

表 1 介護予防ケアプランで重点をおいて提供していることはあるか？

	地域支援・予防給付	介護給付	計
特になし	39 26.5%	44 45.8%	83 34.2%
あり	108 73.5%	52 54.2%	160 65.8%
計	147 100%	96 100%	243 100%

表 2 - 1 生活不活発病があるかをみているか

	予防給付			要介護認定者		
	地域支援・予防給付	介護給付	計	地域支援・予防給付	介護給付	計
どのような人が廃用症候群がよくわからない	0 0.0%	3 3.1%	3 1.2%	0 0.0%	4 4.2%	4 1.6%
必ずしている	51 34.7%	34 35.4%	85 35.0%	47 32.0%	31 32.3%	78 32.1%
ほとんどしている	69 46.9%	29 30.2%	98 40.3%	62 42.2%	35 36.5%	97 39.9%
時々している	20 13.6%	20 20.8%	40 16.5%	29 19.7%	19 19.8%	48 19.8%
ほとんどしていない	6 4.1%	5 5.2%	11 4.5%	8 5.4%	3 3.1%	11 4.5%
全くしていない	0 0.0%	4 4.2%	4 1.6%	0 0.0%	3 3.1%	3 1.2%
回答なし	1 0.7%	1 1.0%	2 0.8%	1 0.7%	1 1.0%	2 0.8%
計	147 100%	96 100%	243 100%	147 100%	96 100%	243 100%

表 2 - 2 生活不活発病の改善や進行予防のケアプラン立案

	予防給付			要介護認定者		
	地域支援・予防給付	介護給付	計	地域支援・予防給付	介護給付	計
必ずしている	39 26.5%	28 29.2%	67 27.6%	34 23.1%	25 26.0%	59 24.3%
ほとんどしている	81 55.1%	36 37.5%	117 48.1%	80 54.4%	38 39.6%	118 48.6%
時々している	22 15.0%	20 20.8%	42 17.3%	28 19.0%	25 26.0%	53 21.8%
ほとんどしていない	5 3.4%	4 4.2%	9 3.7%	5 3.4%	2 2.1%	7 2.9%
全くしていない	0 0.0%	5 5.2%	5 2.1%	0 0.0%	3 3.1%	3 1.2%
回答なし	0 0.0%	3 3.1%	3 1.2%	0 0.0%	3 3.1%	3 1.2%
計	147 100%	96 100%	243 100%	147 100%	96 100%	243 100%

「ほとんどしていない」・「全くしていない」を合計すると地域支援・予防給付 15.0%、介護給付 31.3%であった。

次に要介護認定者については、「必ずしている」は地域支援・予防給付 14.3%、介護給付のみ 11.5%、「ほとんどしている」は 26.5%、20.8%、「時々している」は 43.5%、34.4%、「ほとんどしていない」

は 10.9%、22.9%、「全くしていない」は 3.4%、9.4%であり、「ほとんどしていない」・「全くしていない」を合計すると地域支援・予防給付 14.3%、介護給付のみ 32.3%であった。

具体的対象者については、「特に基準なし」は 63.1%、58.5%、「特定の基準あり」は 14.6%、13.2%にすぎなかった。

表 2-3 生活不活発病改善に向けたケアプラン立案

	地域支援・予防給付	介護給付	計
どのような人が生活不活発病かわからない	2 1.4%	2 2.1%	4 1.6%
とても容易	0 0.0%	0 0.0%	0 0.0%
容易	8 5.4%	6 6.3%	14 5.8%
どちらともいえない	74 50.3%	47 49.0%	121 49.8%
難しい	57 38.8%	35 36.5%	92 37.9%
とても難しい	4 2.7%	6 6.3%	10 4.1%
回答なし	2 1.4%	0 0.0%	2 0.8%
計	147 100%	96 100%	243 100%

表 2-4 生活不活発病がどういうものかの利用者への説明

	予防給付			要介護認定者		
	地域支援・予防給付	介護給付	計	地域支援・予防給付	介護給付	計
必ずしている	23 15.6%	12 12.5%	35 14.4%	21 14.3%	11 11.5%	32 13.2%
ほとんどしている	46 31.3%	21 21.9%	67 27.6%	39 26.5%	20 20.8%	59 24.3%
時々している	54 36.7%	32 33.3%	86 35.4%	64 43.5%	33 34.4%	97 39.9%
ほとんどしていない	17 11.6%	19 19.8%	36 14.8%	16 10.9%	22 22.9%	38 15.6%
全くしていない	5 3.4%	11 11.5%	16 6.6%	5 3.4%	9 9.4%	14 5.8%
回答なし	2 1.4%	1 1.0%	3 1.2%	2 1.4%	1 1.0%	3 1.2%
計	147 100%	96 100%	243 100%	147 100%	96 100%	243 100%

3. 生活機能低下のモデルと生活不活発病発生契機の3類型

1) 生活機能低下のモデルについての知識

「生活機能低下のモデルとして脳卒中モデルと廃用症候群（生活不活発病）モデルタイプがあることをご存知ですか」の問いに対して、「知らない」は33.7%、「あることは知っていた」は48.1%、「よくわかっているつもり」は16.9%であった（表3-1）。

2) 生活不活発病発生の契機分類

生活不活発病発生の契機についての3類型（活動の量的低下、活動の質的低下、参加の低下）に関連して、「生活機能で見た場

合生活不活発病の原因として考えられるものに何がありますか」の問いに対しての答えは表3-2に示す通りで、両群とも複数回答が9割以上であった。そのため項目別でみると、両群間に大きな差はなく、最も多いのは活動（生活行為）の「量」の低下であり84.4%、心身機能の低下がそれに次いで71.6%、参加の低下が75.7%、環境因子の変化が68.3%であった。しかし、活動（生活行為）の「質（やり方）」の低下は57.2%にとどまってあり、活動の質的向上が要介護状態を改善させる上での鍵であるにも関わらず、その認識は6割に満たなかった。

表2-5 生活不活発病についての説明をしている対象者の基準

	地域支援・予防給付	介護給付	計
特に基準なし	65 63.1%	31 58.5%	96 61.5%
特定の基準あり	15 14.6%	7 13.2%	22 14.1%
回答なし	23 22.3%	15 28.3%	38 24.4%
計	103 100%	53 100%	156 100%

表3-1 「生活機能モデル」についての知識

	地域支援・予防給付	介護給付	計
知らない	52 35.4%	30 31.3%	82 33.7%
あることは知っていた	68 46.3%	49 51.0%	117 48.1%
よくわかっているつもり	24 16.3%	17 17.7%	41 16.9%
回答なし	3 2.0%	0 0.0%	3 1.2%
計	147 100%	96 100%	243 100%

4. 生活不活発病についての具体的知識

生活不活発病についての具体的知識を問うために一連の質問を行った。

1) 病気の時の安静

まず「病気時の時の「安静」についてどう思われますか」を質問すると、表4-1に示す通り回答者別では原則として安静は必要最低限にするべきは両群ともに7割で、複数回答が約2割であった。

項目別でみると「原則として安静は必要最低限にするべき」が最も多く9割弱である。これに対し「病気を早く治す基本」は両者とも2.5割、「手術後の半年間くらいは、なるべく安静をとる必要あり」は0%、「高血圧、糖尿病などの慢性疾患でも安静が必要」は2.5%、「特に高齢者は、病気が完全に治るまでは安静が必要」は0.8%であった。病気を早く治す基本がかなり残っていることは、まだ安静の危険性につ

いて十分な理解がすすんでいるといえない状況といえよう。

2) 具体的な症候（廃用症候）

生活不活発病の個々の症候（心身機能）についての知識を知るために「安静のとりすぎによって起こるものは何があると思いますか」を問うと、地域支援・予防給付、介護給付のみともに単独回答は2例のみで他は全て複数回答であった。

そのため項目別でみると両群でほとんど差はなく、「筋力低下」は98.8%、「認知症様症状」は93.8%、「関節拘縮」は90.1%と9割以上であり、「便秘」は86.8%、「うつ的な傾向」は78.2%、「心機能の低下」は77.0%、「呼吸機能の低下」は65.0%、「骨粗鬆症」は47.7%、「静脈血栓症」は37.4%であった。やはり、一部のものを除いては生活不活発病の症候についての具体的知識は十分ではないといえよう。

表3-2 生活機能で見た場合

	回答者別			項目別		
	地域支援・予防給付	介護給付	計	地域支援・予防給付	介護給付	計
よくわからない	1 0.7%	0 0.0%	1 0.4%	1 0.7%	1 1.0%	2 0.8%
活動(生活行為)の「量」の低下	2 1.4%	1 1.0%	3 1.2%	123 83.7%	82 85.4%	205 84.4%
心身機能の低下	0 0.0%	2 2.1%	2 0.8%	108 73.5%	66 68.8%	174 71.6%
参加の低下	0 0.0%	1 1.0%	1 0.4%	113 76.9%	71 74.0%	184 75.7%
活動(生活行為)の「質(やり方)」の低下	1 0.7%	1 1.0%	2 0.8%	86 58.5%	53 55.2%	139 57.2%
環境因子の変化	0 0.0%	1 1.0%	1 0.4%	107 72.8%	59 61.5%	166 68.3%
複数回答	140 95.2%	88 91.7%	228 93.8%			
回答なし	3 2.0%	2 2.1%	5 2.1%	3 2.0%	2 2.1%	5 2.1%
計	147 100%	96 100%	243 100%	541 368.0%	334 347.9%	875 360.1%

表 4-1 病気時の「安静」

	回答者別			項目別		
	地域支援・予防 給付	介護 給付	計	地域支援・予防 給付	介護 給付	計
原則として安静は必要最低限にするべき	103 70.1%	69 71.9%	172 70.8%	131 89.1%	86 89.6%	217 89.3%
病気を早く治す基本	9 6.1%	7 7.3%	16 6.6%	37 25.2%	24 25.0%	61 25.1%
高血圧、糖尿病などの慢性疾患でも安静が必要				4 2.7%	2 2.1%	6 2.5%
特に高齢者は、病気が完全に治るまでは安静が必要	1 0.7%	0 0.0%	1 0.4%	2 1.4%	0 0.0%	2 0.8%
手術後の半年間くらいは、なるべく安静をとる必要あり				0 0.0%	0 0.0%	0 0.0%
複数回答	30 20.4%	18 18.8%	48 19.8%			
回答なし	4 2.7%	2 2.1%	6 2.5%	4 2.7%	2 2.1%	6 2.5%
計	147 100%	96 100%	243 100%	178 12.1%	114 118.8%	292 120.2%

表 4-2 安静のとりすぎによる（廃用）症候

	地域支援・予防 給付	介護 給付	計
筋力低下	145 98.6%	95 99.0%	240 98.8%
認知症様症状	136 92.5%	92 95.8%	228 93.8%
関節拘縮	129 87.8%	90 93.8%	219 90.1%
便秘	130 88.4%	81 84.4%	211 86.8%
うつ的な傾向	118 80.3%	72 75.0%	190 78.2%
心機能の低下	114 77.6%	73 76.0%	187 77.0%
呼吸機能の低下	97 66.0%	61 63.5%	158 65.0%
骨粗鬆症	71 48.3%	45 46.9%	116 47.7%
静脈血栓症	56 38.1%	35 36.5%	91 37.4%
その他	14 9.5%	12 12.5%	26 10.7%
回答なし	1 0.7%	0 0.0%	1 0.4%
計	1,011 687.8%	656 683.3%	1,667 686.0%

3) 年をとると足腰が弱くなること

「年をとると足腰が弱くなることをどう思いますか」の問いに対しては表4-3に示すように、まず回答別では複数回答が両群ともに約5割で最も多く、単独回答としては、「活発な生活を送ることで、防げることもある」は36.7%、32.3%であった。「利用者自身で防げることもある」は11.5%であった。

項目別では、「活発な生活を送ることで、防げることもある」は80.2%、「利用者自身で防げることもある」は55.6%であった。「仕方のないこと」は12.8%、「肺炎や手術の後は仕方ない」は4.1%であった。

5. 不自由な生活行為の改善・向上

次に介護予防として重要な、一旦低下した生活行為の改善の可能時についての認識

を調べた。

1) 不自由な生活行為の改善の可能性

不自由な生活行為をよくすること(自立度・実用性の向上)が可能だと思いますか」の問いに対しては表5-1に示すように、回答者別では「ほとんどできない」は0.4%であった。複数回答が最も多く71.4%、61.5%であった。しかし、単独回答も少なくなく、「介護のやり方でよくすることもできる」は6.1%、16.7%と2群に差があった。「環境の改造や福祉用具を使えばできる」は約2割であった。また、その他は0%であった。

項目別では、「介護のやり方でよくすることもできる」は76.9%、77.1%、「環境の改造や福祉用具を使えばできる」は90.5%、80.2%であった。

表4-3 「年をとると足腰が弱くなること」をどう思うか？

	回答者別			項目別		
	地域支援・予防給付	介護給付	計	地域支援・予防給付	介護給付	計
活発な生活を送ることで、防げることもある	54 36.7%	31 32.3%	85 35.0%	119 81.0%	76 79.2%	195 80.2%
利用者自身で防げることもある	15 10.2%	13 13.5%	28 11.5%	75 51.0%	60 62.5%	135 55.6%
仕方のないこと	6 4.1%	3 3.1%	9 3.7%	19 12.9%	12 12.5%	31 12.8%
肺炎や手術の後は仕方ない	1 0.7%	0 0.0%	1 0.4%	8 5.4%	2 2.1%	10 4.1%
複数回答	69 46.9%	49 51.0%	118 48.6%			
回答なし	2 1.4%	0 0.0%	2 0.8%	2 1.4%	0 0.0%	2 0.8%
計	147 100%	96 100%	243 100%	223 151.7%	150 156.3%	373 153.5%

2) 屋外歩行困難時のケアプラン

「屋外歩行が難しくなってきた場合、どのようにプランを立てていますか」の問いに対して、回答者別にみると、最も多いのは複数回答者で62.1%、「生活を活性化させ、廃用症候群を改善させる」は18.9%、「下肢の筋力増強訓練」は11.1%であった(表5-2)。

項目別でみると、「安全に移動できるよ

うに、なるべく早く車いすを使う」1.2%、「生活を活性化させ、廃用症候群を改善させる」、「下肢の筋力増強訓練」がほぼ同程度でともに約7割であった。

しかし、屋外歩行という「活動」レベルへの直接的働きかけである「杖の使用で歩行が安全に長い距離できるようにする」は3割強にとどまっていた。

表5-1 不自由な生活行為を改善可能と思うか

	回答者別			項目別		
	地域支援・予防給付	介護給付	計	地域支援・予防給付	介護給付	計
環境の改造や福祉用具を使えばできる	28 19.0%	18 18.8%	46 18.9%	133 90.5%	77 80.2%	210 86.4%
介護のやり方でよくすることもできる	9 6.1%	16 16.7%	25 10.3%	113 76.9%	74 77.1%	187 77.0%
その他				14 9.5%	6 6.3%	20 8.2%
ほとんどできない	0 0.0%	1 1.0%	1 0.4%	0 0.0%	1 1.0%	1 0.4%
複数回答	105 71.4%	59 61.5%	164 67.5%			
回答なし	5 3.4%	2 2.1%	7 2.9%	5 3.4%	2 2.1%	7 2.9%
計	147 100%	96 100%	243 100%	265 180.3%	160 166.7%	425 174.9%

表5-2 屋外歩行が難しくなってきた時の対応

	回答者別			項目別		
	地域支援・予防給付	介護給付	計	地域支援・予防給付	介護給付	計
生活を活性化させ、廃用症候群を改善	22 15.0%	24 25.0%	46 18.9%	103 70.1%	67 69.8%	170 70.0%
下肢の筋力増強訓練	18 12.2%	9 9.4%	27 11.1%	111 75.5%	58 60.4%	169 69.5%
杖の使用で、歩行が安全に長い距離可能に	5 3.4%	7 7.3%	12 4.9%	49 33.3%	29 30.2%	78 32.1%
安全に移動できるように、早く車いすを使う				0 0.0%	3 3.1%	3 1.2%
その他	0 0.0%	3 3.1%	3 1.2%	10 6.8%	7 7.3%	17 7.0%
複数回答	99 67.3%	52 54.2%	151 62.1%			
回答なし	3 2.0%	1 1.0%	4 1.6%	3 2.0%	1 1.0%	4 1.6%
計	147 100%	96 100%	243 100%	276 187.8%	165 171.9%	441 181.5%

3) 歩行補助具の活用状況

「これまで利用者さんにすすめたことがある歩行補助具・杖」を問うと、回答者別では「T字杖（1本杖）」は1.6%、「四点杖」は1.2%、「松葉杖」は0%、「ロフストランド杖」は0%、「ウォーカーケイン」は0.4%、「歩行器・歩行車」は18.1%、「その他」は0%であり、複数回答が地域支援・予防給付は81.6%、介護給付のみは62.5%と多かった。（表5-3）。

項目別にみると「歩行器・歩行車」は90.1%、「T字杖（1本杖）」は58.0%、「四点杖」は56.4%であったが、「ウォーカーケイン」は9.1%、「ロフストランド杖」は4.9%、松葉杖は2.1%であった。

次に利用者さんによくすすめる歩行補助

具・杖は何かの問いに対して、「なるべく使用しない」は4.1%いたが、すすめている物が複数回答は地域支援・予防給付、介護給付のみともに1割にすぎなかった。多いのは「T字杖（1本杖）」33.3%、「その他」は42.0%であった（表5-4）。

項目別では頼って歩けなくなるので、「なるべく使用しない」は5.3%、「T字杖（1本杖）」は44.0%、「その他」は51.4%で、ほとんど歩行器であった。歩行器は屋内用に用いるものであり、積極的に屋外移動の自立度向上にむけた歩行補助具の活用が望まれる。

目的行為や使用場所によって歩行補助具の使い分け、すなわち複数使用が望まれる。

表5-3 すすめたことがある歩行補助具・杖

	回答者別			項目別		
	地域支援・予防給付	介護給付	計	地域支援・予防給付	介護給付	計
歩行器・歩行車	20 13.6%	24 25.0%	44 18.1%	136 93.2%	83 88.3%	219 90.1%
T字杖（1本杖）	0 0.0%	4 4.2%	4 1.6%	89 61.0%	52 55.3%	141 58.0%
四点杖	3 2.0%	0 0.0%	3 1.2%	93 63.7%	44 46.8%	137 56.4%
ウォーカーケイン	1 0.7%	0 0.0%	1 0.4%	16 11.0%	6 6.4%	22 9.1%
ロフストランド杖				5 3.4%	7 7.4%	12 4.9%
松葉杖				4 2.7%	1 1.1%	5 2.1%
その他				5 3.4%	2 2.1%	7 2.9%
なし	1 0.7%	2 2.1%	3 1.2%			
複数回答	120 81.6%	60 62.5%	180 74.1%			
回答なし	2 1.4%	6 6.3%	8 3.3%	2 1.4%	6 6.4%	8 3.3%
計	147 100%	96 100%	243 100%	350 238.1%	201 209.4%	551 226.7%

6. 生活機能各レベル別の把握状況

生活機能の各レベル、特に活動と参加についての把握状況を通所者についてたずねた。

1) 「活動」レベルの把握状況

通所中の要介護認定者の生活行為(身の回りの行為等)について、どのような状態を把握しているかの問いに対しては表6-1に示すように複数回答が最も多く、地域支

援・予防給付 86.4%、介護給付 61.5% (75.6%) であった。

項目別では最も多いのは「自宅での日常の状態」で91.8%、67.7% (83.3%) であった。ついで「通所中の日常の状態」が77.6%、56.3% (69.2%) であった。この両者は「している活動」であるが、「できる活動」で、通所中の訓練時は41.2%、自宅でのがんばればできる状態は42.0%であった。

表5-4 よくすすめる歩行補助具・杖

	回答者別			項目別		
	地域支援・予防給付	介護給付	計	地域支援・予防給付	介護給付	計
頼って歩けなくなるので、なるべく使用しない	7 4.8%	6 6.3%	13 5.3%	7 4.8%	6 6.3%	13 5.3%
T字杖(1本杖)	44 29.9%	37 38.5%	81 33.3%	61 41.5%	46 47.9%	107 44.0%
その他	71 48.3%	31 32.3%	102 42.0%	87 59.2%	38 39.6%	125 51.4%
複数回答	17 11.6%	9 9.4%	26 10.7%			
回答なし	8 5.4%	13 10.4%	21 8.6%	9 6.1%	15 15.6%	24 9.9%
計	147 100%	96 100%	243 100%	164 111.6%	105 109.4%	269 110.7%

表6-1 通所中の要介護認定者の生活行為の把握

	回答者別			項目別		
	地域支援・予防給付	介護給付	計	地域支援・予防給付	介護給付	計
直接通所利用者には指導していない	4 2.7%	19 19.8%	23 9.5%	5 3.4%	21 21.9%	26 10.7%
通所中の日常の状態	2 1.4%	1 1.0%	3 1.2%	114 77.6%	54 56.3%	168 69.1%
通所中の訓練時	0 0.0%	1 1.0%	1 0.4%	67 45.6%	33 34.4%	100 41.2%
自宅での日常の状態	12 8.2%	11 11.5%	23 9.5%	135 91.8%	65 67.7%	200 82.3%
自宅でのがんばればできる状態	1 0.7%	0 0.0%	1 0.4%	70 47.6%	32 33.3%	102 42.0%
複数回答	127 86.4%	59 61.5%	186 76.5%			
回答なし	1 0.7%	5 5.2%	6 2.5%	147 100.0%	96 100.0%	243 100.0%
計	147 100%	96 100%	243 100%	391 366.0%	205 213.5%	596 245.3%

2) 移動について：生活の活発化のポイント

「通所者(含む介護予防事業)の「移動」についてどのような状態を聞いていますか」の問いに対して、複数回答者が最も多く85.0%、63.5%（通所者に接していない者を除外すると118人61名78.2%）であった（表6-2）。単数回答では「自宅内移動のみ」が最も多かったが約5%であった。移動には様々な種類があり、活動は目的と移動とが一連のものである場合が多いため、歩行の状況は様々な「活動」の基礎でもある。また参加レベルの反映でもあるため複数であるべきだが、残念なことにその把握

は不十分といえる。

項目別では、「自宅内」が最も多く87.1%、61.5%（75.6%）、次に「屋外（散歩）」77.6%、49.0%（60.3%）、「屋外（買い物）」が57.1%、38.5%（47.4%）であった。通所時について訓練中は5割、訓練以外は4割と少なかった。

訓練時は移動の「できる活動」であり、活動向上の観点から対応が十分に行われているか、また「できる活動」レベルで効果が生じているかをみるためにもその評価は、必須であるにも関わらず、半数にとどまっているのは、大きな問題といえる。乗り物利用は35.0%、車の運転は13.6%と低い。

表6-2 通所者の「移動」についての把握

	回答者別			項目別		
	地域支援・予防給付	介護給付	計	地域支援・予防給付	介護給付	計
通所者に接していない	0 0.0%	18 18.8%	18 9.1%	0 0.0%	19 19.8%	19 9.5%
自宅内	8 5.4%	4 4.2%	12 4.9%	128 87.1%	59 61.5%	187 77.0%
通所時の訓練中	1 0.7%	4 4.2%	5 2.1%	75 51.0%	34 35.4%	109 44.9%
通所時の訓練以外	3 2.0%	0 0.0%	3 1.2%	60 40.8%	32 33.3%	92 37.9%
屋外（散歩）	0 0.0%	2 2.1%	2 0.8%	114 77.6%	47 49.0%	161 66.3%
屋外（買い物）				84 57.1%	37 38.5%	121 49.8%
乗り物利用	1 0.7%	1 1.0%	2 0.8%	55 37.4%	30 31.3%	85 35.0%
車の運転				22 15.0%	11 11.5%	33 13.6%
その他	1 0.7%	0 0.0%	1 0.4%	12 8.2%	1 1.0%	13 5.3%
複数回答	125 85.0%	61 63.5%	186 76.5%			
回答なし	8 5.4%	6 6.3%	14 4.1%	8 5.4%	6 6.3%	14 4.1%
計	147 100%	96 100%	243 100%	558 379.6%	276 287.5%	834 343.2%

3) 参加レベル

参加レベルに関して表6-3にあげている内容について聞いているかを調べると、複数回答が地域支援・予防給付は98.6%、介護給付は96.9%であった。

項目別では「現在の趣味」は91.4%、「過去の趣味」は92.2%と現在、過去ともに趣味は多いが、一方外出先については「現在」77.4%、「過去」は58.8%、活動は「現在」63.0%、「過去」は61.3%であった。

C. 総括的考察

以上の結果を総括すると次のよう現状と課題が明らかとなった。

1. 介護予防の必要性に関する認識は、介護給付にのみ従事しているものでは「要介護状態の進行を予防することも介護予防である」ことの認識が3分の1強で不

十分であった。

2. 生活不活発病（廃用症候群）の把握状況及び生活不活発病予防・改善に向けたケアプランの作成状況は、「必ずしている」と「ほとんどしている」とを併せて7～8割で、2～3割は不十分であった。

また、この種のケアプラン作成の作成を容易と思うかについては、「とても容易」はなく、「容易」が5～6%で、「どちらともいえない」が約半数、「難しい」が4割弱であった。

3. 生活不活発病についての利用者への説明については「必ずしている」「ほとんどしている」をあわせて4割前後、「時々している」「ほとんどしていない」「全くしていない」をあわせたものが6割前後であった。

表6-3 参加レベルの把握

	回答者別			項目別		
	地域支援・予防給付	介護給付	計	地域支援・予防給付	介護給付	計
現在の趣味				139 94.6%	83 86.5%	222 91.4%
過去の趣味	1 0.7%	0 0.0%	1 0.4%	135 91.8%	89 92.7%	224 92.2%
現在の外出先	1 0.7%	1 1.0%	2 0.8%	126 85.7%	62 64.6%	188 77.4%
過去の外出先	0 0.0%	1 1.0%	1 0.4%	93 63.3%	50 52.1%	143 58.8%
現在のコミュニティの中の活動				105 71.4%	48 50.0%	153 63.0%
過去のコミュニティの中の活動				98 66.7%	51 53.1%	149 61.3%
複数回答	145 98.6%	93 96.9%	238 97.9%			
回答なし	0 0.0%	1 1.0%	1 0.4%	0 0.0%	1 1.0%	1 0.4%
計	147 100%	96 100%	243 100%	696 473.5%	384 400.0%	1,080 444.4%

4. 生活機能低下の2類型についての認識は「よくわかっているつもり」は2割弱で、「知らない」が3割強、「あることは知っている」が5割弱と、理解は不十分であった。

5. 生活不活発病の発生の3契機については複数回答で、正しい3選択肢（「活動」の「量」の低下、「活動」の「質」の低下、「参加」の低下）のうち「活動」の「量」の低下と「参加」の低下などをあげたものが8割前後であったが、「活動」の「質」の低下をあげたものは6割弱にとどまり、3契機が明確に認識されているとはいい難かった。要介護認定調査項目の新規追加項目はこの三つの契機を基本概念としているにも関わらず、この理解が不十分だといえる。

6. 「活動」の「質」についての認識の向上が望まれる。3契機のうち最も認識が不十分であった「活動」の「質」の低下とは、まさに介護を必要とする状態であった。

また介護のやり方で生活行為をよくすること（すなわち「活動」の「質」の向上）もできると考えている人は8割にみならず、この観点からのケアプランは立案が不十分といえる。

「活動」の「質」の低下とは「活動」（生活行為）の不自由さであり、「介護とはこの不自由さを補ったり、改善するために行う（よくする介護）もの」である。このような介護にとって本質的な「活動」の「質」についての認識が不十分なことは大きな問題といえる。

7. 生活不活発病（廃用症候群）について、

特に具体的な症候や病気の時の安静との関連性などについては十分な理解がすすんでいるとはいえない状況である。

8. 歩行は生活の活発化の要であるが、その状況また向上への働きかけは不十分といえる。まず、様々な状況下での歩行の把握が不十分である。また、「杖の使用で歩行が安全に長い距離できるようにする」は3割強にとどまっており、よく利用者にすすめる歩行補助具も歩行器・歩行車が多く、より積極的に、特に屋外歩行での歩行補助具の活用や、目的行為や使用場所によって歩行補助具の使い分け、すなわち複数使用が望まれる。

9. また「参加」も生活の活発化に不可欠であるが、この把握も不十分であった。

10. 生活機能のうち「活動」レベルの把握状況も不十分である。例えば、「通所中の訓練時」や「自宅でがんばればできる状態」は4割しか把握されていない。通所中の状況は通所施設でなされている具体的対応を把握するためにも不可欠である。また「できる活動」は潜在的な生活機能を引き出す大きなヒントになるものである。両者共に「よくする介護」としての介護予防で重要な情報であるにもかかわらず把握が不十分であった。

D. 結論

生活機能向上にむけた介護予防ケアマネジメント構築に資するために、介護予防及び介護保険サービスの実務に従事している関係者について、生活不活発病（廃用症候群）の認識に関する調査を行った。

その結果、①生活不活発病（廃用症候群）

の内容及び生活機能の低下の2類型や生活不活発病発生の3つの契機についての理解は限られており、ケアマネジメントの実際における活用は極めて不十分であった。②介護予防のみならず介護一般でも重要な「活動」の質的向上についての認識が極めて不十分である。具体的には「活動」・「参加」とともに大きなポイントとなる移動についての関与も不十分である。③自己決定権の尊重の原則、および利用者本人・家族の正しい理解にもとづく生活の活発化の前提となるべき生活不活発病についての説明は不十分であった。④以上から介護予防ケアマネジメントが十分に機能するには、生活不活発病、また「活動」の「質」の向上、「参加」についての臨床的活用の広範囲の啓発が必要であるといえよう。

E. 健康危険情報

特になし

F. 研究発表

1. 論文発表

- ・大川弥生：生活不活発病（廃用症候群）の予防．認知症の予防と治療．長寿科学振興財団（東京），p49－60，2007

Ⅲ. 研究成果の刊行物

Development of criteria for the qualifiers of activity and participation in the 'International Classification of Functioning, Disability and Health' based on the accumulated data of population surveys

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One of the purposes of this study is to describe the details and rationale of the criteria for qualifiers of the activity and participation of the International Classification of Functioning, Disability and Health that were developed based on population surveys and adopted provisionally by the International Classification of Functioning, Disability and Health Committee, Statistics Commission of Social Security Council of Japan in March 2007. The most important aspect of the criteria is the division of 'independence' of the activity into two different levels of 'Universal independence' (Qualifier 0) and 'Limited independence' (Qualifier 1) and the corresponding division of 'Full participation' (Qualifier 0) and 'Partial participation' (Qualifier 1) in the participation. These divisions reflect the paradigm shift in the basic concept of classification and evaluation of functioning and disability from 'only about people with disabilities' to 'about all people'. Another purpose is to present and analyze the accumulated data of population surveys on functioning in 17 600 older people (aged 65 years and older) living in five different communities throughout Japan as the supporting evidence for the criteria. The analysis of these data

Introduction

The International Classification of Functioning, Disability and Health (ICF; WHO, 2001) constitutes, together with the International Statistical Classification of Diseases and Related Health Problems (ICD; WHO, 1992), the reference classifications of the WHO Family of International Classifications (WHO, 2004). Although ICD is mainly about 'disease', ICF focuses on 'functioning', an umbrella concept for body functions/structure, activity and participation. Comprehensive health status can be addressed only by combining these two classifications in view of the definition of health in the WHO Charter: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1948). The International Classification of Impairments, Disabilities and Handicaps (ICIDH; WHO, 1980), the predecessor of ICF, being a 'consequences of diseases' classification and focusing only on the negative aspects of human life, has failed to indicate well-being. The ICF, being a 'components of health' classification, enabled a comprehensive description of well-being by shifting focus to functioning, the positive aspects (WHO, 2001).

offers good support for the relevance and usefulness of the criteria, especially in that the proposed division of Qualifier 0 ('Universal independence' and 'Full participation') and Qualifier 1 ('Limited independent' and 'partial participation') is a very sensitive tool in the detection of milder problems in the activity and participation. *International Journal of Rehabilitation Research* 31:97-103 © 2008 Wolters Kluwer Health | Lippincott Williams & Wilkins.

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Keywords: disability, functioning, International Classification of Functioning, Disability and Health, older population, population survey, qualifier

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Another feature that separates ICF from ICD and ICIDH is that it grades the severity of problems by providing a 'qualifier'. Although ICD and ICIDH are for 'qualitative evaluation' only, the ICF is for both 'qualitative' and 'quantitative' evaluation. The precise description of an individual's 'physical, mental and social well-being' has become possible with ICF. Five grades of qualifier exist in ICF, ranging from 0 (No problem) to 4 (Complete problem). The currently available criteria for qualifiers are only generic, and 'for this quantification to be used in a uniform manner, assessment procedures need to be developed through research' (WHO, 2001). Except for the Australian group who made earlier attempts, however, to use ICF for disability statistics (Australian Institute of Health and Welfare, 2003) and has developed more or less operational definitions for qualifiers (Australian Institute of Health and Welfare, 2005), few papers on qualifiers are available, and some include only general discussion (Nordenfelt, 2006; Maini *et al.*, 2007). Specific proposals concerning the criteria for ICF qualifier based on empirical data are very few and not operational enough (Kronk *et al.*, 2005; Grill *et al.*, 2007; Uhlig *et al.*, 2007). Even in the Australian attempts, the definitions of

qualifiers are not yet operational enough, although their proposal on such original qualifiers as 'satisfaction with participation' and 'need for assistance' should be highly commended (Australian Institute of Health and Welfare, 2005).

In Japan, ICF has been adopted by legislations and policies in such areas as health care, disability services, long-term care, disability prevention in ordinary life and at the time of natural disasters (Okawa and Ueda, in print).

The importance of disability statistics is also stressed in the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006). Thus, practical utilization of ICF is becoming increasingly important, and simple, objective and operationally defined criteria for qualifiers are imperative. We have made ICF-based population surveys and used their results to design proposals for qualifiers of activity and participation. In contrast, provisional criteria for the qualifiers of activity and participation of ICF were adopted in March 2007 by the ICF Committee, Statistics Commission of Social Security Council, Japan (Tables 1 and 2). The results of our surveys served as their basis. In part 1 the definitions and rationale of the criteria are discussed and some of the supporting evidence are presented in part 2.

Part 1: the provisional criteria

The rationale

Tables 1 and 2 show the provisional criteria for qualifiers adopted by the ICF Committee. The most important aspects of the criteria are the division of 'independence' of the activity into 'Universal independence' (Qualifier 0) and 'Limited independence' (Qualifier 1) (Table 1), and a corresponding division of the 'participation' into 'Full participation' (Qualifier 0) and 'Partial participation' (Qualifier 1) (Table 2).

These divisions reflect the paradigm shift in the basic concept of classification and evaluation of functioning and disability. Until recently, it has been customary, in

Table 1 Provisional criteria for the qualifiers of activity

Qualifier		Definition
0	Universal independence	Independent in all the probable environmental varieties of regular life (on outings, travels, visit, using unusual tools, etc.)
1	Limited independence	Independent only in a limited environment (using limited tools) of the usual living place (home, hospital ward, institution's room, etc.) and its vicinity
2	Partial limitation	Performing with partial human assistance ^a
3	Complete limitation	Performing with full human assistance
4	No performance	Not performing (included: being prohibited)

This table is for the 'performance' of activity. For the 'capacity', 'No performance' shall be read as 'No capacity' and 'Performing' as 'Capable'.

^aPartial human assistance' includes also observation, encouragement, etc.

Table 2 Provisional criteria for the qualifiers of participation

Qualifier		Definition
0	Full participation	Always or often actualizes full participation (irrespective of human assistance) ^a
1	Partial participation	Actualizes participation sometimes or partially without human assistance
2	Partial restriction	Actualizes participation sometimes or partially, supported by partial human assistance ^b
3	Total restriction	Actualizes participation sometimes or partially, supported by full human assistance
4	No participation	Not participating (included: being prohibited)

This table is for the 'performance' of participation. For the 'capacity', 'actualizes' shall be read as 'capable' and 'not participating' as 'not able to participate'.

^aParticipation at high level shall be assigned Qualifier 0, regardless of the frequency of participation or grade of human assistance.

^bPartial human assistance includes also observation, encouragement, etc.

the evaluation of disability, to assign 'Independence' as a whole to the highest rank. For example, in the Barthel activities of daily living (ADL) index (Mahony and Barthel, 1965) the highest level is 'independent' and does not make a distinction within the 'independence' as in our provisional criteria.

This practice, however, is influenced by the old notion that classification and evaluation such as ICF is 'only about people with disabilities' [ICF (WHO, 2001): Introduction P7]. This implies that most people in the target population were presupposed to have some disabilities and 'independence' of activity to be a rather rare phenomenon. This notion is, however, a 'widely held misunderstanding' and ICF is 'in fact about all people' (WHO, 2001).

To classify and evaluate the state of 'all people', it is absolutely necessary that ICF is sensitive enough to detect milder problems than before, because 'all people' consist of quite a wide spectrum of people, ranging from people without any health conditions (diseases, traumas, etc.) or disabilities to those with health conditions but without disabilities, and then to those with disabilities. Besides, they may also have age-dependent and other variations. For ICF to be really 'about all people', it should not overlook the problems in functioning that may occur in a larger part of the population who are in a better state of functioning compared with the people with disabilities.

Universal independence versus limited independence

In the criteria for activity, the Qualifier 0, 'Universal independence' is defined as being 'Independent in all the probable environmental varieties of regular life (on outings, travels, visit, using unusual tools, etc.)', and Qualifier 1, 'Limited independence' as 'Independent only in a limited environment (including the use of limited tools) of the usual living place (home, hospital ward, institution's room, etc., depending where the person lives) and its vicinity'. This distinction is reasonable

because, for example, a person may have no problem of 'eating' (a530) at his/her home, but may have difficulty in restaurants because of different sizes of the table and chair, different dishes and utensils, difficulty in observing due manners.

Complete limitation versus no performance

The distinction of Qualifier 3, 'Complete limitation', and Qualifier 4, 'No performance', in activity is also important because there is a great difference between not doing an activity at all and doing it even with full human assistance. The 'no performance' may also be imposed by prohibitions due to medical reasons or as a result of environmental restriction owing to hospitalization or institutionalization irrespective of the person's potential capability. The same is applied for the distinction of Qualifier 3, 'Total restriction', and Qualifier 4, 'No participation', in participation.

Full participation versus partial participation

For participation, the Qualifier 0, 'Full participation', is defined as 'Always or often actualizes full participation (irrespective of human assistance)' with a comment that 'Participation at high level shall be assigned Qualifier 0 regardless of the frequency of participation or grade of human assistance' (Table 2). This means, 'Full participation' is the highest level of participation qualitatively ('at a high level') and/or quantitatively ('always or often').

Part 2: the accumulated data of population surveys as the supporting evidence

As a part of a huge amount of data supporting evidence for the criteria, the accumulated data on functioning in 17 600 older people (65 + years) living in five different communities were analyzed. These communities were spread throughout Japan and differed in size and geographical, industrial and other characteristics. By combining them, the samples were considered as representative of the entire country.

The participants for assessment of functioning were limited to older individuals who were 65 years of age or older. This was because the older population included a large part of individuals with problems of functioning. Another reason is that the adoption of ICF to legislations and policies in Japan has been better implemented in the healthcare and long-term care for the older population.

Materials and methods

Participants

The participants consisted of three major groups. The first group was the 'Regular' group of 14 311 people, who were not qualified either for the services by the Insurance for Long-term Care (ILC) or the National Disability Services (NDS). The second one was the 'Impaired' group of 1323 people, who were qualified for NDS only.

The third was the 'Needing care' group of 2866 people who were qualified for the services by ILC regardless of the qualification by the NDS. The attributes of each group are described below in detail. The description of the 'Regular' group follows that of the other groups.

'Impaired' group

In Japan a person of any age having more than a certain level of physical impairment (problems in body functions/structures, determined in detail by the Welfare of People with Physical Disability Act, 1949) is qualified (by diagnosis of a designated physician) for the NDS, including tax reduction, disability allowance, medical care on reduced cost (e.g. artificial dialysis for renal impairment), assistive technologies (prosthesis, orthosis, wheelchair, car modification, etc.), special parking permit, institutional services, etc. The qualification is not compulsory, but most people who are eligible are qualified and receive the services. So if a participant answers 'yes' in a survey to the question if he/she is qualified for NDS, it is a good proof of having more than a certain grade of impairment.

'Needing care' group

Also any person aged 65 years or more (40 years or more for some 'age-related' diseases) who has become limited in activity (mainly self-care and domestic life) more than a certain degree (defined in detail by the Insurance for Long-term Care Act, 2000) is qualified (by assessment of social worker and diagnosis of physician) for personal care. This is a good indication for activity limitation of more than a certain degree, and the people answering 'yes' to the question on this point were grouped as 'Needing care' group (irrespective of qualification for NDS). This group was subdivided into six subgroups according to the 'Grades of needed care' as defined by the law, from 'Help needed' to five levels (1–5) of 'Care needed'.

'Regular' group

The people who were not qualified either for ILC or NDS were grouped as the 'Regular' group. They may have health conditions (diseases, traumas, etc.), but no impairment or activity limitation of more than a certain degree.

Methods

The questionnaires used in population surveys in five communities had certain degrees of variation depending on the purpose of the survey (most of the time they were joint surveys with municipal government for policy development and planning of welfare services), time frame, budget, etc., but they invariably included such basic items as outdoor gait (a4602) and gait within the home (a4600) in the activity, which belonged to the most important activity items and had a great influence over other activities. In the participation they included such basic items as work and employment (p840–p859) and

recreation and leisure (p920). In this study, these four items were chosen for analysis. Their data were aggregated, regrouped into the above-mentioned three groups and statistically analyzed. The samples were total in three communities and random in the other two. The questionnaire was either mailed or delivered in person and was collected in person. The recovery rates ranged from 66.5 to 99.2% and were 90% or more in three of the five communities.

Ethical considerations

This study was examined and approved by the Ethics Committee of the institution of the chief investigator. In addition, contracts were made between the municipalities and the chief investigator in accordance with the laws for protection/management of personal information. The participants were enrolled based on the principle of informed consent.

Results

Activities

Outdoor gait

A clear difference in 'Universal independence' (Qualifier 0) in three participant groups was found. It was highest in the 'Regular' group (42.0%), lower in the 'Impaired'

(26.5%) and still lower in the 'Needing care' (4.8%) groups (Tables 3 and 4).

(1) *Relationship between 'Universal independence' and 'Limited independence'* In the 'Regular' group Qualifier 0, 'Universal independence' (i.e. 'Walking independently for a long distance') was 58.9% in the 'Young old' population (aged 65–74 years), 37.5% in the 'Old old' population (aged 75–84 years) and 18.7% in the 'Oldest old' population (aged 85 and over). In contrast to this drastic decrease of Qualifier 0 as age advanced, Qualifier 1, 'Limited independence' (i.e. 'Walking only in the vicinity of one's residence') increased as age advanced, as it was 32.2, 47.0 and 52.6%, respectively. Thus, if the two levels of independence were added to make an 'Independence total', the age-dependent differences would become much less clear, being 91.1, 84.5 and 71.3%, respectively.

In the 'Impaired' group, in contrast, although 'Universal independence' became smaller as age advanced (33.9, 26.0 and 13.0%, respectively), 'Limited independence' remained almost the same (around 47.0%). In the 'Needing care' group, both 'Universal' and 'Limited' independence became smaller as 'Grade of needed care' became higher.

Table 3 Outdoor gait (a4602); 'Regular' and 'Impaired', N=14 734

	Regular				Impaired				Grand total
	65–74 years	75–84 years	85 + years	Total	65–74 years	75–84 years	85 + years	Total years	
Qualifier 0	2505 58.9%	2817 37.5%	306 18.7%	5628 42.0%	130 33.9%	198 26.0%	23 13.0%	351 26.5%	5979 40.6%
Qualifier 1	1371 32.2%	3536 47.0%	860 52.6%	5767 43.0%	180 47.0%	362 47.4%	83 46.9%	625 47.2%	6392 43.4%
Qualifier 2	146 3.4%	445 5.9%	145 8.9%	736 5.5%	25 6.5%	63 8.3%	24 13.6%	112 8.5%	848 5.8%
Qualifier 3	183 4.3%	530 7.0%	263 16.1%	976 7.3%	43 11.2%	117 15.3%	42 23.7%	202 15.3%	1178 8.0%
Qualifier 4	2 0.0%	18 0.2%	11 0.7%	31 0.2%	2 0.5%	10 1.3%	2 1.1%	14 1.1%	45 0.3%
No data	47 1.1%	176 2.3%	50 3.1%	273 2.0%	3 0.8%	13 1.7%	3 1.7%	19 1.4%	292 2.0%
Total	4254 100%	7522 100%	1635 100%	13411 100%	383 100%	763 100%	177 100%	1323 100%	14734 100%

Table 4 Outdoor gait (a4602); 'Needing Care', N=2866

	Help	Care 1	Care 2	Care 3	Care 4	Care 5	Total
Qualifier 0	80 11.1%	41 3.4%	15 2.5%	1 0.6%	2 1.9%	0 0.0%	139 4.8%
Qualifier 1	456 63.4%	558 45.7%	153 25.3%	23 14.7%	2 1.9%	1 1.7%	1193 41.6%
Qualifier 2	65 9.0%	199 16.3%	154 25.5%	19 12.2%	13 12.4%	4 6.7%	454 15.8%
Qualifier 3	103 14.3%	364 29.8%	240 39.7%	65 41.7%	48 45.7%	26 43.3%	846 29.5%
Qualifier 4	4 0.6%	32 2.6%	31 5.1%	45 28.8%	38 36.2%	29 48.3%	179 6.2%
No data	11 1.5%	27 2.2%	12 2.0%	3 1.9%	2 1.9%	0 0.0%	55 1.9%
Total	719 100%	1221 100%	605 100%	156 100%	105 100%	60 100%	2866 100%

Help and Care 1–5 are the grades of needed care, showing the degree of activity limitation.

(2) *Correlation between 'Complete limitation' and 'No performance'* Qualifiers 3 and 4 in the 'Regular' group were 7.3 and 0.2%, and in the 'Impaired' group 15.3 and 1.1%, respectively. In each of these groups the former value was considerably higher. They were, however, 29.5 and 6.2%, respectively, in the 'Needing care' group and the difference was much smaller. In both the 'Regular' and 'Impaired' groups, Qualifier 3 increased considerably as age increased. In Qualifier 4, however, they did not exhibit clear age dependence. In contrast, in the 'Needing care' group, the ratio for Qualifier 3 gradually increased as Grade of needed care increased, although Qualifier 4 exhibited nearly 10 times difference between the first three groups (Help, Care 1 and Care 2) and the last three groups (Care 3–Care 5).

Gait within the home

Qualifier 0, 'Universal independence' ('walking without holding on anything') among the three groups for gait within the home was 85.7, 70.2 and 32.9%, respectively, showing the same tendency as in outdoor gait (Tables 5 and 6).

(1) *Relationship between 'Universal independence' and 'Limited independence'* In the 'Regular' group, 'Universal indepen-

dence' became lower as the age increased. In contrast, Qualifier 1, 'Limited independence' ('walking while touching or clinging on walls or furniture') became higher as the age increased. As a result, the decrease in 'Independence total' as age increased was only slight. The same pattern was observed in 'Impaired' group.

In the 'Needing care' group, gait within the home was managed well in comparison with outdoor gait, although an overall decrease in ratios for Qualifiers 0 and 1 was evident as Grade of needed care increased.

(2) *Correlation between 'Complete limitation' and 'No performance'* In the 'Needing care' group, Qualifier 3 became almost steadily higher as Grade of needed care advanced. In contrast, Qualifier 4 differed considerably between the first three groups and the last three groups. These observations were the same as those in outdoor gait.

Participation

In recreation and leisure, 'Full participation' was generally lower than 'Partial participation' in all groups, although if compared among groups, it was highest in the 'Regular', lower in the 'Impaired' and lowest in the 'Needing care' groups (Tables 7 and 8).

Table 5 Gait within the home (a4602); 'Regular' and 'Impaired', N=14 734

	Regular				Impaired				Grand total
	65–74 years	75–84 years	85+ years	Total	65–74 years	75–84 years	85+ years	Total	
Qualifier 0	3916 92.1%	6425 85.4%	1157 70.8%	11498 85.7%	298 77.8%	531 69.6%	100 56.5%	929 70.2%	12427 84.3%
Qualifier 1	248 5.8%	758 10.1%	334 20.4%	1340 10.0%	52 13.6%	163 21.4%	46 26.0%	261 19.7%	1601 10.9%
Qualifier 2	28 0.7%	108 1.4%	39 2.4%	175 1.3%	17 4.4%	24 3.1%	11 6.2%	52 3.9%	227 1.5%
Qualifier 3	2 0.0%	18 0.2%	24 1.5%	44 0.3%	4 1.0%	7 0.9%	3 1.7%	14 1.1%	58 0.4%
Qualifier 4	5 0.1%	49 0.7%	37 2.3%	91 0.7%	6 1.6%	18 2.4%	14 7.9%	38 2.9%	129 0.9%
No data	55 1.3%	164 2.2%	44 2.7%	263 2.0%	6 1.6%	20 2.6%	3 1.7%	29 2.2%	292 2.0%
Total	4254 100%	7522 100%	1635 100%	13411 100%	383 100%	763 100%	177 100%	1323 100%	14734 100%

Table 6 Gait within the home (a4602); 'Needing Care', N=2866

	Help	Care 1	Care 2	Care 3	Care 4	Care 5	Total
Qualifier 0	342 47.6%	398 32.6%	165 27.3%	22 14.1%	14 13.3%	2 3.3%	943 32.9%
Qualifier 1	345 48.0%	717 58.7%	331 54.7%	61 39.1%	13 12.4%	3 5.0%	1470 51.3%
Qualifier 2	9 1.3%	21 1.7%	20 3.3%	23 14.7%	14 13.3%	2 3.3%	89 3.1%
Qualifier 3	13 1.8%	34 2.8%	37 6.1%	13 8.3%	12 11.4%	3 5.0%	112 3.9%
Qualifier 4	2 0.3%	28 2.3%	38 6.3%	34 21.8%	51 48.6%	50 83.3%	203 7.1%
No data	8 1.1%	23 1.9%	14 2.3%	3 1.9%	1 1.0%	0 0.0%	49 1.7%
Total	719 100%	1221 100%	605 100%	156 100%	105 100%	60 100%	2866 100%

Help and Care 1–5 are the grades of needed care, showing the degree of activity limitation.

Table 7 Recreation and leisure (p920); 'Regular' and 'Impaired', N= 14 734

	Regular				Impaired				Grand total
	65-74 years	75-84 years	85 + years	Total	65-74 years	75-84 years	85 + years	Total	
Qualifier 0	569 13.4%	747 9.9%	86 5.3%	1402 10.5%	32 8.4%	47 6.2%	4 2.3%	83 6.3%	1485 10.1%
Qualifier 1	1761 41.4%	2547 33.9%	375 22.9%	4683 34.9%	117 30.5%	207 27.1%	34 19.2%	358 27.1%	5041 34.2%
Qualifier 2	220 5.2%	553 7.4%	124 7.6%	897 6.7%	22 5.7%	52 6.8%	7 4.0%	81 6.1%	978 6.6%
Qualifier 3	2 0.0%	5 0.1%	6 0.4%	13 0.1%	0 0.0%	2 0.3%	1 0.6%	3 0.2%	16 0.1%
Qualifier 4	1538 36.2%	2988 39.7%	878 53.6%	5404 40.3%	199 52.0%	390 51.1%	115 65.0%	704 53.2%	6108 41.5%
No data	164 3.9%	680 9.0%	168 10.3%	1012 7.5%	13 3.4%	65 8.5%	16 9.0%	94 7.1%	1106 7.5%
Total	4254 100%	7520 100%	1637 100%	13411 100%	383 100%	763 100.	177 100.	1323 100.	14734 100%

Table 8 Recreation and leisure (p920); 'Needing care', N= 2866

	Help	Care 1	Care 2	Care 3	Care 4	Care 5	Total
Qualifier 0	41 5.7%	27 2.2%	6 1.0%	1 0.6%	1 1.0%	0 0.0%	76 2.7%
Qualifier 1	182 25.3%	201 16.5%	56 9.3%	6 3.8%	5 4.8%	0 0.0%	450 15.7%
Qualifier 2	296 41.2%	678 55.5%	374 61.8%	19 12.2%	12 11.4%	5 8.3%	1384 48.3%
Qualifier 3	7 1.0%	11 0.9%	17 2.8%	8 5.1%	10 9.5%	5 8.3%	58 2.0%
Qualifier 4	182 25.3%	283 23.2%	133 22.0%	116 74.4%	75 71.4%	47 78.3%	836 29.2%
No data	11 1.5%	21 1.7%	19 3.1%	6 3.8%	2 1.9%	3 5.0%	62 2.2%
Total	719 100%	1221 100%	605 100%	156 100%	105 100%	60 100%	2866 100%

Help and Care 1-5 are the grades of needed care, showing the degree of activity limitation.

Clear age-dependent differences exist within both Qualifiers 0 and 1 in the two former groups and activity-limitation-dependent differences in the 'Needing care' group. If 'Full participation' and 'Partial participation' were, however, added to make a 'Participation total', these differences would become less clear than in 'Full participation' alone. The data on work and employment (p840-p859) gave a similar picture.

Discussion

'Universal independence' and 'Limited independence'

Within the 'Regular' group, Qualifier 0, 'Universal independence' became smaller as age increased, and, for example, in outdoor gait, in the 'Oldest old' group it was less than one-third of that in the 'Young old' group. If 'Universal independence' and 'Limited independence' were, however, combined to make an 'Independence total', it would be, in the outdoor gait, 91.1, 84.5, and 71.3%, respectively, in the three age groups, thus the age-dependent decrease was not as conspicuous as in 'Universal independence' alone. It could be said that the increase in Limited independence 'canceled out' the decrease of Universal independence to a large extent. It was exactly the same also in the gait within the home in

both the 'Regular' and 'Impaired' groups. In other words, this means that a relatively mild decrease in 'activity' could be successfully detected by introducing 'Universal independence'.

It was, however, a little different in the 'Impaired group' in the outdoor gait. They also exhibited age dependence for Qualifier 0, but that for Qualifier 1 was not as apparent. 'Independence total' in the three age groups, however, was 80.9, 73.4, and 59.9%, respectively, and the differences among them were not as large as in 'Limited independence' alone. This observation could be explained as a phenomenon which is not 'canceled out' but 'neutralized' somewhat by adding rather stable 'Limited independence' to the sharp decrease in 'Universal independence'.

In the 'Needing care' group the phenomenon of 'cancellation' or 'neutralization' was not seen, but some other important details became apparent, suggesting the benefit of use of 'Universal independence'. That is, even in this 'Needing care' group, who show an overall decrease in the activity, there were a certain number of persons who showed a high level of activities ('Universal