

# Chapter 5

## Developing an Oral Care Checklist

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# Chapter 5

## Developing an Oral Care Checklist

Susiana Nugraha and Yuko O. Hirano

This chapter reports on the development of an oral care checklist for Indonesian older people. The list is based on the list developed by Prof. Higashijima, which was developed in Japan (Higashijima and Watanabe, 2018). We modified it into a version that is suitable for the realities in Indonesia, in accordance with the healthcare, long-term care (LTC), and living environment of older people in Indonesia.

The reasons why we chose oral care as the topic of this study amongst the various forms of LTC practices are the following. First, oral health is one of the most significant factors in maintaining physical, mental, and social health. Needless to say, without eating, we could not live, but we do not eat just for surviving. Eating brings us pleasure and joy. It also creates opportunities to maintain social networks through eating with others. Thus, oral care is one of the key forms of care work to support the activities of daily living (ADL) and quality of life (QOL) of older persons. Second, oral care practices require some of the highest levels of care skills to control the critical risks, such as aspiration pneumonia and asphyxiation. As Japan has a history of providing oral care by various specialists, such as doctors, nurses, physical therapists, occupational therapists, nutritionists, and *kaigo* workers (care workers in Japan), many skills and much experience performing oral care have been accumulated. Third, anatomically and physiologically, the structure and function of the human body is universal, and therefore we speculate that a universal model of oral care can be easily established and disseminated globally.

### 1. Importance of oral hygiene

As we become aged, we lose physical abilities. Such a decline in physical abilities can cause difficulties with selfcare and affect oral hygiene, resulting in a loss of dental and oral cleanliness and health. In general, poor oral health has a negative impact on the QOL, health, and even the dignity of older people. The treatment, management, and prevention of oral diseases in older people will improve not only the conditions of their mouths but also their overall health and well-being (Ide et al., 2006). A number of oral diseases can be caused by smoking or poor control of diabetes mellitus. In this sense, oral diseases are relevant to systemic diseases (Razak et al., 2014). Some studies suggest that oral health is significantly related to the development of cardiovascular disease, as oral diseases trigger the inflammatory pathway (Tonetti et al., 2013). Good oral health has a strong positive effect on the nutritional intake of older people (Soini, 2003), and diet plays a key role in maintaining health. Petersen et al. (2018) show that poor oral health can have a significant negative impact on the QOL of older people and their ability to carry out daily routines. A Japanese epidemiological study using longitudinal data targeting a large population of older people has

shown that deterioration in oral health (i.e. a decrease in the number of teeth or an increase in oral health problems) can increase the risk of depressive symptoms in older people (Yamamoto et al., 2017). All this supports the importance of oral health later in life.

## **2. Care work in Indonesia (observation)**

Before developing an oral care checklist for Indonesia, the authors of this chapter made observations on care facilities in Indonesia on 27 August 2018. We visited both government and private care facilities for older people. These facilities were deliberately selected by the Indonesian members of this study so that we could observe the different characteristics of care facilities for older people in terms of social status and the care practices provided in each facility, as described below.

### **2.1. Government-owned care facility**

Panti Sosial Tresna Werdha Budi Mula 1 is a public care facility (*panti werdha*) where 210 older people were accommodated when we visited. Most of the older people in the facility could not be taken care of by their families or relatives or afford to have private caregivers. Amongst the 210 older people, 40% needed total care, 40% were independent, and 20% needed partial care. The classification of the functional status of the elderly was determined based on the results of the assessment of the Activity Daily Living scores using the Barthel Index and the Instrumental Activity Daily Living scores using the Lawton Index. The facility has a clinic where eight nurses work as full-time staff, and doctors make visits once a month. They also have volunteers visiting the facility occasionally. They organise spiritual activities once a week, where the older persons gather according to their faiths, such as Muslims or Christians. We were able to observe this activity by chance at the time of our visit. The older persons who were independent (not dependent on the care provided) participated in these spiritual activities.

The *panti werdha* does not have dining rooms, so the older persons who are totally dependent on the provided care are fed on their beds, whilst the independent older people eat outside their rooms, either sitting on a chair or on the floor. Edentulous older persons also eat by themselves, if possible. We found some older persons who did not sit up in their beds during our stay.

As one of our impressions from our visit, it seems that singing activities contributed to maintaining their ADL, facilitated the development of social relationships, and uplifted them spiritually. The older persons looked happy when they were singing, and some of them danced while singing. These activities definitely contribute to promoting the well-being of the older people.

### **2.2. Private care facility**

Sasna Tresna Werdha Ria Pembangunan (RUSUN Lansia) is a private care facility founded in 1978 by the first lady of former president Soeharto as a welfare institution. It comprises care

facilities for older people, a midwifery school, and an orphanage. It is run by a foundation with five board members who work as volunteers and 46 staff, including 6 nurses, 3 social workers, 1 physical therapist, and (informal) caregivers. Currently, 68 older persons are living there, and most of them are from middle or upper-class backgrounds. The older persons can be accommodated in this *panti werdha* only if the will of the applicant (not the will of their family) to move to the facility is confirmed. The monthly payment of the older persons ranges from Rp800,000 to Rp6 million, including food. The monthly remuneration of nurses is Rp2.5 million, whilst caregivers receive Rp1.5 million. The turnover of staff is high. Although the study members could not observe feeding scenes at the time of our visit, we could see the older persons were actively involved with social activities like handicrafts or pleasantly talking to each other. We talked to a 94-year-old female older person. She maintained a high ADL, was totally independent, was able to speak English and some Japanese, and read a Dutch book. This indicated her high intellectual background. The *panti werdha* sells some of the craft products that the older persons make as part of their fund-raising activities.

### **3. Comparison between Japan and Indonesia in methods of care**

Observing the above-mentioned care facilities in Indonesia, the authors of this chapter noticed the following points in a comparison between Panti Sosial Tresna Werdha Budi Mula 1 and an intensive care home for the elderly in Aichi prefecture, Japan, which the research team visited on 4 March 2019.

In this section, we try to make a comparison of the feeding care practices in both facilities, but it should be noted that the backgrounds of the older persons are quite different, as the older persons at *panti werdha* in Indonesia are selected based on the necessity of social protection of the applicants. Japan's intensive care homes for the elderly select the older persons (at least officially) solely depending on the care needs of the applicants, which are assessed through a universally used care assessment questionnaire. The care facilities for older people in Japan must be equipped with dining rooms separated from bedrooms, in accordance with the ministerial ordinance No. 40 announced by the Ministry of Health, Labour and Welfare on 31 March 1999 (Ministry of Health, Labor and Welfare, 1999).

#### **3.1. Posture and position of caregivers**

The caregivers in Indonesia seem to have more manpower and time to care for older persons than in Japan. Unlike in Japan, the posture and position of caregivers when feeding the older people were not uniform in Indonesia. Some were sitting, whilst others were standing in front of the older persons when feeding them. The facility does not have a dining room, so feeding takes place in the bedrooms (Figure 5.1).

**Figure 5.1. Care Workers in Indonesia**



Source: Photo taken by the author.

**Figure 5.2. Kaigo Workers in Japan**



Source: Photo taken by the author.

In Japan, when *kaigo* workers assist older people in the dining room, they sit in a chair beside or diagonally to the older person at eye level whilst supporting them, so that the *kaigo* workers are able to observe older person carefully, to check they are swallowing foods appropriately. As Japan's care facilities have dining rooms separated from the bedrooms, *kaigo* workers attend to the older persons more intensively than in Indonesia's care facility. If the older persons are able to walk by themselves to go back and forth between the bedrooms and dining rooms, *kaigo* workers need to make sure that they do not fall. If there are older persons who are unable to walk by themselves, *kaigo* workers must convey the older persons using wheelchairs to the dining room before their meals. Because of this, the meal preparation period in Japan's care facilities is hectic due to the lack of manpower and time (Figure 5.2).

### 3.2. Meal preparation period: Waiting for the food to arrive until the food is served

The older people in Indonesia lie on their beds during the meal preparation period (Figure 5.3). At the facility, there were some wheelchairs that were not in use, although they would have been useful in maintaining the older persons' posture whilst eating. When one staff member feeds an older person, another staff member holds the older person's back to maintain good posture, as shown in the left-hand picture of Figure 5.1. This type of care requires double manpower.

In Japan, all older persons were sitting in either a standard wheelchair or reclining wheelchair whilst waiting for the meals to be served, in accordance to the level of Activities of Daily Living of the older persons. The 'PATAKARA Taiso', or oral exercise, was instructed by a *kaigo* worker. The 'PATAKARA Taiso' is a self-managed exercise to strengthen the function of the throat to smoothly convey the food into the oesophagus after chewing. To do this, one pronounces 'PA-TA-KA-RA' to train the muscles of the mouth and throat (Figure 5.4).

**Figure 5.3. Meal Preparation Period in Indonesia**



Source: Photo taken by the author.

**Figure 5.4. Meal Preparation Period in Japan**



Source: Photo taken by the author.

### **3.3. Variation in the form of food**

The form of food served in Indonesia was uniformly provided, and we observed that it was suitable for the potential swallowing functions and abilities of the individual older persons. We did not find any cases whose swallowing functions were below the ability that was necessary to swallow the food provided, so we would need to make further observations to find out how they feed older persons who are unable to eat the food provided at the care facility (Figure 5.5).

**Figure 5.5. Form of Food (Indonesia)**



Source: Photo taken by the author.

**Figure 5.6. Form of Food (Japan)**



Source: Photo taken by the author.

In Japan, a variety of forms of food were provided in accordance with the functions and abilities of the older persons, aimed at reducing the risk of aspiration and asphyxiation. In the care facility that we visited, not only the *kaigo* staff but the non-*kaigo* staff, such as human resource administrators, were also engaged in feeding the older persons, in accordance with the policy of the facility. On each tray, a tag with the name of the recipient was placed beside the food to indicate the swallowing functionality of the individual and the form of food. This system is designed to let every staff member know the information on the status of each older person, so that each staff member can provide appropriate care to the older persons (Figure 5.6).

### **3.4. Self-reliance whilst eating**

We noticed that in the *panti werdha* in Indonesia, caregivers seemed to simply assist the older persons in eating, without assessing the potentiality of the older persons. It also seemed that the caregivers in Indonesia did not have the enough knowledge that the residual functions of the older persons should be utilised and increased by making them exercise in order to maintain their QOL. Prof. Higashijima found that a female older person who was being assisted by a caregiver to eat was able to eat by herself when the spoon was given to her by the professor herself. The woman, whose cognitive function was unimpaired, took the spoon with her non-dominant hand, as her dominant hand was paralysed, and was able to feed herself. Observing this, Prof. Higashijima assumed that this case could become independent from assistance by the caregivers after a short period of training (Figure 5.7).

In Japan, observed a scene where foreign *kaigo* workers provided care in accordance with the level of QOL of the individual older persons. As shown in Figure 5.8, the *kaigo* worker let the older person hold a spoon and assisted her so as not to drop the spoon. This method may help the older persons retain their residual abilities (Figure 5.8).



**Figure 5.7. Self-reliance (Indonesia)**



Source: Photo taken by the author.

**Figure 5.8. Assisting Self-reliance (Japan)**



Source: Photo taken by the author.

#### **4. Modifying Higashijima's oral care list**

After the visits to the care facilities, a workshop was held in URINDO on 28 August 2018 aimed at having discussions amongst local experts and the research team members on the merits and demerits of oral care practices in Indonesia and Japan as well as the possibility and validity of adopting an oral care assessment instrument in care facilities for older persons in Indonesia. The purpose of modifying Higashijima's oral care list is to compare the Indonesian care providers in Indonesia (caregivers) and in Japan (*kaigo* workers) in terms of implementing oral care when they assist meals, so that we can compare the implementation of oral care for older persons in the two different care settings, Japan and Indonesia. The result of the comparative study of the two groups will be shown in the next section.

In the workshop, after watching the video taken at Panti Sosial Tresna Werdha Budi Mula 1 and discussing what could be found from the feeding scenes there, the participants tried to establish an oral care checklist using the oral care list developed by Prof. Higashijima (Higashijima and Watanabe, 2018) as the prototype for the discussion. Since Prof. Higashijima developed the list in the context of the Japanese care facilities for the purpose of providing ideal oral care and feeding support for caregivers in care facilities, it should be modified to be compatible with the care practices and conditions in Indonesia. Finally, the participants selected the most appropriate items to be put in the oral care checklist for Indonesia's version with some modifications, though Higashijima's original list has 92 items (Higashijima and Watanabe, 2018). Higashijima's modified oral care checklist (modified Higashijima-oral-care-list) and the results of the comparative survey are shown in Table 5.2.

#### **5. Comparative survey of oral care performance in Japan and Indonesia**

Taking the example of Indonesian care workers engaged in care work in Indonesia and Japan, we conducted a questionnaire survey to find out how the act of care differs from country to country. In this section, a statistical comparison between Indonesia and Japan will be shown on what kinds of oral care practices are provided to the older persons. The questionnaire was comprised of background information on the respondents and the modified Higashijima-oral-care-list. We asked if they could make observations and confirmations for each item of the list during their actual oral care practices in their workplaces. For each item, we computed the proportions of the respondents who replied that they surely practiced what is mentioned in the item, and we call this the 'performance rate'. We compared the two groups to find the differences in the oral care performed in both countries.

##### **5.1. Sampling of the study participants**

In Indonesia, nonprobability purposive sampling was performed to select the participants. In total, 215 care workers from 18 care facilities (7 government-owned facilities and 11 privately owned facilities) and four prefectures (Yogyakarta, West Java, DKI Jakarta, and Tangerang Banten) were enrolled in the study. Data collection was conducted from September 2018 to January 2019. A paper-based questionnaire asking about social-demographic characteristics and the modified Higashijima-oral-care-list was distributed and collected at the site. The

response rate was 100%. In Japan, a total of 418 Indonesian *kaigo* workers who worked in Japan at that time were called for participation in the study through SNS. An online survey was conducted, and 120 respondents answered the questionnaire. The response rate was 28.7%. The characteristics of the participants by country are shown in Table 5.1.

**Table 5.1. Characteristics of the Respondents**

Characteristic	Indonesian caregivers in Indonesia (n = 215)	Indonesian <i>kaigo</i> workers in Japan (n=120)
Age (SD)	35.2 (11.2)	27.9 (3.1)
Length of work by year (SD)	7.3 (6.8)	3.7(2.8)
<b>Gender (%)</b>		
Female	134 (62.3)	83 (69.1)
Male	79 (36.7)	37 (30.8)
<b>Academic background (%)</b>		
University/college/STIKES graduate	73 (34.3)	120 (100)
High school graduate	98 (46.0)	-
Secondary school graduate or lower	42 (19.7)	-
<b>Occupation at the care facility</b>		
Nurse	52 (24.2)	-
Caregiver	151 (70.2)	120 (100%)
Cadre	1 (0.5)	-
Others	11 (5.1)	-

STIKES = Sekolah Tinggi Ilmu Kesehatan (Polytechnic College for Healthcare Professionals).

Notes: All of the Indonesian *kaigo* workers in Japan had finished the nursing course. A cadre is a community health volunteer.

Source: Original data of the author.

## 5.2. Differences in oral care practices between the two countries

We scored the number of items for which the respondents replied, ‘Yes, I usually make an observation and confirmation of what is stated in this item.’ Table 5.2 shows the differences in the scores for each category provided by the modified Higashijima-oral-care-list between caregivers working in Indonesia and Indonesian *kaigo* workers in Japan.

**Table 5.2. Comparison of Oral Care Checklist Scores Between the Two Study Groups**

No	Observation item	Japan (n = 110)	Indonesia (n = 213)	P value
<b>I</b>	<b>ENVIRONMENTAL OBSERVATION</b>			
1	There is a separation between the dining room and the bedroom.	96%	55%	< 0.001
2	Adjustable dining tables or special chairs that can be used according to needs are available for personal use.	91%	47%	< 0.001
3	There are applicable utensils (e.g. spoons and chopsticks) that can be used in accordance with the impairment of the individual user.*	98%	-	
4	There are variations in the form of food (e.g., porridge cut into bite-size pieces and soft chopped food).	98%	64%	< 0.001
5	There is portable mucus suction.	77%	54%	< 0.001
6	There is a tool that can be used by care workers or patients to notify other care workers if there is an emergency (e.g., a bell).	89%	44%	< 0.001
7	The numbers of care workers and older adults are balanced when conducting meal supervision.	66%	52%	0.008
8	There is an allocation of one care worker for every older people who requires total care.**	28%	60%	< 0.001
9	The care workers understand the dietary needs of each older person.	78%	74%	0.257
	Total score	6.2 (SD:1.4)	4.5 (SD:1.9)	< 0.001
<b>II</b>	<b>OBSERVATION OF FUNCTIONS AND EATING CAPABILITIES</b>			
<b>A</b>	<b>Overall condition before eating</b>			
1	Older adult moves differently than usual.	72%	58%	0.009
2	Older adult is in a poor condition or has sleep deprivation.	42%	57%	0.006

3	Older adult has fever.	20%	50%	< 0.001
4	Older adult is in a state of coughing.	27%	43%	0.004
5	Older adult has different blood pressure (higher or lower) and pulse (bradycardia, tachycardia) than usual.	36%	49%	0.012
	Total score	2.0 (SD:1.4)	2.6 (SD:2.0)	0.021
<b>B</b>	<b>Meal preparation period: Waiting time for food to arrive until food is served</b>			
1	Older adult cannot sit in a stable position.	66%	54%	0.018
2	Older adult is not fully conscious.	39%	41%	0.428
3	Older adult appears calm.	40%	55%	0.008
	Total score	1.5 (SD:1.2)	1.5 (SD:1.2)	0.839
<b>C</b>	<b>Feeding period</b>			
1	The dining table cannot be set up in accordance with the bodily positions of the older adult.	82%	49%	< 0.001
2	There are difficulties when eating (e.g. cannot use a spoon for food or hold food).	79%	65%	0.007
3	There are problems in paying attention to food and the environment.	77%	55%	< 0.001
4	There is a problem when placing food into the mouth (e.g. handshakes or food falls).	72%	67%	0.207
5	There is a speed problem when placing food into the mouth.	72%	55%	0.003
6	There is a problem with the amount of food that is placed into the mouth.	68%	55%	0.014
7	Older adult cannot ask for help when having difficulties during the eating process.	55%	44%	0.035
8	Older adult refuses to be helped when eating (e.g. does not want to open their mouth or feed themselves).	63%	49%	0.014

	Total score	5.7 (SD:1.9)	4.4 (SD:2.9)	< 0.001
<b>D</b>	<b>Swallowing period</b>			
1	Older adult cannot take in food smoothly (e.g. lips cannot close, or food falls out of the mouth).	58%	54%	0.302
2	There are problems with chewing (e.g. lack of chewing, removing or leaving hard food, very fond of eating soft food only, or chewing for a long time).	70%	66%	0.287
3	Older adult cannot chew food into appropriate shapes and sizes to be swallowed.	59%	59%	0.520
4	Older adult hoards food in the mouth (e.g. stores food in the mouth but does not swallow).	65%	57%	0.083
5	There are problems with the process of swallowing food (e.g. cannot swallow food or takes time to swallow food).	71%	54%	0.002
6	There is a swallowing disorder (e.g. food cannot be channelled into the oesophagus).	48%	48%	0.535
7	There is a sound of fluid in the oesophagus.	43%	47%	0.300
8	Older adult is choking when eating.	59%	56%	0.362
9	Older adult does not exhibit coughing when choking.	39%	54%	0.009
10	Older adult takes a lot of time from start to finish when eating.	81%	60%	< 0.001
11	Older adult looks tired when eating.	48%	49%	0.503
12	Older adult looks weak when eating and cannot maintain proper posture (e.g. the body position is always slumped).	66%	53%	0.018
13	Older adult does not finish one portion of the provided food.	72%	55%	0.002
	Total score	7.8 (SD:3.7)	7.1 (SD:4.5)	0.216

E	Post-meal period			
1	Older adult does not brush teeth after meals.	41%	32%	0.070
2	There is shortness of breath after meals.	29%	45%	0.005
3	Older adult cannot use toothbrush.	66%	40%	< 0.001
4	There is leftover food after brushing teeth.	69%	40%	< 0.001
	Total score	2.1 (SD:1.3)	1.6 (SD:1.2)	<0.001

Source: Original data of the author

\*/\*\*: These items were omitted from the questionnaire for Indonesian care workers in Indonesia

The results indicate that Indonesian *kaigo* workers in Japan are more likely to perform environmental observations than Indonesian caregivers ( $p < 0.001$ ). They were more likely to check the items in the oral care lists during the feeding period and post-meal period ( $p < 0.001$ , respectively) than their counterparts.

On the other hand, Indonesian caregivers were more likely to check the overall condition (including physical and mental soundness) of the older persons before eating ( $p=0.021$ ) than Indonesian *kaigo* workers in Japan. We discussed what factors contributed to such differences and concluded that the following four points had affected the results.

First, Japan has the Long-Term Care Insurance Act, and almost all the care facilities in Japan are accredited by this insurance system, and the cost of their services are covered by the insurance under the conditions that they comply with the regulations of the insurance system. Accordingly, Indonesian *kaigo* workers at such care facilities are working under such regulations. For example, an Intensive Care Home for the Elderly must have dining rooms or must be equipped with apparatus or other instruments that meet the physical needs of the older people, in accordance with the regulations enforced by the ministerial ordinance (Ministry of Health, Labor and Welfare, 1999). This may result in Indonesian *kaigo* workers being more likely to answer that they check the environment of the care facility than their counterparts working in Indonesia.

Another point is that caregivers working in Indonesia seem to have more time to pay attention to the conditions of the older persons, probably because a higher number of care workers are assigned per each older person, especially for older persons who are totally dependent on care for their activities of daily living, in Indonesia. We suppose this factor contributed to the higher performance rates of caregivers in Indonesia for the items in category II-A (the items that should be checked before eating).

The third point is that these results may indicate differences in care providers' roles in the care facilities, which may be subject to the regulations of the LTC system in each country. In Japan, *kaigo* workers work together with other specialists, such as nurses, so the work in care

facilities is shared in accordance with occupation categories. Checking whether the older persons have a fever, suffer from coughing, or display other irregular conditions is the responsibility of nurses in Japan. Indonesian *kaigo* workers in Japan, therefore, are likely to focus on the job descriptions assigned to them, for example, managing the timing of bringing food to the mouths of the older persons. Such work sharing, however, sometimes leads the *kaigo* workers in Japan to pay less attention to the holistic approach for older persons. Treating the older persons through a holistic approach is a significant point of the care. In this context, Indonesian caregivers have an advantage over their counterparts in Japan.

Lastly, the researcher must consider that, in this study, the data were obtained through self-rated questionnaires that reflect the subjective view of each respondent, which may have caused data bias.

Further study is required to find out the factors contributing to such differences between the two countries, especially regarding the role of caregivers in Indonesia who engage in care work that may overlap with the role of nurses. In addition, we must keep in mind that the demarcation of assigned duties between nurses and caregivers in Indonesia is different from that in Japan. It is necessary to take this background into consideration for us to further modify the oral care lists to suit the culture of care in each country.

## **6. Conclusion and policy recommendation**

This study developed a modified oral care checklist based on the Japan-developed list that is suitable for use in Indonesia, and, using this checklist, compared care between Japan and Indonesia by examining the performance rates of each item included in the oral care list. Considering the concept of Japan's Long-Term Care Insurance Act, which was enacted aiming to maintain the dignity and independent daily life routines of people who need LTC (Ministry of Health, Labor and Welfare, n.d.), the researchers hypothesised, especially at the outset of this project, that *kaigo* workers in Japan are more likely to attend to every aspect of their work, with broader attention to the physical and mental conditions of the older people. However, the results did not fully support this hypothesis. Indonesian care workers in Indonesia attend even more broadly to the older people through a holistic approach, including checking their vital signs, than their counterparts in Japan.

From the perspective of medical sociology, the role of the medical profession emerges in accordance with the needs of the society. As mentioned in Chapter 1, the certification system of *kaigo* workers was established in Japan in response to the demand for professional caregivers in the course of rapid population ageing, which requires 'socialisation of care' (a shift from family caregivers to professional caregivers). In societies with 'socialisation of care', only fewer care personnel can provide care to each older person than the societies which still have family-care-system. In Indonesia, contrary to Japan, family members are the main caregivers for the older people, as Indonesia has not yet entered the era of socialisation of care.



Generally speaking, the role of the profession develops in accordance with social change, as does the division and specialisation of labour. The conceptualisation of care work can take place in line with such development of occupation categories. Japan developed the concept of care work earlier than Southeast Asian countries like Indonesia, and the Japanese government launched a policy to promote the transfer of LTC technology. However, in this context, Japan cannot be too careful in 'transferring' the concept of care, or care methodology, through a one-sided perspective because such a concept is supposed to emerge differently in countries with different social and cultural backgrounds. In this study, we just targeted in-facility caregivers, but we realise this method cannot fully detect the social change that will influence the conceptualisation of care work. If we have a chance to conduct further study, we will target not only in-facility care workers but also family caregivers.

Lastly, we would like to suggest that optimising the current environment (without introducing any new equipment) is important to improve the quality of care in Indonesia. For example, utilising wheelchairs during mealtimes as backrests is effective in keeping good posture for swallowing, which enables older persons to swallow properly. This small modification can even save manpower because it requires only one caregiver to support one older person who cannot eat by themselves, unlike in the care facility in Indonesia, where one caregiver took the food to the older person's mouth, and another kept their posture. Such small suggestions to optimise the current care conditions are important for the stakeholders of LTC to interact internationally with respect for the local care environment, so as to develop tools and training packages to strengthen the capacity of formal and informal caregivers.

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