more broadly, the issue of how to guarantee the sustainability of the social security system.

Since the introduction of the long-term care insurance system in 2000, the cooperation and integration of medical care and social welfare have been sought. The promotion of the community-based integrated care system is currently advocated as part of this trend. The reason for promoting the community-based integrated care system relates to the problem of the burden on financial resources and its future implications on the public. This is because the increase in benefits, such as the increase in long-term care and end-of-life care in facilities, will increase medical and long-term insurance premiums and tax burdens. However, the choice of in-home services, including end-of-life care, within the junior high school district as the smallest unit, was just given, rather than simply reducing the burden of insurance premiums for the public and the tax burden of facilities. This choice is supported by the philosophy of respect for dignity; in other words, the core philosophy of this system is to not send people who need serious long-term care or who are at the final stages of life to the large residential facilities in depopulated areas, where they live until the end of their lives.

Against this background, the main pillars of reform of medical care and long-term care insurance currently underway are the promotion and enhancement of the community-based integrated care system and the formulation of community medical care plans. In particular, correcting the unequal distribution of medical and long-term care systems in the region is a major issue. The development and transition from hospital-based medical and nursing care systems to community-based medical and long-term care insurance systems occupies an important position. Therefore, in this paper, I will first discuss what is the "community-based integrated care system" and its characteristics; then, I will consider the problem of this system from the viewpoint of the ethics of care and discourse ethics.

1. Why is there the "Community-based Integrated Care System" now?

1.1 Social Background of the Community-based Integrated Care System

The declining birth rate and super-aging population in Japan is progressing more rapidly than that in other countries. When the long-term care insurance system was enacted in 2000 (Heisei 12), approximately 900 million people were latter-stage elderly (75 years or older); by 2015 (Heisei 27), however, their number increased to 1400 million people. The so-called baby-boomers generation will become the latter-stage elderly of 2025 consisting of 21.79 million people (36.57 million aged 65 years or older). These individuals account for 18.1% of the population (30.3% aged 65 years or older)[i] and together are called a super-aged society. Therefore, it is clear that the need for medical care and long-term care for the elderly will increase more than ever before. It is also clear that this society will be characterized by numerous deaths. In particular, it is expected that the number of latter-stage elderly will increase rapidly, especially in urban areas, and that the number of elderly households with only a single individual or a couple and with dementia will increase.

Therefore, the hospital-focused view of medical and long-term care insurance, which targets the acute phase, cannot cope with such new situations. In the integrated reform of medical care and long-term care, "even if each citizen needs medical care and long-term care, it is an urgent task to create an environment wherein they will be able to continue living in their own community in which they are accustomed to living, with peace of mind, if possible to the last stage of their lives in that community as much as possible"[ii]. "2016 (Heisei 28) version of White Paper Ministry of Health, Welfare and Labor" explains the background of the community-based integrated care system as follows: "due to the change of the disease structure and the aging society, there is a need to shift to 'medical care that cures supports' and to continue living with dignity in one's own community, where people are accustomed to living, through various services such as medical care, long term care, and living support service"[iii]. As explained above, there is no superiority or inferiority between medical care and long-term care, and a lack of relation between the two is negated.

While maintaining the existing social security system, the elderly individual's wishes are respected because of being able to lead an independent daily life and effectively and efficiently use social resources, namely, "medical care, nursing care, care prevention, housing, and support in daily living." In other words, it is necessary to ensure that these resources are provided in a comprehensive manner. Accounting for differences in population density and other factors, it is important to establish various services according to the actual conditions of each region and not based on the nationwide system. At the core of this is the community-based integrated care system.; therefore, it is important that the community-based integrated care system is not assumed to be provided as a centralized system of

medical and nursing care, rather as a service that respects the uniqueness of each region.

In this chapter, I neither discuss the detailed history of the previous long-term care insurance system before the proposal of the community-based integrated care system, nor analyze the Long-Term Care Insurance Act (enforced in 2012) that examined the community-based integrated care system in 2011 and the background and history of the revision of medical resources in the long-term care insurance in 2012 [iv].

1.2 History and Significance of the Community-based Integrated Care System

As has often been pointed out, "the concept of community-based integrated care systems" was not first used in the "Act on Concerning the Improvement of Relevant Laws to Promote Comprehensive Securing of Medical Care and Long-term Care in the Community" (abbreviated as "Act on Promotion of Comprehensive Securing of Medical Care")[v]. More information will be provided in related books. Briefly summarized, the term "community-based integrated care system" was already known because in 1984, Mitsugi-General-Hospital's (at that time) director, Noboru Yamaguchi, pointed out the importance of comprehensively developing not only medical care but also prevention, rehabilitation, visiting nursing, long-term care, and welfare[vi]. Furthermore, there is an example of the "home-visit nursing care business for the bedridden elderly" that began in 1971 under the then Director of Tokyo White Cross Hospital (Tokyo Hakujuji Hospital), Satoshi SATO; in 1990, the hospital developed an in-home medical care organization called "Life System." This is an example of inauguration[vii]. According to SHIMAZAKI, the reason for these efforts was "to maintain and improve the quality of life of discharged patients from hospitals"[viii]. Moreover, Satoshi SATO positively evaluated the efforts in this field by pointing out that "community-based integrated care system and in-home medical care were not created in the minds of government officials. They are practical concepts that emerged in the process of developing community healthcare. In fact, whether it is community-based integrated care or in-home medical care, policies are, in many aspects, formed on the model of these pioneering efforts."

Furthermore, in 2003, the promotion of the community-based integrated care system was advocated in the "2015 Elderly Care" report released by "the Elderly Care Study Group" (chaired by Tsutomu HOTTA); in 2010, "Community-based Integrated Care Study Group" (Chairman Shigeru Tanaka) defined the community-based integrated care system as "a system in which a variety of living support services, including not only medical care and long-term care but also welfare services, on the basis of providing housing depending on people's needs, in order to ensure the safety, security and health of people, can be provided appropriately in the field of everyday life (everyday life sphere)"[ix]. Under these circumstances, the "Act on Improvement of Relevant Laws to Promote Comprehensive Security of Medical Care and Kon-term Care in Local Communities" (abbreviated as "Act on Promotion of Comprehensive Security of Medical Care") was endorsed.

On the other hand, the significance of developing the community-based integrated care system was summarized by the Ministry of Health, Labor and Welfare (MHLW) as "the significance of comprehensively securing medical and long-term care"[x] .

The medical and long-term care delivery systems in Japan, which the World Health Organization has evaluated as a medical insurance system that achieves universal health insurance, has been developed under the medical insurance and long-term care insurance system, which has found its roots in society since its establishment 17 years ago. In the past, it was argued that the disease structure shifted from

acute to chronic diseases, but now it is discussed that in the aging population, elderly chronic diseases are increasing and that the disease structure is changing again. Therefore, for medical needs, "the need to maintain and improve the quality of life (QOL) while coexisting with illness is becoming more important than ever" (ibid).

Regarding long-term care needs, the number of people requiring long-term care and the elderly with dementia, which are inseparable from medical care needs, is expected to increase with the aging of the baby boomer generation. Furthermore, the need for collaboration between medical and long-term care is increasing more than ever. In particular, services must be adapted on an individual basis to provide appropriate care in accordance with the stage of dementia, while considering regional properties such as population density. Furthermore, it is necessary to provide appropriate diagnoses and responses from an early stage. In addition, according to the population structure changes, the sustainability of both systems must be ensured by balancing the benefits and burdens on the medical insurance and long-term care insurance systems.

As seen above, the provision system of medical and nursing care needs to "provide services in a seamless and efficient way" from the point of view of each individual using the service. In particular, depending on the actual conditions of each region, such as rapidly aging urban areas or depopulated areas, emphasis will be on securing housing where people can live with peace of mind and living support that supports autonomy and cooperates with disease prevention and long-term care prevention.

Therefore, "building a seamless medical and long-term care provision system from the user's point of view, and continuously realizing care that supports the autonomy and dignity of every citizen in the future is the significance of comprehensive securing of the medical and long-term care"[xi]. There seems to be no particular problem with the MHLW's explanation of the "significance of comprehensive security of medical care and long-term care."

1.3 What Is a Community-based Integrated Care System?

The concept of the community-based integrated care system has been legally defined in Article 4, Paragraph 4 of the "Act on Promotion of Reforms to Establish a Sustainable Social Security System" (commonly known as the "Social Security Reform Program Act"), which was enacted in December 2013 (Heisei 25). In other words, the "Community-based Integrated Care System" refers to "a system that provides comprehensively to secure medical care, long-term care, care prevention (which means prevention of becoming a state requiring long-term care or support, or reduction or prevention of deterioration of the state of requiring long-term care or support, and other services to enable to elderly people to live independent daily lives according to their abilities in their familiar community where they are accustomed to living as much as possible, according to the actual conditions of that area), and support for housing and independent daily life." Furthermore, the "Medical and Long-term Care Comprehensive Security Promotion Act" (abbreviation), especially the "Act on Promotion of Comprehensive Systematic Development of Public Nursing Care Services in the Communities," was revised in 2014 (Heisei 26); this explanation was taken over in Article 2 "Act on Promotion Comprehensive Assurance Medical and Nursing Care in the Community" (abbreviated as the "Revised Act on Promotion of Comprehensive Assurance of Medical Care").

Moreover, in 2015, the MHLW stated that in "realization of welfare services for the construction of

communities where everyone can support each other – a vision for providing welfare in response to a new era" (abbreviated as "New Welfare Vision"), "there is a need to rebuild the ability to support the entire region." It is necessary to note that it proposed to widen the range to "all generations, all subject type regional comprehensive support"[xii]. Certainly, this "new welfare vision" is not an official document of MHLW, but a document of the "project team for studying the ideal way of a new welfare service system etc." However, it is important to consider community-based integrated care systems because in this document, the community-based integrated care systems for the elderly and comprehensive support systems, such as an independence support system for the needy individual, should have a broader range to include not only the elderly and the needy but also other people in every field of the community not per each system" (p.6); or "to build a new community-based integrated care system which all residents in the community, regardless of the elderly, people with disabilities, children, needy, can be supported according to the status of their circumstances" (same as above). When long-term care insurance system was enacted, the idea at the core of this law shifted from "family care" to "socialization of care"[xiii]. However, the idea is not limited to long-term care, but is broadly regarded as care and can be called "care in the community"[xiv]. As shown above, it is significant that the definition of the community-based integrated care system, which was only informally spoken about by the parties concerned, is legally clarified.

However, it has been pointed out that the image received from the term "system" is ambiguous and understood differently, influenced by the conventional way of providing vertical division of service between medical care and long-term care. Therefore, this point is confirmed as follows:

First, it is pointed out that there is a deep-rooted understanding that many people receive the term "system" as a nationwide uniform service provision that is supervised and directed by the national government or MHLW in general, and medical care and long-term care are separate frameworks, or that the range covered by the community-based integrated care system is long-term care, while medical care belongs to the conception of regional medical care. However, as Niki points out, it is not a "system" in the sense of providing uniform services throughout the nation limited to long-term care, but a "network," established by the close cooperation of medical and long-term care, that takes advantage of regional characteristics as seen in the article of the "Revised Act on Promotion of Comprehensive Assurance of Medical Care," shown above[xv]. Even now, the fact that the term "Community-based Integrated Care System" is still used as ever is a factor of confusion.

2. Changes in the "Figure of the Flowerpot" and the Regression of the Meaning of "Self-help, Mutual help, Mutual assistance, and Public assistance"

Since the community-based integrated care system is often explained in terms of the "Figure of the Flowerpot (Figure of Uekibachi)," I briefly explain its meaning and point out certain important changes in the FY2015 version from the FY2012 version.

2.1 Explanation of the changes of "Figure of the Flowerpot"

First, I confirm that relating to the community-based integrated care system, the diagram in Figure 4-3-3 titled "How to understand the community-based comprehensive care system" on page 150 of the 2016 White Paper on Health, Labor and Welfare (hereinafter referred to as the "2016(H28) White Paper") shows several changes (see Figure 1), in comparison to the "flower pot" figure that is placed on the

current HP of MHLW (September 30, 2017) (hereinafter referred to as "2015(H27) White Paper").

In particular, the explanation of "the Plate" to support "the Flowerpot" has been changed from "the choice of the individual/family and their attitude"[xvi] in the 2013(H25) version, to "the choice of the individual and the attitude of the individual and family" in the FY2015 (H27) version[xvii]. The choice of the individual is most respected, and this emphasis on the individual's choice as a basic idea to protect the dignity of the individual is commendable. However, in spite of the already published "2016(H28) White Paper," the two are mixed at present, causing confusion. This is explained in the following figure (Fig 1)[xviii].

Fig. 1 Transition map of "flowerpot"

The Community-based Integrated Care System and regional management (summary version)" in FY2015 (Heisei 27) community-based integrated care study group)

First, the "Flowerpot" illustrates that the five elements of the community-based integrated care system are organically related. I explain Figure 1 of the FY2015 of flowerpot as follows. The "housing and their way of living," which means the basis of life, are indicated by "flowerpots," and the "dish" which supports the flowerpots, and the whole is "the choice of the individual and the attitude of the individual/family." The "soil" represents "long-term care prevention and living support service" in a "bowl," which depicts "housing and the way of living." The three leaves of the plant, which grow due to nutrition in the "soil," denote the specialized services of "medical care/nursing care," "long-term care/rehabilitation," and "health/prevention."

In general, when people talk about care, they tend to focus on professional services corresponding to the three leaves. This figure also shows that such professional services consist of, at first, housing and the way of living as the basis of life to support the QOL and dignity of the individual; second, continuous long-term care prevention/living support services; and third, a choice of the individual and the individual/family's attitude as the basis for realizing such purposes.

Let's compare it with the flowerpots in FY2012 more concretely. First, the plate is the basic foundation. The plate in FY2012 as "the choice of individual/family and their attitude" was shifted to "the choice of individual and individual/family attitude" in FY2015. According to the "Report," this shift in the

flowerpot's meaning was made from the perspective that "the choice of individual and the individual/ family attitude" should be the most important in themselves, while the meaning of the plate in FY2012 was incorporated at first as the basis for the continuation of individual life in the local community.

Although this shift itself is valid as a philosophy, at the end of the explanation, the sentence "it is important for the family to receive the individual's choices firmly and respect the quality of life of the individual even if each needs long-term care" (p.15) [xix] warrants attention. The range of families in this figure is unclear. In consideration of care opened to the community or society, that is, promoting the shift from "family care" to "socialization of care" and further to "care in the community," it may confine each individual's body into one single "body (physical)." In this regard, Niki has evaluated that Shigeru TANAKA, in a paper published in "the 2014/2015 edition of the Japan Medical Association Conference on Medical Policy" and in recent interviews, has stated that "the family refers to the spouse" and that "grown-up children making an independent living should be regarded as another subject or relatives"[xx].

Next, the shift from "health/prevention" to "health/welfare" in the leaf part and the shift from "living support service/welfare service" to "care prevention/living support service" are closely related, and therefore they are explained together. In FY2015, long-term care prevention for the person requiring support has been implemented as a comprehensive program for long-term care prevention and daily living support services. This means that long-term care prevention and living support services are provided integrally and by various subjects (p.13).

In other words, long-term care prevention is not provided as a separate service, but as part of the living support service "ensuring opportunities for social participation through self-help and mutual help." By contrast, the improvement of life function for prevention of disease aggravation and support for independence is largely due to the multidisciplinary collaboration among professionals, mainly in rehabilitation for daily life. (p.14)

Shimazaki points out that focusing on "integration (comprehensiveness)," "continuity," and "community" rather than the flowerpot diagram, can help better understand the essence of the community-based integrated care system. In other words, "integration (comprehensiveness)" refers to the perspective that medical and long-term care services support the whole life of a person, because a person's life comprises numerous smaller parts. "Continuity" refers to the suitability of services while maintaining consistency in providing services because people's lives change while maintaining continuity, for example, because of aging. "Community" means that people's lives are conducted daily and continuously in a familiar place[xxi]. Shimazaki distinguished between the home medical care and community-based integrated care system, because the latter is built as "the seamless provision of services among medical care, long-term care, prevention, housing and living support service," it may no longer be required to understand community-based integrated care and home medical care as independent concepts[xxii].

2.2 About "Self-help, Mutual-help, Mutual-assistance, Public-assistance"

Next, along with the figure of the Flowerpot, "self-help, mutual-help, mutual-assistance, and public-assistance" are mentioned as important concepts in the community-based integrated care system.

First, we examine these concepts in the latest "Report on Community-based integrated care system Study Group in FY2016 (Heisei FY28) – challenge for 2040"[xxiii]. According to it, from the aspect of

cost burden, "public assistance" refers to the burden of taxes, such as elderly welfare program and livelihood protection in general financial resources, and "mutual assistance" refers to risk sharing the insured individual's burden, such as long-term care insurance and medical insurance. "Self-help" refers to taking care of one's own self, including one's own healthcare, but it also includes the purchase of market services. "Mutual help" is not described here, because it is the same as mutual assistance in the sense of supporting each other and voluntary support by neighborhood residents and volunteers without the institutional cost burden.

Notably, in this report, although the tendency to include family members in self-help has disappeared[xxiv], in the section "changes associated with period and regional characteristics," it is clearly stated that there is a transformation from "a standard family care" premised on three-generation households in the context of traditional family system culture. On the other hand, as an example of an increase in single-person households at suburban housing complex in the super-aging society, this report agreed clearly that shifting to mutual assistance and public assistance is difficult and expects self-help and mutual help to play a primary role (p.50). In other words, in urban areas, "mutual help" cannot be maintained unless it is consciously strengthened in community-building, because connections among residents are weak. At the same time, the private service market is large, so it is possible to provide "self-help." By contrast, in non-urban areas, ties among people are strong, so it can be expected that "mutual help" will play a large role, but private services are limited (p.51). The division of roles and meanings of these four concepts will change with period and region, and are summarized as follows: "The need for 'mutual assistance' and 'public assistance' are not insignificant, but considering the decreasing birthrate and aging population, it would be difficult to expect a significant expansion of care-giving institutions. In that sense, it is necessary for everyone to be aware of the increasing role of 'self-help' and 'mutual help', and, therefore, to promote their own efforts consciously knowing the growing roles of them" (same as above).

The FY2016(Heisei FY28) Edition did not include the inclusion of family into "self-help" because of bad reputation, but "self-help" and "mutual help" is emphasized because of the declining birthrate and aging population, financial situation, and the increasing single-person elderly households. Therefore, this report is focused on "support for independence" (p.52); it is clearly a retreat from the fact that "maintaining of dignity" and "support for independent living" seen in the previous report were stated in apposition[xxv]. In the FY2016 edition, there is no longer a presentation of the basic principles seen in the FY2011 edition but there are presentations seen only in the items of minor classification, such as "3. Support for independence is not for improving physical and mental functions, but for maintaining of dignity of the elderly." in the items of the third major classification "3. Prevention to protect 'preservation of dignity' and 'support for independence'." Furthermore, it is contradictory that the prevention is limited to the elderly, even though it points out that in the items of minor classification "maintaining of dignity" and "support for independence" as the realization of "regional symbiosis society" is the purpose of society and the prevention applies not only to the elderly but also to the physically challenged and residents raising children in a community. It should be clear that support for independence is not the only way to maintain dignity.

Therefore, the promotion of the community-based integrated care system, in the sense of shift from family care to community-based care through socialization of care, has reduced maintenance of dignity of each person to the "independence support" of the individual, i.e., individual's decision-making support, or "simply the living support based on individual's will (including potential ones that do not give voice)."

As mentioned above, in this section, I considered "self-help, mutual help, mutual assistance, public assistance" as the basic concepts and the "Figure of the Flowerpot" used to explain the community-based

integrated care system in "the Report". I also pointed out fundamental problems of explanation of those in "the Report." The community-based integrated care system will be considered as a new attempt to balance autonomy and solidarity with each citizen from a discourse ethical perspective.

3. Community-based Integrated Care System and Discourse Ethics
　–Autonomy and Solidarity–

　　The basic concepts of discourse ethics are autonomy and solidarity, both of which are considered as equifundamental (gleich-ursprünglich in German) principles[xxvi]. Autonomy does not simply mean living a life in which one can do as they please on their own. There is autonomy, even with support for daily activities. Therefore, autonomy and solidarity are inseparable.

　　As already indicated, when the long-term care insurance system started, the need for a shift from "family care," modeled on the three-generation family household that did not conform to by social realities, to "socialization of care" or care by community, was declared. The containment of persons requiring long-term care and persons with disabilities in a large-scale care facility will greatly limit their social activities. It may seem that some people who deviate from these restrictions are problematic (see [xiii]). The implication of those views, in fact, not only include persons requiring long-term care, but also cases requiring diet or prevention of long-term care. Therefore, I pointed out that people tend to reduce the problems of the body to simply one's stand-alone body itself. That is, we perceived that the presence of an individual is confined within the private body itself. By contrast, the mutual social interaction through physical care is built in the technological equipment of modern medicine, such as blood transfusion, brain death and organ transplantation, artificial organs, prenatal diagnosis, and gene therapy. It has also come to be represented by an administrative management system centered on hospitals and health insurance systems. In that sense, individual existence is fragmented, and its social characteristics are undermined.

　　The FY2015 report's emphasis on self-help and mutual help assumes, on the one hand, a neglect of economic and social demand of care on the grounds of financial resources; on the other hand, it proves vulnerable autonomy and social solidarity (both are also deep bonds).

　　While the FY2015 report emphasizes independent support, the sublime volunteer spirit and psychological satisfaction such as 'caregiver is healed in the care' should not be substituted for the emotional instability of deeply involved care, or not be substituted socially significant work as professional work for care workers' low wages on grounds of psychological satisfaction. The care worker's low wage, except for medical professions, is problematic today. Even today, the socialization of long-term care does not work as a seamless continuous support for users. As a typical example in-home support, helpers and nurses cannot attend to users seamlessly 24 hours and 365 days, because of depending on the user's financial situation. Long-term care services are used in fragments. Additionally, the FY2015 report's emphasis on self-help and mutual help still assumes that the "family" fills this gap. In other words, when a user (elderly or person with physical challenge, etc.) undergoes a change in their physical or mental condition, the decision and arrangement of responses and treatments for this change depends on the mental and physical burden of the user's family and the burden is never socialized.

　　Therefore, emphasizing "self-help/mutual help," because of an increasing number of single-person households (whether elderly or not), the latest report makes void both the original principles of autonomy and solidarity. Autonomy can only be realized with social support, and solidarity supporting

autonomy should not be sought in mutual help but established as a system of mutual assistance and public assistance. It should be coincidental with the original idea of long-term care insurance law.

The relationship between community-based integrated care systems and integrated care will be discussed later.

Note
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[i]   Ministry of Health, Labor and Welfare(MHLW) "The Community-based Integrated Care System" "Forecast of the elderly population in the future", http://www.mhlw.go.jp/ seisakunitsuite / bunya / hukushi_kaigo / kaigo_koureisha / chiiki-houkatsu / dl / link1-1.pdf
[ii]   This expression uses various names, but see below, for a typical one.
        MHLW "integral reform of the medical and nursing care"
        https: // web.pref.hyogo.lg.jp/kf15/documents/04houshin.pdf
        MHLW "basic policy for a comprehensive secure the medical and nursing care in the community" (Comprehensive ensure policy) 2014(Heisei 26) notice, 2016(Heisei 28) some amendments
        https: //web.pref.hyogo.lg.jp / f15 / documents / 04houshin.pdf
[iii]   MHLW "2016(Heisei 28) edition of the Annual Book of Health, Labor and Welfare White Paper" p.147
        http://www.mhlw.go.jp/wp/hakusyo/kousei/16/dl/1-04_03.pdf
[iv]   Takako TSUTSUI, "Science of Community-based integrated Care Systems," 2014 , Social Insurance Research Institute, pp.16-21
[v]   Ryu NIKI, "Community Comprehensive Care and Community Medical Cooperation," Keiso Shobo, 2015, p. 3.
        Ryu NIKI, "Community Comprehensive Care and Welfare Reform," Keiso Shobo, 2017, p. 20
        Kenji SHIMAZAKI, "Re-questioning Medical Policy," Chikuma Shinsho, 2015, p. 161
        Kenji SHIMAZAKI, "What is the Community-based integrated care system," "nursing White Paper Heisei 26 version" Japan Nursing Association Press, 2014, 2 pages
        The above literature explains the history and historical background of community-based integrated care systems.
[vi]   Noboru YAMAGUCHI, "Endless Dreams for Comprehensive Medical Care," Well-being and Welfare, 3287 , 1984 , pp. 2-6
[vii]   Satoshi SATO "to seek the essence of home health care" Nihon Hyoronsha, 2000.
[viii] Kenji SHIMAZAKI, "Re-questioning Medical Policy," p.161
[ix]   "Report Community-based Integrated Care System"<Community-based Integrated Care study Group>, Mitsubishi UFJ Research & Consulting, p.6
[x]   MHLW "Integrated Reform of Medical Care and Nursing Care"
        http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000060713.html
[xi]   ibid.
[xii]   http://www.mhlw.go.jp/file/05-Shingikai-12201000-Shakaiengokyokushougaihokenfukushibu-Kikakuka/bijon.pdf
[xiii] The "socialization of nursing care" is based on the principle of "national solidarity" as stated in Article 1 of the Long-Term Care Insurance Law, which states that "benefits related to necessary health and medical services and welfare services shall be provided so that individuals requiring nursing care

can preserve their dignity and lead independent daily lives according to their abilities. It also refers to the philosophy expressed in Article 4 of the same law, which states," The people shall bear the costs of the long-term care insurance business fairly based on the principle of common solidarity.

As for the problems involved in the socialization of nursing care, Kiyokazu Washida has already introduced the issues involved in the implementation of this system. (See "The Socialization of Long-Term Care: The Poor Relationships between Bodies, Words to Describe the Predicament of Those Involved" (Asahi Shimbun, evening edition, March 29, 2000)). In this article, Washida raises the question of how to weave "a new form of intimate sphere that does not revert to the traditional family, and at the same time, a new form of social sphere that does not take the form of institutions.

[xiv]   Some people regard this concept by MHLW as a combination of integrated care and community-based care systems and describe it as "community-based long-term care." Takako TSUTSUI, op.cit.,p.31 One of the core concepts that constitutes integrated care is "normative integration." This concept was used frequently in the 2013 Report, but in the 2015 Report, it is described as "setting common goals in the community and sharing them among the parties concerned," "setting specific goals that can be quantitatively evaluated and sharing them among the parties concerned," or "setting specific 'goals' to evaluate the idea of 'what kind of community we want to create' and its progress. or "setting specific 'goals and indicators' to evaluate progress". This was not used, at least in the summary version.

[xv]   Ryu NIKI, "Community Comprehensive Care and Community Healthcare Collaboration," pp. 6-7

[xvi]   As a reference example, the following is given as a diagram for explaining MHLW HP "The Community-based Integrated Care System."
http: //www. mhlw.go.jp/seisakunitsuite/bunya/hukushi_kaigo/kaigo_koureisha/chiiki-houkatsu/dl/link1-3.pdf. This figure is 2017 May 24, the HP or with directly from the link is pasted so it is easily the most accessible. The source is Note 10 which is the source Mitsubishi UFJ Research & Consulting "<Community-based integrated care system Study Group> Community-based integrated care system and regional management" 2013(Heisei 25) White Paper. In the following, it will be referred to as "2013(H25) White Paper"

[xvii]   "2016(Heisei 28) edition of the Annual Book of Health, Labor and Welfare White Paper" p.150 , chart 4-3-3. or http://www.,hlw.go.jp/wp/hakusyo/kousei/16/dl/all. pdf p.166 Fig.4-3. Source is "Mitsubishi UFJ Research & Consulting" <Regional Comprehensive Care study Group> regional comprehensive care system and regional management. http://www.murc.jp/uploads/2013/04/koukai130423_01.pdf (FY2015(Heisei 27) MHLW Geriatric Health Promotion Project 2016 (hereinafter referred to as the "H27 regional comprehensive Care study Group report"). http://www.mhlw.go.jp/file/06-Seisakujouhou-12400000-Hokenkyoku/0000126435.pdf

[xviii]   See below for the transition of the "flowerpot" diagram.
http://www.murc.jp/uploads/2016/05/koukai_160518_c1_03.Pdf 3/7,2015(Heisei 27) "Community-based integrated care system construction plans and services Excerpt from "Research Project Report on the Ideal Way" The Community-based Integrated Care System and Community Management (Summary Version).

For the transition of the "Flower Pot" view refer to the following as an explanation. Tokushima Prefecture Community-based Integrated Care System Systems Association (https: //.www toccs.kp/article.php?aid=148). In addition, Diamond Online "What is the 'Community-based Integrated Care System' that shows the direction of long-term care ? " (http: // diamond.jp/ articles /-/92660? page = 2). Individual blogs were omitted.

For an explanation of the "Flowerpot Diagram," see: Kenji SHIMAZAKI, op.cit., pp.159-160 and Ryu NIKI, "Community Comprehensive Care and Welfare Reform," pp. 25-31.

[xix] "2015(H27) Community-based Integrated Care System Report", p.15.

http://www.mhlw.go.jp/file/06-Seisakujouhou-12400000-Hokenkyoku/0000126435.pdf

In the following, only the number of pages will be included in the text of the citation from the report to avoid complications.

[xx] Ryu NIKI, "Community-based integrated care system and welfare reform" p.30

[xxi] Kenji SHIMAZAKI, op.cit. p.160

[xxii] Regarding this, the so-called "Social Security Reform Program Law" stipulates the same purpose. In addition, the 2013 "Community Comprehensive Care Study Group Report" advocates the integration of medical care and long-term care. For reference. See below:

http://www.murc.jp/uploads/2013/04/koukai130423_01.pdf, especially Chapter 1 "Philosophy of The Community-based Integrated Care System".

[xxiii]   "The Community-based Integrated Care System research project report on the system and services of the way to Develop Community-based integrated care system Study Group report - to challenge towards 2040 -" (2017(Heisei28) elderly health business promotion expenses),

2017 March. For citations, the number of pages published on the following HP is stated in the text. http://www.murc.jp/sp/1509/houkatsu/houkatsu_01/h28_01.pdf

[xxiv]   Ryu NIKI, "Community Comprehensive Care and Welfare Reform," p. 29

[xxv] "Report for 2013," p. 3, above. In light of the fact that the basic principles of comprehensive community care are stated here, and the first item is "'Preservation of Dignity' and 'Support for Independent Living,'" 2015 Report no longer presents the basic principles, and the third item is "Prevention to Protect 'Preservation of Dignity' and 'Support for Independence,'" which reads," 3. The report's third item, "Prevention to protect 'preservation of dignity' and 'self-support,'" has been reduced to "3".

[xxvi]   See below for discourse ethics.

J. Habermas, Erläuterungen zur Diskursethik, Frankfurt am Main, Suhkamp, 1991. translated Koichi Asakura and other "discourse ethics" Hosei University Press, 2005. Also, my book, "Significance and Possibilities of Discourse ethics," Hosei University Press, 2004.