Bundesministerium
für Gesundheit

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Japanisch-Deutsches Zentrum Berlin
ベルリン日独センター
Japanese-German Center Berlin

Austausch zwischen Deutschland, Frankreich und Japan

Bericht über das Symposium „Langzeitpflege“

03. und 04. April 2009, Tokyo

www.bmg.bund.de

Den Bericht verfasste Anna Skarpelis (MPI für Gesellschaftsrecht),
die englische Übersetzung Tracey Kimmeskamp.

Bericht über das Symposium „Langzeitpflege“

Austausch zwischen Deutschland, Frankreich und Japan

Report on the Tripartite Symposium on Long-term Care

between France, Germany, and Japan

Japanisch-Deutsches Zentrum Berlin / Japanese-German Center Berlin
Bundesministerium für Gesundheit / Federal Ministry of Health

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Dear Citizens,

A look at demographic trends shows us that people are living longer and are ageing in a healthier manner. This is in keeping with our society's goals and with our individual needs – and it is good that this is so.

However, societies themselves are changing as the proportion of ageing citizens grows. We have to respond to this development if we are to maintain the stability of our society. The social security systems are being confronted with exceptional challenges in this context, as the steadily growing demands have to be shouldered by a steadily dwindling number of young, healthy individuals. All of us, who bear responsibility, at different levels and in different contexts, are being called upon to acknowledge these changes and engage in an exchange of ideas. Following on from this, we must develop strategies and embark upon new paths: to find sustainable solutions to the challenges of the future, to protect our social security systems from excessive pressure and, at the same time, meet the needs of all generations adequately.

Societal change is affecting almost all industrial countries and is having an impact all over the world. Against this background, a meeting was held, in the spring of 2009, among those in positions of responsibility in politics, science and the administration in Japan, France and Germany. Within the framework of the 'Long-term Care' symposium in Tokyo, the Japanese-German Centre in Berlin organised an exchange among experts, on 3rd and 4th February 2009, at which it was possible to discuss not only differences, but above all similarities and possible solutions.

The knowledge and insights gained from that symposium are to be documented with this brochure and thus kept alive and in our minds. The continuation of this fascinating exchange is also being envisaged, to give us the opportunity to continue to learn from one another.

Yours faithfully,

Dr. Philipp Rösler

Liebe Bürgerinnen und Bürger,

die demographische Entwicklung zeigt uns: Die Menschen leben länger, und sie altern gesünder. Das entspricht den Zielen unserer Gesellschaft und unseren individuellen Bedürfnissen – und es ist gut, dass es so ist.

Die Gesellschaften verändern sich jedoch mit dem zunehmend höheren Anteil älter werdender Menschen. Darauf müssen wir reagieren, soll die Stabilität der Gesellschaft gewährleistet bleiben. Die sozialen Sicherungssysteme stehen dabei vor besonderen Herausforderungen, weil die immer größere Inanspruchnahme von zunehmend weniger jungen, gesunden Menschen geschultert werden muss. Alle, die auf unterschiedlichen Ebenen und vor unterschiedlichen Hintergründen Verantwortung tragen, sind gefordert, diese Veränderungen zu erkennen und in einen Gedankenaustausch einzutreten. Daran anknüpfend müssen Strategien entwickelt und neue Wege beschritten werden, um die Herausforderungen der Zukunft nachhaltig zu meistern, die Sicherungssysteme vor Überforderung zu schützen und dabei den Generationen gerecht zu werden.

Die gesellschaftlichen Veränderungen treffen fast alle Industrienationen und ziehen weltweit Kreise. Im Frühjahr 2009 kam es deshalb zu einem Treffen der Verantwortlichen aus Politik, Wissenschaft und Verwaltung der Länder Japan, Frankreich und Deutschland. Im Rahmen des Symposiums „Langzeitpflege“ in Tokyo hat das Japanisch-Deutsche Zentrum Berlin am 3. und 4. Februar 2009 einen Austausch von Fachleuten organisiert, bei dem Unterschiede, aber vor allem Gemeinsamkeiten und Lösungswege erörtert werden konnten.

Die Erkenntnisse des Symposiums sollen mit der vorliegenden Broschüre schriftlich festgehalten werden und in Erinnerung bleiben. Die Fortsetzung des spannenden Austausches ist vorgesehen – damit wir weiter von einander lernen können.

Ihr

Dr. Philipp Rösler

Bericht über das Symposium „Langzeitpflege“
Austausch zwischen Deutschland, Frankreich und Japan

Eröffnung

OMURA Hideaki (Senior Vice Minister of Health, Labor and Welfare, Japan)

Deutschland, Frankreich und Japan haben ähnliche Ziele in der Pflege: Es soll ein stabiles System zur Verfügung gestellt werden, das in der Pflege die Würde alter Menschen wahrt. Ein Anlass für die Einführung des Pflegeversicherungssystems in Japan im Jahre 2000 war die Erkenntnis, dass die Pflege eine gesamtgesellschaftliche Aufgabe und nicht mehr alleinige Angelegenheit der Familie ist. Seit seiner Einführung ist das System, gemessen an der Zahl der Pflegedienstnutzer, von der Bevölkerung und den Betroffenen sehr gut angenommen worden. Ambulante Leistungen, auf die das Augenmerk der Pflegeversicherung gerichtet ist, werden stark in Anspruch genommen. Es ist klar, dass die Gesellschaft die Einführung des Programms sehr schätzt. Natürlich verläuft die Umsetzung nicht ohne Schwierigkeiten, so gibt es immer mehr Demenzkranke, aber gleichzeitig einen Mangel an Pflegekräften und die Kosten stiegen stetig. Deshalb strebt die japanische Regierung weitere Reformen des Systems an, um Verlässlichkeit und Vertrauen zu stärken. Weil die Alterung der Bevölkerung zunehmen wird, ist es besonders wichtig, dass die drei an dem Symposium teilnehmenden Länder – Deutschland, Frankreich und Japan – ihr Wissen zu diesem Thema austauschen und miteinander über gemeinsame Probleme und Lösungsvorschläge diskutieren.

Agnes LECLERC (Abteilungsleiterin, Europäische und Internationale Angelegenheiten, Ministère des solidarités, de la santé et de la famille, Frankreich)

Das Symposium eröffnet die Möglichkeit, eine nachhaltige Verbindung zwischen den Sozialministerien Frankreichs und Japans zu schaffen und bestehende Verbindungen zwischen Deutschland und Frankreich zu stärken. In Frankreich ist man an den unterschiedlichen Pathologien des Alterns interessiert, das Augenmerk liegt auf der Versorgung von Alzheimerpatienten. Trotz verschiedener familialer Veränderungen bleibt die Solidarität innerhalb der Familie bestehen, auch wenn das nicht unbedingt bedeutet, dass man zusammen wohnt. Um die ambulante Pflege weiterhin gewährleisten zu können, beschloss die französische Regierung Unterstützung durch die Finanzierung professioneller Dienstleistungen. Seit 2002 erhalten 600.000 Personen in ambulanter Pflege und 400.000 Personen in stationärer Pflege die „Allocation personnalisée d’autonomie“ (APA). Dieser auf individuelle Bedürfnisse abgestimmte Zuschuss soll Dienstleistungen finanzieren, die Aktivitäten des täglichen Lebens unterstützen. Die erfolgreiche Aufnahme des Programms stellt gleichzeitig seine Nachhaltigkeit in Frage, da mit einem Kostenzuwachs von sieben Prozent der Fortbestand des

Systems durch den demographischen Wandel bedroht ist, vor allem in den Jahren 2025 bis 2030, wenn Angehörige der geburtenstarken Jahrgänge in die pflegebedürftige Phase kommen. Gerade weil die Nachhaltigkeit der Finanzierung sowohl in Pflege wie auch in Rente fraglich ist, liegt es nun am Staat, Reformen des Systems durchzuführen. Leitlinien des neuen Gesetzesentwurfs zur nachhaltigen Finanzierung der Langzeitpflege sind Folgende:

1. Ambulante Pflegeleistungen sind auszubauen, um Pflegebedürftigen zu erlauben, so lange wie möglich zu Hause zu bleiben. Dies betrifft vor allem Leistungen für alleinstehende und stark pflegebedürftige Menschen.
2. Die Zahl der Plätze in stationären Einrichtungen muss vergrößert und der Zugang zu diesen Plätzen auch für Menschen mit geringem oder mittlerem Einkommen ermöglicht werden.
3. Um die finanzielle Nachhaltigkeit zu sichern, müssen neben Steuern und Sozialversicherungsbeiträgen andere Quellen erschlossen werden. Da ein Risiko der Pflegebedürftigkeit besteht, sollen die Menschen für ihre Pflege vorsorgen. Außerdem könnte man sie verpflichten, ihr Vermögen dafür zu nutzen, diese Maßnahme würde aber nur etwa ein Drittel der älteren Menschen betreffen. Auch die Möglichkeit privater Zusatzversicherungen wird geprüft.
4. Private Zusatzversicherungen sollen gefördert werden. Bisher sind etwa zwei Millionen Franzosen gegen das Pflegerisiko privat versichert.

Deutschland, Frankreich und Japan stehen vor ähnlichen Herausforderungen: Wie definiert und evaluiert man den Pflegebedürftigkeit? Wie organisiert man wirkungsvolle Dienstleistungen für alte Menschen? Wie findet man ein Gleichgewicht zwischen ambulanter und stationärer Pflege? Welche neuen Technologien können zum Schutz älterer Menschen eingesetzt werden? Wie soll die finanzielle Last zwischen Steuern, Versicherungsbeiträgen und Privatpersonen aufgeteilt werden?

Marion CASPERS-MERK (Parlamentarische Staatssekretärin, Bundesministerium für Gesundheit, Deutschland)

Die alternde Gesellschaft ist für viele Menschen eine Chance, aber eine Herausforderung für die sozialen Sicherungssysteme. In Deutschland wurde die Pflegeversicherung 1995 als fünfte und letzte Säule der sozialen Sicherungssysteme eingeführt. Man hat sich vom japanischen System der Care Manager inspirieren lassen und den Beruf der Pflegeberater geschaffen, um Angebote und Leistungen auf kommunaler Ebene stärker vernetzen zu können. Außerdem ist es notwendig, Strategien zu entwickeln, um die Pflegeberufe attraktiver zu machen und den Begriff Pflegebedürftigkeit neu zu definieren.

Seit der Einführung der Pflegeversicherung wurden folgende Veränderungen durchgeführt und stellen sich folgende Zukunftsfragen:

1. Neudefinition und Ausdehnung des Pflegebedürftigkeitsbegriffs von rein körperlichen Problemen auf andere Einschränkungen, z. B. bei Demenzkranken, die zwar keine Pflege, aber Unterstützung oder Betreuung brauchen.
2. Verbesserung der Leistungen für die Pflege demenzieller Patienten
3. Einführung kommunaler Pflegestützpunkte
4. Ausbau ambulanter Betreuung
5. Verbesserung der Situation in stationären Einrichtungen, vor allem der Betreuungsstruktur von Demenzkranken
6. Verbesserung des Ansehens von und der Aufstiegschancen in Pflegeberufen
7. Leistungsdynamisierung
8. Qualitätsevaluierung von Pflegeleistungen und Pflegeeinrichtungen durch die Schaffung eines Qualitätssiegels

Die Herausforderungen, vor denen die drei Länder stehen, ähneln sich. Es geht um die Verbesserung der Pflegeausbildung, um neue Kooperations- und Vernetzungsmodelle, Visionen zu Finanzierung und Weiterentwicklung der Leistungsangebote sowie um die Neudefinition des Pflegebedürftigkeitsbegriffs.

Keynote Speeches

Marie Eve JOËL (Professor, Université Paris Dauphiné, Frankreich)

In Frankreich wird momentan diskutiert, das bestehende System der sozialen Sicherung um eine fünfte – private – Säule zu erweitern, um das Risiko der Pflegebedürftigkeit nachhaltig finanziell abdecken zu können. Im Rahmen der breiteren Diskussion wurden der Solidaritätsplan für ältere Menschen (2007–2012) und der letzte Alzheimer-Plan (Plan-Alzheimer, 2008–2012) entwickelt. Trotz der Mobilisierung von Expertenwissen ist eine genaue Vorhersage über die Entwicklung der Zahlen von Demenzerkrankungen nicht möglich. Dies erschwert den konkreten Ausbau von Leistungen. In Frankreich spielen besonders vier Themen eine Rolle.

Intra-familiale und andere informelle Pflegeleistungen sind durch Vergütung, Pflegeurlaub, Anrechnung der Pflegeleistung auf Rentenansprüche, Weiterbildung und bessere Koordination zu unterstützen. Der SHARE-Studie[1] zufolge ist die Pflege in der Familie stabil in Bezug auf Quantität der Leistungen, allerdings diversifizierten sich ihre Formen zunehmend. Welche Pflegeform

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[1] SHARE Project – Survey of Health, Ageing and Retirement in Europe: wurde erstmals 2004 als repräsentative Befragung der Bevölkerung im Alter 50+ in 11 europäischen Ländern erhoben. Die zweite Befragungswelle von Herbst 2006 bis Frühjahr 2007 wurde mit über 30.000 Befragten in insgesamt 14 europäischen Ländern und Israel durchgeführt. Die dritte Befragungswelle zu retrospektiven Lebensgeschichten (SHARE LIFE) findet seit Herbst 2008 in 15 europäischen Ländern statt. (alle Anm. v. d. Red.)

jemand für sich wählt, gemeinsames Wohnen in einer betreuten Wohnung, ambulante Unterstützung oder Heimunterbringung, hängt u. a. von der möglichen finanziellen Unterstützung und der Verfügbarkeit professioneller Pflegedienstleistungen ab.

Die Institutionen des sozio-medizinischen Sektors haben sich in den letzten Jahren auf Drängen der öffentlichen Hand stark modernisiert, man spricht in Frankreich von der „Industrialisierung“ der Pflege. Auf dem Markt für Wohnungen für Pflegebedürftige entwickelte sich ein Wettbewerb zwischen gemeinnützigen und gewinnorientierten Organisationen. In der ambulanten Pflege wurden durch das Gesetz zur Entwicklung der Dienstleistungen von 2005 unterschiedliche Anreize geschaffen, um das Arbeitskräfteangebot zu erhöhen. Die größten Herausforderungen in diesem Bereich sind die Bereitstellung eines ausreichend großen Arbeitskräfteangebotes, die Koordinierung unterschiedlicher Akteure im Bereich der Pflegedienstleistungen und der Übergang von einer Logik der sozialen Unterstützung zu einer Logik der Managementkultur, in der die Kommunen Qualität und wirtschaftliche Tragfähigkeit der Leistungen und der Dienstleister überprüfen können.

Weiterhin soll die Bevölkerung mithilfe des dritten Alzheimer-Plans (2008–2012) besser über Alzheimer informiert werden. Seit einiger Zeit existieren auch spezielle Einrichtungen („Maisons pour l’autonomie et l’intégration des malades d’Alzheimer“ – MAIA), die sich den Autonomieerhalt und die Integration Demenzkranker zur Aufgabe gemacht haben. Ein weiteres Ziel ist die Verbesserung der Lebensqualität von Alzheimerpatienten und ihren Pflegekräften. Die Pflege bei mental-psychischen Störungen weicht stark von der Pflege bei körperlichen Einschränkungen ab. Pflege selbst bei nur leicht an Demenz Erkrankten erfordere genauso viel Einsatz wie Pflege bei starker körperlicher Beeinträchtigung. Noch ist nicht geklärt, ob die Geldmittel der Kommunen eher in Forschung, Hilfe für Pflegedienstleistende, die Verbesserung der Lebenssituation der Betroffenen oder der Qualifizierung von professionellem Pflegedienstpersonal investiert werden sollen.

Als letzter Punkt wurden Finanzierung und Nachhaltigkeit der Pflege angesprochen. Das französische System zur Unterstützung Pflegebedürftiger (Allocation personnalisée d’autonomie – APA) ist ein Teilerstattungssystem auf einkommensabhängiger Basis. Hier stehen vor allem Fragen zum Leistungskorb der Pflegedienstleistungen für ältere Menschen, zum Verhältnis zwischen öffentlichen und privaten Ausgaben und zur Definition der Anspruchsberechtigung auf öffentliche Leistungen im Vordergrund. Zur Nachhaltigkeit der Finanzierung hat der Senat vorgeschlagen, die Finanzierungslücken durch eine private Zusatzpflegeversicherung oder durch die Pflicht zur Heranziehung des privaten Vermögens der Pflegebedürftigen zu kompensieren. Es ist notwendig, sich über verschiedene Themenbereiche wie die Neudefinition von Solidarität zwischen den Generationen und die Auswirkungen finanzieller Einschränkungen zu verständigen.

MATSUMOTO Katsuaki (Professor, Hitotsubashi University, Japan)

Professor Matsumoto stellt die drei unterschiedlichen Systeme der Pflegeversicherung in Japan, Deutschland und Frankreich aus vergleichender Perspektive vor. Die Einführung der Systeme hat sich über einen Zeitraum von ungefähr einem Jahrzehnt abgespielt. Deutschland war der Vorreiter mit der Einführung der Pflegeversicherung im Jahr 1995. Frankreich führte 1997 die „Prestation spécifique dépendance“ (PSD) und 2002 die „Allocation personnalisée d’autonomie“ (APA) ein, Japan beschloss 1997 das Langzeitpflegegesetz und setzte es im Jahr 2000 in Kraft.

Die Form der Leistungen ist in den Ländern unterschiedlich. In Japan und Deutschland gibt es Sachleistungen, in Deutschland werden diese auch in Form von Pflegegeld angeboten, das nicht an den Kauf bestimmter Leistungen geknüpft ist. Frankreich arbeitet mit Geldleistungen, die aber für den Kauf von Pflegeleistungen ausgegeben werden müssen. Die Anspruchsberechtigen in allen drei Ländern sind Pflegebedürftige, die nach unterschiedlichen Kriterien in verschiedene Pflegestufen eingestuft werden. In Deutschland sind pflegende Familienangehörige indirekt anspruchsberechtigt, da sie durch die Versorgung ihrer Angehörigen Anspruch auf Pflegegeld haben. Die Finanzierung besteht in Japan in einem gemischten System, in dem die Pflegeversicherung zur Hälfte durch Versicherungsbeiträge und zur Hälfte durch Steuern finanziert werde. Das deutsche System wird ausschließlich durch Beiträge finanziert, das französische vor allem durch Steuerbeiträge.

Auch die zugrunde liegende Vorstellung von den Risiken, gegen die das System absichert, unterscheidet sich in den einzelnen Ländern. In Japan ist die Pflegeversicherung vor allem auf altersbedingte Pflegebedürftigkeit ausgerichtet, somit ist die Anspruchsberechtigung an das Alter der Pflegebedürftigen geknüpft (ab 40 Jahren). In Deutschland gibt es diese Altersgrenze nicht, Pflegebedürftige jeden Alters sind anspruchsberechtigt. In Frankreich gibt es eine Altersbegrenzung für die Anspruchsberechtigung (ab 60 Jahren). Wie Frankreich und Deutschland hat auch Japan das Problem der ausreichenden Rekrutierung von Arbeitskräften im Pflegebereich.

Session 1: Pflege für ältere Demenzkranke

HOMMA Akira (Team Leader, Research Team for Promoting Inependence of the Elderly, Tokyo Metropolitan Institute of Gerontology, Japan)

Artikel 1 des Langzeitpflegegesetzes von 2006 betont, dass ein Hauptziel der Pflegeversicherung die Erhaltung der Würde des Pflegebedürftigen sei. Die Zahl der Demenzkranken wird voraussichtlich von zwei Millionen im Jahr 2005 auf gut viereinhalb Millionen Menschen im Jahr 2035 ansteigen, doch es ist schwer abzuschätzen, wie viele an Demenzkranke auch diagnostiziert und behandelt werden. Im Vergleich zu anderen Alterskrankheiten ist Demenz eine Krankheit, die besondere Aufmerksamkeit im Umfeld der betroffenen Person fordere, da Demenzkranke selten von sich aus medizinische Einrichtungen aufsuchen. Weiterhin sei problematisch, dass das Angebot der Vormundschaft für Demenzkranke kaum angenommen wird: Nur drei Prozent der Langzeitpflegeverträge beinhalten auch eine Vormundschaftsklausel.

Um vor allem in den Gemeinden Wissen über Demenzkrankheiten zu verbreiten, sollen auf kommunaler Ebene 150 Demenzversorgungszentren geschaffen und Hausärzte durch ein staatliches Programm weitergebildet werden. Bislang haben 14.000 Hausärzte in Japan an diesem Programm teilgenommen. Auch die Bevölkerung soll für das Thema Demenz sensibilisiert und nichtprofessionelle Hilfe in den Kommunen verstärkt werden. Für dieses Ziel wird ein zehnwöchiges Training für Personen mit Pflegeerfahrung angeboten und kürzere Kurse für Menschen, die in den Bereich neu einsteigen wollen. Nachdem sie das Kurztraining absolviert haben, bekommen die Teilnehmer ein Armband, das sie als Person mit Kenntnissen über Demenz ausweist. Ziel dieser Maßnahme sei es, die Solidarität mit Demenzkranken zu verstärken und mehr Wissen über die Erkrankung und ihre Auswirkungen zu verbreiten.

Sabine JANSEN (Geschäftsführerin, Deutsche Alzheimer Gesellschaft)

Heute gibt es in Deutschland gut 1,1 Millionen Demenzkranke und jährlich ca. 250.000 neuen Fälle. Bis zum Jahre 2050 erwartet man eine Zunahme der absoluten Zahl Demenzkranker auf 2,3 Millionen. Von den diagnostizierten Demenzkranken werden zwei Drittel in der Familie gepflegt, aber dieser Anteil wird sich in Zukunft verkleinern, da immer mehr alte Menschen alleine leben. Grad und Art der Versorgung variieren nach Lebenssituation und Krankheitsstadium der Betroffenen, aber vor allem zu Anfang der Krankheit sind Beratung, Information und Schulungen auch für Angehörige sehr wichtig. Zwar gibt es mittlerweile eine flächendeckende Versorgung für ambulante Dienste durch professionelle Pflegedienstleistungen, doch sind diese nicht immer auf die speziellen Bedürfnisse Demenzkranker ausgerichtet. Zunehmend werden auch informelle Hilfen angeboten, die sich zum Teil aus der Selbsthilfe entwickelt haben. Professionelle Pflegeangebote jenseits ambulanter oder kontinuierlich stationärer Pflege werden ebenfalls angeboten, zum Beispiel Tages- und Nachtpflege oder Kurzzeitpflege, doch sind sie kostspielig und werden deshalb nicht sehr oft in Anspruch genommen.

Um Information und Beratung für Demenzkranke und ihre Angehörigen bereitzustellen, unterhält die Deutsche Alzheimer Gesellschaft (DAG) seit 2002 ein Alzheimer-Telefon, über das 5.500 bis 6.000 Menschen pro Jahr beraten werden. Im Jahr 2008/2009 wurden vor allem drei Themenbereiche oft von den Angehörigen angesprochen: Probleme im Umgang mit den Erkrankten, Fragen zu ärztlicher Versorgung und Diagnose und rechtliche Fragen zu Betreuung und Anspruchsberechtigung auf Zahlung aus der Pflegeversicherung. Es besteht noch viel Informations- und Aufklärungsbedarf. Eine zunehmende Zahl von Demenzkranken wird in nicht auf Demenz spezialisierten Akutkrankenhäusern behandelt, in denen das Personal nicht ausgebildet ist, um gut mit den Patienten umgehen zu können. Auch individuelle Angebote für Pflege und Rehabilitation sollen verbessert werden.

Obwohl sich in den letzten fünfzehn Jahren die Aufmerksamkeit für Demenzkranke und ihre Versorgung stark verbessert haben, gibt es immer noch Defizite. Die DAG schätzt, dass nur für dreißig Prozent aller Demenzkranken eine Diagnose gestellt wurde. Vor allem in ländlichen Gebieten sind Zugang zu Information und Behandlung nicht optimal. Trotz der Ausweitung professioneller Dienstleistungen trägt die Familie immer noch die größte Belastung, deshalb soll die Kooperation zwischen professionellen und ehrenamtlichen Angeboten verbessert werden. In der Forschung sollen vor allem Untersuchungen zur Versorgung gefördert werden. Die DAG ist mit verschiedenen Ministerien in mehreren Forschungsinitiativen involviert. Das Bundesministerium für Bildung und Forschung investiert in ein Zentrum zu neurodegenerativen Erkrankungen und fördert Kompetenznetzwerke. Das Bundesministerium für Gesundheit hat unterschiedliche Leuchtturmprojekte zum Thema Pflege ausgeschrieben, und das Bundesministerium für Familie, Frauen, Senioren und Jugend unterstützt Bemühungen um ein größere Aufmerksamkeit für die Krankheit und erarbeitet Informationsmaterial, auch um bestimmte Bevölkerungsgruppen zu sensibilisieren, wie Polizei, Bankangestellte und Personen im Einzelhandel. Es gib zurzeit viele Pilotprojekte, nach deren Ablauf man sich um die Multiplikation der erfolgreichen Projekte bemühen muss. Das Ziel besteht darin, eine Gesellschaft zu schaffen, in der sich Demenzkranke wohlfühlen können. Jedes Land muss herausfinden, wie viele finanzielle Ressourcen es für die Pflege zur Verfügung stellen will.

Sandrine LEMERY (Projektreferentin, Lenkungsausschuss, Le Plan Alzheimer, Frankreich)

Der demographische Wandel wird nicht nur zu einer größeren Anzahl älterer Menschen führen, sondern auch zu einem rapiden Anstieg der Zahl stark pflegebedürftiger Menschen (Stufe 1 bis 4 auf der AGGIR Skala[2]). Zwischen 20 und 24 Prozent aller Todesfälle bei älteren Menschen können in Frankreich auf Alzheimer und verwandte Krankheiten zurückgeführt werden. Im Gegensatz zu den beiden vorherigen Alzheimer Plänen (2001 bis 2008), die mehr praxisorientiert und weniger auf die Forschung fokussiert waren, sieht der neue Alzheimer-Plan eine Investition von 200 Millionen Euro in die Forschung zu Demenzerkrankungen vor, 200 Millionen Euro für medizinische Versorgung und 1,2 Milliarden Euro für die medizinisch-soziale Unterstützung der Betroffenen. Die Alzheimer-Kommission verfolgt drei Ziele:

Erstens soll durch die Forschung das Verständnis von der Krankheit verbessert werden. Um Forschung zu fördern und schnelle Fortschritte zu garantieren wurde ein nationales Exzellenznetzwerk gegründet, durch das französische und ausländische Forscher rekrutiert werden sollen. Außerdem werden Partnerschaften mit der Industrie sowie Beziehungen zwischen den einzelnen Forschungsteams gefördert.

Zweitens soll die Lebensqualität der Patienten und ihrer Angehörigen verbessert werden. Auf der einen Seite sollen Pflegedienstleistungen in Einrichtungen entwickelt und unterschiedlichen Bedürfnissen angepasst werden, zum anderen sollen Rechte und Qualifizierung der Pflegekräfte wie auch die Überwachung der Gesundheit von pflegenden Angehörigen verbessert werden. Durch ein Pilotprojekt der „Maisons pour l'autonomie et l'intégration des malades d'Alzheimer" (MAIA) wird versucht, die Koordinierungskapazitäten zwischen den unterschiedlichen an der Pflege beteiligten Akteuren zu stärken. Weiterhin sollen eintausend Pflegeberater im ganzen Land eingesetzt werden. Wie auch in Deutschland und Japan sollen ambulante Pflegedienstleistungen durch den Einsatz von Pflegespezialisten und neuen Technologien verbessert werden. Der Zugang zu Diagnose und Pflege soll durch den Aufbau von „Gedächtniszentren" und durch ein neues System für Diagnose und Behandlung der Krankheit vereinfacht werden. Schließlich wird der Versuch unternommen, bestehende Pflegeheime durch spezielle Pflegeeinheiten besser an die Bedürfnisse von Demenzkranken zupassen.

Drittens strebt man eine Sensibilisierung und Mobilisierung der Gesellschaft durch Information und die Unterstützung ehrenamtlicher Hilfe an. Zu diesem Zweck wurde bereits eine telefonische Beratungsstelle eingerichtet. Zur rascheren Implementierung des Alzheimer-Plans und um ethische Gesichtspunkte wie den legalen Status und die Autonomie der Patienten zu diskutieren, werden verschiedene Tagungen veranstaltet. Man möchte in Frankreich die Demenz durch Forschung auf internationaler Ebene zu einer Priorität europäischen Forschens und Handelns machen.

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[2] AGGIR ist eine von der Fondation Nationale de Gérontologie erarbeitete Methode zur Bewertung der funktionellen Autonomie alter Menschen. Die Skala für die Einstufung hat 6 Stufen.

Diskussion zur Session 1[3]

Moderation: HASEGAWA Kazuo (Center Director, Tokyo Dementia Care Research and Training Center

In Session 1 haben wir uns unter anderem mit unterschiedlichen Wohnformen für Demenzkranke auseinandergesetzt. In den drei Ländern wird über die Vor- und Nachteile von ambulanten, stationären oder anderen Formen der Pflege für Demenzkranke diskutiert. Meiner Ansicht nach sind kleinere Arten der Wohnformen, zum Beispiel in Form von Group Homes, eine vielversprechende Möglichkeit für die Pflege. Zur Zeit der Einführung der Pflegeversicherung in 2000 gab es in Japan 400 Group Homes, mittlerweile gibt es über 10.000.

In den Group Homes wird der Versuch unternommen, Kontinuität mit der vorherigen Wohnform des Betroffenen zu ermöglichen. In kleinen Gruppen von ungefähr zehn Personen leben die Demenzkranken ähnlich wie in einer Familie. Es gibt ein Wohnzimmer, in dem man sich treffen und reden kann, Mahlzeiten werden gemeinsam zubereitet, insgesamt ist es sehr lebendig. Seit 2006 gib es das Projekt „Regionalpflege" (*chiiki care*), das vom Gesundheitsministerium unterstützt wird. Im Rahmen dieses Projektes werden nicht so aufwändige, multi-funktionale Dienstleistungen angeboten. Unter anderem bedeutet dies, dass der Tagesservice nun auch für Demenzkranke und nicht nur für alte Pflegebedürftige verfügbar ist. Sollten die Betroffenen nicht jeden Tag in das Day Care Zentrum fahren wollen, so gibt es für sie die Möglichkeit, ambulant zu Hause versorgt zu werden. Weiterhin gibt es einen Nachtservice, um Pflege leistende Freunde und Familienmitglieder zu entlasten. Dieser Service ermöglicht es den Pflegenden, die Pflegebedürftigen für eine oder mehrere Nächte ins Zentrum zu bringen und sie gut versorgt zu wissen. Für Menschen, die keine Familie haben, die sich um sie kümmert, gibt es die bereits genannte Einrichtung des Group Home. Es gibt also vier unterschiedliche Formen der Versorgung: ambulante Pflege im Hause des Betroffenen, Day Care Zentren, Night Care Zentren und Group Homes.

D: In Deutschland diskutierte man, ob man Menschen so lange wie möglich ermöglichen soll, ambulant versorgt zu werden, oder ob sie schon zu einem früheren Zeitpunkt stationär versorgt werden sollen. Wer sind die Träger der Demenzheime in Japan, werden sie privat, durch Vereine oder durch Wohnungsbaugenossenschaften getragen?

J: Soweit ich weiß, gehören Group Homes eher in die Kategorie der ambulanten Pflege und können nicht als stationäre Einrichtungen angesehen werden. Group Homes sind in die Gemeinde integriert. Sie werden in der Regel auch nicht von der Regierung verwaltet sondern von anderen Organisationen, wie zum Beispiel Non-Profit-Organisationen oder privaten Firmen. Die Tagesplanung ist nicht standardisiert und wird vollständig von den Angestellten der Group Homes übernommen.

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[3] Diskussionsbeiträge von Teilnehmern aus D Deutschland, F Frankreich und J Japan.

D: In Deutschland gibt es drei Wohnformen für demenziell Erkrankte: ambulante Tagespflege, Wohngruppen als heimersetzende Maßnahme und klassische Pflegeheime oder Wohngruppen, die der Familienwohnstruktur nachempfunden sind. Bei Demenzkranken ist vor allem die Übersichtlichkeit der Strukturen und die kleine Größe der Gruppe wichtig, so dass ihnen ermöglicht wird, gewohnte Strukturen trotz der Krankheit aufrecht zu erhalten.

D: Einige Formen der Versorgung fallen unter die institutionellen Gegebenheiten der Pflegeversicherung, doch es existieren auch ambulante Wohnformen, die nicht unter das Heimgesetz fallen, wie zum Beispiel Wohngruppen. Um die Menschenwürde zu gewährleisten, muss man die Leistungen auf den einzelnen Menschen ausrichten und darf sich nicht einzig an den existierenden Strukturen orientieren. Dies ist nur sozialräumlich denkbar, privatisiert ist es nicht möglich.

F: Auch in der französischen Pflegeversicherung sind Würde, Universalität und Gleichheit der Behandlung zentrale Punkte. Es wird versucht, die Würde der Betroffenen durch einen holistischen Ansatz zu gewährleisten: Demenzkranke werden in kleinen Gruppen gepflegt, die Pflegeberufe werden professionalisiert und die Bevölkerung über die Krankheit aufgeklärt.

J: Die Ausweichmöglichkeit für die Betroffenen von Pflege zu Hause auf Group Homes ist von großer Bedeutung. Sowohl individuelle Pflege wie auch Group Homes sind adäquate Möglichkeiten der Versorgung, die Herausforderung liegt nun in der Integration unterschiedlicher Dienstleistungen auf kommunaler Ebene.

D: Deutschland orientiert sich bei der Sterbebegleitung von Demenzkranken an anderen Ländern und unterstützt die Fortbildung in der Palliativpflege zum Beispiel durch Hospitationsprogramme von Pflegekräften und Ärzten in Ländern, die erfolgreiche Programme bereits implementiert haben.

J: Eine weiterer Punkt, der der Lösung harrt, sind die niedrigen Löhne, da geeignete Bewerber die Pflegeberufe aus diesem Grund nicht in Betracht ziehen. Auch der geringe soziale Status ist abschreckend. Eine Gegenmaßnahme besteht in der Verbesserung der Aus- und Weiterbildung. In Japan gibt es mittlerweile drei Zentren (Tokyo Center, Sendai Center und Nissan Center), in der zukünftige Pflegefachkräfte weitergebildet werden. Die Weiterbildung richtet sich an Pflegedienstleistende aus allen Stufen der Berufshierarchie, die seit mehr als zehn Jahren in diesem Sektor tätig sind. Momentan nehmen aus ganz Japan gut 1.100 Menschen an dem zehnwöchigen externen Training teil. Die Zentren sind ein Teil der Maßnahmen, die Menschen den Anreiz geben sollen, einen Pflegeberuf zu wählen. Wichtig ist uns auch die Aufklärung der Bürger. Auf kommunaler Ebene sollen sie über Demenz und ihre Folgen informiert und weitergebildet werden, sodass zum Beispiel Familienmitglieder schneller auf die Symptome früher Demenz bei Angehörigen reagieren können.

D: Um auf den von französischer Seite angesprochenen Punkt zurückzukommen: es bietet sich eine gesellschaftspolitische und nicht nur eine rein medizinische oder pflegepolitische Zielsetzung an, wenn Gerechtigkeit zum Thema wird.

F: Vorher ging es um das Thema Würde in der Behandlung von Demenzkranken. Würde spielt auf drei verschiedenen Ebenen eine Rolle: 1. Die Alzheimer-Krankheit muss in der Gesellschaft anerkannt werden. Man sagt, dass Politiker erst sensibilisiert sind, wenn ihre eigene Mutter betroffen ist. Die Menschen haben Angst vor der Krankheit, sie verweigern ihre Anerkennung. 2. spielt Würde in die Organisation von Leistungen mit hinein. Und 3. spielt Würde eine Rolle im direkten Kontakt zwischen der kranken Person und ihrem Umfeld. Die Betroffenen müssen sich gut versorgt fühlen und die Pflegekräfte müssen gesellschaftlich anerkannt werden. Momentan wird ihre Arbeit unterschätzt und sie erhalten auch keine angemessene Hilfe, sobald sie sich mit Problemen konfrontiert sehen.

J: Vielen Dank für die erfolgreiche Diskussion. Einer der Hauptpunkte der Diskussion war die Würde. Außerdem haben die Vertreter der drei Länder einige Schwierigkeiten thematisiert, vor allem den Mangel an qualifiziertem Pflegepersonal.

Session 2 Etablierung eines Pflegesystems, in dem sich die Bürger gut aufgehoben fühlen

Session 2.1 Etablierung einer sozialverträglichen Kostenteilung in der Pflege

Severine SALGADO (Referentin, Direction de la Sécurité Sociale, Ministère des solidarités, de la santé et de la famille, Frankreich)

Auch in Frankreich steigt die Zahl der Pflegebedürftigen stetig an. Zu den Herausforderungen für die Allocation personnalisée d'autonomie (APA) gehören die unzureichende Anpassung der existierenden Langzeitpflegeinstrumente an die individuellen Bedürfnisse Älterer. Auch die individuellen Programme der ambulanten Pflege sind oft nicht ausreichend, und Menschen in stationärer Pflege müssen privat sehr viel zuzahlen. 2007 hat der Staat 6,2 Milliarden Euro für Langzeitpflege ausgegeben, 4,6 Milliarden Euro für das APA Programm, 2,6 Milliarden Euro für Sozialhilfe für alte Menschen sowie 2,2 Milliarden Euro für unterschiedliche andere Programme. Dies entspricht unter einem Prozent des Brutto National Produktes.

Die Regierung beabsichtigt, das Pflegerisiko zu minimieren, aber gleichzeitig die nachhaltige Finanzierung des Systems zu gewährleisten. Unter diesen Bedingungen sollen alte Menschen so lange wie möglich ambulant versorgt werden, zugleich soll die Anzahl der Plätze in Pflegeheimen erhöht werden. Ungefähr 5.000 neue Plätze sollen jedes Jahr geschaffen werden und Pflegeheimkosten für Senioren mit einem monatlichen Einkommen unter 2.000 Euro sollen finanziell gefördert werden, um auch ihnen notwendige stationärer Pflege garantieren zu können. Um das System nachhaltig gestalten zu können, dankt man über eine Förderung privater Versicherungen zusätzlich zu der öffentlichen Sicherung nach. Arbeitnehmer sollen entlastet werden. Da die Pflegebedürftigkeit im Alter ein vorhersehbares Risiko ist, kann es im Voraus durch unterschiedliche Formen des Sparens minimiert werden. Allerdings müssen in einer privat-öffentlichen Partnerschaft zwischen Pflegeversicherern die Beurteilungskriterien harmonisiert und negative Einflüsse von außen eingedämmt werden.

YOSHINO Takashi (Director of Long-Term Care Insurance Division, Health and Welfare Bureau for the Elderly, Ministry of Health, Labor and Welfare, Japan)

Die Einführung des Langzeitpflegesystems ist nicht nur wegen der steigenden Anzahl an Pflegebedürftigen bedeutsam, sondern auch wegen des Anstiegs der absoluten Dauer der Pflegebedürftigkeit. Familien, vormals die Hauptträger der Pflegeleistungen, können diese aufgrund veränderter Familienstrukturen nur noch in sehr viel geringerem Ausmaß übernehmen. Wegen dieser Veränderungen wurde die Pflege in Japan „sozialisiert“ – sie wird nicht mehr exklusiv von der Familie, sondern vermehrt von der Gesellschaft getragen. Das neue System gründet sich auf das Sozialversicherungsprinzip, so dass eine klare Verbindung zwischen Leistungen und Kosten bestehe. Es soll durch Rehabilitationsmaßnahmen die Unabhängigkeit der Betroffenen verbessern und nicht nur die Pflege von stark pflegebedürftigen Menschen sicherstellen.

Das neue System ist benutzerfreundlicher als das vorherige, da die Betroffenen Art der Dienstleistung und Form der Unterbringung frei wählen können. Auch sind medizinische und soziale Dienstleistungen in einen ganzheitlichen, koordinierten Plan integriert. Das Feld der Anbieter hat sich diversifiziert, es können nun neben Kommunen und öffentlichen Organisationen auch gewinnorientierte Unternehmen und Konsumgenossenschaften Pflegedienstleistungen anbieten. Die Selbstbeteiligung ist unter dem neuen System für Pflegebedürftige aller Einkommen auf 10 Prozent begrenzt, einkommensschwache Senioren erhalten zusätzliche Leistungen. Die restlichen 90 Prozent werden zu je 50 Prozent aus Steuergeldern (Kommunen: 12,5 Prozent, Präfekturen: 12,5 Prozent, Staat: 25 Prozent) und Beiträgen finanziert. Alle drei Jahre werden die Pläne für Langzeitpflegedienstleistungen und Versicherungsbeiträge neu ausgehandelt.

Für die Zukunft stellt sich allerdings die Frage der nachhaltigen Finanzierung, da sich das Verhältnis von Beitragszahlern zu Anspruchsberechtigten durch die Bevölkerungsalterung verschieben wird und ohnehin nur über 40-Jährige Beiträge zahlen. Aus diesem Grund muss das Verhältnis von Beitragsbelastungen und Leistungen überarbeitet werden.

Matthias von SCHWANENFLÜGEL (Unterabteilungsleiter Pflegesicherung, Bundesministerium für Gesundheit, Deutschland)

In allen drei Ländern finden parallele Entwicklungen statt: Die Alterung der Gesellschaft beschleunigt sich, die Geburtenrate sinkt und immer mehr jüngere Menschen müssen die Leistungen für immer mehr ältere Menschen finanzieren. In Deutschland steigt der Anteil der über 60-Jährigen an der Gesamtbevölkerung von heute 24,9 Prozent auf 38,9 Prozent im Jahr 2050. Das Risiko pflegebedürftig zu werden, steigt mit dem Alter natürlich an, die konstante altersspezifische Pflegewahrscheinlichkeit zu kennen ist für ein Versicherungssystem somit essentiell. Es stellt sich in der Gesundheitspolitik die Frage, ob und wie man dieses Risiko verändern kann, zum Beispiel durch Prävention oder Rehabilitation. In der letzten Gesundheitsreform wurde ein Rechtsanspruch auf Rehabilitation eingeführt, der ohne Zweifel auch Auswirkungen auf die Pflegeversicherung haben wird. Zieht man eine Bilanz der Pflegeversicherung, so wurde eine Stärkung der ambulanten Pflege erreicht, zwei Drittel der Betroffenen werden ambulant versorgt, ein Drittel stationär. Die Sozialhilfe konnte durch die Einführung der Pflegeversicherung verringert werden. Nur noch 5 Prozent der Menschen, die zu Hause leben und 25 Prozent im stationären Bereich bekommen Sozialhilfe, um ihre Pflegeleistungen finanzieren zu können. Es konnte eine qualitätsgesicherte Infrastruktur aufgebaut werden, die durch den medizinischen Dienst der

Krankenversicherung überprüft wird. Im Bereich der Pflege wurden 300.000 neue Arbeitsplätze geschaffen.

Das deutsche System der Pflegeversicherung ist durch ihren Versicherungsaspekt und dem Umlagesystem sehr eng mit der demographischen und ökonomischen Entwicklung verknüpft. Die 1995 eingeführte Pflegeversicherung ist das jüngste Kind der sozialen Sicherungssysteme und scheint seit ihrer Einführung von der Bevölkerung gut akzeptiert zu werden. Die physischen, psychischen und finanziellen Belastungen der Pflege sollen erleichtert werden. Die Pflegeversicherung ist ein Teilleistungssystem, da sie nur einen Teil des Risikos der Pflegebedürftigkeit abdeckt. Da das System einkommensabhängig ist, findet ein sozialer Ausgleich zwischen unterschiedlichen Bevölkerungsgruppen statt. Aufgrund der Versicherungspflicht sind 70,31 Millionen Menschen in der sozialen Pflegeversicherung versichert, Besserverdienende können sich auch in der privaten Pflegepflichtversicherung versichern lassen. Die Beitragsbemessungsgrenze liegt zur Zeit bei 3.675 Euro Monatsverdienst brutto. der Beitragssatz liegt bei 1,95 Prozent des Bruttoverdienstes, Kinderlose zahlen zusätzlich den Kinderlosenbeitrag von 0,25 Prozent.

Die Beurteilung der Pflegebedürftigkeit in eine von drei Stufen wird vom medizinischen Dienst der Krankenversicherung getroffen. Gerade in Pflegestufe 1 ist in den letzten Jahren ein hoher Anstieg zu verzeichnen gewesen. Die finanziellen Leistungen der Pflegeversicherung richten sich nach Form der Pflege (ambulant oder stationär) und nach Pflegestufe. Gehen die Kosten für Pflegedienstleistungen über diesen Betrag hinaus, so sind die Restkosten vom Pflegebedürftigen zu tragen. Durch die Stärkung des ambulanten Bereichs soll dem Trend zu stationärer Versorgung entgegengewirkt werden. Die Behandlung von Demenzkranken im stationären Bereich wird durch zusätzliche finanzielle Förderung professioneller Demenzbetreuung der Pflegekassen verbessert.

Die Ausgaben der Pflegeversicherung liegen bei ungefähr 18 Milliarden Euro und nehmen jährlich um 1,2 Prozentpunkte zu. Die Ausgaben haben sich unter anderem wegen der vermehrten Aufnahme von teureren Sachleistungen im ambulanten Bereich erhöht.

Session 2.2 Maßnahmen zur Gewährleistung einer ausreichenden Zahl von gut qualifizierten Arbeitskräften in der Pflege

Maryse CHAIX (Stellvertretende Referatsleiterin, Sous-direction de l'animation territoriale et du travail social, Direction générale de l'action sociale, Ministère de l'emploi, du travail et de la cohésion sociale, Frankreich)

Im Jahr 2020 werden ungefähr 4 Millionen Menschen über 80 Jahre alt sein, 80 Prozent mehr als heute. Da in diesem Alter das Risiko der Pflegebedürftigkeit stark ansteigt, zielen Regierungspolitiken auf die Abfederung dieses Risikos durch diverse Formen personalisierter Pflegeangebote, darunter sogenannte intermediäre Formen der Pflege wie befristete Einweisung, Unterbringung in Familien oder Tagespflegeheimen. Diese unterschiedlichen Formen des Pflegeangebotes fallen unter die Kompetenz unterschiedlicher Einrichtungen, (zum Beispiel der Krankenhäuser) oder unter territoriale, private profitorientierte oder private gemeinnützige Einrichtungen. Für alle Formen der Pflege herrscht allerdings ein Arbeitskräftemangel.

Die ambulante Pflege erweise sich als immer schwieriger, nicht nur weil es mehr und mehr Pflegebedürftige gibt, sondern auch weil der Pool von Frauen über 40 Jahren, die heute einen Großteil der formellen und informellen Pflegeleistungen erbringen, in Zukunft schrumpfen wird. Teilzeitarbeitspflicht und niedrige Gehälter verstärken den Arbeitskräftemangel. Die Fluktuation im Beruf ist hoch und es gibt zunehmend Konkurrenz um Arbeitnehmer durch andere Gesundheitseinrichtungen. Heute sind ungefähr die Hälfte der 700.000 Pflegekräfte Hauspflegeleistungserbringer. Pro Jahr wird der Bedarf in der Pflege um zusätzliche 30.000 Arbeitsplätze ansteigen. Um diesen Herausforderungen zu begegnen, müssen sich Bezahlung und Qualifizierungsniveau verbessern.

Bezüglich der Qualifikationsstrukturen würde Einführung einheitlicher Ausbildungsabschlüsse, die zur Arbeit in unterschiedlichen sozialen und medizinisch-sozialen Sektoren befähigen, horizontale professionelle Mobilität zwischen Bereichen, aber auch vertikale Mobilität durch Weiterqualifizierung fördern. Ferner sind eine Anhebung der Arbeitszeit und die Abschaffung erzwungener Teilzeitarbeit denkbar, wie auch eine Diversifizierung der Aktivitäten in der ambulanten Pflege. Sollten Strukturen gesetzlich definiert werden können, ermöglicht dies die Mobilität der Arbeitnehmer, erlaubt die Angleichung von Qualifikationen und einen höheren Umfang von Human Resource Management. Um die Attraktivität der Pflegeberufe zu steigern, gibt momentan verschiedene Kommunikationskampagnen. In einem erfolgreichen Pilotprojekt wurde die Zusammenarbeit zwischen Staat, Regionen und Sozialpartnern bei der Rekrutierung und Qualifizierung von Pflegepersonal verbessert.

Andreas KRÖGER (Geschäftsführer, AHK Pflegeteam GmbH, Berlin, Deutschland)

In den kommenden Jahre wird der Personalbedarf im Pflegebereich wachsen, da sich die Anzahl der Pflegebedürftigen bis 2050 verdoppeln wird. Momentan werden gut zwei Drittel der Betroffenen zu Hause gepflegt und nicht in Pflegeheimen, nur ein Drittel der zu Hause gepflegten Betroffenen werden durch Pflegedienste betreut. Durch die bevorstehenden demographischen Veränderungen wird der zusätzliche Pflegebedarf allerdings nicht mehr nur durch die Pflegeanstrengungen Angehöriger kompensiert werden können. Man befürchtet einen Anstieg der Schwarzarbeit. Um ein ausreichendes Arbeitskräfteangebot sicherzustellen, muss man sowohl Strategien der Personalakquise entwickeln wie auch dafür, dass das Personal bleibt. Was die Personalakquise angehe, so sollen möglichst viele Bewerber durch ansprechende Anzeigen, verbesserte Vermittlung durch Job Center, Kooperation mit anderen Pflegeanbietern und Imagegewinn durch öffentliche Maßnahmen erreicht werden.

Innerbetriebliche Fluktuation, aber auch Fluktuation bedingt durch Betriebswechsel, gefährden die kontinuierliche pflegerische Versorgung. Um die Personalfluktuation im Sozialbereich, die ungefähr dreimal höher ist als in anderen Dienstleistungsbereichen, zu reduzieren, wurden folgende Vorschläge gemacht. Um die Arbeitsbedingungen zu sanieren sollten zusätzliche Leistungen und Prämien geboten werden, Einarbeitungsstandards müssen verbessert, kontinuierliche Mitarbeitergespräche durchgeführt und die Zusammenarbeit mit der Mitarbeitervertretung muss verstärkt werden. Auch eine Verbesserung der persönlichen Entwicklungsmöglichkeiten für Mitarbeiter kann die Fluktuation reduzieren. Dem Problem der begrenzten Aufstiegsmöglichkeiten kann man durch Fort- und Weiterbildung sowie die Schaffung interner Karrieren durch die Einrichtung zusätzlicher Hierarchieebenen begegnen.

HABU Eiji (Director, Promotion Divison, Health and Welfare Bureau for the Elderly, Ministry of Health, Labor and Welfare, Japan)

Ähnlich wie in Deutschland und Frankreich leiden die Pflegeberufe in Japan an hoher Fluktuation (22 Prozent) aufgrund niedriger Löhne und ungünstiger Arbeitszeiten. Der Pflegeberuf wird hauptsächlich von Frauen (80 Prozent) und auf Teilzeitbasis (80 Prozent) ausgeübt. Es gibt einen Mangel an Pflegeberatern (*care manager*), ausgebildeten Pflegekräften (*certified care workers*) und „Home Helps“. Im Bereich der stationären Versorgung dominieren Vollzeitanstellungen, wohingegen in der ambulanten Pflege hauptsächlich Teilzeitkräfte eingesetzt werden.

Durch den fortschreitenden demographischen Wandel kommt es zu wachsendem Bedarf an Pflegekräften: Seit Inkraftsetzung der Pflegeversicherung im Jahr 2000 stieg die Anzahl Pflegebedürftigen, die in eine Pflegestufe eingruppiert sind, um 139 Prozent auf 3.560.000 Personen. Innerhalb dieser Entwicklung ist ein Anstieg um 165 Prozent in der Bereitstellung von ambulanten Dienstleistungen zu verzeichnen und ein Anstieg von 56 Prozent in stationären Dienstleistungen. Zwischen den beiden Formen ambulante und stationäre Pflege bestehen unterschiedliche institutionelle Formen, unter anderem Tagesdienstleistungen, Kurzzeitdienstleistungen und Kurzzeitpflege in Heimen.

75 Prozent der Sozialwesens- und Pflegeangestellten verlassen das Berufsfeld nach drei Jahren. Um dieser hohen Fluktuation entgegenzuwirken, wurden Beratungsstellen für Angestellte und auch Weiterbildungsalternativen geschaffen. Außerdem hat das Parlament 2008 ein Gesetz zur Besseren Behandlung von professionellen Pflegern, um eine sichere Quelle von Arbeitskräften zu garantieren verabschiedet. Weitere Ansatzpunkte, um das Arbeitskräfteangebot zu verbessern, sind z. B. eine Öffnung der Pflegeberuf für Arbeitssuchende, die noch keine Erfahrung in der Pflege haben und in das Berufsfeld eingeführt werden. Um der Unzufriedenheit der Beschäftigten mit ihrem Arbeitsumfeld zu

begegnen, sollen Gehalt und andere Arbeitsbedingungen verbessert werden. 2009 wurde der Lohn von Angestellten in Pflegeberufen um 3 Prozent erhöht.

Diskussion zu Session 2

Moderation: Stephane LEBOULER (Leiter der Forschungsgruppe, Abteilung für Forschung, Studien, Auswertung und Statistik, Ministère des solidarités, de la santé et de la famille, Frankreich)

F: Im Zentrum Ihrer Präsentation ging es um die Vergütung von Pflegepersonal. Das wurde klarer herausgestellt als in der 1. Session. Die Frage, die uns nun interessiert, ist: Kann man einer Aufwertung der Vergütung im Pflegesektor entkommen?

In Frankreich wurde für ambulante Pflegeleistungen eine Steigerung von 25 % durchgesetzt. Die Aufwertungen in anderen Bereichen sind nicht so stark ausgefallen, liegen aber dennoch über dem Inflationsniveau. Trotzdem gibt es ein Personalproblem, da bei der Tarifverhandlung von 2002 einige Dienstleister beschlossen haben, aufgrund der Kostensteigerung Personal abzubauen. In den Pflegeheimen dagegen gibt es Tarifverträge, aber keinen Personalabbau. Doch die Frage der Attraktivität der Pflegeberufe geht über die Bezahlung hinaus.

D: Die alleinige Verbesserung der Rahmenbedingungen für Pflegekräfte, zum Beispiel durch Tariferhöhungen, reicht nicht aus, um die Attraktivität der Berufe aufzuwerten. Professionalisierungsmaßnahmen hingegen erscheinen der Robert-Bosch-Stiftung sinnvoll. Die Wertschätzung der Pflegekräfte wird zum Beispiel durch das Programm „Pflege braucht Eliten“ verbessert. Es geht bei der Professionalisierung der Pflege nicht nur um die Weiterbildung der Pflegekräfte, sondern auch darum, älter werdende Pflegekräfte gesund zu erhalten. Weiterhin brauchen die Pflegeberufe eine größere innere Differenzierung der Profile, um den Markt von potentiellen Pflegern zu vergrößern. Da ein Großteil aller Pflegenden Frauen sind, müssen flexible Arbeitszeitmodelle angeboten werden, damit die Frauen sowohl die professionelle Pflege wie auch die Versorgung ihrer eigenen Familie gewährleisten können.

D: Für die Pflegekräfte ist nicht nur die schlechte Entlohnung ein Problem, sondern vor allem die an den Personalabbau gekoppelte erhebliche Verdichtung der Arbeitszeit. Zeitsouveränität, im Sinne sowohl von Arbeitszeitgestaltung wie auch der eigenen Lebensplanung, wird zum Problem. Auch der kontinuierliche Ausbau von Heimen ist langfristig nicht tragbar, da die Personalkosten nicht bezahlbar sein werden. Nur um die bald pflegebedürftigen Menschen zu versorgen, müsste in manchen Bundesländern jeder zweite Hauptschüler in die Pflege gehen. Die einzige „nachwachsende“ Ressource den Freiwilligensurveys zufolge sind die über 55-Jährigen. Aus diesem Grund muss über Personalmix nachgedacht werden. Grundlegend muss man sich auch über die gewünschte Form der Gesellschaftspolitik verständigen und darf sich nicht nur auf die Sozialpolitik konzentrieren.

D: In Deutschland wurden einige Maßnahmen ergriffen, um der schlechten Bezahlung von Pflegekräften entgegenzuwirken. Seit der letzten Pflegereform müssen Pflegekräfte nach ortsüblicher Vergütung bezahlt werden, ferner wird ein staatlicher Mindestlohn für den Pflegebereich festgelegt werden.

F: Zusammenfassend kann man sagen, dass jede Diskussion über die Attraktivität der Pflegeberufe über die Frage der Entlohnung hinausgehen muss. Auch muss genauer gemessen werden, ob ambulante oder stationäre Pflege mehr Kosten verursachen.

Session 3: Definition des Pflegebedürftigkeitsbegriffs und Methoden der Beurteilung von Pflegebedürftigkeit

TSUTSUI Takako (Chief, Administration, Department of Health and Social Services, National Institute of Public Health, Japan)

Seit Einführung der Pflegeversicherung im Jahr 2000 ist die Anzahl der leistungsberechtigten Pflegebedürftigen in Japan von 2.562.000 Personen auf 4.401.000 gestiegen. Die Pflegebedürftigkeit ist in fünf Pflegebedürftigkeitsstufen und zwei Hilfebedürftigkeitsstufen eingeteilt. Die Hilfebedürftigkeitsstufen zielen im Gegensatz zu den Pflegestufen auf Rehabilitation und Prävention. Die Anteile der Pflegebedürftigen in den jeweiligen Pflegestufen betragen: 11 Prozent in Pflegestufe 5 (höchste Stufe); 14 Prozent in Pflegestufe 4; 18 Prozent in Pflegestufe 3; 19 Prozent in Pflegestufe 2; 17 Prozent in Pflegestufe 1; 11 Prozent in Hilfebedürftigkeitsstufe 2 und letztlich 9 Prozent in Hilfebedürftigkeitsstufe 1.

Finanzielle Leistungen, die an empfangsberechtigte Betroffene für ambulante Pflege gezahlt werden, variieren zwischen 382 Euro monatlich für die Hilfebedürftigkeitsstufe 1, und 2.756 Euro monatlich für die Pflegebedürftigkeitsstufe 5. Pflegeberater (care manager) übernehmen die Aufgabe der Begutachtung und der Einstufung in Pflegestufen. Nach einem Besuch bei der pflegebedürftigen Person und mit Hilfe eines standardisierten, computerunterstützten Verfahrens, in dem die Person nach fünf unterschiedlichen Kriterien bewertet wird (physische und mentale Statuskriterien), fällt das zuständige kommunale Gremium die letzte Entscheidung zur Einstufung der Person. In einem Forschungsprojekt wurden über mehrere Monate hinweg Tests ausgeführt, die die Objektivität des Prozesses der Begutachtung und Einstufung durch teilnehmende Beobachtung bei ambulanten Pflegedienstleistungen messen und damit diesen Prozess verbessern sollen. Die Kosten für Begutachtung und Einstufung belaufen sich auf etwa 61,1 Milliarden Yen (ca. 457 Mio. Euro) jährlich, was ungefähr einem Prozent des Budgets für die Langzeitpflege entspreche.

Emilie DELPIT (Projektreferentin, Projet chargée de la qualité et de la prospective, CSNA – Caisse nationale pour solidarité l'autonomie, Frankreich)

Pflegebedürftige Menschen über sechzig Jahre erhalten von den französischen Gemeinden seit 2001 finanzielle Unterstützung durch das Programm „Assurance personnalisée d'autonomie“ (APA). Das Programm wurde geschaffen, um es Menschen mit körperlichem oder mentalem Autonomieverlust zu ermöglichen, unterschiedliche Hilfen zur Wiedererlangung ihrer Autonomie einzukaufen. Im Jahr 2008 gab es über eine Million Anspruchsberechtigte, von denen sich 62 Prozent in ambulanter und 38 Prozent in stationärer Pflege befanden. Die finanzielle Leistung der APA bemisst sich direkt am individuellen Bedürfnis der betroffenen Person, feststehende Leistungsstufen gibt es nicht. Der Autonomieverlust von Individuen wird durch das Evaluationsraster AGGIR bestimmt, das Personen je nach Pflegebedürftigkeit in sechs Gruppen aufteilt. Personen in den Gruppen GIR 1 bis 4 haben Anspruch auf finanzielle Unterstützung, Personen in den Gruppen GIR 5 und 6 haben keinen Anspruch. Sobald eine Leistung bewilligt ist, entwickelt ein Team von Gemeindeangestellten nach einem Hausbesuch einen Pflegeplan, in dem die Details der Leistungen festgelegt werden.

Wie verlässlich sind die Messinstrumente? Wird eine Person in die Stufe GIR 4 (Anspruch auf APA) anstelle in die Stufe GIR 5 (keinen Anspruch auf APA) eingestuft, so wirkt sich dies direkt auf die Gesamtausgaben des Programms aus. Die Verlässlichkeit der Messinstrumente ist sicherzustellen, um die Gleichbehandlung aller Bürger zu gewährleisten. Das AGGIR-Raster ist in der Vergangenheit kritisiert worden, da es neurodegenerative Krankheiten wie Alzheimer nur unzulänglich erfasst. Aus diesen Gründen wurde 2001 ein wissenschaftlicher Ausschuss gebildet, der 2008 einen neuen Leitfaden zum sachgemäßen Ausfüllen des Rasters veröffentlichte. Außerdem wird bemängelt, dass das AGGIR-Raster zwar die Anspruchsberechtigung der Person auf finanzielle Unterstützung misst, jedoch irrelevant für die Entwicklung von Pflegeplänen ist. Die französische Regierung berät über die Nutzung privater Zusatzpflegeversicherungen, allerdings wenden die meisten Zusatzversicherer eine modifizierte und somit nicht vergleichbare Version des AGGIR-Rasters an. Beurteilungsraster von öffentlichen und privaten Systemen sollen harmonisiert werden. Heute bestehen ungefähr drei Millionen Verträge mit privaten Versicherern.

Jürgen GOHDE (Vorstandsvorsitzender des Kuratoriums Deutsche Altershilfe und Vorsitzender des Beirats zur Überprüfung des Pflegebedürftigkeitsbegriffs, Deutschland)

Im Rahmen des Pflegeweiterentwicklungsgesetzes wurden Pflegestützpunkte eingeführt, in denen Care und Case Management verankert sind. Ein wichtiger Aspekt für die Zukunft ist die Neudefinition des Pflegebedürftigkeitsbegriffs, da die geltende sich zu stark an den Verrichtungen des täglichen Lebens orientiert und somit Menschen mit kognitiven oder kommunikativen Beeinträchtigungen benachteiligt. Ein weiterer Schritt ist die nachhaltige Finanzierung des Systems. Zum Aspekt der Definitionsfrage wurde ein Beirat zur Überprüfung des Pflegebedürftigkeitsbegriffs eingesetzt. Der Beirat bestand aus Vertretern der Leistungsträger und Leistungserbringer, der sozialen Pflegekassen und privaten Kassen, der Betroffenenverbände und der Pflegewissenschaft, Wirtschafts- und Rechtswissenschaften, der Länder und Kommunen und der Arbeitgeber und Gewerkschaften. Der Auftrag des Gesundheitsministeriums an den Beirat lautete, den geltenden Begriff der Pflegebedürftigkeit zu überprüfen, ein Begutachtungsverfahren für die Feststellung der Pflegebedürftigkeit zu entwickeln, wissenschaftlich fundierte Vorschläge und Handlungsoptionen zu erarbeiten und deren finanzielle Auswirkungen zu klären. Man entschied sich gegen bestehende Definitionen aus dem Ausland, die Neudefinition wurde in enger Verbindung mit der

Praxis (Medizinischer Dienst, pflegewissenschaftliche Institute) entwickelt und der Beirat legte ein einstimmiges Ergebnis zu der Neudefinition vor.

Die Definition des neuen Pflegebedürftigkeitsbegriffs beziehe sich im Kern, ähnlich wie in Frankreich, auf die Beeinträchtigung der Selbständigkeit des Menschen und nicht mehr auf den Zeitaufwand der Pflegeleistungen. Sechs Assessmentmodule werden der Beurteilung zugrunde gelegt: Mobilität, kognitive und kommunikative Fähigkeiten, Verhaltensweisen und psychische Problemlagen, Selbstversorgung, Umgang mit krankheits- und therapiebedingten Anforderungen und die Möglichkeiten der Gestaltung des Alltagslebens. Im Gegensatz zur bisherigen Beurteilung der Pflegebedürftigkeit sind außerhäusliche Aktivitäten und Haushaltsführung nicht mehr Bestand der Kriterien, da man durch ihre Erfassung keine zusätzlichen Argumente für die Bewertung der Selbständigkeit erhält. Wie in Japan wird zwischen Pflegebedürftigkeit und Hilfebedürftigkeit unterschieden. Anders als in Frankreich gibt es keine Bedarfsstufe ohne Leistung. Teilweise sind die Leistungen in den unteren Bedarfsstufen nicht hoch, doch ermöglichen sie Prävention und Beratung.

Die Evaluierung der neuen Messinstrumente ist positiv verlaufen. Kognitive Beeinträchtigungen werden nun besser erfasst, dies aber nicht auf Kosten der schlechteren Abbildung von körperlichen Beeinträchtigungen. Das Instrument ist praxistauglich, zuverlässig, nachvollziehbar und geeignet für eine präzise Pflegeplanung und Pflegeberichterstattung. Siebenundfünfzig Prozent aller Deutschen haben Angst, pflegebedürftig zu werden. Dabei spielt die Furcht vor Abhängigkeit, würdeloser Behandlung und Einsamkeit sicher eine wichtige Rolle. Der neue Pflegebegriff zusammen mit einer veränderten Praxis kann helfen, die Angst vor Alter und der Pflegebedürftigkeit zu mindern und Vertrauen in die Hilfsangebote zu schaffen. Eine verbleibende Herausforderung ist die Verbesserung der Schnittstellen von Pflegedienstleistungen zwischen Pflegeversicherung, Sozialhilfe und Eingliederungshilfe.

Diskussion zu Session 3

Moderation: SUZUKI Yasuhiro (Director, Division of the Health for the Elderly, Health and Welfare Bureau for the Elderly, Ministry of Health, Labor and Welfare)

J: Die Struktur des Langzeitpflegesystems unterscheidet sich zum Beispiel in der Dimension der Finanzierung (Steuer- oder Beitragsfinanzierung) in den drei Ländern sehr stark. Folglich ist es erstaunlich, dass es bei der Evaluierung der Pflegebedürftigkeit große Ähnlichkeiten gibt. Aus den Diskussionen über die Neudefinition des Pflegebedürftigkeitsbegriffes konnten wir lernen, dass es immer einer Balance bedarf zwischen Kostenbetrachtung und der Objektivität des Assessments. Deshalb würde ich gerne als Anfangspunkt für die Diskussion die Frage stellen, wie man in den unterschiedlichen Ländern über die Neudefinition des Pflegebedürftigkeitsbegriffes nachdenkt.

F: In Frankreich gibt es separate Programme zur Evaluierung der Pflegebedürftigkeit von behinderten und alten Menschen. Manche Akteure heben hervor, dass die Evaluierungsmethode für behinderte Menschen sehr viel passgenauer sei als die für Ältere. Momentan wird über eine Zusammenführung beider Methoden nachgedacht, allerdings widersetzen sich die Kommunen, die die Evaluierung durchführen, dieser Idee, da eine solche Veränderung deutliche Mehrarbeit für sie bedeuten würde. Außerdem bekommen in Frankreich alte Menschen im Gegensatz zu Behinderten gedeckelte Leistungen, das heißt, dass bei der Evaluierung der Pflegebedürftigkeit die technischen oder wohnungsbautechnischen Bedürfnisse der Älteren oft gar nicht beurteilt werden, weil die Erhebenden ohnehin wissen, dass die staatliche Leistung für nicht viel mehr als für die Finanzierung einer Haushaltshilfe reichen wird. Man sollte trotz Deckelung versuchen, die diversen Bedürfnisse der alten Menschen besser abzubilden.

J: In Japan unterscheidet man wie in Frankreich zwischen Behinderten und alten Menschen. Werden in Deutschland Behinderte und Alte in der Evaluierung zusammengefasst?

D: Zuerst sollte erwähnt werden, dass der Beirat einstimmig der Meinung war, dass die Pflegekosten weiterhin solidarisch finanziert werden sollen. In einem Kontext begrenzter Ressourcen muss die demographische Entwicklung in Mehrkosten abgebildet und gesellschaftlich getragen werden. In Deutschland wird aufgrund des Sachleistungsprinzips die stationäre Hilfe strukturell besser bewertet als die ambulante. Ein dem französischen System ähnelndes Geldleistungssystem existiert nicht, was in Bezug auf die Behindertenhilfe ein Problem sein könnte, da die Eingliederungshilfe aus der Sozialhilfe und somit aus der kommunalen Zuständigkeit bezahlt wird. Nach Paragraph 43a des SGB XI werden von der Pflegeversicherung monatlich 10 Prozent, aber nicht mehr als 256 €, als Ausgleich an die Sozialhilfeträger bezahlt und wird den Behinderten so symbolisch ein Zugang zur Pflegeversicherung gewährt, aber die wahren Kosten liegen sehr viel höher. Wendet man nun das gleiche Assessment auf Behinderte wie auf Alte an, so hat man möglicherweise ein verfassungsrechtliches Diskriminierungsproblem. Soweit allerdings gibt es keine Bedenken gegen die Pauschale, da das höchste deutsche Gericht in dieser Frage Verfassungskonformität festgestellt hat. Unsere Aufgabe ist es, keinen rein technischen Austausch von Ressourcen durchzuführen, sondern stattdessen die Leistungen für die Betroffenen zu verbessern.

J: Eine Frage an die japanische Seite, wie sollen Auswahlkriterien und die Bewertung der Bedürfnisse in Zukunft angepasst werden?

J: Den für Japan wichtigsten Punkt in der Anpassung des Evaluierungssystems haben wir bereits realisiert, nämlich die Verständigung darüber, welche Art und wie viel Pflege man bereitstellen möchte. Wir haben lange daran gearbeitet, objektive Kriterien der Beurteilung zu schaffen. Durch genau messbare Definitionen gibt man der Bevölkerung ein Grundvokabular, das ihr ermöglicht, mit der Situation umzugehen. Unsere Spezialisten können genau sagen, wie lange bestimmte Pflegeleistungen dauern und welche negativen Konsequenzen entstehen, wenn bestimmte Pflegeleistungen nicht zur Verfügung gestellt werden. Noch findet die Evaluierung von Behinderten und Alten in separaten Systemen statt, aber wir hoffen, den Inhalt der Messbögen in Zukunft so zu standardisieren, dass das gleiche Programm angewandt werden kann. Weiterhin wollen wir die Dienstleistungen personenbezogener gestalten.

D: Ich würde gerne den zuletzt genannten Punkt aus der Sicht der Betroffenen aufgreifen, vor allem in einem Kontext der begrenzten Ressourcen. Natürlich gibt es immer mehr Bedürfnisse und Wünsche als realisierbare Dienstleistungen, aber es ist wichtig, dass man auf subjektive Wahrnehmungen der Benachteiligung eingeht und die Angebote individuell und passgenau gestaltet.

J: Aufgrund der Diversität der Leistungen, die Pflegebedürftige dieser Tage erhalten, versuchen wir festzustellen, wie viel Pflege die Betroffenen in bestimmten Pflegestufen bei ambulanter und bei stationärer Pflege brauchen. In Japan sind die Systeme der Definition der Pflegebedürftigkeit und des Care Management unabhängig voneinander.

D: Es geht hier um einen transparenten und trennscharfen Qualitätssicherungsprozess. Aus diesem Grund ist der über einen langen Zeitraum diskutierte Schritt des Care Managements in den Pflegestützpunkten ein Ansatz zu einer verbesserten Versorgungsstruktur. Um die Forderung nach transparenter Bereitstellung von zielgenauen Leistungen erfüllen zu können, müssen die Rollen klar definiert und geschieden werden. Wir sind an dieser Stelle sehr dankbar für die japanischen Erfahrungen.

J: Vielen Dank für den Austausch. Es gibt viele Unterschiede in den drei Ländern, zum Beispiel wie man über die Pflege und über die Rolle der Familie nachdenkt. Bei der Festlegung des Pflegebedürftigkeitsbedarfs gibt es allerdings auch viele Gemeinsamkeiten. Wir haben Erfolge und Misserfolge aus den Berichten über die Erfahrungen in den drei Ländern verfolgen können und hoffen, aus den Fehlern lernen zu können. Vielen Dank für die konstruktive Diskussion.

Session 4: Bereitstellung angemessener Dienstleistungen für ältere Mitbürger

4.1. Integration der Pflege in die Kommunen

Almuth SATRAPA-SCHILL (Bereichsleiterin Gesundheit und Humanitäre Hilfe, Robert Bosch Stiftung, Deutschland)

Die Robert Bosch Stiftung beschäftigt sich seit über 40 Jahren mit Fragen der Gesundheit und Bildung im europäischen und transatlantischen Kontext. Schwerpunkte der Stiftungsarbeit in diesem Feld sind Ausbildungskonzepte, Pflege und Gesundheit und die Bewältigung chronischer Krankheiten. Man muss hinsichtlich des demographischen Wandels sowohl die aktive wie auch die pflegebedürftige Seite des Alterns sehen, da beide Sichtweisen für die Bereitstellung angemessener Dienstleistungen für ältere Menschen eine wichtige Rolle spielen. Chronische Krankheiten und Demenz werden weiter zunehmen, deshalb müssen Möglichkeiten des würdevollen Umgangs mit der Multimorbidität und der letzten Altersphase vor dem Tod gefunden werden. Man darf nicht nur über alte Menschen sprechen, sondern muss sie in die Diskussionen einbeziehen. Umfragen zufolge ziehen ältere Menschen ambulante Pflege in ihrem gewohnten Wohnumfeld einem Heimaufenthalt vor. Wie Menschen alt werden wird sich in Zukunft sehr viel individueller und differenzierter gestalten. Pflegende Familienangehörige sollen unterstützt und individuelle Vorsorge, Prävention und Rehabilitation stärker gefördert werden.

Durch den Ausbau des Ehrenamtes in der Pflege kann die Last der Pflege besser verteilt werden. Ehrenamtliche Helfer oder Assistenten könnten professionelle Pflegekräfte und Familienangehörige unterstützen. Pflegelösungen sollen nicht nur bessere Lebensqualität bieten, sondern auch ökonomisch interessant sein, was durch die Einbeziehung des Ehrenamtes erreicht werden kann. Da die Pflege auf Gemeindeebene stattfindet, soll sie hier auch reguliert werden. Pflegeleistungen können durch bestehende Netzwerke auf kommunaler Ebene schnell und flexibel erbracht werden. Pflegestützpunkte, durch die die ambulante Pflege verbessert wird, sind deshalb im Gemeindeumfeld platziert. Sie bieten individuelles Fallmanagement und Zugang zu Selbsthilfegruppen, vermitteln aber auch Hilfs- und Unterstützungsangebote. Die Probleme im bestehenden Programm liegen vor allem in der mangelnden Integration von Palliativpflege und in der Pflege Demenzkranker. Hierzu gibt es auf kommunaler Ebene allerdings viele Pilotprojekte, die durch die Integration von professionellen und zivilgesellschaftlichen Aktivitäten bereits jetzt die Pflegesituation verbessern. Um ein breiteres Bewusstsein über Demenzkrankheiten zu schaffen, wird das Thema „Demenz in der Kommune“ bewusst in Kleinprojekten auf kommunaler Ebene bearbeitet. Demenz ist nicht nur ein medizinisches und pflegerisches Problem, sondern eine gesamtgesellschaftliche Aufgabe. Weiterbildungsprogramme zu den Besonderheiten von Demenzkrankheiten müssen für professionelle Pflegekräfte entwickelt und angeboten werden.

Bernhard GARRO (Stellvertretender Referatsleiter, L'Action Sociale, Direction de l'Action Sociale,de l'enfance et de la santé, Paris, Frankreich)

Unter dem traditionellen Pflegesystem wurden vor allem einkommensschwache ältere Menschen finanziell durch die Sozialhilfe unterstützt und in stationären Einrichtungen wie Pflegeheimen oder Établissements d'hébergement pour personnes âgées dépendantes (EHPAD) untergebracht. Unter dem neuen System gibt es Leistungen zur Erhaltung der Autonomie (Allocation personnalisée d'autonomie – APA seit 2001, Prestation de compensation du handicap – PCH seit 2005) und Evaluierungsmechanismen sowie neue Bestrebungen in Richtung Koordinierung und Netzwerke. Vor allem aufgrund der vielen institutionellen Akteure ist eine bessere Koordinierung der Programme und Leistungen erforderlich. Paris ist als Beispiel interessant, da die Stadt mit einem Anteil von zwanzig Prozent alter Menschen eine verhältnismäßig „alte" Stadt ist, die außerdem in Arm und Reich polarisiert ist. Es ist schwierig, die Wohnsituation Älterer in Paris zu verbessern oder mehr stationäre Plätze zu schaffen, da Wohnraum sehr teuer ist.

Paris ist gleichzeitig Kommune und Departement und hat somit einen ungewöhnlichen Status, der besonders bei der Koordinierung der Dienstleistungen ins Gewicht fällt. Die Departements intervenieren klassischerweise in den Pflegebereich durch Kontrolle der stationären Einrichtungen und der stationären sowie ambulanten Dienstleistungen; dabei arbeiten sie mit der Zentralregierung zusammen. Die regionalen und zentralen Gesundheitsversicherungsdienstleister arbeiten mit den Departements zusammen, um medizinische Leistungen zu kontrollieren und zu finanzieren. Die Städte schließlich sind für die Organisation lokaler Unterstützungs- und Präventionsdienstleistungen verantwortlich. Um die Koordinierung der unterschiedlichen Akteure auf den verschiedenen Hierarchieebenen zu vereinfachen, wird im Jahre 2010 eine einzige regionale Koordinationsstelle (ARS) für medizinische wie auch pflegerische Aufgaben eingerichtet.

Im Jahr 2001 wurde die APA eingeführt, die von den Departements vergeben und evaluiert wird. Um die institutionelle Koordination zwischen Departement und Kommune zu vereinfachen, wurde die regionale medizinisch-soziale Koordination geschaffen, die den Staat vertraglich mit dem Departement verbindet. Um die unterschiedlichen Akteure innerhalb des Departements zu koordinieren wurden Beratungsstellen eingeführt; die Zusammenarbeit der unterschiedlichen Einrichtungen wurde vertraglich geregelt, um die Transparenz der Leistungen und Kosten zu gewährleisten. Die Koordinierung der Maßnahmen der Departements wird sich stärker auf die Pflege selbst konzentrieren. Lokale Informationsstellen, von denen es in Paris bereits 15 in Paris gibt, sollen Information und Koordination medizinischer sowie pflegerischer gerontologischer Dienstleistungen übernehmen. So gesehen stellen sie eine einfache Version des Case Managers dar. Diese Informationsstellen werden, auch wenn sie in Kooperation mit den „Maisons pour l'autonomie et l'intégration des malades d'Alzheimer" (MAIA) betrieben werden, nicht nur Demenzkranken zugute kommen, sondern allen Alten und Behinderten berücksichtigen. Momentan läuft im zwanzigsten Arrondissement von Paris ein Pilotprojekt zur lokalen Koordinierung sozialer und gesundheitlicher Dienstleistungen durch diese Zentren.

TAKAHASHI Hiroshi (Professor, Rikkyo University, Japan)

Vor der Einführung der Pflegeversicherung wurden einkommensschwache pflegebedürftige ältere Menschen durch das Gesundheitssystem und durch ein separates Wohlfahrtssystem für ältere Menschen versorgt. Da diese Leistungen auf einkommensschwache Senioren begrenzt waren, wurden ältere Pflegebedürftige mittleren Einkommens in Krankenhäusern für Alte gepflegt, eine auf Dauer finanziell untragbare Situation. Seit den 1970er Jahren wurden ambulante Hilfen in Form von „Home Help Services" als öffentliche Dienstleistung institutionalisiert. Seit der Implementierung des Pflegeversicherungsgesetzes von 2000 werden die vorher zumeist in Einrichtungen erbrachten Leistungen nun auch ambulant erbracht. Außerdem werden ehrenamtliche Aktivitäten in der Nachbarschaft zur Pflege älterer Menschen von der Regierung durch die Implementierung eines Gesetzes zur Förderung von gemeinnützigen Organisationen gefördert.

Um die Versorgung innerhalb des gewohnten Lebensbereiches zu verstärken, wurden bereits vor der Einrichtung der Pflegeversicherung Schritte eingeleitet, um das existierende System der ambulanten Pflegedienstleistungssysteme (formal in-home care service systems) zu verbessern und weitere Systeme aufzubauen. Ein weiterer Schritt war die Förderung ehrenamtlicher Dienstleistungen in der Nachbarschaft. Um die Koordinierung professioneller und ehrenamtlicher Pflegedienstleistungen zu verbessern, fördert die Regierung seit den 1990er Jahren durch Subventionen Organisationen zur Koordinierung. Im Pflegeversicherungssystem von 2000 hat die Förderung ambulanter Pflegeleistungen Priorität und Care-Management-Zentren wurden eingerichtet. Die Arbeit der staatlich ausgebildeten Care Manager besteht darin, individuell angepasste Pflegebetreuungspläne für die einzelnen Pflegebedürftigen zu erstellen. Die Care Manager werden inzwischen auch von Krankenhäusern und Einrichtungen zur Erstellung von Betreuungsplänen und deren effizienter Umsetzung eingestellt.

Geschätzte Veränderungen der Anzahl von alleinlebenden pflegebedürftigen Älteren, der Anstieg von Demenzerkrankungen und höhere Kosten für stationäre gegenüber ambulanter Pflege haben dazu geführt, dass in der Reform des Pflegeversicherungsgesetzes von 2005 „Community Comprehensive Support Centers" (flächendeckende kommunale Pflegeunterstützungszentren) gegründet wurden. Drei Prozent der finanziellen Ressourcen, die für die Bereitstellung von Dienstleistungen vorgesehen waren, wurden für die Einrichtung dieser Zentren bereitgestellt. Dies führte dazu, dass im Jahr 2006 bereits 90 Prozent der Kommunen flächendeckende kommunale Pflegeunterstützungszentren aufgebaut hatten. Diese Zentren werden von Care Managern koordiniert, sie beraten Betroffenen über die für sie erhältlichen Dienstleistungen oder über Präventionsmaßnahmen, informieren zu Problemen, die nicht unter das Pflegeversicherungsgesetz fallen, wie zum Beispiel die Misshandlung von alten Menschen etc. Zu Anfang konzentrierten sich die Zentren mehr auf Präventionsarbeit, nun liegt das Augenmerk eher auf Management- und Koordinierungsaktivitäten.

Vor allem in städtischen Gebieten ist ausreichende Pflege ein Thema, da durch die hohen Immobilienkosten weniger Pflegeeinrichtungen als in ländlichen Gegenden geschaffen werden können. Deshalb hat die Förderung ambulanter Pflege gerade in den Städten Priorität.

Das flächendeckende kommunale Pflegesystem besteht aus vier Strategien:

1. Zusammenarbeit von verschiedenen Spezialisten auf den Gebieten Gesundheit, Wohlfahrt und medizinische Pflege und deren Koordinierung mit Ehrenamtlichen.
2. Sicherung durchgehender Langzeitpflege und ambulanter Palliativpflege. Es wird eine Kombination von Dienstleistungen auf der Basis der Langzeitpflegeversicherung und medizinischer Versicherung angestrebt.
3. Gewährleistung der Kontinuität der Pflege zwischen den Pflegestufen und unterschiedlichen institutionellen Einrichtungen.
4. Vorhandensein flächendeckender Pflege.

Das integrierte Pflegesystem soll auch eine bessere Integration stationärer Einrichtungen in die Gemeinde, in der der Kranke lebt, gewährleisten, unter anderem durch die Dezentralisierung von Pflegeleistungen. Dieses System bietet eine Chance für die bessere Versorgung von Demenzkranken, da spezialisierte und auf individuelle Bedürfnisse abgestimmte Dienstleistungen angeboten werden können und die Gemeinde für die besonderen Umstände Demenzkranker sensibilisiert wird.

4.2 Wohnen und Einrichtungen für ältere Mitbürger

Rainer BRÜCKERS (Bundesvorsitzender der Arbeiterwohlfahrt AWO, Deutschland)

Die Arbeiterwohlfahrt erbringt seit über 40 Jahren soziale Dienstleistungen für junge und alte Menschen. Doch gerade zivilgesellschaftliche Akteure sind ökonomischen und rechtlichen Vorgaben unterworfen, die eine ganzheitliche Betrachtung der Betroffenen erschweren. Die Einführung der Pflegeversicherung ist politisch auf das Bestreben, Ausgaben für Sozialhilfe in den Kommunen zu senken, zurückzuführen. Die Verdopplung der ambulanten Dienste scheint dem Grundsatz „ambulant vor stationär“ zu folgen, dennoch wurden stationäre Pflegeeinrichtungen weiter ausgebaut. Eine Herausforderung für stationäre und ambulante Pflegedienste besteht in der steigenden Anzahl Demenzkranker, da hier notwendige Leistungen unter dem traditionellen körperlich-funktionalen Pflegebegriff nicht erstattet werden. Die Debatte über die Veränderung des

Pflegebedürftigkeitsbegriffes zeigt aber in die richtige Richtung um dieses Problem zu beheben.

Obwohl Reformen der Pflegeversicherung in Bezug auf Unterstützungsleistungen, Prävention und Rehabilitation wünschenswert sind, ist ihre nachhaltige Finanzierung und Bereitstellung aufgrund demographischer Entwicklungen nicht unbedingt gesichert. Der Arbeitskräftemangel bei Pflegekräften wird durch die Konkurrenz zwischen familienunterstützenden Leistungen der Pflege und der Kindererziehung gefährdet. Bis zum Jahre 2013 muss man die Zahl der Erzieher verdoppeln und zugleich weitere 50.000 Tagespfleger einstellen, doch es fehlen ausbildende Einrichtungen und interessierte Schüler. Eine weitere Herausforderung ist die Schaffung einer vernetzten Versorgungsstruktur im sozialräumlichen Umfeld der Betroffenen, die alle Akteure und Versorgungskonzepte in Versorgungsketten einbindet. Ein wichtiger Baustein für den Erfolg dieser Bemühung sind sowohl Care wie auch Case Management in Form von Pflegestützpunkten und Pflegeberatern.

Da ungefähr 65 bis 89 Prozent der Pflege außerhalb des professionellen Versorgungswesens geleistet werden, steigt die Bedeutung sogenannter Laiengesundheitssysteme. Ausreichende Pflege kann nicht nur durch die finanzielle Unterstützung professioneller Versorgungsstrukturen erbracht werden, sondern ist auch auf die Anstrengungen Ehrenamtlicher im sozialen Umfeld des Kranken angewiesen. Dies ist eine besondere Herausforderung für Wohlfahrtsverbände, die sich dieser Aufgabe bereits teilweise durch die Ausbildung von Ehrenamtlichen in Freiwilligenakademien annimmt. Die veränderte Sichtweise der Versorgungskonzeption führt dazu, dass mehr auf die Würde des Menschen geachtet wird. Über 90 Prozent alter Menschen wollen den Rest ihres Lebens in gewohnter häuslicher Umgebung verbringen, aus diesem Grund sollte man für geeigneten Wohnraum und sozialräumliche Versorgungsketten einschließlich palliativer Begleitung sorgen, anstelle weitere stationäre Einrichtungen zu finanzieren.

SONODA Mariko (Associate Professor, Department of Architecture, Meiji University, Japan)

In Japan leben nur 4,4 Prozent aller Menschen über 65 in Pflegeeinrichtungen oder in betreuten Wohnanlagen. Ungefähr 70 Prozent aller Älteren wollen in Japan, wie auch in Deutschland und Frankreich, in ihrer gewohnten Umgebung verweilen. In Japan ist allerdings ein größerer Anteil (20 Prozent) der Pflegebedürftigen als in den Vergleichsländern unzufrieden mit ihrer jetzigen Wohnung. Auch scheinen ältere Japaner besorgter um die Verfügbarkeit adäquater Wohnmöglichkeiten, wenn sie auf Pflege angewiesen sein sollten. Von den pflegebedürftigen Menschen über 65 nutzen 88 Prozent ambulante und 7 Prozent stationäre Dienstleistungen. Diese Anteile verändern sich allerdings mit der Stufe der Pflegebedürftigkeit: Bereits 60 Prozent der Älteren mit (japanischer) Pflegestufe 5 und 49 Prozent mit Pflegestufe 4 wohnen in Langzeitpflegeheimen. Inzwischen gibt es jedoch auch intermediäre Formen des Wohnens, wie unterschiedliche

Formen des betreuten Wohnens (zum Beispiel öffentliche, gemeinnützige oder auch private betreute Wohnstätten), von denen einige Einrichtungen aus der Langzeitpflegeversicherung bezahlt werden.

Seit der Einführung der Pflegeversicherung im Jahre 2000 hat sich der Anteil derer, die lieber in Pflegeeinrichtungen wohnen als ambulant gepflegt zu werden, stark erhöht. Aufgrund der höheren Kosten (286.000 Yen pro Monat für einen Platz im Pflegeheim, 110.000 Yen pro Monat für ambulante Dienstleistungen) möchte die japanische Regierung mehr Pflegebedürftige zuhause oder in alternativen Wohnformen pflegen lassen. Zu diesem Zweck werden regionale Pflegedienstleistungen verbessert, der Bau barrierefreier Wohnungen gefördert und mehr betreute Wohnungen mit Pflegedienstleistungen bereitgestellt.

Um bei dieser Problematik die Betroffenen nicht aus dem Auge zu verlieren, müssen die Qualität der Unterbringungsmöglichkeiten und die Würde der Betroffenen gewährleistet werden. Die Integration von Pflegebedürftigen in die lokale Gemeinschaft soll durch Pflegeheime mit geringerer Kapazität (höchstens 29 Pflegebedürftige) erreicht werden. Außerdem sollen in bereits bestehenden Langzeitpflegeeinrichtungen mehr Einzelzimmer geschaffen werden. Ein anderes Problem besteht im knappen Angebot für betreutes Wohnungen für Angehörige der Mittelschicht, die sich weder die teuren Einrichtungen der gewinnorientierten Unternehmen leisten können, noch Anspruch auf Unterbringung in staatlichen Sozialeinrichtungen haben.

Gilles DE LA GORCE (Au sous-directeur des âges de la vie, Direction générale de l'action sociale (DGAS), Ministère des solidarités, de la santé et de la famille, Frankreich)

In Frankreich bilden sich zwischen ambulanter und stationärer Pflege immer mehr intermediäre Lösungen heraus, auch wenn ambulante und stationäre Formen die Mehrheit der Pflegedienstleistungen erbringen. zu den neuen intermediären Formen gehören Wohnungen, die sich an stationären Einrichtungen orientieren, aber auch Einrichtungen, die die Situation in privaten Wohnungen nachzuahmen versuchen. Seit 1975 ist es Ziel der Pflegepolitik, die ambulanten Pflege auszubauen und die Bedingungen in stationären Einrichtungen zu verbessern. In der ambulanten Pflege gibt es Schwierigkeiten in der Koordination des Angebots der Pflegeleistungen und der Professionalisierung der Dienstleister. Auch die Kompetenzteilung zwischen den unterschiedlichen Hierarchieebenen verursacht Probleme, weil z. B. Wohnungsunterstützungsleistungen auf nationaler Ebene koordiniert werden, Leistungen für Ältere und Behinderte dagegen in die Kompetenz der Departements fallen. Die Situation in stationären Einrichtungen hat sich nach der Reform von 2002 stark verändert, zum Beispiel gibt es nun staatliche Qualitätskontrollen, und die Preisfestsetzung wird alle fünf Jahre in Absprache mit dem Staat wie auch dem Departement vorgenommen. Trotzdem gibt es noch Probleme bei der gerechten Verteilung von Leistungen.

Intermediäre Einrichtungen können soziale Einrichtungen für Menschen mit geringer Pflegebedürftigkeit, Einrichtungen für Kurzzeitpflege, Tageszentren oder „Pflegefamilien“ sein. Letzteres ist eine der innovativeren Lösungen, Rechte und Pflichten werden zwischen der „Gastfamilie“ und der pflegebedürftigen Person vertraglich festgelegt. Die Aufnahme pflegebedürftiger Personen in stationäre Einrichtungen hängt von der Pflegestufe ab. Je höher die Pflegestufe, desto wahrscheinlicher der Aufenthalt in stationären Einrichtungen. Trotz aller Bemühungen, die ambulante Pflege auszubauen, besteht immer noch ein großer Mangel an Plätzen in stationären Einrichtungen, die deshalb weiter ausgebaut werden müssen. Die Kosten der Unterbringung sind vermutlich für die innovativere stationäre Lösung teurer als für die ambulante, doch verlässliche Daten für einen Kostenvergleich gibt es nicht.

Diskussion zu Session 4

Moderation: Matthias VON SCHWANENFLÜGEL (Unterabteilungsleiter Pflegesicherung, Bundesministerium für Gesundheit, Deutschland)

D: Nach den Vorträgen scheint es, als ginge es nicht mehr um die Frage, ob ambulante oder stationäre Versorgung die bessere Möglichkeit sei, sondern darum, dass eine breite Palette für pflegebedürftige Menschen vorgehalten werden soll.

D: Es gibt einen hohen Grad der Übereinstimmung in den unterschiedlichen Darstellungen der Wohnformen für Ältere. Die Modelle tragen in den drei Ländern unterschiedliche Namen, die dahinterliegenden Konzepte ähneln sich allerdings sehr. Man sollte darüber nachdenken, ob der ungehemmte Ausbau stationärer Einrichtungen überhaupt eine gesellschaftliche Perspektive ist und nicht etwa in stärkerem Maß zur Ausgrenzung Älterer führt. Die Frage der Finanzierung des Pflegeangebotes für den Mittelstand, von Prof. Sonoda erwähnt, ist relevant. Menschen sollten in der Lage sein, sich durch ihre Einkommen ein auskömmliches Angebot an Pflegeleistungen im Alter zu finanzieren. Der Altenbericht Kassel zeigt, dass Menschen, die Sozialhilfe bekommen und sich keine ambulanten Dienste leisten können, mit zweimal so hoher Wahrscheinlichkeit auf stationäre Unterbringung zurückfallen als Personen mit höheren Einkommen. Wozu sind also ambulante Leistungen, zumeist hauswirtschaftliche Hilfen, da? Zur Vermeidung von stationären Aufenthalten oder zu einem anderen Zweck? Ich würde dazu gerne Meinungen aus Frankreich und Japan hören.

F: Die ambulanten Leistungen in Frankreich sollen vor allem die Zahl von Menschen in stationärer Unterbringung verringern. Doch besteht ein Problem bei der ambulanten Hilfe für Demenzkranke darin, dass man Wünsche der Patienten weniger gut feststellen kann. Zwar wird die Öffentlichkeit über Krankheiten wie Alzheimer immer mehr aufgeklärt, aber die Bedürfnisse der Betroffenen sind immer noch nur unzureichend gedeckt. In jedem Falle besteht ein Gegensatz zwischen der Priorität, die wir in diesem Diskussionskreis ambulanter Pflege geben, und der Praxis, in der man das stationäre Angebot immer weiter ausbaut.

J: Es gibt viele Überschneidungen zu Session 3 in unserer Diskussion über stationäre und ambulante Pflege. Auf kommunaler Ebene wäre es wünschenswert, viele verschiedene Angebote von ambulanter und stationärer Pflege anzubieten. Es gibt keinen idealen Weg, in dem sich die eine oder andere Lösung als die bessere herausstellt. Group Homes in Japan liegen übrigens nicht wie Ressorts außerhalb der Stadt, sondern in der Mitte. Das bedeutet für die Betroffenen, dass sie weiterhin am gesellschaftlichen Leben teilnehmen und auch leichter Besuch von Verwandten oder Freunden empfangen können. In der Reform der japanischen Pflegeversicherung von 2006 wurde ein Programm verabschiedet, das lokale Kontakte ermöglichen soll. In diesem Programm werden lokale Pflegeleistungen im Hause des Betroffenen zur Verfügung gestellt. Aber es gibt auch Pflegestationen und Tagespflegemöglichkeiten ähnlich denen, die Gilles de la Gorce ansprach. Ein Ziel in Japan ist es nun, die Netzwerke unter den Pflegedienstleistern zu verstärken. Allerdings ist das Programm neu und noch nicht vollständig in die Tat umgesetzt.

F: Ich habe die gleiche Antwort wie die japanische Seite. Die Antwort auf die Frage nach der Auswahl der Wohnform wird durch innovative Einrichtungen gegeben werden, die ambulante Pflege genauso effizient und gut organisieren können wie die stationäre Pflege. Das werden keine isolierten Einheiten sein, die sich auf dem Land oder in den Bergen befinden, sondern solche, die in die Stadt integriert sind. Aufgrund der hohen Immobilienkosten in großen Städten werden finanzielle Anreize gebraucht, da sonst diese Art innovativer Einrichtungen kaum gebaut werden kann. Doch sie sind der Weg, um besser auf die Wünsche der Patienten eingehen zu können.

D: Wie gestalten sich in Frankreich die Kontakte zu den Wohnungsbaugesellschaften? In Deutschland haben diese auch die Aufgabe, kommunale Wohnungen für Wohngruppen oder Wohngemeinschaften auszubauen.

F: Die Entwicklung dieser Group Homes ist Teil des Alzheimer Programms der französischen Regierung. Architekten sind bereits in das Programm integriert.

Zusammenfassende Kommentare

Stéphane LEBOULER (Leiter der Forschungsgruppe, Abteilung für Forschung, Studien, Auswertung und Statistik, Ministère des solidarités, de la santé et de la famille, Frankreich)

Die drei vorherrschenden Themenbereiche in den Beiträgen der vergangenen Tage waren staatliche Politik, professionelle Dynamiken und ökonomische Logik. Das Thema der Langzeitpflege ist seit einigen Jahren auf der politischen Agenda aller drei Länder. Sowohl in Bezug auf die Bevölkerungsalterung wie auch auf die Anzahl von Alzheimerpatienten gibt es parallele Entwicklungen. Trotz einiger Divergenzen in den Problemstellungen zieht man in allen drei Ländern die ambulante Pflege der stationären vor. Die Sozialpolitik folgt mit ihren Reformen dem Prinzip des *trial and error*, doch auf der Basis sich vertiefenden Expertenwissens. Um unterschiedliche nationale Erfahrungen miteinander zu vergleichen braucht man Bezugspunkte. Vor allem in Europa ähneln sich viele Herausforderungen, zum Beispiel Fragen der Finanzierung und der Generationengerechtigkeit in der Verteilung der Lasten. Dabei muss vereinbart werden, welche Anteile an der Kostenübernahme die Gesellschaft und die Betroffenen jeweils übernehmen sollen.

Bezugspunkte sind für die Beurteilung der Pflegebedürfnisse und -Leistungen essentiell. Sich individualisierende Bedürfnisse korrespondieren mit der Entwicklung professioneller Methoden ihrer Beurteilung und der Bewertung der Qualität von Dienstleistungen. Das ist nicht nur eine Frage der wirtschaftlichen Effizienz, sondern der Bewahrung der Menschenwürde. Eine weitere Herausforderung ist das Arbeitskräfteangebot in den Pflegeberufen. Fördernde Maßnahmen wie höhere Gehälter und bessere Ausbildung stehen allerdings in Widerspruch zur Finanzierbarkeit des Systems.

Die Finanzierbarkeit des Systems steht in allen drei Ländern im Vordergrund. Sind Zukunftsprojektionen verlässlich genug, um die Pflegebedürftigkeit der kommenden Jahre vorauszusagen? Wenn die Anzahl der Pflegebedürftigen immer weiter ansteigt, stellt sich die Frage, ob dies an einer erhöhten Anzahl oder an der besseren Erfassung der tatsächlichen Zahl der Pflegebedürftigen durch die in den letzten Jahren eingeführten Systeme liegt. Bewertungsmechanismen für die Effizienz von Pflegedienstleistungen sind hierbei essentiell, da die Staatsausgaben im Bereich der Pflege durch den Anstieg der Anspruchsberechtigten immer weiter steigen. Hierzu gehört auch eine genauere Erfassung der Kostendifferenz zwischen ambulanter und stationärer Pflege. Eine weitere Herausforderung betrifft die Balance zwischen Individualisierung und Standardisierung. Individualisierung in der Beurteilung der Pflegebedürftigkeit und in der Gestaltung von Pflegedienstleistungen ist wichtig, um die zunehmende Heterogenität der Bedürfnisse von Pflegebedürftigen abzubilden, und Freiheit in der Auswahl der Anbieter zu ermöglichen. Doch auch Standardisierung ist notwendig, um die gerechte Behandlung der Bürger sowie reproduzierbare Qualität sicherzustellen.

In diesem Sinne geht es auch um Kompetenzverteilung zwischen den zuständigen Trägern.

Wolfgang BRENN (Japanisch-Deutsches Zentrum Berlin, Deutschland)

Forschung und Versorgung sind ein konzertierter Ansatz. Innerhalb der Vielfalt von Pflegeansätzen sollte man nicht stationäre gegen ambulante Hilfe ausspielen, sondern bestimmen, wie die Vielfalt gestaltet werden kann. In den Vorträgen wurden unterschiedliche Ansätze zur Finanzierung des Pflegeversicherungssystems vorgestellt: steuerfinanzierte, auf Versicherungsbeiträgen basierende und gemischte Modelle. Jedes System hat seine Vor- und Nachteile: So scheint das steuerfinanzierte Modell flexibel, das sozialversicherungsfinanzierte bietet dafür einen Rechtsanspruch auf Pflege. Beitragshöhe oder Anteil des Steuerbeitrages sind ein Zeichen für den Wert, der der Pflege beigemessen wird. Im Bemühen, das Pflegerisiko zu reduzieren, wird Prävention immer wichtiger. Jedes Land kann von den Systemen anderer Länder lernen. So orientiert sich Deutschland bei der Neudefinition des Pflegebedürftigkeitsbegriffs in seinen Bewertungskriterien zum Beispiel an japanischen Vorgaben.

Der Arbeitskräftemangel in den Pflegeberufen ist ein weiteres Problem, das den Länder gemeinsam ist. Zwar ist die Verbesserung der Gehaltsstruktur ein Ansatz zur Lösung des Problems, doch müssen daneben auch Arbeitsbedingungen und Ausbildung verbessert werden. So ist zum Beispiel die japanischen Kurzausbildung sehr sinnvoll, auch wenn sich die Idee der Kennzeichnung qualifizierter Helfer durch ein Armband (s. Beitrag von Homma Akira) in Deutschland vermutlich eher nicht durchsetzen wird.

In mehreren Vorträgen wurde auf die Anbindung der Pflege an die unterste Ebene des staatlichen Aufbaus, an die Kommunen, thematisiert. Auch hier gibt es Ähnlichkeiten in den institutionellen Strukturen der drei Länder, wie bei den Pflegestützpunkten in Deutschland und den Community Support Centers in Japan. In allen drei Ländern wird versucht, die Einbindung der Zivilgesellschaft in die Pflege zu verstärken. Mit einer besseren Vernetzung und Veränderung der Versorgungsstruktur ist auch eine bessere Nutzung familiärer Formen gesellschaftlicher Ressourcen möglich.

MATSUMOTO Katsuaki (Professor, Hitotsubashi University, Japan)

Professor Matsumoto erläutert am Beispiel der Illustration eines japanischen Vogels von Siebold die Schwierigkeiten des komparativen Ansatzes. Selbst bei verblüffender oberflächlicher Ähnlichkeit der Illustration mit dem tatsächlichen Tier stellt man beim genauen Hinsehen doch kleine, aber bedeutsame Unterschiede fest. In Bezug auf die Pflege gibt es für Deutschland, Frankreich und Japan ähnliche Herausforderungen, zum Beispiel wurden zur Abfederung des Pflegerisikos ähnliche Systeme entwickelt. Dennoch bestehen signifikante, möglicherweise auf kulturelle Faktoren zurückzuführende Unterschiede darin, wie dieses Problemen institutionell begegnet wird. Das Symposium war nicht nur wichtig, weil hier ein Schritt zum international vergleichenden Austausch getan wurde, sondern auch, weil die unterschiedlichen Delegationen nicht nur aus Ministerialbeamten, sondern auch aus Vertretern der Wissenschaften und der Praxis bestanden. Damit ist ein solider Grundstein für zukünftige Zusammenarbeit gelegt.

Abschließende Stellungnahmen der Delegationen

MIYAJIMA Toshiko (Director General, Health and Welfare Bureau for the Elderly, Ministry of Health, Labor and Welfare, MHLW, Japan)

Nun hatten wir die Gelegenheit, in lebhaften Diskussionen unsere Meinungen auszutauschen. Japan ist eine überalterte Gesellschaft, und unser ausgewiesenes Ziel ist es, die Menschen in Frieden leben und alt werden zu lassen. In Antwort auf die rapide Bevölkerungsalterung und ihre Folgen haben wir ein Langzeitpflegeprogramm entwickelt, wodurch allerdings nicht alle Probleme in Bezug auf die Pflege gelöst wurden. Dieses Symposium war für unsere Seite ein erster Schritt, uns auch um diese Themen zu kümmern.

Session eins hat sich mit der Pflege von Demenzkranken befasst. Die Frage stellt sich, wie man ein Gesundheitssystem schaffen kann, in dem man sich ausreichend um Demenzkranke kümmern kann. Außerdem muss es für Demenzkranke möglich sein, ambulant versorgt zu werden, so dass sie weiterhin bei ihren Familien wohnen können.

Session zwei hat sich mit der Etablierung eines Systems der Pflegeversicherung beschäftigt, in der sich die Menschen gut aufgehoben fühlen. Ein großes Problem in Japan sind derzeit die Arbeitsbedingungen der Menschen, die Pflegeleistungen anbieten. Außerdem wollen mehr Menschen in der Pflege arbeiten, als es tatsächlich tun. Auch ist die Personalfluktuation im Pflegesektor sehr hoch. Um dem entgegenzuwirken, hat die Regierung beschlossen, die Gehälter im Pflegesektor um 3 Prozent anzuheben und es wurden zusätzliche Maßnahmen ergriffen, um mehr geeignete und fähige Menschen für die Pflegeberufe zu gewinnen. Letztlich ist es nicht nur die Bevölkerungsalterung, sondern auch dass es immer weniger junge Menschen gibt, was wir in unsere Planung für das Pflegesystem einbeziehen müssen. Unter anderem muss über eine gerechte Balance zwischen Lasten und Leistungen des Systems nachgedacht werden.

Session drei handelte von der Definition der Pflegebedürftigkeit. In allen drei Ländern war die Ausweitung des Begriffes und die Integration von Demenz ein Thema.

In Session vier ging es u. a. um die Individualisierung von Dienstleistungen für Pflegebedürftige. Ein großer Teil der Diskussion hat sich mit der Kooperation der Pflegedienstleister auf kommunaler Ebene befasst. Um garantieren zu können, dass Pflegebedürftige weiterhin bei ihren Familien leben können, ist die Vernetzung der unterschiedlichen Dienstleister auf lokaler Ebene notwendig.

Herzlichen Dank.

Matthias VON SCHWANENFLÜGEL (Unterabteilungsleiter Pflegesicherung, Bundesministerium für Gesundheit, Deutschland)

Wir werden viele Anregungen aus Japan in unsere konkrete Arbeit nach Deutschland mitnehmen. Einige möchte ich hervorheben: Wir haben gelernt, wie wichtig es ist, dass das Case Management unabhängig von der Frage der konkreten Leistungsgewährung ist. Davon ist wiederum unabhängig das Assessment. Hier finden drei voneinander unabhängige Prozesse statt, um den Hilfebedarf für die einzelnen pflegebedürftigen Menschen zu optimieren. Weiterhin haben wir sowohl aus Frankreich als auch aus Japan interessante Beispiele gehört für das, was in Deutschland unter den Namen Pflegestützpunkte bzw. Vernetzung im kommunalen Bereich firmiert. In Deutschland haben die Kommunen eine starke Stellung, wie der Bund bei der letzten Verfassungsreform zur Kenntnis nehmen musste. Es wird gerade in Japan deutlich, dass man in Deutschland die Kommunen noch mehr in die Vernetzung für die pflegebedürftigen Menschen integrieren sollte. Interessant ist die Praxis der Pflegestufe eins, die in Japan existiert. In der letzten japanischen Reform wurde die Prävention innerhalb des Langzeitpflegesystems weiter ausgebaut. In der deutschen Reform des Pflegebedürftigkeitsbegriffes wird dies noch eine wichtige Rolle spielen.

Interessant fand ich auch unsere Diskussion über die Pflegeberufe und dass es nicht nur auf die Entlohnung ankommt, sondern dass gerade die Arbeitsbedingungen und die Wertschätzung des Pflegeberufs in der Gesellschaft eine ganz zentrale Rolle spielen, um die Menschen zu motivieren, die diese verantwortungsvolle aber auch schwierige Aufgabe leisten, länger in ihrem Beruf zu bleiben. Das Problem gestaltet sich ähnlich in Frankreich und in Japan. In Frankreich und Deutschland kommt wahrscheinlich noch hinzu, dass die Frage der ausländischen Arbeitskräfte eine größere Rolle spielt als in Japan wegen der vielen Grenzen innerhalb der EU, die leicht zu überwinden sind. In Deutschland ist Schwarzarbeit ein Diskussionsthema, das vielleicht mit Frankreich bilateral diskutiert werden sollte.

Wir halten eine Fortführung dieses Austausches für sehr wichtig und effizient und sollten uns Gedanken machen, wie wir ihn in Zukunft gestalten. Letztendlich wird es den Pflegebedürftigen sehr helfen, wenn wir das Rad nicht jedes Mal neu erfinden müssen, sondern auf den Erfahrungen der anderen aufbauen können. Ich möchte mich an dieser Stelle herzlich für die sehr gut vorbereitete Konferenz bedanken. Vielen Dank!

Bernard GARRO (Stellvertretender Referatsleiter, L'Action Sociale, Direction de l'Action Sociale, de l'Enfance et de la santé, Paris, Frankreich)

Herzlichen Dank. Der Vergleich der Sicherungssysteme gegen die Pflegebedürftigkeit ist sehr aufschlussreich für diejenigen, die mit dem Treffen politischer Entscheidungen beauftragt sind.

Die drei Länder haben mehrere Punkte gemeinsam, von denen ich hier vier hervorheben möchte: Ähnliche Werte; spezifische Herausforderungen, die sich um die Alzheimerkrankheit ranken; die Problematik der Pflegedienstleister; und die Steuerung öffentlicher Politik.

Eine neue Säule der sozialen Sicherungssysteme durch die Einführung der Pflegeversicherung wurde in den drei Ländern im Laufe der vergangenen 15 Jahre auf der Basis ähnlicher Prinzipien aufgebaut: zum einem das Respektieren der Würde und der Wahl der älteren Menschen, vor allem die Wahl, zu Hause leben und ambulant versorgt werden zu können; zum anderen die öffentliche Solidarität mit unseren Älteren und der Versuch, gleichwertige Leistungen über das ganze Land anbieten zu können. Dennoch müssen unsere Systeme regelmäßig reformiert werden, um die Weiterentwicklung der Bedürfnisse und die Erfahrungen mit den neuen Programmen berücksichtigen zu können. Zum Beispiel habe ich mir notiert, dass in der Neudefinition des Pflegebedürftigkeitsbegriffes in Japan und in Deutschland die Begrenzung auf physische Probleme aufgehoben wurde, so dass auch neuro-degenerative Probleme und Alzheimer Eingang in den Begriff finden. Eine ähnliche Weiterentwicklung, was die Definition des Pflegebedürftigkeitsbegriffes angeht, steht auch im Zentrum der französischen Reform.

Die wachsende Anzahl demenzkranker Menschen führt auch dazu, dass man sich mehr um die Umgebung dieser Menschen kümmern muss. Ein Arzt, mit dem ich redete, erklärte mir, dass es bei Alzheimer zwei Opfer gebe: den Kranken und den Helfenden. Man muss die Helfenden unterstützen und ihnen Atempausen ermöglichen. Die Fragen nach Organisation und Übernahme der finanziellen Lasten zwischen Steuern, öffentlicher sozialer Sicherung und privaten Ausgaben sind essentiell und werden aufgrund von demografischen Entwicklungen und ihren Auswirkungen auf die Finanzierung anderer sozialer Bedürfnisse, wie der Rente und der Gesundheitsversorgung immer schwieriger. Deshalb ist die Entwicklung der Pflegebedürftigkeit ein Thema, das man langfristig betrachten muss, wobei man im Hinterkopf behalten muss, dass unsere Vorhersagen über einen längeren Zeitraum vermutlich immer wieder revidiert werden müssen. Dies könnte auch mit positiven Überraschungen verbunden sein, z. B. bei der Rate der Neuerkrankungen von Alzheimer, wenn man wirksame Gegenmittel findet.

Unsere drei Länder befinden sich bereits in einem Reformprozess, obwohl die Systeme erst seit zehn oder fünfzehn Jahren existieren. Ich denke, dass es sinnvoll ist, in Frankreich in einem Intervall von jeweils fünf Jahren Reformen vorzunehmen. Dies tun wir bereits mit dem Rentensystem. Die Zukunft und ihre Unsicherheiten verlangen uns viel Vorstellungsvermögen ab, da anpassungsfähige Finanzierungssysteme entwickelt werden müssen, die einerseits diese Unsicherheiten mit einbeziehen, aber die auch schwierigen Zeiten standhalten können wie die, in der wir uns gerade befinden. Was die sozialen Sicherungssysteme angeht, die im 20. Jahrhundert für Gesundheit und Renten entwickelt worden sind, so muss ihre soziale Sicherungsleistung auf reaktive Art und Weise und im Dialog mit den Akteuren modelliert werden. Ein stetiger Fluss des Erfahrungsaustausches muss garantiert sein. Dieser Austausch muss auch mit anderen Ländern stattfinden. Was wir in den vergangenen Tagen ausgetauscht haben, hat uns bereits viel Zeit gespart, da wir gelernt haben, uns nicht in Programme zu stürzen, die in anderen Ländern schlecht funktioniert haben. Viele Informationen wurden ausgetauscht, aber es gibt Bedarf nach Vertiefung. Ich glaube, es wird möglich sein, sich in Zukunft per E-Mail über konkrete bzw. technische Fragen auszutauschen. Aber der direkte Austausch, so wie wir ihn in den vergangenen zwei Tagen hatten, ist eine Voraussetzung für die Dynamik des permanenten Austausches. Vielen Dank.

The Tripartite Symposium on Long-term Care between France, Germany, and Japan

Opening

OMURA Hideaki (Senior Vice Minister of Health, Labor and Welfare, Japan)

Germany, France and Japan all have similar goals regarding care: a stable system of care in which the dignity of elderly people is respected. One reason for the introduction of a long-term care insurance system in Japan in 2000 was the realization that care was an issue for the whole of society and no longer solely a concern for the family. Since its inception, based on the number of those taking advantage of nursing services, the system has been well received both by the general public and those affected directly. At-home care services, on which the nursing care insurance was focused, are much in demand. It is clear that the public appreciates the introduction of the program. Naturally, the implementation has not been without its difficulties; the number of dementia cases is on the rise but at the same time there is a shortage of carers and costs are continually rising. The Japanese government is therefore striving for further reform of the system in order to strengthen reliability and confidence. Because the aging of society is going to increase, it is particularly important that the three countries participating in the symposium—Germany, France and Japan—share their knowledge on this theme and discuss with one another mutual problems and suggestions for their solution.

Agnes LECLERC (Director, Delegation for European and International Affairs, Ministry for Health, Youth and Sport/Ministry for Labor, Labor Relations and Solidarity, France)

The symposium presents the opportunity to form a lasting alliance between the ministries of social affairs of France and Japan and to strengthen the existing bonds between Germany and France. In France there is much interest in the different pathologies of aging and the focus is on the care of Alzheimer patients. Despite various changes within the familial structure, the solidarity within the family persists, even when that does not necessarily mean living together. In order to be able to further guarantee at-home care, the French government resolved to give support through the financing of professional services. Since 2002, 600 thousand at-home patients and 400 thousand residential patients have received the "Allocation personnalisée d'autonomie" (APA). This allowance, based on individual needs, is designed to pay for services, which support the activities of everyday life. The successful uptake of the program at once calls into question its sustainability since the continuation of the system is threatened with a seven percent rise in costs due to demographic change, especially in the years 2025 to

2030 when the baby-boomers reach the age when care is required. Because the financial sustainability for care as well as for old-age pensions is in doubt, it is now up to the state to carry out reform of the system. Guidelines for the new draft bill for the sustainable financing of long-term care are as follows:

1. At-home care services are to be expanded in order to allow patients to stay at home for as long as possible. This concerns especially those without family and those who are particularly dependent on care.
2. The number of residential care places available must be increased and these places must be made more accessible to people with low or middle-level incomes.
3. In order to guarantee financial sustainability, sources other than tax and social insurance contributions must be secured. Since dependency on care is always a future possibility, people should make provisions for it. Furthermore, it could be made a requirement for people to utilize any private assets for these purposes, although this would only affect approximately a third of the elderly. The possibilities of private additional insurance are also being investigated.
4. Private additional insurance should be promoted. At present around two million French citizens are insured against the risk of becoming dependent on care.

Germany, France and Japan all face similar challenges: how does one define and evaluate dependency on care? How can effective services for the elderly be organized? How can we find a balance between at-home care and residential care? What new technologies can be employed to protect the elderly? How should the financial burden be distributed between tax, insurance contributions and private means?

Marion CASPERS-MERK (Parliamentary Undersecretary, Federal Ministry of Health, Germany)

The aging of society is for many people a chance to enjoy a longer, fulfilling life but it is also a challenge for the social insurance system. In Germany, long-term care insurance (LTCI) was introduced in 1995 as the fifth and final pillar of the insurance system. Inspiration came from the Japanese “care manager” system and care advisor posts were created in order to strengthen the network of available services at local authority level. Furthermore, it is necessary to develop strategies to make the care profession more attractive and to redefine the meaning of care dependency.

Since the introduction of LTCI, the following changes and issues have arisen:

1. Redefinition and extension of the definition of care dependency from purely physical problems to other impairments, e.g. in cases of dementia, where support and assistance is required rather than nursing
2. Improvements in services for the care of dementia patients
3. Introduction of local care support points
4. Expansion of at-home care
5. Improving the situation in residential care facilities, especially the system of care offered to dementia patients
6. Improving the image of the care profession and the promotion prospects within it
7. Performance dynamization
8. Standards evaluation of care services and facilities through the creation of a seal of quality.

The challenges faced by the three lands are very much alike. It is a matter of improving training for care-providers, drawing up new models for cooperation and networking, developing a vision for financing and undertaking the further development of services offered as well as redefining the term “care-dependent.”

Keynote Speeches

Marie Eve JOËL (Paris Dauphine University, France)

In France, the expansion of the existing social security system to include a fifth, private, pillar in order to sustainably cover costs for possible future care needs is currently being discussed. Within the context of the wider discussion, the Old-Age Solidarity Plan (2007–2012) and the latest Plan Alzheimer (Alzheimer Plan, 2008–2012) were developed. Despite the engagement of expert knowledge, an exact forecast on trends in the number of dementia cases is not possible. This complicates a definitive expansion of services. In France, four topics in particular are an issue.

Intra-family and other informal provision of care is to be supported through payments, providing respite, the crediting of providing care towards pension claims, training, and better coordination. According to the SHARE[4] Project findings, care within the family is constant with regards to quality but the form this care takes is diversifying increasingly. The type of care chosen, whether cohabiting in an assisted living community, care in the home or moving into a

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[4] SHARE Project – Survey of Health, Ageing and Retirement in Europe: Survey of Health, Ageing and Retirement in Europe: was first carried out in 2004 as a representative survey of the population aged 50+ in 11 European countries. The second round conducted between autumn 2006 and spring 2007 surveyed over 30 000 people in 14 European countries and Israel. The third round concerning retrospective life histories (SHARELIFE) has been in process in 15 European countries since autumn 2008. (All notes are editor’s notes.)

residential care home, depends amongst other things on possible financial support and the availability of professional care services.

The institutions of the socio-medical branch have in the last years and at the urging of the government been greatly modernized, to the extent that references are made to the "industrialization" of care provision. In the market for accommodation for people dependent on care, a competition between non-profit and for-profit organizations developed. In at-home care, various incentives to increase the supply of labor were created through the 2005 law on the development of services. The greatest challenges in this area are the provision of an adequate supply of labor, coordination between the various agents in the field of care services, and the transition from the idea of social support to one of management culture, in which local authorities can monitor the quality and economic capacity of the services and service-providers. In addition, the population should be better informed about Alzheimer's disease, aided by the third Alzheimer Plan (2008–2012). For some time now, special facilities have existed ("Maisons pour l'autonomie et l'intégration des malades d'Alzheimer," MAIA), which have focused on the preservation of autonomy and integration of dementia patients. A further goal is to improve the quality of life for Alzheimer sufferers and their carers. The care required by sufferers of mental-psychological disorders differs greatly from that in the case of physical disability. The demands involved in the care of a patient even in the early stages of dementia are as high as in the case of severe physical limitation. It is not yet clear whether funding in the local authorities would be best invested in research, assistance for carers, the improvement of the living situations of those affected or the qualification of professional care-workers.

The last point to be addressed was the financing and sustainability of care. The French system of support for care patients (Allocation personnalisée d'autonomie, APA) is a partial-reimbursement system based on income. Here, issues of the range of services for the elderly, the relationship between public and private expenditure, and the definition of eligibility for public services are at the fore. Regarding financial sustainability, the Senate has suggested bridging the gaps in financing by means of a private additional insurance or through obligatory employment of the patient's private assets. We need to come to an understanding regarding various issues such as the redefining of solidarity between the generations and the impact of financial constrictions.

MATSUMOTO Katsuaki (Hitotsubashi University, Japan)

Professor Matsumoto introduces the three different systems of LTCI in Japan, Germany and France from a comparative viewpoint. The introduction of the systems took place within the time-frame of about a decade. Germany was the pioneer, introducing LTCI in 1995. France launched the "Prestation spécifique dépendance" (PSD) in 1997 and the "Allocation personnalisée d'autonomie"

(APA) in 2002, and Japan passed the Public Long-Term Care Insurance Law in 1997, bringing it into effect in 2000.

The form benefits take in each country is different. In Japan and Germany there are non-cash benefits; in Germany these may also be offered in the form of attendance allowance, which is not tied to the payment of any service in particular. France works with cash benefits, which must, however, be used to pay for care. Those eligible for benefit in each of the three lands are patients dependent on care who, according to various criteria, are classified as belonging to a particular care level. In Germany, family members who provide care are indirectly eligible for benefit since they can claim attendance allowance for caring for their relative. Funding in Japan exists within a mixed system, in which LTCI is financed half through insurance contributions and half through tax. The German system is financed exclusively through insurance contributions, the French system mostly through tax contributions.

Even the underlying concept of risk, against which the system insures patients, is different in each of the countries. In Japan LTCI is chiefly oriented towards old-age care dependency and so eligibility is tied to the age of the patient (from 40 years of age). In Germany there is no such age limitation and care patients of all ages are eligible. In France there is a lower age limit of 60 years. As in France and Germany, recruiting a sufficient supply of care-giving labor is also problematic in Japan.

Session 1: Caring for Elderly Dementia Patients

HOMMA Akira (Team Leader, Research Team for Promoting Independence of the Elderly, Tokyo Metropolitan Institute of Gerontology, Japan)

Article 1 of the 2006 law on long-term care emphasizes that a key goal of LTCI is the preservation of the dignity of the care patient. The number of dementia cases looks set to rise from two million in 2005 to around 4.5 million people by 2035, yet it is difficult to say exactly how many will be diagnosed and will receive treatment for dementia. In comparison with other diseases of aging, dementia is an illness, which requires the people in the affected person's environment to be particularly alert since dementia patients seldom seek medical help independently. Also problematic is the fact that the possibility of guardianship for dementia patients is seldom taken up: only 3 percent of long-term care contracts include a guardianship provision.

In order to spread awareness about dementia, particularly in the communities, 150 dementia care centers will be created at local authority level and general practitioners will be trained through a state program. To date, 14 thousand general practitioners have taken part in this training scheme. The general public will be made more aware of the issue of dementia and non-professional help in the communities will be reinforced. To this purpose, people with care experience will be invited to take part in a ten-week training program, with shorter courses on offer for those new to the field. Having completed the course, participants will receive an armband identifying them as a person with dementia expertise. The idea behind the scheme is to strengthen solidarity with dementia patients and to disseminate more knowledge about the illness and its impact.

Sabine JANSEN (Managing Director, German Association for Alzheimer Disease)

In Germany today there are around 1.1 million people with dementia and annually around 250 thousand new cases. It is expected that by the year 2050, the total number of dementia cases will rise to 2.3 million. Of those diagnosed with the disease, two-thirds are cared for within the family but this figure is expected to decline in the future as more and more old people live alone. The degree and form of care required varies according to the living situation and the stage of illness of the patient, but above all, advice, information and training at the onset of the illness are very important for the relatives. Comprehensive home-care through profession care-givers is indeed being provided meanwhile but these services are not always necessarily oriented towards the particular needs of dementia patients. Informal help, partly developed through self-help, is also increasingly on offer. Professional care other than home-care or continual residential care is also available, for example day/night-care or short-term care, but they are costly and are therefore not utilized so often.

In order to provide information and advice for dementia patients and their families, the German Association for Alzheimer Disease (DAG) has been running an "Alzheimer Telephone Helpline" service since 2002, counseling between 5500 and 6000 people per year. In 2008/2009 three themes in particular were addressed by the families: problems dealing with the patient, questions about medical care and diagnosis, and legal queries about care and entitlement to benefits. There is still a great need for information and clarification. A growing number of dementia patients are being treated in acute care hospitals in which the staff is not trained adequately in how to deal with such patients. Even customized facilities for care and rehabilitation need to be improved.

Although the attention given to dementia patients and their care has greatly improved in the past fifteen years, there are still shortcomings. The DAG estimates that a diagnosis has been made in only 30 percent of all dementia cases. In rural areas in particular, access to information and treatment are less than optimal. Despite the expansion of professional care services, the family still carries the heaviest burden and so cooperation between professional carers and voluntary ones ought to be improved. In research, studies into care should be encouraged. The DAG is involved in several research initiatives in conjunction with various ministries. The Federal Ministry of Education and Research is investing in a center for neuro-degenerative illnesses and is fostering a network of expertise. The Federal Ministry for Health has announced various landmark projects on the theme of care and the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth is supporting efforts towards greater attention for the illness and is putting together information material to, amongst other things, raise awareness within certain groups of the population, such as police, bank workers and those in the retail industry. There are many pilot projects and efforts have to be made to augment and multiply those which prove successful in the end. The goal is to create a society in which people afflicted with dementia can feel comfortable. Each country must work out how much funding it is willing to make available for care.

Sandrine LEMERY (Project manager, Steering Committee, Le Plan Alzheimer, France)

Demographic change will not only lead to a greater number of elderly people but also to a rapid rise in the number of people extremely dependent on care (Levels 1 to 4 of the AGGIR scale[5]). Between 20 percent and 24 percent of all deaths of elderly people in France can be traced back to Alzheimer's and related diseases. In contrast to the two previous Alzheimer Plans (2001 to 2008), which were more practice-oriented and had less emphasis on research, the new Alzheimer Plan provides for an investment of 200 million Euro for research into dementia,

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[5] AGGIR is a method developed by the Fondation Nationale de Gérontologie to evaluate the functioning autonomy of elderly people. The evaluation scale has 6 levels.

200 million Euro for medical care and 1.2 billion Euro for the medical and social support of those affected. The Alzheimer Commission is pursuing three goals:

First, our understanding of the illness should be improved through research. In order to promote research and to guarantee speedy advances, a network of expertise was established, through which French and foreign researchers may be recruited. Further, partnerships with industry as well as cooperation between individual research teams is encouraged.

Second, the quality of life for patients and their families should be enhanced. On the one side, care services in facilities should be developed and should be tailored towards the various needs, and on the other, the rights and training of care-providers as well as the monitoring of the health of carers within the family should be improved. Attempts are being made through a pilot project of the "Maisons pour l'autonomie et l'intégration des malades d'Alzheimer" (MAIA) to strengthen the capacity for coordination between the various people involved in care. In addition, 1000 care advisers will be employed throughout the land. As in Germany and Japan, at-home care will be improved through the use of care specialists and new technologies. Access to diagnosis and care will be made easier through the setting up of "memory clinics" and through a new system for diagnosis and treatment of the illness. Finally, an attempt will be made to tailor existing care-homes better to the needs of dementia patients through the introduction of specialized care units.

Third is the aim for a heightened awareness and mobilization amongst the public through information and the support of volunteer help. For this purpose, a telephone helpline has already been set up. Various conferences are being organized for the discussion of the speedy implementation of the Alzheimer Plan and ethical aspects such as the legal status and autonomy of patients. In France we would like to see dementia being made, through research on an international level, a priority for European research and action.

Discussion on Session 1

Moderation: HASEGAWA Kazuo[6]

In Session 1 we had a look at, amongst other things, the different forms of accommodation for dementia patients. In each of the three countries, the advantages and disadvantages of at-home care, residential care and the other forms of care for people with dementia are being discussed. In my opinion, the smaller forms of accommodation, for example Group Homes, represent a promising alternative. When LTCI was introduced in 2000, there were 400 Group Homes in Japan; in the meantime, that number has risen to over 10 thousand.

In Group Homes an attempt is made to preserve the patient's way of living. The dementia patients live in small groups of around 10 people, as in a family. There is a lounge room in which one can meet and have a chat; meals are prepared together. All in all, it is really very lively. The "Regional Care" project

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[6] Remarks by participants from G Germany, F France and J Japan.

(*chiiki care*), supported by the Ministry of Health, has been running since 2006. Within the framework of this project, services, which are multi-functional but not quite so elaborate are on offer. Aside from anything else, this means that day care is available now also for dementia patients and not just for elderly care-dependent people. Should the patient not want to travel every day to the care center, there is the possibility of being cared for in the home. Furthermore, a night service is in place to relieve friends and family who provide care. This service allows family carers to bring the patient to the center for one or more nights in the knowledge that the patient will be well-cared for. For patients with no family to provide care, the aforementioned Group Home facilities are available. In summary, there are four different types of care: in the home of the patient, day care centers, night care centers and Group Homes.

G: In Germany it is under discussion whether it is better to care for patients for as long as possible in the home or to treat them as in-patients at an earlier point. Who are the providers of homes for dementia patients in Japan? Are they private or are they run by associations or housing cooperatives?

J: As far as I know, Group Homes belong rather to the category of at-home care and should not be regarded as residential facilities. Group Homes are integrated into the community. As a rule, they are not under government administration and are rather managed by other organizations, for example non-profit organizations or private companies. The daily routine is not standardized and is organized completely by staff.

G: In Germany we have three types of living situations for people with dementia: in-home day care, residential groups as an alternative to a care-home, and classic care-homes or residential groups modeled on a familial living situation. In the case of dementia patients, the clarity of the structure and the small size of the group are of the utmost importance so that they can maintain familiar structures despite their illness.

G: Some forms of care fall under the institutional conditions of care insurance but there are also at-home forms of living, which do not fall under the German Nursing and Care homes Act (Heimgesetz), such as residential groups. In order to guarantee human dignity, services must be oriented towards the individual person and not solely towards the structures already in place. This is only possible in a social/public context, not in a privatized one.

F: Dignity, universality and equality in treatment are also central points in French care insurance. Taking a holistic approach is an attempt to guarantee the dignity of the patients: dementia patients are cared for in small groups, carers are professionally trained and the general public are being enlightened about the disease.

J: The fallback alternative to at-home care represented by Group Homes is of great significance. Both individual care and Group Homes are adequate solutions for care; the challenge lies now in the integration of the various services at local authority level.

G: Regarding terminal care for dementia patients, Germany aligns itself with other countries and supports advanced training in palliative care, for example through visiting and observation schemes with carers and doctors in countries that have already implemented successful programs.

J: Also requiring a solution is the problem of low wages, which discourage suitable candidates from considering a job in caring. The low social status is also off-putting. One answer lies in the improvement of training and further education. Presently in Japan there are three centers (Tokyo Center, Sendai Center and Nissan Center), in which future carers are trained. Training is oriented towards carers from all levels of the professional hierarchy who have been serving in the sector for more than ten years. At the moment, around 1100 people from all over Japan are taking part in the ten-week external training program. The centers are part of the measures taken to make choosing a profession in caring more attractive. We also regard it as important to enlighten the public. They should be informed and trained at a local level so that, for example, family members can react more quickly to signs and symptoms of early dementia in their loved ones.

G: To come back to a point made by one of our French colleagues, when it comes to equality, objectives need to be socio-political and not just purely medical or about the politics of care-provision.

F: We have looked at the topic of dignity in the treatment of dementia patients. Dignity plays a role on three different levels: 1. Alzheimer's Disease must be acknowledged by society. It is said that politicians only take heed when their own mother is affected. People are afraid of the illness and do not want to acknowledge it. 2. Dignity has a part in the organization of care services and 3. plays a role in the direct contract between the patients and their environment. Patients must feel cared for and carers have to be acknowledged by society. At the moment their work is undervalued and they have no adequate help when they find themselves confronted with a problem.

J: Thank you very much for the successful discussion. One of the main topics in the discussion was dignity. Further, our representatives from the three countries made several difficulties, above all the shortage of qualified carers, topic for discussion.

Session 2 The Establishment of a Care System which Citizens Feel They Can Depend On

Session 2.1 The Establishment of a Socially-compatible Financing Solution for Care

Severine SALGADO (Policy Officer, Direction for Social Security, Ministry for Labor, Labor Relations and Solidarity, France)

In France, too, the number of patients dependent on care is rising steadily. Amongst the challenges faced by the Allocation personnalisée d'autonomie (APA) is the insufficient adaptation of the existing instruments of long-term care to the individual needs of the elderly. Even individual programs of at-home care are often inadequate and people in residential care have to pay a lot additionally themselves. In 2007 the state paid out 6.2 billion Euro for long-term care, 4.6 billion Euro for the APA Program, 2.6 billion Euro for social benefits for the elderly and 2.2 billion Euro for various other programs. This totals less than one percent of the gross national product.

The government's intention is to minimize the risk of becoming care-dependent and at the same time to guarantee the sustainability of financing the system. Under these conditions, old people should be cared for as long as possible in their own homes and, additionally, the number of places available in care-homes should be raised. Approximately 5000 new places are to be created every year and the costs of accommodation for senior citizens with a monthly income of less than 2000 Euro will be subsidized, so they can be assured of residential care when necessary. In order to make the system sustainable, the promotion of a private insurance in addition to the public insurance is being contemplated. The burden on jobholders ought to be reduced. Since care dependency in old age is a foreseeable risk, the burden can be minimized through various forms of saving. Nevertheless, in a private-public partnership between LTCI underwriters, evaluation criteria must be harmonized and negative external influences stemmed.

YOSHINO Takayuki (Director of Long-Term Care Insurance Division, Health and Welfare Bureau for the Elderly, Ministry of Health, Labor and Welfare, Japan)

The introduction of a long-term care system is not only important in light of the growing number of patients dependent on care but also because of the increase in the duration of required care. Families, formerly the main source of care, can undertake care only to a much lesser degree these days because of changes in family structure. Because of these changes, care in Japan has become "socialized"—it is no longer exclusively a family duty, rather it is borne increasingly by society. The new system is based on the principal of social insurance, so that a clear relationship between services and costs exists. It will improve the independence of the patient through rehabilitation and not only secure the care needed by severely care-dependent people.

The new system is more user-friendly than before in that the patient can choose how and where they will receive care. Medical and social services are also part of an integrated, coordinated plan. The field has opened up and now besides local and public organizations, for-profit organizations and retail cooperatives may also offer care services. Under the new system, the payable excess is capped at 10 percent for patients of all income levels, with low-income senior citizens receiving extra benefits. The remaining 90 percent is financed half and half by tax (local: 12.5 percent, prefecture: 12.5 percent, national: 25 percent) and insurance contributions. Every three years, the plans for long-term care and insurance contributions will be renegotiated.

Nevertheless we will still have to deal with the question of sustainable financing in the future, since the proportion of those making contributions to those claiming benefits will shift due to population changes, and, in any case, only those aged 40 and upwards pay contributions. For this reason, the balance between the burden on contributions and services offered will have to be reviewed.

Matthias von SCHWANENFLÜGEL (Deputy Director General, Long Term Care Insurance, Federal Ministry of Health, Germany)

In all three countries there are parallel developments taking place. The aging of society is speeding up, the birth rate is sinking and more and more young people are having to pay for services for more and more old people. In Germany the percentage of over 60-year-olds as part of the population will rise from 24.9 percent today to 38.9 percent by the year 2050. The risk of becoming dependent on care naturally increases with age and it is essential in an insurance system to take the constant age-specific probability of care dependency into consideration. The question of whether and how this risk can be modified, for example through prevention or rehabilitation, is one that arises often in healthcare policy. In the last healthcare reforms, the right to rehabilitation was introduced and will without a doubt have repercussions for LTCI. To sum up the care insurance experience so far, we see that a strengthening of home-care has been achieved, with two-thirds of patients being cared for in their own home and only one-third receiving residential treatment. A decrease in the payments of social benefits has been made possible through the introduction of LTCI. Only 5 percent of those living at home and 25 percent of those in residential facilities continue to receive social benefits in order to pay for care. A quality-assured infrastructure could be set up and monitored through the medical services of the health insurance. In the field of care, 300 thousand new jobs have been created.

The German LTCI system is, with respect to its insurance contributions and the cost-sharing system, very closely coupled to demographic and economic developments. Long-term insurance, introduced in 1995, is the youngest off-spring of the social security system and since its inception seems to have been well-received by the public. The physical, psychological and financial burdens of care need to be lightened. LTCI is a partial service system in that it covers only a part of the risk of care dependency. Because the system is income-related, there is a social equalization between the different groups of the population. Because insurance is compulsory, 70.31 million people are covered by social LTCI; those earning more can also take out additional private LTCI. The contribution assessment ceiling is currently set at 3675 Euro gross monthly income, the contribution rate is 1.95 percent of gross income, and those without children pay an extra “childless premium” of 0.25 percent.

The assessment and categorization of care needs into one of three levels lies with the medical services of health insurance. We have seen a steep increase in the last year even within Level 1. The financial benefits of the LTCI depend on the form of care (at-home or residential) and level of care. Should the costs of care exceed this amount, the excess is to be paid by the patient. Through the strengthening of at-home care, the trend for residential care should be reversed. The treating of dementia patients in residential facilities will be improved through additional financial support for professional dementia care via LTCI funds.

The expenditures of the LTCI sit at around 18 billion Euro and rise by 1.2 percentage points annually. Expenditure has risen through, amongst other things, the increased uptake of expensive non-cash benefits in at-home care.

Session 2.2 Measures to Guarantee a Sufficient Supply of Well-Qualified Labor in the Care Industry

Maryse CHAIX (Assistant-Director for territories and social work, General Department of Social Action, Ministry for Labor, Labor Relations and Solidarity, France)

By the year 2020 there will be approximately 4 million people over the age of 80, 80 percent more than today. Since the risk of becoming dependent on care is greatly increased in this age group, government policy is aimed at cushioning this risk through various forms of personalized care options including so-called intermediary forms of care such as limited-term admission to hospital, placement with families or day-care centers. These various forms of care fall under the authority of the different facilities (the hospitals, for example) or under local, private for-profit organizations or private charitable organizations. All forms of care are, however, suffering from a shortage of labor.

At-home care is proving to be more and more difficult, not just because there are ever more people dependent on care but also because the pool of women over the age of 40, who today make up the largest part of both formal and informal carers, will shrink in the future. The part-time employment rules and the low wages exacerbate the shortage of labor. There is a high turnover rate amongst staff and ever more competition for employees from other healthcare organizations. At present, approximately half of the 700 thousand carers are providers of at-home care. The staff requirements in care are expected to rise annually by an extra 30 thousand places. In order to meet this challenge, salaries and qualification standards must be improved.

With regards to the structure of qualifications, the introduction of uniform qualifications for entry into different social and medical-social sectors would encourage both horizontal professional mobility between fields and vertical mobility through further qualification.

Also conceivable are the increase in working hours and the abolishment of forced part-time employment as well as a diversification of activities in at-home care. If these structures could be defined by law, it would enable the mobility of employees, allow the alignment of qualifications and would broaden the scope of human resource management. A range of media campaigns are running at present in an attempt to make the care industry more attractive. In a successful pilot project, cooperation between state, regions and social partners in recruiting and training care-staff has been improved.

Andreas KRÖGER (Managing Director, AHK Pflegeteam, Berlin, Germany)

In the coming years, the staff requirements in the field of care will grow since the number of care patients is expected to double by the year 2050. Presently, a good two-thirds of patients are cared for in their homes rather than in a nursing home; only one third of those at-home patients are looked after by care-services. Because of the aforementioned demographic changes, we cannot expect the future extra care needs to be met via the efforts of family members. It is feared that there will be a rise in illegal employment. In order to secure a sufficient supply of labor, we must develop strategies for recruitment as well as those for keeping staff in the job. As far as recruitment goes, as many potential applicants as possible must be reached through attractive advertising, improved arbitration through job centers, cooperation with other care-providing services and an improvement in image through publicity.

Internal labor turnover as well as turnover through job change jeopardizes continuous nursing care. In order to stem staff turnover in the social sector, which is approximately three times higher than in other service industries, the following suggestions have been made. To improve working conditions, additional services and premiums should be offered. Induction standards must be improved, continuous discussion with staff undertaken and cooperation with staff representatives strengthened. An improvement in further training possibilities for staff will also help to reduce turnover. The problem of limited promotion prospects can be dealt with through further training and professional development as well as the creation of internal career paths via the establishment of additional levels of hierarchy.

HABU Eiji (Director, Promotion Division, Health and Welfare Bureau for the Elderly, Ministry of Health, Labor and Welfare, Japan)

As in Germany and France, care professions in Japan suffer from a high level of staff turnover (22 percent) due to low wages and inconvenient working hours. Carers are mainly women (80 percent) and part-time (80 percent). There is a shortage of care managers, certified care workers and "home helps." Within residential care, full-time positions are more common, whereas in at-home care, carers are more likely to be employed on a part-time basis.

Progressive demographic change is leading to an increasing demand for care workers. Since the implementation of LTCI in the year 2000, the number of patients who have been classed as belonging to one of the care levels has risen by 139 percent to 3.56 million people. Within this development is a rise of 165 percent in the provision of at-home care and a rise of 56 percent in residential care. Falling between these two forms of care, at-home and residential, are the other institutional forms such as day-care, temporary care and short-term care in nursing homes.

75 percent of those employed in social services and care leave the occupational field after three years. To counteract this high rate of turnover, advisory centers for employees and alternatives for professional development have been established. Further, the Diet passed a law in 2008 for the better treatment of professional carers in the hope of securing a steady supply of labor. Other starting points for improving the supply of manpower include the opening up of the care profession for job seekers who have no previous experience in care and are new to the field. To counteract the dissatisfaction of staff with their employment, wages and other working conditions will be improved. In 2009, the salaries of care professionals were raised by 3 percent.

Discussion on Session 2

Moderation: Stephane LEBOULER

F: Central to your presentation was the theme of remuneration for care workers. That was drawn out more than in the first session. The question, which interests us now is, is it at all possible to avoid raising the salaries in the care sector?

In France there has been a wages increase for at-home care workers of 25 percent. The raise for employees in other areas is not just as remarkable but is nevertheless above the rate of inflation. Despite this, there are staffing problems since several service providers decided after the wage negotiations in 2002 to lay off staff due to a rise in costs. In nursing homes, on the other hand, there are wage agreements but no staff cuts. The attractiveness of the care profession depends on more than just salary.

G: An improvement in general conditions alone, for example through wage increases, is not enough to make a career in care more attractive. On the other hand, measures for professionalization make sense, according to the Robert Bosch Stiftung (Robert Bosch Foundation). Appreciation for care workers will be raised through, for example, the "care needs the elite" program. The professionalization of care services is not only about further training but must also deal with keeping older care workers healthy. Furthermore, the care profession needs a greater internal differentiation of job description to widen the market for potential carers. Since the majority of carers are women, flexible working hours must be offered so that women can balance providing professional care with the needs of their own families.

G: For care workers, it is not only the low wages that are a problem but also the growing accumulation of working hours due to the laying off of staff. Having control over time in the sense of how working hours are organized, as well as planning one's own personal life, is becoming difficult. Neither is the continual expansion of nursing homes sustainable in the long-term since personnel costs will become unaffordable. Simply in order to take care of those people who will soon become care-dependent, every second school-leaver in some federal states would have to go into the care profession. The only "growing" resource according to volunteer surveys is the over 55 year-olds. For this reason, the mix of personnel will have to be looked at. It is essential to come to an understanding over the desired form of social policy rather than concentrate solely on welfare policy.

G: In Germany, several measures have been put in place to counteract the low wages paid to care workers. Since the last long-term care reform, carers must be paid in line with local wages. Moreover, a national minimum wage will be established for the care sector.

F: In summary we could say that every discussion about the attractiveness of the care profession must deal with the question of wages. It must also be calculated more precisely, which of at-home care or residential care is the more costly.

Session 3: Definition of Care Dependency and Methods of Assessing Care Needs

TSUTSUI Takako (Chief, Administration, Dept. Social Services, National Institute of Public Health, Japan)

Since the introduction of LTCI in the year 2000, the number of those eligible for care benefits in Japan has risen from 2. 562 million to 4. 401 million people. Care dependency is divided into five care levels and two assistance levels. The assistance levels are, in contrast to the care levels, aimed at rehabilitation and prevention. The proportion of patients in each of the care levels is as follows: 11 percent in care level 5 (highest level of care requirements), 14 percent in level 4, 18 percent in level 3, 19 percent in level 2, 17 percent in level 1, 11 percent in assistance level 2 and, finally, 9 percent in assistance level 1.

Financial benefits paid to those who qualify for at-home care vary between 382 Euro monthly for assistance level 1 and 2756 Euro monthly for care level 5. Care managers undertake the task of assessment and level assignment. Following a visit with the patient and with the help of a standardized computer-aided procedure, in which the patient is assessed according to five different criteria (physical and mental), the final decision on the level categorization of the patient lies with the local authority body responsible. In a research project, tests involving the participation and observation of at-home carers were carried out over several months to measure the objectivity of the process of assessment and level assignment. These tests will allow the process to be improved. The costs for assessment and level assignment run to around 61.1 billion Yen (about 457 million Euro) annually, which corresponds to approximately 1 percent of the long-term care budget.

Emilie DELPIT (Project officer, National Solidarity Fund for Independent Living, CSNA – Caisse nationale pour solidarité l'autonomie, France)

Since 2001, care patients over 60 years of age receive financial benefits from the French local authorities through the "Assurance personnalisée d'autonomie" (APA) program. The program was established in order to make it possible for people with loss of autonomy, either physical or mental, to pay for various forms of help in prolonging their independence. In 2008 there were more than one million people claimants, 62 percent of whom received at-home care and 38 percent residential treatment. The financial benefits of the APA are tailored to the individual needs of the patient—there are no fixed payment levels. The loss of autonomy of the individual patients is assessed using the AGGIR scale, with patients being divided according to needs into six groups. Patients in GIR groups one to four are entitled to financial support whereas patients in GIR groups 5 and 6 have no claim. As soon as benefits are approved, a team of local authority employees visit the patient at home and develop a care plan in which the details of care services are laid down.

How reliable are the tools of assessment? If even one patient is assessed as GIR level 4 (entitled to APA) instead of GIR level 5 (no entitlement to APA), there will be a direct effect on the total expenditure of the program. The reliability of the tools of assessment must be guaranteed in order to assure that all citizens are treated equally. The AGGIR scale has been criticized in the past because it failed to adequately encompass neuro-degenerative diseases such as Alzheimer's. For this reason, a scientific advisory committee was formed in 2001; in 2008 this committee published new guidelines for the proper application of the scale. Another criticism is that the AGGIR scale assesses the entitlement of a patient to financial support, yet this is irrelevant for the development of a care plan. The French government is deliberating on the use of private additional LTCI but most insurers use a modified and therefore non-comparable version of the AGGIR scale. Assessment tools used by public and private systems need to be harmonized. There are around three million contracts with private insurers at the present time.

Jürgen GOHDE (Chairman of the Board of Curatorium German Care for Elderly, and Chairman of the Evaluation Committee for the Terms "Need of Care," Germany)

Within the framework of the law on care development, care support points were established, in which care and case management are anchored. One important aspect for the future is the redefining of care dependency, since this was too strongly oriented towards the performance of everyday skills and therefore discriminated against people with cognitive or communicative impairments. A further step forward is the sustainable financing of the system. Regarding the question of definition, an advisory panel was set up to review how care dependency is defined. The panel consisted of representatives of health care providers, public and private care insurers, patient associations, nursing science, economists and jurists, federal state and community representatives, employers and unions. The task given to the panel by the Ministry of Health was to review the existing notion of care dependency, to develop an evaluation procedure for the ascertainment of care dependency, to develop scientifically substantiated proposals and courses of action, and to clarify the financial implications thereof. It was decided that existing definitions from abroad would not be adopted, rather the new definition would instead be developed in close relation with practice (medical services, nursing institute), and the panel put forward a unanimous appraisal for the new definition.

The new definition of care dependency relates to, rather like in France, the impairment of a person's independence and no longer to the time-scale of required care. Six assessment modules were laid down in the appraisal: mobility, cognitive and communicative skills, behavioral and mental issues, self-sufficiency, ability to deal with requirements vis-a-vis the illness and its treatment, and the capability of organizing everyday life. In contrast to previous definitions of care dependency, activities outside the home and housekeeping are no longer criteria since their inclusion does not provide any extra argument for the assessment of independence. As in Japan, care needs are differentiated from assistance requirements. Unlike the French system, there are no needs levels, which do not entitle the patient to benefits. Benefits in the lower needs levels may not be high but they facilitate prevention and advise.

The evaluation of the new assessment tools has gone well. Cognitive impairments are now better ascertained, though not at the cost of a poorer picture of physical impairments. The tools are practical, reliable, understandable and suitable for drawing up a precise care plan and report. 57 percent of Germans worry about requiring care in the future, with the fear of becoming dependent on others, of undignified treatment, and of isolation probably playing a major role. The new definition of care dependency together with a change in practices can help to reduce this fear of old-age and care dependency and to build trust in the care assistance on offer. One remaining task is to improve the interface of care services between LTCI, social benefits and integration assistance.

Discussion on Session 3

Moderation: SUZUKI Yasuhiro

J: The structure of long-term care is very different in the three countries regarding, for example, the structure of financing (funding via tax or insurance contributions). It is therefore surprising to see how great the similarity is in the assessment of care needs. We learned from the discussion about the redefinition of care dependency that there is always need for a balance between cost considerations and objectivity in assessment. I would therefore like to ask as a starting point for discussion how the redefinition of care dependency is regarded in each of the three countries.

F: In France there are separate programs for the evaluation of care needs of disabled people and the elderly. Some stress that the methods of assessment for the disabled are much more precisely tailored than those for the elderly. At the moment there are deliberations on consolidating the two methods, although local authorities who carry out the assessments are opposed to the idea, saying that such a shift would create considerably more work for them. Furthermore, old people in France, in contrast with disabled people, receive capped benefits; this means that in the assessment of care needs, the technical or housing needs of the elderly are often not taken into consideration since those carrying out the assessment know anyway that the social benefits would not cover much more than the costs of a home-help. A better picture of the various needs of elderly patients ought to be drawn, despite the capping of benefits.

J: In Japan, the needs of the disabled and of the elderly are differentiated, like they are in France. Are the two groups assessed collectively in Germany?

G: First of all it should be mentioned that the panel came to the unanimous opinion that the costs of care should continue to be financed publicly. In the context of limited resources, demographic changes must be reflected in additional costs and borne by society. In Germany, because of the principle of payments in kind, residential care is better evaluated structurally than at-home care. A cash payment system like the one in France does not exist; such a system could be problematic with regard to benefits for disabled people since the Integration Assistance Grants are paid out of social welfare and fall therefore under the responsibility of local authorities. According to paragraph 43a of the German Social Insurance Code No. 11 (SGB XI) a monthly payment of 10 percent of the cost but not exceeding 256 Euro is made to the social assistance authorities, thereby affording disabled patients symbolic entry into the long-term care insurance program, but the real costs are much higher. Were the same assessment to be used now for disabled people as is for the elderly, we could well have a constitutional discrimination problem. So far, however, there have been no complaints about the lump sum since the highest German court has established constitutionality with regards to this question. Our task is not the purely technical exchange of resources, rather the improvement of services for patients.

J: A question for our Japanese colleagues—how should selection criteria and the assessment of needs be adapted in the future?

J: The most important point for Japan in the adaptation of the assessment system has already been realized, namely an understanding as to what form of care and how much thereof should be made available. We worked for a long time on setting down objective assessment criteria. Through precisely measurable definitions, we can give the general public a basic vocabulary, which enables them to deal with the situation. Our specialists can say exactly how long certain care programs run and what negative consequences there would be, should certain care services not be made available. The assessment of disabled people and the elderly still take place within separate systems but we hope in the future to standardize the content of the evaluation forms so that the same program can be used for both. We would also like to make services more personalized.

G: I would like to pick up on the last point made from the point of view of patients, particularly in the context of limited resources. Naturally there are always more needs and wants than practicable services but it is important to be responsive to the patient's subjective perception of what they need and to offer care that is tailored closely to the individual.

J: Because of the diversity of care services that patients receive nowadays, we are trying to establish how much care patients in certain needs levels in at-home and residential care require. In Japan the systems of care-needs assessment and care management are independent of one another.

G: It is a matter of having a transparent and selective quality assurance process. To this end, the long-debated step of having care management in the care support points is a step towards an improved care structure. In order to achieve the transparent provision of carefully targeted services, roles must be clearly defined and divided. We appreciate hearing about the Japanese experiences.

J: Thank you for this exchange. There are many differences in the three countries, for example about how care and the role of the family are looked upon. We also have, however, much in common in the determination of care needs. We have heard in the reports on experiences in the three countries about successes and failures and hope to learn from those failures. Thank you very much for the constructive discussion.

Session 4: The Provision of More Appropriate Services for the Elderly

4.1. The Integration of Care into the Local Districts

Almuth SATRAPA-SCHILL (Director Health and Humanitarian Aid, Robert Bosch Foundation, Germany)

The Robert Bosch Foundation has been involved with the question of health and education in a European and transatlantic context for more than 40 years. The focus of the foundation's work in this field are training concepts, care and health, and overcoming chronic disease. Regarding demographic change, we have to look at the active side as well as the care-dependent side of old age since both sides have an important role to play in the provision of more fitting services for the elderly. The incidence of chronic disease and dementia will rise further so means for a dignified way of handling polymorbidity and the last stages of life before death must be found. One cannot simply talk *about* the elderly, one must include them in the discussion. According to surveys, older people would prefer at-home care in their usual surroundings to residential care. How people grow old will prove in the future to be ever more individual and differentiated. Family members providing care should be supported and individual care, prevention and rehabilitation should be more strongly promoted.

Through the expansion of volunteer work in care, the burden of care provision can be better distributed. Volunteer helpers or assistants could support professional care workers and family members. Care solutions should not only offer a better quality of life but should also be worthwhile economically, and this can be achieved through the integration of voluntary care work. Since the care is provided at local authority level, it should also be regulated there. Care services can be rendered quickly and flexibly on a local level through existing networks. Care support points, through which at-home care can be improved, are situated in the communities for just this reason. They offer individual case management and access to self-help groups, as well as arranging help and support. The problems with the existing program lie foremost in the lack of integration of palliative care and in the care of dementia patients. There are many pilot projects in the communities, however, to try and combat these failings and through the integration of professional and civil activities, the care situation has already improved. In order to raise awareness of dementia-related illnesses, the theme "Dementia in the community" will be presented in small projects on a local level. Dementia is not only a medical and care-related problem but rather the responsibility of the whole of society. Further training programs on the specifics of dementia-related illnesses must be developed and offered to professional care workers.

Bernhard GARRO (Assistant-Director of Social Welfare Department, City of Paris, France)

Under the traditional system of care, old people with low incomes in particular were supported financially through social welfare and accommodated in residential facilities such as nursing homes or Établissements d'hébergement pour personnes âgées dépendantes (EHPAD). Under the new system we have services for the preservation of personal autonomy (Allocation personnalisée d'autonomie – APA since 2001, Prestation de compensation du handicap – PCH since 2005) and assessment mechanisms, as well as new efforts regards coordination and networks. Above all, because of the large number of agents involved, a better coordination of programs and services is essential. Paris is an interesting example since the city, with 20 percent of its population classed as elderly, is relatively-speaking an "old" city, and is additionally polarized into rich and poor. It is difficult to make the living conditions of elderly people in Paris better or to create more residential care places since real estate is so expensive.

Paris is simultaneously a "commune" and a "department"[7] and therefore has an unusual status which carries weight particularly in the coordination of services. Departments traditionally involve themselves in care through the control of residential facilities and residential as well as at-home care services. In doing so, they work with the central government. The regional and central health insurance providers work together with the departments to monitor and finance medical services. The cities are ultimately responsible for the organization of local support and prevention services. In order to make coordination between the different agents on the various levels of hierarchy easier, a single health agency in each region (ARS) for both medical and care-related functions will be set up in 2010. The APA was launched in 2001 and is assigned and assessed by the departments. In order to simplify institutional coordination between department and commune, regional medical-social coordination was established, which the state bound contractually to the regions. Advice points were introduced to aid coordination of the various agents within the departments. The collaboration between the various facilities was contractually regulated to guarantee the transparency of services and costs. The alignment of arrangements made in the regions will concentrate more on care. Local information points, of which there are already 15 in Paris, will provide information and take over coordination of medical and care-related gerontological services. Seen in this light, they constitute a simple version of a case manager. These information points will benefit not only dementia patients but also all elderly and disabled people, even though operated in cooperation with the "Maisons pour l'autonomie et l'intégration des malades d'Alzheimer" (MAIA). A pilot project is currently being run in the 20th Arrondissement of Paris for local alignment of social and healthcare services through these centers.

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[7] A "commune" is the lowest level of administrative division in France, roughly equivalent to a municipality or civil parish, "départements" are administrative subdivisions of the regions.

TAKAHASHI Hiroshi (Rikkyo University, Japan)

Before the introduction of LTCI, care-dependent old people with low incomes were taken care of through the healthcare system and through a separate welfare system for the elderly. Since these services were limited to low-income senior citizens, care-dependent old people with mid-range incomes were cared for in hospitals for the elderly, a situation which was financially unsustainable. Since the 1970s, at-home care in the form of "Home Help Services" has been institutionalized as a public service. Since the implementation of the Long-Term Care Insurance Law of 2000, services which were hitherto mostly provided in residential institutions are now offered as at-home care, too. Additionally, voluntary activities in neighborhoods for the care of elderly people are being sponsored by the government through the implementation of a law for the promotion of non-profit organizations.

Even before the establishment of long term care insurance, steps were taken to improve the existing system of formal in-home care systems and to set up further systems in order to strengthen care within the patient's usual surroundings. A further step was the promotion of voluntary services within the neighborhood. In order to improve coordination between professional and voluntary care services, the government has been offering grants since the 1990s to organizations working on coordination. In the long term care insurance system from 2000, the promotion of at-home care services has taken priority and care management centers have been set up. It is the job of the professionally-trained and certified care manager to draw up individually tailored care plans for each patient. Care managers are now also employed by hospitals and facilities for the formulation of care plans and their efficient application.

Estimated changes in the number of care-dependent elderly people living alone, the rise in the number of Alzheimer's cases and the higher costs of residential care relative to at-home care have led to the founding of "Community Comprehensive Support Centers" in the reform in 2005 of the Long-Term Care Insurance Law. Three percent of the financial resources designated for the provision of care services was set aside for the establishment of these centers. This meant that by 2006, 90 percent of communities had already set up a community comprehensive support center. These centers are coordinated by care managers, they advise patients about the services available to them or about prevention measures, and inform about problems, which do not fall under the Long-Term Care Insurance Law, such as the maltreatment of old people, etc. At the beginning, the centers concentrated more on prevention work but the focus is now rather on management and coordinating activities.

Sufficient care is a topic in urban areas in particular since fewer care facilities can be established there than in more rural areas due to the high costs of real estate. Because of this, the boosting of at-home care is given priority in the cities. The community comprehensive care system consists of four strategies:

1. The collaboration of different specialists in the areas of health, welfare and medical care and the coordination of these with volunteers;
2. The safeguard of continuous long-term care and ambulatory palliative care. The aim is a combination of services on the basis of LTCI and medical insurance;
3. Guaranteed continuity of care within the care levels and different institutional facilities;
4. The availability of comprehensive care.

The integrated care system should guarantee a better integration of residential facilities into the communities in which the patients live through, for example, the decentralization of care services. This system is an opportunity for the better care of dementia patients since specialized services tailored to individual needs can be offered and awareness will be raised in the community of the special circumstances of people with dementia.

4.2 Accommodation and Facilities for the Elderly

Rainer BRÜCKERS (Chairman, Arbeiterwohlfahrt, AWO Bundesverband, Germany)

The Arbeiterwohlfahrt (Workers' Welfare Association) has been providing social services for young and older people for more than 40 years. But even civil-social agents are subject to economic and legal standards which can make an integrated treatment of the patient difficult. The introduction of LTCI stems politically from the aim to lower local authorities' expenditure on social benefits. The doubling of at-home care services appears to conform to the "at-home before residential" guidelines, although residential care facilities have also been expanded. The growing number of dementia patients will prove a challenge for residential and at-home care services since the necessary care will not be paid for under the traditional physical-functional definition of care. It would appear, however, that the debate on the redefinition of care dependency is moving in the right direction to eliminate this problem.

Although LTCI reforms regarding support services, prevention and rehabilitation are desirable, their financial sustainability and availability cannot be guaranteed due to demographic developments. The supply of labor in the care industry is threatened by competition with family support care services and child-care. By the year 2013, the number of child-care workers will have to be doubled and at the same time 50 000 day-care workers will have to be employed; nevertheless, training facilities and interested school-leavers are both lacking. A further challenge is the creation of a networked care structure in the patient's social environment, which will link all agents and care strategies in a chain of care. A vital component for the success of these endeavors are care and case management in the form of care support centers and care advisers.

Since approximately 65 percent to 89 percent of care is provided by non-professionals, the importance of the so-called “layman healthcare” system is rising. Sufficient care cannot be provided solely through the financial support of professional healthcare structures and is also dependent on the efforts of volunteers in the patient’s social environment. This is a particular challenge for welfare organizations, which already partly undertake the task by training unpaid care workers in volunteer academies.

The altered perception of care concepts has meant that more worth will be put on the dignity of the patient. More than 90 percent of old people want to spend the remainder of their lives in their usual home surroundings and for this reason we ought to cater for suitable housing and social care chains including palliative care, rather than financing further residential facilities.

SONODA Mariko (Meiji University, Japan)

In Japan, only 4.4 percent of people over 65 live in nursing homes or assisted-living facilities. Around 70 percent of all elderly people in Japan, as in Germany and France, want to remain living in their usual surroundings. In Japan, however, 20 percent of care patients, a greater proportion than in our two comparison countries, are unhappy with their current accommodation. Elderly Japanese also seem to be more concerned about the availability of adequate accommodation in the event they should become dependent on care. Of care-dependent people over the age of 65, 88 percent receive at-home care and 7 percent residential care. These figures shift, however, according to the level of care dependency: 60 percent of elderly people with (Japanese) care level 5 and 49 percent with care level 4 live in long-term nursing homes. In the meantime there are also intermediate forms of accommodation, such as the different forms of assisted-living facilities (for example public, charitable or private assisted-living housing), of which some facilities are paid for by LTCI.

Since the introduction of LTCI in the year 2000, the proportion of those who would prefer to live in a care facility rather than be cared for in their own home has risen sharply. Because of the higher costs (286 thousand Yen or 2137 Euro per month for a place in a nursing home, 110 thousand Yen or 822 Euro per month for at-home care), the Japanese government would like to have more patients cared for at home or in alternative forms of accommodation. To this end, regional care services are being improved, the building of accessible apartments sponsored, and more assisted-living housing with care services made available.

So as not to lose sight of the patients and their welfare in the solving of this problem, the quality of accommodation and the dignity of the patient must be guaranteed. The integration of patients in the local communities should be achieved via care homes with limited capacities (maximum 29 patients). Moreover, more single rooms should be created in already existing long-term nursing homes. One further problem are the meager prospects of assisted-living accommodation for middle-income patients, who can neither afford expensive private facilities nor qualify for a place in a public facility.

Gilles DE LA GORCE (Directorate-General for Social Action, DGAS, Ministry of Labor, Social Relations, Families and Solidarity, France)

In France there are ever more intermediate solutions springing up between at-home care and residential care, even if at-home and residential forms still represent the majority of care services. Amongst these new intermediate forms are apartments, which are oriented towards residential facilities, and also facilities, which attempt to imitate the situation in a private apartment. It has been the goal of care policy since 1975 to develop at-home care and to improve the conditions in residential facilities. There are difficulties within at-home care in the coordination of the various care services offered and the professional training of the care-providers. Even the division of responsibility between the different hierarchical levels causes difficulties because, for example, the accommodation support services are coordinated on a national level but services for the elderly and disabled are, in contrast, under the authority of the departments. The situation in residential facilities has changed dramatically since the reform of 2002—for example, there are now government quality controls and price setting is carried out every five years in agreement with the government and the department. Nevertheless problems remain in the equitable allocation of services.

Intermediate facilities can be public facilities for people with minor care needs, facilities for short-term care, day centers or "foster families." The latter is one of the more innovative solutions, whereby rights and duties are laid down contractually between the "host family" and the patient. The acceptance of patients into residential facilities depends on the care level. The higher the care level, the more likely a stay in a residential facility. Despite all efforts to bolster at-home care, there still remains a great shortage of places in residential facilities, which therefore need to be expanded. The accommodation costs are probably higher for the more innovative residential solutions than for the at-home care ones, although reliable cost comparison data are not yet available.

Discussion on Session 4

Moderation: Matthias VON SCHWANENFLÜGEL

G: After listening to the presentations, it would seem that it is no longer simply a question of whether at-home or residential care is the best option, rather that a broad range of options is made available to people dependent on care.

G: There is a high degree of concurrence in the different presentations on forms of accommodation for the elderly. The models go by different names in the three countries but the underlying concepts are, however, very similar. We need to think about whether the unbounded expansion of residential facilities is any sort of social prospect at all and does not, for example, lead to a greater degree of isolation of the elderly. The question of the financing of care services for those with middle-incomes, as mentioned by Prof. Sonoda, is a valid one. People should be in the position of being able to finance adequate care in old-age through their incomes. The Altenbericht Kassel (Report on the Situation of the Elderly) shows that people who receive social benefits and who cannot afford to pay for at-home care are twice as likely to end up in residential care as people with higher incomes. Why are at-home services (mostly housekeeping help) there? Are they so that residential care can be avoided or are they there for some other purpose? I would be interested to hear opinions from our French and Japanese colleagues.

F: At-home care in France should above all minimize the number of patients in residential care. Yet there is a problem within at-home care for dementia patients in that it is more difficult to discern the wishes of the patient. The general public are indeed ever more informed about illnesses such as Alzheimer's but the needs of patients are still poorly met. In any case, there is a contradiction between priority, which in this discussion group we have placed on at-home care, and practice, in which residential care continues to be expanded.

J: There are many overlaps with Session 3 in our discussion about residential and at-home care. It would be desirable to offer many different types of at-home and residential care on a local level. There is no ideal path, in which one or the other solution proves to be the best. Group Homes lie, by the way, not like resorts outside the cities but rather in the center of town. This means for the patient that they can still take part in a social life and it is also easier for family and friends to come visit. In the reform of the Japanese LTCI of 2006, a program was set up that facilitates local contact. Under this program, local care services are made available in the home of the patient. But there are also care units and day care options similar to those mentioned by Gilles de la Gorce. One goal now in Japan is to strengthen the networks amongst care-providers. However the program is new and has not been fully implemented.

F: My answer is the same as from the Japanese side. The solution to the issue of choice of accommodation will be provided through innovative facilities, which can organize at-home care just as efficiently as residential care. These will not be isolated units in the middle of nowhere but will instead be integrated into the cities. Because the costs of real estate are so high in the big cities, financial incentives are going to be required if this type of innovative facility is to be built at all. They are, nevertheless, the way forward in better fulfilling the wishes of the patients.

G: How is contact in France with the housing associations? In Germany, housing associations are also charged with the task of expanding communal apartments for residential groups or residential communities.

F: The development of these Group Homes is part of the French government's Alzheimer Program. Architects are already integrated into the program.

Summary Comments

Stéphane LEBOULER (Head of Research Unit, Direction for Research, Study, Evaluation and Statistics, Ministry of Labor, Social Relations, Families and Solidarity, France)

The three predominant themes in the contributions of the previous days were social policy, professional dynamics and economic logic.

The theme of long-term care has been on the political agenda in all three countries for several years. There are parallel developments in relation to both the aging of society and the number of Alzheimer's patients. Despite a few divergences in the way of looking at the problems, at-home is preferable to residential care in all three countries. With its reforms, social policy is following the principle of trial and error, yet on the basis of a deepening expertise. In order to compare the different national experiences, we need points of reference. In Europe, in particular, many of the challenges are alike, for example the question of financing and intergenerational equity in the distribution of the burden. In this, there must be agreement on how much of the costs should be borne by society and how much by the patient.

Points of reference are essential for the assessment of care needs and services. Individual needs correspond to the development of professional methods for their evaluation and the appraisal of the quality of services. This is not simply a question of economic efficiency, but is rather the preservation of human dignity. One further challenge is the supply of care labor. Supportive measures such as higher salaries and better training are nevertheless in contradiction to the financial feasibility of the system.

The financial feasibility of the system is at the forefront in all three countries. Are projections for the future reliable enough to forecast care needs for the coming years? If the number of people dependent on care continues to rise, we have to ask if this is due to an increase in patients or the better ascertainment of actual numbers of care-dependent people through the systems introduced in the last years. Assessment mechanisms for the efficiency of care services are essential since government spending on care rises in accordance with the rise in the number of those entitled to benefits. For this purpose, a more exact picture of the difference in costs between at-home and residential care is needed. A further challenge is the balance between individualization and standardization. Individualization in the assessment of care needs and in the provision of care services is important in reflecting the growing heterogeneity of patients' needs and in facilitating freedom in choosing a care provider. Yet standardization is also necessary in ensuring fair treatment of citizens and reproducible quality. In this sense, it is also a matter of division of competencies between the relevant providers.

Wolfgang BRENN (Japanese-German Center Berlin, Germany)

Research and care constitute a concerted approach. Within the variety of approaches to care, we should not play residential and at-home care off against each other, but rather decide how this variety can be organized. Different approaches to the financing of the LTCI system have been introduced in the presentations: tax-funded, insurance contribution-based and mixed models. Each system has its advantages and disadvantages—the tax-funded model appears to be flexible whereas the one funded through social security offers a legal entitlement to care. The amount of contributions or percentage of tax contributions is a measure of the value laid on care. In efforts to reduce the risk of needing care, prevention measures are more and more important. Every country can learn from the systems in place in other lands. Thus Germany is orienting itself as regards the assessment criteria in the redefinition of care dependency by the example of the Japanese standards.

The shortage of manpower in the care industry is a further problem common to all three countries. Improvements in the salary structure is of course one approach in solving these problems but working conditions and training must be improved at the same time. Thus the example of short-term training programs in Japan makes sense, even if the idea of identifying qualified helpers via an armband (see presentation of Homma Akira) is not likely to catch on in Germany.

The accessibility of care in the lowest level of state structure, local authorities, was a theme in several presentations. Here, too, are similarities in the institutional structures of the three countries, such as the care support points in Germany and the community comprehensive support centers in Japan. In all three countries there is an attempt to strengthen the integration of society in care. With better networking and changes in the care structure, a better use of informal forms of social resources can also be made possible.

MATSUMOTO Katsuaki (Hitotsubashi University, Japan)

Professor Matsumoto used the example of the illustration of a Japanese bird by Sieboldt to demonstrate the difficulties of the comparative approach. Even though the depiction of the bird was amazingly true to the actual animal, if one looks closely enough, one can detect small but telling differences. With regard to care, Germany, France and Japan all face similar challenges, for example similar systems have been developed to cushion the risk of care dependency. Nevertheless significant differences, possibly attributable to cultural factors, persist as to how these problems are approached institutionally. The symposium was not just important because it was a step forward in international comparative exchange but also because the different delegations are made up not just of ministry officials but also representatives from science and praxis. Thus we have laid a solid foundation for future collaboration.

Closing Comments from the Delegations

MIYAJIMA Toshiko (Director-General, Health and Welfare Bureau for the Elderly, Ministry of Health, Labor and Welfare, MHLW, Japan)

We have had the chance to exchange opinions through lively discussion. Japan is an aged society and it is our declared goal to let people live and grow old in peace. In response to the rapid aging of society and the consequences thereof, we have developed a long-term care program which nevertheless does not solve every problem relating to care. This symposium was for our side a first step in dealing with these issues.

Session One was concerned with the care of dementia patients. The question is one of how a healthcare system can be created, within which dementia patients can be taken care of adequately. Furthermore, at-home care must be made available to dementia patients so that they can continue to live with their families.

Session Two was concerned with the establishment of a system of LTCI, which allows people to feel as though they are in good hands. A great problem in Japan at the moment are the working conditions of people who provide care. Furthermore, more people express the wish to work in the care industry than actually do and the employee turn-over rate in the care sector is very high. To counteract these problems, the government has decided to raise wages in the care sector by 3 percent and further additional measures will be taken to entice more suitable and able people into the care profession. At the end of the day, it is not just the aging of the population that we have to take into consideration when planning for the care system, but also the fact that there are fewer and fewer young people. Among other things a fair balance must be struck between the burdens and the achievements of the system.

Session Three dealt with the definition of care dependency. The broadening of the definition and the integration therein of dementia is a topic in all three countries. Session Four dealt with the individualization of services for care patients. A large part of the discussion was concerned with the cooperation of care providers on a local level. The networking of the various care service providers at local authority level is essential in guaranteeing that care patients can remain living with their families. Thank you very much.

Matthias VON SCHWANENFLÜGEL (Deputy Director General, Long Term Care Insurance, Federal Ministry of Health, Germany)

We will be carrying many suggestions from Japan over into our work in Germany. I would like to highlight a few of them here: We have learned how important it is that case management should be independent from the granting care services, as should, in turn, assessment. These three processes, each independent of the others, take place in order to optimize the assistance provided to each care-dependent patient. Furthermore we have heard interesting examples from France as well as Japan of what we in Germany refer to as care support points or networking in the local communities. In Germany the local authorities are in a strong position, as the federal government was forced to recognize in the last constitutional reforms. It will have become obvious here in Japan that the local communities in Germany need to be even further integrated into the network for care-dependent patients. The practicalities of care level 1 in Japan are interesting. In the last Japanese reforms, prevention measures within the long-term care system were expanded further. This will also play an important role in the German reform of the definition of care dependency.

I also found interesting our discussion on the care profession and that it is not simply a question of salary but rather working conditions and society's estimation of the care profession that play a central role in motivating the people who perform these responsible but also difficult services to remain longer in the job. The problem appears to be similar in Japan and France. In France and Germany the question of foreign labor probably plays a greater role than in Japan due to the many, easily crossed borders within the EU. Illegal employment is a topic in Germany that should perhaps be discussed bilaterally with France.

We consider a continuation of these exchanges important and worthwhile, and we should think about how we can set them up in the future. Ultimately it would be very helpful for care patients if we did not set about reinventing the wheel every time but instead could build on the experiences of others. I would like to express my thanks at this point for a well-organized conference. Thank you very much.

Bernard GARRO (Assistant-Director, Social Welfare Department, City of Paris, France)

Thank you very much. The comparison of the insurance systems against dependency on care is very insightful for those who are in charge of meeting with political decisions. The three countries have several points in common, four of which I would like to highlight here: similar values; specific challenges linked to Alzheimer's; the difficulties of care providers; and the management of public policy.

A new pillar was added to the social security system through the introduction of LTCI in all three countries in the last 15 years along the same principles: for one, respect for the dignity and choice of elderly people, above all the choice to remain living at home with ambulatory care; for another, public solidarity with older people and the attempt to offer services equally all over the country. However, our systems require regular reform in order to make allowance for the further development of needs and experience with new programs. For example, I made a note of the fact that in the redefinition of care dependency in Japan and Germany, the restriction to physical problems has been lifted so that neuro-degenerative problems and Alzheimer's can also be included. A similar development regarding the definition of care dependency is also central to French reforms.

The growing number of people suffering from dementia also means that we have to pay more attention to the environment of these patients. A doctor I spoke to explained that with Alzheimer's there are two victims: the patients and the carers. We have to support the carers and make it possible for them to take time out. The issues of organization and acceptance of financial burden between tax, social security and private expenditure are crucial and will become even more complicated because of demographic developments and their effects on the financing of other social necessities such as pensions and healthcare. The progress of care dependency is therefore an issue that must be considered in the long-term, although it must be kept in mind that our predictions over a longer period of time will probably require repeated revision. This might also involve surprises for the better, for example regarding the rate of new Alzheimer cases, should a cure be discovered.

Our three countries find themselves already in the process of reform, even though the systems in place are a mere ten or fifteen years old. I think it would make sense to undertake reforms in France every five years. We do this already with the pension system. The future and its uncertainties requires of us a lot of vision since adaptable finance systems must be developed, which can factor in these uncertainties and at the same time withstand difficult times like the ones we are currently experiencing. With regard to the social security systems, developed in the 20th century for healthcare and pensions, the services provided must also be reactive and modeled through dialog with the people involved. A constant flow of exchange of experience must be guaranteed. This exchange should also involve other countries. What we have shared over the last few days has already saved us much time in so far as we have learned not to throw ourselves into programs which have had little success in other countries. A lot of information has been exchanged but we need to consolidate. I believe it would be possible in the future to exchange e-mails on specific and technical questions. Nevertheless, the direct exchange such as we have had in the last two days is a prerequisite for the dynamic of a permanent exchange. Thank you very much.

Programm des Symposiums / Conference Program

MINISTRY OF HEALTH, LABOR AND WELFARE (JAPAN)
MINISTRY OF HEALTH (GERMANY)
MINISTRY FOR LABOR, LABOR RELATIONS AND SOLIDARITY (FRANCE)
JAPANESE-GERMAN CENTER BERLIN (JDZB)

Program for the symposium on "Long-term Care"

from Tuesday, February 3 to Wednesday, February 4, 2009
at the International Conference room, Mita Kaigisho
2-1-8 Mita, Minato-ku, Tokyo 108-0073

Tuesday, February 3

Master of conference: ITAYA Hidehiko (Internationale Planing Division; Ministry of Health, Labor and Welfare)

Opening Remarks

H.E. MASUZOE Yoichi (Minister of Health, Labor and Welfare, Japan)
Agnès LECLERC (Director, European and International Affairs, Ministry of Labor, Labor Relations and Solidarity)
Marion CASPERS-MERK (Parliamentary State Secretary, Federal Ministry of Health, Germany)

Keynote Speeches

Marion CASPERS-MERK (Parliamentary State Secretary, Federal Ministry of Health, Germany)
Prof. Marie-Eve JOËL (Dauphine University, Paris)
Prof. MATSUMOTO Katsuaki (Hitotsubashi University)

Session 1: Roles of Care for the Elderly with Dementia

Chair: HASEGAWA Kazuo (Center Director, Yokufukai Tokyo Dementia Care Research and Training Center)

HOMMA Akira (Team Leader, Research Team for Promoting Indepence for the Elderly, Tokyo Metropolitan Institute of Gerontology)
Sabine JANSEN (Managing Director, German Association for Alzheimer Desease)
Sandrine LEMERY (Project Manager, Steering Mission of Alzheimer Plan, France)

Session 2: Establishment of a Long-term Care System through which Citizens Can Receive Care at Ease

Chair: Stephane LEBOULER (Head of Research Mission, Department of Research, Study, Evaluation and Statistics, Ministry of Labor, Labor Relations and Solidarity)

Establishment of a Social Long-term Care Cost Sharing System

Severine SALGADO (Policy Officer, Department of Social Security, Ministry of Labor, Labor Relations and Solidarity)
YOSHINO Takayuki (Director of Long-Term Care Insurance Division, Health and Welfare Bureau for the Elderly , MHLW)
Dr. Matthias von SCHWANENFLÜGEL (Deputy Director General, Long Term Care Bureau, Ministry of Health, Germany)

Secureness of Quantitiative Workforce and Human Resources Development

Maryse CHAIX (Assistant Director for Territories and Social Work, General Department of social Action, Ministry of Labor, Labor Relations and Solidarity)
Andreas KRÖGER (Managing Director, AHK Pflegeteam)
HABU Eiji (Director of Promotion Division, Health and Welfare Bureau for the Elderly, MHLW)

Session 3: Definition of the Term "Need of Care" and Methods of Assessment of "Need of Care"

Chair: SUZUKI Yasuhiro (Director of Division of Health for the Elderly, Health and Welfare Bureau for the Elderly, MHLW)

TSUTSUI Takako (Chief, Administration, Department of Social Services, National Institute of Public Health)
Emilie DELPIT (Project Officer, National Solidarity fund for Independent Living)
Dr. h.c. Jürgen GOHDE (Chairman of the Board of Curatorium German Care for Elderly, and Chairman of the Evaluation Committee for the Term "Need of Care"

Wednesday, February 4

Session 4: Providing Appropriate Services for the Respective Elderly

Chair: Dr. Matthias von SCHWANENFLÜGEL (Deputy Director General, Long Term Care Bureau, German Ministry of Health)

Integration of Care in Municipalities

Dr. Almut SATRAPA-SCHILL (Director Health and Humanitarian Aid, Robert Bosch Foundation)
Bernhard GARRO (Assistant Director, Social Welfare Department, City of Paris)
Prof. Takahashi Hiroshi (Rikkyo University)

Role of Housing and Institutions for the Elderly

Rainer BRÜCKERS (Chairman Arbeiterwohlfahrt)
Prof. SONODA Mariko (Meiji University)
Gilles de la GORCE (Deputy Assistant Director for Old Age People, General Department of Social Action, Ministry of Labor, Labor Relations and Solidarity)

Summary Reports

Dr. Wolfgang BRENN (Head of Project Management, JDZB)
Prof. MATSUMOTO Katsuaki (Hitotsubashi University)
Stephane LEBOULER (Head of Research Mission, Department of Research, Study, Evaluation and Statistics, Ministry of Labor, Labor Relations and Solidarity)

Closing Addresses

MIYAJIMA Toshihiko (Director General, Health and Welfare Bureau, MHLW)
Dr. Matthias von SCHWANENFLÜGEL (Deputy Director General, Long Term Care Bureau, Ministry of Health, Germany)
Agnès LECLERC (Director, European and International Affairs, Ministry of Labor, Labor Relations and Solidarity)

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Joël, Marie-Eve	Université Paris Dauphiné, Frankreich
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Schwanenflügel, Matthias von	Unterabteilungsleiter Pflegesicherung, Bundesministerium für Gesundheit, Deutschland
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Takahashi Hiroshi	Professor, Rikkyo University, Japan
Tsutsui Takako	Sektionsleiterin, Dept. Social Services, National Institute of Public Health, Japan
Yoshino Takayuki	Director of Long-Term Care Insurance Division, Health and Welfare Bureau for the Elderly, Ministry of Health, Labor and Welfare, Japan

Anhang

Die einzelnen Beiträge (wie vorgelegt)

Tripartite Symposium on Long-Term Care among France, Germany and Japan

Tokyo,
2009, 3rd to 4th of february

Marion Caspers-Merk,
State secretary,

"Whether young or old – the issue of long-term care affects us all, and people who are dependent upon long-term care require our attention and support.

With the Long-term Care Reform 2008 Germany has taken an important step towards improving the provision of care to those who require it and towards making it possible for them to continue living a dignified life. With higher benefits, better counseling, and enhanced measures to insure quality, the reform shifts the focus towards the needs of those who require care, their relatives, and caregivers. Professional caregivers, volunteers, and those who devote themselves to the care of a relative at home, all deserve our special thanks and respect. Supporting them in the work they do everyday is also one of the primary objectives of the Long-term Care Reform.

Enclosed you will find information on the most important innovations introduced by the Federal Government in the wake of the Long-term Care Reform 2008."

I. Long-term Care Concerns All of Us: The Long-term Care Reform 2008

The Long-term Care Reform of 2008

All industrial countries have one thing in common: their populations are growing older. According to prognoses on population development, the number of older persons (60 years and older) in Germany will increase from 8.5 million in 2005 to 28.5 million in 2030.

A girl who is now seven years old has a good chance of living to see the twenty-second century. This positive development does, however, have a drawback. After the age of 80, the statistical probability of being dependent upon help from others increases rapidly – to 28.4 per cent. That means: the older the population, the higher the number of people requiring long-term care.

In long-term care it becomes clear what it means to live in a society in which people’s lifestyles and family structures have undergone considerable changes. The majority of older people would like to be taken care of at home, yet their relatives often have no idea of how to go about organising long-term care at home.

When children who have jobs assume the responsibility for long-term care, it must be determined how their social security benefits can be maintained during this period. People suffering from dementia not only require help with personal hygiene, but also extensive supervision. And in cases where care in a home is chosen, relatives are concerned about the quality of such long-term care facilities.

The Long-term Care Reform – the Long-term Care Development Act – ensures that structures are adopted in long-term care insurance which better suit people’s needs.

The reform provides tangible and concrete improvements for people requiring long-term care, their relatives, and caregivers. The benefits will be gradually increased by 2012, and the circle of those entitled to benefits will be expanded. For the first time, an individual and comprehensive claim to care counselling (case management) will be established. Long-term care support bases are to be established in order to provide people requiring long-term care, and their relatives, with central, local portals through which they can access services.

A series of measures will contribute to the improvement of the quality of long-term care: easily understandable audit reports will, for example, make it easier for the population at large to recognise and differentiate between good and less commendable facilities.

Thus, the Long-term Care Reform will help people requiring long-term care to live and be cared for in the way they would like to be.

In order to finance the improvements in benefits, the contribution rate will be moderately increased as of 1 July 2008 by 0.25 percentage points to 1.95 per cent (2.2 per cent for people without children).

Positioning long-term care in the midst of society and helping those in need are the goals to which the Long-term Care Reform 2008 aspires.

II. Long-term Care is Valuable

More Financial Support, Better Benefits

In the wake of the Long-term Care Reform, the financial benefits provided by long-term care insurance have been increased tangibly and the claim to support will be expanded. As of 2015, the benefits will also become dynamic, which means that the need for adjustment to keep pace with the development of prices will be assessed every three years. With the increase in the contribution rate, the **monthly** benefits for people requiring long-term care will be tangibly increased.

Outpatient Benefits in Kind (Care Assistance)

	Previously	**2008***	**2010**	**2012**
Category of Care (per month in EUR)				
Level I	384.00	420.00	440.00	450.00
Level II	921.00	980.00	1,470.00	1,100.00
Level III**	1,432.00	1,470.00	1,510.00	1,550.00

* The values for 2008 are valid as of 1 July 2008

** The 1,918.00 per month for outpatient care in Level III hardship cases will remain unchanged.

Care Allowance				
	Previously	**2008***	**2010**	**2012**
Category of Care (per month in EUR)				
Level I	205.00	215.00	225.00	235.00
Level II	410.00	420.00	430.00	440.00
Level III	665.00	675.00	685.00	700.00

*The values for 2008 are valid as of 1 July 2008

Institutional Care				
	Previously	**2008***	**2010**	**2012**
Category of Care (per month in EUR)				
Level I	1,430.00	1,470.00	1,510.00	1,550.00
Hardship Cases	1,688.00	1,750.00	1,825.00	1,918.00

*The values for 2008 are valid as of 1 July 2008

The outpatient benefits in kind in Levels I and II (Level I: 1,023 Euro per month, Level II: 1,279 Euro in month) will remain unchanged.

Short-time Care

The **annual** benefits for short-time care will also be gradually increased in the coming years. Before the Long-term Care Reform came into force, the ceiling was 1,432 euros per year. In the coming years the benefits will increase as follows:

	Previously	**2008***	**2010**	**2012**
Euros (annually)				
Maximum	1,432.00	1,470.00	1,510.00	1,550.00

*The values for 2008 are valid as of 1 July 2008

In addition, it will now be possible to arrange for the short-time care of children under the age of 18 who require care in facilities for the care of the disabled or in other suitable facilities. Up until now, children often had to be cared for in approved facilities for geriatric care, or it was impossible to take advantage of their claim to short-time care.

More Benefits in Day and Night Care

Here the benefits are being increased to the same extent as the benefits for outpatient care. In addition, it will be easier to combine benefits individually. The highest possible total claim that can be made by combining benefits for day and night care with outpatient benefits in kind, or with a care allowance, will be increased through the reform to 1.5 times the previous sum. For example, in cases where 50 per cent of the benefits for day and night care are claimed, it will still be possible to claim 100 per cent of the benefit for a care allowance or for benefits in kind. There will, however, be no increase in the latter when less than 50 per cent of the benefits for day and night care are claimed.

Earlier Claim to Long-term Care Benefits

Anyone who needs to claim benefits from long-term care insurance, can expect to receive help sooner. While the previous requirement stipulated that contributions had to have been made for at least five years before making a claim, it is now sufficient to have made contributions for only two years, or to have been covered under family insurance, in order to be entitled to claim benefits in full under long-term care insurance.

Faster Processing of Applications

Anyone submitting an application to have their need for long-term care recognised, can expect to receive an answer from the long-term care insurance fund as soon as possible; an answer must be provided within five weeks at the latest. In cases of hospitalization, care in a hospice, or outpatient palliative care, the application must be processed within a week. If the applicant is at home, and the person providing care submits an application for long-term care leave, then a two-week deadline for the processing of an application for the recognition of the need for long-term care applies.

Earlier Claim to Holiday Substitutes for Caregivers

Relatives who provide long-term care will be entitled to apply for a substitute to fill in for them while they are on holiday (“stand-in/respite care”) after only six months of long-term care (“pre-care period”) rather than after 12 months, as was previously the case. The long-term care insurance fund will cover the costs for substitute caregivers while a caregiver is on holidays or ill up to a total of as much as 1,470 euros as of 1 July 2008, as much as 1,510 euros as of 2010, and as much as 1,550 euros as of 2012, for a period of up to four weeks per year. In addition, the long-term care insurance fund will continue to pay contributions to retirement insurance for the caregiver while the caregiver is on holiday.

Better Medical Care in Nursing Homes

In many cases the medical care of persons requiring long-term care cannot be provided by local doctors alone, either because there are too few doctors or because the need is too great. In such cases, the long-term care facilities can enter into cooperation contracts with suitable doctors or medical care facilities. In cases where cooperation contracts cannot be agreed to, the nursing home can hire a doctor for the home in order to provide medical care for the residents.

Better Organisation of Transitions

“Discharge Management” ensures the seamless transition of patients into outpatient care, rehabilitation programmes or nursing homes. Counselling already begins in the hospital. Specially trained employees of the discharging hospital, for example, will address the problems facing the person requiring long-term care and begin planning further steps together with the person affected, the person’s relatives and the case manager.

More Deployment of Individual Professional Caregivers

Up until now, independently employed caregivers were only deployed when it was impossible to provide care through long-term care services. In the future, long-term care insurance funds will be able to enter into individual contracts with professional nursing (*Krankenschwester*) or geriatric caregivers (*Altenpfleger*) who are self-employed, provided that care by these professional caregivers is deemed particularly effective or economical, or when this corresponds with special wishes on the part of the person requiring long-term care. People requiring long-term care thereby have more options for making choices.

Support for New Forms of Living – “Pooling” Benefits

The Long-term Care Reform supports people requiring long-term care in their desire to continue to live self-determined lives and also supports new forms of living such as residential groups. This will allow persons sharing the same residence to pool their claims to benefits in kind and to jointly claim benefits for basic care and housekeeping. By pooling claims to benefits in new residential forms, it will be possible to make use of efficiency reserves. The time that becomes free as a result, is to be used by outpatient care services exclusively in the interest of caring for those people requiring long-term care who participate in the pool. Benefits can also be pooled among people requiring long-term care who do not live in the same location.

III. Long-term Care Must Provide Help Where Needed: More Support for Persons Suffering from Dementia

More Support for Persons Suffering from Dementia

In the wake of the ageing of society, the number of persons suffering from dementia will also increase. The Long-term Care Reform will provide tangible and targeted improvements for those affected.

More Outpatient Benefits

There will be an increase in the benefits for people whose competence in coping with everyday life is considerably impaired and who are cared for on an outpatient basis – this includes many persons suffering from dementia, as well as mentally ill and mentally disabled persons. Previously, the benefit for care was limited to 460 euros per year. As of 1 July 2008, those affected will receive up to 100 euros (basic benefit) or up to 200 euros (augmented benefit) per month. This represents a total of 1,200 or 2,400 euros per year. The criteria for being accorded a basic benefit or an augmented benefit will be determined by guidelines developed by the Central Association of the Long-term Care Insurance Funds.

Persons suffering from dementia who require less care than deemed necessary for the classification in Long-Term Care Level I, but who still require some care (so-called “Care Level 0”), will now also be able to receive these benefits.

More Assistance in Inpatient Facilities

Through the Long-term Care Reform, homes will be able to offer special programmes of additional support and activation for persons suffering from dementia, which will be provided by additional auxiliary helpers (*Assistenzkräfte*) and paid for by the long-term care insurance funds.

IV. Long-term Care Requires Individual Counselling: Long-term Care Support bases and Long-term Care Counsellors

Long-term Care Support Bases and Long-term Care Counsellors

The spectrum of benefits related to the topic of long-term care is becoming increasingly complex. In addition to the psychological and physical demands posed by the event of long-term care being required, many of those affected feel overwhelmed by the challenge of organising care. The Long-term Care Reform offers aid in this context, by bringing counselling and other services together in one location and by providing individual care counselling.

Everything in One Location

The long-term care support base will serve as an initial portal for people seeking help and as a place where referrals can be made and coordinated for measures to provide long-term care along with medical and social assistance and support. For example, people requiring long-term care and their relatives will receive support and help in submitting applications or in searching for a long-term care facility or daytime care.

Extensive Regional Coverage

Long-term care and health insurance funds will establish long-term care support bases when the federal *Land* in question opts for them. The long-term care insurance funds will support the establishment of long-term care support bases in joint partnership with the long-term care insurance and the health insurance funds, or with the agencies responsible for providing aid to the elderly and with social assistance, by providing initial financing of up to 45,000 euros for each long-term care support base. If self-help groups and volunteers can be sustainably integrated into the activities of the long-term care support base, then the initial financing can be increased by an additional 5,000 euros. In total, the long-term care insurance funds will make 60 million euros in funding available nationwide by the end of June 2011. When long-term care support bases are established, care should be taken to integrate existing counselling services wherever possible.

The Claim to Individual Care Counselling

As of 1 January 2009, the claim to individual care counselling will be anchored in law. Both the statutory as well as private long-term care insurance funds will then be required to offer comprehensive counselling for all insured persons requiring long-term care, i.e. case management.

Counselling for persons requiring long term care and their relatives will be provided by case managers employed by long-term care insurance funds at long-term care support bases. And even in locations where there are no long-term care support bases, the long-term care insurance funds will be required to provide comprehensive counselling and support through qualified experts. Such experts will mainly be professional caregivers, social insurance employees, and social workers who have acquired the appropriate additional qualification.

IV. Care Means Taking Time: The New Long-term Care Leave

Long-Term Care Leave

In the event that long-term care is required, people who are currently employed will be given the chance to organise long-term care and to provide it themselves for a certain period of time. Through the Long-term Care Reform they will be able to take this time as long-term care leave.

Claim to Long-term Care Leave

As of 1 July 2008, relatives of persons requiring long-term care will be entitled to claim long-term care leave benefits. People employed in companies with at least 15 employees can take leave for a period of up to six months. During this period they will receive no pay, but they will continue to be covered by social insurance.

During this period of long-term care leave, contributions to pension insurance will be paid – as is already the case under current law – by the long-term care insurance fund, as long as the caregiver provides care for at least 14 hours per week. As a rule, health insurance and long-term care insurance coverage is maintained during this period of long-term care through family insurance coverage. In cases where there is no family insurance coverage, the relative providing care must voluntarily continue their health insurance coverage by paying the minimum contribution. The health insurance contributions automatically ensure long-term care insurance coverage. Upon request, the long-term care insurance fund can reimburse the caregiver for their contributions to their health and long-term care insurance up to the level of the minimum contribution. The insurance coverage for unemployment insurance is maintained. The contributions to unemployment insurance are paid by the long-term care insurance fund.

Short-term Leave of Absence from Work

In the event that a relative suddenly requires long-term care, help must be organized quickly. In addition to a claim to long-term care leave, employees are also entitled.

VI. Long-term Care Demands Quality: More Control, More Transparency, Less Bureaucracy

More Control, More Transparency, Less Bureaucracy

The goal of the Long-term Care Reform is to eliminate deficits in the quality of long-term care, to cast off bureaucratic ballast, and to make sustainable improvements in long-term care.

National Quality Standards

The contract parties within the framework of providing long-term care (Pflegeselbstverwaltung) must ensure that national quality standards (expert standards) are developed and continually updated. The Federal Association of Long-term Care Insurance Funds (*Spitzenverband Bund der Pflegekassen*) , the Federal Working Group of Supraregional Social Welfare Agencies (*Bundesarbeitsgemeinschaft der* *überörtlichen Träger der Sozialhilfe*), the Confederation of Municipal Authorities' Associations (*Bundesvereinigung der kommunalen Spitzenverbände*) and the Federal Association Long-term Care Providers all participate in this self-administration.

Annual and Unannounced Quality Inspections

As of 2011, every facility will be reviewed annually and, as a rule, without previous notification. By 2010, every facility will have been reviewed at least once. The focus of the review will be on the quality of the results, i.e. the physical condition and the satisfaction of those requiring long-term care, as well as on the effectiveness of measures to provide care and supervision in long-term care facilities. The Medical Advisory Service will be responsible for conducting quality audits. These will not only involve reviews and assessments, but also include recommendations for improving quality. Contracts with facilities that are found to be not (or no longer) complying with the required standards can now be more easily terminated by the long-term care insurance funds.

Understandable and Easily Accessible Audit Reports

The reports on the results of the quality audits will be published on the Internet and available in nursing homes and long-term care support bases. The results of the audits must be published in a manner that is easily understandable and consumer friendly. Homes will be required to post the last audit by the Medical Advisory Service, the classification of the audit results according to a uniform assessment system, and a summary of the audit results in a highly visible location.

A Comprehensible Assessment System

By the end of 2008, an easily understandable assessment system will be developed. The introduction of a traffic-light system (red-yellow-green) is one possibility, while a system of stars, similar to the type used in hotels and restaurants is another.

More Time for Essential Tasks Through Less Bureaucracy

In order to ensure the quality of care, and to make it more transparent, a suitable means of documenting long-term care activities is essential. This documentation system should, however, be as efficient as possible and within reason. In this conjunction, the associations representing the agencies that cover the costs, and those responsible for operating the facilities on the federal level, will enter into agreements. Moreover, examinations of efficiency and economy in long-term care facilities will only be conducted when there are concrete reasons for assuming that the requirements for receiving approval are no longer being met.

The objective of this simplification is to be able to concentrate on the most essential task, i.e. caring for people who require long-term care.

VII. Care Deserves Commensurate Remuneration: Remuneration for Caregivers and Long-term Care Facilities

The Remuneration of Professional Caregivers and Long-term Care Facilities

Not only will persons requiring care profit from the Long-term Care Reform, this will also be true of caregivers and long-term care facilities. Care facilities are obliged to pay their employees, the professional caregivers, according to local standards. Otherwise they will not be approved or are in danger of losing the approval they have already received.

Commensurate Remuneration of Long-term Care Facilities
In negotiations regarding the levels of remuneration between long-term care facilities and the agencies responsible for covering the cost of care, it will be possible, through a process of benchmarking, to draw comparisons with other facilities of the same quality, if the contract parties choose to do so.
Within the framework of these negotiations, not only the type, content, and extent of the benefits will be determined and agreed to, but more importantly the level of staffing required by the individual facility.

VIII. Long-term Care Requires Dedication: Volunteerism and Self-help

Volunteerism and Self-help

Self-help groups and volunteers make a contribution of inestimable value to the welfare of all of us as well as to caring for people requiring long-term care. The Long-term Care Reform includes improvements for the many people who provide help. The support for low-threshold support offers to provide supervision and for model projects will be increased by 15 million euros per year to 25 million euros. Low-threshold support offers include such measures as groups that provide supervision, day care and helpers' circles, which offer relief for hours at a time to relatives who provide care. Together with the co-financing provided by the Laender and municipal governments, this results in a total of 50 million euros per year now being made available (instead of the previous sum of 20 million euros per year). This money will also be made available to support self-help groups.

In addition, the expenses incurred by those that provide voluntary support can now also be taken into consideration in remuneration for long-term care facilities.

IX. Promoting Prevention and Rehabilitation in Long-term Care

Prevention and Rehabilitation

For many people requiring long-term care, there is reason to hope that their health can be improved through rehabilitation measures. Preventive measures also contribute to older people's being able to continue living independent lives for as long as possible.

Beginning Rehabilitation Measures Quickly

When the long-term care insurance fund ascertains that benefits for rehabilitation are indicated, then it informs the agency responsible for providing rehabilitation of its decision, thereby directly initiating the procedure for beginning rehabilitation measures. If a rehabilitation measure is not provided by the health insurance fund in due time, then it must pay a compensation fee of 3,072 euros to the long-term care insurance fund.

Inducement through Bonuses

In order to provide financial inducements for long-term care facilities, bonuses will be paid to the nursing homes that care for their residents in a manner involving a greater measure of activation and rehabilitation. If it is possible for a person requiring long-term care to be reclassified to a lower Care Level, then the facility will receive a bonus of 1,536 euros. However, if that same person is re-classified into a higher Care Level within six months, the home will be required to return the bonus.

X. Adapting Private Compulsory Long-term Care Insurance to Statutory Health Insurance Regulations and the Promoting Individual Measures

Social long-term care insurance can only partially cover the expenses of long-term care. Private measures are, therefore, advisable.

Social Regulation in Private Compulsory Long-term Care Insurance

Many stipulations to provide social protection already apply to private compulsory long-term care insurance. However, social regulations intended to fund contributions in cases of insufficient income, analogous to the basic contribution in private health insurance, are new.

Brokering Supplemental Insurance Plans

Long-term care insurance funds will be allowed to broker private supplemental insurance plans for long-term care to those who are interested in attaining additional coverage.

Transferring Old-age Reserves

As in private health insurance, there will also be an option to transfer old-age reserves from one private compulsory long-term care insurance company to another. This applies to new and existing cases as of 1 January 2009.

Tripartite Symposium on Long-Term Care among France, Germany and Japan

Keynote Report

Marie-Eve JOËL

Professor Department Health Economics

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ISSUES IN CARE FOR DEPENDENT PEOPLE

In France, the debate about creating a fifth branch of the social security system to finance the risk of dependence, the senior citizens' solidarity plan (2007-2012) and the latest Alzheimer's plan (2008-2012) have placed the question of dependence at the centre of political affairs. Major steps have been taken towards improving awareness of the problem with the production of a set of reports and the mobilisation of greater capacity for expert contributions. However, there are still inaccuracies in the estimates of numbers of dependent people and of patients suffering from neurological disorders, particularly Alzheimer's and related diseases.
Issues in caring for dependent people in France arise at a number of levels.

Issues in family care for dependent people

The burden that dependence represents for families is now better appreciated, from the viewpoints of both the practical support given by family members and the financial contribution made by the elderly person or their family. The SHARE survey shows a stable degree of family involvement in Europe in terms of "quantity", but wide variation in the forms this takes (cohabitation or support from a distance). The forms of family involvement depend on the professional support available and on funding provision. The principal problem is to avoid discouraging family solidarity where it exists, because it contributes greatly to the provision of stable care and avoids the need for costly emergency interventions, which are destabilising for the elderly person. But achieving this requires knowledge of how effective the various means of recognising informal support are: remuneration for family carers in the home (via the personal autonomy benefit), generalising care leave, greater pension entitlements for employees with care responsibilities, training for carers, provision of respite packages and various forms of coordination (such as case managers or disease managers).

The question of "liberating" manpower is central: is it more worthwhile to help dependent family members for nothing, to receive an allowance for this help (with no value being placed on the human experience gained after the patient's death), to receive a salary together with everything that goes along with paid work (professional training, labour inspections, occupational medicine etc.), to employee someone to provide the necessary care and support?

The issues of elderly people's and their families' ability to pay for dependence, the financial resources remaining to the still-healthy spouse and any contributions by children, i.e. the intergenerational transfer of charges, are now being raised in more realistic economic terms. The importance of the proportion payable by the elderly person and their family, or more exactly the acceptable amount, is at the heart of the political controversy about public and private dependence insurance. The equity of the public contribution is called into question because the level of the autonomy benefit is the same for everyone with an income of less than €2200 per month. Various ways of varying the benefit are being considered (establishing a decreasing scale for paying financial support, the personal autonomy benefit (APA, *allocation personnalisée d'autonomie*), in institutions according to the resident's income, varying the APA for Alzheimer's patients etc.).

The organisation of professional care, "industrialisation", new players, cultural change

The sociomedical institutional sector has been modernised in recent years at the instigation of the public authorities, bringing levels up to European standards. Several measures (generalising global fixed payments, the convergence of treatment prices, converting hospital short-stay beds into beds for elderly people, setting up enforceable reference systems for accommodation costs etc.) have

contributed greatly to this evolution.
Home help services are also undergoing modernisation and restructuring. The promotion of innovative action in home help and the professionalisation of home help work are now on the agenda. Public credits worth 77.7 million have been released. Another element to note is the involvement, however modest, of insurers in home help work.
Two strong trends have emerged in the last five years:

1) In the area of accommodation, companies in the for-profit private sector have seen major internal and external growth. The traditional actors (public and not-for-profit operators, mutual insurers, religious foundations and congregations, together making up 80% of the accommodation sector) have experienced difficulties, because maintaining institutions at the standards required demands major capital investment, and the staff are not always able to satisfy current requirements in terms of qualifications, evaluation etc. There is real competition between those actors (not-for-profit private, for-profit private, associations) who have reached a critical size and a sufficient level of professionalisation and management.
2) In the home help sector, there are several provisions to enable the collective funding of jobs working partly with elderly dependent people:
    - support for jobs requiring few qualifications and a reduction in employment costs for low-paid workers,
    - policies to encourage individuals to employ staff (lowering of social security contributions, tax reductions or credits, measures to simplify administration such as the "*chèque emploi service*" (service employment voucher)).
    - These policies were reinforced by the 2005 law on developing personnal services .

Employment by mutual agreement has taken on a great deal of importance: among individuals employing staff at home in the fourth quarter of 2006, 187,000 were receiving the personnel autonomy benefit, accounting for almost a third of APA recipients at home, and black-market work is very common in this sector of home care. Regulation of hourly wages for carers in the home is partly covered by the regulations governing the sociomedical sector (in the context of a service providers' association, for example) and partly by those on direct employment. This dual system of regulation does not simplify the professionalisation of home help work and the improvement of care quality.

In addition, long-term care is set to develop considerably due to reasons relating to demographics, medical advances, the growth in women's employment and changes in lifestyle. This growth is far from over, because the baby boomer generation has not yet reached old age, when the risk of dependence is highest.
It raises several difficulties. The most sensitive point is finding the staff needed to sustain the growth of the sector in the medium term. A second issue relates to the need to manage the many different actors, with different professional cultures, involved in working with dependent elderly people. Many experiments have been conducted with coordinated or integrated care networks, disease managers and care managers at different local, county or regional levels. But it is still difficult to identify an effective coordination model with unanimous support.
Finally, we must not underestimate the cultural transformation under way in this "mass" growth in long-term care. The logic of social support dominant until now is called into question. The management culture among the operators of institutions and services is not yet sufficiently developed. It cannot reasonably be supposed that local authorities will allocate significant funds to this sector without requiring greater economic rigour and without evaluating the quality of the services provided.

A relatively recent collective awareness of the problems associated with Alzheimer's disease

The sensitivity of French public opinion to the issue of Alzheimer's disease increased notably when the third Alzheimer's plan (2008-2012) was put in place. Putting the issue on the political agenda led to significant credits being made available for research. Improving quality of life for patients and carers is a second and equally essential goal. In this context, of the 7,500 new places that will be created for dependent elderly people in 2009, 70 to 80% will be intended for elderly people suffering from Alzheimer's disease. One important innovation is the creation of centres for the autonomy and integration of Alzheimer's patients (MAIA, *maison pour l'autonomie et l'intégration des malades Alzheimer*). These are places where existing health and social services are coordinated, without new structures being added. Ten to fifteen projects will be trialled between 2008 and 2012.
The main issue remains the capacity of civil society to mobilise to deal with the problem in the long term in order to change society's view of patients and their families, leave denial behind, better measure the scale of the problem and the difficulty of living with the disease on a daily basis and provide appropriate support and care.

Dependence caused by mental disorders has its own specific characteristics. The burden on informal carers is very different from that associated with physical dependence. Action on behalf of mentally dependent patients does not mean just looking after them; it involves a much more far-reaching degree of care and responsibility. In the home, the provision of care for people suffering from dementia is similar in numbers of carers to the provision of care for the most serious physical dependencies. This means that provision relying on a single family carer is fragile, and that care (professional and informal) must be accumulated if the situation is to be managed. Setting up rational care is much easier for physical dependence, where the disabilities that need to be compensated for are known precisely.

In the case of Alzheimer's patients, where should the priority be in terms of local authority funding support: cognitive rehabilitation, help for carers or improving patient well-being, and consequently how should staff be qualified? There are many experiments in progress, but they are not being evaluated globally and it is still difficult to draw definitive conclusions.

The funding and economics of dependence

Funding for dependence raises two types of questions:

- What is the basket of services (more or less comprehensive) a dependent elderly person needs access to (physical treatments, social support, housekeeping, technical assistance etc.)?
- What proportion of the costs should be borne by the public purse? Alternatively, which dependent elderly people should be eligible for public support: the poorest, the most seriously affected, either physically or mentally? And what are the mechanisms that should provide this collective support?

With regard to the first point, a prior question is to evaluate the needs of the dependent person. This debate has an important place in the current context, and has mobilised large numbers of professionals in the field. The allocation of the APA, the primary benefit for dependent elderly people, is based on the use of the AGGIR, a tool used to measure the level of loss of autonomy which classify people in 6 groups : persons classified in groups 1 to 4 can receive l'APA but in each group there is a maximum level of aid. There has been a great deal of discussion comparing the validity of the scales available on the market for elderly and disabled people and the diversity of their use, evaluating their reliability, examining how they could be harmonised and made to converge etc. The National Fund for the Independence of Elderly and Disabled People (CNSA, *Caisse nationale de solidarité pour l'autonomie, national solidarity fund for independent life*) is currently responsible for studying this central question with a view to defining good practice for professionals.

On the second point, discussions on the "fifth risk" (in addition to the four other areas covered by the French social security system: health, safety at work, retirement and families) are strongly limited by the financial crisis, the level of public debt and the potential growth in health and pensions spending. In addition, the financial circuits set up in the past to finance dependence in France are unusually complex. The National Audit Office (*Cour des comptes*) has emphasised the accumulation over time of a great variety of services and the construction of financial circuits that are difficult to understand and reform. In addition, the growth in funding requirements for dependence is constraint by the financial crisis, public deficits and potential growth of health and pension expenses.

In this context, the recent Senate report favours two types of proposals: private dependence insurance and funding for dependence taken from the capital of dependent people. The insurance route is put forward in a variety of proposals: converting life insurance policies into dependence policies, without considering the transformation as a fiscal innovation, i.e. without penalty for the insured; enabling extra dependence contributions to be tax-deductible; enabling policies to be transferred when policyholders change wish to change insurer etc. A second proposal consists of creating a voluntary, limited share in the person's assets, affecting the APA recipients with the most assets. Two levels of APA would be defined, with a share recoverable on succession of €20,000 for recipients of full-rate APA with assets exceeding €150,000.

This viewpoint is not universally shared. A number of arguments have been made: equality of treatment for citizens facing dependence and the need to rely principally on national solidarity to deal with this risk, with insurance funding only as a top-up. Whatever the result of the current political debate on funding for the "fifth risk", simplifying the existing financial circuits is a necessity. The division of certain costs between different public funding bodies (central government, social security and the *département* or county) needs to be revised, such as care assistants being funded from the care cost. With the rise in funding requirements for dependence, a better legibility of the possible financial decisions and adjustments and control over how resources are allocated appear indispensable. But this cannot be achieved without modifying the respective roles of the public funding bodies responsible for dependence.

The debate on funding for dependence is sorely lacking in hypotheses on the economic rationality of agents in the sociomedical sector.

Few analyses are available on the strategy of long-term care providers in terms of client selection, the diversification of services, recruitment or service outsourcing. The debates about community values and the risks of privatisation mask a real ignorance about the economic rationality of service providers.

Professional carers are described as providing a service with both medical and social components (in the sense of social bonds) in a complex relationship with the family carer. The question of their contribution to managing the scarcity of resources in the field of dependence is rarely emphasised...

Finally, the economic behaviour of dependent elderly people and their families is a confidential subject in terms of willingness to pay for a given service, decisions between buying services and maintaining the value of capital, if such decisions are taken, the economic variables taken into account when an elderly person enters an institution, by the person or the family etc.

Conclusion: a lack of prospective analyses

In prospective terms, it is currently fairly difficult to say what the structural dynamic of the French sociomedical system will be tomorrow, the care norms that will prevail, the categories of staff recruited, the way the sector is regulated and the breakdown between the public, private and not-for-profit sectors, the speed and nature of growth.
Will financial constraints take priority?
Is the main issue that is emerging a revision of the concept of intergenerational solidarity through a long political process?
Will the initiative come mainly from care personnel (women carers), who will provide the impetus for redefining their tasks and negotiating their working conditions and the way the sector works?
Will a medical logic aimed at targeting the pathologies that lead to dependence take priority? Ultimately, elderly people with major mental problems that would disrupt their environment would make up most of the population of institutions, while all other forms of dependence would be cared for in the home, except for a short period of palliative care.
Will lifestyles change, radically transforming the services offered to "future dependent people"?

Three-Country Symposium
Japan – Germany – France
A Comparison
(Keynote Speech)

Matsumoto Katsuaki
Hitotsubashi University

1. Introduction of Systems

1965	Germany: Long-term care insurance
1997	France: PSD Japan: Enactment of the Long-Term Care Insurance Law
2000	Japan: Long-Term Care Insurance
2002	France: APA

2. Benefits

	Japan Long-Term Care Insurance	**Germany** Long-Term Care Insurance	**France** APA
Form	Benefit in kind	Benefit in kind Cash benefit (no restriction on use)	Cash payment (for application to nursing care service costs)
Beneficiaries	Persons with long-term nursing care needs	Persons with long-term nursing care needs Family caregivers	Persons with long-term nursing care needs)

3. Finances (financial resources)

Japan Long-Term Care Insurance	**Germany** Long-Term Care Insurance	**France** APA
Premiums 1/2 Tax 1/2	Premiums	Primarily tax

4. Targeted Risk

	Japan Long-Term Care Insurance	**Germany** Long-Term Care Insurance	**France** APA
Targeted risk	Risk of need for long-term nursing care in association with advancing age	Risk of need for long-term nursing care	Risk of need for long-term nursing care associated with advanced age
Age of beneficiaries	40 or over	No age limit	60 or over

Care for Persons with Dementia
Issues which have to be solved

Tripartite Symposium on Long-Term Care
among France, Germany and Japan

Tokyo Metropolitan Institute of Gerontology
Akira Homma, MD

February 3, 2009

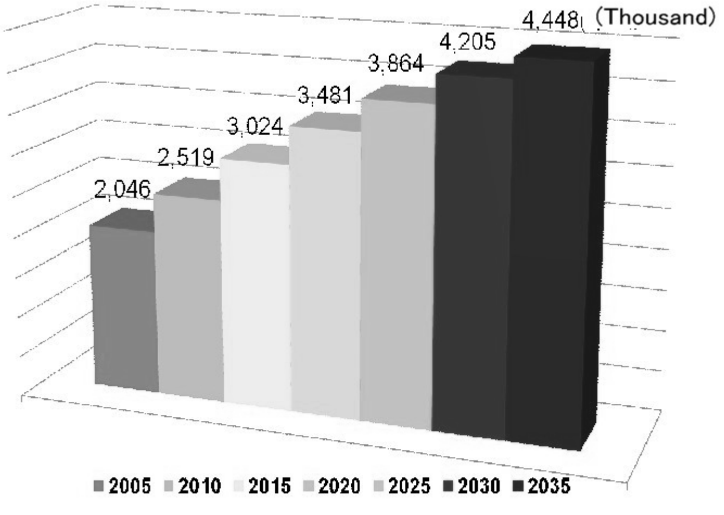
Amended Long-Term Care Insurance Act: Article 1 (2006)

The purposes of this Act are to improve health and medical care and to enhance the welfare of citizens. With regard to people who are under condition of need for long-term care due to disease, etc., as a result of physical or emotional changes caused by aging, and who require care such as for bathing, bodily waste elimination, meals, etc., and require the functional training, nursing, management of medical treatment, and other medical care, these purposes are to be accomplished by establishing a long-term care insurance system based on the principle of the cooperation of citizens, solidarity, and determining necessary matters concerning related insurance benefits, etc., in order to provide benefits pertaining to necessary health and medical services and public aid services so that these people are able to **maintain dignity** and an independent daily life routine according to each person's own level of abilities.

Dignity

How to support the dignity of persons with dementia

Projected Increase of Persons with Dementia 2005-2035 in Japan



(Awata, et al., 2008)

The most serious issue is

- How many persons out of the more than 2 million persons with suspected dementia (of whom half are living at home) in 2005 are appropriately diagnosed and receiving treatment?

- This number is not clear.

Why Is This a Problem?

- **Even if a person with dementia is aware of forgetfulness, there are very few cases where this person visits a medical institution on his/her own.**
- **It is often the case that the timing for consulting with a doctor depends on the understanding and awareness of dementia of those around the person with dementia.**
- **This differs from cases of people with hypertension and diabetes, etc.**

Under Detection/Diagnosis/Treatment

What Is Necessary To Solve This Situation?

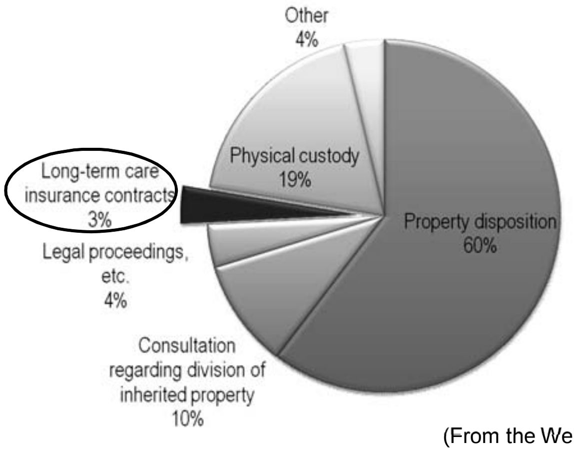
- **Based on the fact that there is not enough awareness of dementia in the community, including by primary care physicians,**
  - **Intensive and extensive promotion of the program to improve the clinical skill of primary care physicians for the detection and the management of persons with dementia. In 2006, the Ministry of Health, Labor and Welfare started the program and as to 2008, approximately 14,000 doctors participated.**
  - **Expansion of functions and personnel of the Medical Care Center for Dementia (target is 150 locations throughout Japan.**
  - **Guarantee of participation by care staff in periodic educational program.**

The current state is one where people with dementia are refused medical admission into general wards and easily bound by physical restrictions because they have dementia

- **Unless medical/surgical support for physical complications is guaranteed, in-home care for people with dementia is difficult.**
- **The actual state is not made clear at the national level.**
- **In particular, there are actual situations where treatment is not carried out as actively for people with dementia who have no relatives than for people with dementia who have family (Homma, 2007).**
- **In addition to investigating what kind of system would enable for support to become possible in general wards, it is necessary to create a guideline (support of people with dementia, drug therapy, etc., and physical restrictions in general wards) that takes the results of such an investigation into consideration as quickly as possible.**

The reality is that for people with dementia who use long-term care insurance, the guardianship system for adults is not being used

(15,151 notions were filed between April 1994 and March 1995)



Only 3% used the guardianship system when concluding long-term care insurance contracts, and even if it is assumed that all have dementia, the actual number is 515 people. If looking at the total number of people with dementia, this is close to no one.

(From the Web site of the *Supreme Court*)

Conclusion: To Support the Dignity of People with Dementia

- **Enhance training program for *primary care physicians* that are currently being used, create guidelines for caring for people with dementia, and share these guidelines among health professionals.**
- **Establish some kind of incentives for care for people with dementia**

Caring for people with dementia

Sabine Jansen
Deutsche Alzheimer Gesellschaft

Tokyo, 3 February 2009

Some facts about dementia in Germany

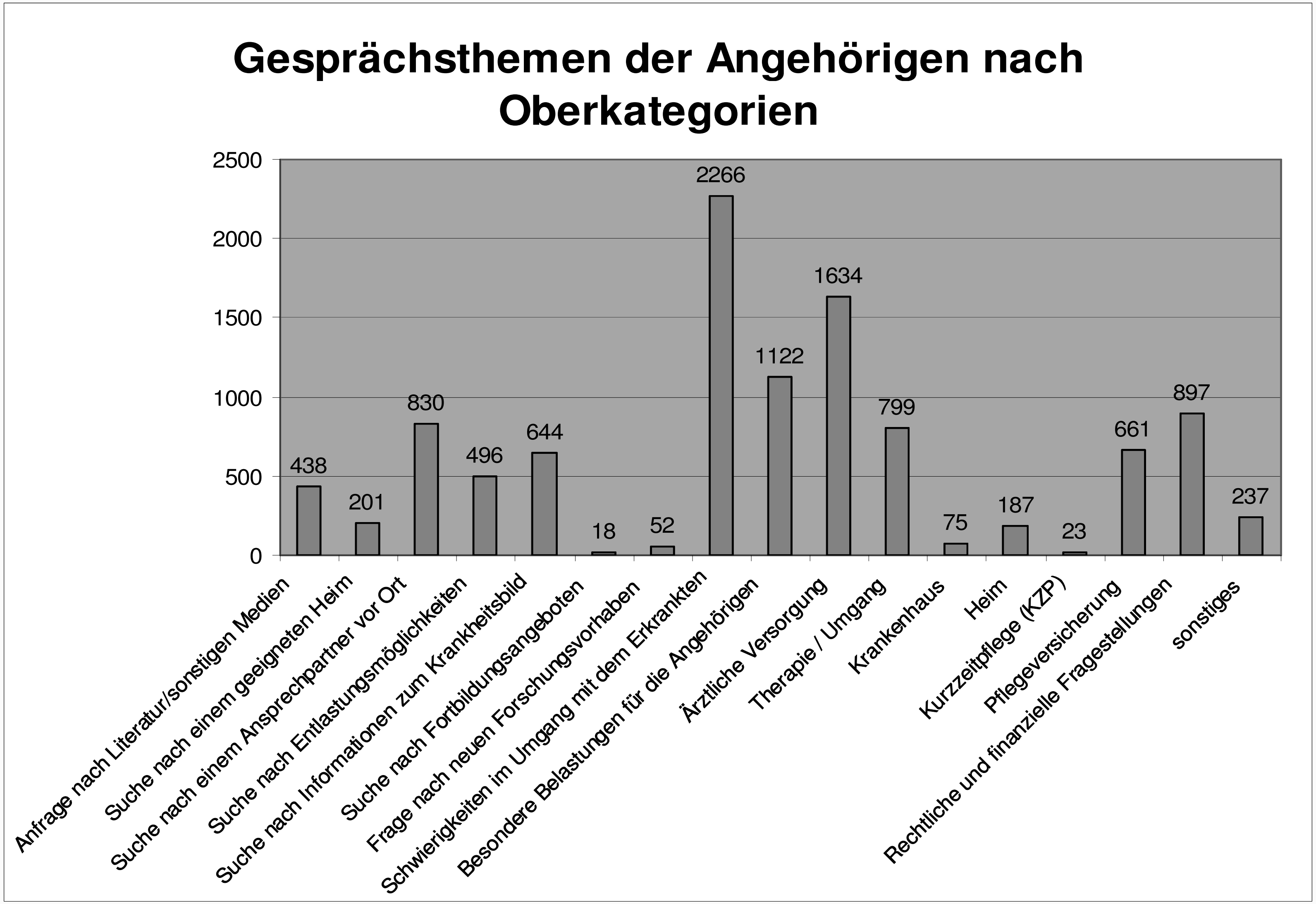
- About 1,1 Mio. people with dementia
- About 2/3 Alzheimer‘s Disease
- 250.000 new cases per year
- Forecast: 2,3 Mio in 2050
- About 2/3 are cared by family caregivers
- Demographic challenge: more and more people live alone

Need of different care levels

- Counselling, information, education
- Home care services
- Informal caregivers (trained volunteers)
- Day- and night-care
- Substitutional care (short time if family caregiver is unable to care)
- Nursing home or flat-sharing community

Alzheimer-Telefon 2007

(total number of calls: 5.252, total number of statistics 5.040)



Many aspects which should be improved

- Diagnosis and therapy
- Rehabilitation (prevention)
- Information and Counselling
- Individual care facilities
- People with dementia in hospitals
- Financing care
- Social isolation

Long term care insurance

- Focussed on somatic care
- But since 2002 additional services for people with dementia
- 2007 more possibilities with informal carers, also for pwd without a care level
- Additional personal ressources for pwd in nursing homes
- But: need of a new definition of care needs which includes pwd in a better way

Positive Development of the last 10/15 years

- Development of therapies
- More awareness
- Home care services nearly everywhere
- Many initiatives for people with dementia
- More knowledge about the disease
- …

Shortcomings

- Only 30 % are getting a diagnosis
- Only 15 % are getting medication
- Still lack of information, counselling and services for people with dementia especially in rural areas
- Familiy caregivers still bear the biggest burden
- Need for more cooperation between professionals, volunteers and caregivers
- Need of research in fundamental, clinical and care research

German initiatives for research

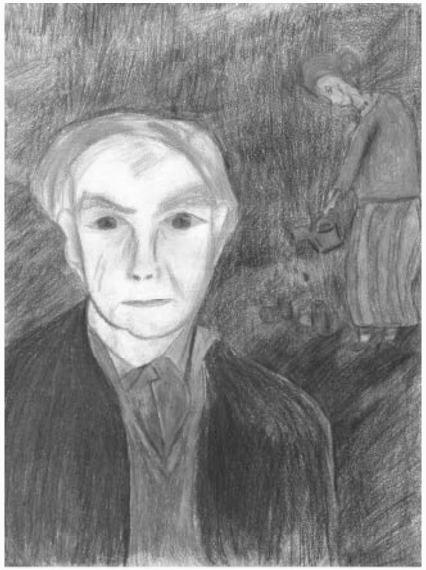
- DZNE (German Centre for Neuro-degenerative Diseases)
- Competence network dementia
- Lighthouse projects
  - 1) Measures of therapie and care: effectiveness in everyday life
  - 2) Evaluation of care settings
  - 3) Protection of evidence-based care
  - 4) Evaluation and development of training programms for special target groups

Three examples of new projects of the German Alzheimer Association

- Youth competition „Alzheimer & you“
- Information sheets for pwd in hospitals
- Education in the municipalities

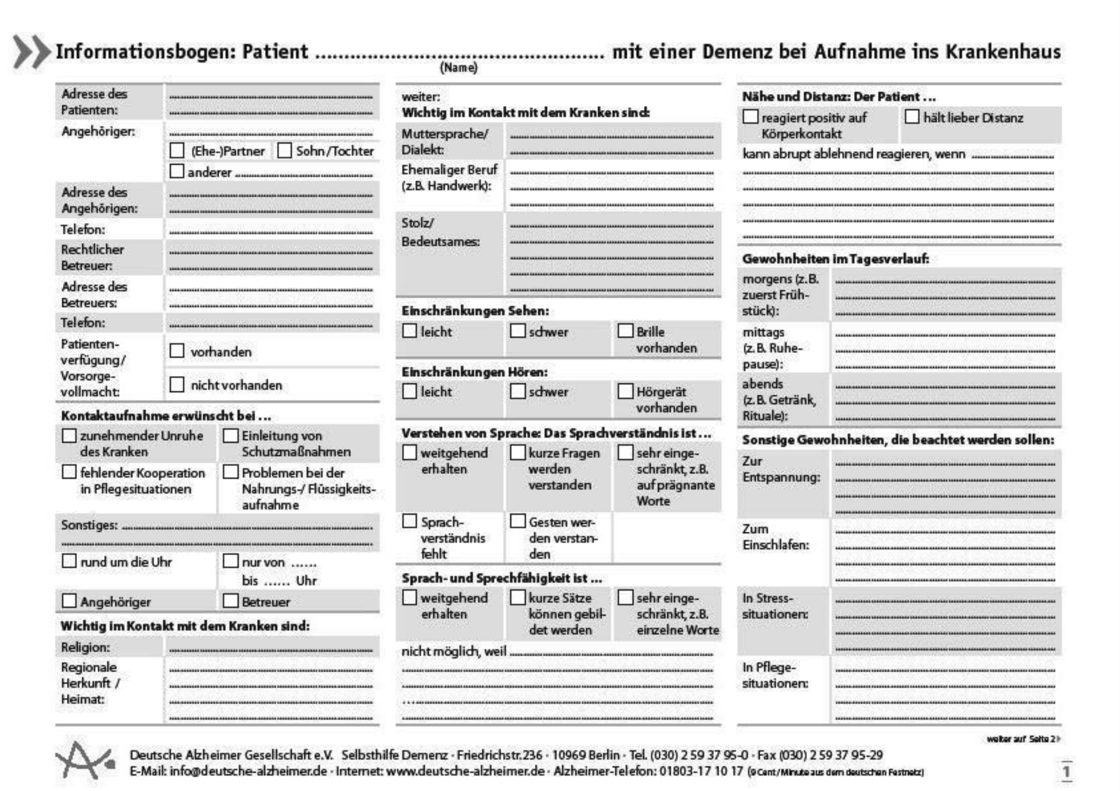
Youth competition „Alzheimer & you“

- Motivation of young people, age: 4-21
- Activities should be documented:



Information sheets for pwd in hospitals

- Members of staff get information about pwd (communication skills, biographical background, contact persons…)



Informationsbogen: Patient ………………………… mit einer Demenz bei Aufnahme ins Krankenhaus
(Name)

Adresse des Patienten: ……………
Angehöriger: ……………
☐ (Ehe-)Partner ☐ Sohn/Tochter
☐ anderer ……………
Adresse des Angehörigen: ……………
Telefon: ……………
Rechtlicher Betreuer: ……………
Adresse des Betreuers: ……………
Telefon: ……………
Patienten-verfügung/ Vorsorge-vollmacht: ☐ vorhanden ☐ nicht vorhanden

Kontaktaufnahme erwünscht bei …
☐ zunehmender Unruhe des Kranken
☐ Einleitung von Schutzmaßnahmen
☐ fehlender Kooperation in Pflegesituationen
☐ Problemen bei der Nahrungs-/ Flüssigkeits-aufnahme
Sonstiges: ……………
☐ rund um die Uhr
☐ nur von …… bis …… Uhr
☐ Angehöriger
☐ Betreuer

Wichtig im Kontakt mit dem Kranken sind:
Religion: ……………
Regionale Herkunft / Heimat: ……………

weiter:
Wichtig im Kontakt mit dem Kranken sind:
Muttersprache/ Dialekt: ……………
Ehemaliger Beruf (z.B. Handwerk): ……………
Stolz/ Bedeutsames: ……………

Einschränkungen Sehen:
☐ leicht ☐ schwer ☐ Brille vorhanden

Einschränkungen Hören:
☐ leicht ☐ schwer ☐ Hörgerät vorhanden

Verstehen von Sprache: Das Sprachverständnis ist …
☐ weitgehend erhalten
☐ kurze Fragen werden verstanden
☐ sehr einge-schränkt, z.B. auf prägnante Worte
☐ Sprach-verständnis fehlt
☐ Gesten wer-den verstan-den

Sprach- und Sprechfähigkeit ist …
☐ weitgehend erhalten
☐ kurze Sätze können gebil-det werden
☐ sehr einge-schränkt, z.B. einzelne Worte
nicht möglich, weil ……………

Nähe und Distanz: Der Patient …
☐ reagiert positiv auf Körperkontakt
☐ hält lieber Distanz
kann abrupt ablehnend reagieren, wenn ……………

Gewohnheiten im Tagesverlauf:
morgens (z.B. zuerst Früh-stück): ……………
mittags (z.B. Ruhe-pause): ……………
abends (z.B. Getränk, Rituale): ……………

Sonstige Gewohnheiten, die beachtet werden sollen:
Zur Entspannung: ……………
Zum Einschlafen: ……………
In Stress-situationen: ……………
In Pflege-situationen: ……………

weiter auf Seite 2

Deutsche Alzheimer Gesellschaft e.V. Selbsthilfe Demenz · Friedrichstr.236 · 10969 Berlin · Tel. (030) 2 59 37 95-0 · Fax (030) 2 59 37 95-29
E-Mail: info@deutsche-alzheimer.de · Internet: www.deutsche-alzheimer.de · Alzheimer-Telefon: 01803-17 10 17 (9 Cent/Minute aus dem deutschen Festnetz)

1

Education in the municipalities

- Interviews with pwd who live alone
- Development of training programm for police, firefighters, staff of banks, trade …
- Contact to some municipalities and at the moment test phase
- The aim is to provide materials for different professions and volunteers in municipalities and to motivate people to feel responsible for pwd

What do we need?

- Earlier diagnosis and better treatment
- Efforts in prevention and rehabiliation
- Efforts in research
- Range of services that fit with the needs of pwd and their caregivers
- Multiplication of successful projects
- Better cooperation between all who have to do with pwd and their caregivers
- Inclusion of volunteers (e.g. young elderly)
- Raising awareness steadiliy

- Laughing and smiling with people with dementia costs nothing!
- sabine.jansen@deutsche-alzheimer.de

Alzheimer
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The French Plan on Alzheimer's Disease and Related Disorders 2008-2012

Symposium on long-term care
Tokyo, 3-4 february 2009

Sandrine Lemery
Steering committee for the Alzheimer plan

The French Alzheimer Plan

- ☐ Main challenges of the plan
- ☐ Knowledge for action
- ☐ Improving quality of life for patients and carers
- ☐ Mobilising around a key social issue

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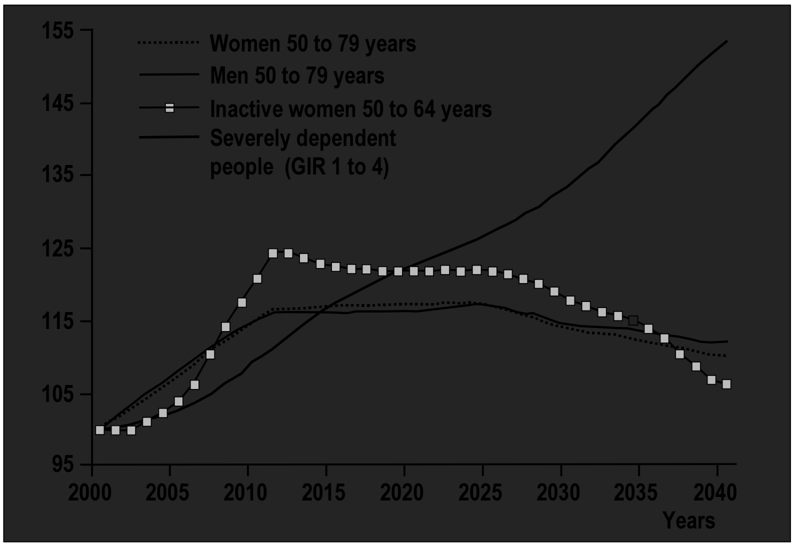
Main challenges of the plan

The burden of Alzheimer disease (dementia) in France (2000 – 2001)

MEN		
Cardiovascular disease	8.9 %	(65 - 94 % deaths)
Lung Cancer	5.7 %	(98 % deaths)
Alcohol-related disease	4.5 %	(23 % deaths)
Alzheimer's and related disease	3.1 %	(24 % deaths)
WOMEN		
Alzheimer's and related disease	7.5 %	(20 % deaths)
Cardiovascular disease	7.1 %	(71 - 95 % deaths)
Nervous depression	7.1 %	(2 % deaths)
Breast Cancer	4.2 %	(86 % deaths)

Source : A. Lapostolle, A. Spira, Unite Inserm-Ined (U 569)

The Demographic Challenge: projected trends of the number of elderly dependant people in France and of the potential number of family carers (base 100 in 2000)



Grand A. et al., BEH 2006 ; n°5-6 :47-49

Two previous plans (2001-2008)

- ALD 15 – list of long-term diseases
- 134 Memory Centres, 22 Reference and Research Memory Centres
- Places in Day Centres and Temporary Hospitalisation
- **No major specific effort on research**

The main challenges of the plan

- **A commission chaired by Pr Ménard**
  - 10 members, 8 working groups, 100 people, 3 months
  - Report to the President on 8 november 2007
- **A financial effort on 5 years**
  - 200 M€ for research
  - 200 M€ for medical care
  - 1,2 billion euros for medico-social support
- **Three main themes**
  - Developing our understanding of the disease
  - Improving the quality of life for patients and carers
  - Mobilising society for the fight against dementia by developing a voluntary approach and synergisms
- **A new governance based on transparency**
  - Direct reporting to the President of the French Republic every 6 months
  - Florence Lustman, Inspector general of finance, with a four member staff : coordination and assessment
  - Steering committee every month
  - Supervisory committee every 4 month

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Research : knowledge for action

Knowledge for action

- Objective : to discover or validate a diagnosis or treatment within 5 years
- A foundation for scientific cooperation set on 29 june 2008
  - A national network of excellence
  - Attract the best French and foreign researchers and give support to the best teams
  - Develop partnerships with industry, including drug companies
  - Develop relationships between all kinds of research, public and private, fundamental, clinical, biological, social science

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Improving quality of life for patients and carers

Improving quality of life for patients and carers
Improving support and respite for carers

- Developing and diversifying respite care services
  - Evaluating existing facilities
  - Experimenting innovative respite solutions
  - Drafting specifications for a therapeutic dimension in all structures
  - Drafting a guide for respite centers
- Strengthening caregivers rights and education
  - 2 days' training a year for carers
  - Support in returning to work
- Improving health monitoring for family caregivers

Improving quality of life for patients and carers
Strengthening coordination between all actors

- Labelling integrated access points *(« MAIA - maisons pour l'autonomie et l'intégration des malades d'Alzheimer »* - houses for autonomy and integration of people with Alzheimer's disease*)*
  - call for experimentation in july 2008
  - 140 applications in october 2008
  - 15 experiments selected - november 2008 – jan 2009
  - « club of volunteers »
- 1000 "coordinators" (case managers) over the whole territory

Improving quality of life for patients and carers
Enabling patients and their families to choose support at home

- Reinforcing home support, favouring home intervention of specialised professionals
  - 500 specialist teams in home nursing services
- Improving home-support using new technologies
  - National and european calls for projects targeting home automation and ICT

Improving quality of life for patients and carers
Improving access to diagnosis and ensuring a continuous chain of care

- Developing and implementing a framework for diagnosis announcement and follow-up
- Experimenting new payment terms for health professionals
- Alzheimer information card for patients in case of emergency situations
  - 100 000 edited cards – 10 000 distributed in 2008 by France Alzheimer on physician request
- New local memory centers in zones without any
  - + 24 in 2008, + 12 in 2009 / 366 CM, 234 labelled
- New research and resources memory centers in zones without any
  - 3 in Auvergne, Corse and Limousin
- Strengthening the very active memory centers (122)
- Monitoring adverse drug reactions
- Improving correct use of drug
  - Study 10-2008 : 18% of alzheimer patients prescribed with antipsychotics

Improving quality of life for patients and carers
Improving residential care

- Creating specific units for patients with behavioural problems within nursing homes
    - Day units / day and night units
    - 12.000 new places
    - Reinforcing 18.000 places
    - 180 M€ investment credits in 2008
- Creating specialized cognitive behavioural units within rehabilitation services
    - 120 structures (24 in 2008)
- Setting up residential services for young patients
- Creating a national reference centre for young patients
    - Selected in jan 2009

Improving quality of life for patients and carers
Developping skill sets and specific training for all care professionals

- New jobs of case-managers and « gerontology assistants »

- Training for ergotherapeuts and psychomotricians

- Training for all staffs

Alzheimer
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Mobilising around a key social issue

Mobilising around a key social issue Providing information and increasing awareness amongst the general public

- Setting up a telephone helpline and local web sites for local information and orientation
- Holding regional conferences to support the implementation of the plan
- Studying disease knowledge and attitudes
  - Qualitative study in oct 2008

Mobilising around a key social issue Promoting an ethical debate and approach

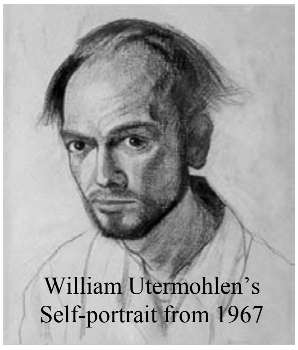
- Creating a national center for ethics on dementia
    - Selected in jan 2009
- Adapting the legal status of those with dementia
- Organizing conferences about the autonomy of patients
    - Patient representation
    - GPS bracelets
- Informing patients and families about trials implemented in France
    - Agreement with ONRA (Toulouse) for access through Internet to the therapeutic and diagnosis research protocols performed or scheduled in France

Mobilising around a key social issue Making dementia a European priority

- Making the fight against Alzheimer's disease a priority for the European Union
    - Conclusions adopted at the competitivity council on 26 september and 2 december 2008
    - Conclusions adopted at the Health council on 16 december 2008
- Publicizing and promoting research at the European level
    - 22 sept : meeting of financing and research agencies
- European conference on 30-31 october 2008

Mobilising around a key social issue
Additional measures

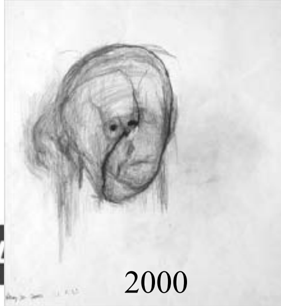
- Opinion and knowledge survey (INPES)
  - 2008 and 2011
  - 2 000 participants, after a qualitative study (130 participants)
- A medico-economic study (DREES)
  - Costs at home and in institutions, / disease stage
  - From the viewpoint of families and community
- Website www.plan-alzheimer.gouv.fr



William Utermohlen's
Self-portrait from 1967

1996

1997



2000

1999

1998

Ministère du travail, des relations sociales, de la famille et de la solidarité
Ministère de la santé, de la jeunesse, des sports et de la vie associative
Ministère du budget, des comptes publics et de la fonction publique

Establishment of Social Long-Term Care Cost Sharing System

Séverine Salgado, Policy Officer

Symposium on Long-Term Care
Tokyo, February 3rd-4th, 2009

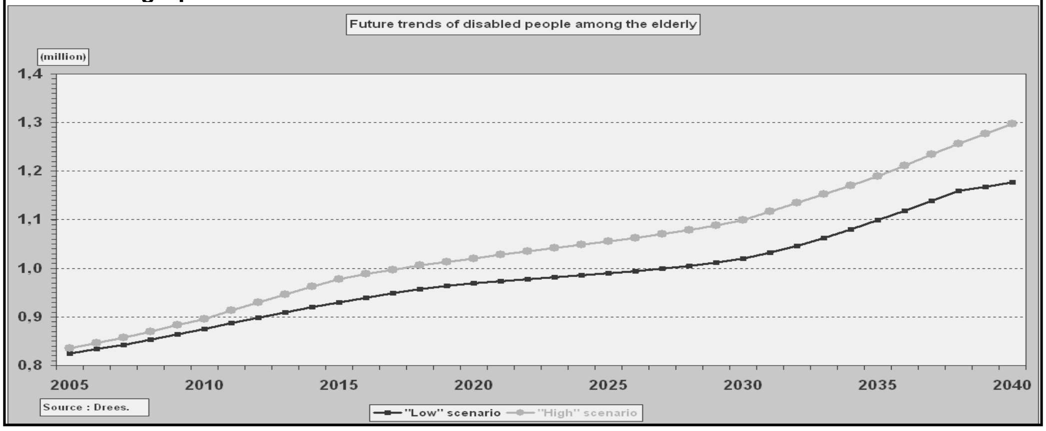
- Background : constraints and challenges
- The Government's strategy : providing a high level of protection together with a sustainable financing
- The development of private insurance

Background : constraints and challenges

- Demographic trends
- Social issues
- Financing

Background : constraints and challenges

Demographic trends



Future trends of disabled people among the elderly

Source : Drees.

Background : constraints and challenges

Social issues

- Long term care devices do not perfectly meet the needs of the elderly.
- Individual compensation plans may be insufficient for persons living at home.
- Many people hosted in homes for the elderly have to bear a high « out of pocket » payment.

Background : constraints and challenges

Financing

Public expenditures for disabled people among the elderly (2007, main programs)

Long-term health care	6,2 Billion €
Individual autonomy Benefit	4,6 Billion €
Social assistance for the elderly	2,6 Billion €
Miscellaneous	2,2 Billion €

Including additional devices (housing benefits, tax credits, etc.) the public expenditures towards disabled people among the elderly might raise up to about 20 billion euros (1.1 % of GDP)

An overview of the current policies

Solidarity towards the old dependent persons

- The individual autonomy benefit (2002) : APA
  - delivered by local authorities (departments)
  - June 30th 2008 : 1,1 million of recipients, total expenditure 4,6 Bn €
  - either for people at home or hosted
  - depends on degree of dependency and income, but not on individual wealth
- The solidarity and elderly plan announced in 2006 establishes the conditions for a free choice:
  - creation of home medical nursing services (SSIAD)
  - Improving the quality of management and medicalization of homes for the elderly
  - Annual expenditures 2008-2012 : 4 Bn €

The French Government strategy : providing a high level of protection in a sustainable way

- **Allowing old-aged people to remain at home as long as possible**
- **Increasing the number of places in homes for the elderly and reducing the « out-of-pocket » payment**
- **Improving the governance of disability programs for the elderly**

The strategy : providing a high level of protection in a sustainable way

Allowing old-aged people to remain at home as long as possible

- Staying at home is a major wish of old people and their family
- Requires an accurate evaluation of their needs and the diversification of in-kind services included in the allowance (APA)

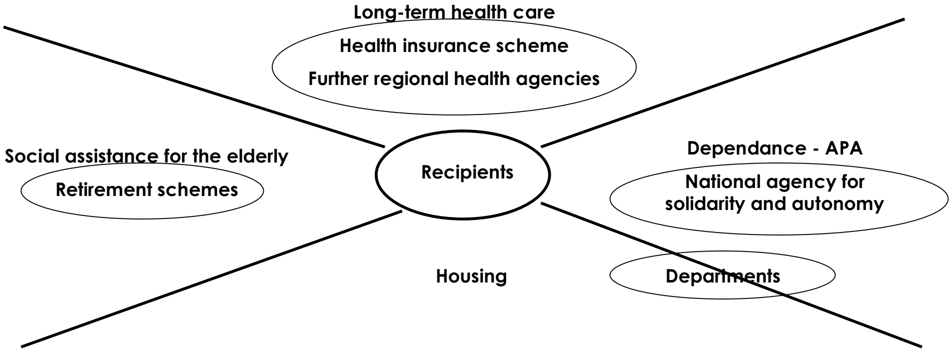
The strategy : providing a high level of protection in a sustainable way

Increasing the number and the quality of places in homes and reducing the « out-of-pocket »

- Estimated needs : 5 000 new places each year.
- 80% of hosted old-people earn an income lower than the cost of the rest home
- Proposal : a new income-tested benefit allowing old-people with monthly incomes less than 2000 € to be hosted in the majority of homes.

The strategy : providing a high level of protection in a sustainable way

Improving the governance of disability devices for the elderly



Long-term health care

Health insurance scheme

Further regional health agencies

Social assistance for the elderly

Retirement schemes

Recipients

Dependance - APA

National agency for solidarity and autonomy

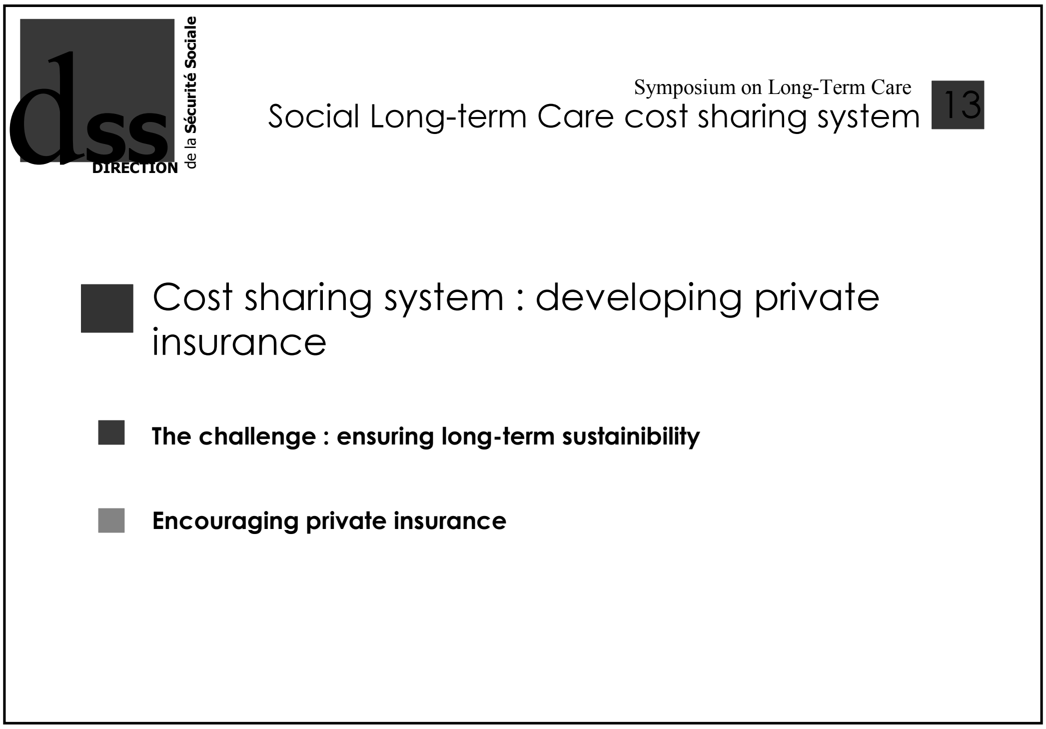
Housing

Departments

The strategy : providing a high level of protection in a sustainable way

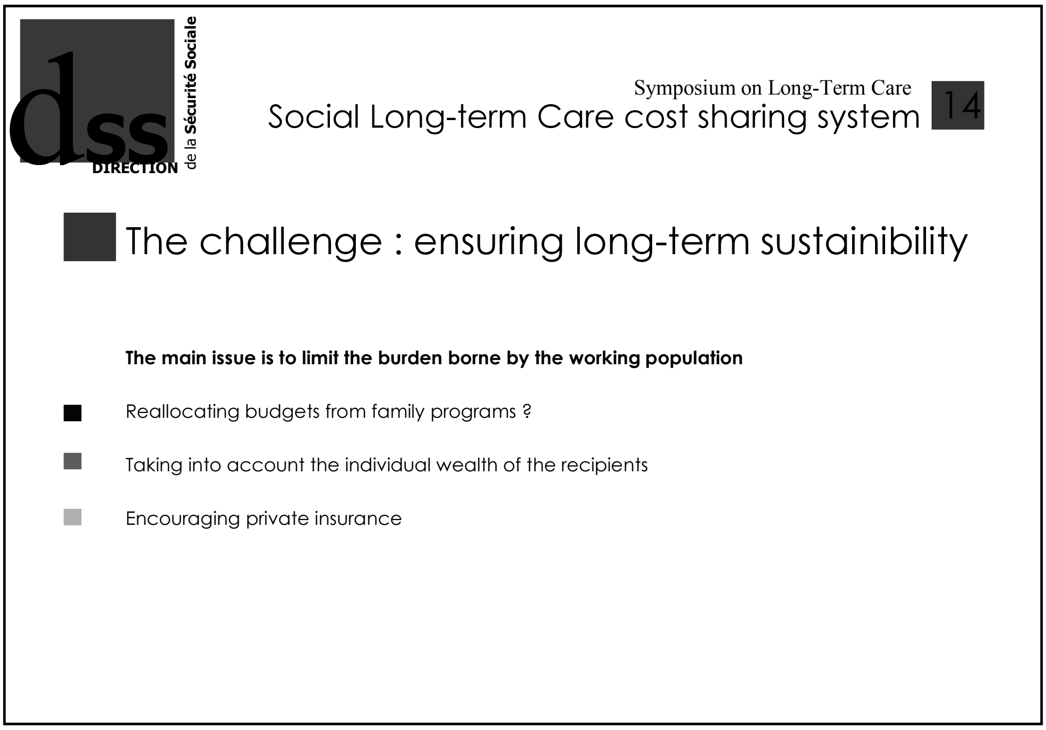
Expected agenda

- Autumn 2008 : drafting and negociations on the basis of a Goverment project
- End of half-year 2009 : discussion and endorsment by the Parliament
- 2009-2012 : implementation of the measures



Cost sharing system : developing private insurance

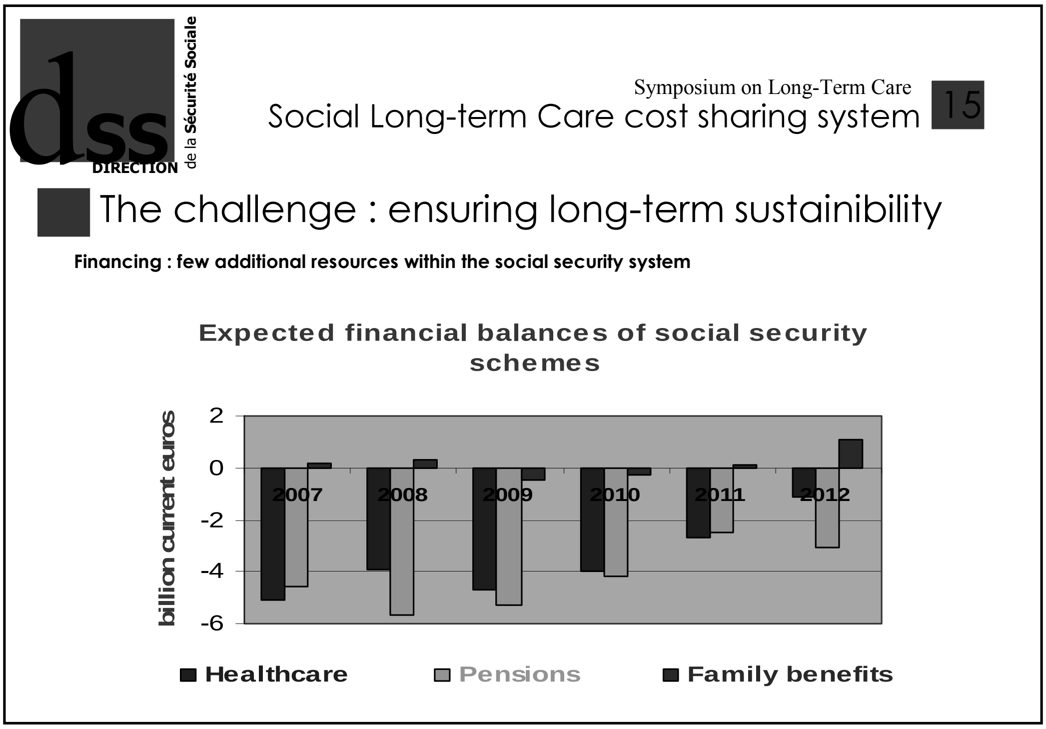
- **The challenge : ensuring long-term sustainibility**
- **Encouraging private insurance**



The challenge : ensuring long-term sustainibility

The main issue is to limit the burden borne by the working population

- Reallocating budgets from family programs ?
- Taking into account the individual wealth of the recipients
- Encouraging private insurance



Symposium on Long-Term Care

Social Long-term Care cost sharing system

The challenge : ensuring long-term sustainibility

Financing : few additional resources within the social security system

Expected financial balances of social security schemes

Symposium on Long-Term Care

Social Long-term Care cost sharing system

The challenge : ensuring long-term sustainibility

Taking into account the individual wealth of the recipients

- The further income-tested benefit allowing old-people with monthly incomes less than 2000 € to be hosted in the majority of homes
- The capped levy on the inheritance of the benefits paid to the elderly

Encouraging private insurance

Building a partnership between private and public disability insurers

- « Developing individual disability insurance, which should complement - rather than substitute - public compensation device » - President of the French Republic, September 2007
- As a long-term risk, old-age disability may be covered in advance through saving devices
- France is yet the second market for private disability insurance in developed countries

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Encouraging private insurance

Building a partnership between private and public disability insurers supposes to adress the subsequent issues

- Convergence of the criteria for disability assemssment used by private and public insurers
- Some market failures may lead to an inefficient provision of coverage : adverse selection and some uncertain long term dyamics of expenditure
- Negative externalities : changes in public regulation, encouragment of an increasing demand for long tem care
- Monetary incentives based on no selection of subscri ber

dss DIRECTION de la Sécurité Sociale

Encouraging private insurance

Coordinating private and public disability devices

- Common disability assessment tools
- Additive or complementary pattern ?
- Governance of the partnership

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dss DIRECTION de la Sécurité Sociale

Description de la présentation

Intitulé de la présentation	Establishment of social Long-term care cost sharing system
Date de la présentation	3 et 4 février 2009 - Tokyo
Evènement	Symposium on Long-Term care
Interne ou Externe	Externe
Expressions et mots clés de la présentation	Dépendance
Confidentialité Oui/Non	Non
Sous-direction pilote	Direction
Sous-directions ayant participé à la présentation	

Tripartite Symposium on Long-Term Care

Session 2① Establishment of social Long-Term Care cost sharing system

Present Condition of Long-Term Care Insurance System and Prospects

Feb 2, 2009

Takashi Yoshino

Director of Long-Term Care Insurance Division, Health & Welfare Bureau for the Elderly, MHLW

Background and Significance of Introduction of the Long-Term Care Insurance System

- **Needs for long-term care are increasing more than ever due to <u>an increasing number of the elderly who need long-term care and prolonged periods of nursing care</u> for each person as the population ages.**
- **On the other hand, a change is also occurring in families who had supported the elderly who need long-term care due to an <u>increase in the number of nuclear family and aging of family members who care for the elderly</u>.**

⇩

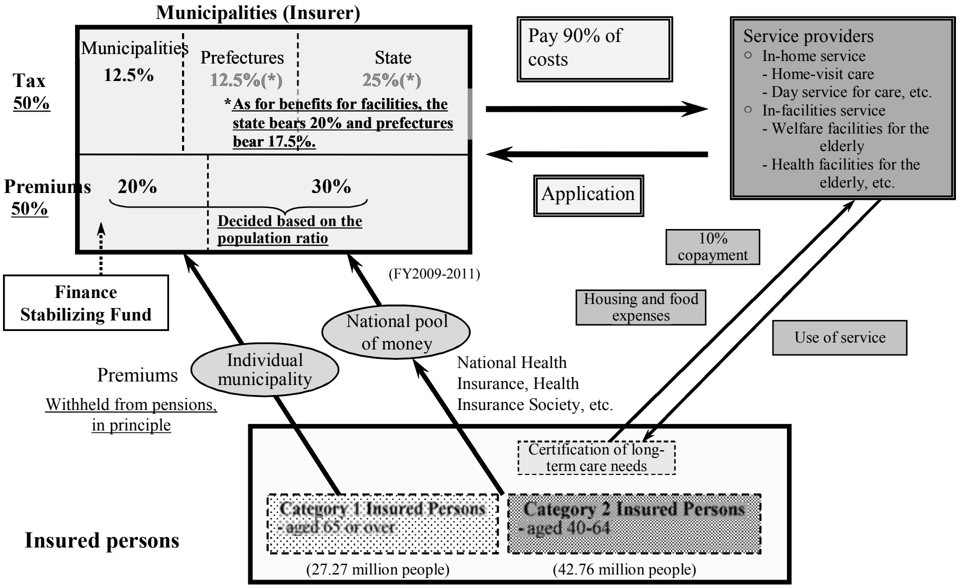
To establish a system where long-term care for the elderly is supported by the society as a whole (long-term care insurance system)

○ **Independence support**	**To aim at supporting the independence of elderly persons, more than just looking after those requiring long-term care**
○ **User-friendly**	**A system where users can receive comprehensively health care and welfare services from various entities of their own choice**
○ **Social insurance system**	**To build a system where the relationship between benefits and costs is clear**

Difference between the Previous System and Long-Term Care Insurance System from the Users' Point of View

Previous system	*Long-term care insurance system* *(at a time of revision)*
(1) Apply at the administrative office window, and municipalities determine the service.	Users can choose the type of service and facilities they use.
(2) Apply separately for medical care and welfare services.	Users will make a long-term care service usage plan (care plan) and use medical care and welfare services comprehensively.
(3) Services provided mainly by municipalities and public organizations (Council of Social Welfare, etc.).	Services provided by various organizations such as private companies, agricultural cooperatives, consumers' cooperatives, and NPO, etc.
(4) For middle and high income earners, services are hard to use due to an expensive cost to bear. <u>e.g. In the case where the householder's annual employment income is 8 million yen, and his or her elderly parent receives a pension of 200,000 yen per month:</u> ○ Special nursing home for the elderly will cost 190,000 yen per month ○ Home helper service will cost 950 yen per hour.	Users will pay 10% charge for the service regardless of their income. <u>e.g. In the case where the householder's annual employment income is 8 million yen, and his or her elderly parent receives a pension of 200,000 yen per month:</u> ○ Special nursing home for the elderly will cost 50,000 yen per month ○ Home helper service will cost 400 yen every 30 to 60 minutes.

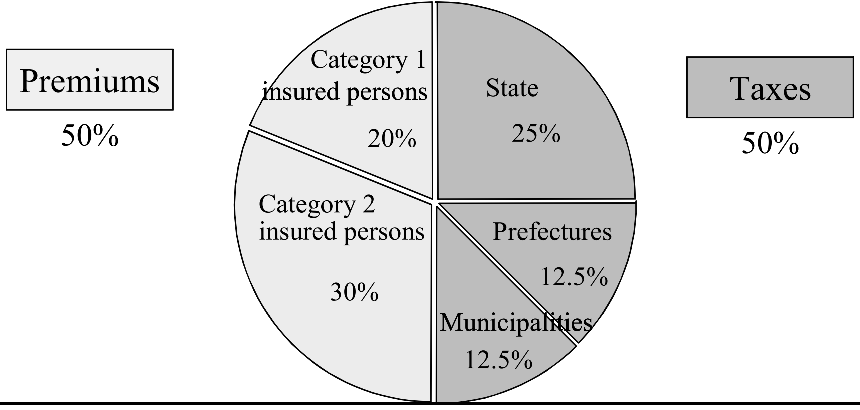
Structure of Long-Term Care Insurance System



Note: The number of Category 1 insured persons is from Report on Long-Term Care Insurance Operation (provisional) (December, 2007), Ministry of Health, Labour and Welfare
The number of Category 2 insured persons is a monthly average for FY2005, calculated from medical insurers' reports used by the Social Insurance Medical Fee Payment Fund in order to determine the amount of long-term care expenses.

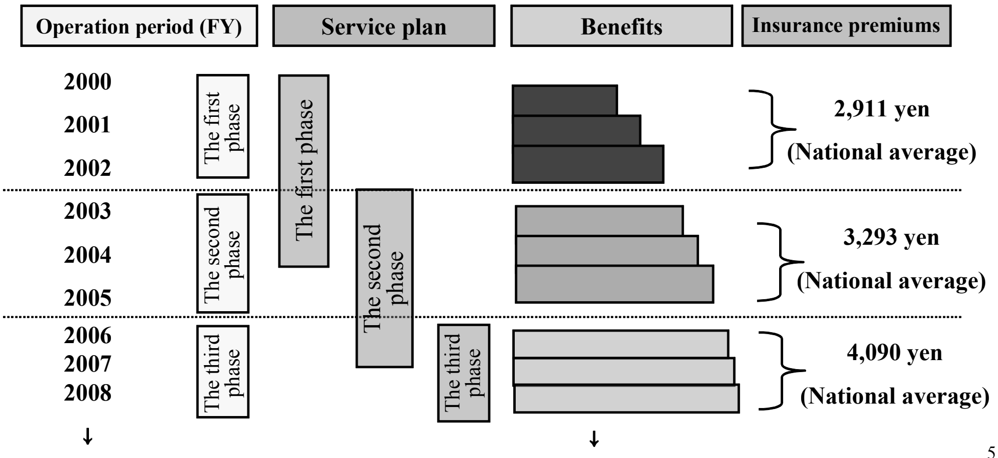
Composition of financial resources for long-term care expenses

- ○ Long-term care expenses (all expenses minus copayment) are financed one-half by taxes and one-half by premiums.
- ○ As for premiums, 20% of them would be paid by Category 1 insured persons and 30% by Category 2 insured persons.
- ○ As for taxes, the state bears 25%, and prefectures and municipalities bear 12.5% respectively. (As for facilities expenses, however, the state bears 20%, and prefectures and municipalities bear 17.5%.)
- ○ Of 25% of expenses borne by the state, 5% is provided as adjustment grants which aim at adjusting insurance finance of municipalities.



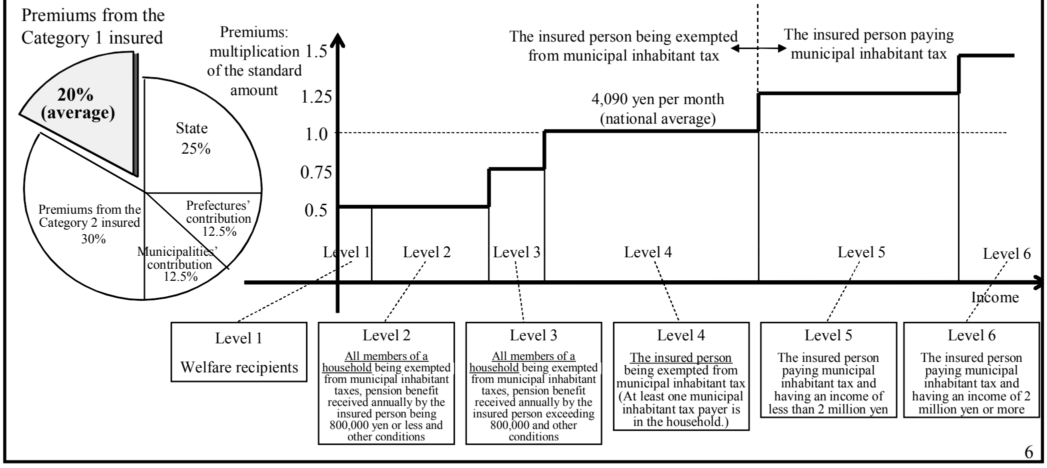
The Long-term Care Insurance Scheme is operated in three-year cycles.

- ○ Municipal governments formulate a long-term care insurance service plan where three years are regarded as one phase (however, one phase is five years until FY2005) and review it every three years.
- ○ Insurance premiums are set every three years based on projected service costs specified in a service plan so that financial conditions can be balanced throughout the next three years. (Insurance premiums are not changed during such three years.)



Premiums from the Elderly (Category 1 Premium)

- ○ Half of the long-term care insurance expenses is divided according to the population ratio of those aged 65 or over and those aged 40-64. Accordingly, municipalities (insurers) cover 20% of half the total expenses by premiums imposed individually on the elderly.
- ○ From the standpoint of having people bear the cost in response to their ability to pay and giving special consideration to low-income earners, the Category 1 premium, in principle, shall be determined 6 levels according to municipal inhabitant tax, etc., imposed on each insured person.



Level 1
Welfare recipients

Level 2
All members of a household being exempted from municipal inhabitant taxes, pension benefit received annually by the insured person being 800,000 yen or less and other conditions

Level 3
All members of a household being exempted from municipal inhabitant taxes, pension benefit received annually by the insured person exceeding 800,000 and other conditions

Level 4
The insured person being exempted from municipal inhabitant tax (At least one municipal inhabitant tax payer is in the household.)

Level 5
The insured person paying municipal inhabitant tax and having an income of less than 2 million yen

Level 6
The insured person paying municipal inhabitant tax and having an income of 2 million yen or more

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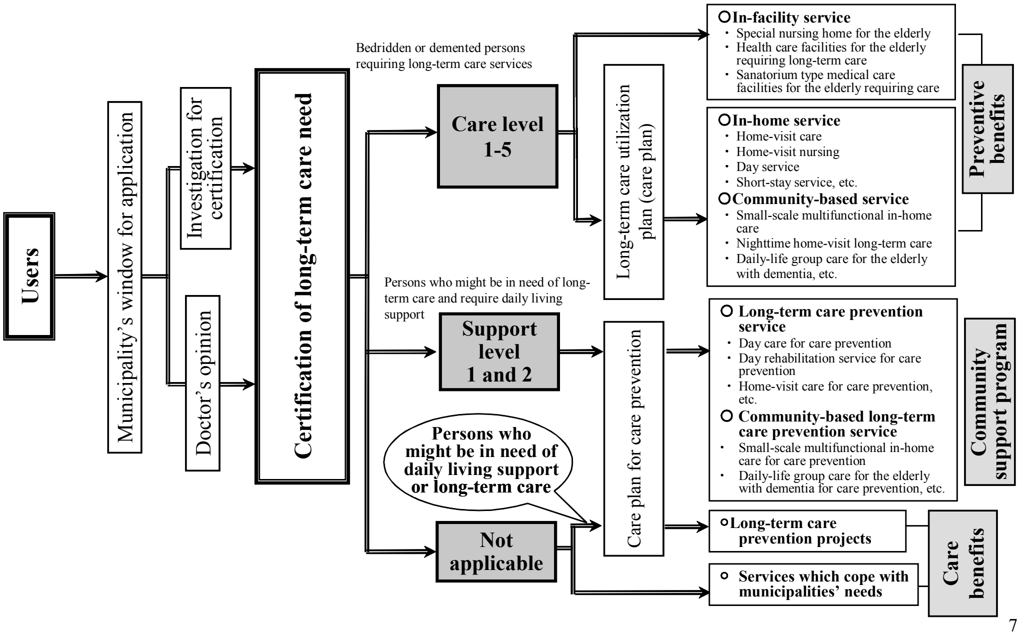
Procedures for the Use of Service



Users

Municipality's window for application

Investigation for certification

Doctor's opinion

Certification of long-term care need

Bedridden or demented persons requiring long-term care services

Care level 1-5

Persons who might be in need of long-term care and require daily living support

Support level 1 and 2

Persons who might be in need of daily living support or long-term care

Not applicable

Long-term care utilization plan (care plan)

Care plan for care prevention

○In-facility service
- ・Special nursing home for the elderly
- ・Health care facilities for the elderly requiring long-term care
- ・Sanatorium type medical care facilities for the elderly requiring care

○In-home service
- ・Home-visit care
- ・Home-visit nursing
- ・Day service
- ・Short-stay service, etc.

○Community-based service
- ・Small-scale multifunctional in-home care
- ・Nighttime home-visit long-term care
- ・Daily-life group care for the elderly with dementia, etc.

Preventive benefits

○ Long-term care prevention service
- ・Day care for care prevention
- ・Day rehabilitation service for care prevention
- ・Home-visit care for care prevention, etc.

○ Community-based long-term care prevention service
- ・Small-scale multifunctional in-home care for care prevention
- ・Daily-life group care for the elderly with dementia for care prevention, etc.

Community support program

○Long-term care prevention projects

○ Services which cope with municipalities' needs

Care benefits

International Comparison of Life Expectancy

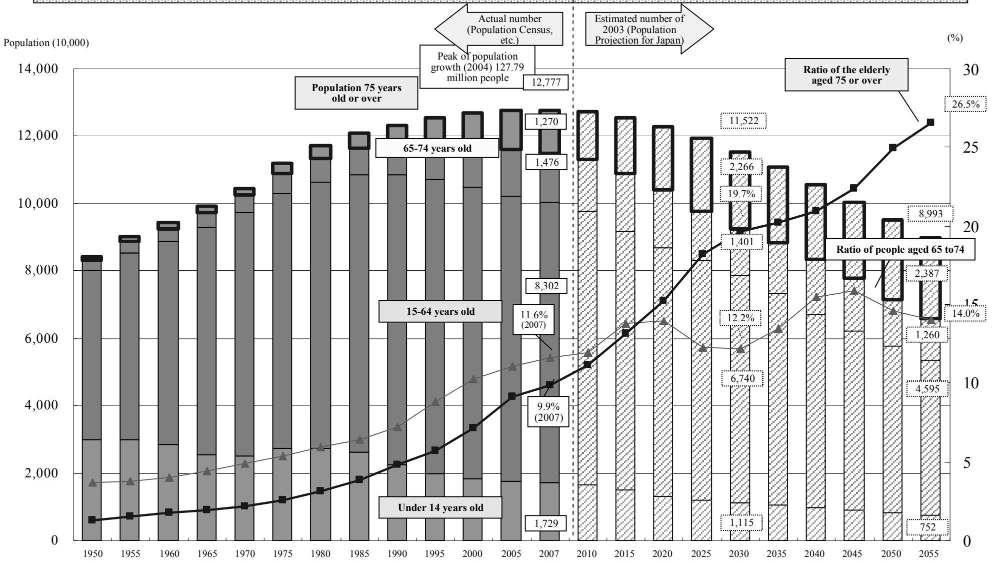
○The average life expectancy is 79 years for men and 86 years for women, which are the longest in the world.

Country	Life expectancy (age)				Country	Life expectancy (age)			
	Men	Rank	Women	Rank		Men	Rank	Women	Rank
Brazil	67	21	74	19	France	76	12	83	3
Canada	78	2	83	3	Germany	76	12	82	9
The United States	75	15	80	17	Italy	78	2	84	2
China	70	19	74	19	The Netherlands	77	8	81	14
India	61	23	63	23	Norway	77	8	82	9
Israel	78	2	82	9	Portugal	74	17	81	14
Japan	79	1	86	1	Russia	59	24	72	22
Korea	73	18	80	17	Spain	77	8	83	3
Malaysia	69	20	74	19	Sweden	78	2	83	3
Singapore	77	8	82	9	Swiss	78	2	83	3
Pakistan	62	22	63	23	The United Kingdom	76	12	81	14
Finland	75	15	82	9	Australia	78	2	83	3

Source: The World Health Report 2006, WHO
Countries are ranked in the order of longest life expectancy among 24 countries above.

Increase in the Number of the Elderly Aged 75 or over

○Although the ratio of population over 75 years of age in Japan is now one to ten, it is estimated the ratio will be one to five in 2030 and one to four in 2055.



Source: Up to 2005: Population Census, Statistics Bureau, Ministry of Internal Affairs and Communications; In 2007: Population Estimates (annual report), Statistics Bureau, Ministry of Internal Affairs and Communications; In and after 2010: Population Projection for Japan (estimated in December, 2006) (Moderate projection), National Institute of Population and Social Security Research

Problems and Countermeasures based on a Future Image of the Elderly (from a viewpoint of the Long-Term Care Insurance Law)

- Increase in the elderly population (the first baby boomers join the elderly)
  - ⇒ Increase in medical care cost for the elderly
  - ⇒ Enhancement of measures for preventing the elderly from becoming in need of long-term care (or support) in addition to long-term care services
  - ⇒ Promotion of individual care
- Increase in the number of the elderly suffering from dementia
  - ⇒ Promotion of care and long-term care for the demented elderly
- Increase in the number of elderly couple household and single-elderly-person household
  - ⇒ Securing housing for the elderly
  - ⇒ Establishment of "Living-alone model" that family members are not counted on to provide long-term care
- Advancement of super-aging society in urban areas
  - ⇒ Securing housing for the elderly in urban areas
  - ⇒ Countermeasures for increasing demand for services based on a future image of the elderly
- Shortage of housing for the elderly
  - ⇒ Development of housing for the elderly and medical care environment (medical treatment and long-term care services)

Future Prospects of Long-Term Care Insurance System

⦿Increase in long-term care expenses due to changes in population composition

Declining birth rate and expanding life span brings about changes in population composition. Specifically, an age group to support Japan shrinks and the elderly especially those aged 75 or over increase in number, which means the number of certified persons requiring long-term care or support increases and long-term care expenses expand.

The long-term care insurance system is supported by premiums (50%) paid by people aged 40 or over and taxes (50%). In future fewer supporters have to bear a burden of increasing long-term care costs.

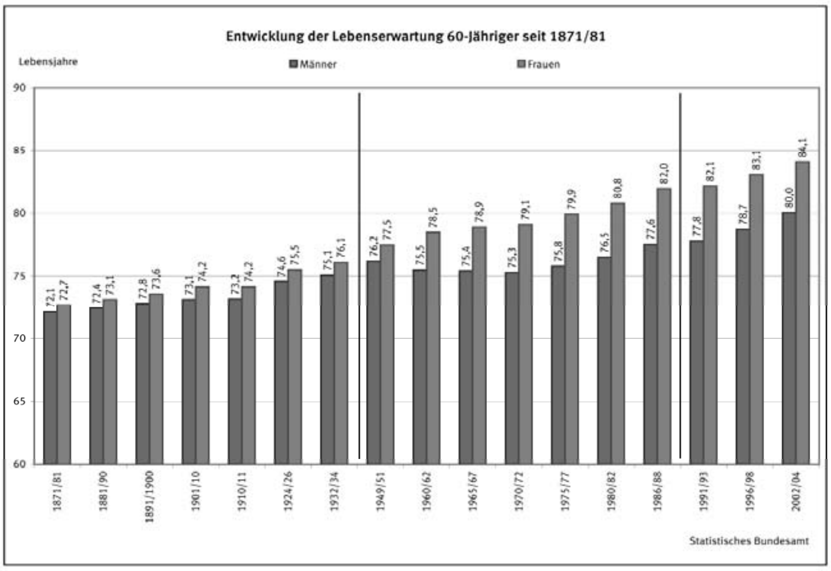
For the purpose of sustaining long-term care insurance system in future, burdens and benefits need to be reviewed.

Establishment of Social Long-Term Care Cost Sharing System

Symposium on Long-Term Care
Tokyo, February 2009

Dr. Matthias von Schwanenflügel, LL.M.Eur.
Head of Directorate for Long-Term Care

Berlin, January 2009



Die Werte sind für folgende Gebietsstände aufgeführt: 1871/81 bis 1932/34 Deutsches Reich, jeweiliger Gebietsstand; 1949/51 bis 1986/88 Früheres Bundesgebiet; ab 1991/93 Deutschland.

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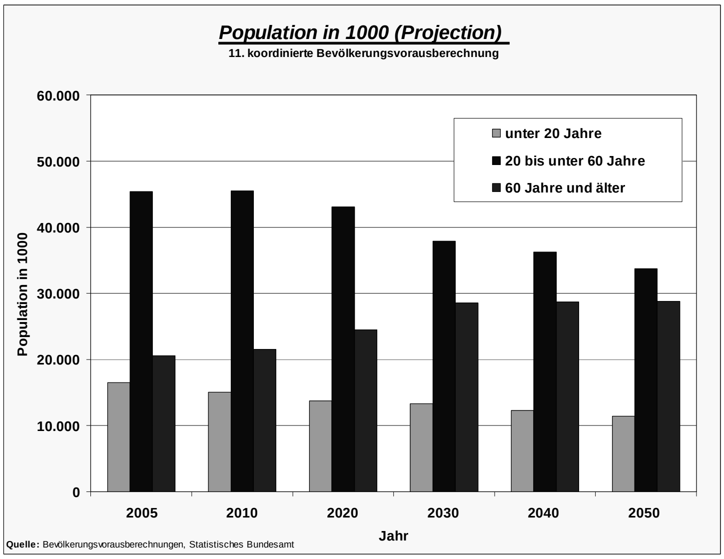

Population in 1000 (Projection)

11. koordinierte Bevölkerungsvorausberechnung

Quelle: Bevölkerungsvorausberechnungen, Statistisches Bundesamt

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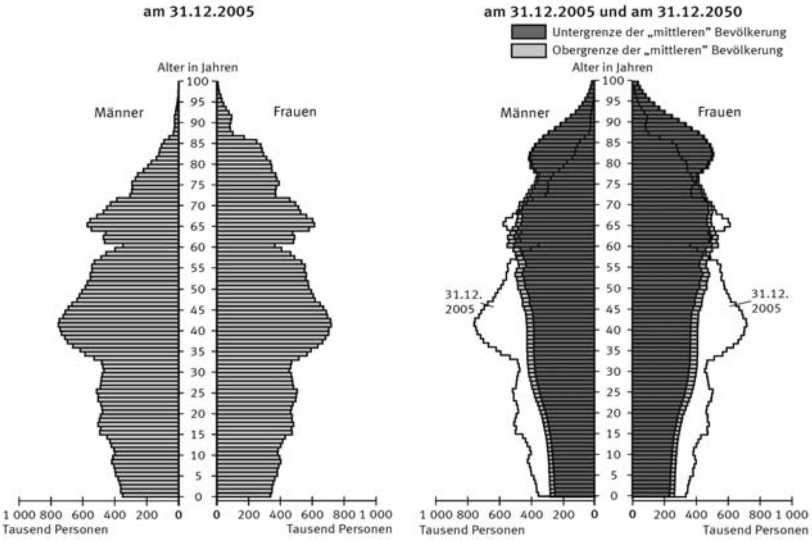
Age Structure

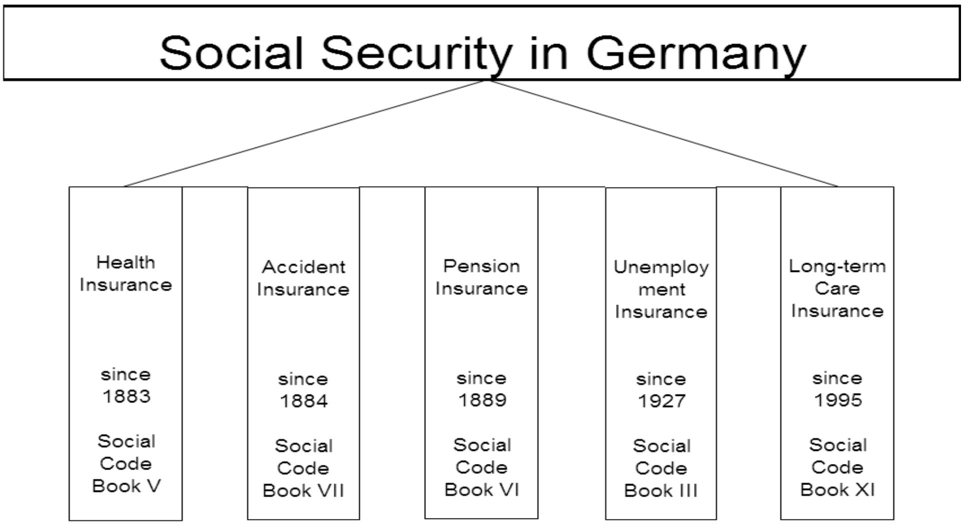


am 31.12.2005

am 31.12.2005 und am 31.12.2050

Quelle: Statistisches Bundesamt, 11. koordinierte Bevölkerungsvorausberechnung.

Social Security in Germany



Health Insurance
since 1883
Social Code Book V

Accident Insurance
since 1884
Social Code Book VII

Pension Insurance
since 1889
Social Code Book VI

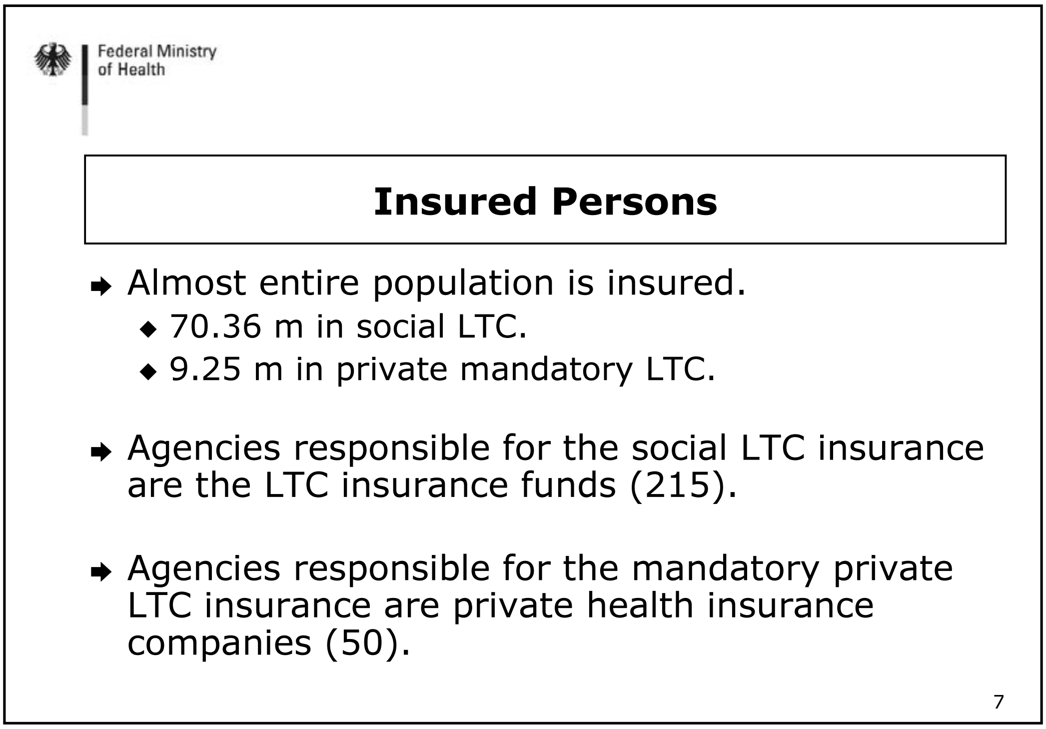
Unemployment Insurance
since 1927
Social Code Book III

Long-term Care Insurance
since 1995
Social Code Book XI

Long-Term Care Insurance

Major Goals and Basic Principles

- ➡ Help to alleviate physical, psychological and financial burdens.
- ➡ Basic form of security.



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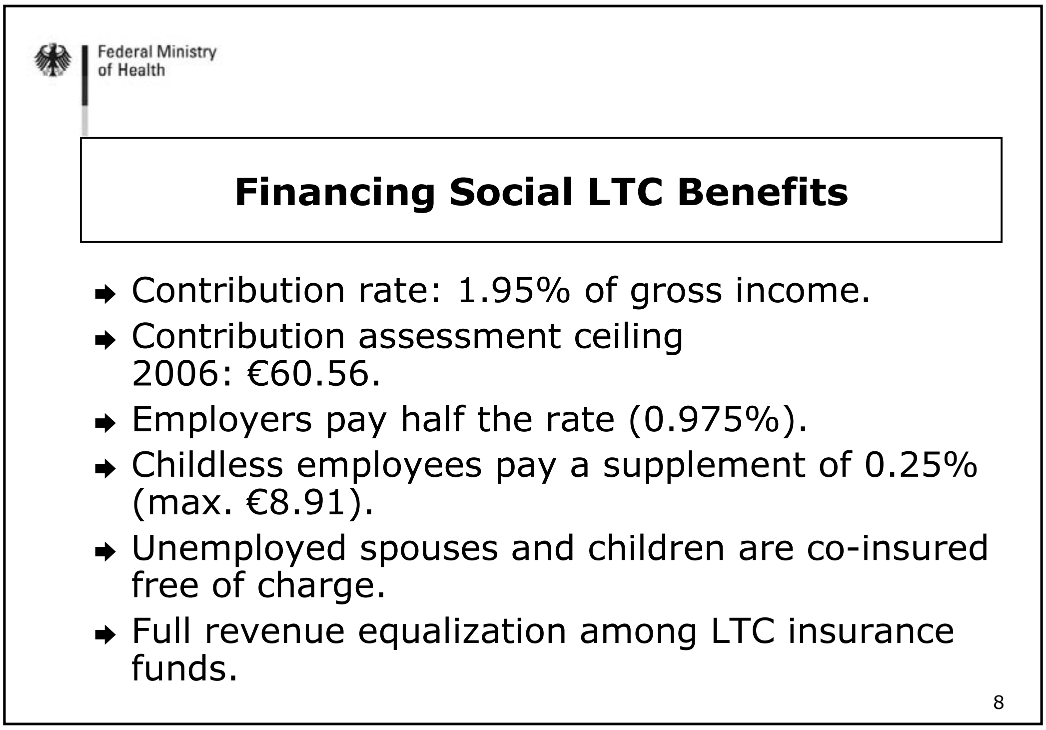
Insured Persons

- Almost entire population is insured.
  - 70.36 m in social LTC.
  - 9.25 m in private mandatory LTC.

- Agencies responsible for the social LTC insurance are the LTC insurance funds (215).

- Agencies responsible for the mandatory private LTC insurance are private health insurance companies (50).



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of Health

Financing Social LTC Benefits

- Contribution rate: 1.95% of gross income.
- Contribution assessment ceiling 2006: €60.56.
- Employers pay half the rate (0.975%).
- Childless employees pay a supplement of 0.25% (max. €8.91).
- Unemployed spouses and children are co-insured free of charge.
- Full revenue equalization among LTC insurance funds.

Financing Private Mandatory LTC Benefits

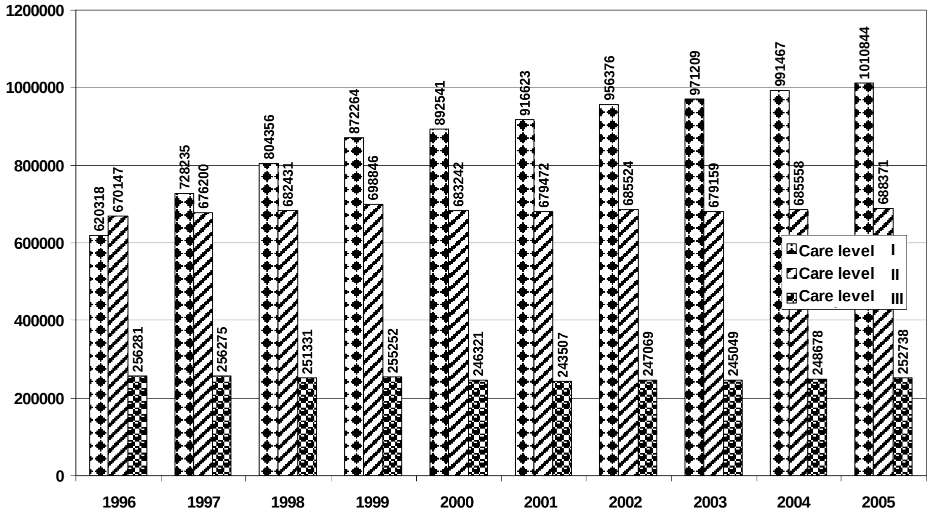
- Financed within framework of fully funded scheme.
- Premiums do not depend on income; paid only by the insured.
- Calculations based exclusively on age at conclusion of contract.
- Children are co-insured free of charge.
- Premiums may not exceed maximum amount of social LTC insurance.

Definition, Eligibility, Assessment Procedure

- Persons in need: physical, psychological, mental handicap which requires help to carry out daily and recurring routines of day-to-day life over a period of at least 6 months.
- Relevant needs: personal care, nutrition, mobility, housekeeping.
- 3 care levels.
- Assessment to identify the care needed.

Federal Ministry
of Health

Trends in number of beneficiaries by care levels
- out-patient and in-patient -



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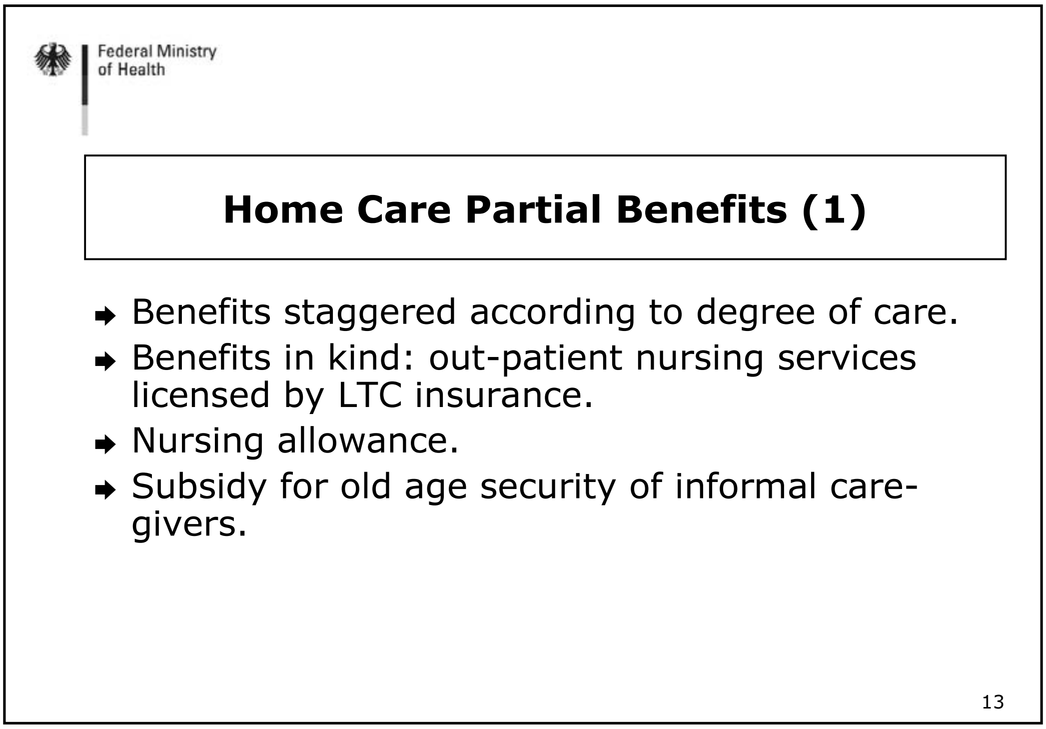
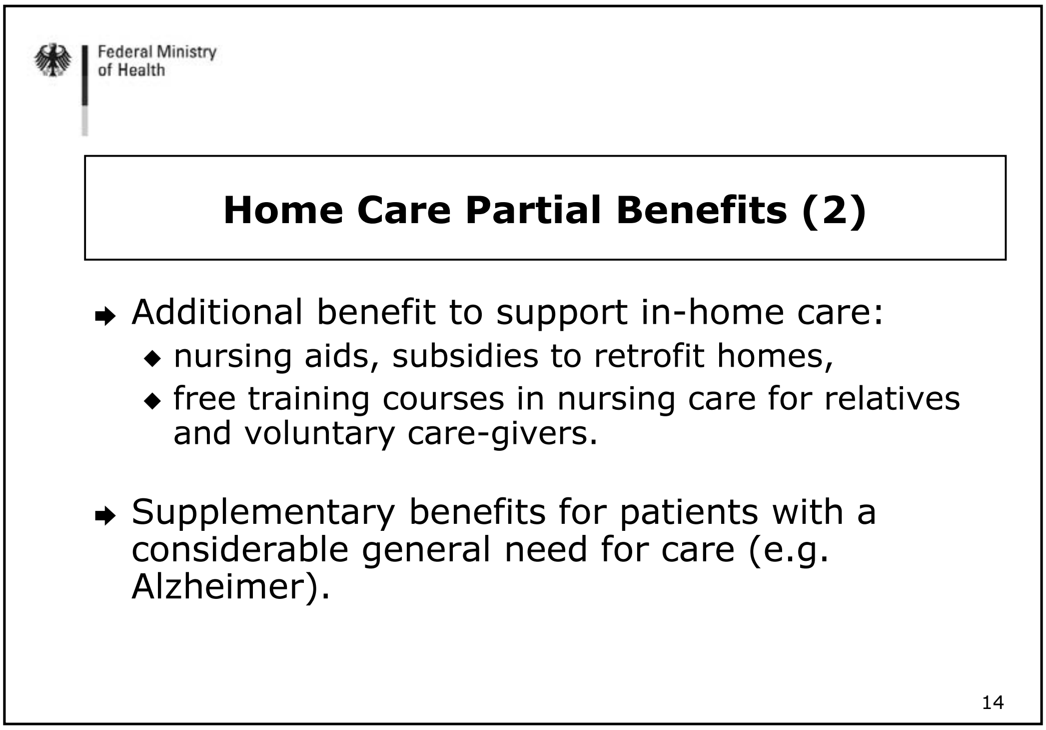
Partial Benefits

- ➡ Benefits for home care, partly in-patient care, in-patient care.
- ➡ Benefits do not depend on income.



Home Care Partial Benefits (1)

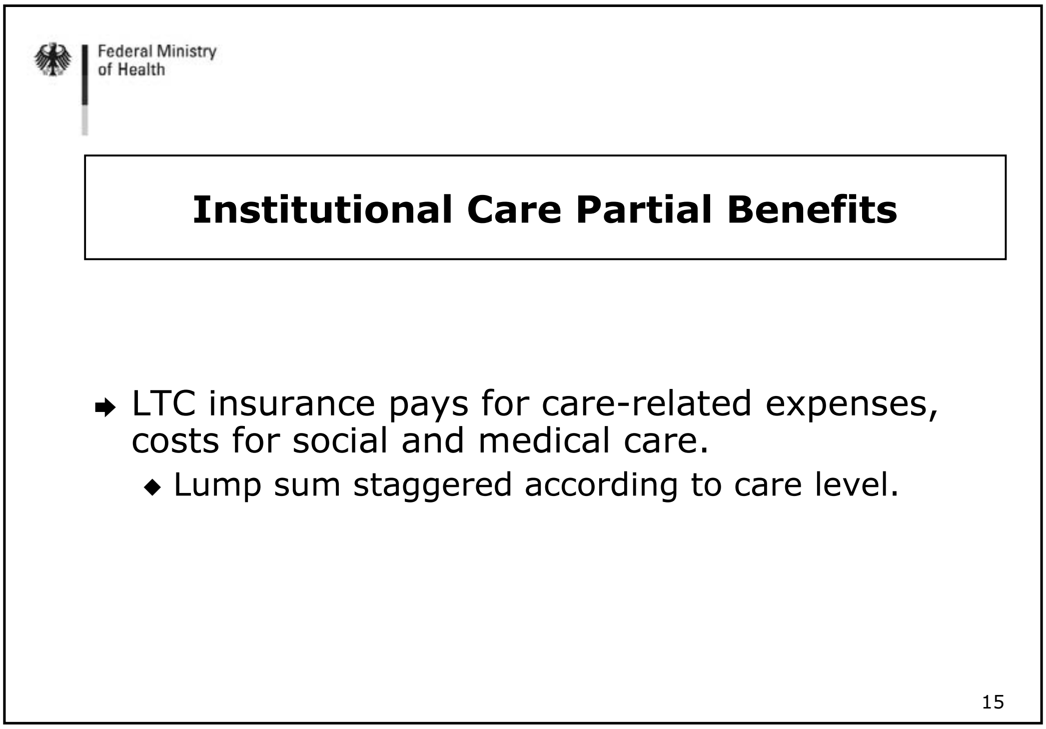
- Benefits staggered according to degree of care.
- Benefits in kind: out-patient nursing services licensed by LTC insurance.
- Nursing allowance.
- Subsidy for old age security of informal care-givers.



Home Care Partial Benefits (2)

- Additional benefit to support in-home care:
  - nursing aids, subsidies to retrofit homes,
  - free training courses in nursing care for relatives and voluntary care-givers.

- Supplementary benefits for patients with a considerable general need for care (e.g. Alzheimer).



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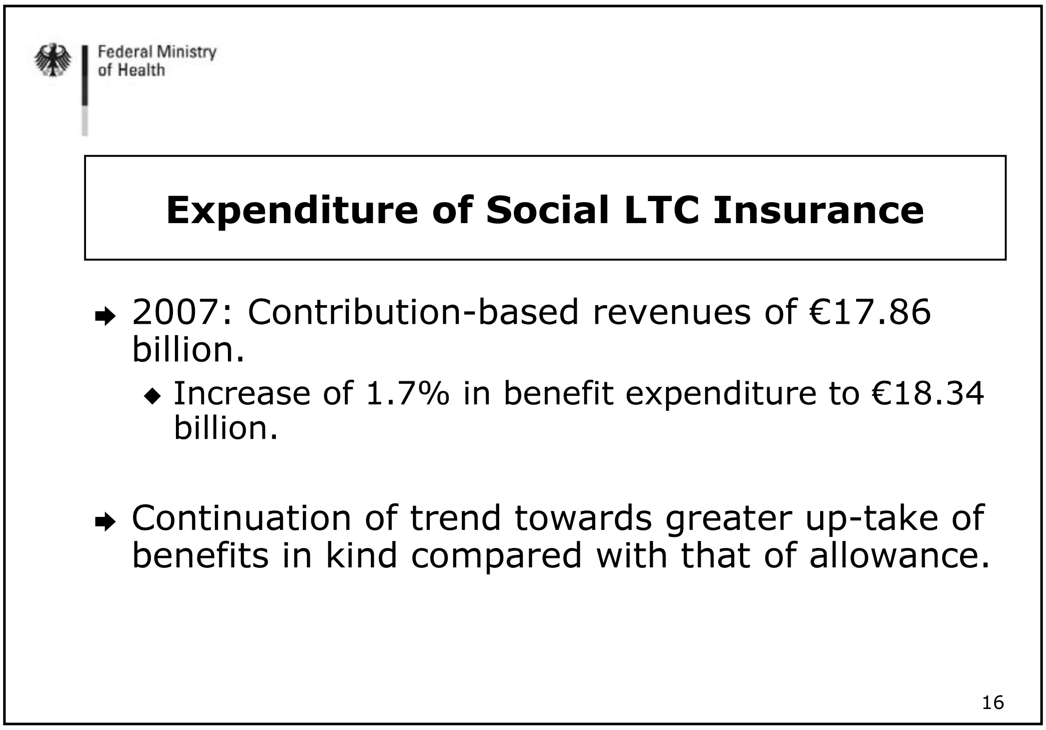
Institutional Care Partial Benefits

- LTC insurance pays for care-related expenses, costs for social and medical care.
  - Lump sum staggered according to care level.



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Expenditure of Social LTC Insurance

- 2007: Contribution-based revenues of €17.86 billion.
  - Increase of 1.7% in benefit expenditure to €18.34 billion.
- Continuation of trend towards greater up-take of benefits in kind compared with that of allowance.

Federal Ministry
of Health

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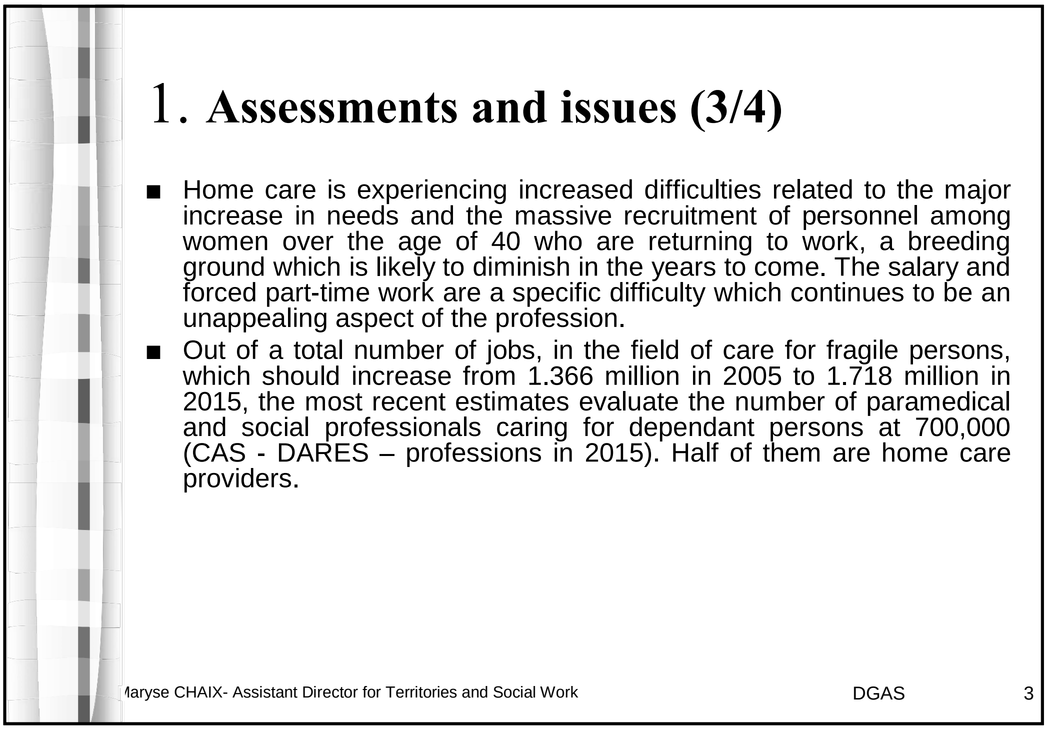
Maryse Chaix: Secureness of Quantitative Workforce and Human Ressources Development

1. Assessments and issues (1/4)

- In 2020, there will be 4 million people aged 80 years and older, an age at which the prevalence of dependence begins to rapidly increase (that is 80% more than in 2000) (Court of auditors-November 2005)
- Government policies (see intervention: role of housing and institutions for the elderly) are developing the means for a personalised response to the care of dependant persons: in institutions, in the home or according to intermediary methods (temporary placement, family placement, day care placement, etc.)
- The structures and services fall under the authority of various statutes, i.e. hospital, territorial (administrative department and CCAS-local social welfare centre) private not-for-profit and private commercial statutes.

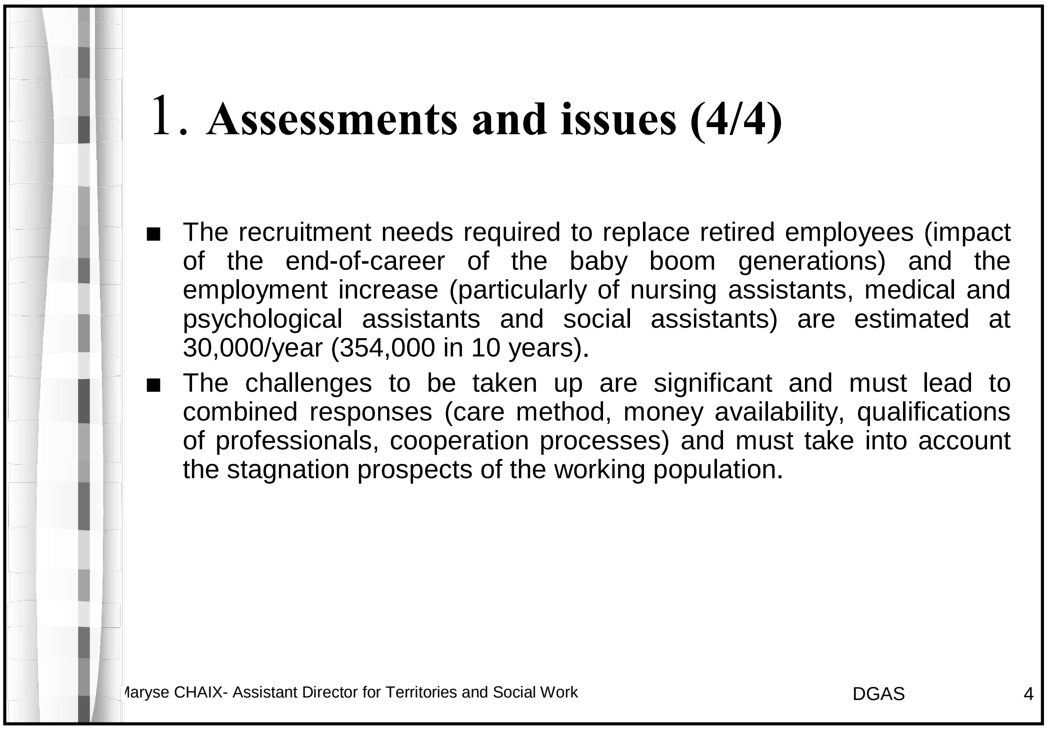
1. Assessments and issues (2/4)

- The profiles of professionals who work with the elderly are changing as a result of the change in care methods, to reinforce the coordination of treatment and develop a geriatric field, for dependant persons placed in institutions for shorter periods of time at the end-of-life.
- Tensions are already appearing, particularly for nurses and caregivers. These tensions are becoming apparent in a sector which is growing steadily (+ approximately 3% per year; government plans to create spaces or services), is largely female (nearly 90 %) and is facing fierce competition from health care institutions. These tensions differ from one area to another (urban or rural) and the turnover is generally significant.



1. Assessments and issues (3/4)

- Home care is experiencing increased difficulties related to the major increase in needs and the massive recruitment of personnel among women over the age of 40 who are returning to work, a breeding ground which is likely to diminish in the years to come. The salary and forced part-time work are a specific difficulty which continues to be an unappealing aspect of the profession.
- Out of a total number of jobs, in the field of care for fragile persons, which should increase from 1.366 million in 2005 to 1.718 million in 2015, the most recent estimates evaluate the number of paramedical and social professionals caring for dependant persons at 700,000 (CAS - DARES – professions in 2015). Half of them are home care providers.



1. Assessments and issues (4/4)

- The recruitment needs required to replace retired employees (impact of the end-of-career of the baby boom generations) and the employment increase (particularly of nursing assistants, medical and psychological assistants and social assistants) are estimated at 30,000/year (354,000 in 10 years).
- The challenges to be taken up are significant and must lead to combined responses (care method, money availability, qualifications of professionals, cooperation processes) and must take into account the stagnation prospects of the working population.

2. The development strategy of an HR response adapted to these challenges

2.1 Measures taken and measures to be supported in terms of qualifications

- diplomas based on fields of professional competence which are common to a practice in different social and medico-social sectors (elderly persons, the disabled, etc.):
  - Accessible both through training (initial and continuous) and the validation of professional experience;

- Whose structure allows for the implementation of bridges from one diploma to another and facilitates horizontal professional mobility (between sectors: the elderly, the disabled, early childhood, exclusion…for same-level professions) or vertical mobility (promotion within a sector, for example with the elderly, to a higher level of qualification) without having to take the entire training course in either case;
- For the retraining of unemployed workers and recruitment to a first level of employment on the labour market, completed by the development of the professional promotion of employees to higher levels of qualifications (avoid the foreseeable competition in the coming years on the labour market of other employment sectors on significant levels of qualifications).

2.2 Measures linked to the organisation of structures and services

- Encourage legal groupings of structures so as to benefit from a wider perimeter of human resources management, facilitate mobility (fight against professional wear) and the mutualization of more sought-after qualifications (social and medico-social groupings for cooperation);
- For home care: increase the working time offered (fight against forced part-time) by diversifying the activities of structures, by organising versatility while respecting the natural lifetimes of accompanied persons; role in the context of the national office of services to persons (ANSP) and the development of the universal service employment voucher;

- Fight against the isolation of professionals by developing the supervision of services, particularly home care services.

2.3 Work on the representations and attractiveness of these professions

- Both with regard to the general public, young people, employees in retraining (jobs with great human wealth and a local community aspect). Major communication campaigns are being carried out for this purpose.

2.4 Organise cooperation among those involved

- The State (major orientations, government plans, etc.), the regions (which received competence in terms of initial health and social training in January 2005) and social partners (lifelong learning) by facilitating the shared conclusions and implementation of veritable regional recruitment and qualifications development plans (tested in three regions, financially supported by the French National Independent-Living Support Fund (CNSA) and will become widespread in 2009).

Andreas Kröger
Managing Director of AHK Pflegeteam GmbH, Berlin

Symposium on long-term care
3-4 February 2009
Tokyo
Session 2

Secureness of Quantitative Workface and Human Resources Development

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Current situation and developments in personnel requirements in long-term care

1. The number of care patients will rapidly increase in the next decades.
   Currently 68% of the patients are being cared for at home – of these about two thirds by family members and one third by nursing services – 32% are being cared for in care homes.

2. The number of employees in the long-term care industry will triple by 2050 to up to 1.6 million, and the market volume is to increase to 85 billion euros.
   In 2007 more than half a million people worked in the long-term care industry generating 25 billion euros.
   Currently it is estimated that 100,000 illegal workers from Eastern European countries are working in home care.

Recruitment of personnel

- Job advertisements in daily papers and city magazines
- Job centres
- Internet presence
- A company's name recognition within the city
- In-service training of caregivers to become state-certified geriatric nurses and full-time vocational training of mostly young applicants is absolutely necessary
- Contacts
- Partnerships with educational institutions
- Partnerships with other care providers
- Improving the company's image through public measures

Andreas Kröger, AHK Pflegeteam

Employee turnover in the long-term care industry

The alleged reasons are quickly established: hard work, low wages, bad image, few opportunities for advancement and opting out of the profession. However it is worth taking a closer look.
First, a distinction should be made between taking time-out of a career and employee turnover.

There are family-related interruptions in the careers of women who make up 85% of long-term care staff.

The work is carried out in shifts and in combination with part time work.

Regularly changing apprentices and trainees.

The main reasons for handing in one's notice in the service business is, firstly human resource management and the lack of possibilities for advancement. Only then is it due to salary levels.

Two factors must be taken into consideration: finding a work/life balance and the physical stress on an ageing staff.

Andreas Kröger, AHK Pflegeteam

Measures for retaining staff and limiting employee turnover

- Multiple-step application process to obtain and retain good long-term care workers
- Comprehensive on-the-job training standards
- Continuous meetings with employees (corporate identity, distinctiveness of the company)
- Offer of additional incentives for the employees: bonuses, company retirement plans
- Improvement of working atmosphere
- Corporate suggestion scheme
- Collaboration in coordinating staff substitutions

Andreas Kröger, AHK Pflegeteam

Human resource development

- Advanced training and further education
- Internal career planning
- Establishing additional levels of hierarchies
- Knowledge of existing employee potentials: language skills, specialisation
- Financial development opportunities

Andreas Kröger, AHK Pflegeteam

Improving the image of the long-term care profession

Parallel to understanding the need for care, the work of the long-term carers should be extended to include social and physical aspects. It is necessary to improve the image of the long-term care profession in order to sway young people to train for this profession. The search for alternative, more fragmented types of care not only benefits those in need of this care, it also re-establishes the attractiveness of the work.

Politics and all those involved must work together to improve working conditions and to adjust the enhancements of the modular system of long-term care insurance to include psycho-social factors such as those which have already been implemented in the care of dementia patients in Germany.

Andreas Kröger, AHK Pflegeteam

Tripartite Symposium on Long-Term Care
among France, Germany and Japan

Session 2 ② Quantitative Expansion and Qualitative
Improvement of Long-Term Care Service Staff

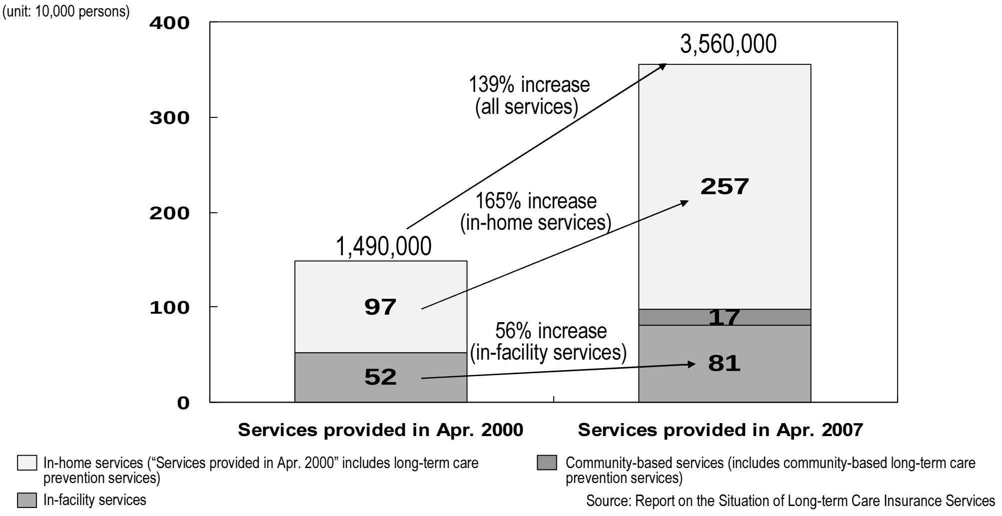
Long-term Care Infrastructure and Staff Recruitment

February 3, 2009

Eiji Habu,
Director, Promotion Division,
Health and Welfare Bureau for the Elderly,
Ministry of Health, Labour and Welfare

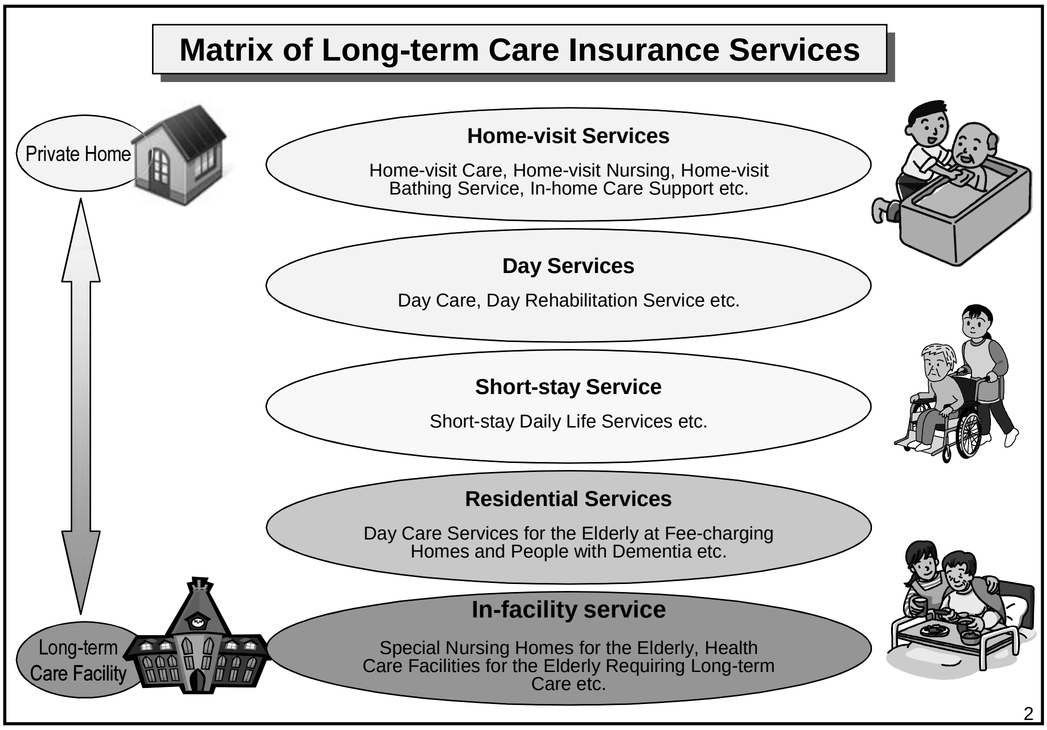
Transition of the Number of Long-term Care Service Recipients

- ○ **The number of long-term care service recipients increased in seven years by approx. 2,070,000 (139%)**
- ○ **Especially, the number of in-home service recipients showed a significant increase (165% increase in seven years)**



Source: Report on the Situation of Long-term Care Insurance Services

* Long-term care prevention services, community-based services and community-based long-term care prevention services were established in 2005 along with the revision of the Long-term Care Insurance System.



Matrix of Long-term Care Insurance Services

Home-visit Services

Home-visit Care, Home-visit Nursing, Home-visit Bathing Service, In-home Care Support etc.

Day Services

Day Care, Day Rehabilitation Service etc.

Short-stay Service

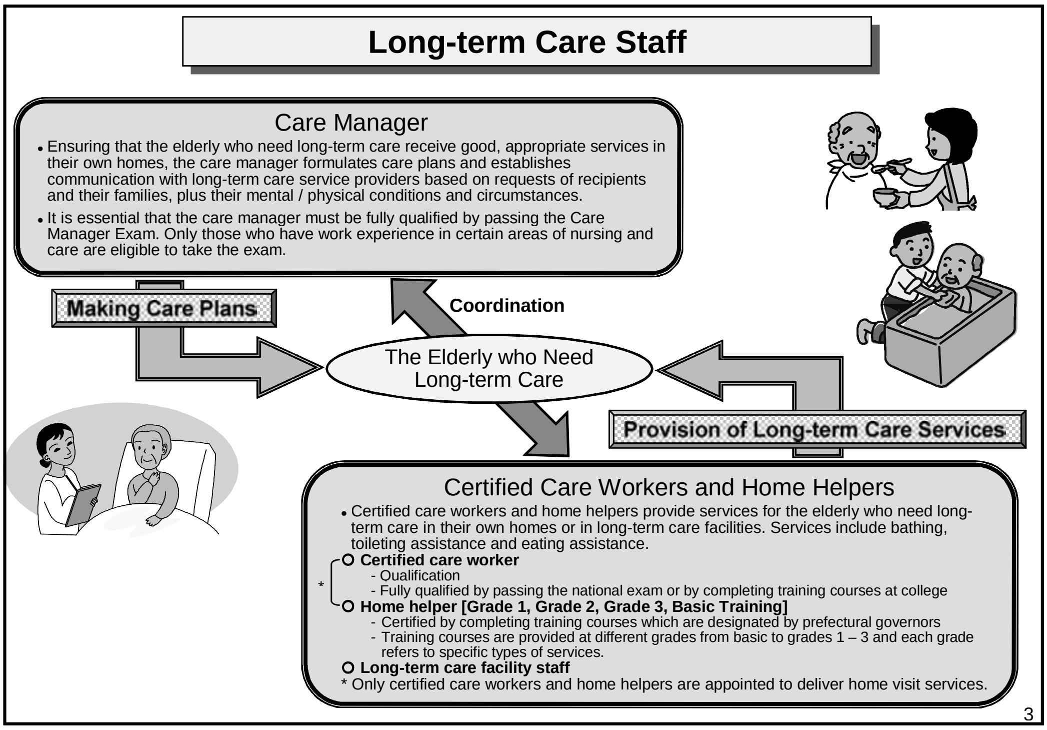
Short-stay Daily Life Services etc.

Residential Services

Day Care Services for the Elderly at Fee-charging Homes and People with Dementia etc.

In-facility service

Special Nursing Homes for the Elderly, Health Care Facilities for the Elderly Requiring Long-term Care etc.



Long-term Care Staff

Care Manager

- Ensuring that the elderly who need long-term care receive good, appropriate services in their own homes, the care manager formulates care plans and establishes communication with long-term care service providers based on requests of recipients and their families, plus their mental / physical conditions and circumstances.
- It is essential that the care manager must be fully qualified by passing the Care Manager Exam. Only those who have work experience in certain areas of nursing and care are eligible to take the exam.

Certified Care Workers and Home Helpers

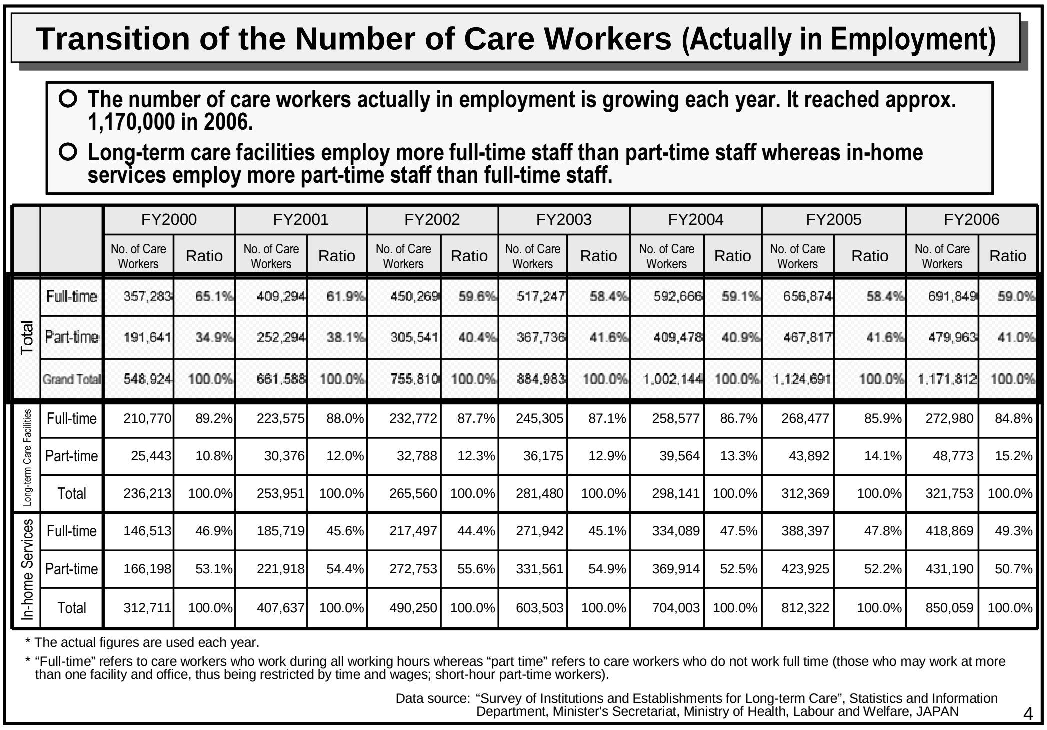
- Certified care workers and home helpers provide services for the elderly who need long-term care in their own homes or in long-term care facilities. Services include bathing, toileting assistance and eating assistance.

○ **Certified care worker**
  - Qualification
  - Fully qualified by passing the national exam or by completing training courses at college

○ **Home helper [Grade 1, Grade 2, Grade 3, Basic Training]**
  - Certified by completing training courses which are designated by prefectural governors
  - Training courses are provided at different grades from basic to grades 1 – 3 and each grade refers to specific types of services.

○ **Long-term care facility staff**

* Only certified care workers and home helpers are appointed to deliver home visit services.



Transition of the Number of Care Workers (Actually in Employment)

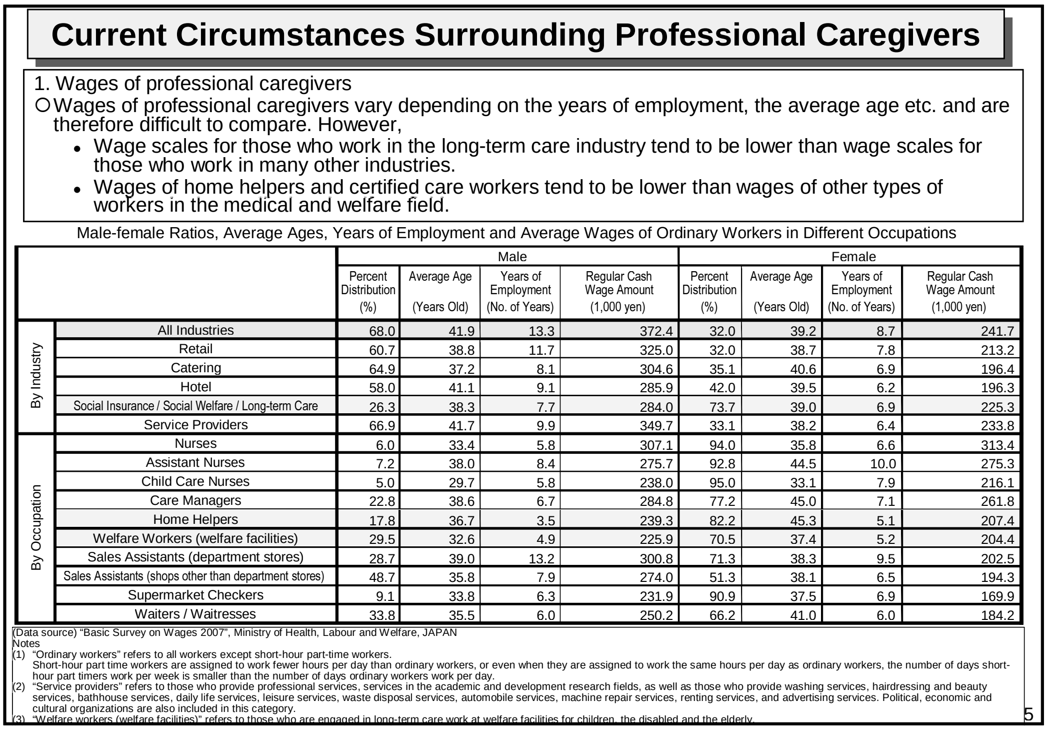
- ○ The number of care workers actually in employment is growing each year. It reached approx. 1,170,000 in 2006.
- ○ Long-term care facilities employ more full-time staff than part-time staff whereas in-home services employ more part-time staff than full-time staff.

		FY2000		FY2001		FY2002		FY2003		FY2004		FY2005		FY2006	
		No. of Care Workers	Ratio	No. of Care Workers	Ratio	No. of Care Workers	Ratio	No. of Care Workers	Ratio	No. of Care Workers	Ratio	No. of Care Workers	Ratio	No. of Care Workers	Ratio
Total	Full-time	357,283	65.1%	409,294	61.9%	450,269	59.6%	517,247	58.4%	592,666	59.1%	656,874	58.4%	691,849	59.0%
	Part-time	191,641	34.9%	252,294	38.1%	305,541	40.4%	367,736	41.6%	409,478	40.9%	467,817	41.6%	479,963	41.0%
	Grand Total	548,924	100.0%	661,588	100.0%	755,810	100.0%	884,983	100.0%	1,002,144	100.0%	1,124,691	100.0%	1,171,812	100.0%
Long-term Care Facilities	Full-time	210,770	89.2%	223,575	88.0%	232,772	87.7%	245,305	87.1%	258,577	86.7%	268,477	85.9%	272,980	84.8%
	Part-time	25,443	10.8%	30,376	12.0%	32,788	12.3%	36,175	12.9%	39,564	13.3%	43,892	14.1%	48,773	15.2%
	Total	236,213	100.0%	253,951	100.0%	265,560	100.0%	281,480	100.0%	298,141	100.0%	312,369	100.0%	321,753	100.0%
In-home Services	Full-time	146,513	46.9%	185,719	45.6%	217,497	44.4%	271,942	45.1%	334,089	47.5%	388,397	47.8%	418,869	49.3%
	Part-time	166,198	53.1%	221,918	54.4%	272,753	55.6%	331,561	54.9%	369,914	52.5%	423,925	52.2%	431,190	50.7%
	Total	312,711	100.0%	407,637	100.0%	490,250	100.0%	603,503	100.0%	704,003	100.0%	812,322	100.0%	850,059	100.0%

* The actual figures are used each year.

* "Full-time" refers to care workers who work during all working hours whereas "part time" refers to care workers who do not work full time (those who may work at more than one facility and office, thus being restricted by time and wages; short-hour part-time workers).

Data source: "Survey of Institutions and Establishments for Long-term Care", Statistics and Information Department, Minister's Secretariat, Ministry of Health, Labour and Welfare, JAPAN



Current Circumstances Surrounding Professional Caregivers

1. Wages of professional caregivers

○ Wages of professional caregivers vary depending on the years of employment, the average age etc. and are therefore difficult to compare. However,

- Wage scales for those who work in the long-term care industry tend to be lower than wage scales for those who work in many other industries.
- Wages of home helpers and certified care workers tend to be lower than wages of other types of workers in the medical and welfare field.

Male-female Ratios, Average Ages, Years of Employment and Average Wages of Ordinary Workers in Different Occupations

		Male				Female			
		Percent Distribution (%)	Average Age (Years Old)	Years of Employment (No. of Years)	Regular Cash Wage Amount (1,000 yen)	Percent Distribution (%)	Average Age (Years Old)	Years of Employment (No. of Years)	Regular Cash Wage Amount (1,000 yen)
By Industry	All Industries	68.0	41.9	13.3	372.4	32.0	39.2	8.7	241.7
	Retail	60.7	38.8	11.7	325.0	32.0	38.7	7.8	213.2
	Catering	64.9	37.2	8.1	304.6	35.1	40.6	6.9	196.4
	Hotel	58.0	41.1	9.1	285.9	42.0	39.5	6.2	196.3
	Social Insurance / Social Welfare / Long-term Care	26.3	38.3	7.7	284.0	73.7	39.0	6.9	225.3
	Service Providers	66.9	41.7	9.9	349.7	33.1	38.2	6.4	233.8
By Occupation	Nurses	6.0	33.4	5.8	307.1	94.0	35.8	6.6	313.4
	Assistant Nurses	7.2	38.0	8.4	275.7	92.8	44.5	10.0	275.3
	Child Care Nurses	5.0	29.7	5.8	238.0	95.0	33.1	7.9	216.1
	Care Managers	22.8	38.6	6.7	284.8	77.2	45.0	7.1	261.8
	Home Helpers	17.8	36.7	3.5	239.3	82.2	45.3	5.1	207.4
	Welfare Workers (welfare facilities)	29.5	32.6	4.9	225.9	70.5	37.4	5.2	204.4
	Sales Assistants (department stores)	28.7	39.0	13.2	300.8	71.3	38.3	9.5	202.5
	Sales Assistants (shops other than department stores)	48.7	35.8	7.9	274.0	51.3	38.1	6.5	194.3
	Supermarket Checkers	9.1	33.8	6.3	231.9	90.9	37.5	6.9	169.9
	Waiters / Waitresses	33.8	35.5	6.0	250.2	66.2	41.0	6.0	184.2

(Data source) "Basic Survey on Wages 2007", Ministry of Health, Labour and Welfare, JAPAN

Notes

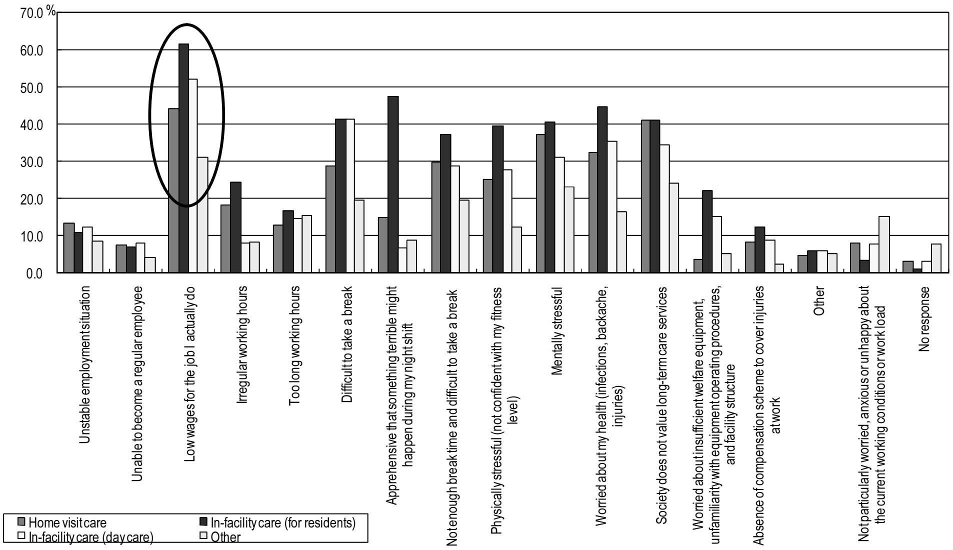
(1) "Ordinary workers" refers to all workers except short-hour part-time workers.
Short-hour part time workers are assigned to work fewer hours per day than ordinary workers, or even when they are assigned to work the same hours per day as ordinary workers, the number of days short-hour part timers work per week is smaller than the number of days ordinary workers work per day.

(2) "Service providers" refers to those who provide professional services, services in the academic and development research fields, as well as those who provide washing services, hairdressing and beauty services, bathhouse services, daily life services, leisure services, waste disposal services, automobile services, machine repair services, renting services, and advertising services. Political, economic and cultural organizations are also included in this category.

(3) "Welfare workers (welfare facilities)" refers to those who are engaged in long-term care work at welfare facilities for children, the disabled and the elderly.

2. Worries, anxieties and dissatisfaction regarding working conditions

○ The number of professional caregivers, who express worries about working conditions, particularly about their low wages, is relatively high.


Worries, Anxieties and Dissatisfaction Regarding Working Conditions (Multiple Answers)

(Source) "Survey of Work Conditions in Long-term Care Services 2007", Care Work Foundation

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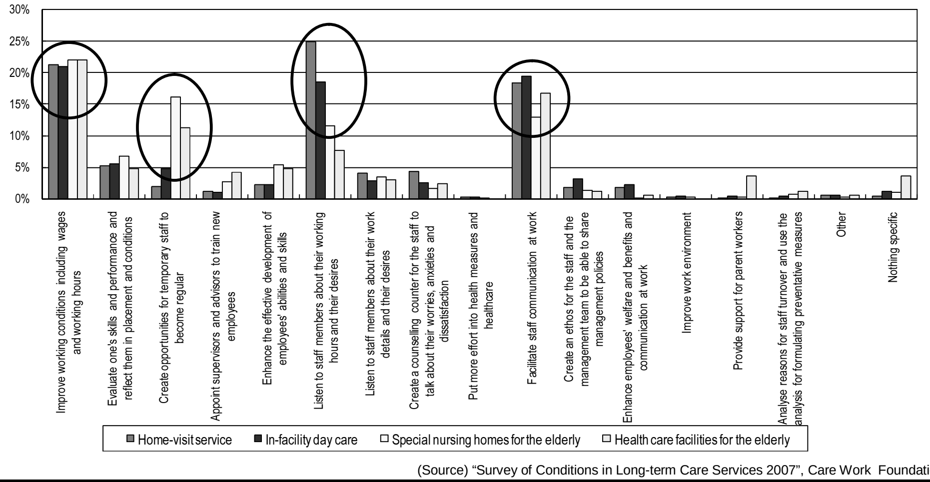
3. Measures for preventing frequent staff turnover and promoting stable employment at care service establishments

○ The measures considered to be most effective by care service establishments are as follows:

- Improve working conditions including wages and working hours
- Facilitate staff communication at work
- Create opportunities for temporary staff to become regular (particularly effective in a care facility situation)
- Listen to staff members about their working hours and their desires (particularly effective in a home-visit situation)


Measures Most Effective in Preventing Frequent Staff Turnover and Promoting Stable Employment

(Source) "Survey of Conditions in Long-term Care Services 2007", Care Work Foundation

Summary of the Employment Situation for Professional Caregivers

○ There are more female professional caregivers than male professional caregivers (approx. 80% are female).

○ The ratio of temporary staff has been on the increase in recent years. (Approx. 80 % of home-visit staff are on a temporary basis.)

○ High accession rate and high turnover rate (accession rate: approx. 27%, turnover rate: approx. 22%)
→ In 2005, when there were 1,120,000 professional caregivers in total, approx. 310,000 started their new jobs at care service establishments and facilities while approx. 240,000 left their jobs (including career moves to other care establishments).

○ Wages for professional caregivers are lower than the average wage of all workers

○ There are many employable care workers with appropriate qualifications
(Approx. 270,000 of 470,000 certified care workers are actually engaged in welfare / care services (as of 2005).

Law Concerning Better Treatment of Professional Caregivers for Securing a Stable Source of Manpower

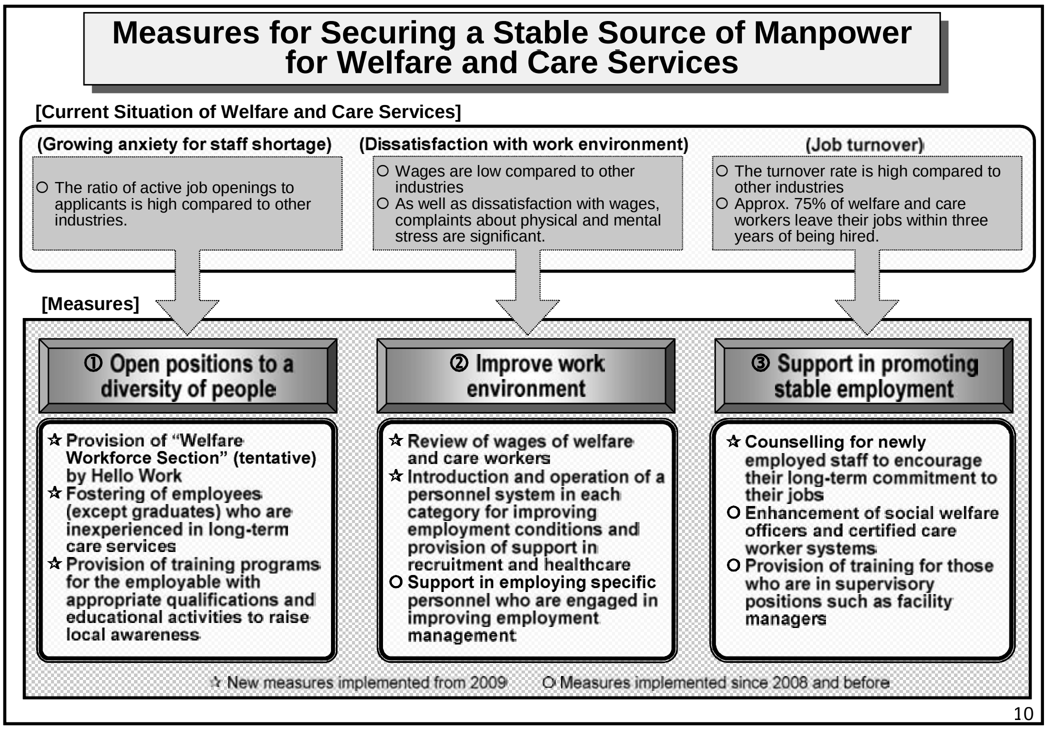
○ The establishment of the "Law Concerning Better Treatment of Professional Caregivers for Securing a Stable Source of Manpower" was agreed unanimously during a regular diet session in 2008.

[Letter of the Law]

The Japanese government recognizes that professional caregivers play an important role in realizing a safe and secure society for the elderly, and with the intention of securing a stable source of excellent manpower in long-term care services, the Japanese government will, by April 1, 2009, take into consideration pay scales for professional caregivers and other work conditions, discuss the parameters of measures conducive to better work conditions for professional caregivers, including their wages, and take actions accordingly.

Supplementary Provision

This law shall be put into effect from the day it is proclaimed.



Measures for Securing a Stable Source of Manpower for Welfare and Care Services

[Current Situation of Welfare and Care Services]

(Growing anxiety for staff shortage)

- ○ The ratio of active job openings to applicants is high compared to other industries.

(Dissatisfaction with work environment)

- ○ Wages are low compared to other industries
- ○ As well as dissatisfaction with wages, complaints about physical and mental stress are significant.

(Job turnover)

- ○ The turnover rate is high compared to other industries
- ○ Approx. 75% of welfare and care workers leave their jobs within three years of being hired.

[Measures]

① Open positions to a diversity of people

- ☆ Provision of "Welfare Workforce Section" (tentative) by Hello Work
- ☆ Fostering of employees (except graduates) who are inexperienced in long-term care services
- ☆ Provision of training programs for the employable with appropriate qualifications and educational activities to raise local awareness

② Improve work environment

- ☆ Review of wages of welfare and care workers
- ☆ Introduction and operation of a personnel system in each category for improving employment conditions and provision of support in recruitment and healthcare
- ○ Support in employing specific personnel who are engaged in improving employment management

③ Support in promoting stable employment

- ☆ Counselling for newly employed staff to encourage their long-term commitment to their jobs
- ○ Enhancement of social welfare officers and certified care worker systems
- ○ Provision of training for those who are in supervisory positions such as facility managers

☆ New measures implemented from 2009 ○ Measures implemented since 2008 and before

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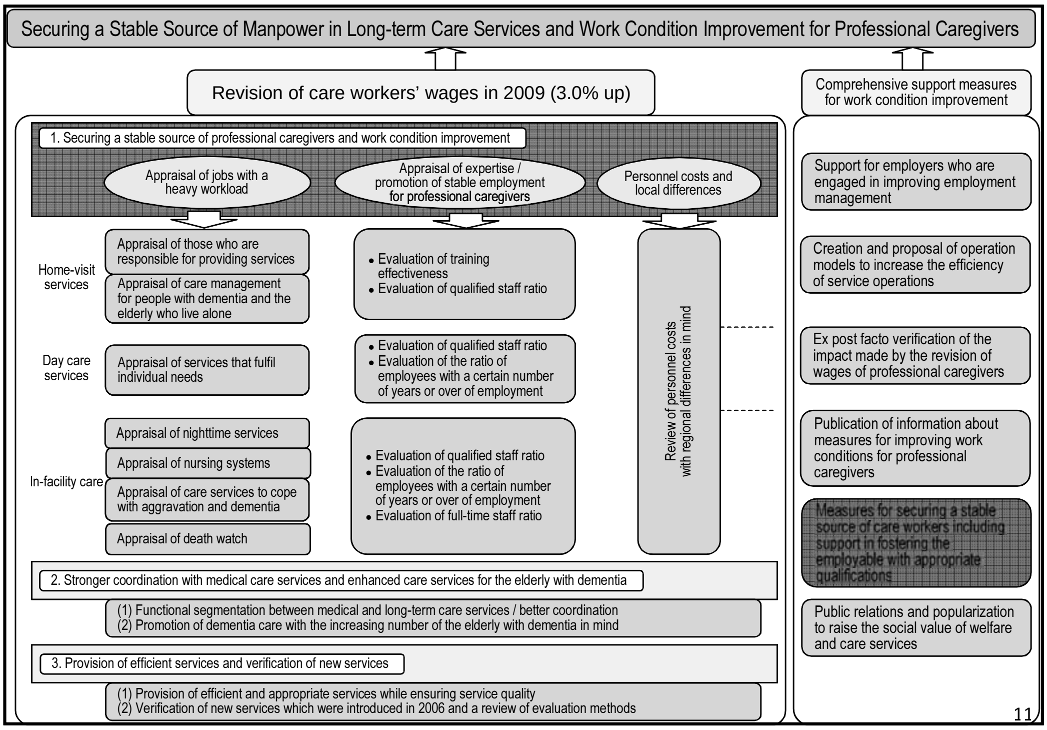

Securing a Stable Source of Manpower in Long-term Care Services and Work Condition Improvement for Professional Caregivers

Revision of care workers' wages in 2009 (3.0% up)

1. Securing a stable source of professional caregivers and work condition improvement

Appraisal of jobs with a heavy workload

- Home-visit services
  - Appraisal of those who are responsible for providing services
  - Appraisal of care management for people with dementia and the elderly who live alone
- Day care services
  - Appraisal of services that fulfil individual needs
- In-facility care
  - Appraisal of nighttime services
  - Appraisal of nursing systems
  - Appraisal of care services to cope with aggravation and dementia
  - Appraisal of death watch

Appraisal of expertise / promotion of stable employment for professional caregivers

- Home-visit services
  - Evaluation of training effectiveness
  - Evaluation of qualified staff ratio
- Day care services
  - Evaluation of qualified staff ratio
  - Evaluation of the ratio of employees with a certain number of years or over of employment
- In-facility care
  - Evaluation of qualified staff ratio
  - Evaluation of the ratio of employees with a certain number of years or over of employment
  - Evaluation of full-time staff ratio

Personnel costs and local differences

- Review of personnel costs with regional differences in mind

2. Stronger coordination with medical care services and enhanced care services for the elderly with dementia

(1) Functional segmentation between medical and long-term care services / better coordination
(2) Promotion of dementia care with the increasing number of the elderly with dementia in mind

3. Provision of efficient services and verification of new services

(1) Provision of efficient and appropriate services while ensuring service quality
(2) Verification of new services which were introduced in 2006 and a review of evaluation methods

Comprehensive support measures for work condition improvement

- Support for employers who are engaged in improving employment management
- Creation and proposal of operation models to increase the efficiency of service operations
- Ex post facto verification of the impact made by the revision of wages of professional caregivers
- Publication of information about measures for improving work conditions for professional caregivers
- Measures for securing a stable source of care workers including support in fostering the employable with appropriate qualifications
- Public relations and popularization to raise the social value of welfare and care services

Definition of “Care Needs Certification” and Method of Assessment

TAKAKO TSUTSUI, Ph.D.
Chief, Administration
Dept. of Health and Social Services
National Institute of Public Health

Feb 3,2009

Content

１.Overview of Long-Term Care Insurance System in Japan, Germany and France

2.Difinition of “Care Needs Certification” in Japan

3. Method of assessment of “Care Needs Certification” in Japan

1. Overview of Long-Term Care Insurance System in Japan, Germany and France

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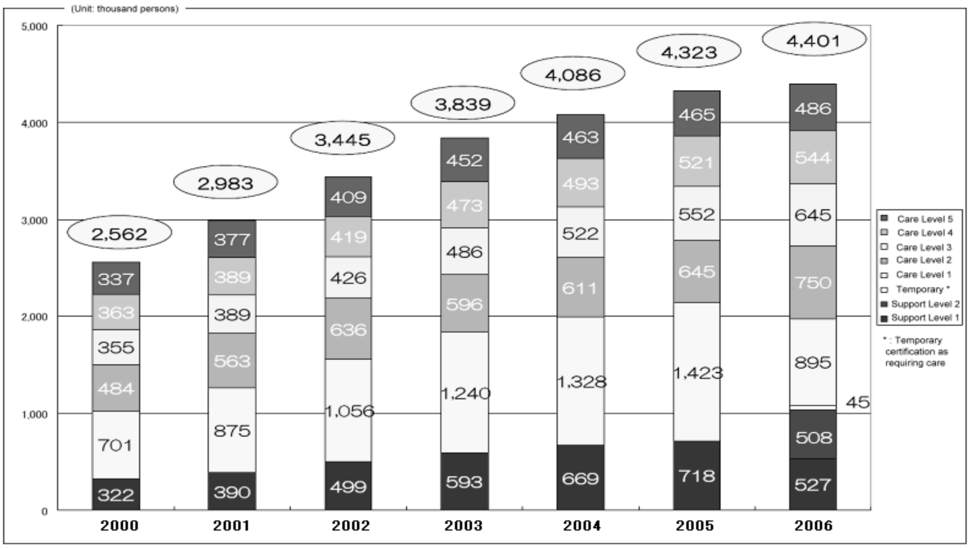
Increase in the Number of the Certified Persons



※■ 2000-2006: Support Level. 2007: Support Level 2

Care (Case) Management in Each Country

DE	**FR**
Introduced with reform of 2008	Care plan prepared by Municipalities, etc.

JP
Care plan prepared by care managers

Number of Benefit Recipients

DE	
Care Lev.3	252,000 (13%)
Care Lev.2	683,000 (35%)
Care Lev.1	1,033,000 (52%)

Total：1,968,505

(End of 2006)
Source: Institute for Health Economics and Policy (2008)

FR	
GIR1	79,000 (8%)
GIR2	289,000 (29%)
GIR3	201,000 (20%)
GIR4	439,000 (43%)

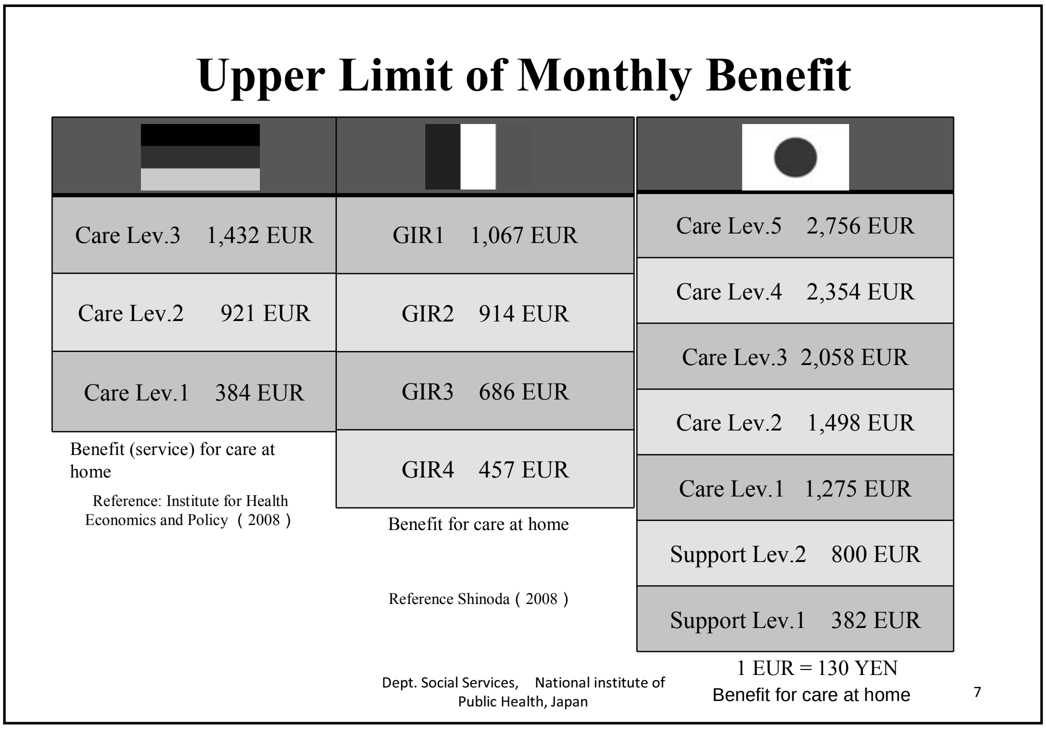
Total：1,008,000

(End of 2006)
Source: Harada (2007)

JP	
Care Lev.5	412,000 (11%)
Care Lev.4	523,000 (14%)
Care Lev.3	645,000 (18%)
Care Lev.2	707,000 (19%)
Care Lev.1	623,000 (17%)
Support Lev.2	416,000 (11%)
Support Lev.1	331,000 (9.0%)

Total：3,360,000

(As of Feb 2008)



Upper Limit of Monthly Benefit

Care Lev.3 1,432 EUR	GIR1 1,067 EUR	Care Lev.5 2,756 EUR
Care Lev.2 921 EUR	GIR2 914 EUR	Care Lev.4 2,354 EUR
Care Lev.1 384 EUR	GIR3 686 EUR	Care Lev.3 2,058 EUR
	GIR4 457 EUR	Care Lev.2 1,498 EUR
		Care Lev.1 1,275 EUR
		Support Lev.2 800 EUR
		Support Lev.1 382 EUR

Benefit (service) for care at home

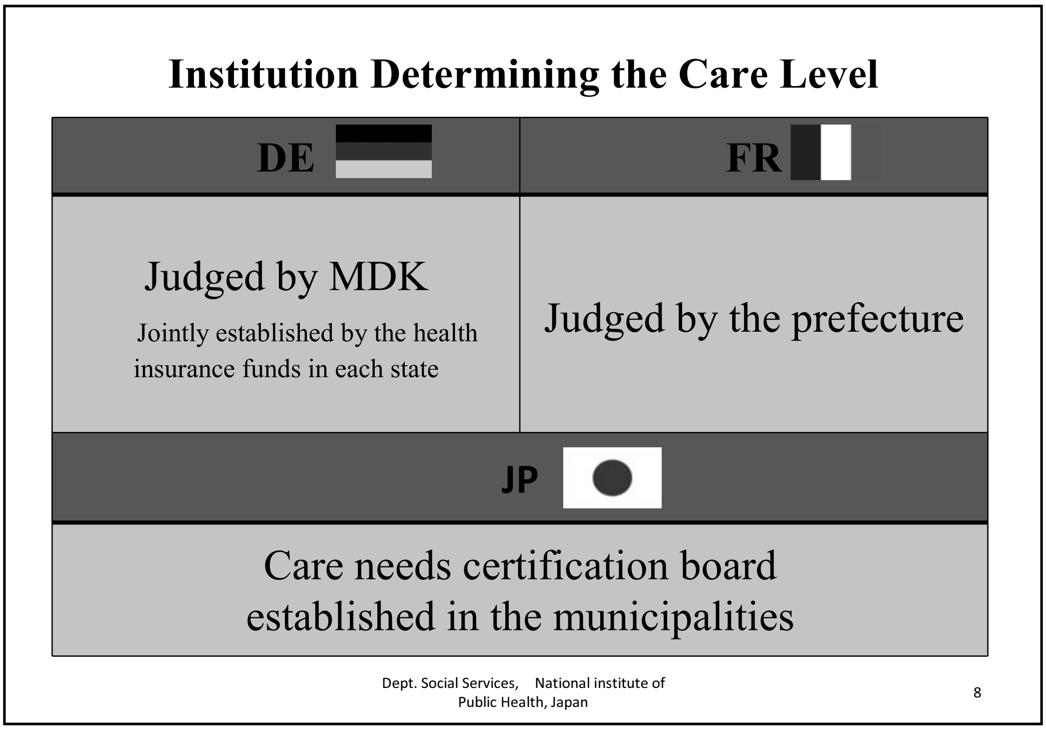
Reference: Institute for Health Economics and Policy（2008）

Benefit for care at home

Reference Shinoda（2008）

1 EUR = 130 YEN

Benefit for care at home



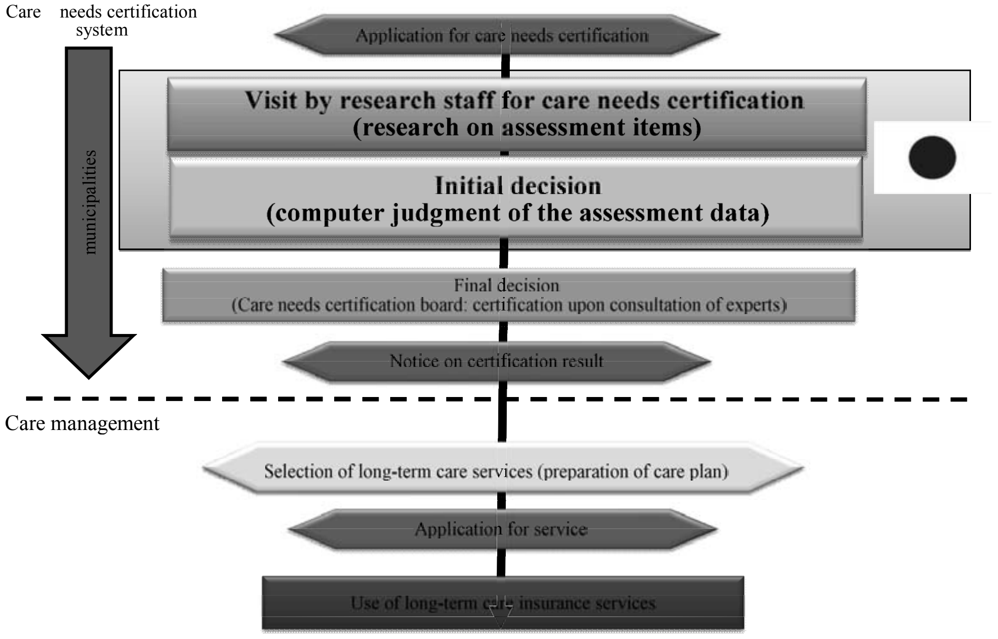
Institution Determining the Care Level

DE	**FR**
Judged by MDK Jointly established by the health insurance funds in each state	Judged by the prefecture

JP
Care needs certification board established in the municipalities

2. Care Needs Certification in Long- term care insurance system
-What is Care Level?-

Process Until the Use of Long-Term Care Insurance Services (1 Month)



Care needs certification system

municipalities

Application for care needs certification

Visit by research staff for care needs certification (research on assessment items)

Initial decision (computer judgment of the assessment data)

Final decision (Care needs certification board: certification upon consultation of experts)

Notice on certification result

Care management

Selection of long-term care services (preparation of care plan)

Application for service

Use of long-term care insurance services

Standards for Care Needs Certification in Germany

Class	Criteria	Required care time	Upper limit for payments (in-home and in-kind benefits)	Reference (Japan / in-home)
Care Level I (Medium Level)	Requiring assistance at least one time a day for at least two activities in one or multiple fields with respect to body care, feeding and moving around. In addition, requiring assistance with household chores several times a week.	At least 90 min/day Among this, at least 45 min. of basic care	384 EUR	2,058 EUR (Care Level 3)
Care Level II (Severe Level)	Requiring assistance for at least three times a day at different hours with respect to body care, feeding and moving around. In addition, requiring assistance with household chores several times a week.	At least 3 hours/day Among this, at least 2 hours of basic care	921 EUR	2,354 EUR (Care Level 4)
Care Level III (Top Level)	Requiring assistance for 24 hours a day including nights with respect to body care, feeding and moving around. In addition, requiring assistance with household chores several times a week.	At least 5 hours/day Among this, at least 4 hours of basic care	1,432 EUR	2,756 EUR (Care Level 5)

Source: Matsumoto (2008)

Standards for Care Needs Certification in France

Class	Image of Condition		Upper limit for payments (in-home)	Reference (Japan / in-home)
GIR1	[Top Level]	Persons who completely lost independence physically and mentally, and who need permanent assistance by another person	1,067 EUR	2,756 EUR (Care Level 5)
GIR2	[High Level]	Persons who cannot move their body but have not completely lost their mental functions, or persons who lost mental independence but maintain their physical activities	914 EUR	2,354 EUR (Care Level 4)
GIR3	[Medium Level]	Persons who require a significant level of daily assistance from the aspect of physical independence	686 EUR	2,058 EUR (Care Level 3)
GIR4	[Low Level]	Persons who need assistance with standing / sitting, dressing / undressing and meals	457 EUR	1,498 EUR (Care Level 2)
GIR5	[Fragile Elderly Persons]	Persons who need limited assistance	none	1,275 EUR (Care Level 1)
GIR6	[Independent Persons]	Persons who are independent	none	–

Source: Shinoda (2008), Matsuda (2006)

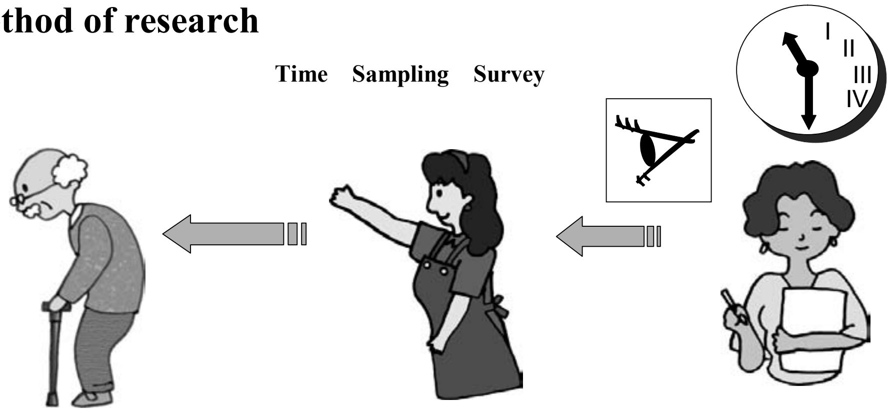
Feasibility: 4.714 million persons are certified as requiring long-term care (support) (as of September 2008)
The total number of valid applications is 45.155 million (April 2008 to December 2008)

Cost: The cost of the clerical work for the care requirement certification was 61.6 billion Yen (estimated) in fiscal 2003, which corresponds to about 1% of the costs for the long-term care benefits.
Huge additional costs are anticipated if all applicants are certified by medical doctors.

Objectivity: Check the condition of the applicant while comparing it with standards. Obtain results that do not depend on the quality of the certification research staff.

Method of research

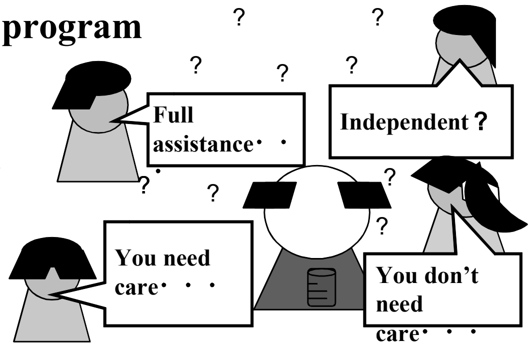
Time Sampling Survey



Elderly **Caregiver** **Researcher**

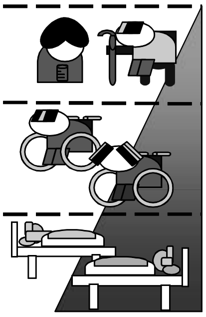
We were able to collect data on some 10 million minutes of in-home services provided.

An efficient needs assessment program



Point1

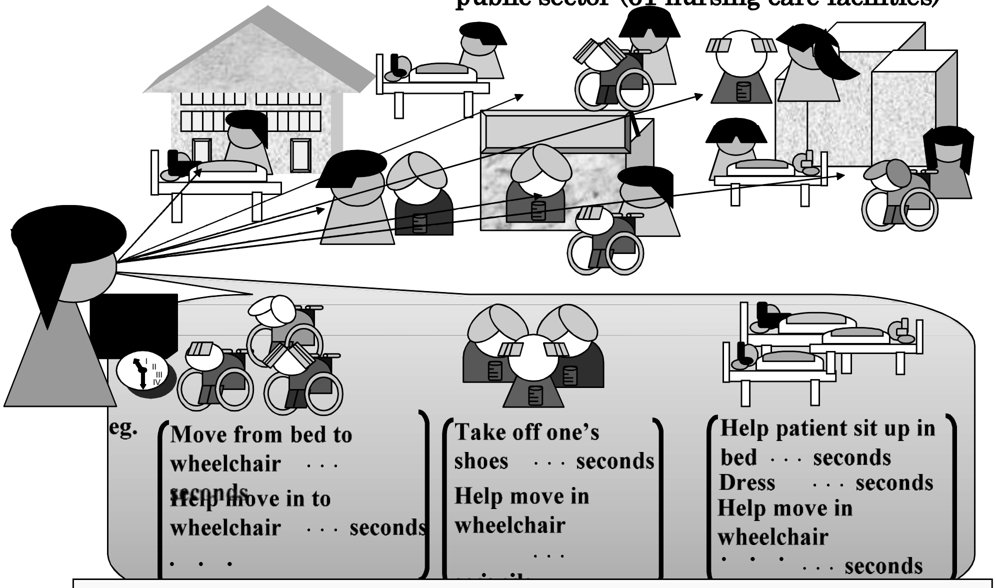
There was a question of assessment standards.



Point2

Once a decision has been made regarding eligibility, it would be necessary to devise a system to rank the eligible people according to their nursing care needs.

public sector (61 nursing care facilities)



eg.

Move from bed to wheelchair ··· seconds
Help move in to wheelchair ··· seconds
· · ·

Take off one’s shoes ··· seconds
Help move in wheelchair ···

Help patient sit up in bed ··· seconds
Dress ··· seconds
Help move in wheelchair
· · · ··· seconds

We measured the specific amounts of time that caregivers spent performing various types of services for these seniors, each of whom had his own unique characteristics.

3. Estimation model for the “The time index for Care Needs Certification” in Care Needs Certification

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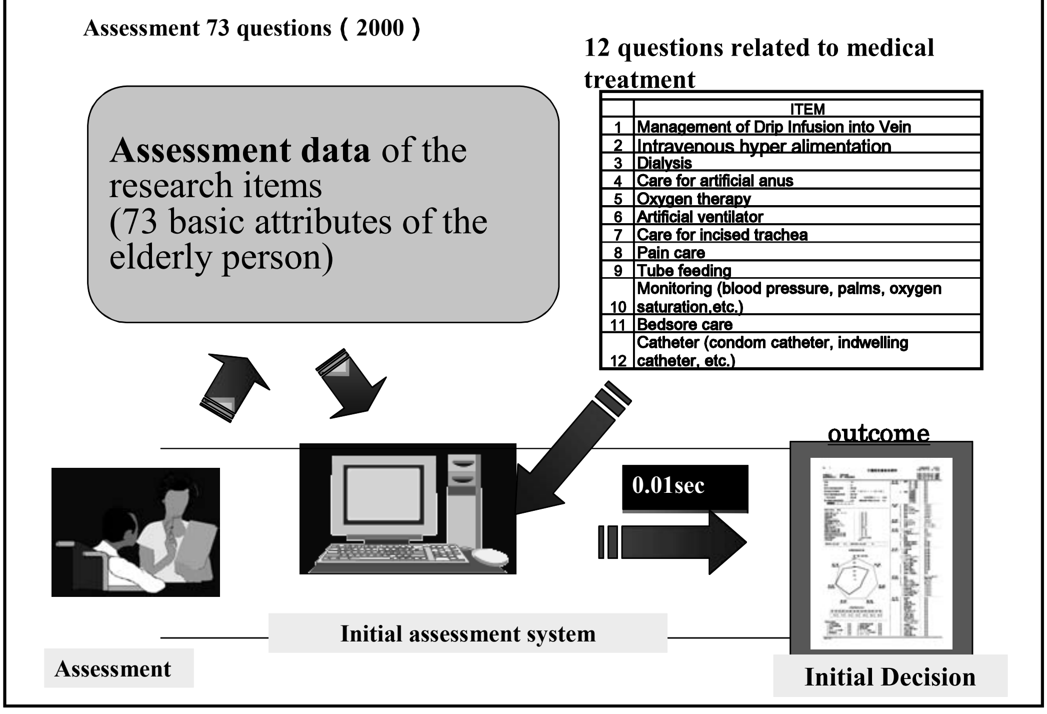
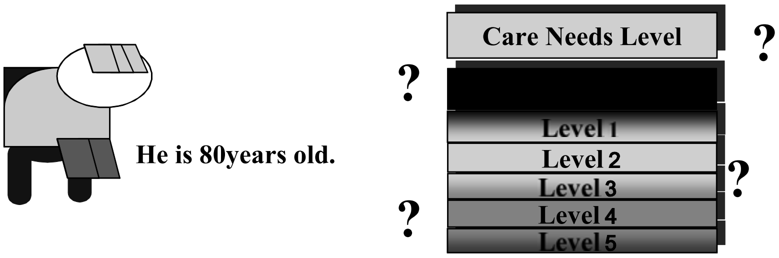


Assessment 73 questions（2000）

Assessment data of the research items
(73 basic attributes of the elderly person)

12 questions related to medical treatment

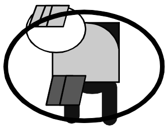
	ITEM
1	Management of Drip Infusion into Vein
2	Intravenous hyper alimentation
3	Dialysis
4	Care for artificial anus
5	Oxygen therapy
6	Artificial ventilator
7	Care for incised trachea
8	Pain care
9	Tube feeding
10	Monitoring (blood pressure, palms, oxygen saturation,etc.)
11	Bedsore care
12	Catheter (condom catheter, indwelling catheter, etc.)



He is 80years old.

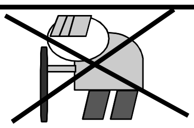
2-3. Maintaining a sitting position with feet on floor. Circle only one.

- [✓ **1. Able to do**]
- **2. Able to do only by holding onto something**
- **3. Able to do only with support from somebody**
- **4. Unable to do**

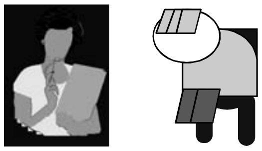


2-6. Walking Circle only one.

- **1. Able to do independently**
- **2. Able to do only with support**
- [✓ **3. Unable to do**]



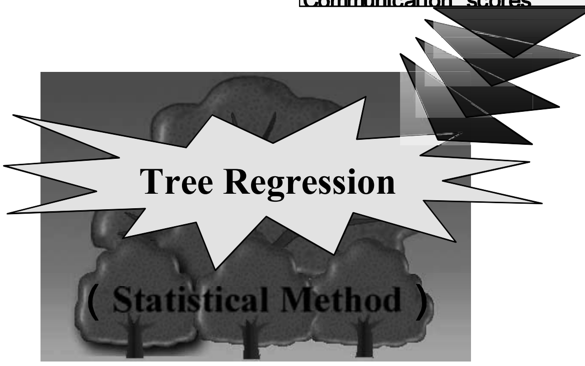
The Elderly Survey (73items)



Mental/Physical state of elderly

7scores

Aging Indicator for 7 Status Quo	
Physical impairment scores	6.6points
Mobility scores	64points
Complicated action scores	41.5points
Personal care scores	37points
Special care provided by healthcare professional scores	78points
Behavioral problem scores	98points
Communication scores	51.8points



Estimated nursing care times

Direct living assistance

- (1) grooming 11min
- (2) elimination 3min
- (3) eating 18min
- (4) bathing 7min
- (5) moving 11min

- (6) Indirect living assistance 8 min
- (7) Assistance for behavioral problem 1 min
- (8) Rehabilitation activities 15 min
- (9) Medical care activities 6 min

Result of Medical care received during 14 days (12 items) past 1 min

Total Estimate nursing care times

81min

! Don't forget that the "Estimated nursing care times" doesn't translate exactly to real time

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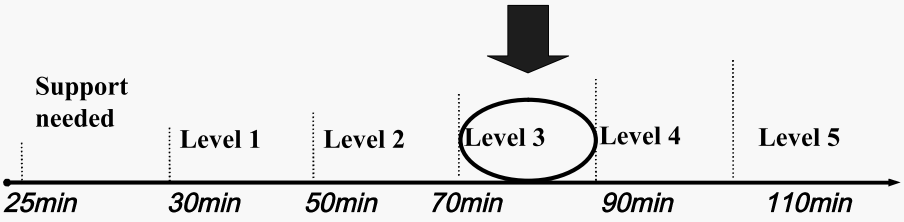
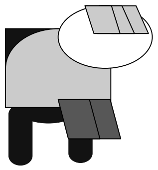
Total estimate for the nursing care times

= (11 + 3 + 18 + 7 + 11 + 8 + 1 + 15 + 6 + 1) min
= 81 min



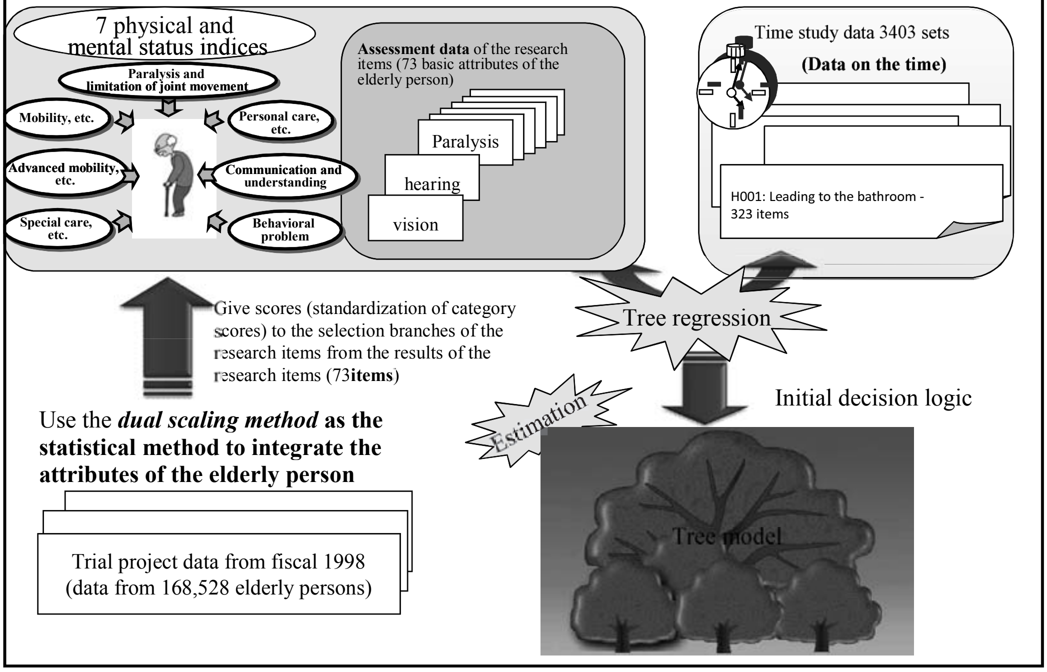


Care Needs Level

Support needed
Level 1
Level 2
Level3
Level4
Level5

Care Needs Level 3!!

Certification logic at the time of the start of the system in 2000



7 physical and mental status indices

Paralysis and limitation of joint movement

Mobility, etc.

Personal care, etc.

Advanced mobility, etc.

Communication and understanding

Special care, etc.

Behavioral problem

Assessment data of the research items (73 basic attributes of the elderly person)

Time study data 3403 sets

(Data on the time)

H001: Leading to the bathroom - 323 items

Tree regression

Give scores (standardization of category scores) to the selection branches of the research items from the results of the research items (73**items**)

Estimation

Initial decision logic

Use the ***dual scaling method*** **as the statistical method to integrate the attributes of the elderly person**

Trial project data from fiscal 1998 (data from 168,528 elderly persons)

Change of Certification Assessment Items in Japan

- Certification assessment items in 1999
- = 73 items+ items related to special medical care (12 items)

2003: Added assessment of dementia and in-home care (79 items)

2006: Added assessment of an item group for long-term care prevention (82 items)

2009: Review of the assessment items and tree models (74 items)

Revision of 2009: Certification Assessment Items

Group 1 Paralysis and limitation of joint movement

1-1 Existence of paralysis
1-2 Limitation of joint movement
1-3 Turning over in bed
1-4 Sitting up in bed
1-5 Remaining in sitting position
1-6 Standing on both feet
1-7 Walking
1-8 Standing up from a sitting position
1-9 Standing on one foot
1-10 Bathing
1-11 Nail cutting
1-12 Vision
1-13 Hearing

Group 2 Personal care

2-1 Transferring
2-2 Moving around
2-3 Swallowing
2-4 Taking meals
2-5 Voiding
2-6 Defecation
2-7 Oral hygiene
2-8 Face washing
2-9 Hair washing
2-10 Putting on and takes off a jacket
2-11 Putting on and takes off trousers
2-12 Frequency of going out

Group 3 Cognitive functions

3-1 communication
3-2 Understanding a daily schedule
3-3 Answering date of birth and age
3-4 Immediate memory
3-5 Remembering own name
3-6 Recognizing the season
3-7 Recognizing the place
3-8 Wandering
3-9 Being lost out of one's residence

Group 4 BPSD (Behavioral and Psychological Symptoms of Dementia)

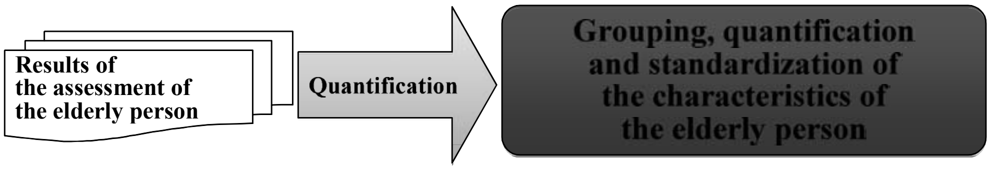
4-1 Suspiciousness
4-2 Confabulation
4-3 Affective incontinence
4-4 Day-night disturbances
4-5 Compulsive behaviors (e.g. frequent asking)
4-6 Verbal outbursts
4-7 Resistance against caregiver
4-8 Restlessness
4-9 Wanders aimlessly in the house during the day
4-10 Collectionism
4-11 Violent behaviors, destruction
4-12 Severe memory disturbances
4-13 Monologue
4-14 Selfish behaviors
4-15 Incoherence of thought

Group 5 IADL

5-1 Taking medication
5-2 Financial management
5-3 Making decisions
5-4 Non-adaptation to groups
5-5 Shopping
5-6 Cooking

Special medical care

Development of Mental and Physical Status Indices (Intermediate Evaluation Items)

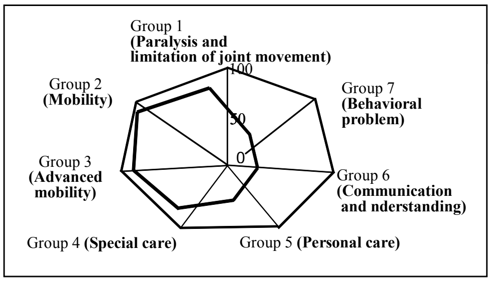

Results of the assessment of the elderly person

Quantification

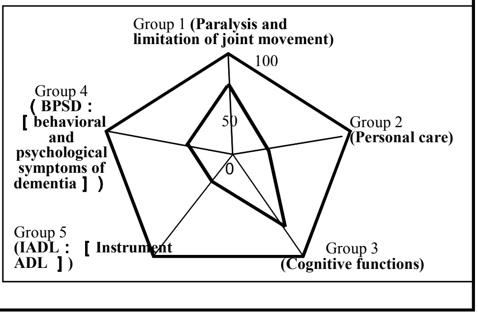
Grouping, quantification and standardization of the characteristics of the elderly person

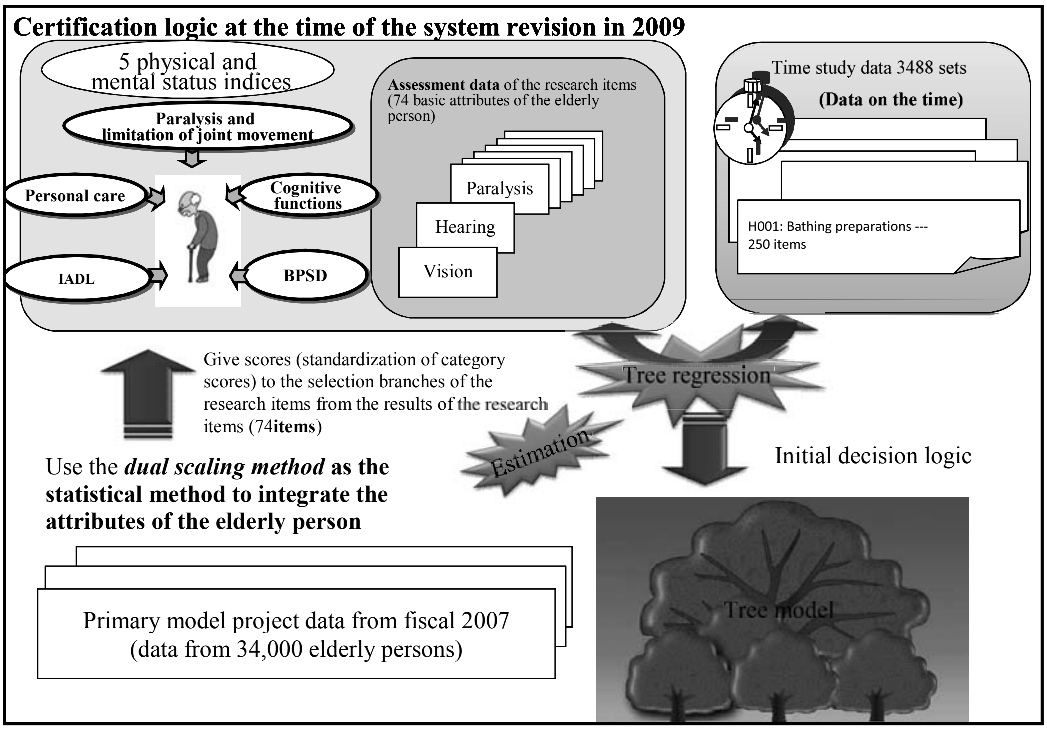
Categorization of 73 assessment data into 7 groups (At time of system start in 2000)

Categorization of 74 assessment data into 5 groups (Revised in 2009)



From 7 to 5 groups





Certification logic at the time of the system revision in 2009

5 physical and mental status indices

Paralysis and limitation of joint movement

Personal care

Cognitive functions

IADL

BPSD

Assessment data of the research items (74 basic attributes of the elderly person)

Paralysis

Hearing

Vision

Time study data 3488 sets

(Data on the time)

H001: Bathing preparations --- 250 items

Tree regression

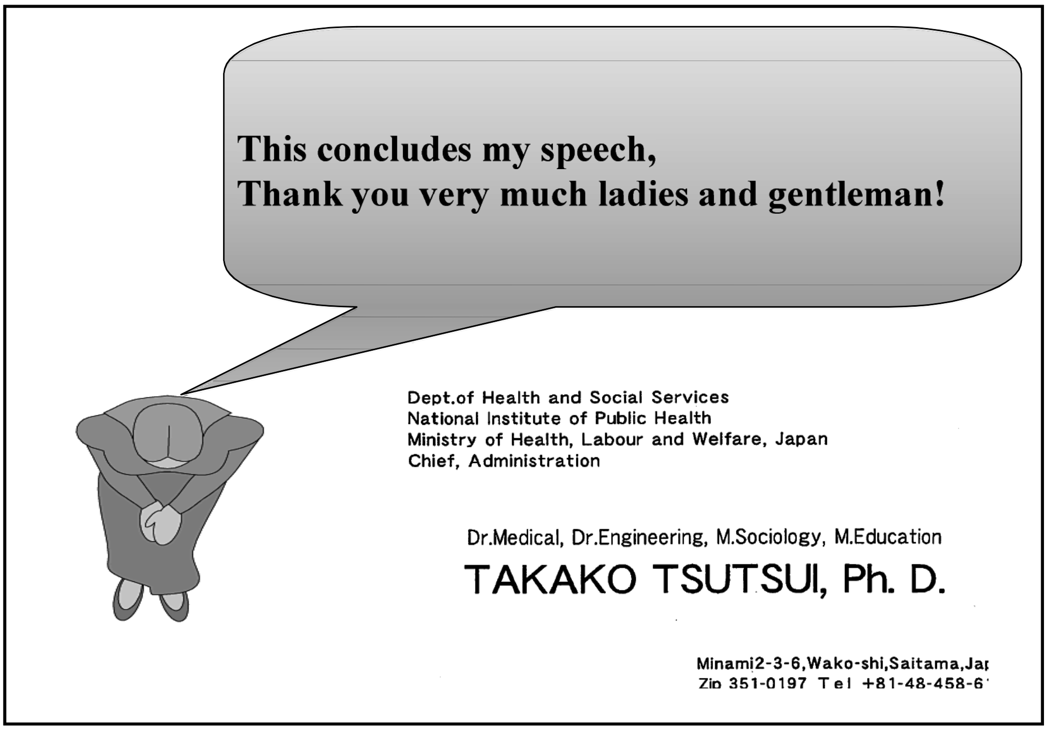
Give scores (standardization of category scores) to the selection branches of the research items from the results of the research items (74**items**)

Estimation

Initial decision logic

Use the ***dual scaling method*** **as the statistical method to integrate the attributes of the elderly person**

Primary model project data from fiscal 2007
(data from 34,000 elderly persons)



This concludes my speech,
Thank you very much ladies and gentleman!

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National Institute of Public Health
Ministry of Health, Labour and Welfare, Japan
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Definition of the Term “Need of Care” and Method of Assessment of “Need of Care”

Session 3 – Symposium on Long-Term Care
Tokyo, February 3rd and 4th, 2009

Emilie Delpit, National Solidarity Fund for Independent Living (CNSA), France

Prerequisite: The different kinds of assistance to elderly people with loss of autonomy

Helping people with loss of autonomy must meet two requirements:

- The medical needs "to cure"
  - nursing care services
  - drugs

The assessment of these needs is medical. These aids and services are prescribed by a doctor.

- Developing autonomy needs: "to care, either at home or in institutions. They cover the needs of:
  - human aid
  - Technical Aid
  - home adaptations ...
  - support to caregivers (financing day care services) ...

The assessment of these needs must take into account the overall situation of the person, his environment.

I-Aid for autonomy are granted according to people needs

1 / An allowance served according to help needed

Ageing people losing their autonomy will receive an allowance: the personal autonomy allowance (APA)

- Created by the law of 20 July 2001 and in force since 2002, today it is attributed to 1 094 000 beneficiaries (as at 30 June 2008) - 62% at home - 38% in institutions. It is a financial allowance to eligible persons to enable them to finance the various aids to independence, beyond care. It is paid and funded by the general council (local authority).

- It is a benefit in kind: it is assigned to meet a specific need, it covers only direct costs incurred to support the autonomy needs, adopted in a personal aid plan.
  - The higher the level autonomy loss, the more the allowance level funded by the APA will be high.
  - There is a effectiveness control of the aid and a possibility of recovering the amounts not used for this purpose.

- It is a universal benefit and it is not subjected to income conditions or to maintenance obligation. It is not subjected to an appeal on succession. But the beneficiaries participate in the financing of this plan of assistance, depending on their resources.

Apart from this specific provision, the loss of autonomy may have other complementary financial aid:

- With tax incentives: tax cuts for the use of home help;
- Extra legal aid may be granted by various agencies including the general advice (welfare).

2 / The evaluation of the situation and needs of the individual at the heart of the device

The APA implies having been defined:
- The definition of eligible persons
- The definition of assistance plan

These two elements are based on an assessment.

The assessment of the level of dependency: eligibility

The APA is paid to people over 60 who are unable to bear the consequences of lack or loss of autonomy related to his physical or mental.

People are losing their autonomy beneficiaries of this provision are those who need assistance for the completion of the essential activities of life or who require regular monitoring.

A tool is used to measure the level of loss of autonomy: the grid AGGIR.

It can classify people into 6 groups (GIR). Those classified in the first 4 groups (GIR 1, 2, 3, 4) are eligible persons classified in groups 5 and 6 are not.
Each GIR level is applied to a ceiling of support, that the aid will not exceed.

The assessment of the situation of the person is carried out by the team of medical and social Council. It involves a home visit by a member of the team.

- The assessment of “needs care”: the development of the care plan

The aid plan is developed for people remaining at home by the team medical and social. It is established taking into account the environment (social environment, family planning and housing equipment). It identifies a caller's needs and aid of all kinds necessary to maintain at home, by nature and quantity). These may include:

- Intervention of professionals (home help, home care)
- Services (porting meals)
- Equipment (remote, work to adapt, medical bed ...)

There are several methods of intervention of professionals in the home, from direct recruitment to the use a service provider. The legislator gave a preference to use a home-help service.

For people in institutions, an assistance plan is not developed. The assessment of the situation of individuals and their classification in a GIR sets the price of the property that will be applicable. This will cover the self-implemented by the establishment.

II-The assessment of the needs of people: the issues

1 / The reliability of the assessment of the situation of people

Particular attention is paid to discussions on the reliability of tools and processes to assessment.

Indeed, the reliability of the tool is first essential in terms of regulatinf expenditure. The classification of persons into GIR 4 (eligible) rather than GIR 5 (ineligible) has a direct impact on global expenditures. This question is connected to debates about the progress of the beneficiaries of APA more dynamic than anticipated and still maintaining strong.

The reliability of the tool, and more widely of the evaluation process, is also essential to ensure equal treatment of persons in the national territory.

Finally, neurodegenerative diseases such as Alzheimer’s are becoming more and more important in the challenges of supporting the elderly. The reliability of AGGIR to assess the level of dependency associated with these diseases is debated.

- A scientific committee was set up in 2001 to adapt the tools for assessment: it has launched different works which led to some strong conclusions (for instance, the importance of the organization of the assessment). A new guide to fill the grid AGGIR was developed and published in 2008.
- Tests are conducted on the use of new tools. The SMAF tool used in Quebec is experienced in some territories.

2 / The assessment of need for care: the convergence of approaches whatever age of the people concerned with lack of autonomy

AGGIR is used to determine eligibility. It is not relevant for the development of care plans. The law of 11 February 2005 has also set up an evaluation system for the disabled and led to the creation of a needs assessment tool for people in order to elaborate the care plan: the *GEVA*.

These approaches developed for disabled people inspire possible future developments in the elderly, especially as the law provides for a convergence of system between the two categories of people.

The law gave the National Solidarity Fund for Autonomy (CNSA), founded in 2004, a mission of expertise in assessment. A committee of the Scientific Council was set up on this issue. It has led works on tools and approaches to assessment. His first scientific meetings are devoted to this issue (11 and 12 February 2009). This work adopts a cross-approcach of assessment of the elderly and disabled.

3 / The harmonization of assessment methods between public and private systems

The government works on the evolution of the long term care system are considering the development of private insurance as another level of coverage.

Insurance contracts, which are already significant in France (around 3 millions), all have different definitions of dependency. They are generally based on AGGIR including adaptations.

There is an issue of lisibility of contracts by the people and their families and good coordination between the public and private systems.

Thus, the reflections on the reliability of tools and approaches to assessment and their development should be discussed between public and private sector under a public-private partnership. A prospect could be the gradual harmonization of tools and approaches and, where appropriate arrangements for mutual recognition of situations.

(

The different levels of loss of autonomy result of the grid AGGIR

- GIR 1: those confined to bed or chair, having lost their autonomy mental body, locomotive and social, which require continuous and indispensable stakeholders. - **87 000 (8%)**

- GIR 2: those confined to bed or chair whose mental functions are not totally corrupted and require support for most activities of daily living, or those whose mental functions are affected but who have retained their motor skills. - **305 000 (28%)**

- GIR 3: those who maintained their autonomy mental partially self locomotory but which require daily and several times a day for self-aid equipment. **216 000 people (20%)**

- GIR 4: People who do not only transfer but, once lifted, can move inside the housing. They must be helped to the toilet and dressing. **486 000 people (44%)**

- GIR GIR 6 and 5: people with little or no care.

Source : DREES – June 30, 2008

Bekommen wir einen neuen Pflegebedürftigkeitsbegriff?

Tokio,3.2.09
Dr. h. c. Jürgen Gohde, KDA
Vorsitzender des Beirats für die Überarbeitung des Pflegebedürftigkeitsbegriffs

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Auftrag

Das Bundesministerium für Gesundheit hat dem Beirat 2006 den Auftrag erteilt (Ausführung eines Beschlusses der Koalitionsvereinbarung 2005),

- **Grundlagen zu erarbeiten für eine Änderung des geltenden Pflegebedürftigkeitsbegriffs und**
- **des damit verbundenen Begutachtungsverfahrens zur Feststellung von Pflegebedürftigkeit**
- **konkrete und wissenschaftlich fundierte Vorschläge und Handlungsoptionen zu erarbeiten,**
- **und die Frage der finanziellen Auswirkungen auf die Pflegeversicherung und/oder andere Sozialleistungsbereiche zu klären**

Anlass : Kritik am geltenden Pflegebedürftigkeitsbegriff

1. **Verkürztes und somatisch verengtes Verständnis von Pflegebedürftigkeit: Hilfebedarf bei Alltagsverrichtungen**
2. **Pflegezeit als Maßstab**

Folgen

- **Fehlende Wahrnehmung des ganzen Menschen**
- **„Inneres Gerechtigkeitsproblem“**
- **Mangelnde Wahrnehmung von Kommunikation und sozialer Teilhabe**
- **Definitionsinduzierte Defizite in der Praxis der Pflege**

Arbeitsprozess im Beirat: Vorphase

Ziel:

"Recherche und Analyse von Pflegebedürftigkeitsbegriffen und Einschätzungsinstrumenten"), vorgelegt am 28. Feb. 2007 vom IPW Bielefeld

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Ergebnis der Instrumentenanalyse

- **Zur näheren Prüfung empfohlen:**
- **FACE – Functional Assessment of the Care Environment for Older People**
- **EASY Care**
- **RAI – Resident Assessment Instrument 2.0 und RAI Home Care**
- **Alternatives Begutachtungsverfahren der MDK-Gemeinschaft**

- Eingeschränkte Empfehlung:
- CANE – Camberwell Assessment of Needs for the Elderly
- RCN-Assessment – Royal College of Nursing's Older People Assessment Tool
- RUM – Resource Use Measure

Empfehlung: Neuentwicklung

Beschluss des Beirats : NBA

Nach IPW

Hauptphase I: Studienprozess

- **Ziel :**
  Entwicklung des neuen Begutachtungsinstruments
- **Ergebnis:**
  "Das neue Begutachtungsassessment zur Feststellung von Pflegebedürftigkeit" (IPW an der Univ. Bielefeld und MDK Westfalen-Lippe, vorgelegt am 29. Feb. 2008 (überarb. Fassung am 25. März 2007).

Pflegebedürftigkeit

- **Beeinträchtigung der Selbständigkeit**
- **... bei der Kompensation bzw. Bewältigung von Schädigungen, funktionalen Einbußen, Belastungen und Anforderungen**

- **= angewiesen sein auf personelle Hilfe (pflegerische Hilfe)**
- **... aufgrund eines Mangels personaler Ressourcen**

(IPW-Studie 2007)

„Neues Begutachtungassessment (NBA) 2008 gemeinsam entwickelt von IPW und MDK WL

- Maßstab: Selbständigkeit statt Zeitaufwand (Abhängigkeit von Personenhilfe)
- Überwindung der Begrenzung auf einige Alltagsaktivitäten
- Erfassung präventionsrelevanter Risiken
- Systematische Einschätzung des Bedarfs an medizinischer Rehabilitation
- Ermittlung besonderer Bedarfskonstellationen

Assessment-Module

- 1. Mobilität
- 2. Kognitive und kommunikative Fähigkeiten
- 3. Verhaltensweisen und psychische Problemlagen
- 4. Selbstversorgung (Alltagsverrichtungen)
- 5. Umgang mit krankheits-/therapiebedingten Anforderungen
- 6. Gestaltung des Alltagslebens und soziale Kontakte
- 7. Außerhäusliche Aktivitäten
- 8. Haushaltsführung

1. Mobilität

0 = selbständig
1 = überwiegend selbständig
2 = überwiegend unselbständig
3 = unselbständig

1.1	**Positionswechsel im Bett**	☐0	☐1	☐2	☐3
1.2	**Stabile Sitzposition halten**	☐0	☐1	☐2	☐3
1.3	**Aufstehen aus sitzender Position / Umsetzen**	☐0	☐1	☐2	☐3
1.4	**Fortbewegen innerhalb des Wohnbereichs**	☐0	☐1	☐2	☐3
1.5	**Treppensteigen**	☐0	☐1	☐2	☐3

3. Verhaltensweisen und psychische Problemlagen

0 = nie
1 = maximal 1x wöchentlich
2 = mehrmals wöchentlich
3 = täglich

3.1	**Motorisch geprägte Verhaltensauffälligkeiten**	☐0	☐1	☐2	☐3
3.2	**Nächtliche Unruhe**	☐0	☐1	☐2	☐3
3.3	**Selbstschädigendes und autoaggressives Verhalten**	☐0	☐1	☐2	☐3
3.4	**Beschädigung von Gegenständen**	☐0	☐1	☐2	☐3
3.5	**Physisch aggressives Verhalten gegenüber anderen Personen**	☐0	☐1	☐2	☐3
3.6	**Verbale Aggression**	☐0	☐1	☐2	☐3

Besondere Bedarfskonstellationen (Bsp.):

- Häusliche Intensivpflege mit permanenter Überwachung
- Außergewöhnlich hoher Aufwand bei der Nahrungsaufnahme
- Extreme, andauernde motorische Unruhe
- Ausgeprägte Krampfneigung
- Extreme Schmerzsymptomatik

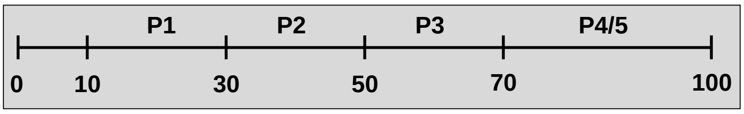
Pflegebedürftigkeit: Gewichtung der Bereiche bei der Ermittlung eines Punktwertes (IPW)

1. Mobilität	10
2./3. Kognitiver Status und Verhaltensprobleme	15
4. Selbstversorgung (Alltagsverrichtungen)	40
5. Umgang mit krankheits-/therapiebed. Anforderungen	20
6. Gestaltung des Alltagslebens und soziale Kontakte	15

Fünf Stufen der Pflegebedürftigkeit (IPW)

P1: geringe ...
P2: erhebliche ...
P3: schwere ...
P4: schwerste Beeinträchtigung der Selbständigkeit

P5: P4 + besondere Bedarfskonstellation



Unterschiede zwischen alter und neuer Stufensystematik (IPW)

- Anderer Maßstab: Zeitaufwand vs. Grad der Selbständigkeit
- Andere Inhalte: Begrenzung auf Alltagsverrichtungen vs. umfassendes Verständnis von Pflegebedürftigkeit
- Andere Spreizung der Stufen bzw. andere Abstände zwischen den Stufen (!)

Studienprozess: Hauptphase II

- **Evaluation der Eignung und mögliche Konsequenzen des Begutachtungsinstruments**
- **Validitäts- und Reliabilitätsprüfung**
- **die Abschätzung möglicher inhaltlicher und finanzieller Folgen**

"Maßnahmen zur Schaffung eines neuen Pflegebedürftigkeitsbegriffs und eines neuen bundesweit einheitlichen und reliablen Begutachtungsinstruments zur Feststellung der Pflegebedürftigkeit nach dem SGB XI"- MDS und IPP an der Universität Bremen. Nov.2008.

Ergebnis: Eignung und Praxistauglichkeit des Instruments

- **Sehr gute Berücksichtigung der Situation von Personen mit kognitiven Beeinträchtigungen**
- **Praxistaugliches Instrument auf einer stabilen fachlichen Grundlage (valide und reliabel)**
- **Abschließende Entwicklungsarbeiten in Detailfragen**
- **Auch zu anderen Zwecken verwendbar (außerhalb der Begutachtung nach dem SGB XI)**

(nach IPW)

Bewertung des Systems

- „ Für den praktischen Einsatz (des Systems) muss eine tragfähige Verknüpfung zwischen den Abgrenzungen der Bedarfsgrade (und damit deren Schwellenwerte in den Score-Werten) und den damit verknüpften Leistungsansprüchen gefunden werden. Hierbei sollte einerseits eine den Grad der Abhängigkeit angemessen berücksichtigende Einstufung sichergestellt werden, andererseits aber auch die Kalkulierbarkeit der damit verbundenen finanziellen Folgen für die sozialen Sicherungssysteme. Die Projektnehmer der Phase 2 haben für verschiedene Szenarien möglicher Stufenbildungen die ökonomischen Konsequenzen berechnet und legen sie dem Beirat zur Information und Meinungsbildung vor. Alternativ oder zusätzlich kommen auch veränderte Zuordnungen von Bedarfsgraden und Leistungssätzen in Betracht.“(Windeler/Görres).

Schnittstellen: Auswirkungen auf andere Gesetze

Jede Neufassung des Pflegebedürftigkeitsbegriffs hat Auswirkungen auf

Pflegeversicherung, Hilfe zur Pflege und Eingliederungshilfe

Ergänzungsprojekt

- Prüfung des Auswirkungen des Instruments auf Personengruppen, die im Verfahren der 2. Hauptphase nicht erfasst würden
- insbes. Bezieher von Leistungen der Eingliederungshilfe in Einrichtungen,
- sonstige Hilfebedürftige (Infas Studie) und
- bisher der sog. Pflegstufe 0 zugeordnete Personen
- Bericht über "Finanzielle Auswirkungen der Umsetzung des neuen Pflegebedürftigkeitsbegriffs und des zugehörigen Assessments für die Sozialhilfeträger und die Pflegekassen" (Prof. Dr. Rothgang - ZES -Univ. Bremen).

Mehr- und Minderausgaben

- Die in der Rothgangstudie angestellten Modellrechnungen im Ergebnis insbesondere strukturell bedingte Mehrausgaben bei Leistungsträgern und bei den Selbstzahlern. Auf den ersten Blick treten je nach Szenario erkennbare Mehrausgaben für die Pflegeversicherung und Mehr- bzw. Minderausgaben für die Sozialhilfe und Selbstzahler auf. Es scheint nicht möglich, das neue Begutachtungsverfahren mit den Schwellenwerten der Ausgangsvariante 1 und das alte Leistungsrecht unverändert nebeneinander bestehen zu lassen, wenn man nicht Mehrausgaben und/oder Leistungseinschränkungen in Kauf nehmen will.

Was tun ?

- Der Beirat stellt fest, dass es möglich ist, auf der gegebenen gesetzlichen Basis unter bestimmten Bedingungen einen Lösungsvorschlag zu erarbeiten, der dem gegenwärtigen Leistungsvolumen weitgehend entspricht.

Wie ? Politisch definierte Ziele und Vorgaben

- Der Beirat sieht es daher als erforderlich an, politische Ziele zu formulieren und rechnerische Festlegungen zu treffen, die eine Umsetzung gestaltbar machen. Sie ließen sich nach der Studie durch Anpassungen von Schwellenwerten erreichen. Denkbar und plausibel sind aber auch andere Szenarien, die Veränderungen im Leistungsrecht und in den Leistungsformen voraussetzen. In erster Linie wäre hier an sozialräumliche Konzepte für Menschen mit Pflegebedarf und/oder Behinderungen, an Leistungsformen besonders im ambulanten Bereich sowie an verstärkte Anstrengungen in der Prävention und Rehabilitation zu denken.

UMSETZUNGSSTUDIE

- Arbeitsprogramm: 3 Arbeitsgruppen

- „Szenarien" - d.h. Modelle zur Wirkung von Schwellenwerten bei der Pflegestufendefinition und bei der Zuordnung von Leistungen
- „Bestandsschutz" – d.h. Überlegungen zur Sicherung der individuellen Leistungen bei einem Systemübergang
- „vorbereitende Maßnahmen" – d.h. Notwendigkeit von administrativen Vorkehrungen, Schulungen usw.
- Abgabe des Berichts : Mai 2009

Ausblick

- **Das neue Begutachtungsverfahren wird zu einer veränderten Betrachtung des pflegebedürftigen Menschen, zu einer veränderten Praxis und damit zu einer besseren Pflege führen. Unsere Gesellschaft muss sich daran messen lassen, wie sie Menschen mit Pflegebedarf und/oder Behinderung begegnet und insbesondere deren Teilhabe am Leben in der Gesellschaft ermöglicht.**

Integration of Care in Municipalities

Almut Satrapa-Schill
Robert Bosch Foundation, Stuttgart

Integration of Care in Municipalities (1)

Robert Bosch Foundation deals with social questions
Life in old age – age and Demography
Old age has two sides:

- potential, innovation, creative power, social commitment, personal responsibility
- chronical diseases, multimorbidity, dementia, intensive care, dignified dealing with dying and death

Integration of Care in Municipalities (2)

What do the elderly want and need?

- community
- family (still) service provider

- ageing and old age are changing
- old age is becoming more colourful and more individual

- necessity of medical attendance and care is fluent – from loss of daily routine skills to a very high level of care
- different variety of offers

Integration of Care in Municipalities (3)

Health care professions

- professionalism
- interdisciplinarity
- relief through service assistants, daily routine carers, back staff
- civic commitment – including the fit elderly

→ community as a central player in services of general interest and in the provision of appropriate services for older fellow citizens

Integration of Care in Municipalities (4)

„Pflegestützpunkte“

Dementia and multimorbidity as a special challenge

Municipal model projects of the Robert Bosch Foundation
- working together for a better live with dementia (e.g. Lern-Werkstatt Arnsberg)
- palliative care for the elderly

Integration of Care in Municipalities (5)

What do we need in connection with demgraphical change?

- change of consciousness in all people
- changed image of old age
- transfer of innovative approaches and well succeeded models (the wheel doesn’t have to be newly invented)
- interdisciplinarity, networks, cooperation
- new tasks that need differentiation
- changed responsibilities in health care professions
- active communities
- civic commitment (yound and old)
- research focussing on health care provision (e.g. dementia, multimorbidity, quality, efficiency, cost-benefit analysis) and transfer into practice

Integration of Care in Municipalities (6)

German-Japanes prospects

www.bosch-stiftung.de

Coordination and Integration of Local Services for Elderly People in Paris

Traditional care:

- Financial support for people on low incomes (social welfare)
- Places in institutions (EHPADs, residential centres for dependent elderly people)

Modern care

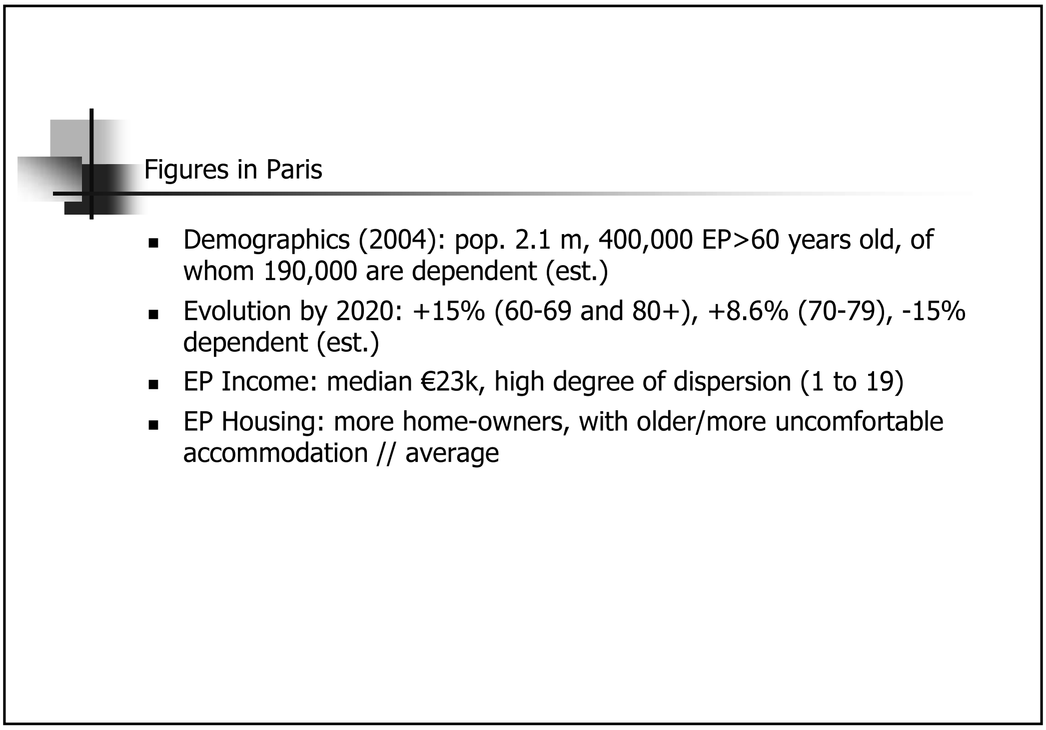
- Autonomy benefits (APA personal autonomy benefit 2001, PCH disability compensation 2005)
- Evaluation - support or compensation plans (grids and reference systems, multidisciplinary teams)
- Service planning (schemas) and coordination (CLIC local coordination and information centres, MDPH *département* centres for disabled people etc.)
- Networking (groupings, labelled networks etc.)

Institutions

- The *département*: produces "schemas" planning all services (liaising with central government) and coordinates/controls/funds "care" services, particularly for dependent people
- Regional, central and health insurance services (ARH regional hospitalisation agencies) plan (liaising with the *département*)/fund/control health and hospital services ("cure")
- Towns (CCAS local social action centres) organise/contribute to local support/prevention services (particularly for retired people who still have some independence)

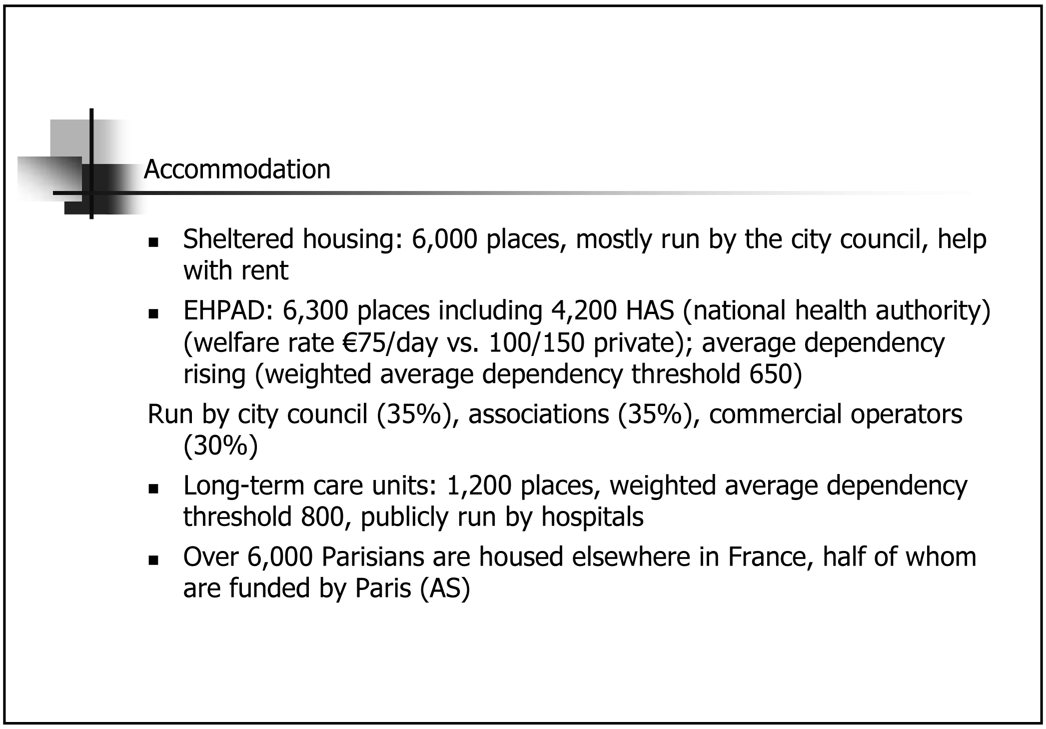
Evolutions in progress

- Creation (2010) of a single regional coordinator (ARS, regional health authority) for both "cure" and "care" (regional plan)
- Combined with *département* coordination focusing more specifically on "care" (*département* schemas)
- Development of "integrated" contact points or services (Elderly people EP - disabled people DP, Cure-care)



Figures in Paris

- Demographics (2004): pop. 2.1 m, 400,000 EP>60 years old, of whom 190,000 are dependent (est.)
- Evolution by 2020: +15% (60-69 and 80+), +8.6% (70-79), -15% dependent (est.)
- EP Income: median €23k, high degree of dispersion (1 to 19)
- EP Housing: more home-owners, with older/more uncomfortable accommodation // average



Accommodation

- Sheltered housing: 6,000 places, mostly run by the city council, help with rent
- EHPAD: 6,300 places including 4,200 HAS (national health authority) (welfare rate €75/day vs. 100/150 private); average dependency rising (weighted average dependency threshold 650)

Run by city council (35%), associations (35%), commercial operators (30%)

- Long-term care units: 1,200 places, weighted average dependency threshold 800, publicly run by hospitals
- Over 6,000 Parisians are housed elsewhere in France, half of whom are funded by Paris (AS)

Services

- Home help ("care"): 16 private services with agreements, 15 others authorised, 100 approved; about 3 m hours, 17,000 regular beneficiaries; funding APA (30%), AS (20%), users (22% with 50% tax deduction) + others (pension funds, health insurers)
- Nursing services ("cure"): 3,000 places + independent nurses + HAD home hospitalisation (600 places)
- Day care (Alzheimer's): 10 centres, 150 places, subsidised prices according to income (€15 to 60/day) + balance funded by APA
- Other optional services (city council): clubs, university, transport, leisure etc.

Service integration

- First step: CLIC coordination (2002)
- Second step: health/social coordination around "complex cases": PRISMA (3 projects including Paris' 20th *arrondissement*: pop. 188,000, 30,000 over 60)
- Third step: functional integration around Alzheimer's cases: MAIA (15 to 30 projects throughout France)

The Prisma 20th arrondissement integration method

- Specialised desk at the CLIC, management of complex cases, shared evaluation and follow-up system (SMAF)
- Staff sharing: 3 full-time equivalent posts (hospitals, *département*, associations)
- Legal support: cooperation grouping

Evolution

- MAIA projects: in addition to Prisma 20th *arrondissement*, 2 projects (north and south Paris) bringing together actors from several *arrondissements* around a shared CLIC (care)-health network "desk". Hospitals/independent (cure): the Prisma experiment and Maia start-up assistance give rise to a new appetite for pragmatic local integration.

Development of Community Care in Japan

Hiroshi Takahashi
Rikkyo University

I　Development of Community Care in Japan

1 Introduction of Community Care

- In Japan, long-term care for elderly people had been supported by the medical care system and the elderly welfare system for a long time. Because the latter system had been a system for low-income elderly people only, medium-income elderly people in need of long-term care had had to stay in elderly hospitals.
- As a result of the increases in the elderly population due to the aging of the Japanese population, it became difficult for hospitals and facilities to accommodate the increasing need for long-term care for elderly people and it became necessary to prepare for the challenge of providing in-home long-term care services.
- In Japan, in-home long-term care for elderly people had been provided by families of the elderly people in need of such care, and the families had used hospitals and facilities only when it had become difficult for them to provide in-home long-term care.
- In the 1970s, the need for social support for in-home long-term care increased and home help services were institutionalized as public services. In that decade, advanced concepts of community care developed in the United States and Europe were brought into Japan and facilitated discussions on the way facility-based care and community care should be, and those discussions led to the development and implementation of care-related policies.

2 Implementation and Institutionalization of In-home Care Services

- In the late 1960s, the Japanese government started providing subsidies to promote the home help system. The system had originally been a system for low-income households only, but was gradually expanded in the 1970s. In the 1980s, the system was evolved into one that covers all ordinary households.
- In around 1970, hospitals and local governments started providing home-visit nursing services. In 1982, the Elderly Health Law was enacted and the Law institutionalized the provision of home-visit nursing services for discharged patients. In the early 1990, a Home-visit Nursing System was established in Japan.
- In 1990, a national plan (including numerical targets) to improve existing policies for elderly people and develop and implement new and effective policies for elderly people was established by the national government. The national plan included plans to improve and expand existing home help services as well as facility-based day services and short stay services. Under the national plan, the national government promoted services that form the basis of community care. In addition, the national plan required the local governments to develop and implement health- and welfare-related plans for the elderly and to develop and implement, in a systematic manner, services that form the core of community care.
- In 2000, the Long-Term Care Insurance Law was put into effect and the above-mentioned services started to be provided as important in-home care services.
- In parallel with the above-mentioned developments, non-institutionalized support activities by local residents to provide various support to elderly people in need of in-home care also gained momentum. Because such activities are ones that strengthen the sense of solidarity among local residents and make the society recognize the importance of informal care, a law was enacted that allowed organizations engaged in such activities to operate as NPOs.

3 Institutionalization of Management Organizations In-home Long-Term Care Support Centers

- To realize a concept of community care, it is necessary to (1) improve existing formal in-home care service systems and create new and effective formal in-home care service systems and (2) promote informal care activities whereby local residents support elderly people who live in their homes and are in need of in-home care.

- As efforts to achieve the above-mentioned goal continued, voices calling for a management function which allows informal support services and institutionalized services provided at the homes of elderly people to be centrally coordinated increased. These voices also emphasized the need to study Western countries' concepts of care management and apply them to Japanese systems.

- In the 1990s, the national government embraced these ideas and decided to establish, through the use of subsidies, organizations that support in-home long-term care and to deploy nurses, public health nurses and social workers at such organizations. The number of such organizations to be established in each municipality was to be determined according to the population of the municipality.

4 Introduction of the Care Support Specialist System into the Long-Term Care Insurance System

- In the Long-Term Care Insurance System established in 2000, promotion of in-home care services was designated as a main objective, and enhancement of community-based in-home care services as well as care services provided at facilities and hospitals was designated as a policy objective. In addition, to make it easier for users of in-home care services to use such services, a Care Support Specialist System was introduced into the Long-Term Care Insurance System. The Care Support Specialist System is a system whereby applicants meeting the specified requirements are certified as Care Support Specialists whose job is to prepare in-home care service plans based on care needs assessments and manage the implementation of the plans.

- Applicants for certification as Care Support Specialists are required to have a public health-, medical care- or welfare-related national qualification. To be certified as a Care Support Specialist, the applicant must take an examination and complete a training course. Today, Care Support Specialists are more often called Care Managers than Care Support Specialists.

- Each Care Support Specialist is to join an in-home care service office. The job of the Care Support Specialist is to prepare a service plan for each of the elderly people who live in their homes and have been certified as elderly people in need of long-term care by selecting, based on the results of the assessment conducted, appropriate in-home services from a list of a wide variety of in-home services in such a way that all of the services selected are covered by the Long-Term Care Insurance System and to manage the implementation of the plan (i.e. the provision of the services). Nowadays, hospitals and facilities are also hiring Care Support Specialists so that they can prepare better care plans and implement prepared care plans more effectively.

5 Introduction of Community Comprehensive Support Centers in 2005 under the Long-Term Care Insurance Law

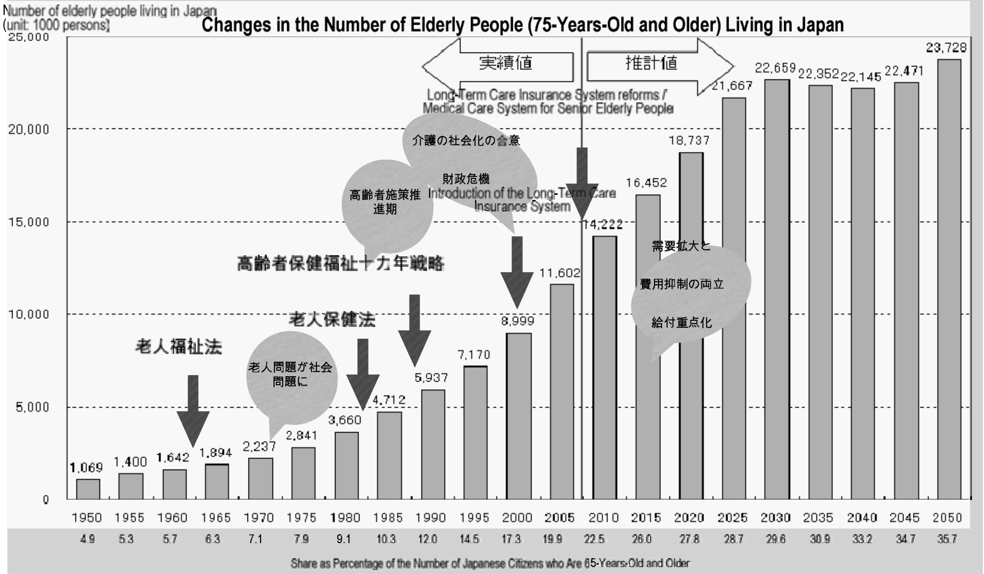
- The Long-Term Care Insurance System institutionalized in 2000 was significantly reformed in 2005. The purpose of the reforms was to make the System capable of coping with (1) the anticipated changes in the ways citizens aliment elderly people (i.e. the anticipated sharp increases in the proportions of single-person households and elderly couple households and in the number of elderly people living in urban areas) due to the anticipated rapid increases in the population of Senior Elderly People and to changes in the lifestyles of Japanese citizens that have been caused by socioeconomic changes and (2) the anticipated sharp increases in the number of elderly people suffering from dementia while reducing the risk of depletion of the nation's financial resources for social security.
- As part of the reforms, efforts were made to (1) reduce the proportion of the facility-based care services, which require higher costs, (2) reform service schemes taking into consideration the anticipated increases in the number of elderly people who live in their homes and need medium/high level care and (3) strengthen management functions in communities. These efforts led to a recognition that it was necessary to "develop community comprehensive care systems."
- As a result, it was decided to establish, taking into consideration the sizes of the areas in which elderly people live their everyday lives in their municipalities, "Community Comprehensive Support Centers," as organizations responsible for developing community comprehensive care systems and to deploy specialists, such as public health nurses, certified social workers and chief Care Support Specialists (i.e. experienced Care Support Specialists who have completed the specified training course), at the Centers.
- It was also decided to use, as the fund for establishing and operating Community Comprehensive Support Centers, 3% of the financial resources reserved for the provision of services under the Long-Term Care Insurance System. As a result, more than 90% of the municipalities established Community Comprehensive Support Centers in 2006. As of present, more than 5000 Community Comprehensive Support Centers have been established in about 1800 municipalities.
- The Community Comprehensive Support Centers are responsible for (1) addressing, upon request from insured elderly people and their families, problems relating to elderly people that are difficult to solve through the provision of Long-Term Care Insurance System-based services alone (such as elderly abuse problems), (2) the care management for long-term care prevention introduced as part of the 2005 reforms, (3) the care management for making the long-term care prevention program available to the elderly people not eligible for the services provided under the Long-Term Care Insurance System in addition to the eligible elderly people and (4) providing guidance and coordination for the Care Support Specialists performing care management work in local communities based on the concept of continuous and comprehensive care management.
- In the beginning, many Community Comprehensive Support Centers were tied up with long-term care prevention-related work. However, Community Comprehensive Support Centers gradually started to engage themselves in community care management activities, which constitute their main task, and it is expected that the Centers will actively pursue the task in the future.

II The Way Ahead - Anticipated Developments and Prospects for the Future

1 The Need to Enhance Community Care amid the Rapid Aging of the Population of Japan and the Intensifying Trend of the Aging of the Populations of Urban Municipalities

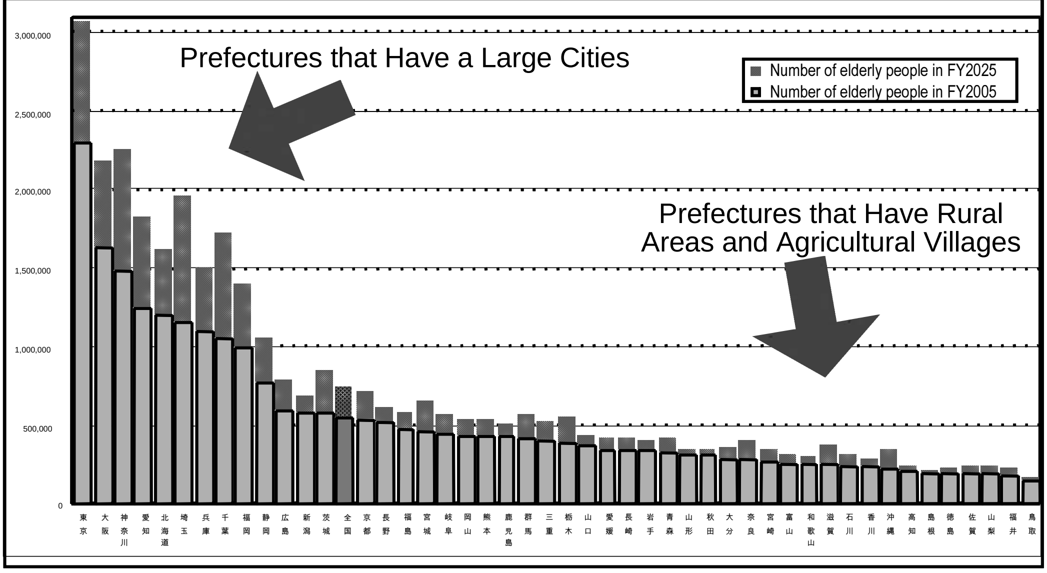
- Two important future turning points for the Japanese society in the 21st Century regarding the Long-Term Care Insurance System are (1) the year 2015, when post-war baby boomers will reach 65, at which point they become eligible for the Long-Term Care Insurance System services, and (2) the year 2025, when they will become Senior Elderly People. One important task for the national and local governments regarding these turning points is to ensure that their long-term care systems for elderly people will be evolved into ones that are appropriate for the Japanese society in 2015 and 2025.
- As mentioned earlier, the determining factors for Japan's long-term care systems are the anticipated increases in the number of elderly people and the fact that many of the elderly people are people who started to live in urban areas during the era of postwar economic growth.
- This means that it is necessary to change the traditional long-term care systems, which have been formed to address the aging of the populations of rural areas and local cities.
- That is, it is necessary to shift the emphasis from facility-based care to community care, to design and implement care services for elderly people taking into consideration the fact that the numbers of elderly people living in urban areas are increasing, and to design and implement care services for elderly people suffering from dementia, who will increase in the future and become an important factor that must be considered in improving existing care services for elderly people and developing and implementing new care services for elderly people.
- The reason is that large cities have tended to lag behind rural areas and local cities in terms of the development of care facilities for elderly people, because development costs are higher in large cities. Large cities have more elderly people who are well off (including in terms of pensions) than rural areas and local cities. On the other hand, large cities also have many low-income people because urban societies inherently have income gaps. Therefore, it is necessary to promote long-term care services for elderly people that take into account the diversity of the economic hierarchy.
- This means that the number of elderly people who live in their homes and need medium/high level care will increase rapidly and it will become more important than now to provide care services suitable for such elderly people.
- It is clear that, in communities of an urban society, solidarity among people tends to become weak. Therefore, it is important to design and implement measures to ensure that appropriate community care services are provided based on a new perspective.
- This means that it is necessary to meet the difficult challenge of developing and institutionalizing sufficient services and reviving in large cities the tradition of mutual help which is being lost. If this challenge is not met, difficulties surrounding long-term care systems will become even more serious.

Changes in the Number of Japanese Citizens who Are 75-Years-Old and Older and Its Share as Percentage of the Number of Japanese Citizens who Are 65-Years-Old and Older and Related Long-Term Care Policies for Elderly People between 1950 and 2050



資料：２００５年までは総務省統計局「国勢調査」、２０１０年以降は国立社会保障・人口問題研究所「日本の将来推計人口（平成１８年１２月推計）」

Increase in the Number of Elderly People (65-Years-Old and Older) by Prefecture in the Period between 2005 and 2025


Prefectures that Have a Large Cities

Prefectures that Have Rural Areas and Agricultural Villages

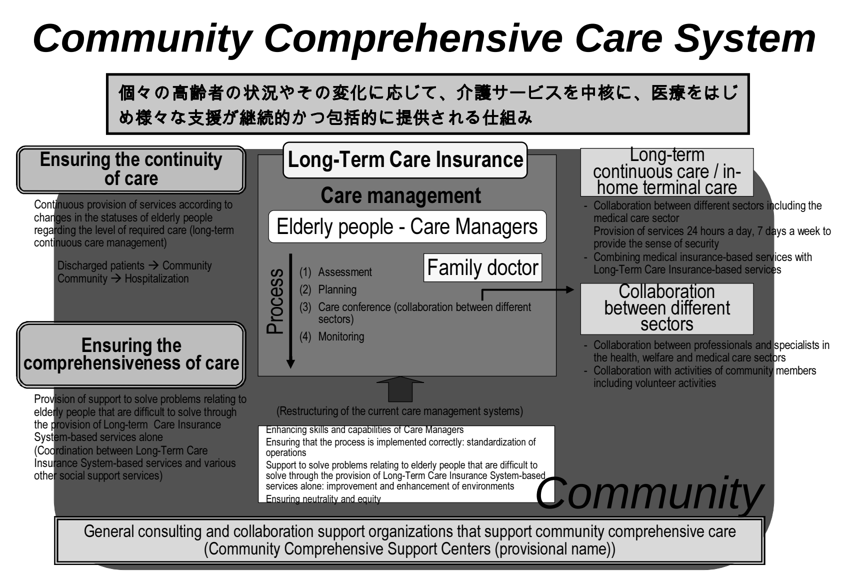
2 Enhancement of Services and Community Care Management Functions

- We are facing the problem of rapid aging of the populations of urban areas, and it is necessary to depart from the traditional “either facility-based care or in-home care” approach and improve and restructure services based on a new perspective.
- One important factor regarding this is measures to ensure the provision of better dwelling-type facilities, about which a presentation will be made in the next session.
- It is also necessary to (1) ensure that facilities that will be developed in the future will be more compact than the existing facilities, (2) deploy facilities in communities in a seamless manner, (3) ensure that an around-the-clock care system will be established in each local community and (4) enhance management functions to coordinate the necessary services in a timely manner according to changes in the statuses of elderly people regarding the level of required care.
- It is necessary to establish comprehensive and continuous care management systems capable of coordinating medical care, nursing, rehabilitation and livelihood support services appropriately taking into consideration their characteristics and of providing them in a coordinated and continuous manner.
- It is necessary to so enhance coordination functions that services of other systems as well as informal care services can be utilized to meet livelihood needs that cannot be met through the Long-Term Care Insurance System alone.
- It is necessary to develop and widely implement support methods that utilize potential abilities of elderly people and help facilitate self help.
- It is necessary to develop and implement service methods which ensure that elderly people can choose the options they like most and realize the principle of self support.
- It is necessary to further enhance community comprehensive care to achieve these.
- These are the tasks to be addressed in the future.

3 Community Comprehensive Care as a Strategic Concept

- The concept of community comprehensive care systems has been used as a key concept for policy programs. I would like to explain this in a reorganized manner.
- Please refer to the next diagram.

The Concept of Community Comprehensive Care Systems Proposed by a Study Group of the Ministry of Health, Labour and Welfare (The Study Group for Long-Term Care for Elderly People, 2003)



Community Comprehensive Care System

個々の高齢者の状況やその変化に応じて、介護サービスを中核に、医療をはじめ様々な支援が継続的かつ包括的に提供される仕組み

Ensuring the continuity of care

Continuous provision of services according to changes in the statuses of elderly people regarding the level of required care (long-term continuous care management)

Discharged patients → Community
Community → Hospitalization

Ensuring the comprehensiveness of care

Provision of support to solve problems relating to elderly people that are difficult to solve through the provision of Long-term Care Insurance System-based services alone
(Coordination between Long-Term Care Insurance System-based services and various other social support services)

Long-Term Care Insurance

Care management

Elderly people - Care Managers

Family doctor

Process
(1) Assessment
(2) Planning
(3) Care conference (collaboration between different sectors)
(4) Monitoring

(Restructuring of the current care management systems)

Enhancing skills and capabilities of Care Managers
Ensuring that the process is implemented correctly: standardization of operations
Support to solve problems relating to elderly people that are difficult to solve through the provision of Long-Term Care Insurance System-based services alone: improvement and enhancement of environments
Ensuring neutrality and equity

Long-term continuous care / in-home terminal care

- Collaboration between different sectors including the medical care sector
  Provision of services 24 hours a day, 7 days a week to provide the sense of security
- Combining medical insurance-based services with Long-Term Care Insurance-based services

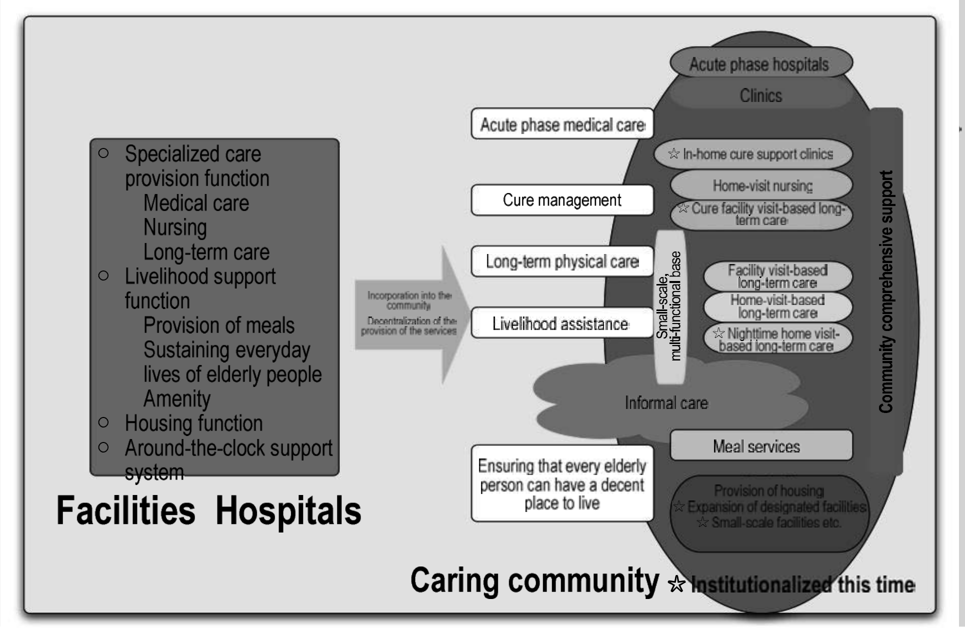
Collaboration between different sectors

- Collaboration between professionals and specialists in the health, welfare and medical care sectors
- Collaboration with activities of community members including volunteer activities

Community

General consulting and collaboration support organizations that support community comprehensive care
(Community Comprehensive Support Centers (provisional name))

Disaggregation of Aggregations of Facility Functions and Incorporation of Disaggregated Components into the Community in the Community Comprehensive Care System

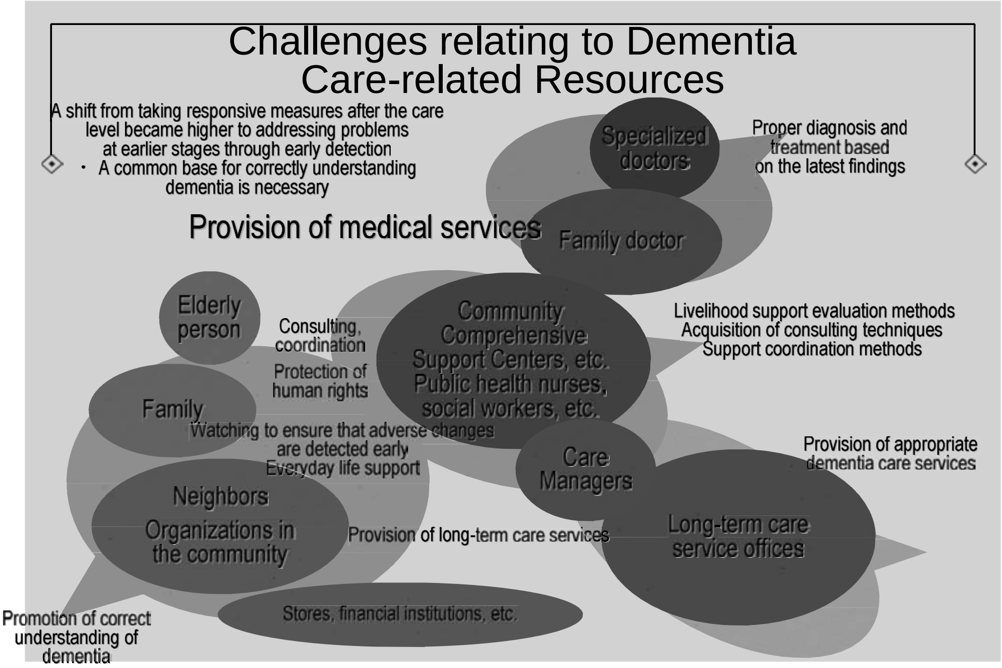


By Hiroshi Takahashi

Care for Elderly People Suffering from Dementia that Requires Community Comprehensive Care

- Significance of comprehensive and continuous support
  - Drastic restructuring of care management systems
- Principle of “care in place”
  - Provision of services with an emphasis on areas in which elderly people live

Challenges relating to Dementia Care-related Resources



A shift from taking responsive measures after the care level became higher to addressing problems at earlier stages through early detection

- A common base for correctly understanding dementia is necessary

Provision of medical services

Proper diagnosis and treatment based on the latest findings

Livelihood support evaluation methods
Acquisition of consulting techniques
Support coordination methods

Provision of appropriate dementia care services

Provision of long-term care services

Promotion of correct understanding of dementia

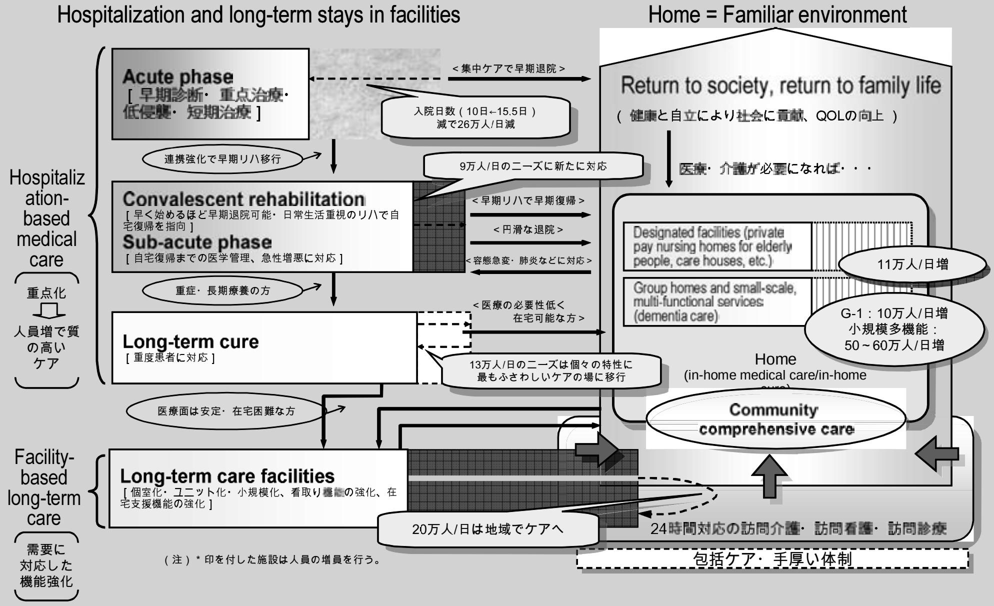
- The concept of community comprehensive care is also important in the area of dementia care, because the number of elderly people suffering from dementia will increase in the future. In this regard, specialized medical care for dementia, long-term care and local communities' understanding and cooperation will become important.

- It will be difficult for hospitals and facilities to provide care to vast numbers of elderly people suffering from dementia. In addition, burdening hospitals and facilities with such a task is not appropriate. Therefore, it is necessary to develop dementia care systems which are based on community care. Such systems should be ones that allow early detection and the provision of appropriate care based on the results of assessments, and these cannot be achieved without using community comprehensive care approaches.

4 Future of Community Care - from simulations by the National Council on Social Security

- The National Council on Social Security established by the Cabinet last year has published their numerical simulations regarding how medical care and long-term care will change in the future. I would like to explain the future prospects in a specific way using part of these simulations.

- The basis of this concept is to facilitate and enhance community comprehensive care, and I have shown what services should be developed and how it should be done based on simulations on the increases in the numbers of elderly people. Here I will present some of the results obtained from the immense work. 。



Hospitalization and long-term stays in facilities

Home = Familiar environment

Hospitalization-based medical care

重点化

人員増で質の高いケア

Acute phase
［早期診断・重点治療・低侵襲・短期治療］

＜集中ケアで早期退院＞

入院日数（10日←15.5日）減で26万人/日減

連携強化で早期リハ移行

9万人/日のニーズに新たに対応

Convalescent rehabilitation
［早く始めるほど早期退院可能・日常生活重視のリハで自宅復帰を指向］

Sub-acute phase
［自宅復帰までの医学管理、急性増悪に対応］

＜早期リハで早期復帰＞

＜円滑な退院＞

＜容態急変・肺炎などに対応＞

重症・長期療養の方

＜医療の必要性低く在宅可能な方＞

Long-term cure
［重度患者に対応］

13万人/日のニーズは個々の特性に最もふさわしいケアの場に移行

医療面は安定・在宅困難な方

Facility-based long-term care

需要に対応した機能強化

Long-term care facilities
［個室化・ユニット化・小規模化、看取り機能の強化、在宅支援機能の強化］

20万人/日は地域でケアへ

（注）＊印を付した施設は人員の増員を行う。

Return to society, return to family life

（健康と自立により社会に貢献、QOLの向上）

医療・介護が必要になれば・・・

Designated facilities (private pay nursing homes for elderly people, care houses, etc.)

11万人/日増

Group homes and small-scale, multi-functional services (dementia care)

G-1：10万人/日増
小規模多機能：
50～60万人/日増

Home
(in-home medical care/in-home care)

Community comprehensive care

24時間対応の訪問介護・訪問看護・訪問診療

包括ケア・手厚い体制

Enhancement of Community-based Medical Care and Long-Term Care Services
- Conceptual Diagram of the Envisaged Evolution of Communities

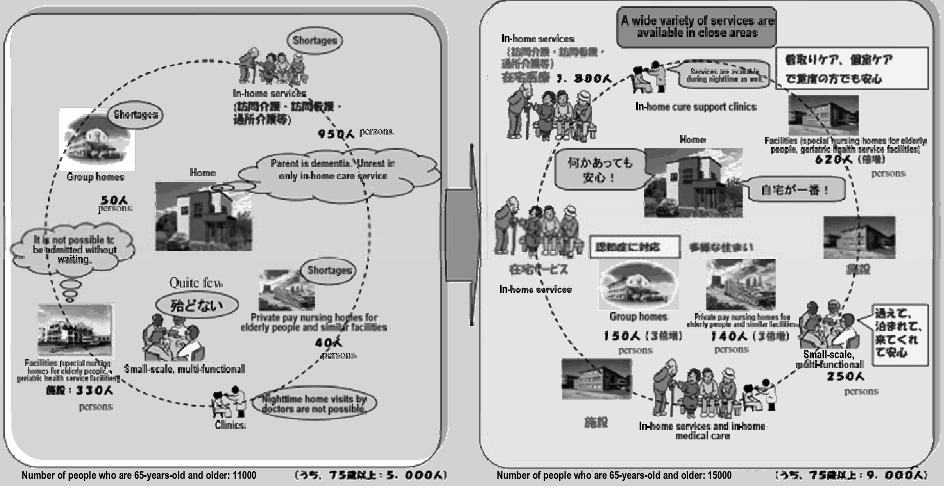
Present situation

○在宅サービスメニュー、量の不足
○居住系整備不足

In 2025

○できる限り住み慣れた地域で暮らし続ける
○自らの希望と選択でよりよいサービスを受けることができる
○施設・居住系サービスをスウェーデン並みに拡充
○２４時間対応など多様な在宅サービス
○施設も地域に密着した小規模化、ユニットケア

<In the case of a community with a population of 50000 people>



Number of people who are 65-years-old and older: 11000 （うち、75歳以上：5．000人）
(75-years-old and older = 5,000 persons)

Number of people who are 65-years-old and older: 15000 （うち、75歳以上：9．000人）
(75-years-old and older = 9,000 persons)

III Examples of Implementation of the Concept of Community Care

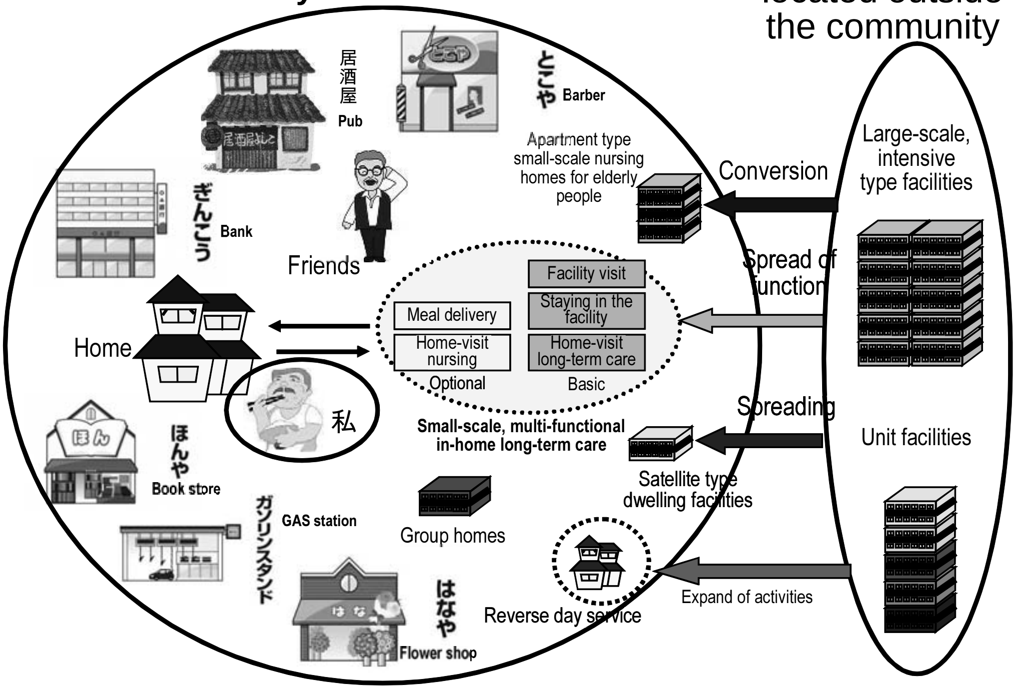
Next, I will present pioneering examples of implementation of the concept of community care in Japan in the area of long-term care. All of the examples are cases found in local cities. The task to be addressed in the future is ensuring that large cities follow suit.

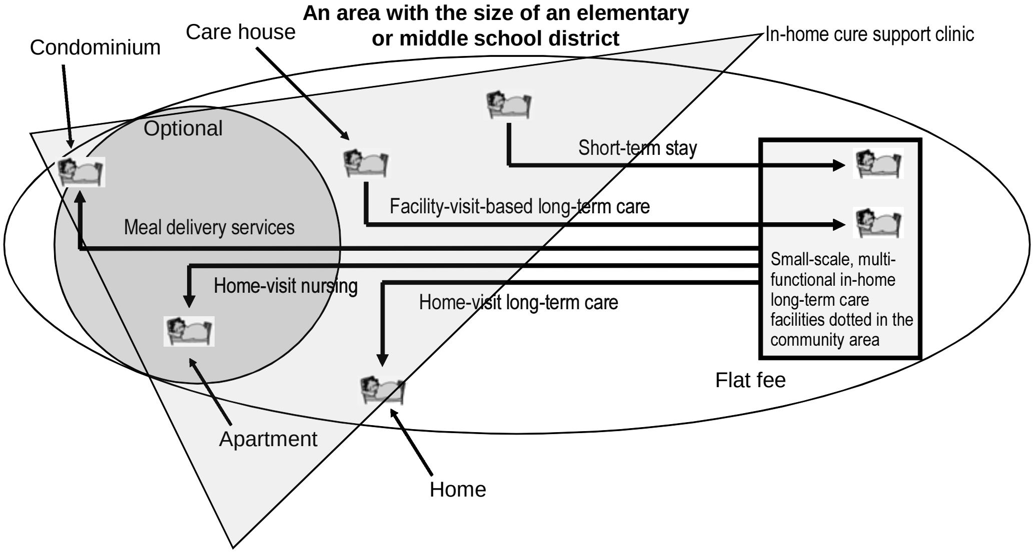
1 Disaggregation of Aggregations of Facility Functions and Incorporation of Disaggregated Components into the Community

- The case of Kobushi Home in Nagaoka City

Elderly people's desire to live their everyday lives in the local communities in which they have built their lives

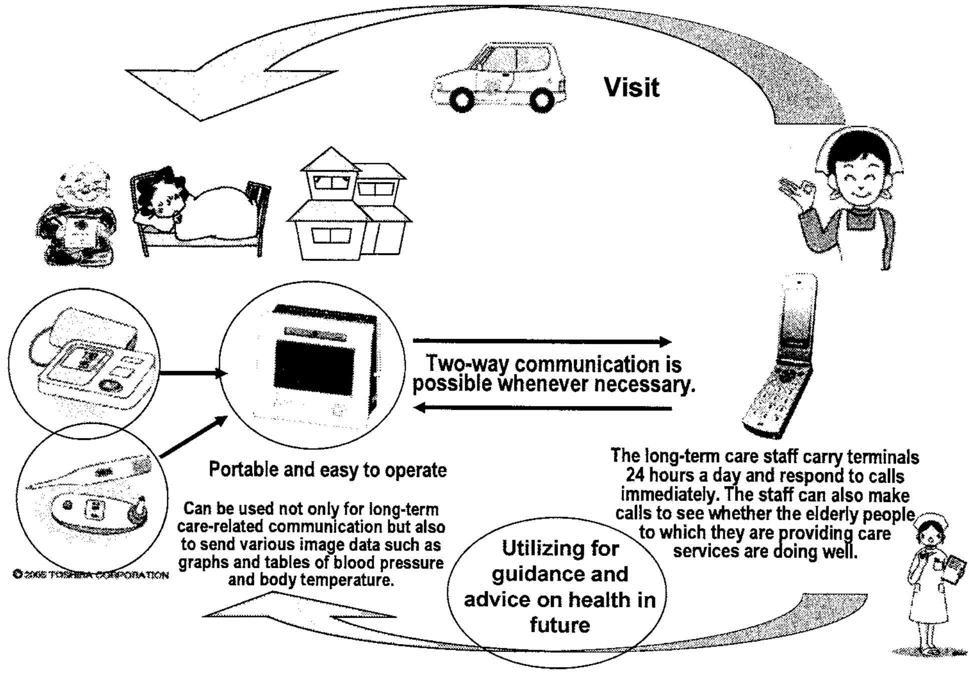
Existing facilities located outside the community





If medical care services and care services that can be used anytime, 24 hours a day, 7 days a week, just by paying a flat fee were available in the everyday lives of elderly people, it would be possible to support the livelihoods of elderly people who require medium and high level care (Care Levels 3, 4 and 5) without their having to go to hospitals or facilities.

Two types (the wired type for low radio reception areas and the portable terminal type) of 2-way communication systems with an image display function, which were developed in a Future-oriented Research Project conducted from 2003 to 2004, are being used.



Visit

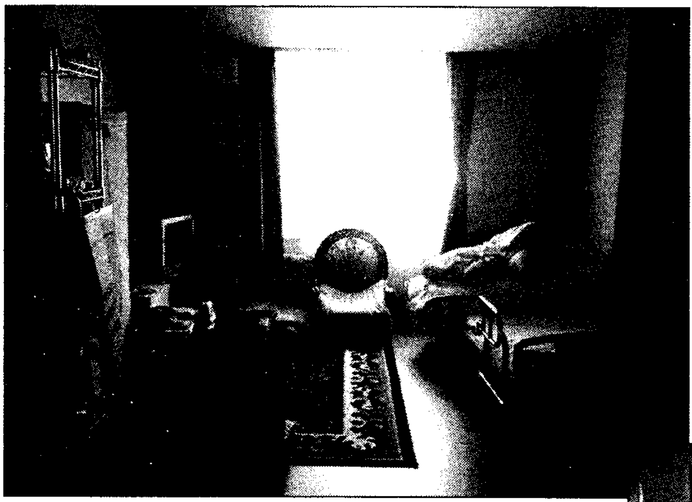
Two-way communication is possible whenever necessary.

Portable and easy to operate

Can be used not only for long-term care-related communication but also to send various image data such as graphs and tables of blood pressure and body temperature.

The long-term care staff carry terminals 24 hours a day and respond to calls immediately. The staff can also make calls to see whether the elderly people to which they are providing care services are doing well.

Utilizing for guidance and advice on health in future



Satellite type dwelling facility-based systems, which assist elderly people in returning to their communities and in improving their living environments, and small-scale, multi-functional systems, which allow elderly people to choose to be provided with services at their homes, are the same in the sense that both types of systems allow elderly people to receive services without the need to change their lifestyles or allow them to return to their communities.

Now

Living environments of elderly people who are Care Level 4.3 elderly people (average) are changing.

Past

2 Example of a Small-scale, Multi-functional Base

- The case of Sakura Home in Tomonoura, Fukuyama City, Hiroshima Prefecture – a small-scale, multi-functional in-home long-term care base that believes in and is implementing the concept of informal care

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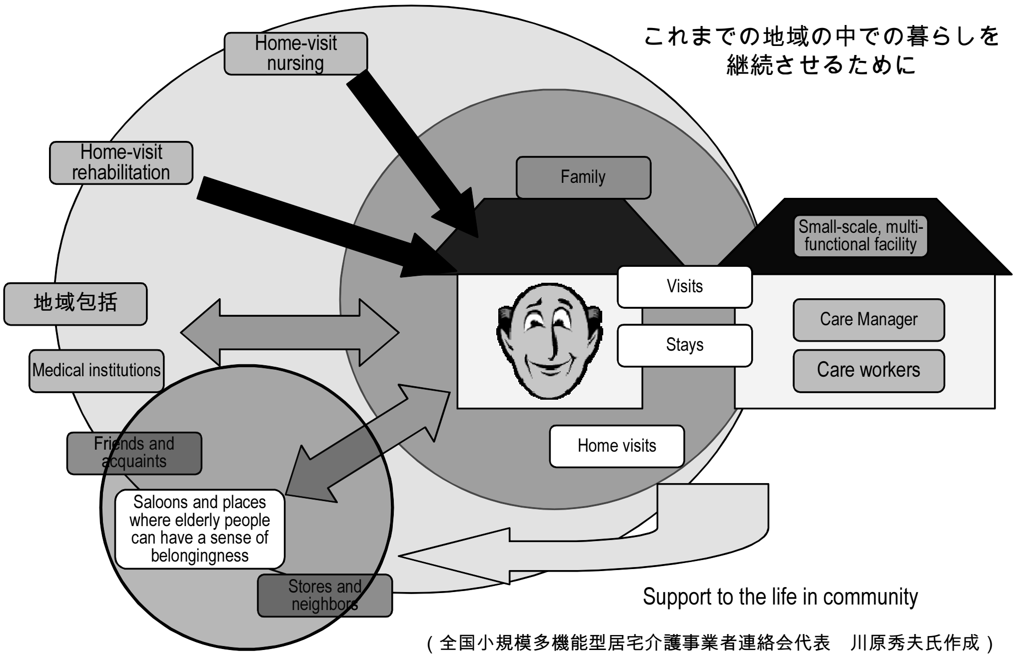
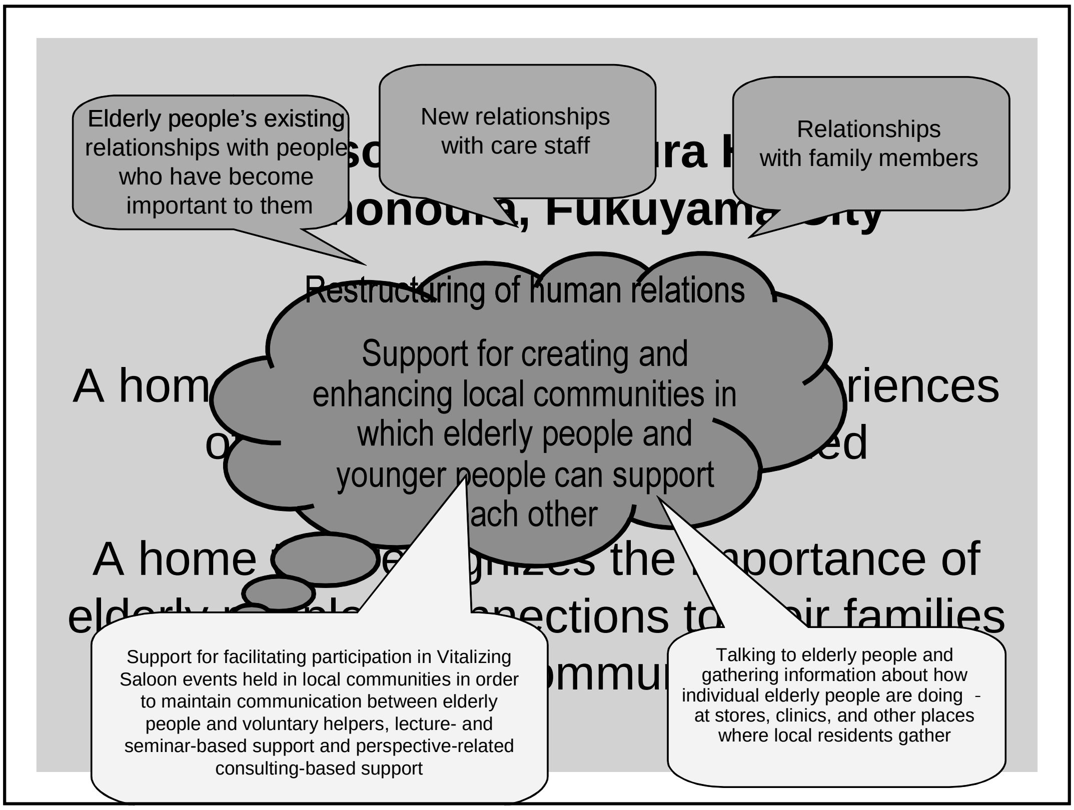
The Concept of Small-scale, Multi-functional In-home Long-Term Care and the Community Care



（全国小規模多機能型居宅介護事業者連絡会代表　川原秀夫氏作成）



Elderly people’s existing relationships with people who have become important to them

New relationships with care staff

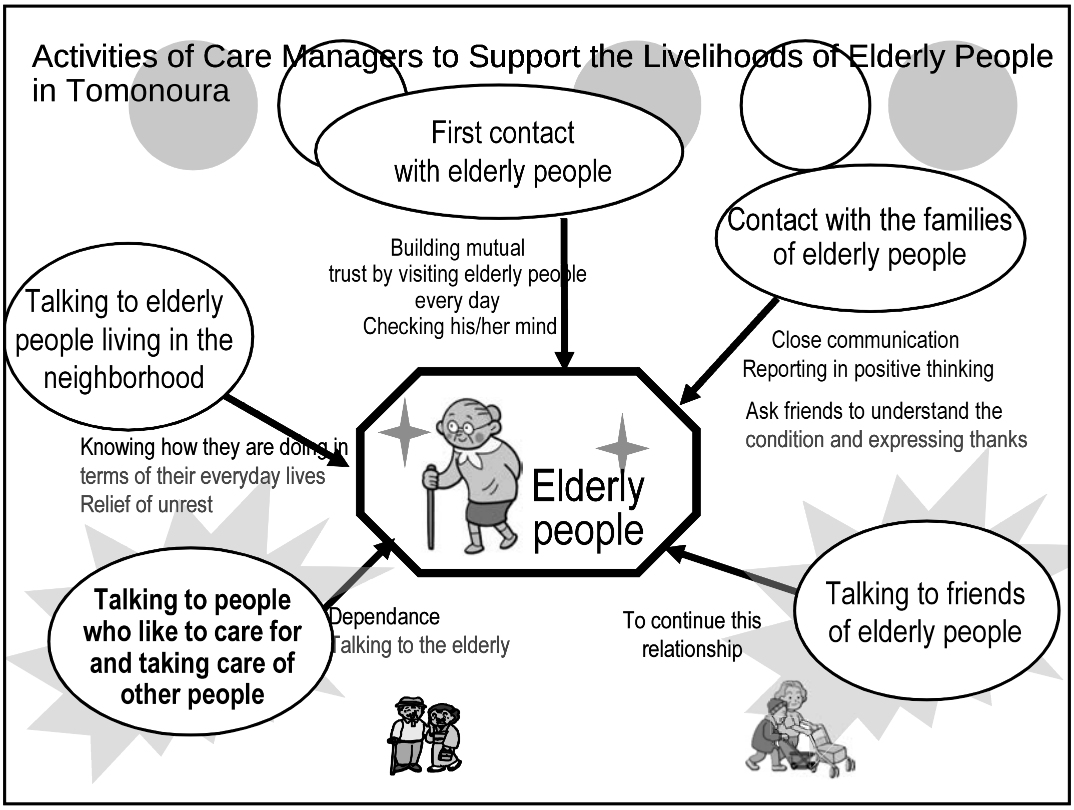
Relationships with family members

Restructuring of human relations

Support for creating and enhancing local communities in which elderly people and younger people can support each other

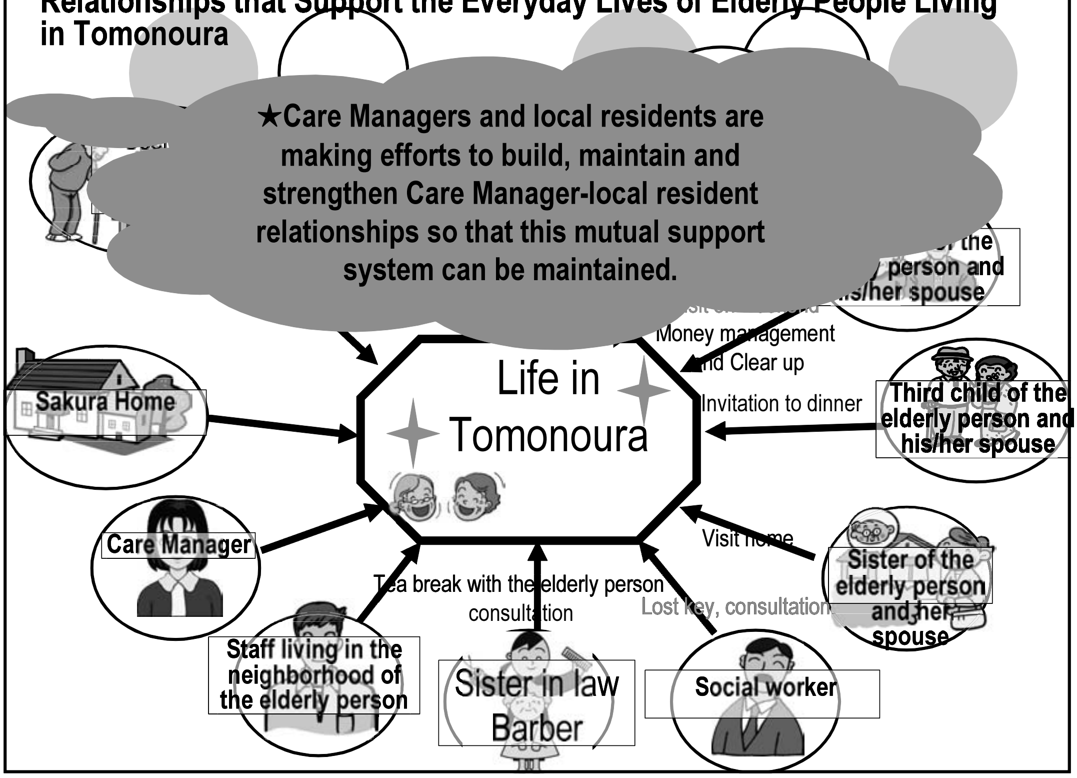
Support for facilitating participation in Vitalizing Saloon events held in local communities in order to maintain communication between elderly people and voluntary helpers, lecture- and seminar-based support and perspective-related consulting-based support

Talking to elderly people and gathering information about how individual elderly people are doing - at stores, clinics, and other places where local residents gather



Activities of Care Managers to Support the Livelihoods of Elderly People in Tomonoura

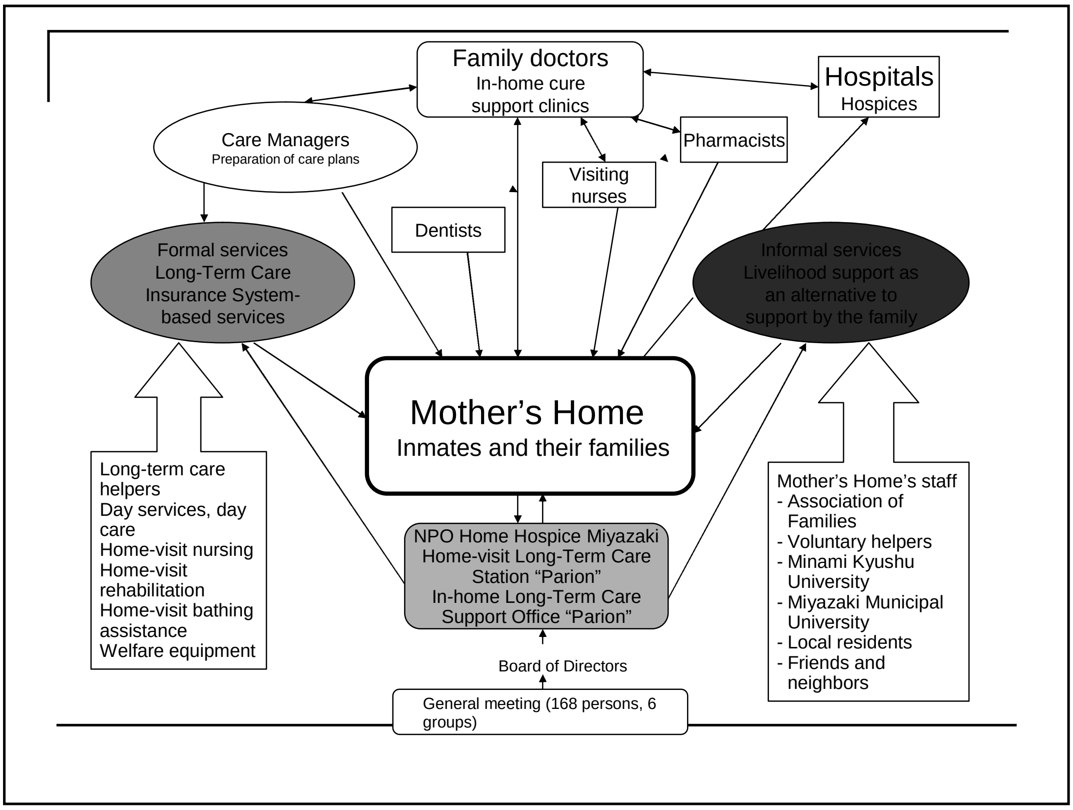
Relationships that Support the Everyday Lives of Elderly People Living in Tomonoura



★Care Managers and local residents are making efforts to build, maintain and strengthen Care Manager-local resident relationships so that this mutual support system can be maintained.

Features of “Mother’s Home”

- Small scale facility
  - At Mother’s Home, groups of 4 to 5 people are formed and the members of each group interact with each other as if they are an actual family.
- Close interaction with the local community
  - Mother’s Home accepts voluntary helpers from the local community and the community association.
- Versatile and multi-functional
  - Users can choose to use all of the available services or to only use some of the services (e.g. stay only, meal only), regardless of the type of disease.
- Collaboration with medical organizations and welfare services
  - In-home medical care and in-home long-term care services
  - Mother’s Home has agreements with local universities and nursing colleges that allow them to send their students to Mother’s Home as part of their student training programs.


Family doctors
In-home cure support clinics
Hospitals
Hospices
Care Managers
Preparation of care plans
Pharmacists
Visiting nurses
Dentists
Formal services
Long-Term Care Insurance System-based services
Informal services
Livelihood support as an alternative to support by the family
Mother's Home
Inmates and their families
Long-term care helpers
Day services, day care
Home-visit nursing
Home-visit rehabilitation
Home-visit bathing assistance
Welfare equipment
NPO Home Hospice Miyazaki
Home-visit Long-Term Care Station "Parion"
In-home Long-Term Care Support Office "Parion"
Mother's Home's staff
- Association of Families
- Voluntary helpers
- Minami Kyushu University
- Miyazaki Municipal University
- Local residents
- Friends and neighbors
Board of Directors
General meeting (168 persons, 6 groups)

Rainer Brückers
Bundesvorsitzender der Arbeiterwohlfahrt

Statement
Deutsch-japanisch-französische Konferenz zur Zukunft der Altenpflege am 04. Februar 2009 in Tokio

Die Bedeutung der ambulanten und stationären Pflege

Meine sehr geehrte Damen und Herren,

ich bin Vorsitzender einer mittlerweile 90 Jahren alten Organisation - der dritt größten in Deutschland -, die aus der Selbsthilfebewegung kommend traditionell Teil des zivilgesellschaftlichen Prozesses ist und seit gut 40 Jahren aus dieser Verpflichtung heraus auch soziale Dienstleistungen für junge und alte Menschen aufgebaut hat.

Ich sage dies deshalb, weil bei aller Entwicklung professioneller sozialer Arbeit der letzten Jahrzehnte die bewusste zivilgesellschaftliche Einbindung zu kurz gekommen ist und gemeinnützige Akteure gerade mit ihren Dienstleistungen so den rechtlichen und ökonomischen Vorgaben unterworfen sind, dass sie den Anspruch auf ganzzeitlich Betrachtung der betroffenen Menschen schwer durchhalten konnten.
Erlauben Sie mir ein Blick zurück in die Einführungsgeschichte der deutschen Pflegeversicherung zu werfen: Zwar war und ist es Ziel der gesetzlichen Pflegeversicherung, eine langfristige Absicherung bei Pflegebedürftigkeit zu erreichen und eine breit angelegte Entlastung für pflegende Angehörige zu schaffen, die den Erhalt der familiären Pflegeübernahme und eine menschenwürdige Versorgung in diesen Krisensituationen darstellen kann. Der primäre und politisch entscheidende Grund für die Einführung der Pflegeversicherung war allerdings die Entlastung der finanziell stark strapazierten Bundessozialhilfe, aus deren Mitteln bis zur Einführung des SBG XI (Pflegeversicherung) die Pflegeleistungen von dem Kommunen bezahlt wurden. Um diese Entlastungswirkung zu erzielen, musste man von dem Vollversorgungsanspruch aus der Sozialhilfe sich auf eine Teilversorgung beschränken, die die Leistungen im Wesentlichen auf somatische Einschränkungen der Pflegebedürftigen reduzierte. Mit der Einführung der Pflegeversicherung sanken erwartungsgemäß auch die Ausgaben der kommunalen Sozialhilfe um zwei Drittel der bisherigen Aufwendungen.

Der Grundssatz „ambulant vor stationär“ schien mit der Verdopplung der ambulanten Dienste eingeleitet. Der Trend zur weiter stationären Pflegeeinrichtungen wurde allerdings nicht gebrochen.

In den letzten Jahren haben sich die Pflegeeinrichtungen selbst gravierend verändert. Sie sind nicht mehr Wohnstätte mit Versorgungs- und Pflegeangeboten, sondern letzte Stationen einer Pflegekette von familiären über ambulante bis hin zur teilstationären Versorgung. In der überwiegenden Zahl der stationären Einrichtungen liegt die durchschnittliche Verweildauer unter einem Jahr und sie sinkt ständig weiter. Außerdem steigt der Anteil der Menschen mit Demenzerkrankungen ständig, so dass sowohl ambulante wie stationäre Versorgungseinrichtungen einen erheblichen Teil ihrer notwendigen Aufwendungen mit einem rein körperlich funktionalen Pflegebedürftigkeitsbegriff nicht mehr erstattet bekommen. Die Anzahl derjenigen, die auf Grund ihrer besonderen Art der Einschränkung keine Leistungen aus der Pflegeversicherung erhalten, steigt ständig. Hier hat die Regierung mit ihrer letzten Reform notwendige Änderungen in die Wege geleitet und mit der Debatte um einen veränderten Pflegebedürftigkeitsbegriff die richtigen Konsequenzen gezogen. Zugleich offenbart diese Entwicklung, dass bei der Konzipierung der Pflegeversicherung, die zukünftige demographischen Indikatoren und die medizinischen Prävalenzen nicht ausreichend im Blick waren.

Die erforderlichen Konsequenzen aus diesen Veränderungen zur angemessenen Versorgung von Pflegebedürftigen, die weit mehr als bisher auf Stützungsleistungen in der Wahrnehmung der Alltagskompetenz und präventiv-rehabilitativer Leistungen ausgerichtet ist, werden mit der bisherigen Versorgungslogik aus zwei wesentlichen Gründen nicht mehr erreichbar sein.

Erstens wir werden nicht über die ausrauchenden ökonomischen Ressourcen verfügen und zweitens wir werden auch nicht über die menschlichen Ressourcen verfügen, die diese Art der Dienstleistung erbringen könnte. Zumindest in Deutschland steigt der Bedarf an personellen und Familien unterstützenden Aufgaben so immens, dass nicht die Menschen für solche Aufgaben in ausreichendem Umfange zur Verfügung stehe. Die Pflege steht dabei in einem Konkurrenzkampf mit den pädagogischen Aufgaben im frühkindlichen Bereich, der heute schon dazu führt, dass es in Großstädten zu einem Mangel an Pflegekräften und Erziehern kommt. Um dem gesetzlichen Betreuungsanspruch erfüllen zu können, muss sich bis zum Jahre 2013 die Zahl der Erzieher verdoppelt haben, hinzukommen 50.000 neue Tagespflegepersonen für die Betreuung der unter Dreijährigen. Alles Arbeitskräfte, die auch potentielle Leistungsträger für die Pflege sind.

Was ist zu tun?
Wir benötigen drei Weichenstellungen:

1. Eine Veränderung in den Versorgungskonzepten im Sinne von ambulanter Wohnversorgung.
2. Eine Vernetzung von ausdifferenzierten Versorgungsleistungen im Sinne von Versorgungsketten, die trägerübergreifend und wohnraumübergreifend auszugestalten sind.
3. Die Gewinnung familiärer und gesellschaftlicher Ressourcen.

Wobei alle drei dieser Entwicklungen aufeinander abgestimmt sein müssen.

Der zentrale Leitgedanke wird sein: Wie schaffen wir im sozialräumlichen Umfeld eine Versorgungsstruktur, die alle relevanten Akteure in Konzepte einbindet, die die Verlagerung von Menschen in stationären Einrichtungen für bestimmte Bedarfsgruppen auf ein Minimum reduziert und gleichwohl solche stationär Versorgungseinrichtungen für die ambulante Versorgung in das Konzept selbst mit einbezieht. Wichtigster Baustein ist die Organisation des Care-Managements, auf das in Deutschland mit der Planung von Pflegeberatern und Stützpunkte bereits reagiert wurde. Dazu gehört auch die Einbindung aller Familien unterstützenden Dienste ebenso wie das Engagement der Wohnungswirtschaft, die mit dafür Sorge tragen muss, dass geeignete Wohnräume und geeignete Zusatzräume geschaffen bzw. umgebaut werden, in denen wohn- und stadtteilorientierte Arbeit im Sinne eines Mehrgenerationentreffs möglich ist. Nicht nur energetische Wohnraumanpassung ist gefragt, sondern auch bedarfsorientierte Anpassung, die es den Menschen ermöglicht unabhängig von ihrem Alter und jeglicher Einschränkung ein selbst bestimmtes Leben bis zum Ende führen zu können.

Im Übrigen muss die Kommune ihre führende Aufgabe in der Organisation in der Daseinsvorsorge wieder übernehmen. Mit der Einführung der Pflegeversicherung hat sie für die Altenhilfe die Verantwortung dafür vernachlässigt und somit vorhandene Strukturen aufgegeben. Ganz entscheidend ist die Stärkung des sozialen Umfeldes. Soziale Unterstützung von kranken Angehörigen, Nachbarn oder Freunden bei der Bewältigung ihrer Krankheit oder der Folgen einer medizinischen Behandlung sowie die dauerhafte Betreuung und Pflege von chronische Erkrankten und Pflegebedürftigen sind heute schon Aufgaben, die vielfach von ehrenamtlich tätigen Menschen übernommen werden. Untersuchungen belegen die außerordentlich Bedeutung von Versorgungsstrukturen durch Laien im Gesundheitssystem und weisen darauf hin, dass ein Großteil aller krankheitsbezogenen Aktivitäten ca.

65 bis 80 Prozent außerhalb des professionellen Versorgungswesens geleistet werden. Nicht nur die finanziellen Aspekte sind dabei von Bedeutung. Es zeigt sich, dass durch dieses System insgesamt eine andere Hilfe bereitgestellt wird, die allein durch professionelle Versorgungsstruktur nicht übernommen werden kann. Das bedeutet für Anbieter professioneller Dienstleistungen aber auch, zukünftig selbst Freiwillige für solche Aufgaben zu gewinnen, zu fördern und zu integrieren. Hier sind Wohlfahrtsorganisationen besonders gefordert. Zur Stützung dieser Organisationsform hat die Arbeiterwohlfahrt u.a. Freiwilligenakademien eingerichtet, die spezielle auf die Ausbildung, Begleitung und Unterstützung von freiwilligen in sozialen Diensten ausgerichtet sind.

Mit einer Veränderung der Versorgungskonzeptionen und Versorgungsstrukturen lässt sich sowohl der quantitativer Herausforderung begegnen, als auch dem Anspruch auf eine menschenwürdige Versorgung und Selbstbestimmung pflegebedürftiger, älterer Menschen gerecht werden. Wenn über 90 Prozent der älteren Menschen in ihrer häuslichen Umgebung den Rest ihres Lebens verbringen wollen, kann dem nur mit einer entsprechender Wohnraumversorgung, sozialräumlichen Versorgungskonzepten ereicht werden, die auch ambulante Palliativversorgung und eine Sterbebegleitung von Freunden und Angehörigen beinhaltet, mehr jedenfalls als durch den Neubau spezieller und spezialisierter Pflegeeinrichtungen oder gar durch das Sterben im Krankenhaus.

Die Arbeiterwohlfahrt hat sich in den letzten 2 Jahren besonders der Frage gewidmet, wie man mit der Weiterentwicklung sozialer Dienstleistungen der Ausgrenzung von Menschen entgeht. Eine vermeintlich optimale Arbeit im Bereich der Pflege, Betreuung, Erziehung und Beratung birgt auch immer die Gefahr einer mit der Spezialisierung verbundenen Ab- und Ausgrenzung. Deshalb bedarf es ständig einer kritischen Hinterfragung und gegebenenfalls der Korrektur.
Dazu hoffen wir zum Ende dieses Jahres einen Beitrag für alle Felder der sozialen Arbeit leisten zu können.

Tokio 4.Februar 2009

明治大学
MEIJI UNIVERSITY

Roles of Housing and Institutions for the Elderly

Housing with Care, Residential Homes and Nursing Homes

International Symposium on Long-Term Care

Mariko Sonoda

Department of Architecture
Meiji University

Senior’s housing condition in Japan, Germany, and France

- Satisfaction with housing
  - In Japan, 20% of senior citizens are dissatisfied with their housing.
  - In Germany and France, this percentage is low
- Convenience of current housing when health has deteriorated
  - In Japan, 47% said some problems exist, and 19% said serious
  - In Germany, 34% said some problems exist
  - In France, 26% said serious problems exist.

table1	Japan	Germany	France
Satisfied	34.9%	74.5%	68.4%
Somewhat satisfied	46.6%	21.3%	26.3%
Somewhat dissatisfied	15.6%	3.6%	4.9%
Very dissatisfied	2.9%	0.6%	0.4%

table2	Japan	Germany	France
Convenient	12.2%	26.6%	22.4%
Somewhat convenient	21.3%	19.4%	26.8%
Somewhat inconvenient	47.3%	34.1%	24.7%
Very inconvenient	18.9%	19.7%	26.1%

Senior's housing condition in Japan, Germany, and France

- Desire concerning housing when health has deteriorated
    - ☐ In Japan, Germany, and France, 70% desire to stay in their own homes.
    - ☐ In Japan, 13% want to live in a nursing home.
    - ☐ Those wanting to live in housing for the elderly account for 18% in Germany and 13% in France both figures are higher than that for Japan.
    - ☐ In Japan, 7% desire to live in a hospital, which is a high percentage compared to the other countries.

table3	Japan	Germany	France
Current residence	50.5%	40.0%	38.9%
Current residence after renovation	16.5%	30.5%	34.4%
With one of children	3.6%	4.7%	4.2%
House for the elderly	5.9%	17.7%	13.3%
Nursing home	12.5%	4.7%	5.8%
Hospital	7.2%	0.1%	0.1%

Yearly changes of living need of Japan's senior when his or her health has deteriorated

- Changes occurring from 1990 to 2005, the number of people who desire to remain in their homes is increasing.

- Since the Long-Term Care Insurance System started in 2000, the number of people who wish to live in a nursing home is increasing.

- The number of those desiring to live in a hospital is extremely low, it still accounts for 7%

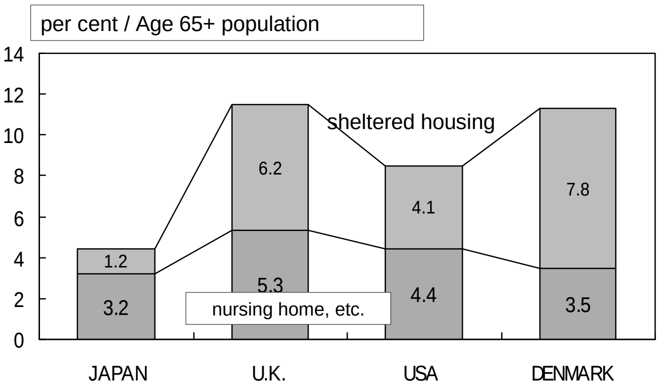
- Between 6 and 8% of people desire to live in housing for the elderly. This percentage has remained fairly constant for 15 years.

table4	1990	1995	2000	2005
Current residence	59%	62%	60%	67%
With one of children	4%	3%	3%	4%
House for the elderly	8%	6%	8%	6%
Nursing home	8%	7%	12%	13%
Hospital	19%	18%	14%	7%

Where Japan’s senior citizens live

- In Japan, 1.2% of persons aged 65+ live in sheltered housing for the elderly and 3.2% live in nursing homes.
- The percentage of people who live in nursing homes does not differ greatly with percentages in the US and European countries
- the percentage of people living in sheltered housing for the elderly is extremely low.

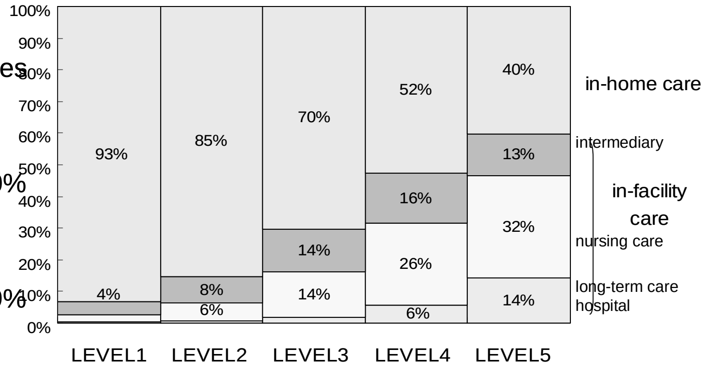
Fig. The elderly living place, percentage of age 65+ population



Where Japan’s elderly who need long-term care live

- In Japan, 16% of senior citizens aged 65+ are certified as being insured by Long-term Care Insurance.
- Level -1 of care need; 88% use in-home services and 7% use in-facility services.
- Level-5 of care need; 60% live in long-term care facilities.
- Level-4 of care need; 49% live in long-term care facilities.

Fig. Using care services by Level of care need



Alternatives of housing with care and residential care facilities for the elderly in Japan

- Sheltered housing
  - Public sheltered housing
  - Non-profit sheltered housing
  - Private residential homes
  - Non-profit residential homes
  - Group-home for Dementia
- Care accommodation insured by Long-term care insurance
  - Nursing homes (intermediary)
  - Nursing homes
  - Long-term care hospitals

Division of roles of in-home care and in-facility care

- In-facility care involves much greater cost than in-home care.
- Users of services that are covered by the Long-Term Care Insurance System, 29% use in-facility services and 71% use in-home services.
- Those using in-facility services require an average of 286,000 yen per month, which is 2.5 times the average amount needed for users of in-home services
- New construction of long-term care facilities costs between 7 and 10 million yen per bed.

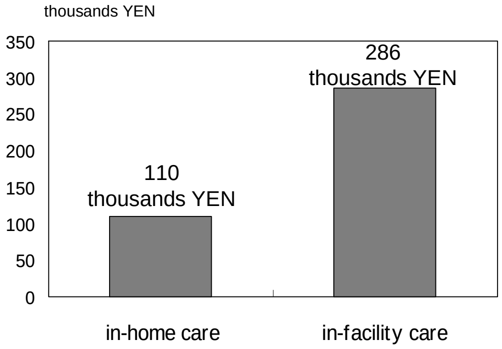


Fig. The monthly average cost of Long-term Care Insurance per a person

Discussion point 1
How do you view the division of roles of in-home care and in-facility care?

Discussion point 2
What should be done to prevent the occurrence of excessive facility demand?

Quality and dignity in daily life for inhabitants of long-term care facilities

- Large-scale long-term care facilities are isolated from the community, and shared “private rooms” do not adequately guarantee the living quality and dignity of inhabitants.
- The following reforms are being made to address this situation:
    - ☐ The size of long-term care facilities will be made smaller, having a capacity of 29 people or less.
    - ☐ In principle, newly constructed long-term care facilities will feature one-person rooms and unit care.
    - ☐ Existing long-term care facilities will be improved, shifting from shared rooms to one-person rooms and unit care.
- However, the existing hospital model for supplying care services - the ratio of staff members to inhabitants is 1:3— remains unchanged.
- If one-person rooms and unit care are to be provided, it will be necessary to double the current number of staff members.

Discussion point 3

What conditions must buildings and rooms meet as living environments for people with high care needs?

Discussion point 4

Who should bear the costs needed for appropriate staffing, and how should such costs be borne?

Expanding supply of appropriate housing with care

- It will be necessary to increase the supply of housing for the elderly with care
- For-profit enterprises already supply housing with care to wealthy classes. However, a problem is expensive residence fees and monthly use charges.
- Efforts are underway to expand the supply of housing with care for poorer classes through use of public housing and social housing. But, most of public/social housing are older and not equipped with elevators.
- The biggest problem is insufficient supply of housing with care for the middle class. The primary reasons for this are a lack of project implementers.

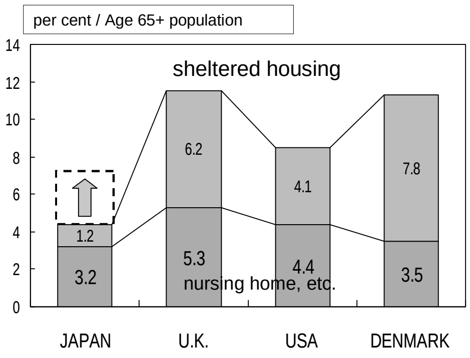


Fig. The elderly living place, percentage of age 65+ population

Discussion point 5

What can be done to increase the supply of housing with care that is affordable for the middle class?

Ministry of Labour, Social Relations, Families and Solidarity

Roles of housing and institutions for the elderly

Gilles De La Gorce, Directorate-General for Social Action (DGAS)

Symposium on Long-Term Care
Tokyo, February 3rd-4th, 2009

1. The Context: Policy on home care and the fitting of medical equipment in care establishments

Since 1975, French policy for dependent elderly people has focused on two areas: developing care in the home and improving conditions in care establishments. These areas were reinforced in 2002 by a series of reforms.

Care in the home relies on a series of support measures:

- Personal autonomy benefit (APA, *allocation personalisée d'autonomie*), created in 2002: a benefit which decreases in line with earnings to finance the purchase of goods and services to compensate for loss of independence.
- Health insurance, either via services providing nursing care in the home or directly (independent doctors and nurses, hospital care in the home)
- Provisions to reduce taxes for employing staff working at home
- Social action by local authorities

Main issues:

- The organisation of how services are provided: multiple parties involved, but a predominant role for the *département* (administrative division analogous to a county).
- The professionalisation of care staff: policy to increase the value of care work (diploma of social life auxiliary and planned salary review through collective agreement), which remains unattractive as salary increases come into conflict with funders' pricing policies.
- Adaptation of housing: possible through the use of housing grants and possibly the APA, but difficult in practice. Inadequate preventive work.

Institutional care was profoundly revised in 2002, with pricing reforms distinguishing between three sections in establishments' budgets: the healthcare section, funded by a health insurance contribution, the dependency section, funded by the APA in the institution, and the accommodation section, funded by the resident or by the *département*'s social care budget. This pricing is combined with a 5-year agreement (known as a "tripartite agreement", because it is signed by the establishment, the state and the *département*), which includes commitments on the part of the institution relating to quality of service, users' rights etc. Establishments with such agreements are known as residential centres for elderly dependent people (EHPAD, *établissement d'hébergement pour personnes âgées dépendantes*).

Main issues:

- Scale of the establishment's remaining responsibilities resulting from the growing financial burden associated with improving buildings and the quality of care.
- Lack of funding consistency arising from the accumulation of various benefits: APA, housing benefits, tax credits, social support.
- Difficulty of including quality requirements in pricing.
- Difficulty integrating specialist hospital services in accommodation for dependent elderly people in long-term care units, whose costs are often too high for them to apply EHPAD pricing.

Between the home and institutions, a range of intermediate provision has developed:

- Residential centres for elderly people (EHPA, *établissement d'hébergement pour personnes âgées*), which also take some elderly dependent people. Certain centres do not have sufficiently dependent a population to become EHPADs. These consist mainly of sheltered housing, groups of independent housing units with shared facilities or services, and rural homes for elderly people (MARPA, *maison d'accueil rurale pour personnes âgées*), small living units designed to preserve rural lifestyles.

Issues: we may wonder about the advantages of developing this type of establishment, which does not always have the facilities to care for a dependent population. An extra difficulty lies in the age of many of these structures, since the facility dates back to 1958. In urban areas, where the housing market is stretched, sheltered housing plays the role of social housing for fragile elderly people. The future doubtless lies in mixed facilities combining the advantages of the EHPAD with those of sheltered housing, which would be more suitable for situations that may evolve towards greater dependency.

- Temporary accommodation aims to preserve the person's independence and provides respite for family members caring for a dependent elderly relative in the home.

Issues: organising the management of temporary accommodation, particularly arrivals and departures, to keep a sufficiently high occupancy rate. Combining such accommodation with an EHPAD makes this management easier.

- Day accommodation takes elderly people living at home one or more times a week. Night accommodation is a still unusual variant.

Issues: the occupancy rate, but also funding for transport, as the high cost of transport is one of the barriers to the development of day accommodation: transport may be funded by the establishment or the local authority.

- Care within a family, provided by individuals for a fee. The care providers must be approved by the *département*. The recipient and provider of the service may be bound by a contract.

Statistical data (as of 31/12/2007)

EHPAD: 492,000 places subject to tripartite agreements
Retirement homes not covered by agreements: about 45,000 places
Alzheimer-specific units: 28,000 places
SSIAD (nursing services in the home): 95,000 places
Sheltered housing: 150,000 places, of which 22,000 are subject to tripartite agreements

Recipients of the APA, according to the person's degree of dependency on 30 June 2008

	Home		Institution		Total	
	Number in thousands	In %	Number in thousands	In %	Number in thousands	In %
GIR 1	20	3	67	16	87	8
GIR 2	121	18	184	44	305	28
GIR 3	149	22	67	16	216	20
GIR 4	385	57	101	24	486	44
Total	**675**	**100**	**419**	**100**	**1094**	**100**

2. A few types of response in terms of housing for dependent elderly people

The sector of housing for elderly dependent people is rich in innovations designed to take their needs into account better. Here are a few examples:

L'Orbe, Charles-Foix hospital, Ivry-sur-Seine, a follow-up and long-term care centre with 90 beds built in 1990. The spatial organisation has more in common with the design of a village, with its squares and meeting places, than the traditional hospital model. In the centre are two freely-accessible patios, there are gardens inside the building and there are no corridors. The bedrooms are arranged around a central space varying in width like a succession of small squares. Bathrooms, care facilities and nurses' offices form kiosks in the centre of this space. This organisation in the form of a loop suits the wandering of disoriented people, leading to a reduction in aggression among residents and making the carers' work easier.

Family home, Rueil-Malmaison, created in 1987, a small living unit based on the principle of the *cantou*, which aims to give residents a degree of social usefulness by involving them in meal preparation and simple domestic tasks. The space is organised by arranging the bedrooms around a shared space, with an easily accessible garden extending the common room.

Relais Sépia, Descartes (Indre-et-Loire), a resource centre to help elderly people live at home, built in 1994 as part of an experimental programme. Inspired by the British community care system, the centre provides day accommodation and temporary housing with 17 bedrooms. Thanks to good coordination of arrivals and departures, the establishment has an occupancy rate of 97%, putting it on a sound financial footing. The garden is freely accessible and its stabilised earth paths are adapted for wheelchairs and people with reduced mobility. The light flooding into the day centre's dining room through its large windows is much appreciated by its users.

Résidence Louis-Fort, Villeurbanne, created in 1995 on the ground and first floors of a block of flats. It consists of 13 studio flats (upstairs) built around collective services (downstairs). The idea is to respect people's autonomy, even partial, as much as possible and to enable individualised follow-up. The centre's incorporation into a normal block of flats limits costs and ensures good social and urban integration. The layout is organised according to the care priorities, which involve maintaining physical and mental activity.

Saint-Apollinaire inter-generational neighbourhood, Dijon. Created in 2000, this project consists of half family housing and half housing for elderly people. The tenants sign an "intergenerational charter", a moral commitment to mutual support (such as babysitting in exchange for shopping, for example). Protected housing for six disoriented people is located at ground level. The building also has collective housing for 14 people with a high degree of physical dependency. A family life area is designed to promote communication between the generations. A free internal telephone network provides added security for elderly residents.

3. Perspectives

The senior citizen solidarity plan (*Plan Solidarité grand âge*) 2007-2012. This plan, currently in progress, has the global aim of improving care for dependent elderly people. It consists of several measures relating to accommodation for elderly people:

- Developing care in the home: doubling the number of home hospitalisation places, creating 6,000 home nursing care (SSIAD) places a year (7,500 from 2010).
- Creating the right to respite care for family carers: creating 2,100 day care places and 1,100 temporary accommodation places a year, and setting up three months' unpaid "family care" leave which can be extended up to a year for employees wishing to care for a dependent relative.
- Accelerating the effort to create accommodation places (7,500 a year) and strengthening the fitting of medical equipment in EHPAD centres when their tripartite agreements are due for renewal.

Alzheimer's Plan (2008-2012). This plan, currently in progress, includes specific measures for the accommodation of elderly people suffering from neurodegenerative diseases:

- Reinforcing support in the home, favouring interventions by specialist personnel: 500 specialist teams, with 5000 places for services in the home, will be created between 2009 and 2012.
- Improving support in the home with new technology: a call for projects specifically targeting home automation and ICT designed to compensate for the loss of orientation and independence characteristic of Alzheimer's disease.
- Creating or identifying 30,000 places in units adapted or reinforced for patients suffering from behavioural problems within EHPADs. A major investment programme will provide funding for these adapted or reinforced units.

The draft "fifth risk" bill provides for the financial help for people accommodated in institutions and the support for housing to be adapted included in the APA to be reinforced.

Impressum

Im Allgemeinen erscheinen die japanischen Eigennamen nach der in Japan üblichen Reihenfolge: Familienname – Vorname. Transkriptionen japanischer Namen und Wörter erfolgen nach der modifizierten Hepburn-Umschrift. Ausnahmen können in Zitaten und bibliographischen Angaben vorkommen.

Herausgeber:
Bundesministerium für Gesundheit
Referat Öffentlichkeitsarbeit
11055 Berlin

Verantwortlich für den Inhalt:
Japanisch-Deutsches Zentrum Berlin
Saargemünder Str. 2
14195 Berlin, Germany
www.jdzb.de

Gestaltung: Titel: Schleuse01 Werbeagentur GmbH

Druck: Druckerei im Bundesministerium für Arbeit und Soziales

Gedruckt auf Recyclingpapier

Wenn Sie Bestellungen aufgeben möchten:

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