介護者の続柄		介護充実感尺度	介護負担感尺度
妻	平均値	17.54	23.96
	度数	115	113
	標準偏差	5.489	17.092
夫	平均値	17.45	22.41
	度数	29	29
	標準偏差	4.785	18.730
娘	平均値	16.56	19.77
	度数	55	52
	標準偏差	5.408	18.180
息子	平均値	14.36	20.68
	度数	39	41
	標準偏差	5.219	17.127
ヨメ	平均値	15.69	26.44
	度数	111	112
	標準偏差	5.260	17.284
その他	平均値	14.81	13.94
	度数	16	16
	標準偏差	5.683	11.287
合計	平均値	16.36	23.19
	度数	365	363
	標準偏差	5.411	17.408

介護充実感を従属変数とする共分散分析の結果

介護充実感を従属変数とする共分散分析の結果は、下表の通りであった。ADLと痴呆症状を統制した場合も、続柄による有意な影響か認められた。

ソース	タイプ III 平方和	自由度	平均平方	F 値	有意確率
修正モデル	2314.067(1)	13	178.005	7.020	.000
切片	38868.846	1	38868.846	1532.773	.000
ADL（共変量）	985.781	1	985.781	38.874	.000
痴呆症状（共変量）	256.157	1	256.157	10.101	.002
地域	14.218	1	14.218	.561	.454
介護者の続柄	729.595	5	145.919	5.754	.000
地域 ＊ 続柄	162.003	5	32.401	1.278	.271
誤差	23101.609	911	25.359		
総和	263337.000	925			
修正総和	25415.676	924			

R2乗 ＝.091（調整済みR2乗 ＝.078）

調整済み平均値

地域	介護者の続柄	平均値	標準誤差	95% 信頼区間	
				下限	上限
葛飾	妻	16.120	.394	15.348	16.893
	夫	16.011	.489	15.051	16.970
	娘	17.367	.425	16.534	18.200
	息子	13.941	.590	12.784	15.098
	ヨメ	14.366	.552	13.283	15.450
	その他	16.227	1.187	13.897	18.557
大館・田代	妻	17.200	.486	16.246	18.154
	夫	17.168	1.029	15.149	19.188
	娘	16.630	.699	15.258	18.001
	息子	14.517	.840	12.868	16.166
	ヨメ	15.869	.503	14.882	16.856
	その他	14.656	1.348	12.011	17.301

このモデルにある共変量は、ADL = 13.4703, 痴呆症状 = 1.89 の値を基に評価。

介護負担感を従属変数とする共分散分析の結果

介護負担感を従属変数とする共分散分析の結果は、下表の通りであった。ADLと痴呆症状を統制した場合も、地域と続柄による有意な影響か認められた。

ソース	タイプ III 平方和	自由度	平均平方	F 値	有意確率
修正モデル	72853.921 (1)	13	5604.148	24.052	.000
切片	87670.838	1	87670.838	376.264	.000
ADL(共変量)	12052.397	1	12052.397	51.726	.000
痴呆症状(共変量)	28606.790	1	28606.790	122.774	.000
地域	1574.600	1	1574.600	6.758	.009
介護者の続柄	3593.389	5	718.678	3.084	.009
地域 * 続柄	1999.288	5	399.858	1.716	.128
誤差	212266.289	911	233.004		
総和	851258.000	925			
修正総和	285120.210	924			

1.00　R2乗 ＝ .256（調整済みR2乗 ＝ .245）

調整済み平均値

地域	平均値	標準誤差	95% 信頼区間	
			下限	上限
葛飾	25.535	.821	23.924	27.146
大館・田代	22.053	1.058	19.976	24.130

このモデルにある共変量は、ADL = 13.5459, 痴呆症状 = 1.91 の値を基に評価。

調整済み平均値

地域	介護者の続柄	平均値	標準誤差	95% 信頼区間	
				下限	上限
葛飾	妻	29.766	1.176	27.458	32.074
	夫	25.309	1.502	22.361	28.258
	娘	23.976	1.296	21.432	26.520
	息子	22.622	1.763	19.162	26.082
	ヨメ	22.360	1.715	18.995	25.725
	その他	29.178	3.599	22.116	36.241
大館・田代	妻	24.791	1.480	21.887	27.695
	夫	23.794	3.058	17.793	29.795
	娘	20.274	2.159	16.036	24.512
	息子	22.188	2.512	17.257	27.118
	ヨメ	23.857	1.508	20.897	26.816
	その他	17.416	3.945	9.675	25.157

このモデルにある共変量は、ADL = 13.5459, 痴呆症状= 1.91 の値を基に評価。

厚生科学研究費補助金（政策科学推進研究事業）
分担研究報告書
同居と介護
分担研究者　　ジョン・キャンベル　ミシガン大学教授

研究要旨：本研究は、介護保険制度の規模の大きさや順調な導入過程を評価しつつ、この制度の充実をはかるうえでの重要な課題として施設入所希望者の増大に着目し、このような状況を生み出した要因を検討した。その結果日本では、「在宅サービス＝同居＝家族介護」が同一次元の事柄として理解され、そこに家族介護をめぐる因襲的なイメージが付与されている状況が把握された。そして介護をめぐる建設的な公私分担とそれを支える仕組みの実現にあたって、上記のような思い込みの図式の解体をはかることが重要な課題として指摘された。

A．研究目的

　本研究は、介護保険制度の規模の大きさや順調な導入過程を評価しつつ、施設入所希望者の増大に着目し、介護保険制度のさらなる充実をはかるうえで解決すべき課題を明らかにするとともに、選択可能な解決策を検討することを目的とした。

B.研究方法

　東京都葛飾区と秋田県大館市・田代町、および周辺地域の自治体職員とサービス提供事業者、関係省庁の政策策定関係者への聞き取りを実施した。あわせて、関連の先行研究の理論的検討を行った。

C.研究結果と考察

　聞き取り調査の結果、施設入所希望が多い理由として、コミュニテイケアの整備が不充分である点が指摘された。同時に、日本固有の在宅介護をめぐる否定的なイメージが注目された。すなわち日本では、「在宅サービス＝同居＝家族介護」という、本来３つの異なる要素が同一次元の事柄として感受される傾向が極めて強い。そしてその理解は、「閉鎖的で抑圧的な介護環境下で、嫁等の介護者が負担を一身に引き受ける」という、家族介護に対する因襲的なイメージによって色づけられている。したがって介護についても、因襲的な「在宅介護」か「施設入所」かという、単純化された二者択一的な図式の中で意思決定が行われることとなり、家族に過度の負担を強いると予想される「在宅介護」を回避する結果、「施設入所」が多く選択されていると思われた。

　本研究では、このような思考回路形成の遠因として、日本固有の家族に対する考え方に言及し、文化人類学領域における先行研究から、考察を展開した。さらに、このような文化的社会的特性を持つ日本において、在宅ケアを現実的かつ有効な選択肢として機能させるための方策を探るうえで、次世代高齢者（とりわけ団塊世代）の意識の変化をうらなった。また、「家族介護＝同居」に変わるパラダイムとして、欧米的な高齢者の地域における「自立」が日本に受け入れられる可能性を探り、それを制度的に支える方策として、住宅のバリアフリー化や緊急通報システムの整備、通所施設のアクセシビリテイの改善、グループホーム、ケア付き住宅等々について言及した。また、高齢者の自立を支援するための住宅施策や施設整備において、地方自治体の積極的な介入も期待された。

D.結論

　介護に関する家族と公的サービスの役割分担と高齢者の自立について、より建設的な意思決定を可能にし、それを支える仕組みを整えることが重要であり、そのためにも、まずは「在宅サービス＝同居＝家族介護」という思い込みの図式の解体をはかることが課題として注目された。

Doukyou & Kaigo
John Creighton Campbell

The first three years of Kaigo Hoken went more smoothly than many expected.   The MHLW's forecasts. of service provision and expenditures turned out to be roughly accurate.   There was, however, one major surprise: with the freedom to choose for themselves what kind of kaigo to receive, a very great number opted for institutional rather than home care.   As a result, there are now long waiting lists for the limited number of institutional beds.

It is important to ask why this surprising development occurred, or in other words why the expectations of MHLW officials and other experts were wrong.   The implications for policy are considerable.   So far the response of the government has been to prioritize admissions to nursing homes (though not to the other two types of institutions) on the basis of whether or not family care is available, as well as the applicant's physical and mental condition as represented by the youkaigodo.

This policy, while inevitable in the short run, is clearly a denial of a basic principle of KH, which explicitly held that benefits would be available to everyone regardless of whether family care was available.   In practice it will mean that particularly in urban areas institutional care will be available only to heavy-care people without families, which was precisely the situation under the old sochisei that had been so widely criticized.

In the longer run, the government faces a difficult policy choice.   If the current situation persists, it will either have to build many more institutions, which would be very expensive, or else risk alienating the public by demonstrating that, in fact, they do not have the free choice promised by the KH system and cannot obtain the services they want despite having paid KH premiums.

WHY THE HIGH DEMAND FOR INSTITUTIONS?

A better alternaive would be to find some way to reverse the current trend of high demand for institutional care can be reversed.   For that to be possible, it is imperative that the cause of the surprisingly high demand be understood.

In a series of interviews in Tokyo and in Touhoku, I posed this question to government officials and service providers, and also drew on interviews of caregivers and older people carried out by my wife Ruth Campbell and others [connected with the xxx research project]..   I heard two kinds of explanations for the phenomenon.

The first explanation is that community-based services are still inadequate.   The argument follows that when true 24-hour care becomes available, including ample use of short-stay and day care/service that gives the caregiver some real respite, people would come to prefer having the older person continue at home rather than going into an institution.   This could be called an institutional explanation.

The other explanation is more pessimistic, and might be seen as a cultural explanation rooted in assumptions that flow from the traditional Japanese family system.   It was put to me most succinctly by a high-ranking MHLW official, who wrote the following on a blackboard:

zaitaku saabisu = doukyo = kazoku kaigo

That is, the assumption among most Japanese is that these three elements come as a package. Receiving in-home services means that the older person continues to live with his or her family, and that the real burdens of care still fall on a child, a spouse, or—in what is always seen as the prototypical case—the daughter-in-law.   Community-based services are seen merely as a supplement that provides only marginal assistance to the caregiver, whose fundamental plight would not really change until the aging parent had been moved to an institution.

Incidentally, under this assumption, many people perceive the emphasis in the KH system on

community-based care to be a deliberate plot on the part of the government to prop up and continue the traditional Japanese family-care system as long as possible. This assertion is clearly incorrect. If the MHLW wanted to preserve the traditional system of family care, it would have included an option for a cash allowance in lieu of services.

According to public opinion polls at the time KH was being enacted, confirmed by current interviews, this option was quite popular among the general public as well as with conservative politicians. Moreover, exactly this policy had been followed by Germany when it started its KH system in 1995, and many expected that Japan would imitate this precedent. That Japan did not is because the predominant view among MHLW officials and many of the strongest supporters of the new program, such as the "Committee of 10,000," was exactly that the traditional pattern of relying on family care should be demolished rather than propped up.

The officials and experts who took this view of the purpose of the KH system have been both gratified and disappointed by how the system developed in its first three years. On the one hand, Japanese have been willing to accept services—in fact, this had been obvious from the time of the Gold Plan in 1990. On the other hand, usage of community-based services has been lower than many hoped, with users taking an average of only 4? percent of the amount of services for which they were eligible at a given level of entitlement. And they certainly have been disappointed that so many people have opted for institutional care. After all, hardly anyone believes that nursing home life is a good idea for people whose physical and mental condition would allow them to live in the community.

THE JAPANESE FAMILY SYSTEM

Above I referred to the second explanation of high demand for institutions as "cultural," rather than the "institutional" argument that it is just a problem of insufficient services. However, the second explanation is "cultural" in a more sophisticated way than the common assertion that Japanese believe in the traditional family system. My point is that people believe in it, in the sense that they believe it is still dominant, but they do not like it and think of it as inherently oppressive.

This way of thinking has been around for a long time: it was in the 1960s that young salarymen had yearned for a life defined as "kaa tsuki baba nuki," and in the 1970s when older people flooded into hospitals as soon as "free medical care for the elderly" (enacted in 1972) made it possible. Indeed, the image of "obasuteyama" that is widely assumed to have been a characteristic of Japanese society centuries ago (although there is no historical evidence that the practice of exposing old people to die was actually widespread), indicates that this way of thinking may have deep roots.

Up until the early 1990s, of course, hardly any community-based services were available, at least for older people who could receive family care. Older people might live on their own so long as they were healthy, but when they became frail there was hardly any choice between an institution (more often a hospital than a nursing home back then) and full-time dependence on a relative.

That this was seen as a black-and-white choice is clear in the commonly observed fact that, in Japan, once the older person left the household to go to an institution, there was often very little contact with the family that up until then had been so intimately involved in all aspects of the older person's life. Similarly, an older person who was living with one child often had little or no contact with the other children. A caregiver was likely simultaneously to resent not receiving any relief for their burdens from their siblings (or siblings-in-law), and to complain about "interference" when they made any attempt to become involved. Kazoku kaigo and doukyo were inextricably bound together in people's minds. This assumption was not strongly shaken when extensive community-based services became available to "normal" older people with the Gold Plan and then with KH.

Why is this assumption so strong in Japan? Perhaps one reason is that it is a reflection of a broader social pattern, which years ago was called Japan's "vertical society" by Nakane Chie. She argued that Japanese are oriented to a particular place, a ba, of which the prototype is the household or ie. As evidence she pointed out that in a traditional household (particularly one with a small family company or farm) non-relatives who had come as employees or servants would, after a decade or so had based, come to be seen as regular family members, while on the other hand children who would not inherent the business and who therefore left the household would, after some years had passed, not really be

taken seriously as family members at all.

Whether or not one accepts this thesis—and in fact it has been widely disputed—there is no doubt that the reification of the household has long been widespread in Japan, and that set of beliefs, in turn, is closely related to the custom of older people and their children living together. Although the doukyoritsu has been steadily decline so today less than half of the over-65 population lives with a child, the proportion is still far higher than in all other rich nations. And it is the prevalence of living together, and even more the assumption that this is the normal and dominant pattern, that has had such a strong effect on how people think about caregiving.

Survey research indicates that in all countries, even those with highly developed long-term-care services, most care for the frail elderly is provided by relatives, spouses of course when there is one who can do it, but also children, frequently more than one. However, except for spouses, usually the caregiver does not live in the same house as the person providing care. That makes an enormous difference. Even in situations where the demands on the caregiver are very high, at least she can usually go home and spend some time with her own family. Most caregiving most of the time will be a compartmentalized, part time activity.

In Japan, caregiving tends to be perceived as an all-encompassing, never-ending burden of responsibility and hard work. Even when the older person is not so frail or demanding, he or she is always around, perhaps inhibiting the caregivers family life and other interests. Indeed, it has often been alleged that daughters-in-law will deliberately not encourage their mothers-in-law to exercise or to get rehabilitation after a stroke or accident precisely because home life is easier when she is safely in bed all day. Such stories indicate that "oppression" is the appropriate word for this sort of caregiving situation.

It should be emphasized that the reality of caregiving in Japan is not as homogeneous, and indeed not as bleak, as this portrayal. For one thing, much family caregiving is by spouses (including not a few men); those burdens may be heavy but in many cases would not carry the image of dutiful involuntary servitude of the yome-shutome relationship. Moreover, appreciable numbers of children and even yome do find many positive aspects of caregiving; some have come to see it as a skilled profession and have gone on to work in that field (for example, by studying for a home helper or care manager license) after the older person has died.

However, my argument here is not based on whatever the reality of caregiving may be in Japan. It has to do with perceptions, images, assumptions, and ideologies. So long as most people assume that zaitaku service = living together = family care, they are likely to see institutionalization as the only alternative even if their own real-life situations are not so dire. That, I think, is the main reason why applications for institutions have been so much higher than expected.

WHAT IS TO BE DONE?

If this second explanation is correct, merely increasing community-based services even to the point of genuine 24-hour care would not have much effect in decreasing the demand for institutionalization. It might seem then that the best strategy would be too wait: to hold off from building many new institutions, and hope that complaints about being denied access do not become too widespread in the next decade or so. It is quite likely that attitudes are and will be quite different among the people who are now in their 60s, many of whom will be frail ten years from now, as well as the generation now in their 40s who in ten years will become responsible for caregiving. Not only are social norms (including conceptualizations of what a family is and should be) changing in Japan, the next generation would have become concerned with the problem at a time when community-based services are widespread and quite accepted. Nore of them will probably see more nuanced possibilities between the black-and-white choice between family caregiving and institutionalization.

Rather than simply waiting, however, the government might encourage older people to live independently as a couple or even alone. That is the way the vast majority of older people live in all other rich countries, and even in Japan, as noted above, today a majority of Japanese 65 live independently. Unlike 20 or 39 years ago, this pattern is now seen as natural rather than strange. However, this trend by itself cannot solve the problem, because many older people will not be able simply to live independently in an ordinary residence until death. Many can expect an extended period in which someone must provide some degree of care.

In Europe and the United States, increasing numbers of people are dealing with this situation by moving into some kind of residential facility designed for the elderly. As well as providing barrier-free living environments with emergency buttons and so forth, in many cases they are designed to provide or assist the provision of care services. These might be provided by the residential facility itself (in which case it would resemble a Japanese yuuryou roujin houmu) or they might come from outside community-based care agencies. A day-care/service location might be in the building or nearby.

Various terms are used for such residential facilities: sheltered or congregate housing, board-and-care homes, continuum-of-care communities, and most often (at least in the United States) assisted-living facilities. They have varied financial arrangements. The popularity of these living arrangements has led to an actual diminution of the number of people in true institutions, such as nursing homes, in most western countries.

In principle, at least, the Kaigo Hoken system should mean that assisted living should be relatively easy to establish in Japan. Since the costs of care, and in particular the risk of future care, is borne by social insurance, a company or non-profit organization can manage the facility essentially in terms of real estate. The costs would not have to be higher than in an ordinary apartment building except perhaps for a few social activities, such as provision of one meal a day in a dining room.

Japan does have a rising number of yuuryou roujin houmu which fulfill this function, but most so far have been designed for a high-income market. They are also quite expensive for a municipality in that KH pays the full gendogaku for a given Kaigo level rather than paying service-by-service. If a person who had been living in the community and using the national average of 40-45 percent of his or her entitlement moved to a yuuryou roujin houmu in the same locality, the burden on the local KH budget would be increased considerably (although less than if the person moved into an institution).

Worse still, there is the possibility that people from outside the community will come to live in a yuuryou roujin houmu or other attractive residential facility and would become residents who would be eligible to receive KH benefits. That could mean higher insurance premiums. This point accounts for why municipal governments are rather wary of building any sort of residential facility—a local official in Touhoku said that the city had been approached by a private developer with such a residential facility in mind, but asked him to wait for exactly that reason.

It would be very helpful if municipalities would take a positive rather than negative view of having new residential facilities, particularly if built by private developers. Within the KH system, it is possible that their incentives could be modified by some kind of fiscal readjustment (zaisei chousei) although it is not clear how this could work. Another barrier is that for many years the responsibility for residential facilities for the elderly has been divided between, originally, the Kensetsushou and Koureishou, and it appears that the situation is much the same with the Kokudo Koutsuu Shou and Kouroushou.

If these barriers could be overcome, one could imagine a national program, carried out by local governments, to offer modest construction and rent subsidies to private developers, subject to a minimal set of regulations. Again, the developers themselves would not need to provide kaigo services themselves, but they would be required to facilitate access by regular community-based agencies including for-profit companies, on a competitive basis. This prospect should be very attractive to service providers since, if they can attract a sizeable number of clients in a given development, they can serve them very efficiently (e.g. a home helper would not have to travel between clients). Such efficiencies could allow a closer approximation of 24-hour care without extra cost.

CONCLUSION

The current high level of demand for entering nursing homes is a serious problem for the KH system, particularly since the new prioritized admissions system means that the wishes of many will be frustrated. According to interviewees, in the community meetings (setsumeikai) held during the planning process for both the first and second kaigo jigyou keikaku in all municipalities, the two concerns most often voiced by residents were the amount of the insurance premium on the one hand and whether or not institutional care will be available on the other. It is not difficult to connect these two concerns, to ask why people should have to pay premiums at all when the services they want are not

available—obviously a potentially serious political problem.

It is possible that our first "institutional" explanation for high institutional demand is correct, and further development of community-based services will make them seem a viable alternative to institutional care for more people. However, if the desire to enter institutions lies in a more fundamental desire to have the older person out of the house—based on our second "cultural" explanation in the sense that the assumption that living together is normal (albeit unpleasant) is rooted in a set of deep rooted norms about the household—then further development of zaitaku services will not do the trick.

It is certainly not clear that developing more old-age residences will solve this problem. In particular, it is probably unlikely that many frail older people who are now living with a child would move to a residential facility—a nursing home that would seem to take care of all possible problems would be more attractive. However, if such residential facilities were available, it would structure people's decisions of how to live before they become frail. They might choose to move to such a facility before they become frail. And in any case, such facilities would be an immediate and direct solution to the problem of older people who are now living along or as an elderly couple, whose current quarters are so inappropriate that even reconstruction would not make them a good place to live.

Finally, one would hope that as the custom of living independently (whether in one's own home or a new type of residential facility) becomes more widespread, we might see the development of what—to the eye of a foreigner—would seem a more normal pattern of family kaigo. With the older person not actually in the house, and with her most onerous care burdens taken care of by KH services, family members might be more likely to visit and help out particularly with people's needs for sociability and emotional support. Certainly a visit to grandma living in her own apartment and able to prepare a little lunch on her own or with family help is far more pleasant than a visit to a nursing home. And paradoxically enough, that sort of meeting may be more beneficial to both sides than the day-to-day interactions inside the house when living together.

What is needed is an "unpacking" of the zaitaku service = doukyo = kazoku kaigo. The possibility of zaitaku service being the main provider of care, outside of doukyo, would become more widely realized. Kazoku kaigo would be redefined to a supplementary, less onerous role. Doukyo itself would become more rare. Indeed, it may well be that only when living together comes to be seen as one possible model, rather than the normal and dominant mode of life for older people, can a more positive form of kaigo kazoku emerge. If that happens, institutions will no longer be seen at the main alternative.

分担研究報告書
介護への適応過程・介護保険サービスの役割・家族と地域
分担研究者　　スーザン・ロング　ジョン・キャロル大学教授

研究要旨：要支援・介護認定を受けた高齢者と、その家族介護者４０ペアから得られた情報をもとに、「主介護者が介護において主たる役割を担っている動機」「主介護者が選択される過程」「家族成員間の介護観や家族役割に対する考え方の相違」「家の quality」のそれぞれに対する回答の range〔多様性の幅〕を明らかにするための質的探索的検討をおこなった。今後は、それら回答の多様性を生み出す関連要因と要因間のダイナミクスについて検討をすすめる。

A．研究目的
　以下の４点に対するデータの range を明らかにするための質的探索的検討を行う。
①主介護者が、介護において主たる役割を担っている動機。
②主介護者が選択される過程
③家族成員間の介護観や家族役割に対する考え方の相違。
④家族の"quality"と関連要因

B.研究方法
　本プロジェクトのアンケート調査の回答者の中で、インテンシブなインタビューへに協力した要支援・介護認定を受けた高齢者と、その家族介護者４０ペア。テープに録音したインタビューデータを日本語にて逐語的に書き起こしたものの内容を質的に検討した。

C.研究結果と考察
①主介護者の動機
－クライシスとしての要介護状態への対応 - 被介護者との関係性
－他の家族員では対応できなかった
－他にできる家族員がいない
－重要な任務もしくは自身が最適格
－ニーズが発生する以前から介護役割を担っていた
－当然の役割という認識
　これまでのところ、動機と負担感の関係に明確なパターンは見出されていない。

②主介護者が選択される過程
－主介護者について事前に暗黙の合意
－子世代の同胞間の話し合い
　家族会議を召集したけーすもあり、どのような場合に意識的な話し合いが必要とされるのか。また、話し合いによって介護の役割分担が促進されるのかが今後の分析の焦点になる。
③介護観
－自立回復・維持を「良い介護」とする場合と、依存をも受容することを「良い介護」とする立場。
－介護者と被介護者の介護観が一致しない

場合の対応
－サービス利用を「介護」の一部とする立場と、サービス利用を前提としない「介護」
④家族の quality（各家族に固有の特質、カルチャー、関係性）
－同胞との緊密な関係の有無
－孫との親密な関係性の有無
－成員の年齢に伴う家族の quality の変化
－家族の規模（成員の数、世代）による quality の相違

D.結論
　今後は、上記のような回答の多様性を生み出す関連要因と、要因間のダイナミクスについて検討をすすめる

介護への適応過程・介護保険サービスの役割・家族と地域
スーザン・ロング

The qualitative interviews are a rich source of material on Japanese family relationships. For this session, and in future work toward publication, I would like to discuss the following topics from which data can be drawn from both the surveys and the interviews. These are focused primarily on the caregiver or the wider family relationships. I have not yet analyzed our data to answer these questions, but I will give examples from the interviews of the type of data that I think can help answer them.

1. *What are the motivations of the caregivers to play "key person" role? What is there in the caregiver's current situation and past history that motivates his/her to provide care? To what extent are motivations based on internal versus external factors?*

Motivations often seem multiple and complex, but perhaps can break down what seems to be primary motivations into categories such as:

Management of life crisis not expected to last

Personal relationship

Didn't work out with other family members

No other family caregiver available

Family care is important/I can do it better than others

Natural extension of previous caretaking roles—this may be perceived as great additional burden or not (we have examples of both)

Role obligation that is more than just extension of previous activities—not dependent on relationship since examples are daughter, eldest sons, new wife, etc. perceived as just extension but rather as role that requires additional education.

I'm not sure what all this means, but I find it interesting that a sense of burden is not necessarily correlated with motivation, and also that the relationship is not always (or even usually) the one expected to be obligatory (eg. successor daughter, or 3rd son's yome).

2. *How was that key person decided? What is the process of decision- making? To what extent is this person considered the "natural" caregiver in the family and how does that*

compare to the normative caregiver? Were there family discussions about caregiving, or was the caregiver role just assumed by the caregiver and/or other family members? Did others serve as primary caregivers in the past or has this person done it consistently? If caregiving is shared among family members, how did this division of labor come about?

Although in many cases who would be the caregiver was just assumed, in some cases there was discussion among siblings. For example, one respondent reported discussing the matter with his youngest brother who apparently handles the mother's finances and helps transport her to the doctor's. The two sisters in another case talked about where it would be best to have their mother move since both lived away from their natal area. A daughter of the woman who didn't think the yome was giving good enough care called a family conference to decide what to do. In another case, the son describes the caregiving situation in his wife's family in which the father-in-law didn't get along with the son's family, so the sisters got together and worked out a plan where they would take turns helping. I would be interested in looking at the question of: In what sort of circumstances or in what sort of families do such discussions occur? Does it result in more sharing of caregiving responsibilites?

3. *Differences in caregiving styles. Caregiving for independence/recovery or for dependence? Is caregiver's emphasis on "being there" or on "doing thing"? Are there tensions among caregiver, care recipient, and other family members over the definition of what constitutes care? How do these definitions relate to the utilization of services? Are they correlated with age, gender, or relationship? How are defitions of caregiving (and tensions based on differences among participants' definitions) related to sense of caregiver burden or satisfaction?*

The most interesting discussion of this was in an interview   in which the son was identified as the primary family caregiver for his mother. In that interview, the daughter-in-law arrived home and joined the conversation mid-way through. She is a nurse, and explained that she thinks her mother-in-law should domore for herself. But her husband (the son) quickly starts to help her. They talked about it and since they can't come to agreement and it's the husband's mother, she thinks he should take care of her. The question of caregiving for rehab vs. total caregiving (what I claim is the "traditional" "Japanese" definition) came up in other interviews as well. A son whose mother was ambivalent about assuming a dependent role as an old person believed she should do as much as

possible on her own. When the desires of the care recipient are not matched by the approach of the caregiver, what happens? Clearly there is frustration expressed in some of the interviews, such as the two wives whose husbands' drinking interfered, at least in their minds, with being able to provide sufficient assistance.

We can also think about different styles of caregiving between those who readily incorporate formal services into their caregiving routines versus those who are resistant to using them. The conflict between the daughter and daughter-in-law in one Tokyo family was in part about differences in approach.

4. *I am also interested in exploring the data for material on Japanese family relationships more generally. How have we (American academics?) misunderstood how families relate in the past? How will the increased emphasis on rehabilitation, expansion of services with kaigo hoken, and historical trends affecting households affect close relationships in the future. Are there patterns to the variation we see in contemporary family relationships?*

For example, because of the structural emphasis on parent-eldest son ties, anthropologists have noted formal, strained or minimal relationships among adultbrothers, but with few exceptions they have ignored relationships among adult sisters and between grandparents and grandchildren who are not direct successors. There is undoubtedly continuity in the qualityof family relationships based on early life experiences, but are there also changes with age (possibly becoming stronger after the death of parent, or possibly becoming weaker as frailty makes it moredifficult toget together). Some of the elderly respondents talked about supportive relationships among siblings, while others seemed to maintain almost no contact. Do the larger family sizes of the past make a difference in how siblings relate compared with the generation of child caregivers?

I think that I need to tease out more specific questions to look at, but I believe that there is a lot of interesting data on sibling and grandparent-grandchild relationships in our interviews. One member of our research team noted that relationships with grandchildren were "cold," but in a few cases grandchildren were a source of joy or support and not only disappointment. What distinguishes these situations?

分担研究報告書
介護への適応過程・介護保険サービスの役割・家族と地域
分担研究者　　ルース・キャンベル　ミシガン大学付属ターナークリニック副所長

研究要旨：要支援・介護認定を受けた高齢者と、その家族介護者４０ペアのうち、自身がインタビューを担当した７ペアから得られた情報をもとに、「高齢者と家族の介護への適応過程」「介護過程に公的サービスが果たす役割」「家族関係の地域的特徴」を規定すると思われる要因を明らかにするための質的探索的検討をおこなった。今後は、他のインタビュアーが収集したデータとあわせ、さらに詳細な検討をすすめる。

A．研究目的
　以下の３点を規定すると思われる要因を明らかにするため、質的探索的検討を行う。
①介護を必要とする高齢者と介護者の「介護」への適応過程
②高齢者と家族の介護過程に、公的サービスが果たす役割
③家族関係の地域的特徴

B.研究方法
　本プロジェクトのアンケート調査の回答者の中で、インテンシブなインタビューへに協力した要支援・介護認定を受けた高齢者と、その家族介護者４０ペアのうち、自身がインタビューを担当した７ペアを分析対象とする。データは、テープに録音したインタビューデータを日本語にて逐語的に書き起こし、さらにそれを英語に翻訳したものの内容を質的に検討した。また、インタビューの折に観察した内容を書きとめたノートも、データ分析の参考にした。

C.研究結果と考察
①適応過程を規定すると思われる要因として、以下の点が指摘された
　- 主介護者の選択過程に被介護者が果たす
　　役割
　- 被介護者が介護関係をコントロールでき
　　る範囲と程度
　- 被介護者の介護関係に対する認知
　- 介護を受けることにより変化する被介護
　　者の自己イメージや役割イメージ
　- 被介護者のライフヒストリーが老いや病
　　に対する姿勢に与える影響
　- 「介護」や「主介護者」という役割が始
　　まる過程
　- 介護者と被介護者のライフヒストリーが
　- 自立と依存に関する考え方や態度
②公的サービスの利用については、以下の点が規定
要因として指摘された。
　- サービス利用に至る過程
　- サービス利用の決定者
　- ケアマネージャーの役割
　- 医師等、その他の専門職の役割

　- 訪問介護等の在宅型のサービスと、通所
　　介護やショートステイ等の外出型のサー
　　ビスのどちらに親和性を感じるか
　- サービス利用の功罪
　- 家族機能の代替か補完か
　- アルコール依存、鬱等への認識と対応
③家族の地域的特徴を規定する要因として、以下の点が注目された。
　- 「暖かさ」「冷たさ」として表現される関
　　係の内容
　- 「介護」を通じて異世代間で何が交換さ
　　れているものの内容
　- 介護保険制度に対する考え方
　- 家族観

D.結論
　以上の枠組みをもとに、今後は、他のインタビュアーが収集したデータとあわせ、さらに詳細な検討をすすめる。

介護への適応過程・介護保険サービスの役割・家族と地域
分担研究者　　ルース・キャンベル　ミシガン大学付属ターナークリニック副所長

I have done preliminary analysis on the seven interviews I participated in which were excellently transcribed and translated by Chie Nishimura. I am missing part of two Akita interviews: an interview with the daughter done by a Japanese research member and an interview with the care recipient done by another Japanese research member. I also reviewed my notes from observing two other interviews done by other members of our team. I will discuss the following topics from which data can be drawn from both the surveys and the interviews. Many of my interests overlap with those discussed by Susan Long. I also think that new ideas will emerge after hearing findings from the quantitative survey. These are the initial areas of interest for me and I will provide examples from the interviews to illustrate them.

1. How does the care receiver (CR) adapt to being cared for? What role did the CR have in selecting the caregiver (CG)? How much control does the care receiver have over the caregiving relationship? How does the CR perceive the relationship and how does the CR modify his/her own ideas of self and changing roles when being cared for? How does the care receiver's personal history affect his/her attitudes toward aging and illness?

2. Perceptions of the Caregiver. When did the caregiving begin and how did the caregiver become the key person? What is the history of the relationship between the caregiver and care receiver before caregiving began? How does their personal history affect the caregiving relationship? How does the caregiver perceive her role? I am also interested in caregiving styles discussed by Susan and particularly how the issues of independence and dependence are worked out between the caregiver and care receiver. I would also like to explore what worries or challenges the caregivers faces as well as what gives the caregiver satisfaction.

3. Use of services. I am interested in how the services were introduced to the family and by whom. Was the care manager active in the process or is the doctor or other professional more influential? I am particularly interested in whether caregivers and care receivers prefer in home services such as helpers or out of home services such as day care and short stay. What are the benefits of using these services and what do people see as the drawbacks. Are services seen as supplements to family care, inferior to family care, or a substitute for family care?　I also felt that counseling services which

could help identify and treat alcoholism, depression, and other psychosocial issues were big gaps in the service system and were really needed.

4. Family Relationships. In my limited sample, there were interesting differences in family structure in Akita and Tokyo. I would like to look at the "warmth" or "coldness" of relationships among various family members both in the past and currently. There are widely varying patterns even among this small sample. I would like to examine how these patterns come about and how Kaigo Hoken as government policy affects family relationships. What is the nature of intergenerational exchange? In previous research reciprocity was an underlying motivation for caregiving. Adult children would say they cared for aging parents as a model to their children about the importance of family care. Is that still true and why does the relationship between grandchildren and grandparents seem so distant?

Statement Examples

1. Care Receiver Adapting to being cared for

Tokyo: Husband (care-recipient) had an accident. He had a dream to pursue, without telling wife (primary care-giver) what he was planning and had an accident shortly after he started to work on the dream. He's bed ridden, has a feeding tube and is at a severe care level.

- Husband: I want to get better. I'm most troubled with my brain. It's messed up.

- Interviewer: You mention how frustrating that accident was. Do you feel your life was changed by it?

    - Husband: Right. The most frustrating thing is that it came from behind ... if it came from front I could have been responsible for watching out but from the behind I can't see.

    - Interviewer: Your life has changed.

    - Husband: Yes. I really wish it hadn't happened. I could have lived my life somewhere else by now.

    - Interviewer: Your dream.

    - Husband: I was so close ... I can't help thinking ... was so close.

2. Caregiver Family care is better?

Daughter, a college student, was also there on vacation. She goes to school in a city which was far from Tokyo. She arranged for short stay respite care in a nursing home but then cancelled it.

- Wife: I cancelled it because my heart gets feeling uneasy as the short stay day gets closer. I feel I'd rather bear with it and do it myself... I want him and the place to get used to it... sometimes nursing staff have a hard time handling his fistula and I get worried.

- Interviewer : Would you talk a bit more about your uneasy feeling?

- Wife: Well, it's like I'm abandoning care for him, hard to understand without the experience of care.

- Daughter: Feeling like you are not doing what you are supposed to.

- Wife: Well, yes, I feel like I'm obligated to take care of him.

- Interviewer: Feeling you are being lazy?

- Wife: Not lazy but I feel pity for having someone else to take care of him.

- Husband: They try to do it at the shisetsu but it doesn't go smoothly..and urine, they can't do it right especially male caregivers.

- Wife: It's like when you take your child to the child care center and this child cries when you leave? That's kind of how it feels, hurts like my body being cut. He makes friends and talks to everyone there and has a good time but there are those people with heavy disabilities and people half gone and when I see him spacing out with his eyes gazing away, I can't take seeing him like that.. but still, if he's home all the time I get tired and I get so irritated and fight all the time. It's not good either. And what if I get sick working too hard, then he's going to have to stay in shisetsu forever. So the doctors and the nurses recommended I use this service.

厚生科学研究費補助金（政策科学推進研究事業）
分担研究報告書
開業医の視点から見た介護保険
分担研究者 マイク・フェッターズ　ミシガン大学助手
スーザンロング　ジョン・キャロル大学教授
アヤノ・キヨタ　ミシガン大学客員研究員

研究要旨：地域の開業医の日常の医療活動に、介護保険制度がどのようなインパクトを与えたのかを検討するために、22名の開業医にインタビュー調査を行った。その結果、介護保険制度導入によるインパクトとしては、肯定的なものと否定的なものの両面について報告が得られたが、とりわけ、介護保険制度を通じて医師が新たな機会や役割を獲得しつつあることが注目された。

A．研究目的

地域の開業医の日常の医療活動に、介護保険制度がどのようなインパクトを与えたのかを検討するために、開業医にインタビュー調査を行った。

B．研究方法

質問内容を概ね定めての半構造化された質的インタビュー調査を実施した。対象は、？？？で改行する開業医２２名である。

定められた質問内容は以下の４点である。

① 介護保険制度との関わり
② 介護保険に関して最も良い体験と最悪の体験
③ 介護保険制度下での診療活動に適応する過程で変化を試みている領域
④ 介護保険制度下での診療活動で将来変化が予想される領域

C．研究結果

１）介護保険制度導入による医療の現場での変化

提供する医療の内容そのものには変化はないが、医療の周辺活動や時間の使い方に変化があったという意見が得られた。具体的な変化の内容は、新たに課された書類作成業務や在宅ケアの増加、地域の介護保険認定委員会への参加等である。

２）介護保険によって得られた新しい機会

介護保険制度によって医師や病院として新しい役割や機会も得られている。具体的には、

訪問看護ステーションやデイサービスの運営、往診増加、地域の健康課、社会福祉専門家、看護婦やパラメディカルとの接触や連携の増加等があげられた。

３）ケアに対する考え方の変化

介護保険制度導入に伴う諸変化の中で、対象者からは、「患者の直接医療には関わらないニーズの存在に気づいた」「医療従事者以外の専門家の役割と、その存在の重要性に気づいた」「家族によって様々に異なる家庭での介護のあり方や高齢者との関係性、家族間の関係性に対する認識が深まった」等、ケアに対して考え方が変化したことがあげられた。

D．考察

本研究結果からは、介護保険制度のインパクトに、肯定的なものと否定的なものの両面が存在する様子

がうかがわれた。医師が介護保険制度に適応することは、医師の新たな機会や役割の獲得につながる。そのことはひいては、介護保険制度の今後のあり方にも影響を及ぼすものと思われ、介護保険制度下の診療活動における医師の役割については、いっそうの検討が必要である。

E．結論

介護保険制度のインパクトには、肯定的なものと否定的なものの両面が存在した。また介護保険制度を通じて、医師は新しい役割や機会を獲得している様子がうかがわれた。

開業医の視点から見た介護保険
マイク・フェッターズ
スーザンロング
アヤノ・キヨタ

1．インタビュー対象者

対象	21人男性　1人女性
年令	34−73歳（平均53歳）
全患者に占める外来患者の割合	70−100％（平均93％）
一週間の外来患者数	20−750（平均370）
60−79歳の患者の割合	20−95％　平均47％
80歳以上の患者の割合	1−25％　平均15％

調査地域
9 東京 (7 葛飾, 2 その他)
5 秋田
3 福島
1 栃木
1 群馬
1 静岡
1 兵庫
1 大阪

2．インタビュー結果
1）介護保険制度導入による医療の現場での変化
　提供する医療の内容そのものには変化はないが、医療の周辺活動や時間の使い方に変化があったという意見が得られた。それらの変化の内容としては、以下のような事柄があげられた。
　　　・患者が介護保険認定を受ける過程で主治医に求められる申請書類の作成
　　　・在宅ケアの増加
　　　・介護保険関係の書類等、制度によって新たに課せられた管理運営上の作業の増加
　　　・地域の介護保険認定委員会への参加

2）介護保険によって得られた新しい機会
　介護保険制度によって医師や病院として新しい役割や機会も得られている。具体的には、下記のような事柄があげられた。
　　　・訪問看護ステーションの運営
　　　・デイサービスの運営
　　　・往診の増加
　　　・　地域の健康課、社会福祉専門家、看護婦やパラメディカルとの接触や連携が増えた

4）ケアに対する考え方の変化
　介護保険制度導入に伴う諸変化の中で、ケアに対する考え方が変化したという報告が得られた。具体的には、以下のような変化が報告された。
　　　・患者の直接医療には関わらないニーズの存在に気づいた
　　　・医療従事者以外の専門家の役割と、その存在の重要性に気づいた
　　　・家族によって様々に異なる家庭での介護のあり方や高齢者との関係性、家族間の関
　　　　　係性に対する認識が深まった

３．まとめと今後の課題
　　今後は、さらに詳細な分析をすすめるが、現時点における暫定的なまとめと今後の課題としては、以下の３点が指摘される。
①　医師の専門性やシステムによって LTCI とのかかわりは異なるが、今回のインタビュー
　　対象者はその全体像を把握しうるだけの多様性を備えていない。さらにインタビュー
　　を重ね、多様性の範囲(range)を明らかにする必要がある。
②　介護保険制度導入によるインパクトは肯定的なものも否定的なものの両面がある。
③　医師が介護保険制度に適応することは、新たな機会や役割の獲得につながる。そのことはひいては、介護
　　保険制度の今後のあり方にも影響を及ぼす。