

Authors, Year	Sample	Data	Methods	Independent variables	Significant variables
Shishido, 2009	Age 30≤	Japan General Social Survey (JGSS) 2000-2006	Logit model	Working hours, frequency of housework, 7-12 yrs. old child(ren), children living in the same home, rate of moving to other communities, financial indicator of local municipality, rate of information support of local municipality, participation rate of senior clubs, no. of NPOs/100,000 population Control variables: sex, age, SES, education, subjective health, spouse, years of residence, population density	Local recycling activity: sex (+), age (+), SES (+), spouse (+), shorter years of residence (-), density (-), working hours (-), frequency of housework (+), children living in the same home (+), participation rate of senior clubs (+), no. of NPOs/100,000 population (-)
Terazawa, 2012	Age 20-89 who volunteer frequently and temporarily (n=4,976)	Japan General Social Survey (JGSS) 2002, 2005	Logit model	Religion (Buddhism, Christianity, New Religion, Other, No religion), level of devotion, membership in an organized religious group, age, age (log), sex, education, are of residence (city or other), spouse, work type (self-employed or temporary employed, unemployed, full time employed)	Frequent volunteering: New religion, age, age(log), education, spouse Infrequent volunteering: Buddhism (individual), Buddhism (family), age, age (log), education
Ono, 2012			Probit Model	Age, age (log), sex, education, having children, caregiving, breadwinner, monthly non-working wage, monthly working wage, savings, loans, health, life satisfaction, area of residence	Age (-), age (log) (+), having children (+), monthly working wage (-), savings (+), health (+), life satisfaction (+), area of residence (towns and villages) (+)

Authors, Year	Sample	Data	Methods	Independent variables	Significant variables
Ishida, 2012	Ages 55-70 (n=230)	Study on the Current Status of Employment among the Elderly JILPT 2009 and Ministry of Home Affairs Census Survey Report	Tobit Model	Participation in social contribution activity, intent to participate in social contribution activity, population, unemployment rate, average age, rate of older adult workforce, rate of having person living in the same household, education, health, own home, apartment, social education expenditures, municipal law implemented for social contribution activity/ volunteerism, community building	Average age (+), education (+), health (+), own home (+), social education expenditures (+)

Table 2. Reasons why he/she did not volunteer in the past 5 years (multiple responses)

Reasons	Responses (%)	Cases (%)
Don't have the time	19.2	33.9
Don't know anyone	7.6	13.6
Don't have enough information	10.2	18.5
Don't have the chance	15.5	27.6
Don't know how to participate	6.6	12.0
Want to protect my own time	9.4	16.9
Not interest in the activities	3.3	5.9
Physically unwell	9.7	17.2
Activities are unrelated to my daily life	1.5	2.7
Bothersome	2.9	5.2
Can't get support from my family	0.6	1.1
Other reasons	13.4	22.4
Total=1017	100%	176.3%

Table 3. Characteristics of older adults ages 65+ with and without volunteer experience in the past 5 years

	<i>N</i>	Volunteer Experience		<i>X</i> ² (<i>df</i>)	<i>t</i>		
		Yes (<i>n</i> =156)				No (<i>n</i> =547)	
		<i>M</i> (<i>SD</i>)	%			<i>M</i> (<i>SD</i>)	%
Age (Range 65-94)	689	71.8(5.0)		73.9(6.3)	4.1***		
Gender							
Male	355		58.7	47.4	6.65(1)**		
Female	343		41.3	52.6			
Number of cohabiting family members (including respondent)	480	3.2(1.5)		3.6(1.7)	2.1*		
Living with spouse							
Yes	500		89.3	74.8	12.0(1)***		
No	122		10.7	25.2			
Alone during the day (1=frequently, 2=sometimes, 3 never)	605	1.8(0.7)		1.9(0.7)	2.3*		
Self-rated happiness (Likert scale 0= very unhappy – 10= very happy)	671	7.4(1.9)		6.8(2.1)	3.3***		
Self-rated health	694						
Somewhat or very healthy			79.9	76.9	.626(1)		
Somewhat or unhealthy			20.1	23.1			
Drink	685	2.5(1.1)		2.8(1.1)	2.5**		
Smoke	677	3.3(0.9)		3.4(0.9)	1.15		
Basic Competence							
ADL	693	10.0(0.1)		9.9(0.7)	1.05		
IADL	672	7.7(0.7)		7.0(1.7)	4.4***		
Expanded Competence							
Intellectual competence	677	2.9(0.4)		2.5(0.8)	4.7***		
Social competence	640	5.7(0.9)		5.0(1.4)	5.1***		
Mental health	644	3.5(0.9)		3.3(1.2)	2.4***		
Interested in paid work							
Yes	119		33.6	18.6	11.9(1)***		
No	382		66.4	81.4			
No. of participated local activities	667	2.1(1.3)		1.3(0.6)	12.7***		

*=*p*<0.5, **=*p*<0.01, ***=*p*<0.001

Table 4. Logistic regression analysis on having volunteer experience in the past 5 years

	<i>B</i>	<i>SE B</i>	<i>B</i>	<i>SE B</i>	<i>B</i>	<i>SE B</i>
Age	-.05	.03*			-.08	.04*
Sex (1=male)	-.17	.26			0.11	.38
Living with a spouse (1=yes)	-1.12	.48*			-.84	.68
No. of cohabiting family members	-.02	.08			-0.6	.13
Alone during the day	-.25	.18			-.19	.26
Self-rated health	.38	.34			.35	.51
Self-rated happiness	.21	.07**			.20	.10*
IADL	.34	.14*			.35	.24
Paid work			-.77	.29***	-.99	.41*
Mental health score			-.16	.13	-.25	.24
Literacy skills score			.65	.28*	-.24	.40
Social capital score			.11	.14	.24	.26
No. of participated local activities			1.06	.16***	1.0	.21***
Constant	-.84	2.29	-4.19	.90***	.30	3.43
Goodness-of-fit statistics ¹ <i>X</i> ² , <i>df</i>	5.84(8)		5.87(8)		9.21(8)	

1. Hosmer and Lemeshow Test.

日独韓における介護保険の現状と課題に関する比較研究

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研究要旨

日独韓の介護保険制度の現状と課題を明らかにするとともに、日独韓の介護保険制度の比較を通して、少子高齢社会における介護保障制度のあり方について検討するため、日独韓の専門家を招いて、国際シンポジウムを開催した。

日独韓の介護保険は、医療保険との関連性、被保険者や利用者の範囲、等級や上限額の設定、ケア・マネジメントの導入など、それぞれに類似点や相違点があり、相互に影響し合っている側面がある。いずれの国においても、少子高齢化の中で、コスト節減と介護サービスの質の確保という二律背反的な課題に取り組まねばならない点では共通している。

今後、更に深刻化する少子高齢化の中で、この二律背反的な課題に取り組むためにも、先進諸国は互いに知恵を出し合い情報交換を行うとともに、これから本格的に高齢化を迎える諸国に対しても、自らの経験を通して学んだ情報を積極的に発信していくことが重要である。

A. 研究目的

本研究は、先進諸国の中でも急速に少子高齢化が進展したドイツ・日本・韓国において、急増する要介護高齢者に対する介護ニーズに対応するため導入された介護保険制度について、その現状と課題を明らかにするとともに、3か国の介護保険制度の比較を通して、今後の介護保障制度のあり方について検討しようとするものである。

B. 研究方法

本研究の目的に資するため、2013年3月14日、「日独韓における介護保険の現状と課題」をテーマに、日独韓の介護保険の専門家の講演およびパネル・ディスカッションを内容とした国際シンポジウム（日英同時通訳付き）を筑波大学で開催した。前半冒頭では、3月11日～13日に実施した特別講義の成果報告があり、その後、2名の講演が行われた。まず、ドイツについて、フルダ大学教授を兼務するマックス・プランク社会法社会政策研究所研究員のハンスヨアキム・ラインハルト博士が「ドイツ介護保険の基本構造と課題」と題する講演を行った。つぎに、韓国について、静岡福祉大学社会福祉学部・張昌鎬教授が「韓国における老人長期療養保険の形成と課題」と題する講演を行った。後半では、まず、岡山県立大学保健福祉学部・増田雅暢教授が「日本・ドイツ・韓国の介護保険制度の比較考

察」と題する講演を行った。つぎに、これらの講演の内容を受けて、本澤がコーディネータとなり、パネラーとして、ラインハルト教授、張教授、増田教授、田宮教授（本研究代表者）が登壇する形で、パネル・ディスカッションを行うとともに、会場の参加者との質疑応答を行った。

C. 研究結果

1. ドイツ介護保険の基本構造と課題

ドイツの介護保険制度は、人口の高齢化に対応するため15年間にわたる議論を経て、1995年に第5番目の社会保険としてスタートした。保険料や保険給付の基準は全国的に統一されているが、しかし実際の運営は各州に任されているため、施設や介護サービスの量や質の確保については、十分とは言えない面もある。

日本と違って、被保険者の年齢制限はなく、子どもも介護保険の給付対象となっている。また、介護保険の保険者は医療保険に連動しており、被保険者は、公的医療保険か民間医療保険のいずれを選択するかによって、介護保険も公的保険か民間保険かが決まることになっている。2009年1月に医療保険加入がドイツ在住者全員に義務づけられたが、民間保険加入者は10%に止まっている。介護保険について言えば、公的介護保険と民間介護保険で、被保険者の支払う保険料と介護保険給付との関係それ自体に違いはない。しかし、民間保険では被保険者の配偶者や子どもの保険料は別に負担する必要があるなどの違いがある。上記のように、2009年1月から医療保険加入が義務づけられているが、医療保険では競争原理が持ち込まれているため、保険給付は介護保険に押しつけられる結果を招いている。しかし、介護保険においてもコスト節減の命題が横たわっており、介護の質の確保には苦慮している。介護保険給付の質の審査は、施設介護についてだけ行われており、在宅サービスは対象になっていないという問題もあるが、質の審査を行うMDKが医療保険の機関であることも問題であり、質の審査は独立機関が行うべきである。こうした介護サービスの質の審査や質のコントロールのためには、十分な職員の確保が必要であり、コスト高となってしまう。これに対し、介護保険の保険料は、被用者（退職者を含む）と使用者が労使折半で各1,025%を負担し（23歳以上で子どものいない被用者は+0,25%）、自営業者は2,05%を負担することになっている。しかし、社会保険料負担は、既に賃金の40%を占めるに至っており、介護保険の保険料を引き上げることは難しい状況にある。ドイツの介護保険の給付には上限額が設定されており、介護ニーズの一部しかカバーされない構造によってコスト増大を抑制することが、当初から企図されてきた。また、当初、介護保険財源は積み立て方式に拠るとされていたが、いずれ賦課方式に変更せざるを得ないと言われている。というのも、現在は1億ユーロの黒字があり、2016年までは収支バランスは取れるとされているが、しかし2020年には赤字に転じると言われているからである。

ドイツの介護保険給付は、要介護Ⅰ～Ⅲの者に支給される。要介護度は、介護の必要時間数で等級分けされており、要介護Ⅰは1時間半、要介護Ⅱは3時間、要介護Ⅲは5時間

となっており、会話などの個人的なケアはこの時間数には含まれないとされている。保険給付には、現物給付と現金給付がある。現物給付である介護サービスの場合、要介護Ⅰは月額 450 ユーロ、要介護Ⅱは月額 1100 ユーロ、要介護Ⅲは月額 1550 ユーロであり、実際に必要なコストの一部しかカバーされない。例えば、要介護Ⅰの場合、実際に必要な現物給付の費用は、月額 800～900 ユーロである。また、要介護Ⅲの人がナーシング・ホームに入所している場合、実際に係る費用は月額 4500 ユーロであり、保険給付との差額は非常に大きく、これを本人や家族が支払えない場合には、租税財源による社会扶助給付でカバーしなければならない。これに対し、在宅で娘や嫁などの家族が介護をしている場合には、被保険者である利用者は現金給付の支給を受けることになる。現金給付の金額は現物給付の金額よりも低く、要介護Ⅰで月額 235 ユーロ、要介護Ⅱで 440 ユーロ、要介護Ⅲで 700 ユーロである。さらに、保険給付として、介護家族には介護時間に応じて年金保険の保険料が支払われ、家族介護に従事している期間について年金権が保障されることになっている。保険給付分野における課題としては、在宅介護の場合には、人間関係などの家族問題が表面化することもあり、また家族介護者のための介護研修が必要であったりすることが指摘されている。また、介護施設における介護従事者の労働条件の悪さ（夜勤や低賃金など）ゆえに介護の質が低下しやすく、介護の質を高くするためにも、介護従事者の賃金を引き上げる必要があると指摘されている。特に介護施設の閉鎖によって行き場のない要介護高齢者が発生することを防ぐためにも、介護労働者の労働条件の改善によって、介護の質を確保することが重要な課題の一つとなっている。

2013 年 1 月からは、認知症の人により多くの保険給付を支給するため、従来は給付対象となっていなかった要介護「0（ゼロ）」という介護等級が新たに設けられた。また、要介護認定の審査期間を短縮する目的で、5 週間以内に要介護認定の結果を出すことが保険者に義務づけられ、もしできなければ週 70 ユーロの罰金が課せられることになった。さらに、保険給付は、従来の介護時間に応じた給付だけでなく、一定比率の給付を選択することもできることになった。さらに、グループ・ホームにおける在宅サービス利用の場合には、通常の保険給付に加えて 200 ユーロの付加給付が支給され、また 4 名以上が常時的に利用する浴室等の改装についても 2557 ユーロが付加的に支給されることとなった。このほか、基本介護や家事援助を受けている場合に限っては、新たな給付として、一緒に会話をしたり散歩したりしてくれる者に係る経費も支給されることになった。さらに、月額 5 ユーロで 10 ユーロの付加給付を受けられる私的付加保険が新設された。なお、今後における更なる課題としては、介護サービスの質の確保、介護者のための介護研修、財源確保、家族介護と保険給付との間のバランスなどが挙げられる。

2. 韓国における老人長期療養保険の形成と課題

韓国には介護という言葉が存在しないので、ドイツや日本の介護保険は、韓国では老人長期療養保険と呼ばれている。従来、韓国における家族計画は、子どもの出生を抑制する

政策を意味していたが、現在は、高齢者介護を意味するようになっている。ドイツや日本に比べて、韓国では余り高齢化が進展していない段階で（2008年の高齢化率は9.3%）老人長期療養保険が導入された。その背景には、大統領や行政機関の大きな影響力があった。国会や政党、利益集団（医師会や看護協会）の影響力もあったが、しかし一般国民の世論は余り影響を与えなかった。

老人長期療養保険の保険者は、国民健康保険公団である。被保険者は、国民健康保険の加入者であり、ドイツと同じく子どもも対象となるが、保険給付の給付対象者は、65歳以上の高齢者および65歳未満の老人性疾病による老人長期療養等級1～3に該当する者である。保険財源は、国民健康保険料と一緒に徴収される長期療養保険料（2012年で通常月給の0.37%）、国および地方自治体負担金（長期療養保険料予想収入額の20%＋医療給付受給者の給付費用）、利用者負担（在宅サービスの場合は15%、施設サービスの場合は20%）により賄われている。

老人長期療養保険の給付は、在宅給付の場合、訪問調査により判定される等級1～3の者が対象となる。等級1が月額114万600ウォン、等級2が月額100万3700ウォン、等級3が月額87万8900ウォンである。施設介護の場合には、老人療養施設で等級1が日額5万120ウォン、等級2が日額4万6420ウォン、等級3が日額4万2710ウォンであり、グループ・ホームで等級1が日額4万8900ウォン、等級2で日額4万5290ウォン、等級3で日額4万1670ウォンである。ただし、介護サービスの利用ができない離島や過疎地では、家族療養費が支給される。保険給付のサービスは、療養保護士により提供されるが、療養保護士の資格は当初は240時間の教育課程履修であったのが、2010年度から試験制度へと変更され、さらに2013年度からは、療養保護士の処遇改善のため、サービス利用料が引き上げられた（ただし、利用限度額は据え置き）。また、家族の中に療養保護士の資格を有する者がいる場合には、家庭療養保護士として、1日60分月20日の範囲内で、保険給付の対象としてのサービス利用が認められることになっている。

老人長期療養認定者数は、2008年末には20万人を少し上回る程度であったが、2010年末には30万人を突破し、特に等級3の軽度者の増加が著しい（2008年末10万弱、2011年末21万超）。こうした軽度者の増加は財政支出の増加をもたらしており、財政支出の無駄をなくすために、地域包括支援センターが設置された。こうした財政的理由から、地域包括支援センターが設置されたが、しかし老人本人の状態のみを考慮対象とし、生活環境を考慮していない現状は問題であり、ケア・マネジメントを導入する必要があると考えられる。

D. 考察

日本における介護保険の導入目的は、従来の老人福祉制度を改革すること、それによって利用者本位・自立支援を実現することであった。これに対し、ドイツおよび韓国では、制度導入によって介護サービスの基盤整備を促進することが目的であった。ドイツや韓国

では、医療保険の加入者を対象とするため子どもも含まれているが、日本や韓国では保険給付の対象は原則 65 歳以上の高齢者に限られている。介護保険の給付は、ドイツで 1995 年 4 月（在宅）、日本で 2000 年 4 月、韓国で 2008 年 7 月から支給されている。等級ごとに給付の上限額が設定されている点は 3 か国に共通しているが、ドイツと韓国では、財政的理由から比較的重度の 3 等級しか給付対象としていないのに対し、日本では、要支援と要介護を合わせて 7 段階の等級が設定されている。さらに、ドイツ・韓国では経費節減のために見送られたケア・マネジメントが日本では当初から導入されており、日本の介護保険制度は、ドイツ・韓国に比べ、対象者や給付の範囲が広く給付面ではより充実しているが、その分だけ財政支出が増大するという基本構造となっている。

ドイツ・日本・韓国の介護保険制度に共通して言えることは、介護の質の確保のために、介護労働者の労働条件の改善と継続的研修によるスキルアップが必要であること、これら介護労働者によるフォーマル・ケアと家族等のインフォーマル・ケアをどう組み合わせていくのか、地方自治体の高齢者保健福祉行政との関係も含めて検討しなければならないことが明らかとなった。また、コスト節減のために設けた等級ごとの上限額ゆえに生じている差額負担について、本人や家族が支払えない場合には、租税財源による扶助給付が必要となり、高齢者介護分野に保険制度を導入した意味そのものが問われる事態が生じる可能性があることも明らかとなった。

E. 結論

ドイツ・日本・韓国における介護保険は、医療保険との関連性、被保険者や利用者の範囲、等級や上限額の設定、ケア・マネジメントの導入など、それぞれに類似点や相違点があり、互いに影響し合っている側面もある。これら 3 か国に共通して言えることは、少子高齢化の中で、コスト節減と介護サービスの質の確保という二律背反的な課題に取り組まねばならないことである。

今後、更に深刻化する少子高齢化の中で、コスト削減と介護サービスの質の確保という二律背反的な課題に取り組むためにも、ドイツ・日本・韓国を初めとする先進諸国は、互いに知恵を出し合い情報交換を行うとともに、これから本格的な高齢化を迎える諸国に対しても、自らの経験を通して学んだ情報を積極的に発信していくことが重要である。

F. 研究発表

1. 論文発表 なし
2. 学会発表 なし

G. 知的所有権の取得状況の出願・登録状況

なし

Literature Review: Caregiving for the Dementia Elderly among Ethnic Groups in the U.S.

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研究要旨

The drastic change of the demographic structure by global aging provides the various social issues in all over the world. As an example of such issues, the U.S. has experienced the rapid growth of the older ethnic populations, and struggles with meeting their diverse needs. Showing and learning from its experience can be an example for the future policy making in the world. In this study, as a first step to understand such diverse needs, literature reviews about caregiving for the dementia elderly among ethnic groups in the US are conducted using PubMed.

As several authors mentioned, the articles sensitive enough to the ethnic differences were not many. Despite the limited number of the literatures and some conflicted results, existing studies showed significant findings: difference with the perception toward the dementia, caregiver's well-being, institutionalization, etc. These results provided us great insight to be more sensitive toward the cultural differences with the caregiving, and to establish appropriate welfare/health services when providing services in different communities and countries.

A.研究目的

The global aging is likely to be considered a delighted achievement. It often implies that people are promised to have fortified long and healthy life; however, the drastic change of the demographic structure provides the new and complicated social issues all over the world. For instance, the U.S. has experienced the rapid growth of the older population especially among the ethnic groups, and it has struggled with meeting diverse needs of the elder cares. Due to the projected aging population 65 years old and over in the U.S. from 2010 to 2015 (United Census Bureau, 2012), even though the Caucasian will be predicted to be still dominant and its elder population will keep growing by 114%, the elder population of the African American and the Hispanic will increase by 120% and 132% respectively. Therefore, considering the increase rate of the

elderly, ethnic minority groups will experience more rapid growth than Caucasian counterparts. As a result, the differences of the growth rate can contribute to change the demographic balance around the U.S. and various elder care services will be demanded to satisfy their various cultural backgrounds.

In addition, growing elder population can bring severe impacts on society and family members. One of such impacts is the increase of the dementia patients. It is known that more population of the elderly increases, more people suffer from the dementia. As a consequence, the dementia population's increase requires more number of the caregivers.

Given the necessity of knowing the diverse caregiving needs and caregivers' situations among different ethnic groups in the U.S., this study conducted the literature reviews on the dementia caregiving by two objectives: 1) to review published articles which compare dementia caregiving behaviors among the different ethnic groups in the U.S., and 2) to find out differences and similarities on dementia caregiving among these different ethnic groups.

B 研究方法

PubMed was used to collect articles for this study and the used search terms are: minority, ethnic*, Hispanic, Latin*, Asian, African American, Black, White, Caucasian, caregiving, dementia, and Alzheimer's. Also, articles are filtered by: Human, English, and aged 65 years and older. To supplement the search, other related articles were identified from the reference lists of some articles. The method of the literature search is provided as a figure 1 in the appendix 1.

Using the method above, 99 articles were found in PubMed and five articles were retrieved as supplement articles from the referenced lists (total n=104), and the following two steps were used to decide if articles were included or excluded for this study.

As a first step, all articles were reviewed by titles and abstracts, and 40 articles were rejected due to any of the following reasons. First, if articles were not conducted in the U.S., they were not used (n=9) since it is assumed that the cultural influences should not be consistent if he or she grows up in the U.S. or in the other countries. Second, if the samples are too small (n<15) or the articles are qualitative studies (n=4), these articles were rejected because the result of such studies can be difficult to be generalized. Third, the review articles (n=8) and articles which are not available in Japan (n=5) were excluded. As a result, forty articles were rejected by these criteria and 64 articles were remained.

As a second step, the remained 64 articles were fully reviewed and 44 articles were rejected due to the following four reasons. Most critical reason of the rejections in this step is how these articles define ethnic groups. In details, since the main purpose of this study is to see the differences of ethnic groups on the dementia caregiving, the articles were excluded if they used only single ethnic group or did not specify ethnic groups properly. Among 64 articles, 23 articles were rejected due to this criterion. In addition, if the studies were about the model/scale development or program interventions, these articles were excluded because these studies intended to analyze the outcomes of their experiments. Also, one article was not used for this study because it did not focus only on dementia, but includes other aging diseases as a main topic.

Twenty articles meet all inclusion criteria for this study. The remained articles are comparison of the dementia caregivers of: African American and Caucasian (n=10), Hispanic and Caucasian (n=6), and African American, Caucasian, and Hispanic (n=4). More varieties of ethnic groups, such as Asian, were prospected to include in this study, but they were not selected by this research criteria.

C. 研究結果

All twenty articles were divided into the eight categories based on their main topics: 1) depression prevalence among caregivers (n=8), 2) self-efficacy/self-appraisals on caregiving (n=4), 3) institutionalization (n=3), 4) positive aspects on the caregiving (n=2), 5) formal/informal service utilization (n=2), 6) cultural justification on caregiving (n=1), 7) religiosity and caregiver's well-being (n=1), and 8) perception about Alzheimer's disease (n=1). Since some articles contain more than one topic, the total numbers of articles are not twenty. The result is shown in the figure 2 in the appendix 2. From these eight categories, this study focuses on the first three topics.

i. Dementia Caregivers' Demographic Characteristics

Before exploring the results of the topics, this study provides the demographic characteristics of the dementia caregivers using all selected 20 articles.

Regarding the dementia caregivers' gender, the ethnic groups (African American and Hispanic) have more female caregivers than Caucasian in 11 articles*. In addition, among three ethnic groups (Caucasian, African American, and Hispanic dementia caregivers), African American caregivers are more likely to be female than other ethnic groups (Gugler et al, 2006) (Sorensen et al, 2005) (Morano et al, 2005).

Considering the relationship of the dementia caregivers with their care recipients, Caucasian caregivers are likely to be spouse, and caregivers among African American

and Hispanic groups tend to be adult children. Interestingly, non-family members, including their relatives and friends, becoming caregivers is higher for African American (Stevens et al, 2004) (Haley et al, 1995) and Hispanic (Valle et al, 2004) than the Caucasian.

※(Haley, 1996; Haley, 2004; Harwood, 1998; Roth, 2001; Haley, 1995; Miller, 1995; Clay, 2008; Dilworth-Anderson, 2005; Williams, 2005; Valle, 2004; Karlawish, 2011)

ii. Caregivers' Well-Being (Depression)

The dementia elderly requires wide variety of assistances to live and such cares are often provided by their family members if they live at home. For family members, behaviors associated with the dementia can be a source of great distress and family caregivers have often negative consequences on mental health, depression. This study attempts to see if the depression prevalence is different among Caucasian, African American, and Hispanic caregivers.

As measurements to assess the degree of depression, most studies use The Center for Epidemiological Studies Depression Scale (CES-D) and Geriatric Depression Scale (GDS). In sum, when the Caucasian caregivers were compared with African American and Hispanic counterparts, the Caucasian caregivers are likely to get higher depression scores than its counterparts. However, only one article had a controversial result (Harwood et al, 1998) and it showed that Hispanic caregivers had higher scores than Caucasian caregivers using the CES-D scales. Additionally, one article shows the differences of depression scores among all three ethnic groups (Haley et al, 1995) and no difference were found on scores between African American and Hispanic caregivers. Therefore, the results imply that the Caucasian is more likely to be depressed by caring the dementia elderly than African American and Hispanic counterparts, but no differences are found on the prevalence of depression among African American and Hispanic caregivers.

When seeing details of the depression prevalence among these ethnic groups, some regression and statistic models showed interesting evidences. For instance, considering the reasons for caregivers' depression between the Caucasian and the Hispanic caregivers (Harwood, 1998), the causes of depression for the Caucasian spouses are gender (female) ($<.05$), recipients' cognitive impairment ($p<.05$), and for the Caucasian adult children are gender (female) ($<.05$). For Hispanic spouse, the causes of depression are same as Caucasian spouse caregivers; however, for the Hispanic adult children caregivers, care recipients' cognitive impairment matters ($<.05$) to be depressed, not gender as the Caucasian adult children caregivers do.

Another study attempts to see if the depression symptoms of the caregivers have changed over time between the Caucasian and the African American (Roth, 2001). As a conclusion, even though the baseline scores of depressions are higher among Caucasian caregivers than Hispanic counterparts when the study started, there were no differences about the elevation of depressive symptoms across the time. Therefore, the study show that the Caucasian caregivers' depression symptoms keep worsening over time and the African American caregivers are also vulnerable by continuing the care even if they are more resistant to distress than the Caucasian caregivers at the beginning. Moreover, some articles presented that the ethnicity does not affect the depression prevalence among the dementia caregivers directly; however, other mediators, such as sense of control of caregivers, affect depression scores (Miller et al, 1995).

iii. Psychological Responses to the Caregiving Behaviors

Some caregivers can handle unmanageable caregiving tasks well but others are likely to feel a great stress on them. The personal characteristics may affect the responses on these caregiving tasks, but we wonder if the ethnic backgrounds may also influence on the differences of such reactions. As psychological variables of the reaction to the dementia caregiving, self-efficacy and positive aspects are examined. Specifically, self-efficacy about the dementia caregiving means that the caregivers' subjective belief about their ability to organize and execute caregiving tasks. For instance, people with higher self-efficacy believe that they can handle both good and bad situations on their caregiving tasks (i.e. care recipients' memory loss, behavioral issues) and also believe that their actions are effective to deal with these issues. On the contrary, people with low self-efficacy are likely to give up their caregiving jobs because they feel powerless toward their actions on caregiving. On the other hand, positive aspects about caregiving are focused more on caregivers' benefits in return of their caregiving actions. It means that caregivers' perception of benefits by caring for someone with health issues. For instance, people feel positive about dementia caregiving if they feel themselves useful appreciated during their caregiving actions.

Regarding self-efficacy on the dementia caregiving, Depp (Depp et al, 2005) analyzes the differences of its degrees between the Caucasian and Hispanic caregivers and another article analyzes it between Caucasian and African American caregivers (Haley, 1996). As a result, Hispanic caregivers obtained higher self-efficacy scores than Caucasian counterparts and the difference was significant ($p < .001$). Also, African American caregivers reported higher self-efficacy scores than Caucasian caregivers

($p < .05$). These main results show that the minority dementia caregivers are more likely to believe that they can handle difficult caregiving issues more effectively than Caucasian counterparts.

Regarding the positive aspects on dementia caregiving, three studies showed the consistent results between African American and Caucasian dementia caregivers (Haley et al, 1994; Roff et al, 2004; William, 2005). In these studies, the African American caregivers tend to feel more useful and appreciated when engaging in their caregiving tasks than Caucasian counterparts and to find meanings on caregiving. Also, Roff (Roff et al, 2004) attempted to see why there are ethnic differences on the positive aspects on caregiving. The study found that the intermediate factors, such as African American's lower socio-economic status, lower care recipients' behavioral issues, higher religiosity, and lower anxiety level can partially explained the relationship between ethnicity and positive aspects on caregiving.

In sum, the ethnicity can affect the caregivers' perceptions on the dementia caregiving; however, the relationship may not be able to explain such simple correlation. In addition to their cultural backgrounds, other related factors can also matter why certain ethnic group views their dementia caregiving tasks favorably and others do not. Other mediating factors might have crucial roles on the caregivers' mental health; therefore, if we can find out such mediating factors and provide appropriate services to support them, it would be possible that the dementia caregiving tasks would be much easier for caregivers.

iii. Institutionalization

As the previous results show, depression prevalence among the dementia caregivers and perceptions for the dementia caregiving are different among Caucasian, African American, and Hispanic dementia caregivers. Even if some ethnic groups are more likely to consider their dementia caregiving tasks positively and favorably, it does not change the fact that the caregivers face stressful work every day. As a consequence, some caregivers and care recipients choose to reside in the nursing homes. Then, it is wondered if there is any ethnic difference on the timing to move to the nursing homes among ethnic groups.

Three articles attempt to analyze the timing of the institutionalization between African American and Caucasian (Sevens, 2004), Hispanic and Caucasian (Mausbach, 2004), and among African American, Caucasian, and Hispanic dementia recipients (Gaugler, 2006). All three studies found that Caucasian care recipients were placed to the nursing home sooner than African American and Hispanic counterparts. Regarding

the timing of the placement, it is not different until about 200 days between Hispanic and Caucasian care recipients. However, after 200 days, the Caucasian care recipients are more likely to be placed to the nursing homes than Hispanic counterparts (Mausbach, 2004).

In Gaugler's study (Gaugler, 2006), its model shows the geographic locations also matter for the timing to the institutionalization. Therefore, it can be assumed that the nursing home placement is not influenced only by the cultural backgrounds, but characteristics of the community, including the number of institutions, available services and so on, also plays an important roles.

D. 考察

This study has several limitations. First, generalization is a main limitation on this study. All articles included in this study have different sampling methods, analysis, number of samples, and research locations. Therefore, it may not reasonable to compare their results simply.

Second, definitions of the ethnic group are too ambiguous and heavily depend on how each article recruits their study samples. In real world, ethnicity is not able to define simply by 'Caucasian' 'African American' and 'Hispanic.' There are huge diversities within each ethnic group and they are more complicated in terms of their cultural, genetic, geographic, and other backgrounds. Especially, in the U.S., interracial marriages are popular and it is not easy to classify their children into a specific ethnic category. Therefore, it is possible that ethnicity of the participants do not represent its ethnicity. Moreover, since they are raised in the U.S. even if their ethnic background is different, it is difficult to deny the effects of Caucasian cultural influences which is still dominant values in the U.S.

There are some limitations on this study. However, the main purpose of this study is to grasp differences of ethnic differences of the dementia caregiving and not to compare and/or analyze articles in details. Therefore, in this sense, we can say that this study method can achieve its purpose and show that there are apparent differences on the dementia caregiving behaviors among some ethnic groups.

E. 結論

Although there are other limitations in this study, we can show ha there are actual differences on dementia caregiving among ethnic groups. These results tell us we should more sensitive about such existing differences even if they reside within a same country when considering future policy making for the dementia elderly and their

caregivers,

F.健康危機情報

N/A

G.研究発表

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