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?

Miharu Nakanishi*, Taeko Nakashima
Institute for Health Economics and Policy, Minato-ku, Tokyo, Japan

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.

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 Medical 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 (LTCl) 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
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) the 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 visited 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
there are a wide range of social-care services in Australia, the Commonwealth Respite & Carelink centers are established to provide information on services that are available for elderly persons, persons with disabilities, and family caregivers [8].

The national dementia policy in Australia began in the 1990s with the National Action Plan for Dementia Care 1992–1997 [9] and the National Framework for Action on Dementia 2006–2010 [10]. Alzheimer’s Australia works in partnership with the Commonwealth government on the basis of evidence-based policy and delivers the National Dementia Support program. Under the national initiatives, the Dementia Behaviour Management Advisory Service was established to provide support and consultation services for persons with BPSD [11]. In August 2011, the productivity commission reported fragmentation in that case management is implemented within each care package but not within different care systems [8]. The Commonwealth government published the response to the productivity commission report in April 2012 [12]. The report stated that the government’s aged care reform will increase the amount of support, home care, and residential care; recognition of carers and those from culturally diverse backgrounds; support for those with dementia; and better access to information [12].

3.2. France

The health-care system in France has universal health insurance coverage with multiple health insurance programs [13]. General practitioners are the front-line health-care professionals in terms of their interactions with patients.

The social-care system for adults in France is based on benefits for community and residential care services. The social-care services for the aged are covered by the Personal Autonomy Benefit (Allocation Personnalisée d’Autonomie) [13]. The National Social and Medico-Social Evaluation Agency (Agence Nationale de l’Évaluation Sociale et Médico-Sociale) conducts needs assessment and determination of the level of care for Personal Autonomy Benefit applicants and manages the care plan of home-care services. The social-care services for the disabled are covered by the Disability Compensation Benefit (Prestation de Compensation du Handicap) [14]. Several measures have been developed to bridge the lack of coordination, including the Local Center for Information and Coordination (Centre Locaux d’Information et de Coordination) and the gerontology networks [13]. For family caregivers of persons with dementia, voluntary organizations such as France Alzheimer have been established to provide information and combat their isolation.

The National Alzheimer Disease Plan 2008–2012 was published in February 2008 [13]. The plan is divided into 6 objects and 44 measures, including the establishment of several agencies that will provide specific services for persons with dementia. The Resources and Research Memory Center (Centre Mémoire de Ressource et de Recherche) aims to implement research and provide training for professionals in areas such as early diagnosis of dementia. The memory consultation (consultations mémoire) provides consultation of persons with BPSD with other professionals. In addition, the Center for the Autonomy and Integration of Alzheimer’s Patients (Maison pour l’Autonomie et l’Intégration des Malades d’Alzheimer) and a case manager (coordonnateur) are established as a single access point that coordinates several services for persons with dementia. The Autonomy and Integration of Alzheimer’s Patients works in close collaboration with the Local Center for Information and Coordination and the Local Social Action Center (Centres Communaux d’Action Sociale).

3.3. South Korea

The health-care system in South Korea has a universal health insurance coverage with one health insurance program (National Health Insurance) [15]. Although healthcare providers are divided into three levels of care, there is no registration system of general practitioners.

The social-care system for adults in South Korea consists of the public long-term care insurance program for the aged [15] and tax-funded services for the disabled [16]. The National Health Insurance Corporation is the single insurer of the long-term care insurance program and is responsible for needs assessment and management of care plans.

The national dementia policy in South Korea was announced as “Dementia Comprehensive Management Measures (시대 종합관리 정책)” in September 2008 [17]. One of the primary measures in the policy was to provide early diagnosis of dementia through the establishment of public health centers (보건소), including dementia counseling centers. Furthermore, a comprehensive National Dementia Center (종합 치매센터) was established and replicated in regional hospitals (기초의료기관) to provide diagnosis of dementia, treatment, and consultation for BPSD. In July 2012, the Ministry of Health and Welfare published the second National Dementia Management Master Plan (국가지하관리 종합계획) 2013–2015 [18]. The second plan includes the following four initiatives: early detection and prevention, tailored treatment, infrastructure for the management of dementia, and family support and improvement of social recognition.

3.4. The Netherlands

The health-care system in the Netherlands has a single statutory insurance regime that covers all residents. The health insurance system consists of the following three components: basic medical care aiming to cure (Zorgverzekeringswet), major medical risks and care in the Exceptional Medical Expenses Act (Algemene Wet Bijzondere
Ziektekosten), and supplementary private insurance [19]. The Exceptional Medical Expenses Act covers health care for chronic disorders, long-term inpatient care, and some components of social-care services such as home care, outreach nursing, care for the disabled, and long-term mental health care. The Care Indication Determination Center (Centrum Indicatiestelling Zorg) conducts certification of care needs for the Exceptional Medical Expenses Act applicants. Insurers of basic medical care and the Exceptional Medical Expenses Act manage the care plans of the insured persons.

The social-care system in the Netherlands is based on the Social Support Act (Wet Maatschappelijke Ondersteuning) [19]. The city government (gemeente) is responsible for providing social supports for persons who have difficulty in daily life. Social home-care services such as household assistance and guidance have been transferred from the Exceptional Medical Expenses Act to the Social Support Act. The Exceptional Medical Expenses Act has a respite care scheme that pays for informal care by families, friends, or neighbors (mantelzorg). Wmo also provides financial support to informal caregivers.

The National Dementia Program (Lndelijk Dementie Programma) 2004–2008 was implemented to formulate improvement areas in health-care regions [20]. After this program, the Integrated Dementia Care (Ketenzorg Dementie) 2008–2010 was used to integrate various stakeholders, including dementia organizations such as Alzheimer Nederland, insurers, health- and social-care providers, and local governments [21]. Although the two national programs achieved coordination in dementia care, large disparities remained between regions in the level of accomplishment of integrated dementia care. Therefore, the Ministry of Health (Vilans) and Alzheimer Nederland developed the Standard of Dementia Care (Zorgstandaard Dementie) in May 2012 [22]. In some regions, the memory clinic (geheugenpolikliniek) provides diagnosis of dementia and the geriatric team (geratrische team) provides services for persons with BPSD. Both agencies can be covered by basic medical care or the Exceptional Medical Expenses Act. Furthermore, the national policy in the Netherlands is characterized by the development of dementia case managers who can work as health-care providers, social-care workers, public officers, elderly advisers (ouderenadviseur), or elderly consultants (consultatiebureaus ouderen) [23].

3.5. Denmark

The health-care system in Denmark sets the state government (region) as the principal health-care sector [24]. The state governments regulate primary and secondary care. Any person who has the right to public health-care benefits can choose between coverage in Group 1 or Group 2. Persons covered in Group 1 must register with a specific general practitioner and have the right to receive free health care from the general practitioner. Persons in Group 2 have the right, but not the duty, to register with a specific general practitioner of their choice. They must pay part of the cost of health care from a general practitioner. State governments and city governments have health agreements on discharge planning among elderly, preventive treatment, and rehabilitation [25].

The social-care system in Denmark is based on the tax-funded services for persons who require social care [26]. The city government (kommune) is responsible for the assessment of care needs and service provision. All dwellings for elderly are housings with service except the sheltered dwellings (beskyttede lobig) and nursing dwellings (plejehjem) that existed before the reform of dwellings for elderly (ældreboligreformen) in 1987. Since 2007, the Free Care Housing Act (friplejeboligloven) enables people to choose private housing with service in competition with the public sector. The private entities accounted for 0.5% of all residents in housings with service in 2011 [27]. Social workers in city governments typically coordinate health- and social-care services for clients. The Services Act (Serviceloven) also regulates use of force and interventions for persons with impairment in mental capacity. Interventions for persons with dementia include the use of a personal alarm system or special door opener, restraint to prevent injury, restraint during personal hygiene situations, forced isolation in the home, the provision of fabric straps to prevent falls, and involuntary admission to housing with service.

The national dementia policy in Denmark was published as “National Dementia Action Plan (National Handlingsplan for Demensindsatsen) 2010–2014” in December 2010 [28]. The national plan consists of seven measures, including diagnosis of dementia and social interventions. Along with the national plan, the Ministry of Social Affairs and Integration and the Danish Health and Medicines Authority reported “Mapping of Dementia in Denmark (Kortlægning af Demensområdet i Danmark) 2010” [26]. The mapping of dementia care revealed that some health-care agencies established multidisciplinary teams among geriatrics, neurology, and psychiatry that provided diagnosis of dementia and support for persons with BPSD. The name of the multidisciplinary team varies from area to area, such as “memory clinic” (hukommelsesklinik) and “dementia clinic” (demensklinik). In addition, most city governments had a dementia coordinator (demenskoordinator) or dementia consultant (demenskonsulent) to coordinate care for persons with dementia. Voluntary organizations such as Alzheimerforeningen and Ældre Sagen play a central role in providing advocacy and a respite for family caregivers.

3.6. England

The health-care system in England is characterized by the National Health Service, which provides free health-care services for all residents [29]. General practitioners and primary care trusts are responsible for managing local health-
care services. Intermediate-care services have been developed to help persons avoid unnecessary hospital admission and to speed recovery and rehabilitation.

The social-care system for adults in England provides the tax-funded services for the aged and disabled [29]. The city government (local authority) is responsible for the assessment and certification of applicants’ care needs. Service provision is typically commissioned to private entities. In 2010, the private entities accounted for 93% of all residence in care homes [30]. The social workers in city governments typically coordinate health- and social-care services for clients. The social-care services from local authorities are typically means-tested, with National Health Service continuing care and National Health Service-funded nursing care schemes in which the National Health Service pays a contribution toward care services [31]. National Health Service and local authorities are responsible for discharge planning for patients in line with the single assessment process [32]. The social-care system in England is also characterized by the Carers Strategy, which offers family caregivers services in considering their options and making informed choices about their lives.

The national dementia policy in England, “The National Dementia Strategy 2009–2014”, was published in February 2009 [33] independently from the strategy in Wales [34], Scotland [35], and Northern Ireland [36] in the United Kingdom. The development of the national strategy involved close cooperation between the Department of Health and the Alzheimer’s Society. The national policy in England describes 17 objectives and the dementia care pathway, which summarizes the themes of the National Dementia Strategy and the commissioning challenges. The memory clinic provides diagnosis of dementia to patients who are referred from the general practitioner, and the Community Mental Health team provides services for persons with BPSD [33]. The national dementia policy also addresses the dementia adviser, who facilitates easy access to appropriate care, support, and advice for persons with dementia and their caregivers. The national strategy has an implementation plan to evaluate and monitor the progress of implementation within areas. The outcome of the implementation plan was published in September 2010 [37].

3.7. Sweden

The health-care system in Sweden sets the state government (landsting) as the principal health-care sector [38]. Since January 2010, patients can choose any primary-care agency in the state governments [39]. The health center (vårdecentral) provides information on the primary-care resources that are available in the area.

The social-care system in Sweden is based on the tax-funded services for persons who require social care [38]. The city government (kommun) is responsible for the assessment of care needs and service provision. Since January 2009, the Act on System of Choice (Lagen om Valfrihetssyst-

3.8. Japan

The health-care system in Japan includes universal health insurance coverage with multiple health insurance programs [44]. There is no registration system of general practitioners; thus, insured persons can access any health-care provider (called “free access”). The Medical Center for Dementia was established in the Emergency Project to provide dementia diagnosis and support for persons with BPSD at home-care settings [3].

The social-care system for adults in Japan consists of the public LTCI program for the aged and tax-funded services for the disabled [44]. Although municipal governments manage the LTCI program as insurers, the provision of services is open to the private sector and health-care services. A care manager is assigned to a client to coordinate home- and community-based care services under the LTCI program. Care management is terminated when the client is admitted to a residential-care facility or health-care institution. Elderly persons who receive preventive services are covered by the Community General Support centers that provide comprehensive support for
community residents under the LTCI program [45]. LTCI services are available for persons with younger onset dementia; however, employment services are not covered. Thus, the disabled must access tax-funded services for the disabled on the basis of the Services and Supports for Persons with Disabilities Act [3].

The Ministry of Health, Labour, and Welfare published the Orange Plan, which planned to establish health care, social care, and advocacy services for persons with dementia during the 5-year period from 2013 to 2017 (Appendix 2). The Orange Plan is characterized by the establishment of the Initial-Phase Intensive Support Team in the Community General Support Center and by the presence of a dementia coordinator in local governments. The model of the Initial-Phase Intensive Support Team was derived by the Croydon Memory Service model in England [46]. The Initial-Phase Intensive Support Team conducts home visits and assessments and provides information and advice. In addition, the national policy plans to establish the definition of “persons with dementia who require psychiatric inpatient care” to prevent individuals with dementia who may not need psychiatric care from prolonged hospitalization in psychiatric beds. BPSD increases the difficulty of providing continuing home care and residential-care services, and some facilities reject admission because they are unable to care for persons with BPSD. Hence, psychiatric beds result in accommodations for persons with BPSD [47]. Japan has the highest number of psychiatric beds among Organisation for Economic Co-operation and Development countries, with 2.7 per 1000 population in 2010 [48], and most psychiatric beds are managed by private entities (92.4% in October 2011) [49].

4. Discussion

The dementia care pathways of several countries were summarized into a “referral” system from general practitioners or other primary-care providers to secondary-care services that provide diagnosis of dementia. In Japan, the first access point of the dementia care pathway is undetermined in primary health-care services because of the absence of general practitioners.

Some countries, such as Denmark, England, and Sweden, have local government personnel who coordinate health- and social-care services for dementia. The social-care system in these countries is managed by city governments, which sustain care coordination from home to residential-care settings. By contrast, the care system in Australia has been fragmented. The complicated social-care system requires a new care coordination agency such as the Autonomy and Integration of Alzheimer’s Patients in France and the dementia case manager in the Netherlands. The coordination of dementia care in Japan is still fragmented among the Initial-Phase Intensive Support Team, the dementia coordinator, and care managers. Community General Support centers are based on the LTCI program; thus, the Initial-Phase Intensive Support Team may have little capacity to provide information on the resources available for persons with younger onset dementia. Even if the Initial-Phase Intensive Support Team works well in the early stage of dementia, fragmentation can occur as the person is transferred from preventive care to home care, residential care, and inpatient care. Furthermore, Community General Support centers and city governments are not involved in discharge planning as local authorities are in Denmark [25], England [32], and Sweden [41].

Secondary services in several countries (except the multidisciplinary team in Denmark and the Medical Centers for Dementia in Japan) are typically divided into those that diagnose dementia and those that provide community support for persons with BPSD. The number of Medical Centers for Dementia will be increased to 500; however, this number is insufficient to cover all community residents with BPSD. Thus, the Japanese national initiative should explore a model that helps psychiatric service providers transfer patients from inpatient care to Community Mental Health services (with a functionality similar to the community mental health teams in England).

Finally, several countries have developed national dementia policies to support family members as well as individuals with dementia in joint initiatives with their Alzheimer’s associations. A Japanese strategy for family support and advocacy remains to be explored. There is no legislation on advanced directive/care planning in Japan. Although adult guardians have authority to contract the use of health-care services and LTCI services, they are not involved in the decision-making process for the arrangement of services. In dementia care, the final decision-making process typically relies on family members. Nonetheless, the social-care system in Japan does not have a support program for family caregivers, such as the respite care program in Australia, funding for mantelzorg in the Netherlands, and the Carer Strategy in England. The national government should examine fundamental revisions in health- and social-care services as well as advocacy in joint initiatives with Alzheimer’s Association Japan to improve the national dementia strategy.

It is important to note that the study presented here did not include the National Alzheimer’s Plan (as seen in the United States) or other recent national dementia policies. Future studies should more extensively investigate international models to improve national dementia policies around the world.

5. Conclusions

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. The article presented here described features of the Japanese dementia strategy in comparison with international dementia policies. The Japanese
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References


Appendix

Appendix 1 illustrates the care pathway and multidisciplinary team for a person with dementia in each country. A left square shows a dementia care pathway in which a person with dementia (blue circle) is transferred to health care (blue box), social care (red and green), and other agencies (purple) according to arrows. A right square shows a multidisciplinary team following a person with dementia from home (upper left) to residential-care settings (bottom right).

Appendix 1. Care pathway and multidisciplinary team for a person with dementia in Japan and seven other countries. LTCI, Long-Term Care Insurance; GP, general practitioner; HACC, Home and Community Care; CACP, Community Aged Care Package; EACH, Extended Aged Care at Home; EACH-D, Extended Aged Care at Home–Dementia; DBMAS, Dementia Behaviour Management Advisory Service; RAC, Residential Aged Care; PCH, Disability Compensation Benefit (Prestation de Compensation du Handicap); APA, Personal Autonomy Benefit (Allocation Personnalisée d’Autonomie); NHIC, National Health Insurance Cooperation; ZVW, basic medical care aiming to cure (Zorgverzekeringswet); AWBZ, Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten); Wmo, Social Support Act (Wet maatschappelijke ondersteuning); CMH, Community Mental Health.
Appendix 1. (Continued)
Appendix 1. (Continued)

Appendix 2 shows the seven measures and 21 objectives of the “Five-Year Plan for Promotion of Measures Against Dementia (Orange Plan)” in Japan.

Appendix 2
Summary of the “Five-Year Plan for Promotion of Measures Against Dementia (Orange Plan)” in Japan

<table>
<thead>
<tr>
<th>Measure</th>
<th>Objective</th>
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<tr>
<td>Standardized dementia care pathway</td>
<td>Establish a dementia care pathway at each municipality</td>
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| Early diagnosis and intervention       | Implement the pathway in the municipal Long-Term Care Insurance plan from 2015 to 2018
|                                        | Increase the number of physicians who serve as a family doctor of persons with dementia from 35,000 to 50,000                               |
|                                        | Increase the number of dementia support doctors who provide support and advice to family doctors from 2500 to 4000                           |
|                                        | Establish 500 memory clinics (including Medical Centers for Dementia)                                                                       |
|                                        | Develop a model of Initial-Phase Intensive Support Team in community general support centers under the Long-Term Care Insurance program        |
| Health-care services                   | Implement a Community Care Conference in all municipalities                                                                                |
|                                        | Establish a guideline for pharmaceutical therapy for dementia                                                                             |
|                                        | Develop a definition of “persons with dementia who require psychiatric inpatient care”                                                   |
|                                        | Establish a critical pathway for discharge planning                                                                                         |
| Long-term care services                | Enhance workforce of community-based services under the LTCI program                                                                       |
| Family support, peer support           | Increase the number of dementia coordinators to support persons with dementia in the community from 175 to 700                              |
|                                        | Increase the number of dementia supporters from 3,000,000 to 6,000,000                                                                         |
|                                        | Establish a system to train and support citizen guardians for adults in all municipal governments                                              |
|                                        | Increase the number of dementia cafes and other community resources available for families                                                  |
| Younger onset dementia                 | Develop a handbook of younger dementia resources                                                                                           |
|                                        | Assess care needs for younger onset dementia in state governments                                                                          |
| Health and long-term care workforce    | Develop a model of “Dementia Life Support (Dementia Care)”                                                                               |
|                                        | Increase the number of Dementia Care Practice Leaders (direct care workers under the LTCI) from 26,000 to 40,000                               |
|                                        | Increase the number of Dementia Care Advisers (directors of direct care workers under the LTCI) from 1600 to 2200                             |
|                                        | Provide training for 87,000 health-care workers in general (acute) hospitals                                                                    |