The Role of Home Nursing Visits in Supporting People Living with Dementia in Japan and Australia: Cross-National Learnings and Future System Reform

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INTRODUCTION

Japan and Australia are two Western Pacific countries with relatively high incomes, both tackling the challenge of aging populations, although Japan is more advanced than Australia in its aging profile. One of the greatest challenges in health systems reform for an aging population is...
supporting the increasing numbers of people living with dementia, an age-related neuropsychiatric condition of great concern from a public health perspective. The greatest risk factor for developing dementia is age: beyond the age of 65, the risk of developing dementia doubles every five years.\(^1\)\(^,\)\(^2\)

According to the World Health Organization, dementia is a neuropsychiatric condition, an umbrella term that includes Alzheimer’s disease and other dementias, Parkinson’s disease, multiple sclerosis, schizophrenia, and depressive disorders, among others.\(^3\) Dementia can be caused by a number of diseases, with common symptoms including degeneration in cognition significantly greater than would be expected from normal aging, loss of executive cognitive functioning, and loss of the ability to remember, learn, make decisions, and solve problems.\(^4\) Personality changes and behavioral or psychological symptoms can also be experienced. People with dementia may lose the ability to conduct activities of daily living such as shopping, driving, showering, dressing, and going to the bathroom independently, and many people with dementia eventually require 24-hour care. The disease is terminal, although this fact is often not understood by family carers.\(^5\)

Because of the debilitating and degenerative nature of dementia, public health costs are high. One comparison showed similar disease burden for dementia and all tropical diseases for the Pacific region.\(^3\) The estimated medical cost for dementia in 2014 in Japan was 1,911 billion yen (inpatient care 970 billion yen, outpatient care 941 billion yen). The estimated social services cost was 6,444 billion yen (home care of 3,528 billion yen, facility care of 2,916 billion yen), and estimated informal care cost was 6,158 billion yen.\(^6\) The cost of dementia care is therefore a substantial health investment. This article discusses how home nursing is contributing to the support of people with dementia in the two countries. Though Japan and Australia have in common their aging populations and relatively high incomes for the region, the cultural, historical, and societal contexts are unique to each country. Attitudes regarding family, the role of older people in society, and even stigma regarding mental health are different in the two countries,\(^7\)\(^-\)\(^9\) yet at the individual level, the health needs of people living with dementia are to some extent universal.

### Demographic Change in Japan

Japan is leading the world in population aging. Current estimates indicate that the total population is approximately 127 million, with over a quarter being older adults. The changing demographic profile shows that in 2000 the population over 65 was 17.4% of the total population\(^10\); in 2016, that had risen to 27.2% of the total population.\(^11\) Consequently, the number of people living with dementia has also increased. A systematic review of dementia prevalence in Japan indicated that estimates range from 2.9% (3.6 million) to 12.5% (15.9 million).\(^12\) According to the Alzheimer’s Association in Japan, more than 4.6 million people are living with dementia in Japan.\(^13\) As in other countries, the health care system and policy for elderly people care is shifting from institutional care to home care, and community support services increasingly address the needs of people with dementia and their families. Consequently, home nursing and Japanese visiting nurse service stations (VNSS) are taking an increasing role in the health system supporting older people.

### Development of Nursing Services for People With Dementia in the Community and Their Carers in Japan

The system for regulation and financing of community services in Japan has developed during the 21st century.\(^14\) As discussed by Murashima et al.,\(^14\) informal care systems for older people developed in the late 1980s, and in 2000, the Japanese government implemented long-term care insurance (LTCI) as a public social care system to formalize this development. People over the age of 65 who applied to their municipal office and received a certification of care need receive home care services, facility services, and community-oriented services. A care manager is assigned to each client for planning and coordination of care services according to the care need levels (support care levels 1 and 2 and long-term care need levels 1 to 5). Home visit nursing is one of the home-based care services that provides medical assessment and care. Home visit nursing started voluntarily in Japan around the late 1970s to meet the needs of disabled and older people. As a result of these efforts, home visit nursing came to be reimbursed with public health insurance. After LTCI was implemented, home visit nursing became one of the home-based services available, in addition to home help services (home visit care), home visit bathing services, and home visit rehabilitation. This change from a volunteer service to a publicly reimbursable service came about largely due to the change in public health insurance. Today home visit nursing is provided both under the LTCI system and the health insurance system. The number of VNSS was only 277 in 1983, but the number increased to 3,570 by 1999 and further increased to 9,070 in 2016.\(^15\) Social services for the elderly are financed under a public LTCI system that commenced as government policy in 2000.
The long-term care system reinforces the importance of home care rather than residential care in order to reduce medical costs.\textsuperscript{14} The care need level of clients as assessed by municipalities determines the maximum amount and the range of the services they can receive. The services consist of home care services, facility care services, and community-oriented services. Though care managers take responsibility in care planning and coordinating, services are not packaged and not dementia specific, and each service might be provided by different providers. Home visit nursing is one of the home-care services together with home-help service, home-visit bathing service, home-visit rehabilitation, and short-stay service. Home visit nursing requires a primary doctor’s referral and the nurses report to the doctor monthly.

Community services for people with dementia in Japan have also benefited from a national strategy for the development of dementia services. In 2012, a national Japanese dementia strategy (Orange Plan) was announced and further replaced by a New Orange Plan in 2015, which aims to promote that people with dementia continue to live in their own home with ease. This is a five-year plan for promotion of (1) a standardized dementia care pathway, (2) early diagnosis and intervention, (3) medical services, (4) long-term care services, (5) family support, (6) early onset dementia, and (7) a care workforce. The government set numerical goals to achieve each measure, such as introduction of a number of dementia support doctors to assist general physicians. The New Orange Plan was presented to accelerate the dementia strategy and promote coordination with other ministries.

This change in policy has been partly driven by societal expectations about remaining at home for as long as possible. Though a public opinion survey showed that 43.7\% of the people want to live at home even after being diagnosed with dementia, 74.9\% worried about the burden on their family carer.\textsuperscript{16} In this public opinion survey, 13.4\% reported that they would like to live in their home community independently, and 30.3\% wanted to stay in their community utilizing available services. A further 27.5\% preferred to stay in facilities because they did not want to place burden on their family; 20.1\% preferred to stay in facilities because they thought they might not be able to take care of themselves and needed much support. Only 4.6\% reported that they want to stay alone.

Because many researchers have shown the burden on family caregivers for people with dementia,\textsuperscript{17} there is a great need from family care in social services, including home visit nursing. The Orange Plan finances municipalities to establish initial-phase intensive support teams, dementia coordinators, and several training courses for care providers. These attempts aim to implement integrated care for people with dementia and to promote the efficacy and sustainability of service provision to people with dementia.

**Demographic Change in Australia**

Australia has only one-sixth the population of Japan—an estimated 23 million—and the number of people living with dementia is 342,000. In Australia, there has also been a significant policy shift from institutionalized care or residential aged care facilities to provision of home-based nursing and community care services over the past decade.\textsuperscript{18,19} Community care services are delivered through a wide variety of programs that provide assistance to older people (aged 65 years and over), the largest being a state-based home and community care (HACC) program.

The Australian HACC program endeavored to enable individuals who were frail or having difficulty completing activities of daily living to remain in their own home, safely and independently, for as long as possible\textsuperscript{20} through the provision of a range of home-based services including health-related care, assistance with meals and personal care, transport, social services, and respite care. Services are allocated after an initial assessment and generally delivered by HACC-accredited organizations mandated to provide the government with quarterly reports about their service delivery.\textsuperscript{21}

Recent changes to funding structures in 2016 have led to the state-based HACC program becoming a federal government initiative delivered under the Commonwealth Home Support Program (CHSP).\textsuperscript{20} Other support services, such as the National Respite for Carers Programme, day therapy centres, and assistance with care and housing for the aged have recently been consolidated and are also now delivered under the CHSP program.

In addition to the CHSP program, the Commonwealth provides home care packages for those who are in need of more complex levels of care. This includes older people who need coordinated services to help them stay in their home or younger people with a disability or dementia or other special care needs that are not met through other specialist services.\textsuperscript{22} Types of services that can be accessed under a home care package include personal services, such as bathing, showering, toileting, dressing, and undressing; mobility and communication; nutrition, hydration, meal preparation, and diet; mobility and dexterity; transport; nursing and allied health and other clinical services; continence management; and management of skin integrity. Home care packages can also be used to support the use of telehealth, assistive
technology, and aids and equipment. In order to provide care and services that meet the needs of consumers, all home care packages must be provided on a consumer-directed care basis (providing clients with greater control over the care they want to receive) that aims to enable them to live more active and independent lives.22

An Australian Dementia Strategy has also been initiated by the Australian federal government.23 Australia now has a Dementia Action Plan and a Dementia Health Priority Initiative, the latter providing funding of over 239 million USD over a five-year period to increase dementia services across the country. The federal policy for dementia services, education, and training is also linked to state dementia strategies and a national framework for action on dementia.24 Together these policy frameworks direct service development focused on maintaining people with dementia in their own homes supported by government health and social care services.

**Development of Services for People Living With Dementia in Australia**

In 2011, the Dementia Services Pathways Project was conducted to inform government service planning that would assist organizations to improve dementia services along the continuum of care for people living with dementia and their carers.25 The development of the service pathways considered populations with specific requirements such as Aboriginal and Torres Strait Islander populations, people from culturally and linguistically diverse communities, those with early onset dementia, and those living alone.

Four stages of dementia management were identified:

- Awareness, recognition and referral.
- Initial assessment and diagnosis, and postdiagnosis support.
- Management, care, support, and review.
- End of life.

Service pathways provide steps, activities, and roles of health professionals, general practitioners, and care workers to guide best practice care.

The National Framework for Action on Dementia 2015–2019 was developed under the auspices of the Australian Health Ministers Advisory Council following an extensive national consultation process involving people with dementia, their carers, families, peak bodies that represent them, clinicians, and service providers. The aim of the framework is to build on the 2006–2010 framework by further improving the quality of life for those living with dementia and their carers.26

Home and community services in Australia have been criticized, however, for being fragmented, leading to poor outcomes and a waste of resources27,28 and compromising coordination of care due to different providers offering multiple services to older persons. In response to this lack of coordination, a case manager/coordinator role was introduced to oversee the process of assessment, planning facilitation, and advocacy, with the intent of meeting individuals’ health needs and promotion of cost-effective outcomes.29

Though there is some evidence for the efficacy of case management in regard to improving client outcomes and reducing health care utilization, criticism remains in regard to coordination of care, because case managers do not always have autonomy over supply or availability of services.30 Consequently, there has been a promotion of integrated care to improve connectivity, alignment, and collaboration between and within funding and administrative sectors and health services.29 More recently, consumers have also advocated for the introduction of consumer-directed care—the ability to make choices regarding the care they and their caregivers receive.29

Australian nursing services for people living with dementia complement primary health care. Nurses interact with and refer to general practitioners in regard to client needs. Providing nursing care at home reduces length of hospital stay/transition to home programs, lessens the need for hospitalizations, reduces carer strain, and delays permanent placement in residential aged care home.29

Despite the policy change toward increasing support for people with dementia to remain in their own homes for as long as possible, there have been no studies on the extent to which home nursing visits are supporting people with dementia in Japan or Australia. Previous work by the authors14 analyzed the VNSS data in Japan and found that half of VNSS patients suffered from dementia as a primary or secondary diagnosis, but no further information has been available since that survey was conducted 19 years ago. This article is a first attempt to address this question. We provide some preliminary data on home visits for people with dementia as a primary diagnosis in the community in Japan and Australia and open the discussion on further system reform by comparing preliminary cross-national learnings from our analysis of the two systems.

**METHODS**

**Study 1 (Japan)**

In Japan, we conducted an annual survey on VNSS and checked the number of people with dementia as a primary...
diagnosis and collected data on presenting conditions on 2012. Subjects were the 3,856 member stations of the National Association for Home Visit Nursing Care, which is a general incorporated association established to promote home visiting nurse services and provide the support and network for the member stations. We sent a questionnaire via fax asking about the number of clients with or without dementia, and those who consented to join the study returned the questionnaire by mail.

**Study 2 (Japan)**

The 475 VNNS who answered that they have clients with dementia in study 1 were then asked to complete a questionnaire regarding the clinical and sociodemographic status of one or two of their typical clients with dementia—a convenience sample to provide a snapshot of the type of care offered. Variables to describe the sample included gender, age, diagnosis, marital status, living status, use of other social welfare services, frequency and length of home visit nursing services, telephone consultation, and the type of care provided by home visit nurses.

**Study 3 (Australia)**

Home visit or HACC services in Australia are provided by a number of organizations, including the Royal District Nursing Service (RDNS). Though anecdotal evidence from visiting nurses has suggested that more than half of the services provided are to clients with either cognitive impairment, short-term memory loss, Alzheimer’s disease, or dementia, many clients do not have a formal diagnosis or are not being treated for one of these conditions, therefore, this information is not routinely collected. To obtain insight into client profiles, services being provided, and whether these had changed over a seven-year period, RDNS undertook a retrospective secondary data analysis of routinely collected client records of two HACC-funded cohorts of RDNS clients, located in Melbourne, Victoria, Australia, who received health-related services in 2006 and in 2012. We identified client demographics, the number of hours of care provided to people with dementia and the most common forms of health-related support provided to clients, including those with dementia.

**RESULTS**

**Study 1 (Japan)**

Among 3,856 stations that were members of the National Association for Home Visit Nursing Care, 1,125 stations agreed to participate in the study and answered the questionnaire (response rate was 29.2%). Out of 1,125 stations, 753 stations (69.6%) had clients with dementia as a primary diagnosis. The average number of clients was 72.9 (SD = 48.6); of these, the average number of clients with dementia was 6.2 (SD = 7.0, n = 753) per station. It was noted that there is no caseload limit and no specific catchment area for each VNNS. VNNS provide home visit nursing services not only for patients with dementia but also for other older people and people with physical or mental disorders. There are also regional disparities in availability of services.

**Study 2 (Japan)**

For the second study, data from 187 clients with dementia were collected. Of these clients, 46 (24.6%) were male and 133 (71.1%) were female. A total of 133 (71.7%) lived with their family or another person and 43 (23.0%) lived alone. A total of 133 (71.7%) lived with their family or another person.

| Gender       | N   | %   |
|--------------|-----|-----|
| Male         | 46  | 24.6|
| Female       | 133 | 71.1|

| Age          | N   | %   |
|--------------|-----|-----|
| Under 60     | 2   | 1.1 |
| 60s          | 8   | 4.3 |
| 70s          | 44  | 23.5|
| Over 80      | 118 | 63.1|
| Missing      | 15  | 8.0 |

| Diagnosis    | N   | %   |
|--------------|-----|-----|
| Alzheimer-type dementia | 104 | 55.6|
| Vascular dementia       | 33  | 17.6|

| Living status | N   | %   |
|---------------|-----|-----|
| Living alone  | 43  | 23.0|
| Living with family or another person | 134 | 71.7 |

| Marital status      | N   | %   |
|---------------------|-----|-----|
| Married             | 88  | 47.1|
| Not married         | 11  | 5.9 |
| Bereaved or separated | 77  | 41.2|

| Other services uses | N   | %   |
|---------------------|-----|-----|
| Day services        | 80  | 42.8|
| Home help services  | 63  | 33.7|
| Respite services    | 16  | 8.6 |
| Home visit bathing care | 14 | 7.5 |
| Home visit rehabilitation | 7 | 3.7 |
| Other visiting nurse services | 3 | 1.6 |
| Home visit individual living support | 1 | 0.5 |

| Length of care/visit | N   | %   |
|----------------------|-----|-----|
| Under 30 minutes     | 181 | 22.1|
| 30–60 minutes        | 534 | 65.2|
| Over 60 minutes      | 104 | 12.7|

**TABLE 1.** Demographic and Clinical Status of Clients with Dementia (n = 187) in Japan
lived alone. A total of 88 (47.1%) were married, 11 (5.9%) were not married, and 77 (41.2%) were bereaved or separated. Eighty (42.8%) clients used day care services and 63 (33.7%) used home help services in addition to the home visiting nurse services. The average frequency of home visit nursing was 5.5 times per month and the most frequent period of stay was 30–60 minutes per visit. A total of 13.4% of relatives received a telephone consultation on average 2.0 times per month from home visit nurses. The average duration of telephone consultation was 22.6 minutes (see Table 1).

The type of care provided to dementia clients during the latest home visit is shown in Figure 1. The most frequently provided care (63.1%) was communication, which included “supportive listening,” “promoting the verbal communication of the clients,” “reminiscence therapy approach,” and “keeping their mental status stable through a conversation.” A total of 56.7% of clients received support to “secure the clients’ safety and comfort,” which included “arranging living environment for fall prevention/accident prevention” and “monitoring.” Nursing care including the categories of “respecting client decisions,” “assessment of physical, cognitive, and mental status,” “constructing a care and support network,” “enhancing the family’s capacity,” and “explaining about the clinical state of dementia” were also provided for around 40% of clients.

Among 187 clients, home visit nurses provided family care to 42.2%. We categorized the free descriptions about family care into nine categories:

1. Monitoring and supporting families who are experiencing burdens and difficulties in caring.
2. Managing and consulting with families about utilizing other welfare services to reduce their burden.
3. Explaining and giving advice to families regarding physical care for the patients.
4. Providing physical care and psychological support to family members.
5. Providing care for mental health problems among family members.
6. Mediating between clients and family members.
7. Managing the relationship between clients and family members.
8. Providing consultation for family regarding other welfare services.
9. Providing terminal care for family members.

Study 3 (Australia)
Like VNSS, the RDNS provides nursing care to older people living in the community, many of whom have dementia. Medicine management may be provided to clients with dementia to assist them in staying at home, and some clients receiving other nursing services such as wound care may have dementia. The Clinical Holistic Assessment Tool (CHAT) is used to assess clients’ needs and care goals on admission to the service and then on an as-needed basis. Cognitive status screening tools may also be used as part of this assessment.
If nurses have concerns regarding client assessments, they refer/interact with the client’s doctor.

In total, 28,940 client records in 2006 and 26,308 in 2012 were included in our analysis. Though there were no statistically significant differences observed in the two cohorts in regard to gender and country of birth, in the seven years between 2006 and 2012, the median age of HACC consumers increased significantly by two years (median age 77 versus 79 years, Mann-Whitney U test, $p < 0.001$; see Table 2).

The median hours of care, per episode of care, provided to clients increased significantly between 2006 and 2012 (median 8.95 versus 9.20 hours, Mann-Whitney U test, $p < 0.001$). Like Japan, it was noted that there were no set limits on caseloads. Currently, four sites operate with multiple local area teams (LATs) of approximately seven nurses with 200 clients per LAT. The number of LATs differs between the sites and the number of clients fluctuates, scaled up as required, depending on package availability and health system constraints (see Table 3).

Mental disorders including dementia and dementia-related diseases have been increasing in prevalence since 2006 and received the highest median number of hours of care per episode of care in both 2006 and 2012. Unadjusted for the increase in hours of care provided in 2012, changes were evident in the median hours of care provided to consumers in relation to their primary disease diagnosis as classified by *International Classification of Diseases*, version 9, coding. 32

Consumers with a diagnosis of dementia received the highest median hours of care per episode of care in both 2006 (21.73 hours) and 2012 (22.06 hours). The most common forms of health-related care provided to HACC clients, including those with dementia, in both 2006 and 2012, included skin care (ulcers, cellulitis, and pressure sores), incontinence, and wound care. The average length of time for each visit was 31 minutes (visits for medicine management usually lasted 25 minutes, wound care visits lasted 45 minutes, and catheterization visits lasted 50 minutes). Though the demand for skin care decreased from 16.5% in 2006 to 14.6% in 2012, the demand for assistance with both incontinence and wound care increased between 2006 and 2012 (continence 13.4% versus 16.8% and wounds 10.6% versus 13.3%). Other services provided during this same period included neoplasms, diabetes management, heart disease, and renal failure. In 2012, one third of client visits (8,226) needed either medicine management (6,305) or personal care (1,921).

Currently, over four million home and community care visits are being provided to 112,000 RDNS clients, including some under the Commonwealth Home Care Packages initiative (470 packages consisting of 217 at level 1 and level 2 [basic/low-level needs]; 166 at level 3 [intermediate care needs]; and 87 at level 4 [high-level care needs]).

**DISCUSSION**

Cross-national comparisons of dementia care in Europe have found that specialized services for people living...
with dementia and their carers are sparse; instead, clients usually receive care on a general, basic level.\textsuperscript{33} We found here that within generalist services there is still room for tailored, person-centered care for people with dementia. In line with population aging, we found that in the Australian data sample, the proportion of older clients (over age 80) increased with time. In comparing these two higher income countries, one cross-national learning that was evident was that both systems would benefit from better recording systems to understand what is being provided for clients with dementia. The Japanese system does not incorporate specific assessment tools for clients with dementia, whereas the Australian system has introduced specific tools as part of the dementia model of care implemented by the general district nursing service. On the other hand, Japan has introduced dementia support doctors whose primary function is to support generalist doctors in the medical care of people with dementia,\textsuperscript{34} whereas in Australia, access to psychogeriatric care support is still sparse. Dementia support doctors in Japan have been promoted through the Orange Plan, and the service has been encouraged to help primary doctors in assessment, diagnosis, and treatment of dementia. In Australia, the dementia strategy continues to evolve, and recent developments have centralized advice regarding behavioral and psychological symptoms of dementia for family carers into a telephone support service (Dementia Support Australia). In both countries, the services are led by allied health professionals, though in Japan, whereas LTCI services such as home help services, home visit rehabilitation, and home visit bathing services are mostly led by allied health professionals, home visit nursing is a medical, nurse-led service and mainly provides medical assessment and care.

Tools to understand the role of family carers may be beneficial for VNSS to introduce, because research has shown that family carer stress is high and a predictor of institutionalization for the person with dementia. In Australia’s RDNS, a family carer stress assessment is undertaken as part of the dementia model of care. The introduction of more telehealth services in both countries may go some way toward better supporting family carers.\textsuperscript{35} The Australian system may benefit from learning more about Japan’s emphasis on communication with clients.

**Future Directions for System Reform**

The lessons learned from the comparisons are necessarily preliminary, and further analysis is required once more in-depth data are available. Despite health care services’ increasing awareness of the needs of people with dementia, there are still delays in gaining a diagnosis of dementia and access to appropriate health care services. This delay can potentiate the risk for misdiagnosis, inappropriate management, poor psychological adjustment, and a reduced coping capacity and ability to plan for the future.\textsuperscript{36} To address this unmet need and gap in services, the RDNS implemented the role of the specialist clinical nurse consultant (CNC). The purpose of the CNC role is to address the issues of timely diagnosis for the client and accommodate carer support and to support generalist nurses in providing holistic and person-centered services for older people and their families experiencing memory loss and/or dementia. The CNC is able to undertake a comprehensive assessment of elderly individuals using processes and tools from the RDNS’s dementia model of care.\textsuperscript{36} This information is then shared with the client’s local doctor and geriatrician to assist in making a diagnosis. The CNC also assists RDNS staff to provide support to older persons and their family members through the promotion of coping capacity, facilitation of advanced care planning, and navigating access to in-home services and support programs.\textsuperscript{35}

Additionally, the recent changes to the community health service funding structures and the requirement for health service providers to deliver consumer-directed care that enables a more active and independent life has led to the development of a more senior clinician role, that of a senior clinical nurse advisor (SCNA) for aged care and dementia. The SCNA requires extensive experience in speciality areas, internal and external to RDNS, and must be able to foster change and influence best practice, evidence-based care delivery within the RDNS and externally through policies; models of care; peak bodies, locally and nationally; and relevant guidelines. The SCNA also provides support to CNCs by facilitating discussions regarding best practice, changes in practice ideas, and appropriate professional development. Additionally, to further address client and staff needs, the RDNS has extended the number of CNCs and SCNAS with high-level expertise in aged care and dementia.

This increasing specialization of staff to support clients with dementia is likely to expand in the future in both countries. In Japan, the Dementia Strategy will promote the development of medical centers for dementia, dementia workshops for service providers, and intensive early support teams.\textsuperscript{37} Some academic groups, municipalities, and hospitals are also providing education workshops for service providers and caregivers. The Japanese system may benefit from introducing the specialist dementia CNC role that has been introduced in Australia. The RDNS has implemented the
specialist dementia CNC role permanently across its four site locations to support consumers experiencing memory loss, cognitive impairment, and/or dementia (pre or post a diagnosis); carers/family members; and staff providing health care to this population.

The analysis provided here was limited by the lack of data available in both countries regarding staffing and training required to support clients with dementia.

Both countries are continuing to refine assessment processes for people with dementia. The RDNS uses CHAT. As a Victorian Department of Health–funded HACC provider, the RDNS is required to undertake living at home assessments. The CHAT tool, developed to meet the requirements of a living at home assessment under the HACC program, applies an active service model approach to assessment and care planning, with a greater focus on identification of client strengths and capacities and person-centered goals. CHAT is an electronic tool that is completed by RDNS nurses on admission to the service and then on an as-needed basis if the client’s situation changes. In Japan, as noted by Murashima et al., the role of the home visiting nurse is more practical than assessment focused, although this emphasis is shifting as the availability of certified care workers is increasing and it becomes clear that financing of nurse visits is more expensive than visits by less trained care workers.

Under the LTCI system, the level of care needs of clients are assessed with formalized assessment index and a primary doctor’s opinion. For those with dementia, the level of activities of daily living is also evaluated. However, these assessments are mainly used to determine the amount and range of services the client can receive.

Though care plans are shared among service providers, there is no formalized and specialized assessment tool for dementia to be shared across service providers. Because services are not packaged and each service might be provided by a different provider, assessment and service records are fragmented.

In Australia, service providers have a common mapping sheet and share the assessment and service process among a multidisciplinary team. To enhance the provision of integrated care in Japan, there are needs to establish a recording system and assessment tools that several service providers can share.

In the future, further integration of home visit information with hospital systems will be more efficient than duplication of information. In Japan, home visiting may be more integrated with hospital systems than in Australia because of its origins in medical insurance. Home visits in Japan require a physician’s referral, and nurses report to the family’s physician. In this way, the Japanese recording system is integrated with patient medical records. Visiting nurses share patient information about medical conditions and medication. On the other hand, medical records are not completely open to the Japanese community care team. Members working outside the hospital should share the information another way. Care managers are often writing care records in parallel. Care processes for people living with dementia and their families should be shared by all members of the team. A centralized care planning system such as that used in some groups of residential care facilities in Australia could be of benefit for community care services in Japan.

Consumers with a diagnosis of dementia in both countries are living with minor and major physical problems. Consumers who are taking medication for behavioral and psychological symptoms of dementia require specific assessment to prevent stroke by careful monitoring of medication. Nurses need knowledge of both medication and physical conditions to best support these clients. Sometimes family members are eager to give a higher dosage than prescribed due to anxiety about behavioral or psychological symptoms. Nurses in Japan hear family members’ feelings of anxiety and advise them about appropriate medication use. Incorporation of this advice together with information about modifiable risk factors provided by home visit nurses—for example, about diabetes, heart disease, physical activity, and smoking—will continue to expand the complexity and depth of services being provided by nurses to clients in both countries. Finally, further research on the relative cost of services for people with dementia relative to other categories of health spending would help to inform future policy changes in delivery of services for this vulnerable group. How these services best complement more institutional services is an ongoing policy debate as the balance between community and residential care continues to shift and knowledge about the impact of nursing older clients with dementia in acute hospitals continues to improve.

CONCLUSIONS

People with dementia will increase in prevalence in the future in these two relatively high-income countries. With advanced health systems and national dementia strategies, both countries are well placed to be regional leaders in demonstrating best practice in dementia care. Both countries promote supporting people in their own homes and enabling family carers to continue their care role for as long as possible before requiring residential care. Generalist nursing services such as VNSS and the RDNS will require ongoing specialized training for their staff to support the special needs of clients with dementia. With increased evidence for environmental influences on dementia,
nursing staff will need to become familiar with the evidence base regarding lifestyle modifications to maximize health into old age. The interface between hospital, home, and residential aged care continues to shift as health policy increasingly reflects patients’ wishes to remain in their own homes for as long as possible. Careful monitoring and recording systems will enable better evaluation of the impact of health system reforms targeted to caring for people with dementia.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

The authors have no conflict of interest.

ACKNOWLEDGMENTS

The RDNS data analysis was undertaken in 2013 by former RDNS Research Officer Kira Harvey as her Honours research project at Monash University, Department of Epidemiology and Preventive Medicine.

FUNDING

Study 1 and study 2 in Japan were conducted as a part of the research supported by Health Labour Sciences Research Grant, Japan (H22-seishin-ippan-018).

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