スウェーデン、オランダ、ベルギー、スイス、ドイツ、フランス、ギリシャ、オーストリア、イスラエル、イタリア）における介護者と被介護者は、別居が圧倒的に多い（6割～9割）のに対し、韓国は同居の割合が約9割である。

D．考察

質疑応答では、OECDのデータに関して、韓国のデータが公表されているのに対し、日本のデータが掲載されていない事に関して質問が出た。日本は、高齢化に関してデータはあるものの、それらのデータは公表されていないことが説明された。

E．結論

グローバルエイジングを研究する上で、互いの経験を学び、共有することは重要である。高齢化の進行する諸国における制度や課題を検討することにより、今後高齢化を迎える諸国は、その国の社会や文化に沿った制度やサービスを提供することができる。また、途上国における共助の精神を再度学ぶことにより、高齢化の進む先進国は、新たな知見を得ることができる。しかし、今回のシンポジウムにより強調されたことは、互いの経験を学ぶ上で必要となるデータについてである。韓国は、すでにデータが整備され、それらのデータに自由にアクセスすることができる。しかし、日本は、まだこのレベルにまで達していない。日本の優れた技術や政策を広く世界に普及するためにも、また解決が難しい課題に挑戦するためにも、今後日本のデータが整備され、公表されることが期待される。

F．健康危険情報

なし

G．研究発表

1. 論文発表
2. 学会発表

H．知的財産権の出願・登録状況
（予定を含む。）

1. 特許取得
なし
2. 実用新案登録
なし
3. その他
なし

＊プログラム、各演者から掲載許可を得た演題ＰＰＴを次ページ以降に添付。

厚生労働科学研究費補助金
（地球規模保健課題解決推進のための開発研究事業）

グローバルエイジングへの国境なき挑戦

—経験の共有と尊重を支える日本発学際ネットワークによる提言

田宮菜奈子(代表) 筑波大学医学医療系 教授
本澤巳代子 筑波大学人文社会系 教授
（筑波グローバルエイジングセンター準備室共同代表）
高橋 秀人 福島県立医科大学医学部 教授
野口 晴子 早稲田大学 政治経済学術院 教授
林 玲子 国立社会保障・人口問題研究所 国際関係部長
増田 研 長崎大学環境科学部 教授
山本 秀樹 帝京大学大学院公衆衛生学研究科 教授
柏木 聖代 横浜市立大学医学部看護学科 准教授
陳 礼美 関西学院大学人間福祉学部 高齢者福祉 准教授

World Population Prospects

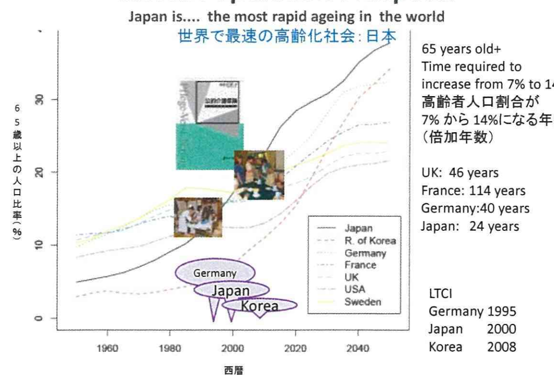
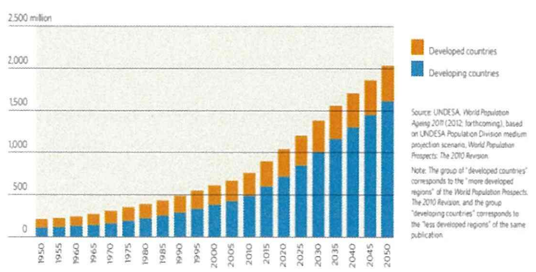


Figure 2: Number of people aged 60 or over:
World, developed and developing countries, 1950-2050



After achievement of less child mortality, and could live longer, the happy old age should be waiting! But.....?

4つのポイント Four Focuses

①インフォーマルケアとフォーマルケア
Informal Care and Formal Care
政策の中でどう位置付け、支えるか

②医療と介護・福祉の連携
Coordination between Medical Care , Long-term care and social care
医療モデルと生活モデルのバランス

③ケアの質の評価・保障 Quality Assurance of Care
在宅も施設も チョイスの尊重

④エンドオブライフにおけるケアの在り方 End of Life Care

ケアが必要な人、そしてケアする人をも支える
・・それには、暮らしの場において適切な医療が提供され、人の暮らしを支えるしくみと調和することが重要
↓
国境を越えグローバルにお互いの経験を尊重し共有しあう必要

ケアする人の人権も尊重したドイツ介護保険の政策過程
Long-term Care Insurance and Welfare Mix – informal care and formal care. The German Experience

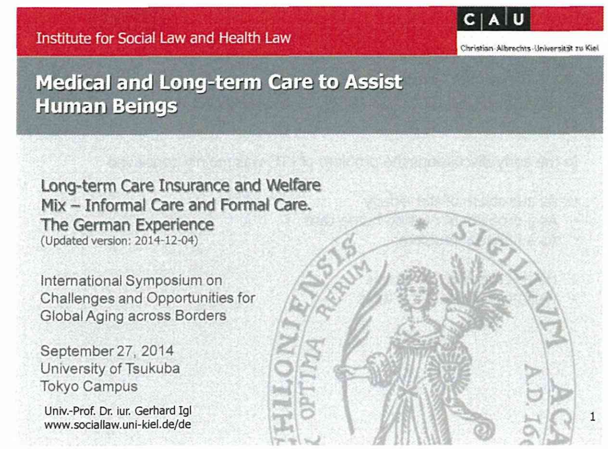
最長寿国日本における高齢者肺炎の地域・施設での適切な医療
Pneumonia is a "bad" friend in the elderly with nursing – To Treat, or Not to Treat?

これから高齢化を迎える国々における課題
Non-communicable diseases and older people in developing countries: why they matter and why they are neglected by policy-makers?

米国patient centered medical homeからみる高齢国地域医療の在り方
Clinical Practice Transformation in an Aging World: Care by Design and the American Patient-Centered Medical Home

日独の先例に学び制定された韓国介護保険と国際比較
Regulating Long-term Care in Korea: International comparison

グローバルな視点で皆様とともに"人を支える医療と介護"について共に考えてまいりましょう。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Medical and Long-term Care to Assist Human Beings
Long-term Care Insurance and Welfare Mix – Informal Care and Formal Care. The German Experience
(Updated version: 2014-12-04)
International Symposium on Challenges and Opportunities for Global Aging across Borders
September 27, 2014
University of Tsukuba
Tokyo Campus
Univ.-Prof. Dr. iur. Gerhard Igl
www.sociallaw.uni-kiel.de/de
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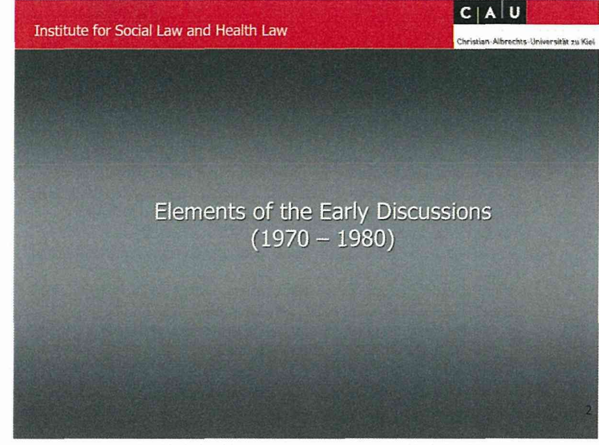
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Elements of the Early Discussions
(1970 – 1980)
2

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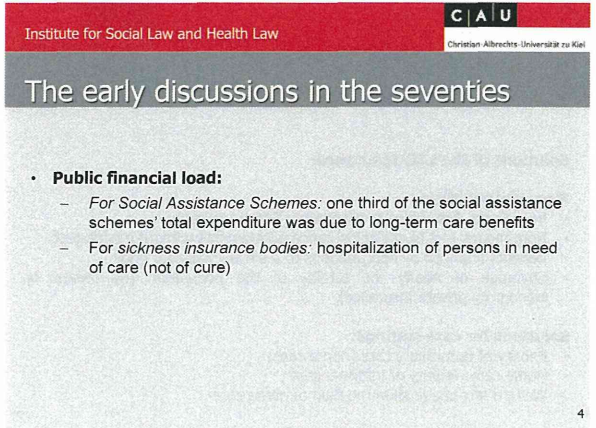
The early discussions in the seventies
Terminology: „The frail elderly" – bedridden in nursing homes
No awareness of frail people living at home
Discussion starts on behalf of the cost load caused by the frail elderly in nursing homes
3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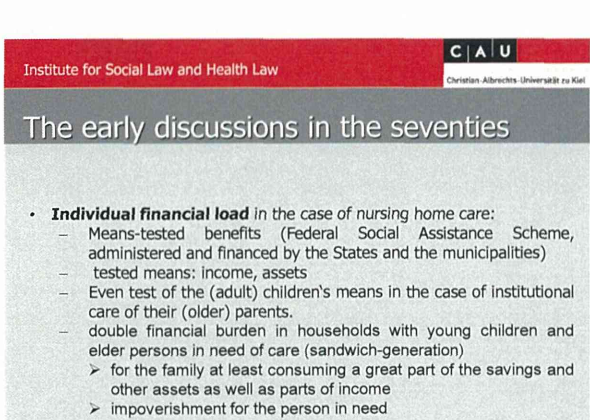
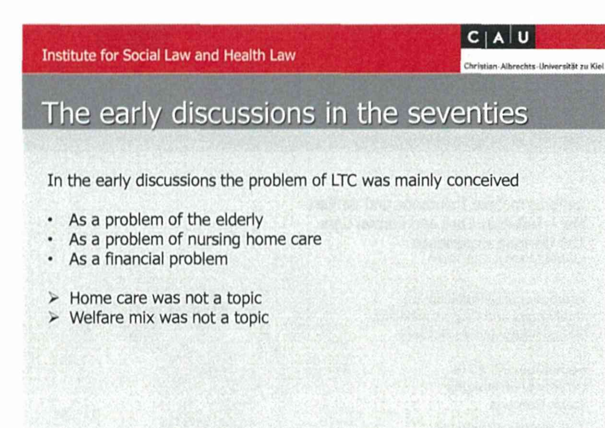
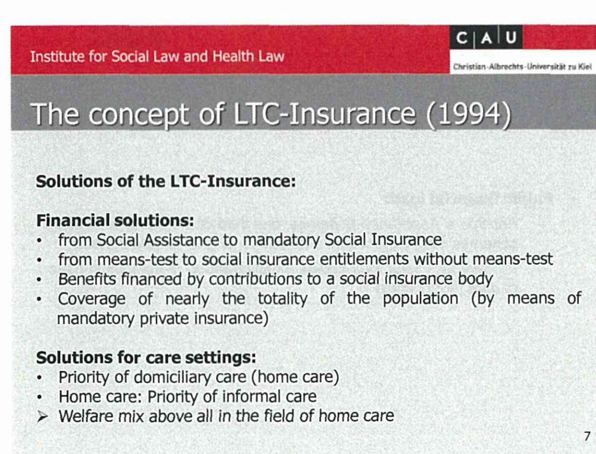
The early discussions in the seventies
Public financial load:
For Social Assistance Schemes: one third of the social assistance schemes' total expenditure was due to long-term care benefits
For sickness insurance bodies: hospitalization of persons in need of care (not of cure)
4



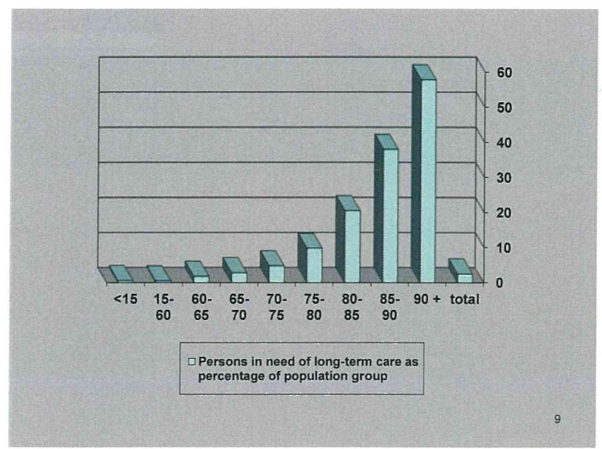


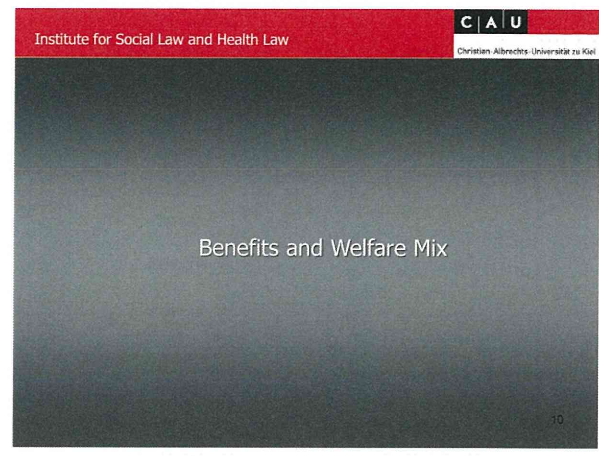


Persons in need of care (2011)

Age	Number	Percentage in population group (total population: 81,8 Mio.)
Under 15	67,734	0.6
15 – 60	268,672	0.5
60 – 65	85,761	1.8
65 – 70	114,504	2.8
70 – 75	238,982	4.8
75 – 80	357,058	9.8
80 – 85	484,818	20.5
85 – 90	522,001	38.0
90 and more	381,911	57.8
Total	2 501,441	3.1

8


60
50
40
30
20
10
0
<15
15-60
60-65
65-70
70-75
75-80
80-85
85-90
90 +
total
Persons in need of long-term care as percentage of population group
9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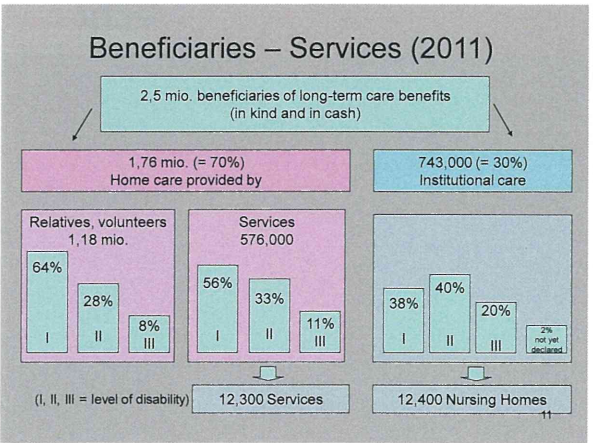
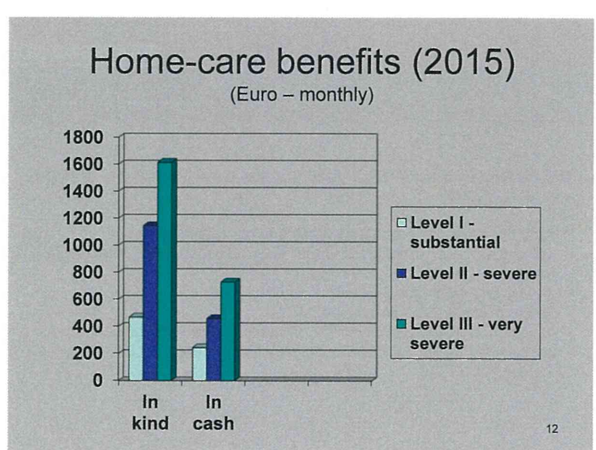
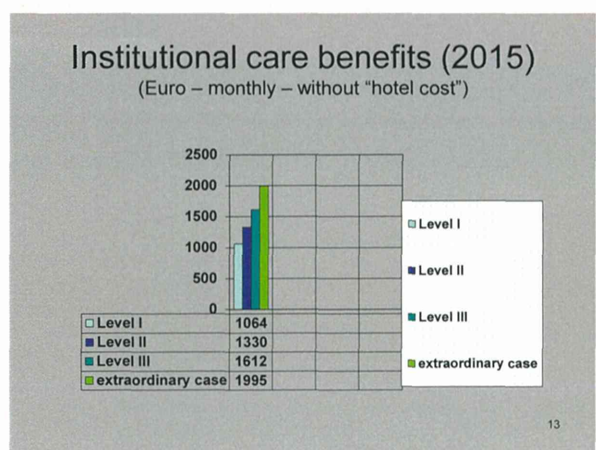
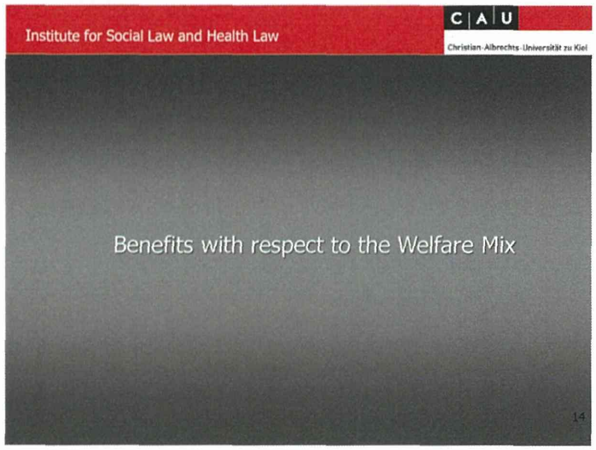
Benefits and Welfare Mix
10


Beneficiaries – Services (2011)
2,5 mio. beneficiaries of long-term care benefits (in kind and in cash)
1,76 mio. (= 70%) Home care provided by
743,000 (= 30%) Institutional care
Relatives, volunteers 1,18 mio.
64% I
28% II
8% III
Services 576,000
56% I
33% II
11% III
38% I
40% II
20% III
2% not yet declared
(I, II, III = level of disability)
12,300 Services
12,400 Nursing Homes
11


Home-care benefits (2015)
(Euro – monthly)
1800
1600
1400
1200
1000
800
600
400
200
0
In kind
In cash
Level I - substantial
Level II - severe
Level III - very severe
12



Institutional care benefits (2015)
(Euro – monthly – without "hotel cost")
2500
2000
1500
1000
500
0
Level I 1064
Level II 1330
Level III 1612
extraordinary case 1995
Level I
Level II
Level III
extraordinary case
13



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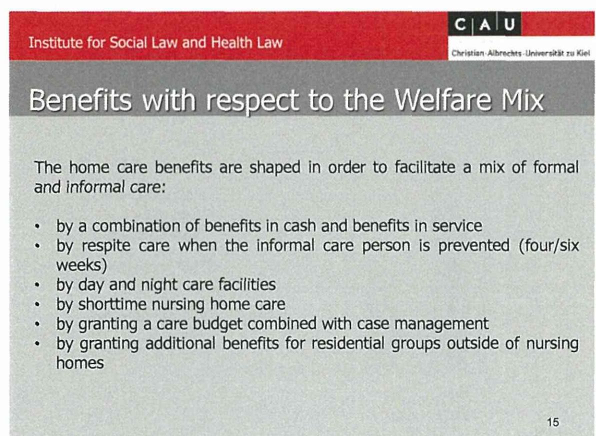
Benefits with respect to the Welfare Mix
14



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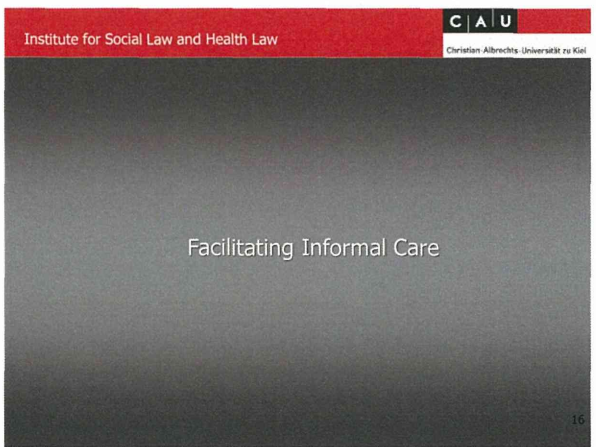
Benefits with respect to the Welfare Mix
The home care benefits are shaped in order to facilitate a mix of formal and informal care:
• by a combination of benefits in cash and benefits in service
• by respite care when the informal care person is prevented (four/six weeks)
• by day and night care facilities
• by shorttime nursing home care
• by granting a care budget combined with case management
• by granting additional benefits for residential groups outside of nursing homes
15



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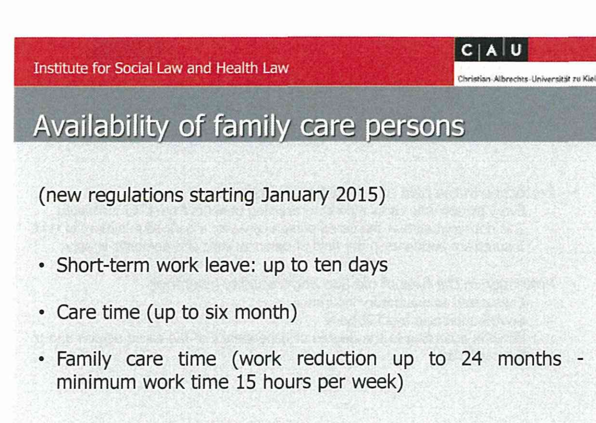
Facilitating Informal Care
16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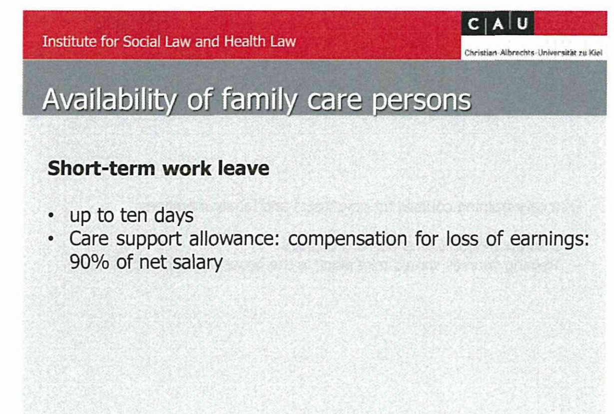
Availability of family care persons
(new regulations starting January 2015)
• Short-term work leave: up to ten days
• Care time (up to six month)
• Family care time (work reduction up to 24 months - minimum work time 15 hours per week)
17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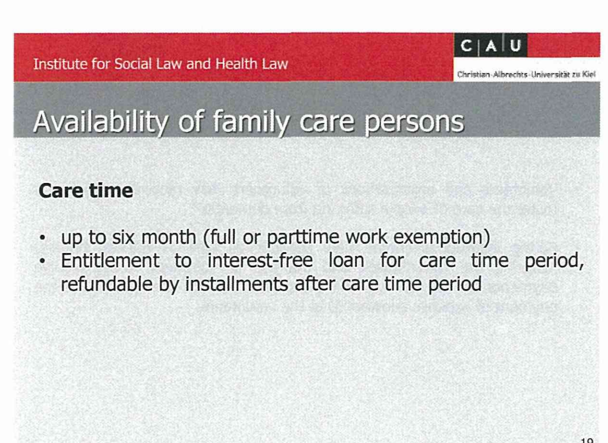
Availability of family care persons
Short-term work leave
• up to ten days
• Care support allowance: compensation for loss of earnings: 90% of net salary
18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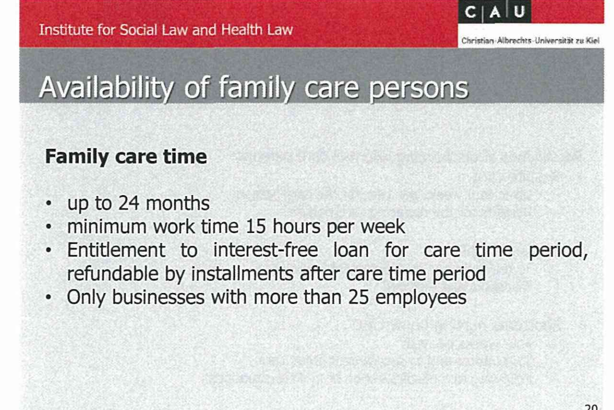
Availability of family care persons
Care time
• up to six month (full or parttime work exemption)
• Entitlement to interest-free loan for care time period, refundable by installments after care time period
19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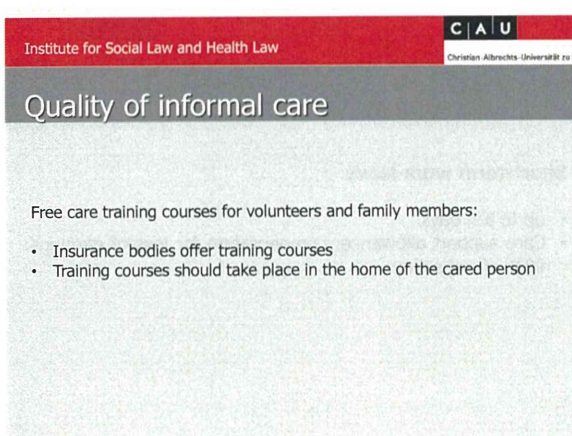
Availability of family care persons
Family care time
• up to 24 months
• minimum work time 15 hours per week
• Entitlement to interest-free loan for care time period, refundable by installments after care time period
• Only businesses with more than 25 employees
20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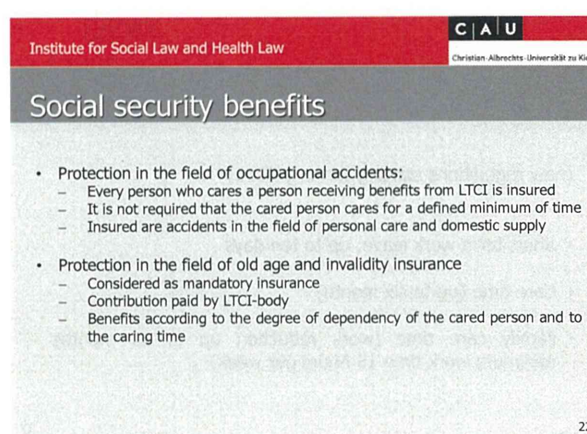
Quality of informal care
Free care training courses for volunteers and family members:
• Insurance bodies offer training courses
• Training courses should take place in the home of the cared person
21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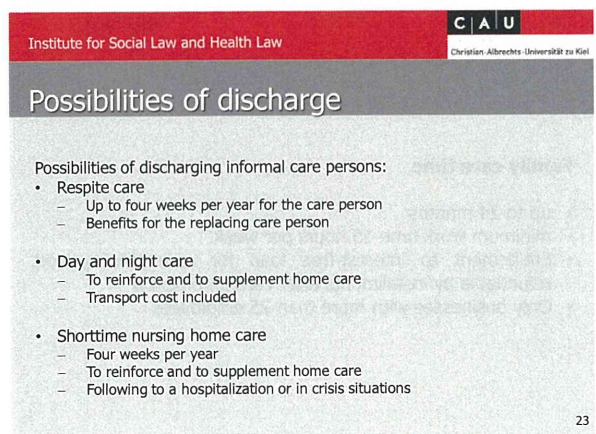
Social security benefits
• Protection in the field of occupational accidents:
– Every person who cares a person receiving benefits from LTCI is insured
– It is not required that the cared person cares for a defined minimum of time
– Insured are accidents in the field of personal care and domestic supply
• Protection in the field of old age and invalidity insurance
– Considered as mandatory insurance
– Contribution paid by LTCI-body
– Benefits according to the degree of dependency of the cared person and to the caring time
22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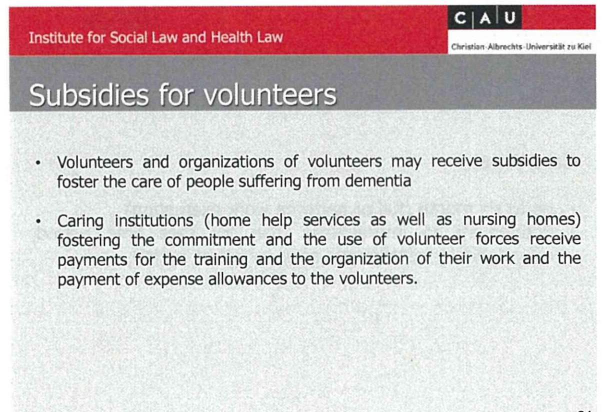
Possibilities of discharge
Possibilities of discharging informal care persons:
• Respite care
– Up to four weeks per year for the care person
– Benefits for the replacing care person
• Day and night care
– To reinforce and to supplement home care
– Transport cost included
• Shorttime nursing home care
– Four weeks per year
– To reinforce and to supplement home care
– Following to a hospitalization or in crisis situations
23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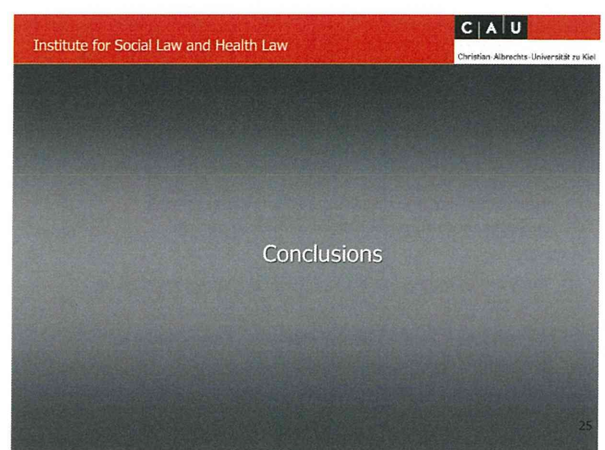
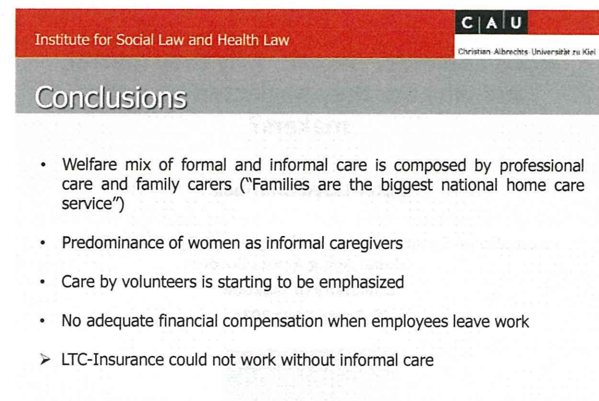
Subsidies for volunteers
• Volunteers and organizations of volunteers may receive subsidies to foster the care of people suffering from dementia
• Caring institutions (home help services as well as nursing homes) fostering the commitment and the use of volunteer forces receive payments for the training and the organization of their work and the payment of expense allowances to the volunteers.
24





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"In most countries, family carers and friends supply the bulk of caring, and the estimated economic value exceeds by far the expenditure on formal care. A continuation of caring roles will be essential given future demographic and cost pressures facing long-term care (LTC) systems across OECD. This is also what care recipients themselves prefer. Continuing to seek ways to support and maintain the supply of family care appears therefore a potentially win-win-win approach: For the care recipient; for the carers; and for public systems."

Source: *Colombo F. et al.,* Help wanted? Providing and Paying for Long-term Care, OECD Health Policy Studies, 2011, p. 121

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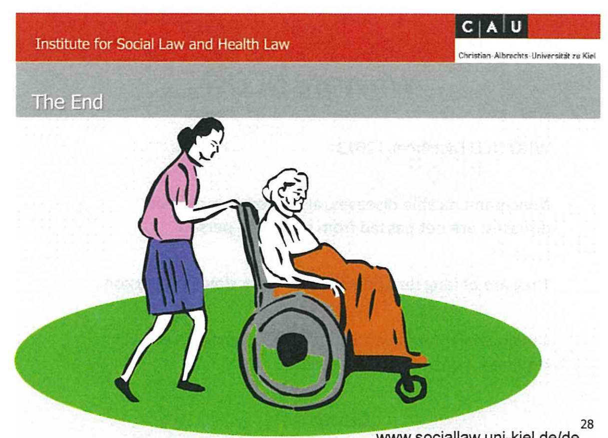
The End



28

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NCDs and older people: why they matter, and why are they neglected by policy-makers?

Peter Lloyd-Sherlock

International Symposium on Challenges and Opportunities for Global Aging Across Borders
University of Tsukuba
27 September 2014

What are NCDs?

WHO NCD Factsheet , 2013:

Noncommunicable diseases, also known as chronic diseases, are not passed from person to person.

They are of long duration and generally slow progression.

4 main types: cardiovascular diseases, cancers, chronic respiratory diseases and diabetes.

What are NCDs?

WHO NCD Factsheet , 2013:

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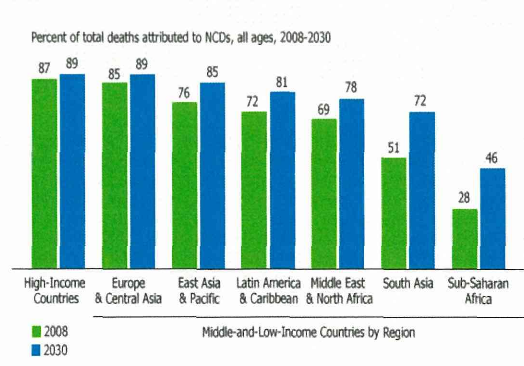
DEMENTIA??

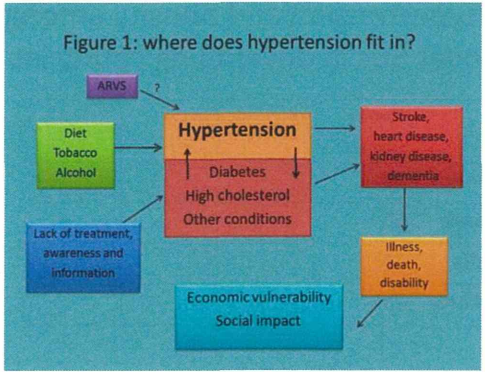


5 leading risk factors for death, **high** income countries, 2004

Risk factor	Deaths (millions)	%of total
High blood pressure	7.5	12.8
Tobacco use	5.1	8.7
High blood glucose	3.4	5.8
Physical inactivity	3.2	5.5
Overweight/obesity	2.8	4.8

5 leading risk factors for death, **low** income countries, 2004

Risk factor	Deaths (millions)	%of total
Childhood underweight	2.0	7.8
High blood pressure	2.0	7.5
Unsafe sex	1.7	6.6
Sanitation/hygiene	1.6	6.1
High blood glucose	1.3	4.9



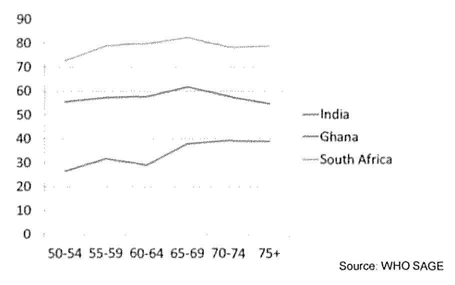
Population ageing and NCDs

WHO Global Status Report on NCDs, 2010:

Foreword:

"The epidemic of these diseases is being driven by powerful forces now touching every region of the world: **demographic ageing**, rapid unplanned urbanization, and the globalization of unhealthy lifestyles".

Prevalence of hypertension by age group



Changing Levels and Trends in Mortality: the role of patterns of death by cause, UN DESA 2010

Age specific mortality from NCDs (per 1000 population)

Africa: 7.9
Asia: 6.3
Europe: 3.9

Changing Levels and Trends in Mortality: the role of patterns of death by cause, UN DESA 2010

Age specific mortality from NCDs (per 1000 population)

Africa: 7.9
Asia: 6.3
Europe: 3.9

Poverty and poor health services are the main drivers of NCDs

Hypertension and obesity among over 50s in developing countries

	Hyper prev %			
China	60			
Ghana	57			
India	33			
S Africa	78			

Hypertension and obesity among over 50s in developing countries

	Hyper prev %	Obese/ ovrwgt prev %		
China	60	35		
Ghana	57	30		
India	33	13		
S Africa	78	72		

Hypertension and obesity among over 50s in developing countries

	Hyper prev %	Obese/ ovrwgt prev %	Hyper aware %	
China	60	35	44	
Ghana	57	30	23	
India	33	13	38	
S Africa	78	72	38	

Hypertension and obesity among over 50s in developing countries

	Hyper prev %	Obese/ ovrwgt prev %	Hyper aware %	Hyper contrl %
China	60	35	44	8
Ghana	57	30	23	4
India	33	13	38	14
S Africa	78	72	38	8

Population ageing and NCDs

WHO Global Status Report on NCDs, 2010:

Premature death is a major consideration when evaluating the impact of NCDs, with approx 44% of NCD deaths occurring before the age of 70.

In low- and middle income countries, a higher proportion (48%) of all NCD deaths are estimated to occur in people under the age of 70, compared with high-income countries (26%).

The difference is even more marked for NCD deaths in younger age ranges: in low- and middle-income countries, 29% of NCD deaths occur among people under the age of 60, compared to 13% in high-income countries.

Lancet 19 Sept 2014

"Avoiding 40% of the premature deaths in each country, 2010—30: review of national mortality trends to help quantify the UN Sustainable Development Goal for health".

-O. Norheim et. al.

Co-author Sir Richard Peto:
"Death in old age is inevitable, but death before old age is not".

Main points

NCDs = leading cause of death in developing countries

Effect of population is NOT inevitable

Cheap and simple interventions for NCDs such as hypertension

BUT: global NCD priorities explicitly exclude older people (premature mortality)

2015-05-19 2

The outline of the presentation

- The need of comparative analyses in public health
- Research of comparative study 1: Long term care quality control
- Research of comparative study 2: Long term care: informal care patterns
- Challenge to the macro comparative analysis
- Conclusion

2015-05-19 3

Why we need the cross-national comparison study

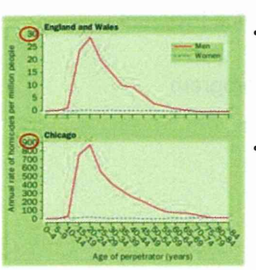


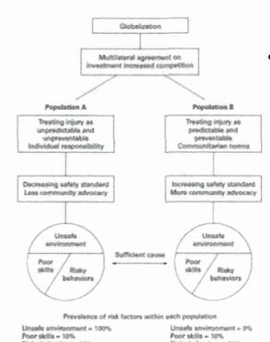
Figure 1: Rates of homicide in Chicago and England and Wales by age and sex of perpetrator

- Limits to risk factor epidemiology
  - If everyone smoked 20 cigarettes a day, then clinical, case control and cohort studies alike would lead us to conclude that lung cancer was a genetic disease
- The type3 error and strategy of public health
  - Disease etiology always concerns two distinct issues, which are the determinants of individual cases and those of the incidence rate in the population as a whole

(Rose, 1992; Rose, 1985, 2001). This slide from Dr. HJ Jung's talk (2011)

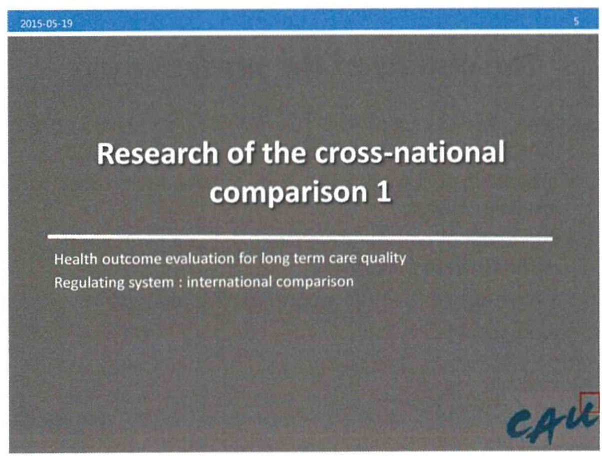
2015-05-19 4

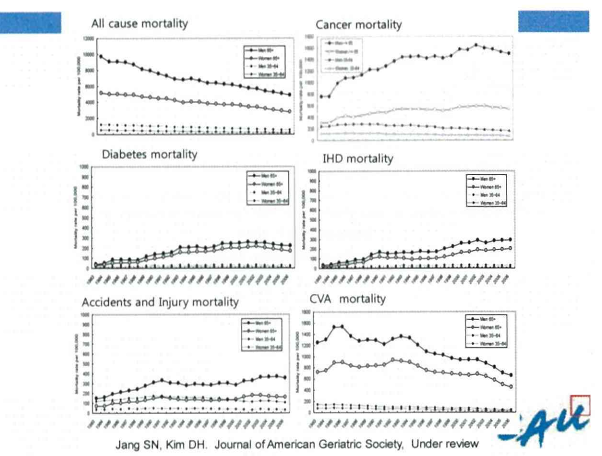
Re-thinking of Schwartz and Carpenter's model



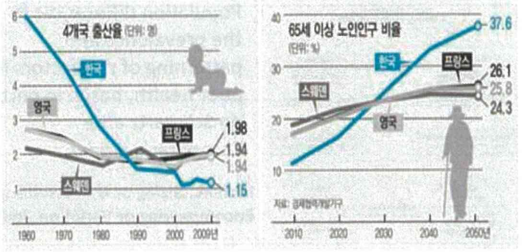
- Population differences in the prevalence and patterning of risk factors for poor health, based in part on Schwartz and Carpenter's model

Individualizing or Universalizing
Encompassing or Variation finding





Increasing elderly population and decreasing birth rate



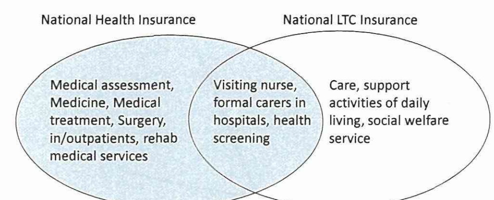
Three aims of healthcare security

- The National Health Insurance Program
- Medical Aid Program
- Long term care Insurance program

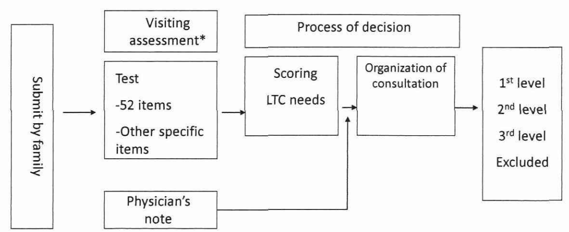
Long term Care Insurance Program

- Elderly people with serious functional limitation
  - those aged 65 years or older, or those aged less than 65 years old but suffer from an age-related disabling condition such as Alzheimer's disease, Parkinson's disease, or paralysis due to stroke
- The Government finances 20% of total long-term care insurance
- Users of the services pay: 15% (in-home services)–20% (institution services) of the expenses for care services.

Public Health Insurance and LTC insurance

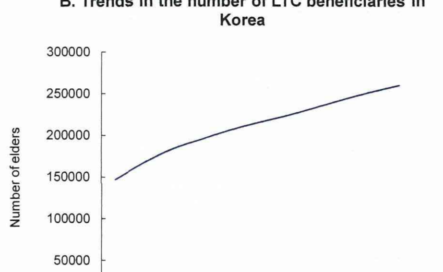


Eligibility test process

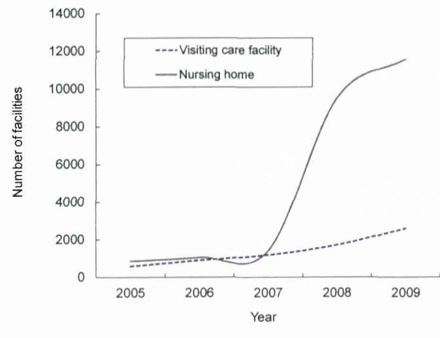


* Visiting assessment tool-modified MDS-HC

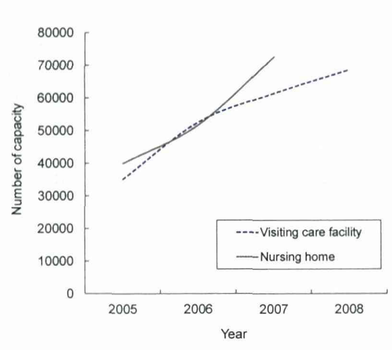
-physical functions(12 items), cognitive functions(7 items), Behavioral change(14 items), Nursing treatm... items), Rehabilitation (mobility, ROM restricts) (10 items)



A. Trends in the number of LTC facilities in Korea



C. Trends in the number of LTC service capacity in Korea

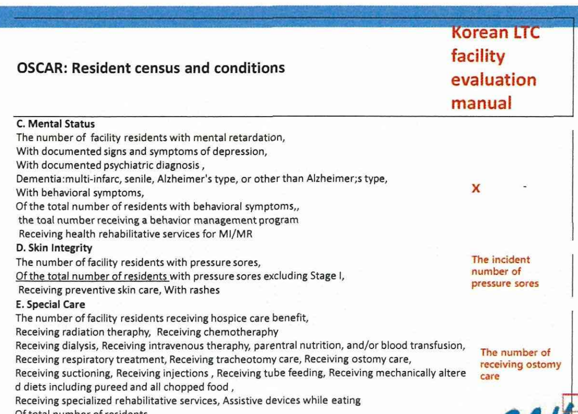


Evaluation tools for facilities

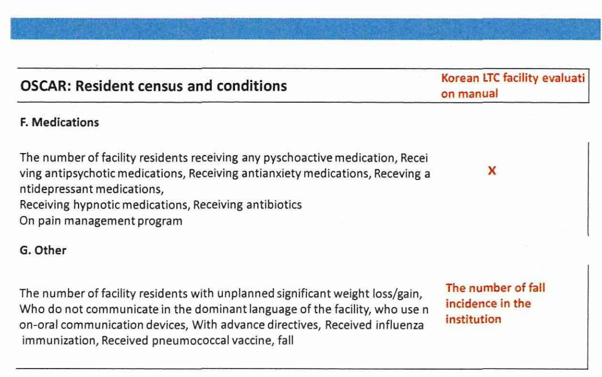
- Address only basic requirement
- Comprehensive health outcome indices rarely address the health needs of residents
- Lack of information on organizational structure and characteristics of patients residing in facilities.

Health outcome oriented assessment tool

OSCAR: Resident census and conditions	Korean LTC facility evaluation manual
ADL	
Bathing , Dressing, Transferring, Toilet Use, Eating	X The number of facility residents who are improved their LTC level
A. bowel/Baldder Status The number of facility residents with indwelling or external catheters, Of total number of residents with catheters, Occasionally or frequently incontinent of bladder, Occasionally or frequently incontinence of bowel, *On individually written bladder training program* On individually written bowel training program	X
B. Mobility The number of facility residents bedfast all or most of time, In chair all or most of time, Independently ambulatory, Ambulation with assistance or assistive device, Physically restrained, Of total number of resident restrained, With contractures, Of total number of residents with contractures	X



OSCAR: Resident census and conditions	Korean LTC facility evaluation manual
C. Mental Status The number of facility residents with mental retardation, With documented signs and symptoms of depression, With documented psychiatric diagnosis , Dementia:multi-infarc, senile, Alzheimer's type, or other than Alzheimer;s type, With behavioral symptoms, Of the total number of residents with behavioral symptoms,, the toal number receiving a behavior management program Receiving health rehabilitative services for MI/MR	X -
D. Skin Integrity The number of facility residents with pressure sores, Of the total number of residents with pressure sores excluding Stage I, Receiving preventive skin care, With rashes	The incident number of pressure sores
E. Special Care The number of facility residents receiving hospice care benefit, Receiving radiation theraphy, Receiving chemotheraphy Receiving dialysis, Receiving intravenous theraphy, parentral nutrition, and/or blood transfusion, Receiving respiratory treatment, Receiving tracheotomy care, Receiving ostomy care, Receiving suctioning, Receiving injections , Receiving tube feeding, Receiving mechanically altere d diets including pureed and all chopped food , Receiving specialized rehabilitative services, Assistive devices while eating Of total number of residents	The number of receiving ostomy care



OSCAR: Resident census and conditions	Korean LTC facility evaluati on manual
F. Medications The number of facility residents receiving any pyschoactive medication, Recei ving antipsychotic medications, Receiving antianxiety medications, Receving a ntidepressant medications, Receiving hypnotic medications, Receiving antibiotics On pain management program	X
G. Other The number of facility residents with unplanned significant weight loss/gain, Who do not communicate in the dominant language of the facility, who use n on-oral communication devices, With advance directives, Received influenza immunization, Received pneumococcal vaccine, fall	The number of fall incidence in the institution

Outcome evaluation on LTC

- Need to pay more attention to the regulations that are necessary to place **more focus on the quality of care** provided to residents rather than on trivial measurement
- OSCAR might act as the driving force for **voluntary quality assurance efforts** in each institution
- Potentially **educate consumers** with regard to choosing qualified providers.

Outcome evaluation on LTC

- The adoption of **computerized evaluation** systems should be considered in order to maintain current data and information on LTC facilities.
- **Linkage to data** from Korea's national health system would provide a powerful tool to assess quality of care and utilization trends (e.g. variation in rates of hospitalization)