

実感している。

今後は、さらに学内外での連携を深めるとともに、具体的な共同研究活動、共同教育活動につながるステップを検討したい。

具体的には、国際会議の発表を踏まえた、発表者同士、多彩な学問分野間のコラボレーション研究を推進する。その為の学際的研究者ネットワークの形成、コラボレーション研究プロジェクト会議などを運営し、研究の遂行がスムーズに行く環境作りをする。さらに、国際会議の参加企業等を中心に、産学連携の下での研究実施の準備を行う。また、国際連携としては、本研究代表でCGAT代表の田宮がSpecial Editorを務めるGlobal Aging (BioMed Research International Hindawi Publishing)の編集チームを核に、すでに交流のあるハーバード大学、ユタ大学、マイアミ大学(米国)、ブレーメン大学(ドイツ)、ウプサラ大学(スウェーデン)、シンガポール大学、チュラロンコン大学(タイ)との連携の強化と拡大を図り、共同研究の論文化、学生(院生)交換などをさらに推進する計画である。

また、第2回国際会議を、本研究とCGATの共催で、筑波キャンパスと東京大塚キャンパスとの二か所で行い、国際レベルでの参加者を募る。筑波キャンパスで実施の会議は、学内研究者・学生を主な発表者とし、東京キャンパス実施日には、学内外を問わず、広くエイジングに関わる研究の発表と招待講演を盛り込む。

さらに、1~2か月に1度、学内教員の持ち回りによる研究発表のほか、本研究分担者をはじめとした国内外のエイジングにかかわる研究者や実務家をゲストス

ピーカーに招き、グローバルエイジングセミナー等の勉強会を実施する。

専攻横断型の関連教育プログラムも継続して実施する。学内のグローバルエイジング関係の諸活動とも連携し、エイジングに特化した学際的学位プログラムや、国際的な介護人材育成プロジェクトにも本拠点の人材や蓄積した知を相互共有して進める予定である。

また、研究者同士の情報交換及び研究成果の一般化を目的として、季刊の英文ニュースレターの発行を継続し、2013年度に立ち上げたWebサイトを研究情報の拠点としても充実させる。

## E. 結論

CGATの使命は、地球規模の課題となった高齢化に全方位的に対応できる国際的かつ学際的研究・教育拠点として、超高齢社会のフロントランナー日本の経験、知見を世界に発信し、共有することである。

具体的には、エイジング関係の研究者らを有機的に結びつけ、学際的視点から研究を推進すること、そして、その成果を一般化または政策提言につなげることを目指している。その肝は、研究者一人一人である。CGATの今後の活動、共同研究に関心やアイデアのある研究者の方々、ぜひ協力を募りたい。

## 健康危険情報

N/A

(総括研究報告書にまとめて記入します)

## F. 研究発表

### 1. 論文発表

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Pedro Olivares-Tirado, Nanako Tamiya		Pedro Olivares-Tirado, Nanako Tamiya	Trends and Factors in Japan's Long-Term Care Insurance System: Japan's 10-year Experience (SpringerBriefs in Aging)	Springer	New York USA	2013	1-138
林玲子	宗教と健康・死亡力	早瀬保子・小島宏	人口学ライブラリー13『世界の宗教と人口』	原書房	東京	2013	63-85
本澤巳代子	家族関係における暴力・虐待に対する日本の立法と対策の特徴	本澤巳代子、ウタ・マイヤー＝グレーヴェ	家族のための総合政策Ⅲ－家族と職業の両立	信山社	東京	2013	185-202

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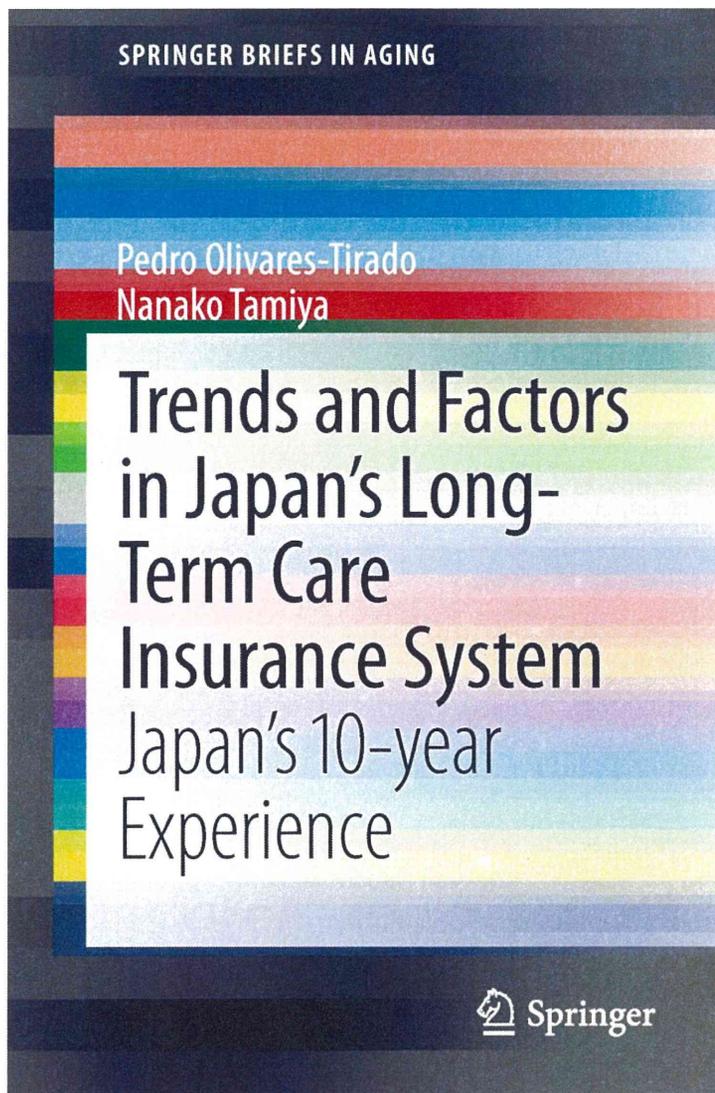
本書より、以下、一部抜粋のみを添付する（著作権は著者にある）。

Acknowledge Contents

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# Chapter 1

## The Aging Population of Japan

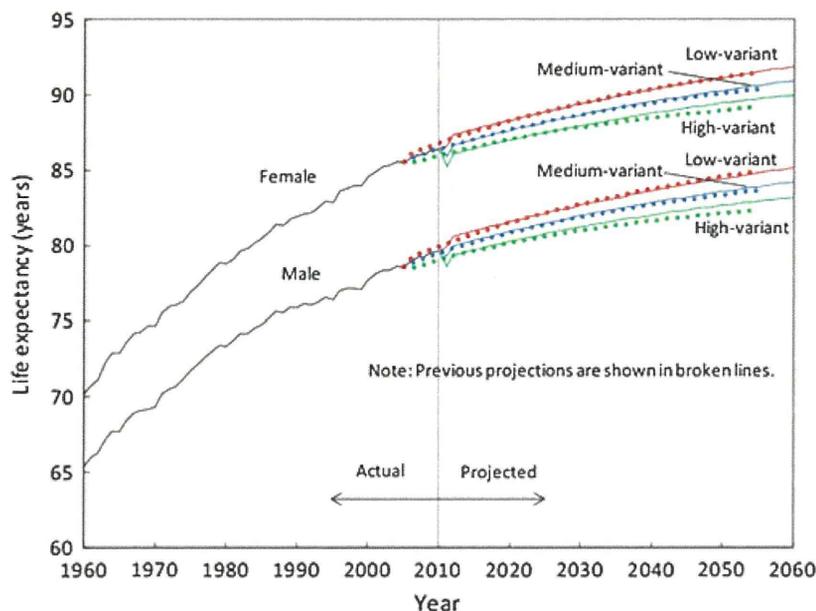
### 1.1 Introduction

The aging of the population (i.e. the shift in the age distribution towards people  $\geq 65$  years) has had a profound impact on modern society and will require increasing attention from social scientists and policymakers during the 21st century. This trend is a reflection of the success of human development as it is the result of lower mortality rates combined with decreased fertility and increased longevity (World Economic and Social Survey 2007).

The United Nations (2007) has predicted that elderly individuals will account for 26.2 % of the population of developed countries and 14.6 % of developing countries by 2050. However, the change in developing countries will occur much more rapidly than that in the developed world. Whereas the percentage of individuals  $\geq 65$  years in France and Sweden increased from 7 to 14 % over a 100 year-period, the same change occurred over a 25-year period in Japan, and most developing countries, including highly populated ones such as China, India, and Brazil, are predicted to follow a course similar to that of Japan.

The rapid increase in the life expectancy (LE) in Japan during the third quarter of the 20th century is attributable to the substantial overlap of both epidemiological and demographic transitions (Secretary of State for Health U.K. 2009; Horiuchi 2011; Horiuchi and Wilmoth 1989). The progress in the first stage was due primarily to a reduction in mortality from infectious and parasitic diseases as well as from maternal, perinatal, and nutritional disorders. The second stage of this increase involved the initiation of a substantial decline in mortality from chronic and degenerative, particularly cardiovascular, diseases. As LE increased, fertility rates decreased and mortality declined, particularly at older ages, which led to the accelerating growth of the elderly population.

Using data drawn from the standard future life tables, Fig. 1.1 shows that LE, which was 79.64 years for men and 86.39 years for women in 2010, is expected to increase to 80.93 years for men and 87.65 years for women in 2020, to 81.95 years for men and 88.68 years for women in 2030, and to 84.19 years for men and 90.93



**Fig. 1.1** Life-expectancy trends in Japan, 1960–2060. *Source* National Institute of Population and Social Security Research in Japan, 2012

years for women in 2060 (National Institute of Population and Social Security Research in Japan 2012).

Japan has been considered to be an aged society since 1994, with  $\geq 14\%$  people  $\geq 65$  years. Indeed, it became the country with the highest proportion (20.1%) of people  $\geq 65$  years in 2005 (International Longevity Center-Japan 2010). Moreover, the 2010 Japanese Population Census showed that the total population of Japan was 128.056 million, 23.1% of which was aged  $\geq 65$  years as of October 1, 2010. Thus, Japanese society has now crossed into the “hyper-aged” category according to the Coulmas classification (Statistic Bureau, Japan 2011c; Coulmas 2007).

According to estimates issued by the Japanese National Institute of Population and Social Security Research (NIPSSR) based on the 2010 Population Census, the  $\geq 65$ -year-old population is expected to increase from 29.48 million in 2010 to over 32 million in 2013, when the first “baby-boom generation” (i.e. people born between 1947 and 1949) enters this group; at this point, more than one-quarter of the population of Japan will be at least 65 years of age (National Institute of Population and Social Security Research in Japan 2012; Ishikawa and Beppu 2008).

As in other Asian countries, Confucianism is the social norm in Japan, and providing care for elderly persons is linked to household inheritance. For most families, this means that the co-residing son has the ethical obligation to care for his parents and that his wife performs the actual caregiving tasks (International Longevity Center-Japan 2010). Until the late 1980s, Japan’s national policies reflected the basic belief that children should take care of their aged parents (Ihara 2000). However, the dramatic economic and social changes in Japan since the 1980s have had a major impact on the social structure at the family level. Indeed, crucial changes in living arrangements and the increasing participation of women

in the labour force have led to a steady decrease in the number of potential family caregivers (International Longevity Center-Japan 2010; Ihara 2000).

Thus, the rapid aging of the population in Japan after the 1980s was inevitably accompanied by a growing demand for long-term institutionalised care in hospitals and nursing homes, resulting in increased pressures on the current social insurance scheme (Shimizutani 2006). To deal with the accelerated aging of the population and, especially, with the increased needs for nursing care for elderly individuals, Japan implemented a mandatory social Long-term Care Insurance (LTCI; i.e. *Kaigo Hoken*) system in April 2000, making long-term care services an universal entitlement for every elderly person in Japan (Tsutsui and Muramatsu 2007; White Paper on the Aging Society FY 2007). However, the demand for LTC services has experienced a remarkable expansion since its inception and, consequently, LTCI expenditures are growing dramatically, threatening the financial sustainability of the system (White Paper on the Aging Society FY 2007; All-Japan Federation of National Health Insurance Organizations (Kokuho Chuokai 2010). The total LTC expenditure for FY2010 was ¥7.91 trillion (US\$ 90 billion), representing 1.6 % of GDP and an increase of 118 % in the LTC budget since 2000 (Tsutsui and Muramatsu 2007; MHLW 2007, 2010).

In this context, the aging of the population poses critical social and economic challenges for Japanese society and has become an increasingly important issue related to planning a range of social policies, including those regarding pensions, healthcare, and long-term care. Given the increase in the proportion of elderly individuals in the population and, particularly, given that the oldest group ( $\geq 80$  years) has been the most rapidly expanding segment, the future demand for healthcare and long-term care is expected to increase substantially over the next three decades. Consequently, spending on health and long-term care will increase and place considerable pressure on future government budgets (World Economic and Social Survey 2007; Christensen et al. 2009; OECD 2006).

## 1.2 Demographic Changes

The change in the age composition of the Japanese population is reflected in the changing shape of its population pyramid. Figure 1.2 shows that Japan had a standard-shaped pyramid with a broad base of younger people in 1950. However, the shape of the pyramid has changed dramatically as both the birth and death rates have declined. Moreover, the population pyramid in Japan is characterised by significant irregularities due to acute fluctuations in previous fertility rates. A decrease in the number of live births was observed from 1945 to 1946 in line with the termination of World War II, an increase in the first baby-boom from 1947 to 1949, a subsequent decrease from 1950 to 1957 and a sharp single-year drop in 1966, which corresponded to a period in the Chinese sexagenary cycle that due to traditional beliefs was accompanied by a sharp decline in birth rate. This was followed by a subsequent increase, referred to as the second baby-boom cohort,

## Chapter 2

# Development of the Long-Term Care Insurance System in Japan

The traditional Japanese value system, which emphasises filial piety and respect for older people, has placed primary responsibility for the support of older people on families. Throughout the 20th century, Japan developed rapidly from an agriculture-based society to a high-value industrial and services-based society. After World War II, rapid industrialisation and urbanisation have produced a steady change in population structure and traditional social patterns in Japan. Rapid population aging was a consequence of this remarkable success. A second consequence was equally rapid change from the social forms of agricultural communities to those of modern, urban social life. These changes have had important implications for health, and welfare policies in Japan.

Major demographic, economic and social changes in Japan, issues such as access, benefits, costs, quality of care and particularly, the respective roles of central and local government, have become crucial factors for creation of an economically and politically sustainable framework for the development and funding of a long-term care system.

### 2.1 Development of Welfare Policies for the Elderly

Social welfare became an important national goal in the late 1940s. During the 1950s and 1960s, new public assistance laws significantly improved the living conditions and welfare of older people. In 1973, a system of free medical care services for older people was introduced. However, to cope with the increasing healthcare demands of older people, a cost-sharing arrangement, along with co-payments by older patients, was adopted in 1983. The public pension system was restructured in 1985 to cater to the projected aging of the population, and retirement benefits were rationalised.

Since the early 1980s, general hospital services in Japan have often been used for ‘*social admissions*’ of older people as a substitute for long-term care. Japan’s Long-term Care Insurance scheme, introduced on 1 April 2000, further developed the mechanism for older people requiring long-term care to be supported in institutional

aged-care environments, and so enabled acute healthcare services to focus on short-term treatment and rehabilitation care. However, as the proportion of elderly people in Japan increased, welfare policies for the elderly began shifting in emphasis from institutional care services to at-home and community care services. A summarised overview of the evolution of the welfare policies for the elderly in Japan will be described for a better understanding of the development of the LTCI system.

### ***2.1.1 Early Welfare Policies for the Elderly (1922–1982)***

Although a ‘poverty’ law (*Jyukkyu Kisoku*) which provided assistance for older, sick persons  $\geq 70$  years who had no relatives to support them, was introduced as early as 1874, the first important milestone in the history of the Japanese welfare state was the introduction of National Health Insurance in 1922 and the foundation of the Ministry of Health and Welfare in 1938. A pension for workers was introduced in 1941. It was not until after World War II, though, that the development of a modern welfare state began. The 1947 Constitution stipulates that all Japanese citizens have a right to enjoy a minimum standard of living. Thus, a Child Welfare Law was adopted in 1947 and a Welfare Law for Handicapped was enacted in 1949 (Karlsson et al. 2004; Maruo 1997).

A government council on Social Security was established in 1950, and a coherent public welfare system began to develop in the next few years, as an Income Support Law (1950) and a Social Service Law (1951) were enacted (Maruo, 1997). In the 1960s, the aim of the welfare policy was to go ‘*from selective to universal*’ measures and ‘*from relief to prevention*’. Accordingly, health and pension insurances were reformed in 1961, after which the national health insurance system covered all Japanese citizens (Maruo 1997).

A brief summary of the history of the welfare policies for the elderly in Japan is shown in Table 2.1. An important step was taken in 1973, when medical care was made free for all aged  $\geq 70$  years; however, social services remained means-tested. As a consequence, the number of hospitalised elderly increased rapidly over the next 20 years, and most stayed in hospitals paid by medical insurance (Campbell and Ikegami 2000).

At the end of the 1980s, there was increased political concern regarding long-term care for the elderly due mainly due to the problem of care for frail older persons in an aging society, which was widely covered by the mass media. Japan already had one of the oldest populations in the world at this time, and there were no signs of a halt in this process. At the same time, the traditional system of informal caregiving, widely viewed as being in crisis, or at least inadequate as a traditional caring arrangement based on three-generation households and obligations on children to look after elderly parents showed signs of breaking down (Campbell and Ikegami 2000). Thus, the Japanese government presented a ‘Gold Plan’ in 1989 that laid down a 10-year strategy to promote healthcare and welfare for the elderly (Karlsson et al. 2004; Campbell and Ikegami 2000).

**Table 2.1** History of health and welfare policies for the elderly in Japan

Time	Ratio of the elderly population (%)	Major policies
1960s Start of welfare policies for the elderly	5.7 (1960)	1963 Enactment of the welfare law for the aged <ul style="list-style-type: none"> <li>• Setting up of special nursing homes for the elderly</li> <li>• Legislation of home helper system</li> </ul>
1970s Increase in medical costs for the elderly	7.1 (1970)	1973 Free medical care for the elderly
1980s Recognition of the elderly's hospitalization for non-medical reasons and bed-ridden elderly as social problems	9.1 (1980)	1982 Enactment of the health and medical service law for the Elderly <ul style="list-style-type: none"> <li>• Introduction of partial payment of medical expenses for the elderly</li> </ul> 1989 Formulation of the gold plan (The 10-year strategy to promote healthcare and welfare for the elderly) <ul style="list-style-type: none"> <li>• Urgent development of facilities and promotins of in-home welfare</li> </ul>
1990s Promotion of the gold plan	12.0 (1990)	1994 Formulation of the new gold plan(The New 10-year strategy to promote Healthcare and welfare for the elderly) <ul style="list-style-type: none"> <li>• Improvement of in -home welfare</li> </ul>
Preparation for introduction of the long term care insurance system	14.5 (1995)	1996 Policy agreement of three ruling coalition parties Ruling parties agreements as to the establishment of the long - term care insurance system
2000s Implementation of the long-term care insurance system	17.3 (2000)	1997 Enactment of the long-term care insurance law 2000 Enforcement of the long term care insurance law 2005 Partial revisions of the same law

Source Overview of the long-term care insurance system. MHLW 2008

Other government policies to deal with problems related to the aging society were considered. The Basic Law on Measures of the Aging Society enacted in 1995 aimed to create a society in which people of all ages could live their entire lives with a sense of security. In 1996, the Government stipulated '*an outline of measures to tackle the aging society*', and released its revised version in 2001. The Government also encouraged employers to hire more senior people. Legislation enacted in 2006 ensured that companies would keep employees until the age of 65 years to promote retention of aged workers in the labour force. However, they were allowed to achieve this goal gradually over a few years and employers were able to cut pay to older workers; indeed, many had their salaries halved when they reached 60 years even if they remained in the same position (Fuyuno 2007). The Government also proceeded with comprehensive aging-society measures to encourage the elderly to be more independent. '*Innovation 25*', Japan's first long-term policy roadmap on innovation, released in May 2007, called for greater working opportunities for women and the elderly and improving productivity over the next two decades with the advent of the aging society. In fiscal 2007, the Government set aside 13.63 trillion yen to support employment, nursing care, education, social participation, living environment, and research into cancer (Fuyuno 2007).

### **2.1.2 Gold Plan (1989–March 2000)**

The Japanese government developed and implemented the 10-year Strategy to Promote Health Care and Welfare for the Elderly, commonly known as the '*Gold Plan*' in December 1989 to cope with increased and expensive '*social admission*' to general hospitals (beginning in 1973 the frail elderly were entitled to free hospitalisation) and the inadequate supply of both home care and nursing homes under social services, and the perceived decline in the capacity of families to provide care for elderly relatives. The Gold Plan defined specific goals to be achieved over a 10-year period ending in 1999 (Campbell and Ikegami 2000; Ihara 1997; Welfare for Older People 2006).

The Gold Plan goals included numerical targets for major expansion of services, such as doubling the number of nursing home beds, tripling the number of home-helpers, and (from a small base) increasing the number of adult day-care centres tenfold. Also added were some new programs, such as local agencies to co-ordinate home care (Ihara 1997; Welfare for Older People 2006). Each municipal government conducted a fact-finding survey on older persons living within its jurisdiction to implement the Gold Plan and formulated a specific action plan to develop a service infrastructure based on survey results. Local governments also developed their action plans based on those of the municipalities within their districts. Making plans at the district and municipal levels increased public interest and became an opportunity to raise the policy priority of the issue of long-term care to a higher level, at both the national and district political levels (Ihara 1997).

The Gold Plan represented a major shift from long-term institutionalised care in hospitals and nursing homes to home programs and community-based rehabilitation facilities. At the same time, the government formulated a plan to make long-term care services universally available to older persons (Ihara 1997). Following introduction of the Gold Plan, Japan experienced rapid growth in the formal care sector, and costs increased by 10–15 % annually (Campbell and Ikegami 2000). Subsequently, it became apparent that the target levels specified in the Gold Plan were insufficient to meet the needs of the people while improving the welfare service infrastructure and creating action plans at local levels. So, the Japanese Government revised the Gold Plan in 1994 and formulated the New Gold Plan by raising the goals regarding the increases in nursing home beds, day care centres, home care services and sheltered housing (care houses) (Campbell and Ikegami 2000; Ihara 1997).

The New Gold Plan had resulted in various improvements by FY1999, including an increase in the number of home helpers for elderly persons, improvements in the capacity of short-stay facilities to accept them for periods of rest and special care, including meals and physical exercise at day-care centres, and expansion of at-home services—such as visits by physicians and nurses who provide special care and guidance of physical exercises for regaining impaired function (Welfare for Older People 2006).

However, existing arrangements (based on the Gold Plan for long-term care published during the 1990s) were proving expensive and unsuitable for the anticipated major expansion in demand. Access to services was controlled by municipal welfare bureaucrats without relevant professional training who were believed to rely heavily on discretionary judgement; access was means-tested, provisions varied among municipalities, and individuals had no choice of service provider (Ikegami 2007).

It became obvious that a new financing mechanism was necessary due to the growing care sector and the reliance of the financing social care system on taxation, and, hence, subject to budget restraints (Campbell and Ikegami 2000). Following a long discussion, a mandatory long-term care insurance policy for the elderly was approved in the Japanese Diet (parliament) in December 1997; the new system became effective in April 2000 and was to be expanded gradually over the next 10 years. This insurance system represented a radical break with Japanese welfare tradition, as it entitles all insured lives to benefits and thus shifted the responsibility for long-term care from families to the state (Campbell and Ikegami 2000).

## **2.2 Long-Term Care Insurance System: (*'Kaigo Hoken'*) (April 2000–June 2005)**

Implementation of Japan's Long-term Care Insurance System (*'Kaigo Hoken'* in Japanese) in April 2000 as a third pillar of social security—the other two being pensions and healthcare—was the culmination of a long period of policy deliberation on aged care. Most of the discussion was carried out within a fairly narrow

# Chapter 7

## Future Challenges in Establishing a Sustainable Long-Term Care Insurance System in Japan

### 7.1 Introduction

Japan entered the twenty first century as the country with the highest proportion of elderly. The increasing number of elderly who require medical and social care has become one of the largest social policy issues in Japan. Despite enactment of the LTCI law in April 2000 and the several revisions that have been carried out, some issues such as continuing pressure on available institutional care provision (i.e. waiting lists for nursing homes are growing) coverage by LTCI for domestic and other help with non-personal care and the current age restrictions on eligibility for long-term care insurance (such as exclusion of most disabled people <65 years from insurance benefits), have been debated continually (Ogawa 2001).

A major reform, which focused on curbing total expenditure and benefits costs for LTCI to guarantee its sustainability through a shift to a prevention-oriented system, was implemented in 2005 (KEMPOREN 2008). However, the increase in the elderly population living alone and/or with dementia, lack of human resources and the limited budget for LTC, along with the rapidly aging population of large cities, are important challenges.

In this final chapter, an overall picture of the Japanese LTCI Act revision of 2012 is outlined and the issues are discussed. The focus is placed on promoting an integrated community care system (Murakawa and Yasumura 2011). After discussing the notable points and issues, I conclude by showing that the trends in the Japanese LTCI reforms suggest that other countries should investigate their future LTCI systems.

### 7.2 The Long-Term Care Insurance Act Revision of 2012

A new reform of the LTCI system was introduced in Japan in 2012 to cater to the aging population and increase care for the elderly. In 2011, the Government of Japan announced a major revision to the LTCI Act starting in 2012 to control the LTCE; this was accompanied by expanded services for an ever-increasing aging

**[Information]****Emerging Population Ageing Challenges in Africa: A Case of Ethiopia**Abu G. Moges<sup>1)</sup>, Nanako Tamiya<sup>2)</sup>, Hideki Yamamoto<sup>3)</sup>

1) Faculty of Humanities and Social Sciences, University of Tsukuba

2) Department of Health Services Research, Faculty of Medicine, University of Tsukuba

3) School of Public Health, Teikyo University

**Abstract**

Population ageing is an emerging challenge in Ethiopia whose demographic features indicate slow but steady changes. As of 2010, about 5.1 percent of the Ethiopian population were 60 years old or over whereas 53.1 percent are younger than 15. If current demographic projections for Ethiopia hold, population ageing would accelerate and 10.3 percent of its population, or about 19.4 million people, will join the club of the elderly by 2050.

**Objective**

To analyze the trend and possible consequences of population aging in Ethiopia and explore policy options.

**Method**

Use data from Demographic and Health Survey and United Nations population estimates and projections to assess the current as well as likely future demographic dynamics in the country.

**Results**

Ethiopia is facing daunting demographic growth and population aging challenges without the commensurate financial and infrastructural resources. It is time to pursue policies that jointly address the problems of unsustainable population growth and rapid population aging.

**Keywords:** population aging, demographic transition, public policy, Ethiopia

**I. Introduction**

Population ageing is the phenomenon in which the median age of the population exhibits a steady rise over time and the elderly would have an increasing share of the total population. Economic development, social value changes and institutions were the driving forces behind the historical demographic transitions<sup>1-3)</sup>. Recent demographic transitions, however, were initiated by fast declines in death rate in response to improvement in health services and public health measures. The fertility rate has followed a gradual decline sustaining the population aging process. As a result, population growth rate increased steadily until it peaked during the late 1960s at about 2.5 percent and started its steady decline afterwards to its current

level of about 1.3 percent per annum<sup>4)</sup>.

Population ageing is an emerging challenge in Africa. The problem is not yet pervasive and only 5.3 percent of the population is older than age 60<sup>4)</sup>. There is, however, a process of demographic change in African countries that indicate possible shifts in the population ageing situation in the foreseeable future.

Ethiopia has emerged as one of the most influential driving forces of the demographic future of Africa. Ethiopia, with about 87.1 million population which grows at a rate of about 2.6 percent per annum, is not only the second most populous countries in the continent but also exhibits demographic transition processes that shape the population ageing phenomena of the continent. The central theme of this research is

Contact address: Faculty of Humanities and Social Sciences, University of Tsukuba  
Tennoudai 1-1-1, Tsukuba city, Ibaraki 305-8571  
TEL/FAX: 029853 4059  
E-mail: moges.abu.gm@u.tsukuba.ac.jp.

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to examine the extent and speed of population ageing in Ethiopia and assess the population, economic, social and policy issues of the country in shaping the behavior of families towards family size and the ageing process.

Ethiopian demographic features are unique among African countries in that most projections indicate rapid population ageing, decline in birth rate, and rise in median age of the population. We explore policy options and coping mechanisms that combine both traditional and modern methods to deal with challenges of population ageing in search of an environment in which the elderly live a long, healthy, and dignified life. The rest of the paper is organized as follows. Section two briefly highlights the main demographic features and trends in Ethiopia and analyzes political, social and economic issues that influence demographic outcomes. The focus of section three is population ageing in Ethiopia and discusses policy options and constraints in the country. Section four draws concluding remarks.

## II. Ethiopia: Demographic Characteristics

Africa is home to more than 1.03 billion people in 2010 and its population growth rate of 2.46 percent is relatively fast. Between 1950 and 2010, total population increased by more than four-fold which amounted to about 13.2 million net annual average addition for the last 60 years<sup>4)</sup>. African population growth rate was accelerating until it peaked during the mid-1980s at about 2.8 percent per annum giving the continent an exceptional pace of population growth. This population growth momentum has reflected itself in not only on the size of the total population but also on the composition and age structure of Africans.

Ethiopian population, according to the 2007 population census, was dominated by the young dependents under the age of 15 whose share was about 45 percent of the population. The share of the elderly, over 65 years old, was about 3.2 percent of the population<sup>5)</sup>. Ethiopia had one of the highest fertility rates in the world with about 7 children given birth per woman for much of the period from 1950 to 2000. The current fertility rate of 4.8 children per woman is a significant reduction from earlier decades and yet it is still high compared to the average global fertility rate of 4.9 during the 1950s<sup>4, 6)</sup>. At the current rate of population growth of about 2.2 percent per annum, the Ethiopian

population would double in about 30 years.

Ethiopia has high but gradually declining fertility rate. There are a number of peculiar economic, socio-cultural, environmental, and policy issues and factors that shape the fertility transition and its impact on demographic variables. First, both women and men enter into marriage at an early age. The average median age for women to enter into their first marriage was about 16.4 years old by 2000 and currently it is about 16.5<sup>6)</sup>. Marriage and childbearing are closely related and socially acceptable and encouraged. This provides a long span of childbearing years for women. Among women in 25-49 age group, 30 percent got married by age 15 whereas 63 percent got married by age 18, and 91.4 percent by age 25<sup>6)</sup>. Second, marriage is almost universal for both men and women. Survey results in 2011 indicated that by the age of 30, only 4.1 percent of women and 10.1 percent of men were never married<sup>6)</sup>. This social norm provides ample and socially acceptable opportunities for childbearing for families. Third, childbearing starts relatively early among Ethiopian women. Nearly 34 percent of women give birth to their first child by age 18 and 54 percent by age 20 and the birth interval is quite short. More than 20 percent of births occur within 24 months of the previous birth and about 56 percent within three year<sup>6)</sup>. Fourth, fertility in rural areas is still at 5.5 children per woman as compared to 2.6 children per woman in urban areas where education of women, relative wealth status, and better access and practice of family planning influence the birth choices of families. Fifth, the actual fertility behavior of families is influenced by the knowledge and availability of family planning services.

The total wanted fertility rate in Ethiopia is about 3 children per woman as compared to the actual total fertility rate of 4.8<sup>6)</sup>. This suggests that fertility would have been much lower if unwanted pregnancy and births were prevented. Knowledge of contraceptive method seems nearly universal in Ethiopia with about 98 percent of survey respondents aware of both modern and traditional methods<sup>6)</sup>. The deviation could largely be explained by lack of or limited access to contraceptive methods.

Ethiopia has adopted an aggressive public sector drive recently to increase families' access to modern contraceptives. In contrast to the earlier notion that