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**Report of the Study Group for Japan's International  
Contribution to 'Active Aging'**

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**(Original in Japanese)**

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International Affairs Division  
Minister's Secretariat  
**Ministry of Health, Labour, and Welfare of Japan**

## Table of Contents

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Introduction .....	2
<b>1. Purpose and significance of the Study Group</b> .....	2
<b>2. Consideration process</b> .....	2
<b>3. Target countries of the consideration</b> .....	3
Chapter 1 Background and International Trends in Active Aging .....	5
<b>1. Current situation of aging population in ASEAN countries</b> .....	5
<b>2. International trends in Active Aging</b> .....	7
<b>3. Perspectives on promoting cooperation in Active Aging</b> .....	10
Chapter 2 Current Approaches and Issues Regarding Aging in ASEAN and Japan .....	12
<b>1. Current situation of the social security system and aging policies in ASEAN</b> .....	12
(1) Viet Nam .....	12
(2) Thailand .....	14
(3) Indonesia .....	17
(4) Malaysia .....	19
<b>2. Aging policies and Active Aging in Japan</b> .....	21
(1) Transitions in aging policies .....	21
(2) The current framework for aging policies .....	24
(3) Results of field survey in Japan .....	28
Chapter 3 Recommendations for Future International Cooperation .....	32
<b>1. Significance of Japan's contribution to the area of aging policies</b> .....	32
<b>2. International cooperation needs in ASEAN aging policies and directions for cooperation</b> .	33
<b>3. Japan's approach to international cooperation</b> .....	38
<b>4. Priority issues for each country and appropriate cooperation</b> .....	40
(a) Viet Nam .....	40
(b) Thailand .....	41
(c) Indonesia .....	41
(d) Malaysia .....	42
(e) Other ASEAN countries .....	42
Conclusion .....	44
Annex .....	47
(1) Study group members (in hiragana order) .....	47
(2) Discussion points .....	47
(3) Overview of the Study Group .....	48

## Introduction

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### 1. Purpose and significance of the Study Group

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- The world population is aging rapidly, and it is estimated that people aged 60 years or over will reach 2 billion by 2050<sup>1</sup>. In ASEAN, aging rates in some countries will be similar to or even higher than those experienced by Japan in the past.
- Japan, which is experiencing the world's highest rate of aging, has a long history of adapting policies and legislation for aging society. Aging policy is a part of an overarching restructuring of social infrastructure, and composed of responses to the elderly's health, welfare and social security needs. Therefore it is essential to be undertaken from an early point. For this reason, the Study Group believes that the Japanese efforts are valuable reference for ASEAN countries, which will face actual aging society hereafter, and have to adapt their policies to aging society.
- Until now, Japan has provided to ASEAN countries training programs and technical cooperations on health and welfare, which are related to aging. However, integrated strategies of cooperation regarding aging have not been elaborated clearly, because it is a new domain within international cooperation.
- For this reason, this Study Group made clear the current situation, the challenges and needs for responding to aging process in ASEAN countries. Then the Study Group took an overview of the whole ASEAN region and defined specific recommendations for cooperation based on Japan's experience and knowledge to the region and each country in ASEAN.
- By utilizing these recommendations and developing policy dialogues with ASEAN countries, international contributions by Japan on aging policies will be able to support each ASEAN country materialize policies and strategies on the health and welfare for the elderly and further develop a polices for Active Aging.
- Furthermore, because the capacity of elderly to live independently and actively is a common key issue to both Japan and the ASEAN countries, the concept of Active Aging<sup>2</sup> was taken as the central theme for this Study Group's deliberations.

### 2. Consideration process

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- This Study Group reviewed elements of Active Aging as represented in the current international trends, and presented Japan's future directions in the international cooperation on aging in the ASEAN region.
- In detail, the Study Group analyzed the challenges on aging in ASEAN countries and reorganized the knowledge and experience in Japan that can be utilized for cooperation to ASEAN region.

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<sup>1</sup> Since the main audience of this report is in the ASEAN countries, the Committee has used the Western calendar instead of Japanese calendar for dates in the text.

<sup>2</sup> There are other concepts regarding the support and activities of the elderly, such as "productive aging" and "Aging in Place".

From there, the Study Group gave consideration to the possible projects and methods which Japan could contribute to ASEAN countries.

- Regarding to international cooperation, a unidirectional delivery of knowledge or transfer of technology is not appropriate. It is important to cooperate on what the partner country needs. The Study Group, therefore, attempted to conduct its deliberations based on 'user-oriented' approach (Figure 1).

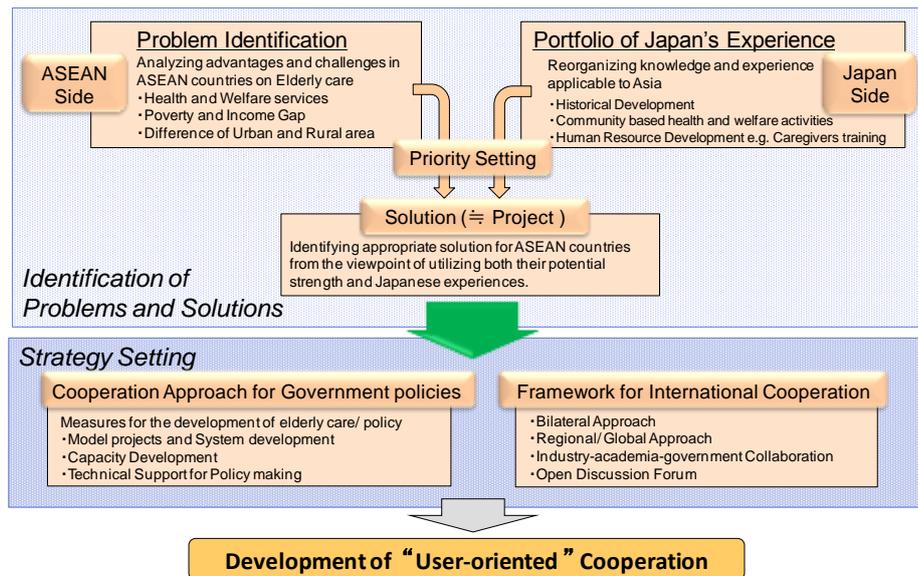


Figure 1: Deliberation approach taken by the Study Group

### 3. Target countries of the consideration

- The target of the Study Group's discussions was centered on the ASEAN countries. Because, Japan has abundant experience and a long history on international cooperation with these countries, these countries are close to Japan geographically, and are expected to continue their economic development and aging of their population rapidly. In particular, the Study Group focused on the recipient countries of Official Development Assistance (ODA), and countries with their aging speed moderate or above (Figure 2). The Study Group conducted hearings from officers and field surveys in Viet Nam, Thailand, Malaysia and Indonesia in order to collect information about the needs of international cooperation on aging policies under limited resources for the study.

	<b>Rapid Aging</b> 2025 aging rate $\geq$ 20% (60+) (2010→2025)	<b>Moderate Aging</b> 10% $\leq$ 2025 aging rate < 20% (60+) (2010→2025)	<b>Young</b> 2025 aging rate < 10% (60+) (2010→2025)
<b>High Income Country</b> GDP per Capita: >15,000\$	Japan(30.7%→35.8%) Singapore (14.1%→24.2%) Republic of Korea (15.6%→27.0%)	Brunei Darussalam(6.2%→15.6%)	
<b>Middle Income Country</b> GDP per Capita: >1,000\$	Thailand (12.9%→23.1%) China(12.4%→20.0%)	Malaysia(7.8%→12.5%) Indonesia(7.6%→12.0%) Vietnam(8.9%→15.5%)	Philippines (5.9%→8.7%) Lao PDR(5.6%→7.4%)
<b>Low Income Country</b> GDP per Capita: <1,000\$		Myanmar(7.7%→12.2%) Cambodia(7.2%→11.1%)	

ODA countries

資料：1) UN: World Population Prospects: The 2012 Revision Population Database  
 2) World Bank Search 2011 (Myanmar; National Accounts Estimates of Main Aggregates, 2010, United Nations Statistics Division)

Figure 2: Classification of ASEAN+3 countries according to aging and GDP per capita

## Chapter 1 Background and International Trends in Active Aging

### 1. Current situation of aging population in ASEAN countries<sup>3</sup>

- Table 1 shows indicators associated with aging in the ASEAN+3 countries (including China, Korea and Japan).
- High aging rate countries amongst ODA recipients in ASEAN+3 as of 2010 were in the order of Thailand (12.9%), China (12.4%), Viet Nam (8.9%) and Malaysia (7.8%). Looking at prospect of aging rate in 2025, it is predicted that aging rates of Thailand and China will be 20% or over and Viet Nam will be over 15%. Furthermore, the average life expectancy is rising and life expectancy at birth is 70 years or over for both men and women in those countries.

Table1: Indicators of aging in ASEAN

	Aging rate 1990 (60+) (%) <sup>1)</sup>	Aging rate 2010 (60+) (%) <sup>1)</sup>	Prospect of aging rate 2025 (60+)(%) <sup>1)</sup>	Prospect of aging rate 2050(60+) (%) <sup>1)</sup>	Total fertility rate <sup>1)</sup>	Life expectancy at birth <sup>2)</sup>		Labor-force participation ratio (60-64year-old) <sup>2)</sup>		Per capita GDP (US\$) <sup>3)</sup>	Income disparity (Richest 10% to poorest 10%) <sup>4)</sup>
						Male	Female	Male	Female		
Japan	17.4	30.7	35.8	42.7	1.34	79.2	86.0	75.6	45.8	46,720	4.5
Republic of Korea	7.7	15.6	27.0	41.1	1.23	76.5	83.2	70.2	41.5	22,590	7.8
Singapore	8.4	14.1	24.2	35.5	1.26	78.7	83.7	67.5	35.4	51,709	17.7
Thailand	7.1	12.9	23.1	37.5	1.49	70.0	76.7	50.1(60-)	29.5(60-)	5,480	12.6
China	8.6	12.4	20.0	32.8	1.63	73.2	75.8	58.3	40.6	6,091	21.6
Brunei Darussalam	4.0	6.2	15.6	28.3	2.11	75.6	79.5	45.5	11.2	41,127	-
Vietnam	8.1	8.9	15.5	30.6	1.89	70.2	79.9	69.4	58.2	1,755	6.9
Malaysia	5.6	7.8	12.5	23.1	2.07	71.8	76.4	52.3	17.1	10,432	22.1
Myanmar	6.7	7.7	12.2	22.3	2.07	62.1	66.2	-	-	880	-
Indonesia	6.1	7.6	12.0	21.1	2.50	67.6	71.6	78.9	47.3	3,557	7.8
Cambodia	5.1	7.2	11.1	21.2	3.08	66.8	72.1	69.5	33.0	944	12.2
Philippines	4.7	5.9	8.7	13.7	3.27	64.5	71.3	79.0(55-64)	54.8(55-64)	2,587	15.5
Lao PDR	5.6	5.6	7.4	15.7	3.52	64.5	67.0	-	-	1,417	8.3

Sources : 1) UN: World Population Prospects: The 2012 Revision Population Database

2) Statistical data of respective countries.

3) World Bank Search 2011 (Myanmar ; National Accounts Estimates of Main Aggregates, 2010, United Nations Statistics Division)

4) Human Development Report 2007/2008: Published for the United Nations Development Programme (UNDP)

- It is important to extend the Healthy Life Expectancy, which measures the number of years a person of certain age lives with their daily life free from health difficulties. Although Healthy Life Expectancy varies in its definition and not always comparable among countries, each country needs to pay attention to extending Healthy Life Expectancy as well as life expectancy (Table 2)

<sup>3</sup> The definition of 'elderly' in ASEAN countries is usually 60 years of age and older. When not specified otherwise, the statistics and data in this report referring to 'elderly' and 'aging rate' take this 60 years and above as the criteria.

Table 2: ASEAN+3 countries' Average Life Expectancy and Healthy Life Expectancy

	Male							Female						
	Life expectancy			Healthy life expectancy			Difference (A-B)	Life expectancy			Healthy life expectancy			Difference (A-B)
	1990	2010	Difference (A)	1990	2010	Difference (B)		1990	2010	Difference (A)	1990	2010	Difference (B)	
Japan	76.0	79.3	3.3	67.7	70.6	2.9	0.4	82.0	85.9	3.9	72.3	75.5	3.2	0.7
Republic of Korea	68.1	76.5	8.4	60.6	67.9	7.3	1.1	76.2	82.7	6.5	67.1	72.6	5.5	1.0
Singapore	72.8	78.8	6.0	64.8	69.6	4.8	1.2	77.9	83.3	5.4	68.2	72.6	4.4	1.0
Thailand	69.2	70.9	1.7	60.7	62.7	2.0	-0.3	75.7	77.5	1.8	65.7	67.8	2.1	-0.3
China	67.3	72.9	5.6	60.1	65.5	5.4	0.2	71.5	79.0	7.5	63.5	70.4	6.9	0.6
Brunei Darussalam	73.1	75.5	2.4	64.0	66.2	2.2	0.2	76.0	79.1	3.1	66.0	68.6	2.6	0.5
Vietnam	65.5	71.6	6.1	56.7	62.6	5.9	0.2	72.3	79.6	7.3	62.2	69.1	6.9	0.4
Malaysia	69.5	71.3	1.8	60.6	62.6	2.0	-0.2	73.7	76.5	2.8	63.6	66.4	2.8	0.0
Myanmar	54.4	60.7	6.3	47.1	53.2	6.1	0.2	58.7	67.6	8.9	50.2	58.3	8.1	0.8
Indonesia	63.5	67.7	4.2	55.1	59.3	4.2	0.0	66.5	71.8	5.3	57.3	62.5	5.2	0.1
Cambodia	56.9	64.6	7.7	48.4	55.9	7.5	0.2	61.2	70.1	8.9	51.6	60.0	8.4	0.5
Philippines	64.0	66.6	2.6	54.8	57.4	2.6	0.0	72.0	73.8	1.8	61.0	63.2	2.2	-0.4
Lao PDR	54.0	62.4	8.4	46.7	54.1	7.4	1.0	58.5	67.1	8.6	50.1	57.8	7.7	0.9

Source : Prepared by the Secretariat based on Global Burden of Disease Study 2010<sup>4</sup>

- According to Table 3 showing Doubling Time<sup>5</sup>, while it took 25 years for the percentage of people 65 years or older in population of Japan to grow from 7% to 14%, in Viet Nam it is estimated to be 15 years, in Indonesia 17 years, in Laos 19 years and in Myanmar 20 years. This shows the aging will progress faster in those countries than in Japan.

Table 3: ASEAN indicators of aging and Doubling Time

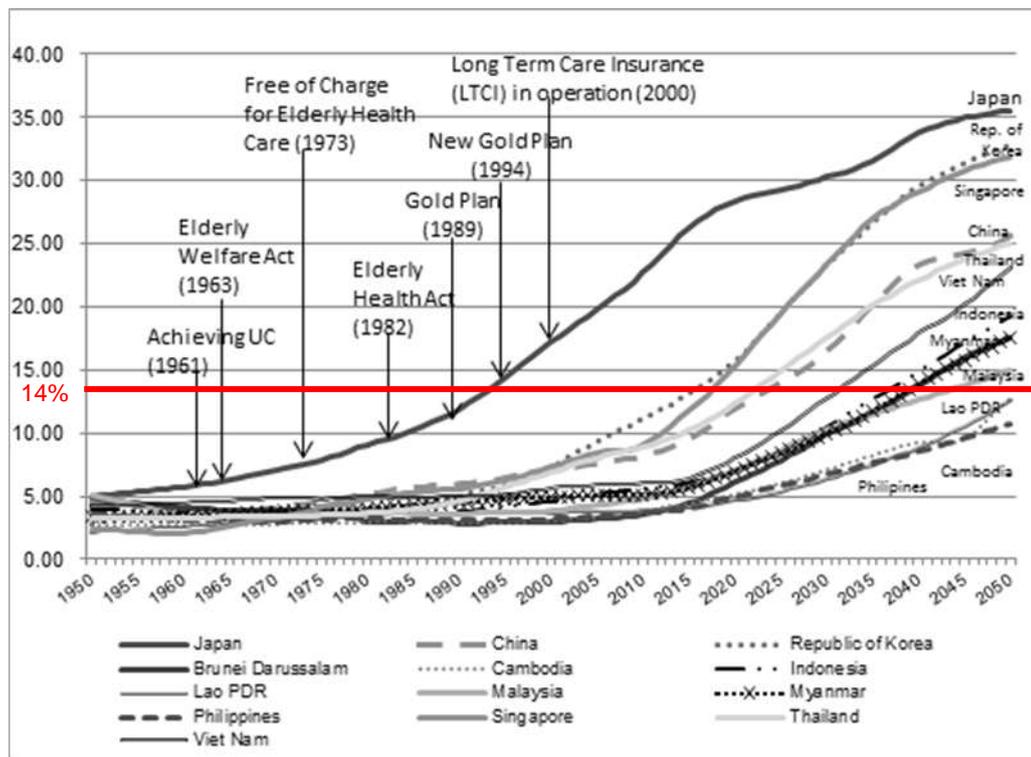
	Population (million)	Aging rate (65+) 7% Aging society	Aging rate (65+) 14% Aged society	Doubling time Number of years required for the proportion of the aged population from 7% to 14%	Aging rate (65+) 21% Super Aged society
Philippines	94.85	2032	2062	30	2088
Malaysia	28.86	2020	2046	26	2073
Japan	127.82	1970	1995	25	2008
China	1,344.13	2000	2025	25	2037
Cambodia	14.31	2030	2053	23	2068
Thailand	69.52	2001	2024	23	2038
Myanmar	48.34	2021	2041	20	2060
Singapore	5.18	1999	2019	20	2027
Lao PDR	6.29	2034	2053	19	2065
Republic of Korea	49.78	1999	2017	18	2027
Brunei Darussalam	0.41	2023	2041	18	2063
Indonesia	242.33	2021	2038	17	2056
Vietnam	87.84	2018	2033	15	2047

Source : Prepared by the Secretariat based on World Bank, World Development Indicators database and United Nations' World Population Prospects, the 2010 revision.

<sup>4</sup> The indicators shown on this figure are different from the data presented by MHLW of Japan, due to the differences in their definition.

<sup>5</sup> The number of years required for the proportion of the aged population (65 years and older) from 7% to 14%, and it is used as an indicator of the speed at which aging is progressing.

- Though aging is progressing rapidly in ASEAN region, sufficient preparation for the aging has not been seen. Figure 3 shows transformation of aging rate in ASEAN+3 together with the years when policies related to aging were implemented in Japan. According to this information, policies such as Universal Health Coverage (UHC) <sup>6</sup>, the Elderly Welfare Act, enactment and reform of Free of Charge Health Care for the Elderly, enactment of the Elderly Health Act, “Gold Plan”<sup>7</sup>, “New Gold Plan” and Long-Term Care Insurance were all implemented in Japan before the aging rate reached 14%. In contrast to Japan, UHC has been realized in only a few of the ASEAN countries, and many countries have not established legal systems for sufficiently supporting elderly people.



Source : Prepared by the Secretariat based on UN, World Population Prospects, The 2010 Revision.

Figure 3: Aging rate (65 years and older) in ASEAN+3 countries and policies for Aging Society in Japan

## 2. International trends in Active Aging

- According to the World Health Organization (WHO), “Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age.”<sup>8</sup>

<sup>6</sup> According to the WHO definition, UHC refers to the situation in which the entire population has access to basic health care services when needed and at costs that can people are able to pay.

<sup>7</sup> Ten Year Strategy for Health and Welfare of the Elderly, which included a specific targets of doubling institutional beds and tripling special nursing homes and community-based services for older people over 10 years. This strategy was replaced by “New Gold Plan.”

<sup>8</sup> WHO (2002) Active Ageing Policy Framework

- Specifically, The Active Aging Policy Framework organized efforts to improve the quality of life of the elderly by three pillars, “Health”, “Participation”, and “Security” (Figure 4). The Study Group reviewed challenges in ASEAN region and considered potential areas for contribution from Japan based on this 3- pillared framework.
  - Health: When the risk factors (both environmental and behavioural) for chronic diseases and functional decline are kept low while the protective factors are kept high, people will enjoy both a longer quantity and quality of life; they will remain healthy and able to manage their own lives as they grow older; fewer older adults will need costly medical treatment and care services. For those who do need care, they should have access to the entire range of health and social services that address the needs and rights of women and men as they age<sup>9</sup>.
  - Participation: When labour market, employment, education, health and social policies and programs support their full participation in socioeconomic, cultural and productive activities, according to their basic human rights, capacities, needs and preferences, people will continue to make a productive contribution to society. Under that environment, elderly can continue in both paid and unpaid activities as they age.
  - Security: When policies and programs address the social, financial and physical security needs and rights of people as they age, older people are ensured of protection, dignity and care in the event that they are no longer able to support and protect themselves. Families and communities are supported in efforts to care for their older members.



Source : WHO (2002) Active Aging: Policy Framework ([http://whqlibdoc.who.int/hq/2002/who\\_nmh\\_nph\\_02.8.pdf](http://whqlibdoc.who.int/hq/2002/who_nmh_nph_02.8.pdf))

Figure 4: Conceptual diagram of the three pillars of WHO Active Aging

- In 2012, the WHO chose “ageing and health” as the World Health Day’s theme, as a part of its efforts to increase the international momentum for aging. In that same year, Japan proposed a resolution, “Strengthening non communicable disease policies to promote active ageing”, emphasizing the importance of integrated framework including countermeasures against Non-Communicable Diseases (NCDs). The resolution was adopted at the 65th WHO General Assembly in 2012.

<sup>9</sup> The WHO concept of ‘health’ is not limited simply to physical conditions, but includes the condition in which people are able to participate in family, as well as local, regional and national society.

- In addition to this, Japan has supported policy making and technical assistance for strengthening health systems such as primary health care for the elderly, development of medical technologies for the management of health conditions of the elderly and early detection and treatment of diseases, and nurturing of human resources for health care.
- The European Union (EU) designated 2012 as the European Year for Active Aging and Solidarity between Generations 2012, promoted approaches to Active Aging at the level of the EU regional level<sup>10</sup>. In the background of this action, there are common severe economic and financial situations in current developed countries. Conventional social and economic models are found difficult to meet aging societies. Thus, how to maintain public services including pension and healthcare is a common challenge for EU countries along with the increase of aging population. The three pillars have been taken for the EU's Active Aging efforts as follows<sup>11</sup>:
  - Employment: As the age at which pension can be received has been raised in the EU, many people are unsure of whether after retirement age they will be able to continue employment until they receive their pension or whether they will be able to attain new employment. So there is a need for the labor market to provide employment.
  - Social participation: The European Year seeks to ensure greater recognition of what older people bring to society and create more supportive conditions for them.
  - Independent life: Active ageing also means empowering us as we age so that we can remain in charge of our own lives as long as possible.
- Furthermore, “ASEAN Strategic Framework on Social Welfare and Development (2011-2015)”<sup>12</sup> was established by ASEAN countries to show the priorities in building a people-oriented ASEAN with special emphasis on the protection of the interests and rights, equal opportunities, high quality of life and standard of living for the elderly.
- The Framework includes plans for building capacities and understanding of social pensions, carrying out health and aging conference for government officials and other key stakeholders, and workshop to exchange views on the promotion of older people's association, building capacity on aging policies, and ASEAN wide research network on ageing, and training caregivers.

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<sup>10</sup> EU Webpage (<http://europa.eu/ey2012/>)

<sup>11</sup> European Year for Active Aging and Solidarity between Generations 2012 website  
<http://europa.eu/ey2012/ey2012main.jsp?catId=971&langId=en>

<sup>12</sup> ASEAN Strategic Framework on Social Welfare and Development (2011-2015)  
[http://www.asean.org/images/2012/publications/ASEAN%20Strategic%20Framework%20for%20Social%20Welfare%20and%20Development%20\(Nov\).pdf](http://www.asean.org/images/2012/publications/ASEAN%20Strategic%20Framework%20for%20Social%20Welfare%20and%20Development%20(Nov).pdf)

### 3. Perspectives on promoting cooperation in Active Aging

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#### (a) Active Aging and the definition of 'elderly'

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- Regarding the definition of 'elderly', ASEAN countries usually use 60 years and older. In Japan, the common definition is 65 years and older, as stipulated in the Elderly Welfare Act. Regardless of which definition is used, it is necessary to separate age from health condition of elderly people. In Japan, it is common for elderly aged 75 or under that they keep good health and often engaged in employment. The percentage of registration under the long-term-care insurance system (the proportion of people receiving insurance benefits because of need for support or care in daily life) for the 65-69 year-old age group is quite low at 2.6%. It indicates that most of the elderly in Japan are healthy at this stage.
- According to the policy of Active Aging, the elderly are both recipients of assistance from society and supporters of families and society. In some cases, they are still workers, and play active roles in communities.

#### (b) Self-care

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- The concept of 'Self-care' is an essential component to promote Active Aging. It means the elderly themselves take responsibility of making decisions about their own life with their dignity and manage their health by themselves. Encouraging individuals to manage their own health and developing programs useful for learning self-management of health by each other in communities will play key role to achieve self-care.
- Based on the recognition that starting self-care after reaching old age is too late, it is thought that self-care should be taught during student and working generations. The education for self-care includes various elements such as health, social security, disease prevention, and lifestyle. The establishment of life style in exercise, nutrition and rest is an essential base to prevention of non-communicable diseases.

#### (c) The role of national and local governments in Active Aging

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- Strengthening the commitments of national and local governments is important to cope with the aging population. Currently, there is often inadequate coordination among national agencies involved in policies for aging society, and there is limited awareness of aging policies in local governments. Sharing of Japan's experiences can provide support for the development of human resources, measures to build linkages between administrative and finance sector for elderly policies.

(d) Other issues to be considered with regards to Active Aging

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- Based on the difference of average life expectancy, women generally tend to have a longer elderly life than men. So, aging policies need to be explored based on the fact that female elderly exceed male elderly. For example, in income security, living security of female elderly is on the top agenda.
- There is also a need to give consideration to differences in capabilities and roles of families and communities among geographic areas. In rural areas of ASEAN, people usually belong to large families, so when the need for care appears, it is supposed that multi-generation households and local community cooperation will take care of those needs. However, rapid economic growth in recent years has seen the increase in number of nuclear households and single-person households, while some rural areas are experiencing demographic gaps because of high rates of labour migration to urban areas among working generation.
- Every country, not limited to ASEAN countries, have diversity of cultural and religious background, and ways of thinking about aging and lifecycle are different from those in Japan. Recognition and respect for this diversity is required for planning international cooperation on aging policy.
- Dementia has grown into big challenges for developed countries including Japan. In December 2013, the G8 Dementia Summit was held in the United Kingdom. The deterioration of cognitive function, prevention and treatment for dementia, are expected to become common challenges in ASEAN countries as well. It is necessary to share information based on premise that new social challenges will continue to emerge with the expanding aging population.

## Chapter 2 Current Approaches and Issues Regarding Aging in ASEAN and Japan

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### 1. Current situation of the social security system and aging policies in ASEAN

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#### (1) Viet Nam

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##### (a) Relevant policies and the current situation on aging

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- Relevant government agencies on aging in Viet Nam are Ministry of Labor and Invalids and Social Affairs (MOLISA) and Ministry of Health (MOH).
- Relevant policies and plans on aging in Viet Nam are “Decree on the Elderly” in 2000 and National Action Plan on the Older People 2010-2020.
- Prompt establishment of aging policies and systems are considered necessary since the estimated doubling time of aging rate over 65 years old (from 7% to 14%) in Viet Nam is the shortest among ASEAN countries. The economy has been booming in the urban area but there remains much room for improvement in current state of nationwide social infrastructure, because social resources that can form the basis of aging policies such as both public and private basic medical resources, elderly care institutions, and policies for the elderly are limited.

##### (b) The current social security system

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- The Viet Nam Social Security (VSS) is a universal social security system covering all nationals, but in practice coverage is limited to civil servants and employees of private enterprises of a certain scale (mandatory).
- The old-age pension is based on a pay-as-you-go system, where basically the pension age is 60 for male and 55 for female, and the insured are required to pay a contribution for at least 20 years. But except in large companies, employers cannot afford social insurance cost and coverage is limited.
- As most of the elderly who are not civil servants do not have pensions, those in need of financial assistance can apply to the old-age welfare pension and cash benefit program for the elderly. Viet Nam War widows also are able to receive cash benefit.
- There is universal health insurance managed by VSS mainly for government officials and private companies and the government is targeting completion of universal coverage by 2020 (it is estimated that current coverage rate is around 70% of the total population).
- The “health insurance card” is issued to elderly people. Premiums are exempted for people over 80 and out-of-pocket payments are exempted for those over 90. Approximately 90,000 people, equivalent to 67% of the elderly aged 90 and over are enrolled. However, sometimes services may not be received by all who are entitled in some rural areas, due to the disparity in the distribution of medical resources.

(c) The current situation in the elderly care

- In-home care is currently provided mainly by families and local communities. Public and private in-home services are not provided. Regarding facility care, there are two types of elderly institutions, one is Nursing Room and the other is Social Protection Center. Nursing Rooms for the elderly are under the jurisdiction of the MOH and have provided medical and social protection to the elderly. Social Protection Centers are under the jurisdiction of the MOLISA, which have accepted poor people and the elderly without family. The elderly aged 80 or over may apply for the above facilities at the local People's Committee. The cost of living in the facilities is free. There are a few private facilities and facilities for the elderly attached to private hospitals (photos below).

(left : A room for two elderly in the private elderly facility, right : Medical care room in the private elderly facility)



(left and middle: A room for one elderly and TV monitors showing the elderly in the private facility, right: A room for the elderly in the private hospital)



Photos taken by the Study Team

Figure 5: Private Elderly Facility in Viet Nam

(d) Health promotion and social participation for the elderly

- With the National Action Plan clearly referring to measures against NCDs, there are programs targeting life-style diseases on-going in some local areas. The government is shifting to preventive measures (e.g. early detection), but currently there is focus on treatment (especially, programs for high blood pressure and diabetes).
- Viet Nam Association of the Elderly (VAE) plays a central role in social participation of the elderly. The coverage of VAE has exceeded 90% of the elderly. Enrollment is especially high in rural areas. VAE's role is not only for caring the elderly, but also enhancing their potential of social participation, health promotion, and advocating human rights for the elderly. Under the 2002-2010 National Action Plan, the VAE, in cooperation with MOLISA has implemented

various programs for the elderly (new farm village creation program, disease prevention and health promotion).

- The National Action Plan views the elderly as social resources that can make great contributions to society, but job training, research, basic data collection etc. for the elderly are rarely conducted.

#### (e) Features and challenges on Active Aging

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- Due to lack of awareness of professional long-term care, people assume that the elderly should be supported by their families. Number of the long-term care facilities for the elderly are limited and only for the poor elderly. It is difficult for the elderly in the middle income class to stay in private elderly facilities due to high cost. Uniform standards for elderly care have not been developed yet. Issues to be solved include the different quality among facilities and lack of a management system for care.
- With the National Action Plan clearly referring to the measures against NCDs, the government is shifting on preventive measures (e.g. early detection), but currently there is focus on treatment (especially, programs for high blood pressure and diabetes). While many elderly live with chronic diseases (over 95% according to our interview), they cannot access adequate continuous treatment due to lack of basic medical resources. Regarding elderly employment the Department of Employment under MOLISA recognizes that the elderly could make great contributions to and play a key role in society, and there is a perceived need for more effort on measures such as elderly job training, research, regular collection of statistical data.
- There is a need for international cooperation in terms of developing elderly policies, model development, measures against NCDs, management of facilities for the elderly, basic research and human resource development.

## (2) Thailand

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### (a) Relevant policies and the current situation on aging

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- Relevant government agencies on aging in Thailand include Ministry of Health (MOH) and Ministry of Social Development and Human Security (MSDHS).
- Relevant policy and plan on aging in Thailand is "Second National Plan for Older Persons (2002-2020)". First review was conducted in 2009 and currently it is in process of second review.
- Aging rate in 2010 was 12.9% in Thailand and this figure was the highest in ASEAN countries. Prompt and concrete support measures for universal elderly care are considered necessary. Development of basic medical and health resources have progressed significantly as seen in nationwide national health centers and the 30 baht (about 100 yen) health care system, which enabled people receive medical care services with a small out-of-pocket cost. Future challenges

include developing more specialized technical services for caring the elderly and measures to promote regional care service development.

(b) The current social security system

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- There is the Government Pension Fund (GPF) for civil servants and the Social Security Fund (SSS) for private employees. Additionally for private employees there are some voluntary base funds such as the Thai Provident Fund (TPF) and the Retirement Mutual Fund (RMF). However most of the informal sector (including self-employed and farmers) are not covered. Due to delay in implementation of the new National Saving Fund (NSF), income security for the elderly in the informal sector, accounting for over 40% of the total population, has become an issue. It is also anticipated that SSS may not provide enough income for living.
- With the 30 baht healthcare scheme (Gold Card) for the informal sector established in 2002, together with the Civil Servant Medical Benefit Scheme (CSMBS) and the SSS for private employees, universal coverage has been completed.
- The elderly are exempted from out-of-pocket payments and chronic diseases are included in the scope of coverage. The primary care system has been well-developed, despite lack of medical experts, which have been compensated by approximately 1,000,000 health-care volunteers nationwide who provide basic health-care services.
- To support the lives of the elderly, THB600-1,000/month is paid to the elderly, depending on the economic conditions.

(c) The current situation in the elderly care

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- The policy in the National Plan is to promote in-home care for the elderly provided primarily by their families and local communities with support of approximately 80,000 volunteers nationwide. The target number of elderly volunteers is one person per 15 people requiring long-term care. Each volunteer is paid THB600/month. These costs are temporally paid by central government but basically are incurred by local governments. Existing facilities shall play a key role in providing support for in-home care. Training for nursing care volunteers for in-home care by the existing facilities is being considered. The "Tambon nursing care program" where any tambon (a local government unit between district and village) meeting 6 conditions specified by the MOH will be certified as a nursing care promoting municipality, has been implemented. Various programs have been launched on a trial basis. As most of them are financed by the central government only for the first 2 years, sustainability is a concern.
- Regarding in-facility care, there are four types of facilities in Thailand. One is public facility for the elderly (Elderly Social Welfare Development Center) (Figure 6), managed by the MSDHS for the low-income elderly without a family. The second is private long-stay hospitals mainly for the high income elderly with expensive fee. The third is Nursing Home for the elderly who need medical service. The last is hospice (usually temple). There is no one governmental agency that

collects information such as the number of Nursing Home facilities. The Ministry of Commerce registers private Nursing Homes.

(left : The elderly using exercise machines in public facility, right : Room for the elderly with dementia)



Photos taken by the Study Team

**Figure 6 : Private Elderly Facility in Thailand**

(d) Health promotion and social participation for the elderly

- In addition to the existing 290 multi-purpose centers, “Old People’s Better Life Centers” are planned to be set up nationwide (target: 878 centers) to promote social participation of the elderly.
- The elderly have been encouraged to participate in old people’s clubs to promote their social participation. The organizational form of old people’s clubs varies, such as those within health centers. Membership in some clubs is small in certain areas,
- The MOH and the MSDHS have jointly managed the Elderly Fund to provide financial support to programs contributing to self-sufficient lives of the elderly. “Brain Bank” to utilize elderly resources (more than 20,000 registrants) is ongoing.
- All nationals aged 15 or over, including the elderly, are provided health checkup (e.g. high blood pressure, diabetes, myocardial infarction). Screening is done by utilizing volunteers, and blood tests are provided to the identified risk groups. Approximately 80% of qualified persons have taken the health checkup. The checkup may be taken in various places such as offices, schools and public facilities. Mobile checkup services are also available in some areas.



Photo taken by the Study Team

**Figure7 : Handmade products made in public facility for the elderly (Activity Center) in Thailand**

(e) Features and challenges of Active Aging

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- Currently NGOs and regional volunteers collaborating with the government are main actors in home care for the elderly and private companies which provide home care services are rarely seen. Improving the skills for long-term care (e.g. quality of care) at the community level has also been a challenge in Thailand.
- Possible cooperation includes support to the elderly in the informal sector and in rural areas, and promotion of employment of the elderly.

**(3) Indonesia**

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(a) Relevant policies and the current situation on aging

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- Relevant government agencies on aging society in Indonesia include the Coordinating Ministry of People's Welfare (CMPW), the Ministry of Social Affairs (MoSA), the Ministry of Health (MOH).
- Relevant policies and plans on aging society in Indonesia are Social Welfare for Elderly Law (Law No. 13/1998) and Governmental Regulation on Implementation of Measures for Promotion of Welfare for Elderly (Governmental Regulation No. 43/2004).
- It is estimated that aging rate over 65 years old in Indonesia will be over 14% in 2038, and it will be surpassing 7% in 2021. Aging is progressing faster soon after Viet Nam.

(b) The current social security system

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- There are several pension schemes such as TASPEN (pension scheme for civil servants), THT (old-age savings for civil servants), JHT (private old-age savings) and ASABRI (income security for the security and armed forces). For private employees, JKK (workers' compensation insurance) and JK (death security) are managed by PT. JAMSOSTEK. For the informal sector, ASKESOS (social welfare insurance managed by the MOSA), and pension and other income security schemes partly financed by the MOMT and managed by JAMSOSTEK are in operation. Old-age welfare allowance (IDR300,000/month) is paid to low-income earners.
- Regarding medical security systems, there are three types of schemes such as ASKES for civil servants, JAMSOSTEK for employees in private companies, and JAMKESMAS which is a public medical security scheme for low-income earners.
- JAMKESDA (public medical security scheme by the local governments) covers the poor and the near-poor not covered by JAMKESMAS.
- The government is in the process of implementing the national social security scheme (medical security under the SJSN Law) covering all nationals by 2014.

(c) The current situation in elderly care

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- Welfare facilities for the elderly are managed by the MOSA, the state governments or private enterprises, and shelters and different social activities (health maintenance, recreation, religious events) (Figure 8) are provided. The elderly policies mainly focus on those without family or with disabilities. The service fee depends on the income of the user (free for low-income earners). The community-based day service program (Pusaka) is also one source of support to facilities. There are private projects to construct facilities for the increasing middle-class, but the number of facilities is very limited.



Photos taken by the Study Team

**Figure 8 : Private facility for the Elderly in Indonesia**

- BK3S is a local welfare association mainly consisting of local volunteers that perform various local social welfare activities by government subsidies and private donations (their activities are not limited to the elderly). Community-based home help services for the elderly that are being provided by NGOs in some areas focus on home-visit, not specific services regarding day-to-day care. Under the community-based day service (Pusaka) program, free in-facility services (e.g. meals, basic medical services, recreation opportunities (e.g. handicraft, exercise), religious activities) are provided.

(d) Health promotion and social participation for the elderly

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- Under the Posyandu program, community-based local healthcare activities have been performed regularly, with collaboration of Puskesmas (healthcare centers) and by technical guidance and subsidies from the MOH. In facilities for the elderly, some disease prevention initiatives (e.g. through doctor's visits) have been taken, but not in a systematic way. Facilities providing treatment services could not be found in our survey. Under the Posyandu program conducted by MOH, various local mutual aid activities (e.g. recreation, short trips) have been provided for the elderly. These activities have spread throughout the country as social participation activities.
- While the Posyandu program is a local community-based activity, the government has provided necessary technical assistance, as well as subsidies for its operation.

- The government has promoted measures against NCDs mainly for the middle-aged and elderly (50 years and over), particularly community-based prevention and health promotion. However, implementation of services has not been progressing as planned.

(e) Features and challenges on Active Aging

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- Indonesia has vast area of land and consists of many islands having the largest population in ASEAN. Currently series of institutional changes and systematic revision are being implemented for the achievement of the universal health coverage. However, there are several challenges. There is disparity in the distribution of medical resources. The financial sustainability of tax based care for informal sector is unstable, and there is a need to increase the participation rate of the social security system.
- Future challenges include the elderly care service gap between urban and rural area in terms of access to health and medical resources and providing adequate human resources and facilities. In addition, management of elderly care services and guidelines for care (though there is national unified standard for elderly facilities) need to be established.

#### (4) Malaysia

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(a) Relevant policies and the current situation on aging

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- Relevant government agencies on aging society in Malaysia include the Ministry of Women, Family & Community Development, the Ministry of Health (MOH), and the Prime Minister's Office.
- Relevant policies and plans on aging society in Malaysia include National Policy for the Elderly, National Action and Plan for Elderly, National Health Policy for Older Person and so on.
- Malaysia is one of the most rapidly growing countries in terms of GDP per capita among ASEAN countries. The government has set out in the national development plan to become a high income country by 2020. The number of middle income population is growing. It is estimated that aging speed is relatively slower compared to Viet Nam and Indonesia. The aging rate over 65 years old will be above 14% in 2046. On the other hand, the government recognizes the importance of support for elderly care. There is a concern that traditional regional tie is weakening as the middle income class and nuclear families expand especially in urban areas.

(b) The current social security system

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- Civil servants are entitled to the Government Pension Scheme (GP), which is the retirement pension scheme financed by tax revenues. Private employees are covered by the Employee Provident Fund (EPF) and Social Security Organization (SOCSO/PERKESO) where both the employee and the employer make contributions, and benefits are paid to the employee upon

reaching age 55 in lump sum. In 2011, the number of enrollees was 13.4 million but only half of them received benefits.

- Malaysia's medical service scheme is similar to the NHS in UK, where the insured may obtain medical services at public medical institutions for free or a very limited out-of-pocket payment. Middle- and high-income earners typically use private medical institutions with full out-of-pocket payment or under a private medical insurance policy.
- Civil servants may also use private medical institutions as one of the benefits under the Government Pension Scheme.
- Elderly people aged 60 and over staying at home, without regular income, or without supporting family are entitled to MYR300 (approx. JPY9,300) per month.

(c) The current situation in the elderly care

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- Families and communities play the main role of supporting the elderly. Home-help service provides a wide range of services, including escort service for those with mild disabilities that require support for instrumental activities of daily living (IADLs) and physical care for the bedridden elderly. Home helpers are local volunteers. The service has been operated by the Ministry of Women, Family and Community Development or NGOs supported by the Ministry. With approximately 1,400 users nationwide, it is at a trial stage.
- Regarding facility care, there are "Old folks homes" registered under the Care Center Act and "Nursing Homes" registered under the Private Healthcare and Medical facility Service Act. Both are for the elderly in need of long-term care. Nursing homes are subject to stricter standards than Old folks homes. The number of Nursing homes is less than 20. Old folks homes are organized and managed by NGOs and other private organizations and there are nearly 200 of them. In addition, 11 facilities for the poor elderly without families are organized and managed by the Ministry of Women, Family and Community Development.

(d) Health promotion and social participation for the elderly

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- Free health checkups have been provided to the elderly registered at a healthcare center. Home-visits (subject to fees) have also been provided, but the scale is limited due to resource constraints.
- Activity centers called PAWE are utilized for recreation, learning activities, health checkup, etc. by the elderly who are relatively more self-sufficient. 22 centers located nationwide are organized and managed by NGOs with support of the Ministry of Women, Family and Community Development (Figure 8). In some cases, healthcare centers are used for club activities, as well as health checkup, massage and recreation.



Photos taken by JICA

**Figure9 : Private Day Care Facility for the elderly (Activity Center) in Malaysia**

- Regarding the promotion of employment for the elderly, the retirement age has been gradually extended since 2001 from 55 to the current age of 60. The employment information database for the elderly has been established. In particular PAWE the Economic Empowerment Program (EEP) for enhancing financial ability of the elderly is ongoing, but it is not regarded as sufficient income source to support the elderly.

(e) Features and challenges of Active Aging

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- The government emphasizes the roles to be played by the elderly in local communities and at home, as well as their financial independence. The government is aiming to establish a community-based support system by the initiatives of local people (including the elderly) and volunteers.
- However, the current initiatives have been limited in terms of scale and area. There is a need to develop a concrete strategy to establish an integrated and systematic supporting system that may further promote the development of elderly care.
- Free health checkup has been provided to the elderly registered at a healthcare center. Home-visits (subject to fees) have also been provided, but the scale is limited due to resource constraints.

## 2. Aging policies and Active Aging in Japan

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### (1) Transitions in aging policies

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- The pension insurance system and medical insurance system have been in operation since before the Second World War, but some people in the informal sector, including agriculture and self-employment, were not enrolled. The problem of informal sector coverage was addressed, during the post-War period of high economic growth, when universal coverage in pension and health insurance was achieved in 1961. Along with the concurrent success in promoting public sanitation, universal insurance coverage is considered to have contributed to the rapid extension of the average life expectancy during the period of economic growth.

- The history of universal insurance has seen periods of challenge and success. In 1973, Free Health Care for the Elderly was adopted, but elderly health care costs continued to increase rapidly with the growth of the elderly population. In 1983 the Elderly Health Act was enacted and a co-payment rate was established, but rise in elderly medical expenses continued to be an issue.
- Another problem arising in the 1970s was the so-called “social hospitalization”. Despite a low level of actual medical need, the long-term hospitalization of elderly people due to difficult conditions for providing treatment and care in the household became a social problem. To respond to this problem, in-home care was promoted, non-hospital facilities were established through financial support of the Gold Plan (the ten-year strategy for health and welfare for the elderly), and the Long-Term Care Insurance Act was enacted.
- With regards to Active Aging, there has been no government policy that includes the term in Japan. However in the ‘Aging Society White Paper’ several measures are mentioned to comprehensively promote policies based on the fundamental principles of the Aged Society Basic Act: 1) revising the basic understanding and awareness of ‘elderly’, 2) establishing a social security system to ensure the peace of mind of the elderly, 3) utilizing the motivations and capabilities of the elderly, 4) realization of stable local society and strengthening of local community, 5) realization of safe and comfortable lifestyle environment, 6) promoting aging policies by advocating to people to prepare from a young age for the ‘90 years of life’ and the 6 basic ideas for realizing a circulation of generations.<sup>13</sup> These are seen as being in line with the international trends in Active Aging.
- As a measure of health promotion for the elderly, the “Second Movement to Strengthen Citizen’s Health in the 21<sup>st</sup> Century” (also known as Healthy Japan 21 [First Movement 2002-2012, Second Movement 2013-2023]) was initiated. This movement sets out the basic points necessary to ‘comprehensively promote the citizens’ health, and thereby creating a sustainable social security system, through the improvement of lifestyles and the social environment, supporting each other from youth to old age, with hopes and aspirations, creating a society in which people have the dynamism to live healthy and fulfilling lives through each life stage’ and is thought to embody the same approach as that of WHO’s Active Aging.<sup>14</sup>
- With regards to support of the elderly in local communities, the 2012 Revised Care Insurance Act and Revised Insurance Benefits, promoted the establishment of the integrated community care system. Provisions were added to Section 5 of the Long-term Care Insurance Act, thereby providing a legal basis for the integrated community care system and resulting in the spread of local approaches to support the elderly<sup>15</sup>.

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<sup>13</sup> Cabinet ‘White Paper on Aging Society 2013’

<sup>14</sup> Ministry of Health, Labor and Welfare, Healthy Japan 21 website ([http://www.mhlw.go.jp/bunya/kenkou/dl/kenkounippon21\\_01.pdf](http://www.mhlw.go.jp/bunya/kenkou/dl/kenkounippon21_01.pdf))

<sup>15</sup> Mitsubishi UFJ Research and Consulting (2013) “Points of discussion for the Construction of Comprehensive Local Care Systems” (see attached “Report on Research into Comprehensive Local Care Systems and Sustainable Care Insurance Systems”).

Table 3: Japan's experience with Policy for Aging  
(Health, Treatment, Care)

Systems/Laws	Detail	Achievements and challenges
Implementation of universal health coverage (1963)	Universal coverage of medical insurance was implemented.	Achieved universal health coverage as the 4th country in the world
Enactment of the Act on Social Welfare for the Elderly (1963)	The Act clearly stipulates the principle of social welfare for the elderly as well as the obligations of the central and local governments in terms of aged peoples' welfare administration, which is the origin of aged people's welfare.	With awareness of aging issues (e.g. elderly people who live alone due to advancement of nuclear families), special elderly nursing home was established. Since 2000, most of its services have been subject to the Long-Term Care Insurance Act.
Introduction of free medical care for the elderly (1973)	Medical care for the elderly aged 70 or over became free. Other policies implemented in 1973 include establishment of a major medical service system and introduction of 70/30 split for families.	1973, when various policies were implemented, was called the "first year of welfare". However, increasing medical expenses for the elderly eroded the public finances for the national health insurance system.
Health and Medical Service Act for the Elderly (1983)	The out-of-pocket scheme with a fixed amount was introduced in medical care for the elderly (abolition of free medical care). A mechanism to adjust medical care financing for the elderly among the insured was introduced (medical care financing system for the elderly).	With the medical care financing system for the elderly, which continued until the introduction of the medical care system for the elderly aged 75 or over in 2008, the financial burden on the employees' medical insurance increased.
Formulation of Gold Plan (1989)	The plan aimed to enhance in-home welfare and caring facilities	Due to the higher number of people in need of long-term care than expected, the Plan was replaced by the "New Gold Plan" with revised targets in 1994.
Revision of 8 welfare-related laws (e.g. the Act on Social Welfare for the Elderly, the Health and Medical Service Act for the Elderly) (1990)	Each province/municipality started to develop its own health and welfare plan for the elderly (1993).	On the assumption that programs are implemented by each local government, policies and targets of care services at home, in facilities and for the elderly were defined on a local government basis.
Formulation of New Gold Plan (1994) Basic Act on Measures for the Aging Society (1995)	Proposing enhancement of in-home care, targets set included training of 170,000 caretakers and establishment of 5,000 of home care service stations. The government announced promotion of the establishment of the base for the elderly to receive proper care services so that they could live an independent life.	The targets set for care services for the elderly were revised upward. The government announced promotion of consideration of a comprehensive elderly policy, including establishment of a new public long-term care system.
Formulation of Gold Plan 21 (1991) Enactment of the Long-Term Care Insurance Act (2000)	The Gold Plan 21 included introduction of the group home scheme. Establishment of the long-term care insurance scheme as part of the social insurance system changed long-term care from measures to contracts.	The policy included quantitative expansion of services and introduction of a new profession (i.e. care manager). However, the issue was how to ensure the quality of services.
Enactment of the Act on Prevention of Elder Abuse (2006)	The Act provides the definition of elder abuse and stipulates the obligation of an operator, etc. to notify any violation.	The Act has raised public awareness, including in-home support centers which were introduced in 2006 are responsible for receiving reports.
Medical care system for the elderly aged 75 or over (2008)	An independent medical care system for the elderly aged 75 or over was established. The conventional medical care system for the elderly was abolished.	The conventional medical care system for the elderly was replaced with the medical care system for the elderly aged 75 or over.
Revision of the Act on Securement of Stable Supply of Elderly Persons' Housing (2011)	The serviced housing system for the elderly was established under co-jurisdiction of the Ministry of Land, Infrastructure, Transport and Tourism and the Ministry of Health, Labor and Welfare.	The revision intended to promote supply of serviced housing for the elderly where monitoring and consulting services are provided. (Number of registered housing as of June 2013: 114,315).
Outline of measures to cope with the aging society (2012)	The outline highlighted the possibility of the elderly to support the society (e.g. utilization of motivations of skills of the elderly). It also demonstrated the concept of active aging by referring to work-life balance and other preparations by the young.	The outline aimed to ensure stable implications of the measures by setting numerical targets in each area. It will be reviewed every 5 years according to changes in the economic and social situation.

## (Income Security and Social Participation)

Systems/Laws	Detail	Achievements and challenges
Workers' Pension Insurance Act (1942)	The Act stipulated that the pension age for males was 55.	Female workers were not covered.
Revision of the Employees' Pension Insurance Act (1944)	The Act stipulated that the pension age was 55 for both males and females.	Female employees were also covered.
Revision of the Employees' Pension Insurance Act (1954)	The pension age for male was revised from 55 to 60 (no change for female, 55).	The pension age for males had been gradually extended for 15 years since 1957.
Act on Welfare for the Elderly (1963)	With this legislation, aged people's clubs became entitled to public subsidies.	The aged people's clubs spread throughout the country along with advancement of population aging. The clubs have contributed to improvement of welfare for the elderly in local communities through various activities such as health-building, preventive care and charitable activities. Amidst population aging, the aged people's clubs are expected to promote social inclusion of the elderly.
Introduction of the Respected for the Aged Day (1965)	Along the spreading popularity of Old Folks' Day in Nomadani-mura, Taka-gun, Hyogo, September 15 was held as Respected for the Aged Day nationwide.	Due to the Happy Monday System, Respected for the Aged Day was held on the 3rd Monday of September and Aged Day was held on September 15.
Revision of the Act on Promotion of Employment of the Elderly (1976)	The Revised Act stipulated the non-binding target of the ratio of elderly aged 65 or over to total employees to be 6%.	
Commencement of the silver human resource center project as the government subsidy project (1980)	Bodies engaging in the silver human resource center business became entitled to public subsidies.	This was spread nationwide.
Revision of the Employees' Pension Insurance Act (1985)	The old-age pension age was revised from 60 to 65 for males and from 55 to 60 for females.	The elderly aged 60 to 65 are entitled to a lump-sum benefit. The old-age pension age for females had been gradually extended for 12 years since 1967.
Act on Employment Stabilization for the Elderly (1986)	The Act on Promotion of Employment of the Elderly changed its name to the Act on Employment Stabilization for the Elderly. The changes included legislation of silver human resource centers and non-binding target setting on a retirement system at age 60.	This embodied a drastic legal revision regarding measures for employment of the elderly.
National Health and Welfare Festival (Nenrinki) (1988)	This is a sport and cultural event for the elderly aged 60 or over.	Since the first event in Hyogo, the Festival has been held 25 times up to 2012.
Gold Plan (1988)	Prefectural offices to promote a prosperous longevity society were set up in order to promote prosperous and healthy life for the elderly (currently, set up in all prefectures).	With participation and cooperation of the Council of Social Welfare, old people's clubs and welfare organizations, healthcare/medical organizations, private businesses, administrative bodies, etc., various activities have been systematically promoted.
Revision of the Act on Employment Stabilization for the Elderly (1990)	The Revised Act clearly stipulated the non-binding target to re-employ required people who so wish.	
Revision of the Employees' Pension Insurance Act (1994)	The old-age pension (fixed portion) age was revised from 60 to 65 for both males and females.	The old-age pension (fixed portion) age will be gradually extended for 12 years since 2001 for males and since 2006 for females.
Revision of the Act on Employment Stabilization for the Elderly (1994)	The revisions included mandatory introduction of a retirement system at age 60 (effective in 1996), instructions on preparation of post-retirement system, and recommendations on change/review of the plan.	
Revision of the Act on Employment Stabilization for the Elderly (2000)	The revisions included the non-binding target of introduction of measures to secure employment of the elderly aged 65 or less (e.g. extension in retirement age).	
Revision of the Employees' Pension Insurance Act (2000)	The old-age pension (remuneration-based portion) age was revised from 60 to 65 for both males and females.	The old-age pension (remuneration-based portion) age will be gradually extended for 12 years from 2013 for males and from 2018 for females.
Revision of the Act on Employment Stabilization for the Elderly (2004)	The revisions included the binding target of introduction of measures to secure employment of the elderly aged 65 or less (e.g. extension in retirement age).	
Revision of the Act on Employment Stabilization for the Elderly (2012)	The revisions included abolition of any system which allows applicable employees to a post-retirement system.	

Source: Prepared by the Secretariat

**(2) The current framework for aging policies****(a) The social security system**

- The characteristics of the Japanese social security system are: 1) all citizens' pension, medical and care are covered, 2) fiscal and administrative management is done combining insurance premiums and taxes by injecting public funds into the social insurance system, and, 3) national, prefectural and municipal agencies share responsibilities and coordinate with each other.
- Under the Universal Insurance System, citizens can receive necessary medical services when they are sick, by showing their health insurance card and paying co-payments at a fixed rate. The characteristics of this system are: 1) all citizens are secured under public insurance, 2) health care facilities can be chosen freely, 3) inexpensive but high quality treatment, 4) in principle a social insurance system, with injection of public funds. In the event that the needed treatment is extraordinarily expensive, there is a high-fee treatment system that reimburses costs that exceed the predetermined individual payment capacity limit.

- Medical expenditures are increasing each year. The national medical expenditure as a proportion of gross domestic product increased from 2% in 1955 to 7.81% in 2010. In order to respond to increasing medical expenditures, the systems in place were reviewed, with emphasis on future sustainability; for example the rate of co-payment under medical insurance was increased, the structure of the health care system was reviewed, along with introducing measures against lifestyle-related disease.
- The public pension system is part of the social infrastructure to ensure income for the elderly. The public pension system is managed as a system for inter-generational support, as the current working generation pays into the insurance system and pension funds are provided to the elderly generation. One further characteristic of the system is that people can receive benefits for the rest of their life, with adjustments made to compensate for increase in salaries and price of goods. Against the backdrop of aging society, the 2004 Pension System Reform moved to control rising insurance costs shouldered by the working generation and set an upper limit. With a system to automatically adjust the payments made from the funds collected (macro-economic slide), efforts were made to establish balance between long-term paying out of benefits and contributions. Moreover, in the system reforms of 2012, the conditions were prepared for setting in motion macro-economic slide through the removal of pension amounts that were higher than the normal standard (special case standards). The government pension contribution was made permanent at one-half. Through these efforts the pension fiscal framework was completed.
- The number of elderly needing care has risen with the general trend of the population towards aging, while there was a lengthening of the period requiring care and an overall increase in demands for care. The domestic situation of households supporting elderly people who need care has also changed, with the increase in nuclear households and aging of the family members themselves providing care. For these reasons, the need for a system in which members of society can each other support care for the elderly was widely perceived and long-term care insurance was established when the Long-term Care Insurance Act was enacted in 2000. In long-term care insurance, the thinking behind support for self-reliance was clearly established in the law. Long-term care insurance tries to reduce the burden on family members providing care by making payments for necessary health care services and welfare services. As the number of registered people needing care increases, the total costs of long-term care insurance have increased yearly. Insurance premiums have increased alongside this. In addition to reviewing contributions and administration of the system, reforms to maintain and improve the quality of services are also being carried out

(b) Countermeasures against non-communicable diseases (NCDs)

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- Previously, communicable diseases such as tuberculosis were the main cause of death in Japan. But improvements in sanitation brought about decrease in the death rate, and in the post-War period of high economic growth, the incidence of deaths due to diseases such as cancer and stroke

increased and measures to counter NCDs were developed. Some positive results were seen, such as the decrease in the death rate from stroke. Regarding the health of the elderly, health check-ups became standard across the country as a result of public "Elderly Health Programs". The national health insurance system itself implemented efforts such as "the Health-up program", which include health promotion activities for the many elderly enrolled. In this way, NCD countermeasures were implemented at the local level.

- The Healthy Japan 21 program (Movement to Strengthen Citizen's Health in the 21<sup>st</sup> Century) was initiated in 2000, and the Health Promotion Act was issued in 2002. Under Healthy Japan 21, the focus was not just on secondary prevention measures just as health examinations, but went further to emphasize primary prevention measures such as improvements in diet and lifestyle. The program was assessed in 2012, and in the following year the second phase of Healthy Japan 21 was initiated. In this phase, the basic direction was prevention of onset of illness and worsening of conditions. Measures placing emphasis on the primary prevention of diseases such as cancer, cardiovascular disease, diabetes and chronic obstructive pulmonary disease (COPD), are promoted, while preventive measures the development of complications and progression to critical conditions are also emphasized.
- In 2012, the 'Five-Year Plan to Promote Policy Measures on Dementia' (also known as Orange Plan) was drawn up, with the local government (city, district, village) as the primary actor. A dementia clinical care path was created, and the Plan was aimed to achieve earlier diagnosis and provide appropriate treatment and care to the elderly with dementia, so that they may continue to live in the areas where they live.

(c) The construction of elderly facilities and ensuring quality

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- During the period of high economic growth starting in the 1960s, the history of building facilities for the elderly began, under the auspices of the Elderly Welfare Act, the Elderly Health Act and the Gold Plan. As a result, the number elderly facilities are at a high standard among developed nations, as well as facilities per elderly population. However, there is a strong sense among the elderly that they would prefer to live in their homes as long as possible. Maintaining many public facilities is considered costly and not sustainable. For these reasons, the main direction now is towards promoting home-based care services, rather than increasing facility construction.
- On the other hand, as part of the efforts being made to maintain the quality of elderly facilities, the regulations on the assignment of personnel and structure or facilities have been implemented. Furthermore, in 2006, the 'Prevention of Abuse of the Elderly Act' was issued, providing a basis for notification and measures against the infringement of human rights.

(d) Implementing in-home services and improvement of local resources - the integrated community care system

- In 2000, considering the need to reduce so-called social hospitalization and the burden of care placed on the family (the socialization of care), long-term care insurance was introduced as a social insurance scheme. At the point of initiation of the system, the number of enrollees that was 2.15 million now has grown to more than 5 million. The financial burden has increased as well. How to create a system that can meet the demands of the growing number of elderly with in-home services that are effective and efficient, has become the current challenge.
- Thus, Integrated Community Care System, an approach that offers comprehensive care within the community, is being promoted at the local level, so that the elderly may be able to continue living their lives in the local areas they are used to. Local coordinating systems are being created, joining medical care with long-term care (Figure 10).

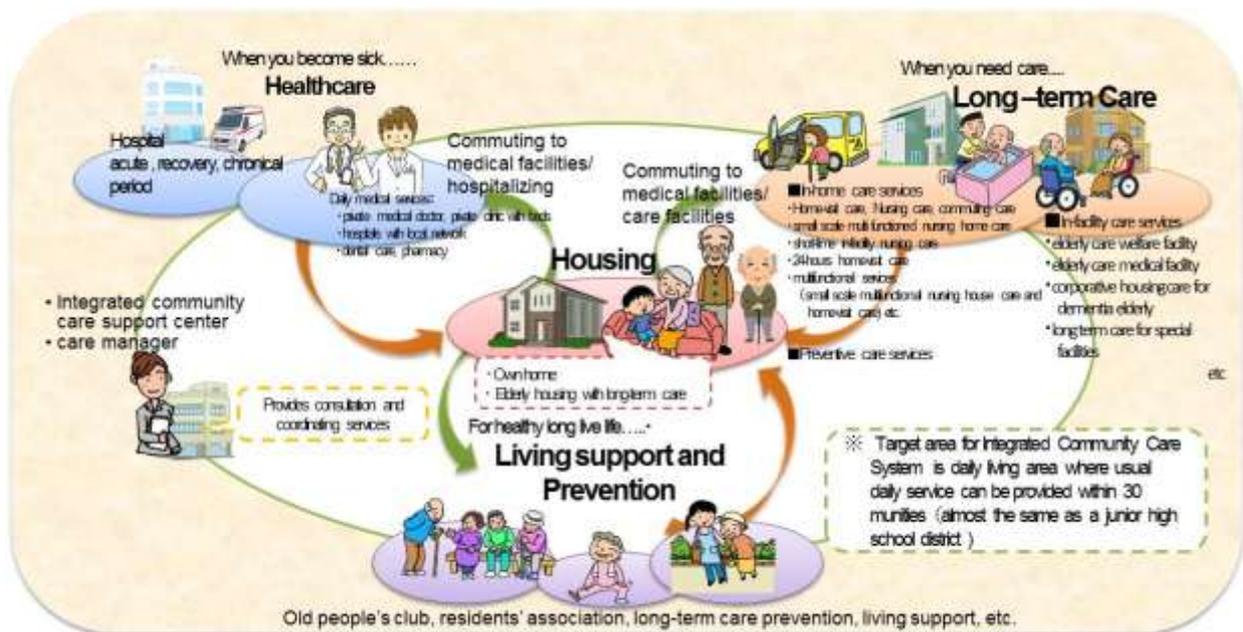


Figure 10: Community Based Integrated Care System

- In Section 2.4 of the Long-term Care Insurance Act, the prioritization of in-home care is mentioned, stressing the need to promote high quality in-home services with emphasis on promoting quality facility services as well.
- For a long time, the percentage of small-size service providing businesses for in-home services was larger in local areas compared to urban areas. This situation has been a barrier to integrated care (Integrated Community Care), because the coordination among many services providers and specialists is challenging. Recently, linking treatment and care, and coordinating between multiple specialty service providers has become an important agenda in local areas. Approaches that are appropriate for each region are being developed and tested.

- In Japan, the roles played by the mutual assistance between local people that has been deteriorating amidst the history of high economic growth and urbanization are being rediscovered.

(e) Social participation of the elderly

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- For many years elderly clubs and other similar organizations have been active in the local community, working to promote the social participation of elderly people. In recent years, with diversification of the values of elderly people and the development of the Internet, new forms of participation are emerging that are not limited to a specific geographical area. As aging progresses, organizations such as elderly clubs will be called on to facilitate their social participation.
- Silver Personnel Centers have been organized for the elderly that implement measures for the elderly to take on light labor tasks, thereby getting fulfillment out of employment, and making contributions for vitalizing the local community.
- Furthermore, in recent years we have seen some local areas having cutting-edge approaches to elderly participation developed by the elderly themselves. For example, there have been cases of elderly people developing their own businesses and working towards the solution of local problems without relying on public funds.

(f) Others

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- The social statistics regarding situation of elderly people in Japan have been built by using data including but not limited to the National Livelihood Survey and the National Census. In recent years, in order to design detailed policies for the elderly at the local level, basic checklists and Daily Life Needs Surveys based on these checklists have been developed.
- With regards to national level indicators related to the elderly, there is the degree of independence in daily life, and the assessment system introduced with the initiation of long-term care insurance. The Care Needs Certification System in Japan was developed and is implemented by using these indicators that classify according to the needs for care. These data has been continuously collected and used as evidence for planning policies.

**(3) Results of field survey in Japan**

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- In this project, we conducted field survey in Japan. Four good practices were selected as references for cooperation with ASEAN countries by Japan on Active Aging. Some key points of each practice and activity are listed below.
- Common success factors for these activities in Japan are “multi-dimensional approach at the regional level with collaboration of wide range of stakeholders from many sectors” ,

“participation of local residents and the elderly” and “originality and ingenuity of local government”

(a) Kashiwa city, Chiba prefecture

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**■Establishment of collaborative relationships between medical and long-term care services through coordination by municipalities and local medical associations for promoting in-home medical care and nursing care**

- There is collaboration between municipalities and local medical associations, recognizing that healthcare should be changed from “treatment” to “support” so that the elderly can continue to live in their homes. Collaborative sessions are initiated by municipalities and local medical associations to create a face-to-face relationship among local specialists. A model service point that combine housing for the elderly with 24-hour in-home care support is constructed alongside with facilities such as an in-home care clinic, and a home-visit nursing care station for providing elderly care services.

**■Multi-dimensional measures to care prevention**

- Kashiwa city has multi-dimensional preventive care approach for the elderly through supporting physical and mental health support, providing medical and nutrition advice, and providing opportunities to make friends and motivate life.
- Second life careers are promoted by “Job assistance for a life worth living” program, recognizing that it is necessary to make it easy for the elderly to step out (naturally) and make contributions to the local community.

(b) Hokuto city, Yamanashi prefecture

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**■Collaboration with related stakeholders for the elderly care**

- Initiatives to support the elderly have been taken under collaboration between the local governments, related organizations and local people, focusing on devising a way for the elderly to live self-sufficiently in the region.
- A gathering place is built based on local human networks that provides in-facility support services for the elderly, together with transportation. It plays a role as a place for social interaction among the elderly through various programs such as meal (lunch) serving, shopping support, handicraft, exercise classes, as well as contributing to health promotion of the elderly. The booklet “Genki Yobo Techo” has been distributed as part of efforts to encourage participation of local volunteers and promote the long-term care volunteer program.

**■Clear and detailed plan and implementation structure for the elderly care**

- Prioritizing long-term care prevention, the “Hokuto medium- and long-term care prevention program” has been implemented to establish a comprehensive community care system whereby the elderly are supported by the local community with emphasis on realizing “Aging in Place”. In

consequence, while the population aging rate is high (as of April 1, 2014, 32.1%), the long-term care certification rate is low (as of December 31, 2012, 11.3%).

- Especially for preventive care, it is made clear that there are 5 steps in the middle to long-term care preventive program, and each step is associated with a detailed project.

(c) Shinagawa City, Tokyo

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■ **Collaboration with related stakeholders for the elderly care**

- As with the example of Hokuto city, Shinagawa local government has taken strong leadership to establish supportive system and to manage for the elderly care. Shinagawa city also promotes participation of civil societies and related institutes on elderly care.

■ **Support for the elderly through “participation”**

- There are quite a number of projects for the elderly to participate into social activities. More than 700 voluntary senior citizen's groups including Silver (the elderly) University are registered in the city. Main activities include dancing, calligraphy, carving, photography, chorus, musical instruments, traditional music, exercise, social volunteer activities. These activities contribute to the elderly welfare and health promotion. Registered groups can use city meeting places and 15 elderly centers free of charge, where some of them have massage and spa services.
- Other than the above, there are more than 100 old people's clubs with 12 thousand members, which over 60 year-old residents make groups at community level. Every club has the goal to make life of those participating enriched and happy through hobbies or contributing in social activities. These activities prevent the elderly from being isolated in the society.
- By utilizing unused schoolrooms in elementary schools due to decreasing population of children, the elderly has opportunity to communicate with children as well as enjoying recreation.

(d) Higashi Omi City, Shiga Prefecture

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■ **“Face-to-face” relationship among medical and care stakeholders to solve the common obstacles**

- Through study sessions consisting of local medical and long-term care experts, that inherit the local traditional concept of “sanpo-yoshi (three-way satisfaction: good for the elderly, facility, and community)”, a “face-to-face” relationship among specialists has been created in the region. Close communications and regular study sessions are good examples for medical and long-term care experts for exchanging information as well as finding ideas to respond to obstacles in care. It is quite important that the key persons and institutions for coordinating all stakeholders are clearly determined for establishing this kind of structure.

■ **Local resource circulation model combining welfare, environmental conservation and agriculture, developed by local volunteers and supported by the local government**

- In the Aito region, “Aito Welfare Mall”, which consists of various facilities, including day service facility, home-visit nursing care facility, in-home care support office, café with a working

place for people with disabilities, restaurant serving local vegetables, and food and woodwork shops, was established with local government support, with the aim of creating a circular flow of economy within the region through selling food, wood products and so on.

■ **Elder people's networking expanding from the welfare facility utilizing an old folk house**

- In the Notogawa-area, a small multifunctional in-home care facility which is a renovated old folk house and a group home for the elderly are located, matching with the surrounding historical townscape. In this area, a local activity center has been established to support activities through various initiatives with the cooperation of graduates from the old people's university that was located nearby. With the help of a volunteer group mainly consisting of the elderly, efforts are being made in this center to support self-reliance and care for the elderly.

## Chapter 3 Recommendations for Future International Cooperation

### 1. Significance of Japan's contribution to the area of aging policies

- Since the 1970s, Japan has built up the current social security system implementing various policies in response to the aging population. The proportion of payouts to the elderly comprised 48.2% of total social security costs in 2011. This amounts to 14.9% of GDP. Together these demonstrate the central position that social security for the elderly holds within the social system<sup>16</sup>. As described in Chapter 2, Japan's policies for aging have seen both challenges and successes on their way to developing to its current form. Japan continues its efforts to create sustainable approaches to meet the continuing trend of aging.
- In the ASEAN region, some countries' rate of aging outpaces that of Japan, and there is a need to create effective and efficient social systems in a short period of time. In contrast to Japan, which enjoyed the conditions for creating a social security system amidst a period of unprecedented high economic growth, the ASEAN countries, even as they show impressive economic growth, may have to deal with rates of aging that equally or more higher than those experienced by Japan, with financial constraints and before they have been able to create sufficient social infrastructure.
- The ASEAN countries can respond to the need by fully analyzing Japan's experiences in meeting the challenges of aging society, including ways of maintaining a balance between realizing sufficient services and financial discipline. Based on lessons that can be learned, it is hoped that they will be able to construct an effective approach in a shorter period of time.

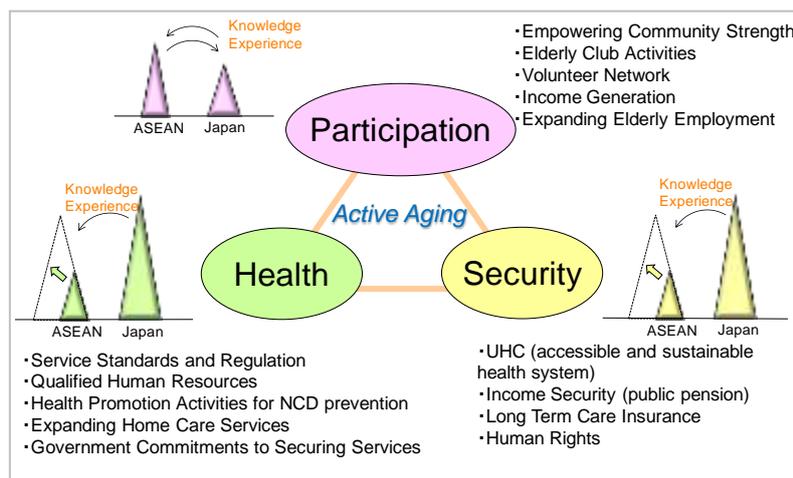


Figure 11: International cooperation in Aging Policies as a mutual learning process

<sup>16</sup> National Institute of Population and Social Security Research, 'Statistics on Social Security Costs (2011)' <http://ipss.go.jp/ss-cost/j/fsss-h23/1/3/kyuufuhi.pdf>

- Japan has many years of experience with the development of elderly care services (as social security systems and specialized service provision) and formal service development such as NCD countermeasures. At the same time, however, arrangements for mutual assistance within local regions have declined with economic growth. ASEAN countries have many more examples of these types of arrangements, and Japan has much to learn from these countries in this regard. International cooperation on issues of aging population society should not be unilateral transfers of technology; rather, Japan should be ready to learn together with its cooperation partners (Figure 11).

## **2. International cooperation needs in ASEAN aging policies and directions for cooperation**

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### **(a) Formulation of mid-to long-term national strategies to respond to aging**

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- The most important factor of an aging population is the speed of change in population structure. When a society experiences aging rapidly, it is necessary to change and improve not only the social security system, but also the various systems that support society, such as employment, industrial structure and lifestyles. Within the ASEAN countries receiving ODA, the group with the most pressing need to improvement of policies on aging society is Thailand and Viet Nam. Both countries are expected to experience major changes in the population structure over the next 20 years. Due to this rapid demographic change, urgent establishment of social systems are considered necessary at the national level over the short term in those countries. Malaysia, Indonesia, Myanmar and Cambodia are transitioning into aged society after Thailand and Viet Nam. The Philippines and Laos are moving towards aged society at a comparatively slower pace.
- Facing aging populations, these countries are formulating strategies and long-term plans to respond to the challenges of aging. These approaches identify the directions that are to be taken, but at the present, there are few services or systems expanded universally at the national level. Services or systems having budgets that are secured continuously are limited.
- In ASEAN countries, it is common that ministries responsible for health and welfare are separated. In this case, on one hand, the Ministry of Welfare has responsibility to manage policies or national committees to respond aging society. However they may give special attention to socially isolated elderly people in their limited resources, and they are not covering facilities providing universal services for elderly at the national scale. On the other hand, Ministries responsible for health may have many insights on various issues on physical and psychological conditions of the elderly including physical disability and dementia, and providing medical service. However, it is common that the mandate focuses on provision of basic health infrastructure. For these reasons specific policies for elderly tend to develop slowly.
- Formulation of sustainable and effective strategies to respond to aging that includes approaches related to health is important, and it is believed that the need to support the development of

approaches and measures to bridge the gaps between the areas of responsibility among different ministries will rise in the future with regards to aging.

- However, because it is essential that assistance to the establishment of social systems must fit with the various social infrastructure of the receiving country, the receiving country must have ownership of the assistance. Aging policies are no exception to this principle. Therefore it is necessary that Japan's assistance be fully aware of the receiving country's role and requests.

#### (b) Development of social security systems

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- Since the 1997 currency crisis, ASEAN countries have promoted the development of social security systems depending on the circumstances of each country.
- Many countries have moved forward with systems, such as elderly pension systems, in order to insure income for the elderly. In many countries, the target population of these systems has been expanded from civil servants to the private sector, but currently this is limited to beneficiaries in large-scale enterprises. Many small and medium sized enterprises and individual enterprises are not yet included in these schemes. This raises the need for support to increasing the awareness and understanding of a universal pension system and the measures needed to implement such a system.
- With regards to medical insurance, each country is moving towards universal health coverage (UHC). Building financially sustainable system that pays benefits for agricultural and other family business workers remains a common challenge among many ASEAN countries. Even if the financial mechanisms for a medical insurance system are created, under local conditions where basic resources for medical services are not universally distributed, improvement of the quality of peoples' lives cannot be achieved. There is a need for assistance to promote the development of medical infrastructure, together with the development of the financial backbone of the medical insurance system.

#### (c) NCD countermeasures

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- Many ASEAN countries have already experienced economic-growth-driven changes in dietary practices that have brought about a transformation of the structure of disease occurrence in the country. Lifestyle-related disease has become a main cause of death, and this means that NCD countermeasures have become a key issue. The impacts of increase of NCD incidence on medical costs is of high interest in ASEAN countries. Medical NCD-oriented service delivery systems and other basic social measures to promote health and prevention have emerged as important themes within cooperation on the efforts to reduce the burden of NCDs.
- The importance of these efforts is recognized by health-related agencies. Measures against smoking, such as the restriction of areas where smoking is allowed, have begun, but there is still much room to work further on issues related to education and nutrition. While continuing to pursue these policies, from the perspective of secondary prevention it is believed that further

development drawing knowhow from Japan's experience with health examinations for example, together with communication of Japan's previous experience with NCD countermeasures, will provide an effective platform for international cooperation.

- From the point of view of Active Aging promotion, lengthening the period in which one can live a healthy life (healthy life expectancy) is important, and NCD countermeasures that include guidance on lifestyle improvement play a large role.

#### (d) Establishment and regulation of facilities for the elderly

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- Currently, elderly facilities in ASEAN countries can be divided into three categories: shelters for the poor, high-class aging homes for the rich, and aging homes for the middle class.
- In ASEAN countries, shelters for the poor are generally public facilities, but they are still relatively few and residence is not limited to the elderly. Rather, these facilities are open to a much broader section of marginalized members of society, such as the disabled and homeless. For this reason, those elderly who have entered these facilities are limited to those experiencing economic difficulty and have lost a place to live. Countries are not taking an aggressive stance in building new facilities for the poor.
- With regards to the other categories, aging homes for the rich and middle class, these continue to appear as the result of private funding. A broad range of facilities is being constructed as the middle-income sector of society expands in tandem with the recent years of economic growth. It is expected that privately funded elderly facilities will continue to grow in the future in each country.
- For promoting construction of facilities, creating master plans or roadmaps for elderly care is an urgent need, including the consideration of what sort of balance will be sought between home care and facility care.
- Some countries are working to prepare registration systems, certification systems and facility standards in order to maintain the quality of service of private facilities, but it is difficult to conclude that the content of standards are effectively set at a level that ensures the quality of care provision. Many facilities do not seem to meet these standards. Thinking about to what degree the government should be involved in the content and quality of service provision in private facilities is different in each country, but it is necessary to consider the establishment and application of a set of minimum standards for the quality of services provided in private aging facilities targeting the middle income population. In addition to the content and quantity of care services, it is important to consider the issue of the human rights of the elderly, in the case of unregistered or uncertified facilities, with regards to issues such as physical restraint and privacy.
- Japan has past experience with improving service provision and encouraging the institutionalization of rules, in order to respond to this type of problem. By implementing support activities to help design systems and create minimum standards, it is believed that the maintenance and improvement of the quality of services provided can be achieved.

#### (e) Development of home services and expansion of local resources

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- In ASEAN countries, home care is the basic principle, but the question for many governments is how to establish and build this approach in local areas.
- In reality, the provision of home care is still quite limited. Aside from Malaysia, where mobile care services are provided to the wealthy in certain areas, the most commonly provided form of home care is through so called 'maid' services.
- With the many financial constraints faced, many countries take the basic strategy of finding local resources involving NGOs and volunteers, working together in collaboration with public health agency specialists, in their efforts to build the basic system to support home care. These efforts may be focused on the support of families rather than public services, or provision of technical support to volunteers, in recognition of the strong role that is still played by the family, particularly in rural areas.
- However, as demand for home care is expected to rise, there will be limitations to relying on the family and community. In this area, JICA is implementing 'The Project of Long-Term Care Service Development for the Frail Elderly and Other Vulnerable People' in Thailand. This project aims to reduce the burden shouldered by the family by establishing a service provision system for elderly care. The experiences of this project are expected to be of use in other ASEAN countries as well.

#### (f) Social participation of the elderly

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- Japan has promoted developing a society in which people are encouraged to work and participate in social activities, regardless of age. The government has tried to change the way of thinking dominated by the concept of retirement by age, and built facilities such as the Silver Personnel Centers according to law, for promoting the expansion of employment opportunities for the elderly. Local governments also work to promote social participation of the elderly, providing public space for the elderly to come together, in hopes that this will draw out the skills and knowledge of the elderly. Furthermore, Local Integrated Care Support Centers display long-term care equipment and provide advice in order to enhance the independence of the elderly. It is hoped that these approaches can be shared in the context of aging society in ASEAN countries.
- At the same time, it is recognized that the maturation of the social security system in Japan and the establishment of services provision system have resulted in the weakening of the support capacity of local communities. For this reason, in recent years the promotion of Integrated Community Care System has seen a reconsideration of the mutual support function of local communities.

#### (g) Empowerment and the development of human resources

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- Aging is a new field of policy for the ASEAN countries, and there are many different agencies involved. The concept of Aging policy is not well organized, and specialists possessing insight on

aging policies are few. When considering the mid- to long-term approaches to aging society, it is necessary to move forward proactively with measures such as capacity development of government staff and academic exchange, together with the collection of information and knowledge regarding aging policies.

- At the level of actual implementation, the development of highly skilled specialists is an issue in all countries. In many countries, besides family members, the roles of caregivers are mostly taken by maids and volunteers. However, at this stage, outside of the domain of doctors and nurses, the discussion of improvement of skills and roles of care professionals in local sites, is still insufficient. Policy dialogue, training programs and seminars are necessary in order to improve the quality of care by sorting out the role of elderly care specialists and developing their skills.
- Moreover, for the development of these approaches, it is necessary for local people including the elderly to proactively promote community development. Much is currently left to the naturally occurring activities. Support to raise awareness of the self-determination of local communities may be among future options.

#### (h) Establishment of social statistics on aging society

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- One common point among the ASEAN countries is the lack of social statistics regarding the elderly. Data on the population is provided by the national census, but national-level statistics on the physical and psychological health of the elderly and their lifestyles are non-existent, aside from a small number of surveys carried out by academic institutions. It is believed that there is potential for cooperation on development of methods for continuous data-collection efforts. In cases where data is available, there is potential for collaboration on research and analysis.
- Moreover, in order to conduct dialogue and discussion that is based in scientific evidence, there is potential for cooperation on 'National standards regarding degree of independence of the elderly', 'Understanding the national-level situation of care needs among the elderly', 'Scope and contents of elderly care' and 'Establishment of indicators regarding health'.

**Table 4: ASEAN issues and potential areas for Japan's contribution**

		Situation in ASEAN countries (based on field survey)
Health	Facility services	<ul style="list-style-type: none"> <li>✓ Public facilities are mostly limited for the low-income class and the elderly without family. Most facility services for middle-income class are provided by volunteers or NGOs.</li> <li>✓ Private facilities targeting the high-income class have been increasing, but relevant regulations (e.g. minimum service requirements) have not been well established yet.</li> <li>✓ Elderly care standards, and maintaining/improving the quality of care services are yet to be established.</li> </ul>
	Home services	<ul style="list-style-type: none"> <li>✓ Home services provided by private enterprises are yet to be developed, and most services are provided by NGOs and community volunteers in cooperation with the government.</li> <li>✓ Day Care Service is available in some community centers and medical institutions, but the variety is still limited.</li> </ul>
	Measures against NCDs	<ul style="list-style-type: none"> <li>✓ In Thailand where the primary health care system has been developed, various measures against NCDs are taken by utilizing the network of more than 1,000,000 "health volunteers" nationwide.</li> <li>✓ Most of these measures are prioritized for the provision of primary health services with scarce focus on actions specific to the elderly.</li> </ul>
Participation	Social participation	<ul style="list-style-type: none"> <li>✓ Each country has organizations of aged people which are engaged in various activities. The government of each country depends highly on these organizations in implementing measures for the elderly.</li> </ul>
	Measures for employment and livelihood	<ul style="list-style-type: none"> <li>✓ Majority of workers are engaged in the informal sectors. Even among waged workers, many of them are engaged in family business and have little awareness of retirement age.</li> <li>✓ In rural areas, most households consist of multi-generations. Traditional mutual aid has remained for raising children and other household matters. Meanwhile, the working generation tends to move to major cities for work.</li> </ul>
Security	Health security program	<ul style="list-style-type: none"> <li>✓ In Thailand and Malaysia, universal coverage (UC) of health security has been achieved.</li> <li>✓ In Vietnam and Indonesia, the governments have launched policies to achieve UC.</li> <li>✓ Thailand has limited medical doctors assigned to PCUs (Primary Care Units directly operated by the Ministry of Health).</li> </ul>
	Income security for the elderly	<ul style="list-style-type: none"> <li>✓ In Thailand, 500 baht (approx. 1,500 yen) monthly allowance is provided to all the elderly. In the other countries, this kind of allowance is limited.</li> <li>✓ In other countries, a small amount of old-age allowance is provided for targeted groups from tax resources.</li> <li>✓ Collecting social security premiums is not easy where informal sector workers are dominant.</li> </ul>

(simplified from Japanese original)

### 3. Japan's approach to international cooperation

#### (a) Multi-level approach

- Japan is currently participating in inter-governmental meetings, such as the ASEAN+3 Health Ministers' Meeting/Senior Officials' Meeting and the ASEAN+3 Social Welfare Ministers' Meeting/Senior Officials' Meeting. In addition, Ministry of Health, Labour and Welfare is hosting the ASEAN-Japan High-Level Senior Officials' Meeting for Caring Societies every year since 2003. Last year the theme of the High-Level Meeting was 'Active Aging'. Since mid- to long-term continuous commitments are necessary in aging policy by each country, it is important to have regular ASEAN-level policy dialogues such as these.
- In addition to these regular policy dialogues, multi-year long technical cooperation projects are also being implemented and discussed. With Thailand, JICA has been implementing technical cooperation projects "Community Health Care and Social Welfare Services Model for Thai Older Persons" (CTOP) followed by the "Project of Long-term Care Service Development for the Frail Elderly and Other Vulnerable People" (LTOP). In the CTOP project, support was provided for the development of local mechanism based on the identification of local resources and connections between health and welfare services. In the current LTOP project, specialized care services, such as care management, are being developed. A new project with Malaysia is under preparation to share experiences on aging policies.
- JICA training programs for social security and social welfare administrators delivered Japan's experiences to ASEAN Country officials, but at the same time, gave Japan the opportunities to

learn the experiences of ASEAN countries. Since there will be training programs separately focusing on Universal Health Coverage (UHC) and aging policies, it is hoped that these JICA training programs will provide good opportunities to share more concrete experiences.

- It is expected that support for active aging by private companies will also be important approach in the future. Grass-roots activities at the local level are also an effective approach, since concrete measures for aging are often implemented at the local level in small areas. Such activities are mainly conducted by NGOs and non-profitable organizations. Recent years have also seen the emergence of private firms seeking ways of promoting medical and care equipment and care services in Asia. In Japan, most medical and care services are provided by private sectors. It is expected that private companies, the private sector more in general, with flexible ideas and technical capacity, will provide products and services that match the local needs, thus contributing to active aging in ASEAN countries.
- Policy dialogue, technical cooperation projects, training programs and private sector collaborations are the four pillars of cooperation in aging policy currently being implemented simultaneously. In the future as well, it is important that actions be implemented simultaneously at multiple levels. (Table 5)
- As described in Chapter 1, various considerations of aging have taken place within international frameworks. The frameworks for dialogue and support are not limited to bilateral approaches, but cooperation through the contributions to international organizations (WHO, OECD, etc.) and active participation in international frameworks (ASEAN, East Asia) are highly expected.

Table 5: Approaches to international cooperation

Assistance Schemes	Targeted Countries	Examples
Policy Dialogues	ASEAN countries	<ul style="list-style-type: none"> <li>• Policy Dialogues among ASEAN countries (e.g. ASEAN &amp; Japan High Level Official Meetings, the ASEAN Plus Three Meeting for Social Welfare and Development (AMMSWD+3))</li> <li>• Policy Dialogue at High Level Officials</li> <li>• Policy Dialogues at the international Meetings such as WHO</li> </ul>
Projects	ODA countries in ASEAN region	<ul style="list-style-type: none"> <li>• Technical Assistance of JICA projects</li> <li>• Dispatching Specialists based on country's requests</li> </ul>
Trainings and Seminars	ODA countries in ASEAN region	<ul style="list-style-type: none"> <li>• Trainings and Seminars of JICA projects</li> <li>• Trainings and Seminars utilizing WHO scheme</li> <li>• Trainings and Seminars with the partnerships among national research centers (e.g. National Institute of Public Health, The National Institute of Infectious Diseases, National Center for Global Health and Medicine)</li> </ul>
Private Partnerships	ASEAN countries	<ul style="list-style-type: none"> <li>• Promotion of Private Partnerships among companies, NGOs/CSOs, Japanese Elderly Volunteers and so on in terms of human and goods resource provision</li> </ul>

(b) Creation of ASEAN network for aging policies

- It is important that aging policies include multidirectional exchanges among and between ASEAN countries, and are not limited to unidirectional provision of information and technology from Japan. It is also expected that from this type of inter-ASEAN discussion, Japan will also be able to obtain useful hints on how to overcome the challenges it currently faces. The Study Group

invited officers on aging policies from Thailand and Malaysia to exchange ideas and have discussions. Formation of a network of experts on aging policies within ASEAN will also be an important approach to expand these multi-directional exchanges of ideas.

- In order to vitalize the exchange of information and discussion on aging policies among ASEAN countries, Japan may propose regular policy dialogues among ASEAN countries and have active interaction among the experts.

#### (c) Reorganizing knowledge to be delivered from Japan

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- Responding to the growing opportunities of international cooperation on aging policies, Japan needs to prepare itself for effective cooperation. Especially, Japan needs to implement cooperative activities on aging policies by adjusting it to match with the cultural and socio-economic conditions of the recipient countries. Therefore, simply trying to deliver Japan's experiences is not sufficient. Instead, there is a need to reorganize the delivery of knowledge so that they are appropriate in each counterpart country. In order to promote international cooperation on aging with the help of Japanese policies, well-systemized information written in English is absolutely necessary. However, such information is still not sufficient, and the compilation of such information remains an important issue.
- In order to move forward with international cooperation, there is a need to identify and develop human resources in Japan. Personnel who can convey Japan's experiences at multiple levels through the central government and local government agencies, with clear understanding of the positions and conditions of the recipient countries and capable of conducting technical cooperation, are needed. Presently, specialists that can conduct technical cooperation in ASEAN countries on aging are limited, but relevant experiences are accumulated in Japan. It is important to support human resources that can conduct cooperative activities appropriate to the ASEAN Country conditions.

## 4. Priority issues for each country and appropriate cooperation

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### (a) Viet Nam

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- It is predicted that aging in Viet Nam advances most rapidly in ASEAN. After exceeding an aging rate of 7%, it will take approximately 15 years to reach and exceed an aging rate of 14%. It means that policy makers may have to prepare for aging society in a short period of time.
- During the field survey, the government of Viet Nam showed strong interest in international cooperation, in areas including strategy setting for aging policies, project model identification, countermeasure for NCD, management of elderly facilities, primary data collection and research, and human resource development.

- In Viet Nam, construction of new elderly facilities by private sectors and NGOs has been increasing. It raises the government's interests on how to secure service quality and how to regulate facilities. Therefore, the establishment of standards for those facilities can be a good theme for cooperation.
- At this stage, in addition to consideration of specific policies, objectively predicting the issues that may emerge as a result of aging, and considering the long term grand design policy for their solution should be an important priority.
- In Viet Nam, implementation of program for UHC is ongoing. In order to materialize measures for UHC and aging policies, providing basic information on Japan's experiences, policy history and social impact of aging may be important for Viet Nam as well as developing primary medical resources in the country. In the future, human resource development of experts and administrators, provision of information to and conducting joint research with academic researchers, are considered effective in the short and mid to long term.

#### **(b) Thailand**

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- In Thailand, where aging has been progressing rapidly, it seems that the spread nationwide concrete support measures in the short term will be necessary. Basic health and medical resources are quickly developing throughout the country, as a result of nationwide development of health centers and the 30 baht health insurance program. Thus the future issues will be the development of specialized care services for elderly and specific ways to deliver services in local areas.
- Since 2007, technical cooperation projects have been implemented by JICA. In the projects, a model for the community based integrated service of healthcare and welfare was developed under the CTOP project. Since 2013, specialized long-term care services for elderly such as home-care service, day-care service and long-term care management have been developed under the LTOP project. In this project, analysis of cost-benefit and efficacy of services, collection of evidence from services and policy dialogue have been conducted. It is hoped that this project will contribute to building elderly support systems at the national policy level as well as the dissemination of specialized services.
- Through the technical cooperation project, it is one option to propose a plan to establish an institutionalized nation-wide system with services combining specialized and volunteer services under limited resource setting.
- Thailand is a leading country in ASEAN region for pioneering several approaches to social security, and has already begun technical cooperation on UHC with neighboring countries. The Study Group expects Thailand can continue that cooperation and expand their theme.

#### **(c) Indonesia**

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- It is prospected that demand for various specialized services will arise in Indonesia growing together with the aging population. Much effort for developing human resources with specialized

skills is needed for elderly facilities and services. To grasp the needs of the elderly and to support human resources development in the elderly welfare sector should be essential. There also should be high priority on establishing nation-wide standard and regulation for qualified long-term care.

- Land of Indonesia is composed of many islands, which have large variety of local cultures, ethnicities and social structures. Policies for aging society are, therefore, necessary to be promoted appropriately to meet each locality. This means development of capacities is needed not only in the central government but also local governments.
- Indonesia has the largest population among the ASEAN countries, it has been prospected the future speed of aging is more rapid than that of Japan. In this context, the government of Indonesia is aiming to establish UHC and other social security systems, and therefore there is potential for cooperation through training programs on social security system for sustainability design. Mutual cooperation on basic exchange of information on social security, and technical cooperation on establishment of social statistics, producing guidelines for ensuring long-term care service quality are also other possible areas of cooperation with Indonesia.

#### **(d) Malaysia**

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- The Malaysian government's stance is to enable elderly to play their own role within the family and society, emphasizing financial independence and focusing on mobilizing funding of private sectors. For the role of government, the government regards itself rather than being a provider of services, but a regulating body. Therefore, the government aims to establish a system for supporting elderly within local communities with elderly themselves, families and volunteers, responding to the needs of the elderly care.
- However, the current status of implementation is limited in both quantity and geographic coverage, and not being conducted in an integrated or systematic way. It seems that a specific strategy to organize the system is needed at this stage. Furthermore, there is a trend towards ever-increasing private facilities for the elderly, and regulation of the quality of the facilities has become an important issue.
- The basic direction towards home care service has many things in common with Japan's policy for Integrated Community Care System, and it is believed that there is potential for cooperation on sharing ideas about measures for income generating activities, prevention care and social participation in local areas.

#### **(e) Other ASEAN countries**

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- Singapore and Brunei are not ODA recipient countries, but policies to deal with aging society are important nonetheless. It is believed that policy dialogue, sharing of Japan's experiences and knowledge, exchange of ideas would be effective. More specifically, because in these high-income countries it is predicted that needs for care will increase within the mid- and upper-income groups, there is potential to provide information from Japan about the long-term

care services, assistive devices and development of caregivers including encouragement of their use and application.

- The Philippines has the slowest rate of aging among the ASEAN countries. The aging rate is predicted to reach 14% in 2062, the latest in ASEAN. Therefore, policies for aging society are not an immediate priority. Because decentralization was promoted at an early stage in the island country's development, there are large gaps in basic medical service provision among local island areas. Filling these geographic gaps on medical care and improving benefits from the health insurance system should be the more immediate priority to prepare for future the aging society. Additionally, the Philippines is a country which is prone to natural disasters such as typhoons like Japan. It is thought that there is potential for cooperation to share experiences of recovery from disasters such as the East Japan Earthquake, for example assistance to the elderly and welfare responses during natural disasters.
- Myanmar, Laos and Cambodia also have relatively slow rates of aging and per capita GDP in comparison to other ASEAN countries. Priorities for cooperation in the future could be supporting establishment of basic health and medical resources and efforts towards achieving UHC. By moving forward with cooperation on UHC, it is expected that preparation for aging society (such as countermeasures for NCD) will be developed, so the training program for UHC carried out in Japan can contribute to these countries. Furthermore, Thailand has already introduced UHC for medical services in 2002, and cooperation supported by Thailand may be possible.

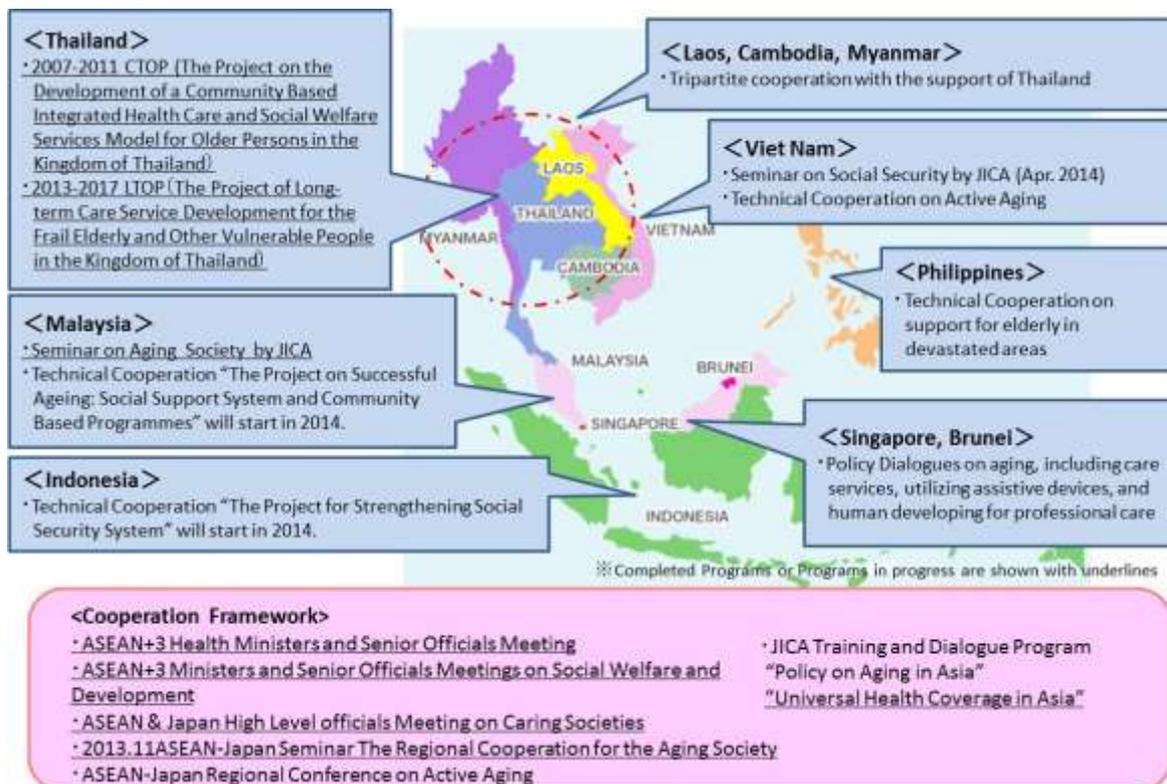


Figure 12: Japan's contribution for Active Aging: Possible future scenario

## Conclusion

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- Since its initiation in June of 2013, this Study Group has met on four occasions to discuss the international cooperation from Japan on aging society. During this period, field surveys in ASEAN countries were carried out, and the Study Group confirmed growing interests in aging policies among the ASEAN countries. At the ASEAN+3 Ministerial Meeting on Social Welfare and Development held in September 2013 in Siem Reap, Cambodia, recommendation stressing on the importance of strengthening cooperation within the ASEAN+3 and the importance of community-based approach was adopted to improve social welfare for all people including elderly. Following on this, the 'ASEAN-Japan Seminar: The Regional Cooperation for the Aging Society' was held in November in Jakarta where more than 70 from the ASEAN countries and Japan participated. In December, the 'ASEAN and Japan High Level Officials Meeting on Caring Societies' was held in Tokyo with the central theme of Active Aging. More than 80 government officials attended this meeting. In the same month at the ASEAN-Japan Commemorative Summit Meeting held in Tokyo, enhancing of cooperation on aging issues between Japan and ASEAN was confirmed. This report was produced and finalized through the above process.
- In 2014, in addition to the 'ASEAN and Japan High Level Officials Meeting on Caring Societies', Ministry of Health, Labour and Welfare is preparing a new event named 'ASEAN-Japan Active Aging Regional Conference' (tentative title) in June. Also, ASEAN+3 Health Ministers Meeting is scheduled in the same year. It is expected that Japan will continue to actively contribute to these efforts towards Active Aging in the ASEAN region.
- In order to materialize "Japan's International Contribution to 'Active Aging'", it is necessary to utilize this report.
- Domestically, sharing this report with government agencies, research institutions, academic institutions, relevant individuals in international cooperation agencies, and organizations and other groups working for Active Aging in Japan will help further strengthening international cooperation on aging.
- Internationally, this English version will help in sharing the contents of the report with ASEAN countries and international organizations and provide an opportunity to discuss policies for aging society. Progress of further international cooperation from Japan is expected from that discussion.
- The initial goal of this Study Group was to produce this report. But the production of a report is not a goal of international cooperation, but rather it is starting point. From that point of view, this Study Group will follow up materialization of the report and the progress of ongoing projects, and if needed, make additional recommendations.



Table 6: International Cooperation in the field of Japan's Social Security and Aging Society in 2013 and 2014

Japan	ASEAN
	Thailand 2007-2011 CTOP : Prevention, Promotion 2013-2017 LTOP : Long-term care
<b>2013</b> Jun. ~ Study Group for Japan's International Contribution to Active Aging July. Presentation from Thailand and Malaysian officials	
	Aug.-Sep. Field studies in Vietnam, Thailand and Indonesia
Nov. JICA Training and Dialogue Program " Universal Health Coverage in Asia"	Nov. ASEAN-Japan Seminar The Regional Cooperation for the Aging Society (Indonesia)
Dec. The 11th ASEAN & Japan High Level officials Meeting on Caring Societies The ASEAN-Japan Commemorative Summit Meeting	
<b>2014</b>	Apr. Seminar on Social Security by JICA (Viet Nam)
	Jun. ASEAN-Japan Regional Conference on Active Aging (Indonesia) ASEAN+3 Senior Officials Meeting on Health Development (Thailand)
Sep. JICA Training and Dialogue Program "Policy on Aging in Asia"	Sep. ASEAN+3 Health Ministers Meeting (Viet Nam)
Oct. The 12th ASEAN & Japan High Level officials Meeting on Caring Societies	4Q. ASEAN+3 Senior Officials Meeting on Social Welfare and Development (Laos)
Nov. JICA Training and Dialogue Program " Universal Health Coverage in Asia"	

## Annex

### (1) Study group members (in hiragana order)

Committee chair and members are listed below.

Chair	Shigeru OMI	President, Japan Public Hospital Group financed by Pension and Health Insurance Contributions Regional Director Emeritus, World Health Organization, Regional Office for Western Pacific
Members	Takahiro EGUCHI	Professor of Law, Kanagawa University Professor emeritus, Tsukuba University
	Keiichiro OIZUMI	Senior Economist, Economics Department, The Japan Research Institute Ltd.
	Nobuko KAYASHIMA	Director General, Human Development Department, Japan International Cooperation Agency
	Takao SUZUKI	Director of Research Institute, The National Center for Geriatrics and Gerontology
	Tomofumi SONE	Director for Planning and Coordination, National Institute of Public Health, Ministry of Health, Labour and Welfare
	Reiko HAYASHI	Director, Department of International Research and Cooperation, National Institute of Population and Social Security Research
	Satoko HOTTA	Research Analyst, The Japan Institute for Labour Policy and Training
Secretariat	International Affairs Division, Minister's Secretariat, Ministry of Health, Labour and Welfare	
	Yutaka HORIE	Deputy Assistant Minister for International Affairs
	Masahiko HAYASHI	Deputy Assistant Minister for International Policy Planning
	Kazushi YAMAUCHI	Director of International Cooperation Office
	Yasuhiro ARAKI	Deputy Director of International Cooperation Office
	Shio SUGITA	Assistant Director of International Cooperation Office
	Yohei MATSUURA	Section Chief of International Cooperation Office
Observer	Kazunari YOSHIDA	Deputy Director, Health and Welfare Bureau for the Elderly, Ministry of Health, Labour and Welfare
Research Assistant	Reisuke IWANA	Senior Analyst, Social Policy Group Leader, Economic and Social Policy Department, Mitsubishi UFJ Research & Consulting Ltd.
	Izumi TAKEI	Senior Research Analyst, Department of International Studies, Mitsubishi UFJ Research & Consulting Ltd.

### (2) Discussion points

- (a) Basic survey on aging society and elderly care in developing countries including Asian countries
- (b) Discussion on international cooperation in the field of health and welfare for the elderly
- (c) Others

## (3) Overview of the Study Group

Date	Agenda	Note
The 1 <sup>st</sup> meeting June 14, 2013	1.Current situation and policies on aging society in Asian countries 2.Demands to support aging society in Asian countries and their responses 3.Others	
The 2 <sup>nd</sup> meeting July 19, 2013	1.Discussion on international cooperation in the field of health and welfare of the elderly 2.Interview and field survey in Japan and overseas 3.Others	Interviews conducted below; •Dr.Chanvit Tharathep, Deputy Permanent Secretary, Ministry of Public Health, Thailand •Ms. Ruhaini binti Zawawi, Senior Principal Assistant Director, Department of Social Welfare, Ministry of Women, Family and Community Development, Malaysia
Field survey in Japan	Survey on measurements regarding active aging and the elderly care which are to be referred as institution building and development in Asian countries	July: Kashiwa city, Chiba prefecture, Hokuto city, Yamanashi prefecture, Shinagawa city, Tokyo August: Higashiomi city, Shiga prefecture
Field survey in overseas	Survey on current situation, experience and demands for international cooperation on health and welfare of the elderly	August: Vietnam, Thailand September: Indonesia
The 3 <sup>rd</sup> meeting October 30, 2013	1.Results of field survey in both Japan and overseas 2.Discussion on international cooperation in the field of health and welfare of the elderly 3.Others	
(Related event) The 11 <sup>th</sup> ASEAN-Japan High Level Officials Meeting, December 3-5, 2013	Theme : Active Aging Main agendas : •Universal health coverage and health and welfare services of the elderly towards achieving Active Aging society •Community to support the elderly •Social participation and contribution of the elderly •Lessons learnt on Active Aging from Japanese experience •Role of government on Active Aging •Future ASEAN cooperation and collaboration on aging society	
The 4 <sup>th</sup> meeting February 18, 2014	1.Final report on Japan's contribution to international Active Aging 2.Others	