Function of Geriatric Health Services Facilities for Elderly to Promote Home Care, Including the Ingestion of Hospice Care

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Abstract

The process of the establishment including enacted laws and regulations, the meaning in Japan that as an aging, advancing society of the population in the world, the outline of institutions and the future figure of the Geriatric Health Facilities for Elderly People, which is an institution of a characteristic system in Japan, are described.

Keywords: Disabled elderly, Act, Home rehabilitation, Prevention, Care level

1. History of Health Services

An overview of the Japanese society and why the history of Geriatric Health Services Facilities for Elderly was needed is summarized.

1.1. Incunabula

The Child Welfare Act, the Disabled Persons Welfare Act, and the Daily Life Security Act were promulgated. The Daily Life Security Act was established to guarantee the life of the Japanese nation by the hardships of defeat in 1946. Then, the Child Welfare Act was enacted for the protection of war orphans, and healthy training of the child who bears the next generation further was enacted in 1947. Moreover, the Disabled Persons Welfare Act focusing on the support of physically handicapped persons, such as a disabled veteran, etc. was enacted in 1949. The Social Welfare Services Act which specifies the common basic point covering the whole social welfare work was enacted in 1951. The Japanese society continued the rapid economic growth from 1954. The National Health Insurance Act was enforced in 1959, and the medical insurance for the whole nation became accomplished in 1961. Moreover, the Old-Age Welfare Act focusing on the maintenance of the mental and physical health and the life for an old man was enforced in 1963. The Japanese rapid economic growth reached the end by the Oil Crisis of 1973.

1.2. The social situation

1975-1988 was a period of confusion about social security as a social system. The deterioration of service for an elderly person began both of medical treatment and welfare together. Neither was the way of thinking about geriatric medicine decided nor responding to the treatment of illnesses or disabilities. Similarly a medical insurance system was not able to define a progress payment or blanket payment. The Japanese rapid economic growth reached the end. The question to the Japanese rapid economic growth myth had arisen. The introduction of regulation of total emission was achieved as a new view. There was public outcry in reaction to the increasing medical expenses, and the regulation of total emission of medical expenses was performed. It may be said that such societal situations showed the pitfalls of a vertical administrative system, the boundary barrier of medical treatment and welfare, and closeness of a hospital or an institution, and being home.

2. Geriatric Health Services Facilities for Elderly (GHSFE)

2.1. Foundation of the GHSFE system

Many problems of disabled elderly people actualized from the defect of the medical treatment and the welfare system as described above in 1.2. The social situation. GHSFE system foundation was reported in the round-table conference interim report of the transitional facilities (interim report) in August, 1985.

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As for the foundation reasons become basic, following:
i, "...with aging of population increasing, the increase in elderly requiring nursing care from now on is expected, and the need is also diversified...” and
ii, "In response to the diversified needs, the services should be secured quantitatively and qualitatively, and we have to implement programs on the basis of the plans from the view of future...”.

In other words, the fusion of medical treatment and welfare was raised as scientific, clinical, and social concerns and a new system of medical treatment united with welfare as a test site of problem solving was born. GHSFE introduced a team approach for the analysis and solution to various needs of inpatients including attention to dementia by various functions service personnel.

Problems of geriatric medicine were 1-4 fundamentally:
i. the deference between CURE and CARE,
ii. the view of medical expenses on an insurance system such as diagnosis-related groups, prospective payment systems and diagnosis procedure combinations / per-diem payment systems were fixed amount payment systems for hospitals using advanced technology in Japan.
iii. Rehabilitation and
iv. Dementia.

CURE is a completely effective treatment for a disease and CARE. Elderly care is a fulfillment of the special needs and requirements of senior citizens. The GHSFE cannot yet completely show solutions for these subjects. Although the GHSFEs are trying hard to find a direct correlation, it can’t be shown yet. They are still on the way, through trial and error. But they are showing the correlation that as an institution, a service person's team approach for a hospitalization person is required. And that is the only clear point.

### 2.2. The difference between GHSFE and other hospitals

The difference was arranged based on act No. 141 that was proclaimed on December 6, 2000, which named reforms to parts of the Medical Service Law. It is shown in Table 1.

### 2.3. Effect of the interim report

The defect of the medical treatment and the welfare system before the establishment of GHSFE
system shows many problems. It became a test site of problem solving in the fusion of medical
treatment and welfare. The measure against an increase of dementia also became important. Trying
hard to find a direct connection, but it can’t show a clear solution. The solution is still being sought
through trial, and error. The only clear thing is that inpatients are required by the institution service
person’s team approach and the rehabilitation is important for them. An inpatient is called a user in the
GHSFE.

This interim report brought about many changes shown below on the social security system of
Japan;
i. it is converting to evaluation/ recognition of individuals from group treatment,
ii. the importance of normalization, barrier-free measures in the society and importance of the
universal design.

Since establishment of the GHSFE had received this influence, respect to individuals, care
conference and rehabilitation were foundations. Moreover, the social security system could also ask
for change to the system of “providing the service which a user can choose” from “a system that
regulates a user”, and has resulted in the present system.

3. Future Subjects

3.1. To listen.

The staff of a GHSFE who have technical knowledge, wisdom and experience nestled up and
listened to the user. Then the service that matches needs of the user was born.

3.2. Hospice care

It is important to give hospice care with the possibility for users to choose. For understanding it,
there are two famous people.

3.2.1. Kübler-Ross

Kübler-Ross made the basics of the thanatology and hospice care. She encouraged the hospice
care movement, believing that euthanasia prevents people from completing their ‘unfinished business.’
She moved to the United States in 1958 to work and continue her studies in New York. As she began
her psychiatric residency, she was appalled by the hospital treatment of patients who were dying. She
began giving a series of lectures to medical students featuring ill patients who were dying. Kübler-Ross’ words looked to appeal following;
i. For even an acute term dying patient, please contact as a human being,
ii. Do not want to be controlled by a machine,
iii. Not HEAR but LISTEN to their feelings with respect.

3.2.2. Sicily Saunders

Sicily Saunders helped the dying and terminally ill end their lives in the most comfortable ways
possible. She was a nurse, social worker, physician, writer, and facilitator in the birth of the hospice
movement. She emphasized the importance of palliative care in modern medicine. She showed how to
touch in the terminal-stage.

Though the definition of terminal-stage is not decided in Japan, generally, terminal-stage is said
as follows;
i. the stage when oral ingestion became impossible, and
ii. the period when consciousness began to disappear secularly.

3.3. Future of the GHSFE

Though the GHSFE system birth and recognition of the need are realized as results of the social
security system of Japan, the acute term medical treatment is in a dominant position in Japan. It is very
important to reach people in the terminal-stage, both elderly and young people about acute disease,
chronic disease, and senility.

Do needs’ users desire to die at home or in a hospital or institution? There are various opinions
and hope between these extremes irrespective of both senile state and youth term. By thinking of these
present conditions, maintenance of optional and selectable services without force seem important in
order to promote recuperation at home.
The following functions are necessary for a home hospice to enable; 
i. a network mechanism with the medical institutions (an acute term ward, a rehabilitation ward, hospice, etc. are included) supporting a local life,
ii. mutual information dispatch and information sharing,
iii. an educational training system and
iv. the selectable service.
It is necessary to examine directionality of the correspondence in the GHSFE, when ingestion of user lapses into an impossible state. Considering the Hospice care, the GHSFE exists as a key of the important network of the institution supporting a home hospice.

4. Conclusion

The significance of existence and a function of the GHSFE were clarified. And Japanese experience was clarified as following;
i. Japan has an aging, advancing society of increasing aging population in the world and has enacted laws and regulations,
ii. the process of the establishment of the GHSFE is an institution with a characteristic system of service and care,
iii. outline of the GHSFE institutions and
iv. the future figure of the GHSFE.

The author desires to be more helpful to the construction and execution of measures in aging countries all over the world.

References