

Features of the Japanese national dementia strategy in comparison with international dementia policies: How should a national dementia policy interact with the public health- and social-care systems?

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Abstract

Background: The Ministry of Health, Labour, and Welfare of the Japanese national government announced a “Five-Year Plan for Promotion of Measures Against Dementia (Orange Plan)” in September 2012. This article described features of the Japanese dementia strategy in comparison with international dementia policies.

Methods: An international comparative study was implemented on national dementia policies to seek suggestions for Japanese national strategy. The study consisted of a bibliographical survey, a field survey, and an online case vignette survey in several countries.

Results: The Japanese health- and social-care system had multiple access points in the dementia care pathway, as did Australia, France, South Korea, and the Netherlands. Contrary to Japan, a simplified access point was observed in Denmark, England, and Sweden. The Orange Plan aimed to establish specific health-care services, social-care services, and the coordination of agencies for persons with dementia. However, fragmentation remains in the dementia care pathway.

Conclusion: The national government should examine fundamental revisions in health, social-care services, and advocacy in joint initiatives with Alzheimer's Association Japan to improve the national dementia strategy.

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Keywords:

Australia; Dementia; Denmark; England; France; Japan; Public policy; South Korea; Sweden; The Netherlands

1. Introduction

Japan has experienced an unprecedented increase in the aging of its society, with the proportion of elderly persons reaching 23.3% of the total population in 2011 [1]. The elderly population rate is estimated to reach 33.4% in 2035 and 39.9% in 2060. In 2003, the Ministry of Health, Labour, and Welfare of the national government established a research committee and published the report “Long-Term Care for the Elderly in 2015”. The report estimated that the total number of persons with dementia was 1.49 million in 2002 and will reach 2.50 million in 2015 and 3.78 million in 2045. The revised estimation was released in August 2012 as 3.45 million in 2015 and 4.70 million in 2025 [2].

In 2008, the Ministry of Health, Labour, and Welfare launched the “Emergency Project for Improvement of Med-

ical Care and Quality of Life for People with Dementia” [3]. The report of this project, which was published in July 2008, stated that the public Long-Term Care Insurance (LTCI) system covered most persons with dementia but that a lack of early diagnosis and coordination between health-care services and social-care services caused some unsuccessful cases. Unsuccessful cases included individuals with earlier onset dementia who did not have access to care services and those with severe behavioral and psychological symptoms of dementia (BPSD) who were admitted to psychiatric beds because of unavailable community care support. The report suggested that an international comparative study was required to standardize dementia care in Japan. Therefore, the Institute for Health Economics and Policy implemented the international comparative study on national dementia policies to seek suggestions for Japanese national strategy during the 2-year period from April 2010 to March 2012. The study consisted of a bibliographical survey, a field

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survey, and an online case vignette survey in several countries. The main concerns addressed in the study were (1) the coordination between health- and social-care services, (2) the coordination in transition from home to residential care setting, and (3) specific professionals in dementia care.

After the study report, the Ministry of Health, Labour, and Welfare published a report entitled “Directions of Policies on Dementia” in June 2012 and announced a “Five-Year Plan for Promotion of Measures Against Dementia (Orange Plan)” in September 2012 [4]. The article presented here describes features of Japanese national dementia strategy in comparison with international dementia policies in Australia, Denmark, England, France, South Korea, Sweden, and the Netherlands.

2. Method

A previous study summarized five dementia strategies [5]. In addition to the primary goals of the study, we selected seven countries that have used a national dementia strategy since at least 2010 and in which public health- and social-care services are available for all elderly individuals. The bibliographical and field survey collected information on the (1) health-care system, (2) the social-care system for adults, (3) the first access point to care services for individuals with dementia and their families, (4) the coordination/care management/case management of dementia care, and (5) the secondary care for persons with BPSD in each country.

An online case vignette survey was distributed to social workers, public health nurses, or other professionals responsible for dementia care in each country. A total of 18 respondents were recruited from the participants of the field survey and from referrals by other respondents. The case vignette was developed based on unsuccessful cases in Japan and was reviewed by the professional panel, which consisted of psychiatric nurses, public health nurses, and social workers. The case vignette presented a series of three case stories about a hypothetical Mrs. Ivy, as given below. The participants were asked to describe a typical dementia care pathway in his/her community that Mrs. Ivy could utilize. The pathway consisted of (1) the first access point to dementia care for Mrs. Ivy, (2) health-care agencies that could perform a detailed diagnosis of dementia, (3) agencies that can coordinate health- and social-care services, (4) available support for Mrs. Ivy when she indicates BPSD, and (5) coordination of the transition from the home to a residential care setting.

Case story 1: Mrs. Ivy is an 85-year-old whose husband passed away 10 years ago. She now lives alone in the house. She lives away from her son (60 years old) and daughter (58 years old). It takes 3 hours by car to visit their mother. She has little relationship with her neighborhood. Recently, Mrs. Ivy's son phoned her, but she did not answer. He tried for several times, but no one answered, and he became anxious that his mother had an accident or became ill. Then, he called the city's town hall and asked a staff member to go and see his mother. As requested by the son, a staff member vis-

ited her house and rang a doorbell. Mrs. Ivy answered the bell, but she did not open the door.

Case story 2: The following day, the staff member visited Mrs. Ivy's house again. He told her that he had come because Mrs. Ivy's son had asked him to see her to find out if she was doing alright. Mrs. Ivy invited the staff member into her house. He found plastic containers of preprepared food left around; therefore, Mrs. Ivy seemed to be having meals each day, but she still appeared thin. While they were talking, she repeated the same thing and was getting confused with the date and time.

Case story 3: A half of a year later, Mrs. Ivy has a very short memory, and she leaves the water running or the stove on. She often shows difficult behaviors such as wandering and resistance to help with activities of daily living. She cannot express her preference for home or residential facility (and there is no planning in advance).

3. Results

The international comparative study figured multiple access points of the dementia care pathway in Japan as well as Australia, France, South Korea, and the Netherlands. Contrary to Japan, a simplified access point was described in Denmark, England, and Sweden (Appendix 1).

3.1. Australia

Australia's health-care system has general practitioners as the entry point for most people. Universal health care is provided by the federally funded Medicare scheme, which subsidizes payments for services provided by physicians and other health-service providers [6].

The social-care system for adults in Australia includes the Home and Community Care program, packaged community and residential care services under the Aged Care Act [6], and services under the National Disability Agreement [7]. The Home and Community Care program provides community care services for the aged and the disabled. Under the Aged Care Act, community care services include Community Aged Care Packages, Extended Aged Care at Home packages, and Extended Aged Care at Home–Dementia packages. In addition to the Aged Care packages, the National Respite for Carers program funds direct and indirect respite care options, offering respite care in a range of accommodation settings, including day centers and in-home respite services. Transitional Care packages provide short-term therapy and support to elderly persons after a hospital stay to enable them to return home. Residential Aged Care services provide accommodation and support for elderly persons who can no longer live at home. Aged Care packages require recipients to undergo assessment and certification of care needs by the Aged Care Assessment Team. Persons with disabilities or younger onset dementia can use Aged Care packages if there are no National Disability Agreement services available in the community. Because

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