TERM OF REFERENCE

The 10th Anniversary Fukuoka Active Aging Conference in Asia Pacific 2016

Title: Challenges for Active Aging in Asia Pacific: Constructing an Age-friendly Collaboration among Academic, Industrial, Governmental and Civic Circles

5-6 March, 2016
Fukuoka Convention Center, http://www.marinemesse.or.jp/eng/

Steering Committee of the 10th Anniversary Fukuoka Active Aging Conference in Asia Pacific 2016 (Steering Committee of the 10th Anniversary Fukuoka ACAP 2016): Fukuoka city, (NPO) Asian Aging Business Center, and (Public Incorporated Foundation) Fukuoka Asian Urban Research Center.
Chairperson Takeo Ogawa, Ph.D. Professor Emeritus of Kyushu University

Supporters: Research Institute of Science and Technology for Society/Japan Science and Technology Agency, Asia Center/Japan Foundation, Toyota Foundation

Introduction
The Active Aging Conference in Asia Pacific (ACAP) was started in Fukuoka-city, 2005. In order to realizing active aging in Asia Pacific areas, researchers/policy makers/community leaders organized an international consortium and shared the concept and solutions for the active aging.

We had conferences in Fukuoka-city &Suo-oshima-cho(JPN), Honolulu (USA), Namhae-county (Korea), Shanghai (China), Fukuoka, Bali (Indonesia), Kitakyushu-city (JPN), Kuala Lumpur (Malaysia), and Singapore. The consortium members are expanding in Japan, U.S.A., Korea, China, Hong Kong, Singapore, Malaysia, Indonesia, Mongolia, Australia, New Zealand, Philippines, and so on.
We will celebrate the 10th Fukuoka Active Aging Conference in Asia Pacific in Fukuoka-city, 2016. (In accordance with Japanese sense, the March, 2016 is still 2015 fiscal year.)

Nowadays, almost countries and areas are aware of the inevitable population aging. In a next stage, we will challenge its solutions globally. The concept of active aging and age-friendly city is an ideal framework of social policy. We will have to enhance the collaboration among academic, industrial, governmental and civic circles for resolving tasks which will be occurred with population aging. Therefore, we will come together in Fukuoka-city and discuss about some topics.

Objectives
1. Designing health
2. Designing ICT technologies
3. Designing long-term care
4. Designing communities

Programs

5th March, 2016
Morning: Opening Ceremony conjunct with ArakanFesta

Opening ceremony will be held in conjunct with ArakanFesta, which is organized by Fukuoka-city for an exposition of the active latter life.

Host: Soichiro Takashima, Mayor of Fukuoka-city
Guest Speaker: WHO (under negotiation)
Guest Speaker: Kirk Caldwell, Mayor of Honolulu (under negotiation)
Guest Speaker: Kathryn Braun, President, Active Aging Consortium in Asia Pacific

The Secretariat of Fukuoka ACAP 2016:
C/O Fukuoka Asian Urban Research Center
Audience: Citizen, ACAP members and their delegates, Arakan Festa supporters. Expected participants, about 300 persons (including 10 countries and regions, 100 international participants)

**5th March, 2016, : Symposium**

**Designing Health for Aged Society**
10:30-12:00  
(Open to the public with simultaneous translation)

“Global Strategy and Action Plan on Healthy Ageing”, WHO  
“Fukuoka-city’s Challenge”, Yasuko Arase, Deputy Mayor of Fukuoka-city  
“Age-friendly City for Kupuna to Keiki”, Honolulu-city  
Coordinator: Kathryn Braun, President, ACAP, Professor, University of Hawaii

**Designing ICT for Aged Society**
13:00-14:30  
“Cyber family, Cyber neighbor, and Cyber community”, Donghee Han, President, Research Institute of Science of Better Life for the Elderly  
“Utilizing Open Data for Health Promotion”, Apple Computer (Under Negotiation)  
“Remote Health-check and Feed-back system”, Carna Health Support co.inc.  
Coordinator: Cullen Hayashida, Senior Advisor, Kupuna Monitoring Systems

**Designing Long-term Care for Aged Society**
15:00-16:30  
“LTC for the Elderly in Communities”, Tri Budi Rahardjo, Professor, University of Indonesia  
“Brain Circulation of LTC Masters”, Reiko Ogawa, Associate Professor, Kyushu University  
“Challenges in Korean LTC Insurance System”, Sunwoo Duk, Project Manager,

The Secretariat of Fukuoka ACAP 2016:  
C/O Fukuoka Asian Urban Research Center
Korea Institute for Health and Social Affairs  
Coordinator: Takeo Ogawa, President of AABC

Poster Session  
10:00-17:00  
Aging Studies and Solution of Aging-related Tasks

Sociability Session  
17:30-18:30

6th March, 2016, Morning: Symposium

Designing Communities for Aged Society  
10:00-11:30  
“Intergenerational Action in Singapore”, LengLeng Tan, Professor, National University of Singapore  
“Age-friendly Communities in Honolulu”, Christy Nishita, Interim Director and Associate Specialist, Center on Aging, University of Hawaii.  
“Redesigning communities for aged society”, Hiroko Akiyama, Project Professor, University of Tokyo  
Coordinator: Thelma Kay, Ministry of Community Development, Youth and Sports Singapore

6th March, 2016, Afternoon  
Poster Session  
11:30-13:00

Workshops  
13:00-15:00  
(Method of World Café)
“A Perspective of Ubiquitous Services”
Coordinator: Cullen Hayashida

“A Perspective of International Long-term Care Training Center”
Coordinator: Takeo Ogawa

“A Perspective of Resource Center for Aged Society”
Coordinator: Thelma Kay

Wrap-up Session
15:30-16:30
Debriefing of Workshops
Commendation of Best Award of Poster
Declaration for a Next Decade
Coordinator: Kathryn Braun

7th March, 2016 (Options)
Study Tour: Challenges in Fukuoka-city
A: Island City Course (Hospital, Long-term Care Facility, Primary &Secondary School, Hot-Spring, East Suburban Area) Max 20 persons
B: Down Town Course (Citizen Welfare Center, Health Promotion Center, Group Home for Dementia Patients, South Suburban Area) Max 20 persons
C: West Suburban Course (Health and Social Service Complex for Older Persons) Max 20 persons

Registration Fee: Free
Poster Session Fee: Free
Study Tour: JPY 5,000
# Application Form

Fill out the form below:

<table>
<thead>
<tr>
<th>First/Given Name</th>
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<tbody>
<tr>
<td>Middle Name</td>
<td></td>
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<tr>
<td>Last/Family Name</td>
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<tr>
<td>Honorific Title</td>
<td>1. Dr.</td>
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<td></td>
<td>2. Mr.</td>
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<td>3. Mrs.</td>
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<td>4. Ms.</td>
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<td>5. Miss</td>
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<td>6. Professor</td>
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<td>Organization</td>
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<td>City</td>
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<td>Fax Number</td>
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<td>Poster Presentation</td>
<td>1. Yes, I will.</td>
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<tr>
<td></td>
<td>2. No, I will not.</td>
</tr>
<tr>
<td>Paid Study Tour</td>
<td>1. Yes, I will.</td>
</tr>
<tr>
<td></td>
<td>2. No, I will not.</td>
</tr>
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</table>

The Deadline for Application: 25th December, 2015

Please send this form to ogawa @urc.or.jp
The 10th Anniversary Fukuoka ACAP 2016

http://acap2016fukuoka.com/enindex/
ACAP History and Recommendations

Kathryn L. Braun
Professor, University of Hawaii
President, Active Aging Consortium Asia-Pacific

FUKUOKA ACTIVE AGING CONFERENCE IN ASIA PACIFIC 2016

The 10th Anniversary
Fukuoka ACAP 2016
Dates: 5(Sat)-6(Sun), March 2016

Percent of population 60+ will double or triple in many regions

<table>
<thead>
<tr>
<th>Region</th>
<th>2012</th>
<th>2050</th>
</tr>
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<tbody>
<tr>
<td>Japan</td>
<td>20</td>
<td>40</td>
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<tr>
<td>Korea</td>
<td>10</td>
<td>25</td>
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<tr>
<td>Singapore</td>
<td>5</td>
<td>15</td>
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<tr>
<td>Hong Kong</td>
<td>5</td>
<td>15</td>
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<td>China</td>
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<td>15</td>
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<tr>
<td>Thailand</td>
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<td>15</td>
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<tr>
<td>Indonesia</td>
<td>5</td>
<td>15</td>
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<td>Europe</td>
<td>5</td>
<td>15</td>
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<tr>
<td>US</td>
<td>5</td>
<td>15</td>
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<tr>
<td>World</td>
<td>5</td>
<td>15</td>
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By 2050, 1 in 4 people (25%) in Asia will be age 60+
Number of working-age people (age 15-64) for every person 65+ is decreasing.

<table>
<thead>
<tr>
<th>Country</th>
<th>2012</th>
<th>2050</th>
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<tbody>
<tr>
<td>Indonesia</td>
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<td>3</td>
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<tr>
<td>Japan</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Korea</td>
<td>6</td>
<td>2</td>
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<tr>
<td>Singapore</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Thailand</td>
<td>8</td>
<td>2</td>
</tr>
</tbody>
</table>

Question

How should we respond to the increased longevity of individuals and the rapid aging of society?
Active Aging

Active Aging is the process of optimizing opportunities for health, participation, & security over the life course as people age.

World Health Organization 2002 Policy Framework

It all started in 2005...

Suuoshima
Opportunities for:
• Sharing history & culture
• Participating in government
• Contributing to family
• Lifelong learning
• Digital literacy
• Volunteering

Opportunities for:
• Showing positive images of aging
• Self development

Support for:
• Elder-friendly environment
• Universal design
• Physical activity & healthy foods

Access to:
• Basic medical care
• Health promotion
• Home/community care
• Quality LTC workforce

Universal safety net & other protections

Opportunities for:
• Continued work
• Living wage jobs
• Lifelong savings

Social Policy Environment

Conferences and Meetings in...

Hong Kong, Mongolia, Melbourne, and Jakarta
Conferences & Meetings in

Busan, Hawaii, Beijing, Ching Mai, Bali, and Kuala Lumpur

Conferences and Meetings in

Namhae, Singapore, Kita-Kyushu, and Fukuoka
Tenets of Active Aging

Individuals and families must:
- Prepare for old age and adopt positive health practices.

Social policy must:
- Make healthy choices easy choices.
- Recognize, encourage, and reward participation.
- Support innovative, cost-effective systems of caring.
Mission
To provide a forum in Asia Pacific for the sharing of:
• Research
• Policy ideas
• Best practices

Benefits
• No dues! (no staff)
• Bi-monthly bulletin
• International network

To join:
Give me your business card, or email kbraun@hawaii.edu

Recommendations for Social Policy:
Support healthy aging.

Promote lifelong learning for and participation of older adults.

Build age-friendly communities.

Favor home and community care over institutional care.
Recommendations for this Meeting

Learn
Contribute

Make new friends
Have fun

Thank You

Fukuoka-City government
The Japan Foundation Asia Center
The Toyota Foundation
The Research Institute for Science and Technology for Society of the Japan Science and Technology Agency
The Asian Aging Business Center
The World Health Organization
And the many cities, countries, and organizations with representatives

FUKUOKA ACTIVE AGING CONFERENCE IN ASIA PACIFIC 2016

I look forward to a fun and productive meeting, where we will share ideas and develop stronger partnerships for an Active Aging society!
Long Term Care (LTC) for the Elderly in The Community
As Part of Healthy Ageing Strategy in Indonesia

Supported by Asia Aging Business Center, Toyota Foundation and Japan Foundation

Presented at ACAP Conference, Fukuoka 5 – 6 March 2016

TRI BUDI W. RAHARDJO, DINNI AGUSTIN, HERNANI DJARIR, TRI SURATMI, CICILIA WIDI, DAMONA KWINTATMI, AND LINDAWATI KUSOHANY

CENTRE FOR AGEING STUDIES UNIVERSITY OF INDONESIA
UNIVERSITY OF RESPATI INDONESIA

Introduction
Of the 2010 Population Census, Adioetomo, 2013, suggests that the size of disability based on the limitations of climbing stairs,
The rate of disability of women is higher than men, the proportion increased by increasing age.

The size limitations of the elderly will be more apparent from their ability to care for themselves as an indicator of the need for long-term care
In developing country like Indonesia, providing the support of long term care which enables older persons with care needs to stay at home as long as possible can help greatly to improve their situation, and it is what most want.
DEMOGRAPHY

WORLD POPULATION PROSPECT 1950 -2050

Graph 1: Population Prospects of World Regions 1950 - 2050
Source: UN World Population Prospects: The 2015 Revision
PERCENTAGE OF OLDER PERSONS BY PROVINCE

Gambar 5: Penduduk Lanjut Usia Menurut Provinsi
Sumber: Sensus Tahun 2012, Badan Pusat Statistik RI

HEALTH
MORBIDITY

- Basic Health Research in 2013 showed the number of hypertension (57.6%), arthritis (51.9%), stroke (46.1%), oral health problems (19.1%), chronic obstructive pulmonary disease (8.6%) and diabetes (4.8%).
- CASUI 2014 provided data on visual impairment with a high proportion, especially in elderly men 92%, and 75% of elderly women; followed by memory impairment in men 52% and women 48%, joint disorders, hearing loss, urinary disorders, osteoporosis and fatigue.

HEALTH STATUS: DISABILITY
(VITALIA SUSANTI, 2010)
Having difficulties in self-care, women suffer more than older men do.

Older women are more likely to suffer severe difficulties in self-care. Long-term services will be highly needed by those who are bedridden. Therefore, it is important to focus on the availability of long-term care and rehabilitation professionals in the near future. The total of them reached 5 to 10 percent.

Policy and Concept of Long Term Care In The Community
DEFINITION OF LONG TERM CARE

WHO, 2012 defines Long Term Care (LTC) as a system of activities undertaken:

- by informal caregivers, or professionals to ensure that a person who is not fully capable of self care, can maintain the highest possible quality of life, according to his or her preferences,
- with the greatest possible degree on independence, autonomy, participation, personal fulfilment and humanity.

WHO SEARO, 2013

The WHO South East Asia Regional Office /WHO SEARO, 2013 has formulated Regional Healthy Ageing Strategy 2013 – 2018. There are six key directions consist of:

1. Policy and strategy formulation;
2. Development of human resources for quality health care;
3. Raising the awareness of the population to active ageing;
4. Long-term Care;
5. Mental health needs of elderly; and
6. Financing of the care of the elderly.
LTC in the community is more supporting an older person in their own home, and generally costs less than keeping them in a nursing home or other residential care.

For those, MOH with WHO Indonesia is developing the standard of LTC service, conducting advocacy about LTC, will be giving such training to health providers and care givers, developing transitional nursing facilities and doing monitoring and evaluation.

In the implementation, a multi sector approach would be conducted.

On the other hand, such traditional LTC services have been being conducted by the family and informal care givers in the community as volunteers,

The quality of service is still being improved. Hence, the standard of LTC in the community is highly needed.
LONG TERM CARE SYSTEM, WHO 2015

• A comprehensive system for long term care that can be provided at home, in communities or within institution should be to maintain a level of functional ability in older people with, or at high risk of, significant losses of capacity.
• This is consistent with ensuring older persons’ human rights and dignity.
• Putting this in practice will also acknowledge older persons’ legitimate and continuing aspirations for healthy ageing and well-being

QUALITY OF LTC (WHO, GENEVA 2015)

• Developing and disseminating care protocols or guidelines that address key issues
• Establishing accreditation mechanism for services and professional care givers
• Establishing formal mechanisms for care coordination between LTC and health care services
• Preventing and reporting elder abuse
• Ensuring access to essential medicines, including those for pain relief
• Establishing quality of management system to help ensure that focus on optimizing functional ability is maintained
COMMUNITY NETWORK OF CARING FOR OLDER PERSONS IN THE COMMUNITY, YOGYAKARTA (SUDIMAN, 2013)

OLDIER PERSONS

Hospital
Institutional Care
Sub village
Health center
Comm leader
Older person Family
Village-Sub district
Community Volunteer
Small shops
FP Field staff
Healthy center
Village-Sub district
Subvillage

MULTI-DISCIPLINARY SERVICES REQUIRED FOR COMPREHENSIVE LTC THAT WE WOULD LEARN FROM THAILAND, 2013

Medical Doctors
Nutritionists
Dentists
Social Workers
Pharmacists
Physical Therapists
Home Health Care (HHC): Home Care
Senior Centers
Respite Care
Adult Day Service (ADS): Programmes
Lab Technicians
Emergency response systems
Socio-Health Care
Case managers/geriatric care managers
Transportation services
Community based organisations (CBO)
Home Health Care
Community Health Promotion Hospital
Transitional Care/Intermediate Care
Home visit/Companion services
Meals programmes
LTC is Continuing Process
Hospital based → Community based

1. Completed the acute phase
2. Discharge planning
3. Care at home/ Home Health Nursing
4. Promotive, Preventive rehabilitative activities
5. More limited informal care
6. Paid by local community
7. Some personal care
8. Domestic assistant
9. Professional staff involvement
10. Growing into institutional care and social system-based home care

**Hospital-based**
- Acuf ward
- Polyclinic
- No Chronic ward
- Day-care

**Community LTC**
- Health Center
- Social older home
- Home-care
- Comm Day-care

---

**The Steps of Getting the Client for LTC Services** (Casui and WHO Indonesia, 2015)

- General data collection in the field
- Specific data collection of LTC needs
- Classifications of LTC clients
- Care planning by health providers and care givers
- Providing LTC care by both health providers and care givers
THE ROLE OF FAMILY TO ENHANCE LONG TERM CARE FOR OLDER PERSONS

(BKKBN 2014)

- Family Development to enhance resilience of older persons on spiritual dimensions
- Family Development to enhance resilience of older persons on intellectual dimensions
- Family Development to enhance resilience of older persons on physical dimension
- Family Development to enhance resilience of older persons on emotional dimensions
- Family Development to enhance resilience of older persons on social community dimensions
- Family Development to enhance resilience of older persons on professional dimensions
- Family Development to enhance resilience of older persons on vocational dimensions
- Family Development to enhance resilience of older persons on environment dimensions
Centre for Ageing Studies
University of Indonesia

Activities Centre for Ageing Studies (CAS) UI

WORKSHOP ON LTC IN JAKARTA AND VISITING COMMUNITY SERVICE IN YOGYAKARTA
CONCLUSION

The demand of LTC services in the community is significant, hence the standard of LTC in the community is highly needed. In this regard, the collaboration between Japan, Korea and Indonesia in developing harmonization of training, and the standard of services supported by AABC is highly appreciated.

RECOMMENDATION:
ESTABLISHING INTERNATIONAL TRAINING CENTER
(LTC WORKSHOP, AABC, TOYOTA FOUNDATION, JAPAN FOUNDATION, JAKARTA, 2015)
Designing Long-term Care for Ageing Society: Korea’s Experiences
5 March, 2016

Dr. SUNWOO, DUK
Head
Research Center for Long-Term Care Policies
KIHASA
(Korea Institute for Health and Social Affairs)
sunwoo5704@daum.net
duksw@kiasa.re.kr

Ageing of Population in Korea
(Statistics Korea, 2015 Statistics on the Aged)

- Total population
  - 2015: 50,617 thousands

- Elderly people aged 65+
  - 2015: 13.1% of total population
  - 2030: 24.3%

- Oldest-old people aged 85+
  - 2015: 1.1% of total population
  - 2030: 2.5%

- Major caregiver group(50~64 yrs.)
  - 2015: 21.4% of total population
  - 2024: 24.4% (peak)
  - 2030: 23.3%
Life Expectancy & TFR
(Statistics Korea, Final Results of Birth Statistics in 2014)

- Life Expectancy (2014)
  - At birth: Male, 79; Female, 85.5
  - At 60: Male, 22.4; Female, 27.4

- TFR (Total Fertility Rate)
  - 2000: 1.00
  - 2005: 1.08
  - 2014: 1.21

Population ageing policies in Korea

- 2000, Entry into Ageing society (7.2% of total population)
- 2000, Started to develop public long-term care system officially
- 2003~2004, Discussed Korean-type public LTC insurance model
- 2005~2008 (June), Implemented pilot project of public LTCI
- 2006, The 1st Master plan for Population and Ageing Society
- 2007, Long-Term Care Insurance Act for the Elderly (10.3%) (April)
- 2007, Basic Elderly Pension Act
- 2008, Implemented Long-Term Care Insurance program for the Elderly (July)
- 2011, The 2nd Master plan for Population and Ageing Society
- 2014, Suggest improvement issues to develop LTC system by MOHW and NHIC
- 2015, The 3rd Master plan for Population and Ageing Society
- 2017, Entry into Aged Society (14%)
Framework of Korea’s LTC system

- Public long-term care systems for those with care needs in Korean people are composed of,
  - Long-Term Care Insurance for the Elderly (LTCI, Type 1) based on insurance premiums
  - Tax-funded Community Aged Care Service scheme (CACS, type 2) based on ‘Welfare Act for the Elderly’
  - Tax-funded Personal Assistance Support scheme for the disabled (PAS, type 3) based on ‘Welfare Act for the Disabled’

Those aged 18 or more with care needs

Those aged 65 and over

- Higher needs of care (LTCI)
- Lower needs of care (CACS)

Those under the age of 65

- Registered disabled persons (PAS)
- Non-disabled persons with age-related diseases

(Note: --- Conditional eligibility: for example, those with stroke, dementia, etc.)

Brief beneficiary coverage of LTCI

- Insured: whole population aged 18 and over who are the insured of NHI program, etc.
- Applicants’ qualification: older persons aged 65 and over, plus those under 65 with age-related chronic diseases, excluding younger disabled persons
- Beneficiary qualification: persons recognized as a care level 1~5

- Percentage of A is 7.1% of total older persons aged 65 and over as of Dec. 2015.
Insured & insurer of LTCI program

- **The insured (applicants for insurance benefits)**
  - Those aged 18 and over, including recipients of public assistance scheme
  - However, excluding younger disabled persons under the age of 65. (Instead, the Personal Assistance Service Program for the Disabled in October 2011 was introduced)

- **Insurer**
  - National Health Insurance Services (NHIS), which is an insurer of National Health Insurance program.
  - 6 Regional headquarters, 178 Branch offices
  - Long-term care support centers are established in each branch office.

Care grade of LTCI program

- **Recipient qualification**
  - Those aged 65 and over; regardless of age-related chronic diseases
  - In the case of less than 65; those with age-related chronic diseases such as dementia, stroke and so on
  - 5 care grades (from July 2014)

<table>
<thead>
<tr>
<th>Category</th>
<th>Care scores</th>
<th>Persons (Dec. 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 1 (very severe status)</td>
<td>95 points and more</td>
<td>37,921 (8.1%)</td>
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<tr>
<td>Grade 2 (severe status)</td>
<td>75 ~ 94 points</td>
<td>71,260 (15.2%)</td>
</tr>
<tr>
<td>Grade 3 (moderate status)</td>
<td>60 ~ 74 points</td>
<td>176,336 (37.7%)</td>
</tr>
<tr>
<td>Grade 4 (mild status)</td>
<td>51 ~ 59 points</td>
<td>162,763 (34.8%)</td>
</tr>
<tr>
<td>Grade 5 (special status, only mild demented status)</td>
<td>Mild demented persons with 45 ~ 50 points</td>
<td>19,472 (4.2%)</td>
</tr>
</tbody>
</table>
Beneficiary determination process of LTCI program

- Process
  1. Apply to NHIS (insurer) in order to recognize as a beneficiary
  2. Determine qualification as a beneficiary through eligibility assessment tool
  3. Receive standardized care utilization plan sheet (SCUPS) which help choose care
  4. Purchase institutional or home care service by providers chosen by themselves

Beneficiaries eligible for LTCI benefits

- Increase in qualified elderly people as a beneficiary
  - Personal care for older persons is regarded as a new social risk
  - Beneficiaries' qualification ratio to the total elderly population
    * 4.2% (2008) -> 6.6% (2014) -> 7.1% (Dec. 2015)
    - Due to lowering of eligible care scores to qualify for receiving care benefit
  - Change of care grade
    * 1st ~ 3rd, 2008~June 2014
    * 1st ~ 5th, July 2014~ now

- Graph showing ratio of qualified persons as a share of total older persons from 2008 to 2014.
Benefit types of LTCI program

- Benefit type
  - **Institutional care benefit**
    - In principle, only those with very severe (grade 1) and severe (grade 2) disability and the demented (grade 3~5) are permitted to enter institutional (residential) care facility
  - **Home & community care benefit**
    - home-help, home-visit bathing, home-visit nurse care, day & night care, short-stay services, assistive care-aids
  - **Exceptional cash benefit (family caregivers' benefit):**
    - persons living in islands or remote rural areas
    - Monthly fixed sum irrespective of care level
  - In the case of home & community care benefit, maximum benefit limit is set according to care level, considering the amount of institutional care benefit

Benefit expenditures by type of LTCI program

- Benefit spending by type
  - Increase in ratio of institutional care benefits
    - * 43.3% (2009) -> 52.1% (2014)
  - The demented persons can enter nursing homes, irrespective of care grade
  - Insufficiency of home care services
  - Lack of family caregiver support

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<tr>
<th>Category</th>
<th>2009</th>
<th>2014</th>
<th>Growth rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional care service spending</td>
<td>7,513 (43.3)</td>
<td>18,234 (52.1)</td>
<td>242.7</td>
</tr>
<tr>
<td>Home &amp; community care service spending</td>
<td>9,856 (56.7)</td>
<td>16,748 (47.9)</td>
<td>166.9</td>
</tr>
<tr>
<td>Total</td>
<td>17,369 (100.0)</td>
<td>34,981 (100.0)</td>
<td>201.4</td>
</tr>
</tbody>
</table>
Home & community care expenditures of LTCI program

- Home & community care spending by type
  - The ratio of home-help service spending
    * 78.3% of total home care expenditures in 2014
  - Concentration on domestic services such as cleaning, laundry, meal preparation plus emotional care

<table>
<thead>
<tr>
<th>Category</th>
<th>2009</th>
<th>2014</th>
<th>Growth rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home-help service (KRW 100 billion)</td>
<td>7,334 (74.4)</td>
<td>13,119 (78.3)</td>
<td>178.9</td>
</tr>
<tr>
<td>Home-visiting bathing service (KRW 100 billion)</td>
<td>406 (4.1)</td>
<td>711 (4.2)</td>
<td>175.1</td>
</tr>
<tr>
<td>Home-visiting nurse care (KRW 100 billion)</td>
<td>62 (0.6)</td>
<td>75 (0.5)</td>
<td>120.9</td>
</tr>
<tr>
<td>Day &amp; night care (KRW 100 billion)</td>
<td>618 (6.3)</td>
<td>1,745 (10.1)</td>
<td>282.4</td>
</tr>
<tr>
<td>Short-day care service (KRW 100 billion)</td>
<td>843 (8.6)</td>
<td>163 (1.0)</td>
<td>-517.2</td>
</tr>
<tr>
<td>Assistive device rental service (KRW 100 billion)</td>
<td>592 (6.0)</td>
<td>934 (6.0)</td>
<td>157.8</td>
</tr>
<tr>
<td>Total</td>
<td>9,856 (100.0)</td>
<td>16,748 (100.0)</td>
<td>169.9</td>
</tr>
</tbody>
</table>

Funding system of LTCI program

- Mix of public funding(taxes), premium and co-payment
  - The share of government subsidies (taxes) is around 20% of total expenditures, including care costs for public assistance beneficiaries
  - The share of insurance premiums is around 60% of total expenditures
  - The share of co-payments by users is around 20% of total expenditures

- premiums; around 0.4% of average income in 2014
  - 6.55%(2016) of health insurance premiums
    * 4.05%(2008) → 4.78%(2009) → 6.55%(2010~2016)

- Co-payment; difference between home and residential (institutional) care
  - Home & community care benefit; 15% of care costs (however, 7.5% in the case of lower income-brackets)
  - Institutional care benefit; 20% of care costs (however, 10% in the case of lower income-brackets)
Copayment system of LTCI program

- Copayment in the case of institutional care benefits
  - Middle & higher income brackets: 20% of total costs
  - Lower income brackets: 10%
  - Public assistance recipients: free charge
  - Even if including hotel costs such as room charge, meals

- Copayment in the case of home & community care benefits
  - Middle & higher income brackets: 15% of total costs
  - Lower income brackets: 7.5%
  - Public assistance recipients: free charge

- Example: out-of-pocket payment of 1st grade (including hotel costs)
  - Middle & higher income brackets: 36% of total costs
  - Lower income bracket: 26%
  - In the case of middle & higher income brackets using single room: 59%
  * heavy burden for family member

Trend in LTCI expenditures

- Total expenditures: 0.26% of GDP (2014) ← 0.18% (2009)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total expenditures (A)</th>
<th>GDP (B)</th>
<th>(A)/(B)(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>554.9</td>
<td>1,026,452</td>
<td>0.05</td>
</tr>
<tr>
<td>2009</td>
<td>1,908.5</td>
<td>1,065,037</td>
<td>0.18</td>
</tr>
<tr>
<td>2010</td>
<td>2,589.1</td>
<td>1,173,275</td>
<td>0.22</td>
</tr>
<tr>
<td>2011</td>
<td>2,787.8</td>
<td>1,237,128</td>
<td>0.23</td>
</tr>
<tr>
<td>2012</td>
<td>2,837.3</td>
<td>1,377,457</td>
<td>0.21</td>
</tr>
<tr>
<td>2013</td>
<td>3,318.0</td>
<td>1,428,295</td>
<td>0.23</td>
</tr>
<tr>
<td>2014</td>
<td>3,849.7</td>
<td>1,485,078</td>
<td>0.26</td>
</tr>
</tbody>
</table>

Note: 0.41% (2009) in Korea according to OECD data, including LTC hospital expenditures.

- Canada: 1.30% (2009)
- Japan: 1.0% (2009)
- Germany: 1.0% (2009)
LTC Infrastructures

- Any private businesses can establish long-term care facility
- During the past 6 years, sharp increase in facility quantitatively
  - Due to increasing in small-sized & for-profit facilities

### (no. of facilities by type)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>home care facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>home-help</td>
<td>4,206</td>
<td>9,073</td>
<td>2.16</td>
</tr>
<tr>
<td>home-visit bathing</td>
<td>2,959</td>
<td>7,479</td>
<td>2.53</td>
</tr>
<tr>
<td>home-visit nursing care</td>
<td>592</td>
<td>586</td>
<td>△</td>
</tr>
<tr>
<td>day &amp; night care</td>
<td>790</td>
<td>1,688</td>
<td>2.14</td>
</tr>
<tr>
<td>short-stay</td>
<td>694</td>
<td>322</td>
<td>△</td>
</tr>
<tr>
<td>institutional care facilities</td>
<td>1,700</td>
<td>4,871</td>
<td>2.87</td>
</tr>
</tbody>
</table>

- Over-supply (excessive supply) in urban areas, and short supply in rural areas, compared to demands.
- But, the lasting waiting lists for entering large-sized facilities (particularly, much more waiting lists in capital area)

### No. of average users(2013)

- Around 46 persons per institutional (residential) care facility
- Around 28 persons per home-help service center
- Around 20 persons per day & night care center

<table>
<thead>
<tr>
<th>Type</th>
<th>Dec.2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>institutional care facility (10 persons or more)</td>
<td>46.3</td>
</tr>
<tr>
<td>group-home facility (5~9 persons)</td>
<td>10.6</td>
</tr>
<tr>
<td>home-help service</td>
<td>28.4</td>
</tr>
<tr>
<td>home-visit bathing service</td>
<td>13.3</td>
</tr>
<tr>
<td>home-visit nurse care service</td>
<td>21.9</td>
</tr>
<tr>
<td>day &amp; night care service</td>
<td>20.2</td>
</tr>
<tr>
<td>short-stay service</td>
<td>18.1</td>
</tr>
</tbody>
</table>
LTC Infrastructures
: Major characteristics of facilities

- Whilst increase in quantity, there is an unbalanced distribution between urban and rural areas

- Highest share of small-sized institutional (residential) care facility
  - Because of lower initial investment costs
  - Less than 10 persons, 43.8% of total in 2013
  - 10~29 person-sized facility, 25.1% of total in 2013
  - In conclusion, less than 30 persons, 68.9% of total facilities

- Highest share of for-profit facility (as of Dec. 2013)
  - For-profit, 67.0% (In the case of home care sector: 75.2%)
  - Non-profit and charitable, 30.6%
  - Municipal, 2.4%

LTC Infrastructures
: Major characteristics of facilities

- Increase in facility infra by participation of private (for-profit) providers
  - For-profit org. can establish irrespective of institutional or home care
  - Ratio of private (for-profit) providers (2014)
    - Nursing group homes, 87.6% (small-sized facility)
    - Home-help services, 82.3%
    - Home-visiting bathing services, 84.3%
    - Home-visiting nurse services, 77.8%
    - Short-stay care services, 78.0%
    - Assistive device rental services, 85.8%
  - Participation of the private (for-profit) providers in long-term care contributed to soft-landing of LTCI
  - However, private (for-profit) operate small-sized facilities.
  - * economy of scale, quality care
Professional care worker
(yo-yang-bo-ho-sa)

➢ Certificate process

Applicant

Certified care-worker’s Education & training center

Education completion
(theory education, 80 hrs.
(practice, 80 hrs.)
(work experience, 80 hrs.)

Apply for an examination three times a year

National qualification exam. ➢ Certificate

If passing an examination

Professional care worker
(yo-yang-bo-ho-sa)

➢ Professional training of care workers
  ➢ 240-hour curriculum and training
  ➢ Introduction of national qualification exam (test) in 2010
    * At present, three times a year (March, July, November)
  ➢ However, the ratio of successful applicants is high
    ▪ March 2014, 90.7%
    ▪ July 2014, 65.7%
    ▪ Nov. 2014, 92.4%
    ▪ July 2015, 78.7%
  ➢ Only 22% of the certified are being employed.
  ➢ Problems: lower wages, poor working conditions
  ➢ Most of care workers are aged 40+
Performances and challenges since the introduction of LTCI

- Performances
  - Accessibility: universal access to LTC system regardless of income and easy choice of providers due to increase in facilities quantitatively
  - Affordability: different burden of costs according to income level and actual decrease in out-of-pocket money due to insurance benefits
  - Satisfaction: decrease in family caregiving burden and higher social participation activity of family care-givers
  - Economic impacts: new job-creation and reduction of elderly’s medical expenditures

- Challenges
  - Lack of quality care, particularly targeting at small-sized and for-profit facilities
  - Lack of good skilled care-workers due to frequent turnover
  - Lack of continuum between medical and social care services
  - Lack of mutual collaboration with long-term care facilities and long-term care hospitals, being in mutual competition

The challenges to be addressed in LTCI

- Growing demands for LTC
  - Ageing of baby-boomers (1955~1963), those aged 75+ in 2030
  - Increase in demented people
    * dementia prevalence, 9.79% (2015) -> 10.03% (2030)
  - Increase in elderly household, coupled or living alone
    * ratio of elderly household, 20.6% (2015) -> 35.4% (2020)
The challenges to be addressed in LTCI

- A supply reduction of future professional carers
  - Lack of paid-formal carers (professional care worker)
    - reduction of labor force (15~64)
  - Lack of unpaid-informal care-giver support (family, neighbor, volunteer, etc.)
    - reduction of family member due to low fertility
    - reduction of neighbor of volunteer due to introduction of public scheme
    - lack of work-care life balance policy
    - Formal care workers cost more than informal unpaid carers.
    - European countries with the highest numbers of paid care worker also tend to be countries spending the highest proportions of GDP on long-term care.
  - Introduction of family caregiver leave service as a respite care (2015)

- Good quality of care
  - Improvement of professional care worker training program
  - Expectation of good-quality of care, especially future elderly generation
  - Lower quality care of for-profit providers (especially small-sized care providers), than that of not-for-profit, or large sized providers
  - Poor physical environment in urban areas, regardless of outdoor & indoor of facility (especially small-sized care facilities)
The challenges to be addressed LTCI

- Financial stabilization
  - Increase in care spending due to unit cost, population ageing
  - Tight public budgets due to economic recession
  - Difficulty in raising the insured’s premium
  - Increase in demands for public accountability for care spending
    * according to the LTC finance forecast, the deficit is estimated to occur in 2024
  - Therefore, construction of cost-efficient expenditure system
    * The community-based care management system need to be developed.
    * strengthening of community and home care services based on AIP(ageing in place) concept
  - Preventive program for improving physical and cognitive function

Thank you very much for your attention!

From Dr. SUNWOO
Migration of Nurses and Care Workers in Asia

- **From Indonesia**
  - Between 1989-2007, 5,000 nurses have migrated.
  - Since 1989, approx. 1.3 million have migrated as domestic workers/caregivers.

- **From the Philippines**
  - Between 1994-2006, 110,000 nurses have migrated.
  - Filipino nurses share 15% of the foreign born nurses in OECD countries.
  - Since 2001, approx. 75,000 have migrated as caregivers.

- **In Singapore**
  - More than half of the foreign born nurses are from the Philippines.
  - More than 210,000 migrant domestic workers are working in private homes while more than 80% of those who work in long term care facilities are migrants.

- **In Taiwan**
  - More than 200,000 migrant caregivers are working in private homes and institutions.

- **In HK**
  - More than 310,000 domestic workers are working.

- **In the USA**
  - Half of the passers for the USA’s nursing exam (NCLEX) are Filipinos.

There are more than 710,000 foreign born nurses in OECD countries comprising 10.7% of the workforce.
Migration of Care Workers to Japan

- Conditions from the Japan Nursing Association to pass the national exam for caregiving (kaigo fukushishi) within a limited time. If they cannot pass, they have to return.
- Migrants will receive one year free Japanese language training
- Involvement of the state agencies in recruitment, deployment, training and allocation of caregivers
- Migrants are allowed to work only in institutions

Who are the migrant care workers?

- Indonesian caregiver candidates are all graduates of nursing school. (D3 or S1)
- Filipino caregivers are either RN with less than three years of clinical experience or university graduate with any major and completed the 6 months caregiver course by TESDA.
Assessment of Indonesian Care Workers

<table>
<thead>
<tr>
<th>Skill/Attribute</th>
<th>Agree, Somewhat Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have respect towards the elderly</td>
<td></td>
</tr>
<tr>
<td>Good at building relationship with patient/elderly</td>
<td></td>
</tr>
<tr>
<td>Good at team work</td>
<td></td>
</tr>
<tr>
<td>Cheerful</td>
<td></td>
</tr>
<tr>
<td>Keep the time</td>
<td></td>
</tr>
<tr>
<td>Be considerate and recognize what has to be...</td>
<td></td>
</tr>
<tr>
<td>Work with patience</td>
<td></td>
</tr>
<tr>
<td>Eager to study/learn</td>
<td></td>
</tr>
<tr>
<td>Equipped with knowledge on physical health and...</td>
<td></td>
</tr>
<tr>
<td>Equipped with high skill in physical care</td>
<td></td>
</tr>
</tbody>
</table>

Source: Ogawa R., Hirano, Y., Kawaguchi, Y. Ohno, S., 2010

Response of the Japanese staffs and local community

- “The Indonesians are very kind, gentle and they have all the basics in caregiving. Therefore, they became a source of inspiration to all of us. The working environment has improved to be more kinder, our communication has improved (because we have to be more careful) and the teamwork among staffs are strengthened.” (Supervisor)

- “The Indonesians are very kind. I think they are having a hard time traveling this far to work but they are doing very well. We all trust them and count on them because when we call them they always come running.” (Elderly)
Contradictory mobility

- All the Indonesian care workers in Japan are educated as nurses (D3 or S1).
- Without having a prior information and idea of ‘care work’ in Japan the first and second batch thought that they will be practicing nursing for the elderly.
- They thought they can learn high-tech nursing in Japan which resulted in disillusionment.
- “The people will return even though we pass because we didn’t know that nursing and caregiving are two different occupations”. (1st batch Indonesian certified caregiver)

Maximizing the Human Resources

- Indonesian Nurse
- Caregiver in Japan
- Employee at Japanese Company
  - Geriatric Nurse
  - Trainers for Puskesmas & Posyandus
  - College teacher
- Intermediary between Indonesia and Japan on Long Term Care
Brain Circulation

• Win-win-win through capacity development

Indonesian nurse/caregiver

- Knowledge, skill and experience in caregiving
- Theories and legal framework in caregiving

Japanese care facilities

- Quality workforce
- Cross-cultural learning experience

Indonesian Community Care

- Utilization of returnees
- Raising the standard of care
- Promoting active aging

Conclusion

• Migrant care workers are becoming an integral part of the welfare state in East Asia.
• Under the rapid demographic change in East Asia, migration of care workers should not result in “brain drain” or “care drain”. We need a strategy to raise the social status of both the migrants as well as care work.
International Training Center for Long Term Care

The group brainstormed the idea of having an international training center for Long Term Care (LTC). The idea for the Training Center was suggested sometime ago and the need has been felt to harmonize the certificate in LTC in order to learn from each other's experiences and facilitate the cross border mobility of care workers. The discussion mainly revolved around 1) Why do we need a training center, 2) Who are we going to target, and 3) How are we going to handle it.

Some strongly asserted the need to establish a formal institution that provides degree in LTC, others suggested a more informal arrangement that provides training in gerontology and LTC for professionals such as nurses, PT and OTs. The center will serve as Training of Trainers (TOT) who will disseminate the knowledge and skills to the broader beneficiaries such as the community, families, volunteers and students.

The need to establish a curriculum that caters to both home care and institutional care were proposed with more focus on care management rather than direct care. The training center was hoped to serve as a co-ordination center between different organizations, research and practices in LTC in Asia and the Pacific. Already different trainings have been taking place such as the one in Yokohama on double care or Hawaii’s dementia care so we should take stock of these existing training. Also, the importance for scientific approach towards LTC has been raised so that we will not indulge in cultural differences.

The two main obstacles have been identified as lack of financial resources and political will but suggestions such as public private partnership or Corporate Social Responsibility (CSR) were made to overcome these obstacles. The IT technology and long distance learning should be utilized in reducing the financial cost of the training.

Finally, the need to consider the work of care as self-worthy and give honor to the person should be the core principle of this center.
If International Training Center of Long Term Care is established, could you advice its functions?

Based on the discussion, we conclude that the training material and system should be:

1. Concerning community care is recommended in order to maintain contact each other and human relationship, in which other people can also give such contribution. However older people can be isolated too, if caring is provided in his or her home. Hence, Elderly Center in the community should be established to provide engagement of the elderly with community member.
2. Focussing ADL and IADL are needed to provide physically and mentally activity assistance.
3. Focussing both bio – medical and psycho social approaches are needed as holistic approach, and should be considered in the training material, being addressed to care giver candidate and all the stake holders.
4. Focussing generic care that is needed by all the elderly, however specific care such dementia care would also be important, depends on result of assessment. Therefore comprehensive assessment tool should be considered, that would be done by the doctor.
5. Concerning both direct care and management care are needed. In this regard, direct care could be modified with traditional care in relation to cultural value, while management care is needed for sustainability.
6. Focussing on advance level would be important, the longer the better, as we would produce the trainers. In addition entry level should also be provided for care giver particularly informal care giver.
7. Both short term and long term training are needed, however in International Training Center, we should focus on long term training to produce trainers.
8. Both casework and community work should be considered to provide holistic care in the community.
9. Geriatric nursing and long term care giving are highly needed for multiplying effect that could enhance care giver in individual country.
10. Both qualification and standardization are needed in every level of training, to provide such ability of care giving that can be implemented in every country.
11. Professional workforce is more important in the capacity as trainer in the individual country, where the graduates of training can be able to share to informal care giver in her or his individual country.
If an International Training Center of Long Term Care is established, could you participate in it?

We conclude that:

All the participants of discussion would join in the center, depending on her or his interest and capability, such as being a program officer, a member of advisory committee, just as a fellow, a researcher, trainer of the trainer, or just practical trainer, an intern or a scholar. Amazingly ACAP member of Singapore, Thailand and Honolulu would join in the networking if International Training Center would be established in Japan, Indonesia and Korea.

Jakarta 19 March 2016

Reporter,
Tri Budi W. Rahardjo and Lili Indrawati
Fukuoka Declaration of ACAP 2016

We, participants in the 10th Anniversary Fukuoka Active Aging Conference in Asia Pacific, titled “Challenges for Active Aging in Asia Pacific: Constructing an Age-friendly Collaboration among Academic, Business, Governmental and Civic Circles” have discussed and shared our vision to create a preferred future for an age-friendly world. We acknowledged that rapid demographic transition presents opportunities and challenges to Asia and the Pacific. We learned of WHO’s guide for active aging, the Japanese government’s vision of health care, and the governmental challenges of Fukuoka, Busan, and Honolulu to create age-friendly cities. We also discussed important issues for Information Communication Technology, long-term care competencies, and community development not only for older persons but also for younger generations.

We used the world café method to share our collective wisdom on issues related to high technology services for the elderly, international training centers of long-term care, and solutions-oriented active aging resource centers. Finally, we have learned from our participants’ excellent poster presentations.

Therefore, we declare the following goals of active well-being of all generations.

1. We advocate for a policy framework of active aging based on a life-course approach, intergenerational actions, participatory action research with older adults, the international harmonization of standards, and big-data/open-data utilization.

2. We advocate for the engagement and empowerment of older persons in society and the encouragement by society for older people to be active and productive.

3. We advocate for active collaboration between the academic sector, the governmental sector, the business sector, and all people in addressing the challenges of a rapidly aging society.

4. We advocate for the establishment of accessible international centers, portals, and networks for the rapid and efficient sharing of best practices for active aging, universal design, and long-term care.

Finally, we appreciate the hospitality of Fukuoka-city. Your city is indeed one of the great centers of learning and practical discovery for active aging. We recognize this 10th anniversary Fukuoka ACAP 2016 as a marker and a permanent keystone in our ACAP activities. We know Fukuoka-City will continue to promote excellence in health, wellbeing, and active aging.
Fukuoka-city Challenges to Aging

Steering Committee
The 10th Anniversary Fukuoka Active Aging Conference in Asia Pacific

Welcome to a Study Tour on Age-friendly Fukuoka

• Fukuoka city is a No.5 big city in Japan.
• Fukuoka city is a younger one in Japan, but it is a near-prospected situation for other Asian countries and areas.
• Let’s learn challenges of active aging in Fukuoka-city.
## Study Tour Courses

### Course 1
- Hotel New Otani
- “I am fine” ICT System
- Community-based Residential Facility for Long-term Care
- City Council of Social Welfare
- Hotel New Otani

### Course 2
- Fukuoka City Hall
- Dissemination Center of LTC Practice
- Assisted Living Facility
- Friendly and Lively Saloon
- Fukuoka City Hall

### Course 3
- SB Hotel Hakata-eki
- Day Service Center
- Friendly and Lively Saloon
- Dissemination Center of LTC Practice
- SB Hotel Hakata-eki

### Course 4
- SB Hotel Kitatenjin
- Preventive Care Exercise
- Dissemination Center of LTC Practice
- Small-scale Multifunctional In-home Care
- SB Hotel Kitatenjin
Study Tour Courses

Course 5
- Residential Suite
- Food Education based on Dietary, Nutrition, and Oral Hygiene
- Community Café & Chore Services
- Light Cost Residential Home
- Residential Suite

Course 6
- Residential Suite
- Food Education based on Dietary, Nutrition, and Oral Hygiene
- Light Cost Residential Home
- Community Café & Chore Services
- Residential Suite
For Self-help Healthy Older Persons

- Health Promotion Support Center (AIREF)
- Preventive Care Lectures and Practices
- Health Check of Metabolic Syndrome
- Health Check of Cancer
- Vaccination
- Food Education based on Dietary, Nutrition, and Oral Hygiene (Nakamutra Gakuen Univ.)
- Physical Training: Slow Jogging (Fukuoka Univ.)
For Workable Older Persons

• National Law Concerning Stabilization of Employment of Older Persons, 2013
• Fukuoka-prefecture “70 in Active” Support Center
• Fukuoka-city Silver Human Resource Center
• “Fukuoka-city New Second Life Programs” (preparing)

For Livable Older Persons

• Consultation Center of Residential Remodeling
• Subsidy for Residential Remodeling
• Assisted Living facility for Older Persons/Private Residential Home (West Life Minami-katae)
• Introducing Center of Rental Housing for Older Persons
• Public Housing for Low-income Citizens
• Rental Housing with Public Financial Support for Older Persons
• Care House/Light Cost Residential Home (Choun-so)
• National Law of Barrier-free of Transportation and Public Facilities for the Elderly and the Disabled
Assisted Living facility for Older Persons/Private Residential Home

- Fee-based homes for older persons
- Managed by the private sector
- Authorized by the Ministry of Land, Infrastructure, Transport and Tourism
- Clients change their address into the location of the facility.
- Residents can use in-home LTC/ day service/ community-based Care with using LTC insurance.

Care House/
Light Cost Residential Home

- Fee-based homes for older persons
- Clients change their address into the location of the facility.
- Managed by Social welfare Corporation
- Authorized by the Ministry, Health, Labor and Welfare
- Housing for the low-income elderly
For Active Older Persons

- City Council of Social Welfare (Fukufuku Plaza)
- Senior Clubs
- Elderly Citizens’ Welfare Centers
- Elderly Citizens’ Rest House
- Supportive Transportation Services
- Life-long Learning Programs
- Volunteer Coordination
- Friendly and Lively Saloon (Public Hall: Tsutumi, Akasaka, & Mitoma)
- “I am fine” ICT System (Befu Public Hall)
- Chore Service (Mitoma-otasuke-tai)

City Council of Social Welfare

- Promoting citizen participation in welfare activities
- Collaboration between government and private-sectors involved in such areas as social welfare, LTC, healthcare and medicine, education and labor
- Utilizing grant & subsidy by a municipality, tax-free donations, membership fee, and enterprise income
Friendly and Lively Saloon

- Providing opportunities and a place for meeting, interacting and exchanging in relaxed atmosphere
- Elderly people, people with disabilities, parents bringing up children, and etc.
- Supported by City Council of Social Welfare

“I am fine” ICT System

- Senior citizens will be provided with telephones on which they can press an "I am fine" button 24 hours a day, 365 days a year. By organizing mutual support functions in the community, an information flow that enables responses to changes in the physical or mental conditions of senior citizens.
- Utilizing ICT for watching on those who live alone.
- Not IOT
Chore Service

• Chore Service is the leading in-home care resource for stay-at-home services
• Shampoo your carpet, Clean the closets, housecleaning, Clean the refrigerator, Shine your shoes, Decorate your house, Defrost the freezer, Launder sheets for guests, Dust your books, Fix the livingroom lamp, and etc.

For Weak-IADL Persons

• Rental fire alarm, automatic sprinkler and electromagnetic cooker.
• Watching System for Those Who Live Alone and/or Dementia Patients
• Visiting Home-help
• Supportive Transportation
• Respite Care for Family Caregivers
• Subsidy for Welfare Equipment
For Weak-ADL Persons in Private Home

- Home Visiting Long-term Care Services (Feeding, Bathing, Toileting, Positioning, Cooking, Washing, etc.)
- Home Visiting Nurse
- Home Visiting Rehabilitation
- Guidance for Management of In-Home Medical Long-Term Care
- Day Service/Day Care (Yatten-do)
- Short-stay in LTC Facilities
- Community General Support Center

Day Service/Day Care

- Providing commuting, bathing and meals, monitoring the health status of older people, and counseling to frail older persons
- Providing respite care for family caregivers
- Japanese distinguish between the day service and day care: The former is some welfare services and the latter is rehabilitation services.
For “Aging in Place” Persons

- Home-visit at Night for Long-term Care
- Communal Daily Long-term Care for a Dementia Patients /Group Home for Dementia Patients (Yoriai-no-Mori)
- Small-scale Multifunctional In-home Care (Nanakuma-no-sato)
- Small-scale Community-based Residential Facility for Long-term Care (Yoriai-no-Mori)
- Dissemination Center of LTC Practice (Fukufuku Plaza)

Communal Daily Long-term Care for a Dementia Patients/Group Home for Dementia Patients

- Community-based Long-term Care
- Continuing Care for Dementia patients in their own home through Home-visiting, Day service and Overnight Stay
- Authorized by a Municipality
Small-scale Multifunctional In-home Care

- Community-based Multi-functional Long-term Care Facilities
- Support continued in-home living even for those requiring moderate to heavy amount of care
- “Commuting”, “visitation”, and/or or “overnight stays” in accordance with the conditions and wishes of persons requiring long-term care.
- Clients need not change their address.
- Authorized by a Municipality

Small-scale Community-based Residential Facility for Long-term Care

- Institutional Long-term Care
- Under 29 beds
- Only older citizens can be admitted to utilize it. Community-based Service.
- Clients should change their address into the location of the facility.
- Admitted by a Municipality
Dissemination Center of LTC Practice

- **Purpose:** Supporting for the elderly and the disabled to live in their own home and in their own community independently.
- **Strategies:** Dissemination of knowledge and skills of long-term care through lectures and dissemination of techno-aid equipment through showcasing, consultation and partnership with medical, health and social services.
- **Facilities:** Lecture room, showroom, model renovation, self-help devices laboratory, and practical training room.

For Institutionalized LTC Persons

- Health Care Facility for the Elderly
- Facility Covered by Public Aid Providing LTC to the Elderly
- Geriatric Hospital/ Sanatorium
- Hospice
Health Care Facility for the Elderly

- Rehabilitation facility for the elderly
- Improving the client's function to enable them to go back home
- More bio-medical care for the elderly
- Hospitalizing about 3 month
- Clients need not change their address

Facility Covered by Public Aid
Providing LTC to the Elderly

- Residential Long-term Care Home for the Elderly
- Welfare facility for the elderly requiring long-term care: Living facility for older people who require long-term care
- Clients should change their address into the location of the facility.
- Managed by Social Welfare Corporations Only
- Available of Long-term Care Insurance
- Annexed of Day Service Center
Geriatric Hospital/ Sanatorium

- Originally the Geriatric Health Care Facility covered by Medical Insurance
- The Long-term Care Insurance Act was enacted in April 2000 and the Geriatric Hospitals became the "Designated Medical Long-Term Care Sanatoriums"
- In near future, this kind of facilities will be abolished, because of its cost in Japan.

Status Quo of LTC in Fukuoka-city

- Residential Care Facilities 75
- Community-based Multi-Functional Small-size Facilities 24
- Community-based Day Care Services 506
- Community-based Visiting Services 723
- Population 1,500,000
- Aged 65+ 297,000
- Recognized LTC 38,000
Study Tour Snapshot
1. 日時  Date

平成28年3月6日（日）13:00～15:00
Sunday, March 6th, 2016 13:00-15:00

2. 会場  Venue

福岡国際会議場 国際会議室501
（福岡市博多区石城町2-1）
Fukuoka International Congress Center International Conference Room(501)
（2-1 Sekijo-machi, Hakata-ku, Fukuoka City）

3. 主催  Organizer

厚生労働省
Ministry of Health, Labour and Welfare

4. プログラム（予定） Programs（Plan）

＜開会挨拶＞ Opening Remarks
厚生労働大臣 塩崎恭久
Yasuhisa SHIOZAKI, Minister of Health, Labour and Welfare

福岡市長 高島宗一郎氏
Soichiro TAKASHIMA, Mayor, Fukuoka City

公益社団法人日本医師会会長 横倉義武氏
Yoshitake YOKOKURA, President, Japan Medical Association
基調講演　Keynote Speech
アクセンチュア株式会社マネジメント・ディレクター　武内和久氏
Kazuhisa TAKEUCHI, Managing Director, Accenture Japan Ltd
（「保健医療2035」策定懇談会　構成員）
(Member of Health Care 2035 Advisory Panel)
パネルディスカッション　Panel Discussion
（ファシリテーター）　Facilitator
特定非営利活動法人日本医療政策機構理事　小野崎耕平氏
Kohei ONOZAKI, Board Member, President, Health and Global Policy Institute
（パネリスト） Panelists
公益社団法人日本医師会会長　横倉義武氏
Yoshitake YOKOKURA, President, Japan Medical Association
福岡市副市長　荒瀬泰子氏
Yasuko ARASE, Deputy Mayor, Fukuoka City
東京大学大学院医学系研究科国際保健政策学教室教授　渋谷健司氏
Kenji SHIBUYA, Professor, Department of Global Health Policy, Graduate School of Medicine, The University of Tokyo
アクセンチュア株式会社マネジメント・ディレクター　武内和久氏
Kazuhisa TAKEUCHI, Managing Director, Accenture Japan Ltd
厚生労働省政策統括官（社会保障担当）　武田俊彦
Toshihiko TAKEDA, Director-General, Policy planning and Evaluation for Social Security, Ministry of Health, Labour and Welfare