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The impact of the COVID-19 pandemic on services for community-dwelling adults and people with dementia, and their families' intentions to use those services

Dear Editor,

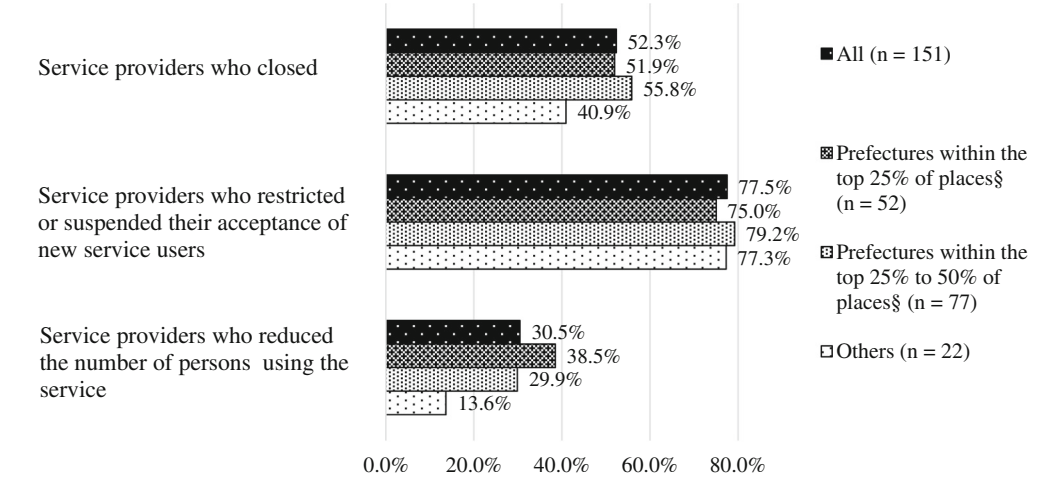
The coronavirus disease 2019 (COVID-19) pandemic has affected community-dwelling people with dementia (PWD) and their families. In Japan, the first COVID-19 diagnosis occurred in January 2020,[1] and infection outbreak has occurred repeatedly since. Public long-term care insurance services, particularly services for community-dwelling adults, such as short-stay and day-care services, have been temporarily reduced or suspended.[2] Community-dwelling PWD's lives might be threatened if they depend on paid services disrupted by the pandemic. Furthermore, concerns regarding infection risk associated with face-to-face and group-based service usage by PWD and their families also affect the use of services.[3,4] Understanding how the nearly 2-year pandemic affected services for community-dwelling adults and intention to use services might contribute to considering sustainable service delivery systems in the future.

The present cross-sectional study aimed to identify the COVID-19 pandemic's impact on long-term care insurance service providers offering services for community-dwelling adults, including home-visit services, day services and short-stay services, and PWD and their families' intentions to use these services. An anonymous online self-administered questionnaire survey of care managers registered with the Japan Care Manager Association was carried out from October to December 2021 by Hiroshima University and the Japan Geriatrics Society. Care managers are responsible for persons certified for long-term care insurance, and their care planning and care coordination.[5] Responses were classified by prefectures with the highest cumulative number of new positive COVID-19 cases per population between January 2020 and November 2021, and then tabulated.

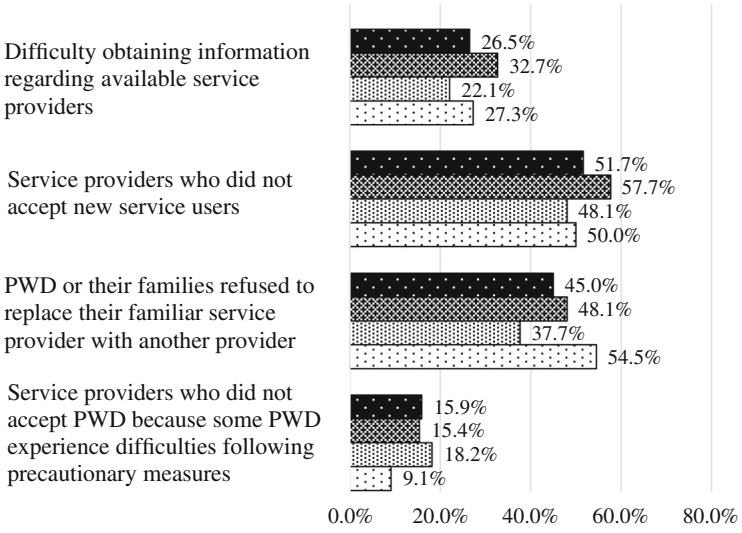
We approached 13 736 care managers through the association's email newsletter, and 241 participated in this survey. Of 241 care managers, 151 (62.7%) responded that COVID-19 affected services for community-dwelling adults (Figure 1a). Service providers' restrictions or suspensions on the acceptance of new service users were the most common consequence overall, although there were no differences by prefectures' status of infection spread. In prefectures with a higher cumulative number of positive COVID-19 cases, long-term care insurance service providers tend to pause or reduce the number of people using services. Figure 1b shows the difficulties in replacing the long-term care service providers that shut down or reduced their services. The most frequent responses were that service providers did not accept new service users, and that PWD or their families refused to replace their familiar service provider with another provider.

Furthermore, we asked all 241 participating care managers about changes in community-dwelling PWD and their families' intentions to use long-term insurance care services. The most common consequence was stopping service use to reduce contact with people (50.2%), followed by reducing the number of services (36.5%), cancelling short stays (15.8%) and switching from day services to home-visit services (10.0%).

Our results highlighted that during the COVID-19 pandemic, services for community-dwelling adults were intermittent due to the pandemic's impact on service providers and users' fear of infection. It is necessary to ensure PWD's continuous service use during infection spread. First, service providers might be required to create flexible service provision, such as switching to small group-based or combined face-to-face and remote service delivery modes or multiple providers complementing each other. Government and medical experts, including infectious disease and dementia specialists, should provide information to service providers on infection prevention measures according to PWD's disease characteristics. Furthermore, service providers should discuss care plans with PWD and their families, and collaborate with them to provide person-centered dementia care and prevent COVID-19-related unfavorable effects. Second, service providers should provide PWD and their families with accurate and individualized information regarding both the risk of refraining from



1A. How the service providers managed



1B. The reason for difficulties in replacing long-term care service providers that shut down or reduced their services

Figure 1 Changes in long-term care insurance services for community-dwelling adults and difficulties in replacing service providers. (a) How the service providers managed. (b) The reason for difficulties in replacing long-term care service providers that shut down or reduced their services. [§]At the time of the second survey (1 November 2021), the cumulative number of new positive cases was calculated for each prefecture. Thereafter, the cumulative number of new positive cases per 100 000 people (the population was calculated using the population estimate as of 1 October 2021, based on the national statistics survey) was calculated. The prefectures were then listed in order of the number of cumulative new positive cases, and quartiles were used to classify the prefectures as follows: (i) The 12 prefectures within the top 25% (75th percentile or higher) were Okinawa, Tokyo, Osaka, Kanagawa, Chiba, Saitama, Fukuoka, Hyogo, Aichi, Kyoto, Nara and Hokkaido; (ii) the 12 prefectures within the top 25–50% (50th to 75th percentile) were Gifu, Shiga, Gunma, Ibaraki, Mie, Kumamoto, Okayama, Tochigi, Hiroshima, Shizuoka, Oita and Saga; (iii) others. PWD, people with dementia.

service use (a decline in cognitive and physical function and feelings of loneliness) and its benefits (COVID-19 infection prevention). Previous studies reported that COVID-19-related information overload led to stress and anxiety.[6] Supporting PWD and their families' decision-making regarding service use might contribute to mitigating their anxiety about its associated risk of COVID-19 infection. There were two limitations in this study. First, the participation rate of this study was low, which might cause selection bias. Second, there are no data for without dementia and we could not evaluate whether the presence/absence of dementia affected service use.

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Disclosure statement

The authors declare no conflict of interest.

Data availability statement

The datasets analyzed in the present study are not publicly available. Informed consent for the secondary use of the data was not obtained from the participants.

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COMMENTS

Healthcare use for older patients in urban and rural settings

Dear Editor,

We read with great interest the study by Kaneko *et al*., which described the healthcare use of the oldest old (aged ≥90 years) compared with younger older (aged 75–89 years) adults residing in a Japanese city.[1] The authors found that in comparison with the younger older adults, the oldest older adults had more emergency department visits, hospitalizations and home visits. The oldest old also used facility services and home care services more frequently than the younger old adults.

We agree that, as the authors pointed out, a limitation of this study was the results might not generalize to rural areas. We have previously examined utilization patterns of psychiatric emergency services by patients residing in a rural county in California.[2,3] We found that elderly patients (aged ≥65 years) were more likely to have unrecognized medical illnesses and utilized the mobile emergency team. Even in a rural county limited by healthcare resources, both the oldest old and younger older adults would benefit from a dedicated mobile emergency team to provide home visits and/or home care services. Nevertheless, remote geographic location, small size, limited health professionals and financial resources would require creative ways to deliver quality care in rural areas. The growing and aging global population will require policy changes within and beyond healthcare to achieve better health outcomes. Innovative strategies using technology and social media would be necessary to improve quality care for older adults residing in both urban and rural settings.[4]

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Data availability statement

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study

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