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The Community-based Integrated Care System in the Context of the Novel Coronavirus disease (COVID-19) Pandemic

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The Community-based Integrated Care System in the Context of the Novel Coronavirus Disease (COVID-19) Pandemic

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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 advocated in COVID-19 Pandemic. But "H30 Research Report on Community-based Integrated Care" expects mutual aid based on self-help, while accepting economic and health disparities on the ground of "inevitable disparities". We will discuss the Community-based Integrated Care System in the era of emerging viruses with a view to infectious disease pandemics such as the novel coronavirus pandemic in relation to the significance and prospects of ACP (Advance Care Planning).

Keywords: The Community-based Integrated Care System, Ability Discrimination (Meritocracy), Participation and Collaboration, Participation and Collaboration, Inequality in Health (Health Ineqality)

Introduction

The concept of Community-based Integrated Care System has been studied extensively.[1] The "Report of the Study Group on Community-based Integrated Care" for the fiscal year 2008[2] announced the restoration of "support for independent living" and "preservation of dignity" as basic principles. However, there has been a biased shift towards "support for independent living," and with the fact that these two concepts had the same status being ignored. In other words, the "participation and collaboration" of each citizen as an individual, which used to be a basic principle of the Basic Act on Long-Term Care and the Community-based Integrated Care System, has been constricted to "support for the person's decision-making as 'independence support'." This translates to "support for life based solely on the person's (including unexpressed, latent) will" or "support for the person's life based solely on his or her own will (including unexpressed potential)." Additionally, in the 2008 Reportd,[3] "self-help, mutual aid, mutual assistance and public assistance," of which "self-help and mutual aid" were emphasized, has been taken up again, and neoliberal values have been confirmed. However, in the "Report of the Study Group on Community-based Integrated Care 2040: Community-based Integrated Care System in a Pluralistic Society - An Inclusive Society Created through 'Participation' and 'Collaboration'" of the fiscal year 2008, "self-help, mutual aid, mutual assistance and public assistance" are not mentioned.[4] Indeed, the novel coronavirus infection (COVID-19) pandemic (hereafter referred to as the novel coronavirus pandemic) has caused the theoretical collapse of this neoliberal concept itself—for example, financial support and compensations for absence from work in sectors that suffered severe deterioration in sales and other activities due to suppression of economic activity; benefits for individuals; and cutting value-

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added tax[5] (equivalent to the consumption tax in Japan, where the tax payment was only postponed with conditions rather than reduced). The opposite of neoliberal policies has been adopted in many countries. Additionally, the bankruptcy of the neoliberal theory of self-responsibility is obvious; additionally, Japan stands out, compared to other countries, in international awareness surveys concerning the questions: "infection is self-responsibility or you get what you deserve,"[6] "is the theory of self-responsibility work available for child poverty?" and "does the theory of self-responsibility apply to young people called young careers?" Furthermore, the declaration of the novel coronavirus emergency, in which unnecessary and hasty restrictions were demanded, emphasized the practicality of "waste" elimination and a strict focus on the practical from the perspective of efficiency and productivity. However, as people search for the "new everyday life" when new variants of the virus emerge and spread, a transformation of people's awareness, values, and lifestyle seems inevitable.[7] Accordingly, the concepts of "social inclusion," "participation" and "collaboration" were highlighted in the "H30 Research Report on Community-based Integrated Care" in the fiscal year 2008 ("H30 Community-based Integrated Care Research Report"); here, the emphasis on "self-help and mutual aid" seems to have disappeared. Is the neoliberal ideology, emphasizing "self-help and mutual aid" in the Community-based Integrated Care System, no longer reflected in the "H30 Research Report on Community-based Integrated Care"? We discuss the Community-based Integrated Care System in the era of emerging viruses and variants, with a focus on infectious disease pandemics, such as the novel coronavirus pandemic, in relation to the significance and prospects of Advance Care Planning (ACP).

1. Social background

Japan has entered a "super-aging society (with low fertility)"[8] and is also a "society of multiple deaths." According to the 2020 (R2) Vital Statistics of population (fixed number) released by the Ministry of Health, Labour and Welfare (MHLW), the number of deaths was 1,372,755, down 8,338 from the 1,381,093 deaths the previous year; however, this number is expected to increase once the current novel coronavirus disease has settled.[9] In terms of cause of death, malignant neoplasms (tumors) ranked first (27.6% of all deaths), followed by heart disease (excluding hypertension; 15.0%), senility (9.6%), and cerebrovascular disease (7.5%). Malignant neoplasms (tumors) were the cause of 1 in 3.6 deaths. The instances of death by senility has been increasing since 2001 (H13), becoming the third highest cause of death since 2018. According to the 2020 Health and Labour White Paper, the number of deaths is projected to be increase to approximately 1.68 million by 2040.[10]

In 2007, the number of deaths in medical institutions (including clinics) was 80%; however, in recent years, this proportion has fallen to 70%; the number of people who spend their final days in nursing homes other than at hospitals and at home is increasing (8.6% in nursing homes in 2019)[11]. Therefore, it is becoming increasingly clear that multidisciplinary cooperation helps people at the end of their lives, wherever they may be. However, social inequality and economic disparity are widening in Japan,[12] which are the determinants and cause of increasing "inequality in health."[13]

According to the 2011 National Survey of Lifestyle Preferences (Cabinet Office),[14] the percentage of respondents who answered "definitely agree" or "somewhat agree" to the question "The world is gradually becoming a better place to live," decreased from 37.3% in 1978 to 14.3% in 2011; those who answered "somewhat unlikely" or "not at all likely" increased significantly from 53% in 1978 to 85.3% in 2011. The proportion of those who answered "completely agree" or "somewhat agree" to the question "I

have a bright outlook on my retirement" also fell sharply from 35.2% in 1978 to 14.4% in 2011, while the proportion of those who answered "somewhat disagree" or "completely disagree" rose from 43.8% in 1978 to 89% in 2011.

These numbers suggests that people find it difficult to live their lives or they feel a sense of stagnation. It is reasonable to assume that the situation has worsened since the time of the survey, given the increase in the number of people reporting difficulties in living due to unemployment or reduced income as a result of the novel coronavirus pandemic.

In connection with difficulties in life, it is crucial to examine the number of suicides and their details by age group, as the number of suicides, which had been declining for 11 years until 2019, began to increase again in 2020 due to the pandemic. Moreover, the number of suicides by women increased considerablyk. According to the annual number of suicides announced by the NHLW in March 2021, there were 21,081 confirmed cases of suicide in Japan in 2020—an increase of 912 (about 4.5%) from the previous year (2019) and the first increase in 11 years[15] (Figure 1). Considering the number of suicides by gender, that among males decreased for 11 consecutive years, while that among females increased for the first time in 2 years (however, the total number of suicides is about twice as high for males compared to females). The increase among women and young people can be read as the reason or background for the overall increase. The rate of increase from the previous year was 15.4% (935 persons) for females and 17.9% (118 persons) for minors; among minors, 44% (95 persons) were females, a significant increase (Figure 2). Furthermore, examining the number by age group, in 2020, compared with the previous year, there was an increase in all age groups except for those in their 50s and 60s; the decrease by 170 persons for those in their 60s is the largest, while the increase by 404 persons (19.1%) for those in their 20s is the highest; for those in their teens, the number increased by 118 persons (17.9%) (Figure 3).

Examining the statistical chart as a whole, it can be discerned that after a continuous downward trend for 11 years, the number of suicides increased sharply from around July 2020, particularly among young people and women. According to the "Analysis of Trends in Suicide in the Corona Disaster (Urgent Report),"[16] published in October 2020 by the Center for Suicide Prevention and Countermeasures for Supporting Life (JSCP), a corporation designated by the Minister of Health, Labor and Welfare: "(1) the trend of suicides in 2020 is clearly different from previous years, (2) the number of suicides from April to June has decreased compared to previous years, (3) the number of female suicides is increasing in various age groups, (4) there is an increase in suicides, possibly due to suicide reports in media, (5) the number of female high school students' suicides increased in August, (6) the number of male suicides is still higher than that of female suicides, and (7) various government support measures may be imposing the increase in suicides."

Particularly, the report points out that the increase in female suicide rate is due to problems in economic life, work, domestic violence, child-rearing, and caregiving fatigue, and "in the coronavirus disaster, the increasing severity of these potential suicide causes may contribute to the increase in the suicide rate among women" (Urgent Report). In addition, it reportst a number of consultations on anti-suicide social networking services, in particular, from young people, female junior, and senior high school students who have been affected by the novel coronavirus disaster; reasons included such answers as: "I changed classes after the school closed, and it's hard to fit in"; "my mother stays home all the time, and it is frustrating. She uses me to vent her stress"; and "I can't keep up with my online classes and want to quit high school."

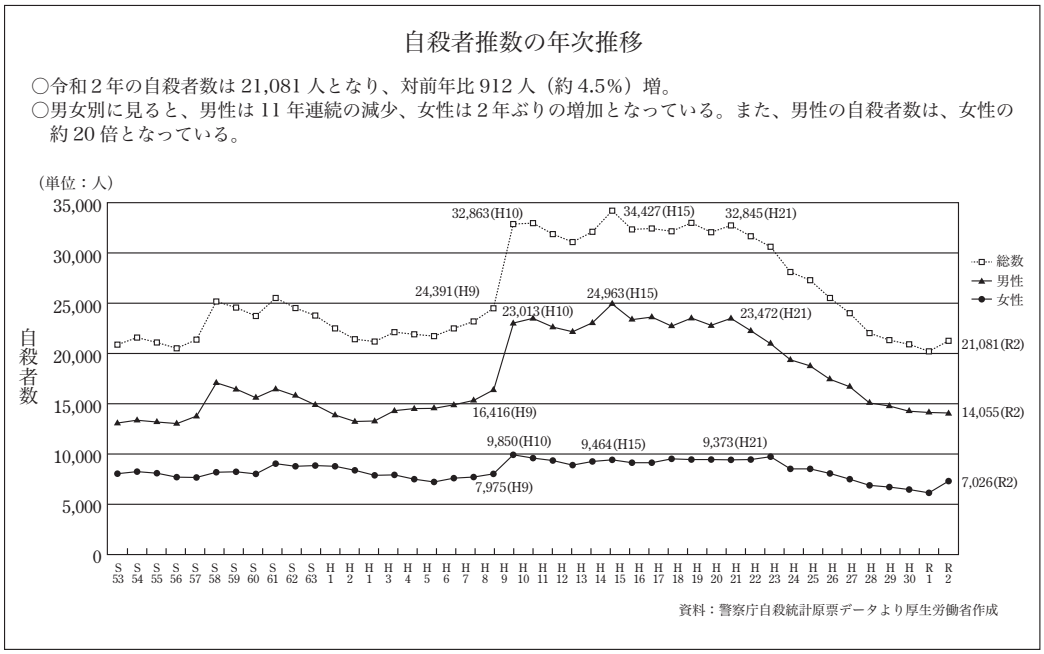

Figure 1: from NHLW, “Status of Suicides in 2020” (March 16, 2021), https://www.mhlw.go.jp/content/R2kakutei-01.pdf

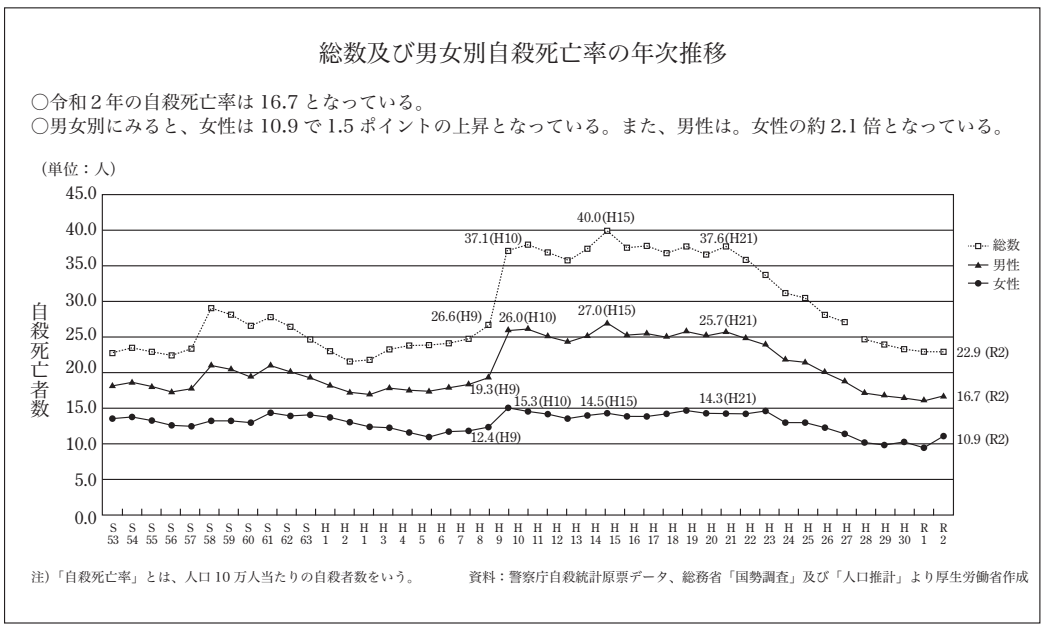

Figure 2: from NHLW, “Status of Suicides in 2020” (March 16, 2021), https://www.mhlw.go.jp/content/R2kakutei-01.pdf

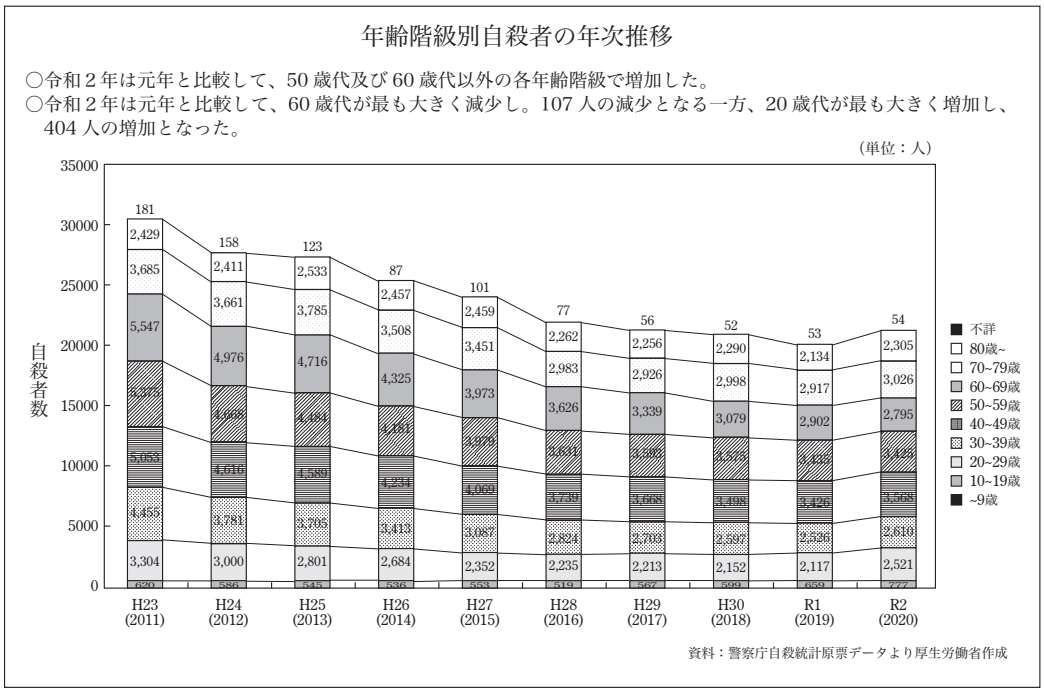

Figure 3: from NHLW, "Status of Suicides in 2020" (March 16, 2021), https://www.mhlw.go.jp/content/R2kakutei-01.pdf

When considering suicides among older adults, the high rate—including double suicide—has remained largely unchanged over the years. Statistics show that suicides among the older adults in their 70s and above account for more than 40% of all suicides (Figure 3). "Loss of meaning and value in life" is considered a trigger. According to the NPO *Lifelink*, "White Paper on the Actual State of Suicide 2013" (1st edition)[17], the factors directly linked to suicide among unemployed people of working age (78 people excluding housewives and students) include depression, living difficulties/debts, family discord, and alcohol problems (White Paper on the Actual Situation 2013 [1st ed.] 1-16).

Thus, it is assumed that people find it considerable difficult to live their lives and lose its meaning with the current excessive competition and social divisiony. Here, I would like to point out that the loss of meaning of life and "ability discrimination" are linked, as seen in the recent indiscriminate mass killing. On July 26, 2016, 45 people—including residents of Tsukui Yamayuri En, a facility for persons with intellectual disabilities in Sagamihara City, Kanagawa Prefecture—were stabbed with knives consecutively, in what is now called the "Sagamihara Incident"; 19 residents died, and 26 others, including two staff members, were seriously injured. A former employee of the facility had reportedly said, "I wish the disabled would disappear," which shocked people. This case is considered the worst murder incident in the post-war period, and it is clear that the motive was ability discrimination based on the assumption that "the elderly and the disabled are useless."[18]

On October 31, 2021, a 24-year-old criminal stabbed and seriously injured a man in the chest on a private railway station in Tokyo; they then spread oil on the train's floor and set it afire. Sixteen passengers were taken to the hospital due to smoke inhalation injuries. The perpetrator said: "I failed

at work and lost my job, my friendships faded away. I wanted to die. I wanted to kill about two people, anyone, and get the capital punishment" (Some people point out that this suicide, namely taking anyone's life unwillingly, is "extended suicide.")[19]; This event is still fresh in the country's memory. The motives of the criminals in these cases reflect "loss of the meaning of life" and "meritocracy (ability discrimination)" at the core. Although not limited to the suicides of older adults, "meritocracy (ability discrimination) toward self and others" can be seen as an underlying motive for recent suicides.

Furthermore,, it is also true that even during the novel coronavirus pandemic, under the name of triage, "selection for life" based on meritocracy (ability discrimination) was overtly stated: "Since this is an emergency situation, the elderly who do not work and are not useful for society should give respirators to the young who have a future." Additionally, "selection for life" based on meritocracy and ability were encouraged.

The seriousness of this problem was pointed out on March 30, 2020 by a Study Group for Bioethics and Medical Ethics, a group of lawyers and doctors involved in bioethics, in their study, "Recommendations on the process for determining the allocation of respirators during a COVID-19 infection explosion."[20] The recommendations point to the possibility that "triage" (prioritizing transport and treatment according to the level of urgency when a large number of people are injured at the same time in a large-scale accident or disaster) be applied due to the shortage of medical resources caused by the novel coronavirus pandemic, and it expresses a sense of crisis, arguing that "we will be forced to shift from medical care that does the best for each patient to medical care that saves as many lives as possible":

> Even in a crisis of a shortage of respirators, the decision to apply a respirator should, in principle, be made based on medical indications and the patient's own wishes, just as in normal times. However, we are faced with unprecedented ethical issues: which patients should use the limited number of respirators, whether it is acceptable to remove a respirator from a patient whose life is being sustained and give it to a patient whose life is more likely to be saved, and if so, what process should be used to make this decision?

Needless to say, "the patient's will" is emphasized as the basis for judgment, but, in the post-coronavirus eras, "ability discrimination" is likely to become the standard institutional design principle in a super-aged society.

2. Neoliberal values behind the Community-based Integrated Care System

The basic principles of the Community-based Integrated Care System, its components, and some of its problems have already been discussed[21]; this section provides a brief overview to avoid duplication. The concept of the Community-based Integrated Care System is based on the purpose of long-term care insurance, to preserve the dignity of older adults and support independent living (Article 1 of the Long-Term Care Insurance Act, as amended in 2005). It is defined as:

> a system in which, based on the provision of housing that meets the needs of the elderly, a variety of lifestyle support services, including not only medical and nursing care but also welfare services, are provided to ensure safety, security, and health in daily life. […] A system in the community where various lifestyle support services, including not only medical and nursing care services but also welfare services, can be provided appropriately in the place of daily living (daily living area) to ensure safety, security, and health in daily life (H24 Community-based Integrated Care Study Group

Report, p. 1)[22]

In addition, its components are "housing," "life support," "nursing care," "medical care," and "prevention" (ibid.). Another report[23] states that to "support the independent living" of older adults, "it is essential to have a system to support them lead independent lives, according to their abilities, even when they are in need of care" (Report of the H25 Study Group on Community-based Integrated Care, p. 3). It also points out that it is important to provide the best combination of support at the time of "changes in physical and mental conditions, such as during the acute, convalescent, chronic, and terminal phases, and changes in 'the way they live' (family relationships and relationships with neighbors and friends)" (ibid.). However, it also argues that support center for older adults (community-based integrated support center), care support specialists (care managers), the disability welfare section of the ward office, and the social welfare council, all control each other to prevent the fire falling on them as possible.[24]

The most recent "H30 Community-based Care Report"[25] focuses on a pluralistic society and emphasizes "social inclusion" and "preservation of dignity" in a pluralistic society. Social inclusion in this report refers to "respecting the wishes of each individual and allowing them to continue living in their community or society without being excluded." Preservation of dignity refers to "a way of being in a society where people can decide their own lives and also be respected as individuals by those around them." It is important to emphasize that this concept is a basic principle of both the Community-based Integrated Care System and the long-term care insurance system. The report also states that "based on the premise that family members are also individuals with their own concerns, it is necessary to consider how to create a system that respects the wishes of individuals with regard to their own lives, and how to build social systems and support systems based on the concept of support for the individual and each family member, rather than on the family or household as a unit as an existing idea." Since the number of older adults over the age of 85 will reach 10 million by 2040, it is proposed that incentives such as the establishment of Community-based Integrated rewards be considered to actively promote home medical care and nursing care (H30 Community-based Integrated Care Report, p. 22).

According to the document "Considerations for the Interim Re-examination Review of Home Healthcare" in the 2019 "9th Working Group on Home Healthcare, Medical and Nursing Care Coordination," demand for home medical care is expected to "increase significantly associated with the 'aging of the population' and the 'functional differentiation and coordination of hospital beds according to the regional healthcare plan.'"[26] According to this document, the expected increase is about 1 million people in FY2025, of which "the number of new services such as nursing care facilities and home medical care" will amount to 300,000 people in FY2025."

In addition, according to "(3) Status of Home Healthcare" in "Annual Trends in the Estimated Number of Outpatients Receiving Home Healthcare" in the 2017 (Heisei 29) "Summary of Patient Survey"[27] published by the NHLW, the number of patients receiving home medical care has been increasing since 2008. In particular, the estimated number of outpatients who received home medical care remained largely unchanged until 2005, and began to increase in 2008. On the survey date,[28] the number of patients before 2008 was approximately 70,000, increasing dto 98,700 in 2008, 110,700 in 2011, and 180,100 in 2017.

Furthermore, according to the "2016 (Heisei 28) First Home Medical Care Conference" reference material, "Current State of Home Medical Care,"[29] the number of recipients increased from 198,166 per month in 2006 to 645,992 in 2014. Considering the 2014 recipients' number by age, 59.2% (382,204)

were aged 85 years and above, and 29.8% (192,807) were aged 75–84 years. Many patients receiving home medical care were aged 75 or older, but there were also several children and adults; this number is increasing every year.

Thus, has the H30 Community-based Integrated Care Report abandoned its neoliberal perspective, with its emphasis on self-help and mutual aid? The report states that "by 2040, more than 10 million elderly people, aged 85 and over, will be living in the community, including single people" (p. 5) and points out that the composition of the older adults will become more diverse than before. In other words, the report states that there will be "people who are still working hard to maintain their health and participating in society even at the age of 90" and "people who are forced to lead a withdrawn life due to chronic illness even at the age of 65" and that "policies based on an average image of the elderly will no longer have meaning" (p. 7).

Nevertheless, it is important to note here that the report unconditionally assumes the widening of economic and health inequalities. It considers the fact that although income security in old age has improved on the whole, concerns about the increase in the number of older adults who cannot receive adequate security in old age due to such reasons as pension non-payment and increase in irregular employment, persist. Further, it states that even now, "income inequality in old age is growing more than in young age, and these trends are expected to continue. The relationship between income, years of education, and the level of health is also attracting attention and is being discussed as 'health inequalities' (original note) in the future trend of widening income inequalities" (original note: "Health Japan 21 [2nd stage]," p. 7l; Katsunori Kondo [2017], "A prescription for a health inequality society," Igaku Shoin). Therefore, it states that by 2040, it is essential to design a system that provides support those who need care (i.e., does not assume family care in the household unit, as in the past), and also includes family support for those who do not need care. In addition, it proposes that it is important to "consider how to switch the social security system, which is currently designed on the basis of the household unit, to a social security system that incorporates the individual unit and the regional unit." (p. 10).

The report states that, "'Participation and collaboration' can be defined as designing and coordinating services and their provision systems based on the actual conditions of each region and in communication with users and their families who live there." As concrete examples of "participation and collaboration," the report states that older adults who gather "at exercise classes" spontaneously start initiatives to support their daily lives and the "health center for daily life, where professionals and residents/users interact with each other and participate in the community structure" (p. 17).

Thus, "participation and collaboration" in the community are expected in this report, while economic and health disparities are uncritically assumed. Certainly, this report does not emphasize self-help and mutual aid, but instead is based on the increase in the number of single older adults and the difficulty of designing a system based on the household unit, as represented by family care. It proposes the construction of a social security system based on the individual rather than the household on the one hand, and places expectations on "self-help and mutual aid" through community participation on the other.

From a similar perspective, "social inclusion" advocates respect for the will of each individual and the continuation of life within the community in which they live. However, it also expects mutual aid based on self-help, while accepting economic and health disparities on the ground of "inevitable disparities" (p. 12).

In light of the above, we must ask whether it is possible to "preserve the dignity" of older adults while

accepting economic and health disparities. This concept has been repeatedly emphasized not only as a principle of Long-Term Care Insurance Law but also as a basic principle of the Integrated Community-based Care System. However, this report indicates a disparity in the "preservation of dignity," which depends on the person's financial situation and health conditionden. It must be seen as a report based on the typical neoliberal values of the self-responsibility theory found in previous reports.

3. "Guidelines for the Decision-Making Process for Medical Care in the Final Stage of Life" and Advance Care Planning (ACP, commonly known as "Life Conference")

A close relationship exists between home medical care and ACP[30] in a Community-based Integrated Care System. The "Guidelines for the Decision-Making Process of Medical Care and Care in the Final Stage of Life" (revised in March 2008),[31] which incorporates the concepts of the Community-based Integrated Care System and ACP, emphasizes that "medical care and care in the final stage of life" should be based on discussions between the patient or user and medical professionals. It also underscores the importance of decision-making by a team of multidisciplinary professionals as well as of the need for holistic care to mitigate symptoms. Additionally, it proposes the establishment of an institutional committee consisting of multiple experts and the necessity of reviewing and advising on difficult cases. The following three points are included in the ACP: " as the patient's wishes can change, medical and care policies should be continuously discussed;," "the possibility that the patient may become unable to communicate his/her wishes should be taken into account, and repeated discussions should be held in advance, including trusted persons who can estimate the patient's wishes;" and "the guidelines should be designed for hospitals, nursing homes, and home settings."[32] These three points summarize the significance of ACP, which also emphasizes that active euthanasia and assisted suicide is not allowed.

The introduction of this perspective is important because it semphasizes that in the final stage of life, continuous care is provided, respecting the patient's will of how they wish to live, regardless of whether the place of care changes according to the patient's condition.[33] Furthermore, even under the novel coronavirus pandemic, whether through the Community-based Integrated Care System or the ACP, the importance of multi-professional collaboration and continuous communication between the patient and their family and friends is reaffirmed.[34] However, many people feel that the basic principles of ACP ("what is valued and desired of patient is the top priority of care" [preservation of dignity] and "repeated communication" [normative integration]) have collapsed in the face of the infection prevention measures implemented during the novel coronavirus pandemic.[35]

According to the NHLW's "2017 Survey on Awareness of Medical Care in the Final Stage of Life,"[36] when asked whether people have discussed medical care and recuperation in the final stage of life with their families, 55.1% of the general public said they had not (35.1% were doctors, 45.2% were nurses, and 47.2% were caregivers). When asked whether they had a written statement of one's intentions, 91.3% said they did not. When asked in the awareness survey, they acknowledged the importance of the discussion but did not do so in reality.

Although educational campaigns have been conducted on "living wills," "advance directives," and more recently, "ending notes," in which people state their wishes for medical treatment and care in the final stages of life in writing, it is difficult to argue that these campaigns are widely known to the general public. They have received a living will or an ending note as the instructions based on the assumption that "one day, one's body and mind will deteriorate peacefully in old age"; in other words, the instructions

are based on the implicit assumption that there is sufficient time for preparation. In this sense, it is fair to say that "someday" is not an urgent issue for many people but rather a vague "still ahead."

However, the risk of becoming seriously ill and dying suddenly, which is characteristic of the novel coronavirus infection, can happen to anyone regardless of age; "still ahead" as "not yet" no longer exists, as symbolized by the sudden deaths of famous celebrities that occurred in succession in 2020. Given that we now live in an era of emerging viruses (infectious diseases) and that once an infection spreads, it takes considerable time to bring the infection under control, it can be said that now is the time for an ACP.[37]

Nevertheless, it is important to point out that this need for ACP also becomes an important issue when it is introduced not merely as a matter of self-determination or respect for the person's will but rather an important issue that takes on the character of "self-determination to triage" based on the "competence principle:"

> When you become unable to sustain life without the use of limited medical resources such as a respirator, what do you really want to do? Even if you have the option of giving it to an infected person younger than yourself, do you want CPR or not? Especially for those who do not want so-called "life-prolonging treatment," do they still think so now? We need to think hard once again, assuming specific situations, such as using a respirator, and have serious discussions with each other. […] I believe that the government is strongly required to formulate a method of utilizing medical resources to give priority to patients with severe illnesses and triage criteria, to widely inform the public in advance and seek their understanding. It is also essential to determine how to ensure the supply of medical care for patients other than those infected with the novel coronavirus. I strongly urge the national and local governments, which are ultimately responsible for these matters, not only to be prepared but also to disclose information so that the public will have some subject matter to think about.[38] (Mainichi Shimbun, "Medical Premier," April 7, 2020)

One should not be coerced into making treatment decisions by ACP or social pressure, nor should those called vulnerable members of society be pressured into making such decisions. However, as this article shows, ACP can force decision makers to apply or accept "ability discrimination (meritocracy)" in the name of triage or self-determination. ACP and Community-based Integrated Care System should be created based on an institutional design that does not allow such pressures.

Conclusion

Globalization, which has deepened since the end of the twentieth century, has widened economic and social disparities, transformed people's behavior, and brought about cultural change. The novel coronavirus pandemic has both widened and laid bare these inequalities. Today, a "new life" in the era of emerging viruses (or the post-coronavirus era) is beginning to be explored. As pointed out, economic disparity leads to health disparity. To discuss the nature of the Community-based Integrated Care System for social security while unconditionally accepting this economic and health disparity means to accept, unconditionally and systematically, the "ability discrimination (meritocracy)" that is at the root of the self-responsibility theory, by which "infection and illness are one's own responsibility"; additionally, discrimination is based on ability, which was exposed during the novel coronavirus pandemic. Undoubtedly, the H30 Community-based Integrated Care Report no longer emphasizes self-help and mutual aid but is in fact conceived based on this self-responsibility theory or neoliberal view of human

nature in the name of "participation and cooperation" and "social inclusion."

Humans are unaware of—and have become accustomed to—similar information and values due to algorithms (computational methods that determine the priority of information displayed in search engines); these are one of the technological achievements of the digital age. The problem is also contemporary, in the sense that algorithms have given rise to the echo chamber phenomenon, in which people who share similar ideas are exposed to similar views, thereby becoming more radical and extreme in their opinions as they only empathize with each other through social networking services; this makes them unable to accept a variety of ideas. While it is not possible to proceed with discussions solely in a nongovernmental manner without placing any trust in the government or the state, discussions have been raised widely between nongovernmental organizations and individuals, including academic institutions, media organizations, sand corporate think tanks, to determine what role the state and government can play in a super-aged society. This is a wide-ranging issue and will be discussed in a separate article.

Note

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https://www.murc.jp/sp/1509/houkatsu/ houkatsu_01_pdf01.pdf

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htttps://www.murc.jp/sp/1509/houkatsu/houkatsu_01/ houkatsu_01_1_2.pdf

5 It is reported that value-added tax cuts have been or are planned to be implemented in 56 countries and regions. ("VAT Tax Cuts Spreading Around the World: 'Don't Let the Tax System Kill Business'," March 19, 2021, National Federation of Chamber of Commerce and Industry).
https://www.zenshoren.or.jp/2021/03/29/post-8926.
Already, as of August 2020, It is reported that value-added tax cuts being implemented in 20 countries, including Germany, the UK, and Belgium ("Politics on 'consumption tax cuts'! The obvious reason why 'consumption tax cuts' in the Corona Disaster are common sense economic policy", in Diamond online,

August 4, 2020, https://diamond.jp/articles/-/244818). There is also a report of 50 countries/regions as of the end of 2020 (Shimbun Red Flag, December 27, 2020, https://www.jcp.or.jp/akahata/aik20/2020-12-27/2020122701_02_1.html).

6 I have already discussed this issue. My article, "The Pitfall of the Theory of 'Self-Responsibility': Toward the Reconstruction of the Concept of Responsibility" (TOYOHOGAKU, Vol.64, No.3, March 2021, pp. 169-187) https://toyo.repo.nii.ac.jp/? action=pages_view_main&active_action=repository_view_main_item_detail&item_id=12667&item_no=1&page_id=13&block_id=17

7 See: my article "For the Age of Emerging Viruses" (TOYOHOGAKU, Vol.64, No.2, 2021, pp. 47-65) https://toyo.repo.nii.ac.jp/? action=pages_view_main&active_action=repository_view_main_item_detail&item_id=12586&item_no=1&page_id=13&block_id=17

8 A society in which the aging rate, which indicates the percentage of the population aged 65 and over in the total population, reaches 7% is called an aging society, a society in which the aging rate reaches 14% is called an aged society, and a society in which the aging rate reaches 21% is called a super-aged society. (See "H30 Community-based Integrated Care Report," p. 5) According to the Cabinet Office, Japan's population reached 21.0% in 2005 and 28.4% in 2019. Cabinet Office, "2020 White Paper on Aging Society (Summary Version)," Section 1: Aging Population (Trends in Aging Population and Future Plans), https://www8.cao.go.jp/kourei/whitepaper/w-2020/html/gaiyou/index.html

9 https://www.mhlw.go.jp/toukei/saikin/hw/jinkou/kakutei20/dl/15_all.pdf

10 https://www.mhlw.go.jp/wp/hakusyo/kousei/19/dl/1-01.pdf, p. 5

11 MHLW, Demographic Surveys (2019), "Percentage of deaths by year by place of death", https://www.e-stat.go.jp/stat-search/files?page=1&layout=datalist&toukei=00450011& tstat=000001028897&cycle=7&year=20190&month=0&tclass1=000001053058&tclass2=000001053061&tclass3=000001053065&result_back=1&tclass4val=0

12 See the following. Toshiaki Tachibanaki, Nihon no Keizai Kakusa [Economic Inequality in Japan], Iwanami Shinsho, 1998. Toshiki Sato, Inequality in Japan, Chuokoron Shinsha, 2000. Koichi Hiraoka, Elderly and Social Inequality, University of Tokyo Press, 2001. Masahiro Yamada, "Kibou Kakusa Shakai (Hope Disparity Society)," Chikuma Shobo, 2004.

13 Some point to this inequality in health as 'health inequalities'. See the following. Katsunori Kondo, Kenko kakusa shakai (Health Inqalities in each society), Igaku-shoin, 2005.

14 https://warp.da.ndl.go.jp/info:ndljp/pid/10361265/www5.cao.go.jp/seikatsu/senkoudo/h23/23senkou_03.pdf

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16 Center for Suicide Prevention and Countermeasures for Supporting Life (JSCP), a corporation designated by the Minister of Health, Labor and Welfare, "Analysis of Trends in Suicide in the Coronary Disaster (Urgent Report)" https://jscp.or.jp/assets/img/00976d469059fd56d5cda0f8e74e8ea10d3f 3719.pdf

17 NPO Lifelink "White Paper on Suicide Facts 2013" (1st edition) https://www.lifelink.or.jp/Library/whitepaper2013_1.pdf

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For more information on extended suicide, see the following as an example. The Yomiuri Shimbun Online, "How to Prevent 'Extended Suicide': Ask an Expert, One Month after the Kitashinchi Arson (Part 2)," 202/01/18.
https://www.yomiuri.co.jp/local/kansai/news/20220118-OYO1T50021/
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24 Masako Akiyama, "Tsunagaru, Sasaeru, Tsukuridasu: In-Home Community Integrated Care", Igaku Shoin, 2016, pp. 2-17.

25 H30 Community Integrated Care Report, above.

26 https://www.mhlw.go.jp/content/10802000/000545064.pdf

27 NHLW "Summary of Patient Survey," 2017 (2017)
https://www.mhlw.go.jp/toukei/saikin/hw/kanja/17/dl/kanja-01.pdf

28 Survey date means one day designated by each hospital out of three days from Tuesday, October 17 to Thursday, October 19, 2017, for hospitals, and one day designated by each clinic out of three days from Tuesday, October 17, Wednesday, October 18, and Friday, October 20 of the same year for clinics. The day designated for each clinic among the three days of October 17 (Tuesday), 18 (Wednesday), and 20 (Friday) of the same year.

29 NHLW, "The First National Home Healthcare Conference," Reference Material 2, "Current Status of Home Healthcare,"
https://www.mhlw.go.jp/file/05-Shingikai-10801000-Iseikyoku-Soumuka/0000129546.pdf
There is also an explanation of ACP on the Japan Medical Association website. "End-of-life Advanced Care Planning (Thinking from ACP)"
https://www.med.or.jp/dl-med/teireikaiken/20180307_31.pdf

30 The name "Life Council" given to Advance Care Planning has been used by the NHLW since November 2018 as a nickname, and is known to have caused controversy in November 2019, when the content of the

announcement poster caused controversy.

31 NHLW “Guidelines on the Decision-Making Process for Medical Care and Care in the Final Stage of Life” (revised March 2008)
https://www.mhlw.go.jp/file/04-Houdouhappyou-10802000-Iseikyoku-Shidouka/0000197701.pdf

32 According to the NHLW ACP awareness leaflet, about 70% of people with life-threatening conditions are unable to make their own decisions or communicate with others about their medical treatment and care, so it is stressed that the person, family, friends, staff and others should share records by repeatedly discussing them in advance.
https ://www.mhlw.go.jp/content/10802000/000536088.pdf

33 Tatsuya Morita et al, Palliative Care Reaching Patients and Families through Evidence, Igaku Shoin, 2016.

34 ‘Overview of COVID-19-related advance care planning in the UK, US and Australia’
https://www.covid19-jma-medical-expert-meeting.jp/topic/2792

35 “The Novel coronavirus and the Ethics of Nursing Practice,” Home-visiting Nursing and Care, April 2021 (vol. 24, n. 4), Igaku Shoin, pp. 266-272.

36 NHLW, “Fiscal 2009 Survey on Attitudes toward Medical Care in the Final Stage of Life Results”
https://www.niph.go.jp/h-crisis/wp-content/uploads/2018/02/20180226103319_file_05-Shingikai-10801000-Iseikyoku- Soumuka_0000194867.pdf

37 It should also be pointed out that the recommendation of the Study Group on Bioethics and Medical Ethics mentioned above also says, “When the patient does not have sufficient capacity to make decisions, prior declaration of intention, including advance care planning, and the presumption of the patient’s intention by family members and others, should be respected”.

38 Mainichi Shimbun, “Medical Premiere: Living a Hundred-Year Life, Preparedness for the Novel coronavirus, Now is the Time for a ‘Life Conference’”,
https://mainichi.jp/premier/health/articles/ 20200406/med/00m/100/007000c