Municipal service planning for elderly with dementia in Japan and in Sweden : A comparative study

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Abstract

To establish better community based support system for people living with dementia (PwD) we have to develop comprehensive health and social service plan in local government level. I did comparative study between Japan and Sweden. I collected 43 municipal Kaigohoken plan in Japan by web. All municipality in Japan must publish this plan every third years. And they have to include some programs for PwD in their plan. I did quantitative and qualitative analysis. Focus was programs implemented and planned in year 2017. In Sweden I got 3 'municipal service plan for PwD' on site in year 2018 and 2019. I chose one plan and did content analysis. Finally I pointed out the difference of these two local planning system and its contents.

Key Words: people with dementia, municipality, planning, Japan, Sweden

Introduction

Community based support system for people living with dementia (PwD) needs multi-disciplinary components, from medical, nursing, rehabilitation and social services. And responsibilities for these multiple services are held by some layers of central and local governments in many countries. So coordination of these elements is important to create better system. So comprehensive service planning in local government level become vital for both professionals and residents. But these kinds of planning initiatives are rather recent phenomena in many countries. So it is not easy for us to find research findings at this moment.[1]

This paper is a kind of exploratory research. I compared Japanese system with Swedish one. In both countries, responsibility of elderly care (including PwD) is placed on municipality basically. I chose 43 municipalities in Japan and collected documents by web. I did document analysis, both in quantitative and qualitative perspectives. Then I analyzed some municipal documents in Sweden, which I got in year 2018 and in 2019. After that I compared the data I got in these two countries.

Data I collected in Japan

1. Background – Kaigohoken and Municipal Kaigohoken Plan

Main system of Japanese elderly care is Kaigohoken, the Long Term Care Insurance (LTCI), which started in year 2000. Kaigohoken includes medical, nursing, rehabilitation and social services. Every

municipality take responsibility for service planning and financing of Kaigohoken for its residents. But ‘pure’ medical treatments like operation of cancer in hospital is managed by medical insurance system, besides Kaigohoken. Kaigohoken do not include pharmaceutical services.

Kaigohoken law obligate all municipality to establish their own ‘Municipal Kaigohoken Plan’ for every third years. Municipality have to estimate needs of elderly and delivery of all Kaigohoken services for coming 3 years. When they set these numbers, municipality totalize the Kaigohoken expenditure for coming 3 years. After that each municipality calculates ‘Municipal Kaigohoken Tax’ for coming 3 years. The law mandate all municipality to publish Municipal Kaigohoken Plan for their residents. Most cities publish current plan by their own web-site.

After year 2012, the law required all municipality should write some programs for PwD in their Municipal Kaigohoken Plan. Japanese government emphasized dementia care in medical and Kaigohoken services after year 2008 (Yoshihara 2014). In year 2008, 2012, 2015 and in 2019, government published important policy documents and comprehensive national plan for dementia care. National government published ‘guideline’ for Municipal Kaigohoken Plan every third years. In these years, priority of dementia care in these national guideline became higher and higher.

So when we read Municipal Kaigohoken Plan carefully, with focusing on dementia care, we can understand reality and priority of dementia care in local government level. And we can get materials from web-sites of municipality.

2. Sampling and data collection

Japan has two tier system for local government basically. We have 47 prefectures and 1718 municipalities at this moment. I chose one prefecture, Osaka Prefecture (about 8,800,000 inhabitants) where I live. Osaka Prefecture has 43 municipalities. All municipality has Municipal Kaigohoken Plan with some programs for PwD. I got all plans from their web-sites.

Population size of 43 municipalities varies. Biggest was Osaka city with 2,700,000 and smallest was Chihayaakasaka village with 5,000 residents. Proportion of elderly aged over 65 also varies in these municipalities. Highest was Chihayaakasaka village with about 40 %, lowest was Izumi city with about 23 %.

In general, we have 4 legal status of municipalities in Japan. They are delegated city, city, town and village. The delegated city has more legal power than ‘ordinary’ city, almost equal to prefecture (regional local government). Town and village has less population size, with less legal power than ‘ordinary’ city. You can imagine that delegated cities located in urban area with central business districts (CBD). And town and village located in countryside. We have 2 delegated cities, 31 cities, 9 towns and 1 village in Osaka prefecture.

3. National guideline for Municipal Kaigohoken Plan

Before presenting my research findings, I summarize national guideline for Municipal Kaigohoken Plan in year 2017. It emphasized following points about dementia care.

(1) Municipality should educate residents about dementia issues. Developing more ‘citizen supporter for

PwD' is recommended.

(2) Municipality should deliver 'municipal information package for dementia care' for PwD and their family. It must be 'local' information package, listing all services residents can apply. Japanese government named it 'Dementia Care Path'. It should include the route from early stage to the end of life, hopefully.

(3) Municipality should establish 'early stage support team' for PwD and their family. The team must be professional and interdisciplinary. They help PwD before diagnosis and some months after diagnosis.

(4) Municipality should employ or appoint 'dementia care coordinator'.

(5) Municipality should support younger dementia patients.

(6) Municipality should develop more support for family carers.

(7) Municipality should establish 'dementia café' for PwD and their family.

(8) Municipality should appoint more guardians for PwD.

(9) Municipality should develop more 'neighborhood support (informal support by neighbors)' for PwD and their family.

Method – Document analysis in this paper

I did document analysis of 43 Municipal Kaigohoken Plan I collected. I read all pages of those plans which wrote about program for PwD and their family. All plan was published in March 2018. All of them are 3 years plan from year 2018 to year 2020.

When I read these plans I took notes, focusing on following issues as follows.

(A) What program had done or achieved in years from 2015 to 2017.

(B) The new program which they plan to do in years from 2018 to 2020.

(C) Plan of the volume of Kaigohoken services for PwD in from 2018 to 2020.

So this is a kind of content analysis.

Results

1. Programs implemented and planned in 43 municipalities

Results were summarized in Table 1. Percentage of PwD program implemented in year 2017 were shown in column 'IMP'. Program planned in year from 2018 to 2020 were shown in column 'PLN'. The column 'TOL' is sum of IMP and PLN.

2. Explanations and analysis of Table 1

The top 3 programs were remarkable. 'Developing citizen supporter' is program providing basic information about dementia for the residents. For ordinary citizens, policeman, students, shop clerk, bus and taxi driver, bank clerk, staff in train station and post office, workers in housing and real estate business and so on. To develop supporters, they give 90 minutes lectures to the residents. Government set guideline for those lectures. The lectures includes basic knowledge about dementia disease and how citizen can support PwD in the community. This program was originally invented by some professionals and municipalities. National government approved this and nationalized it in year 2005. Government also set 'target number'

Table 1　Percentage of PwD program in 43 municipalities

	Name of the program	IMP	PLN	TOL
1	Develop more citizen supporter	100	0	100
2	Appoint more guardians for PwD	98	0	98
2	Finding ‘lost’ PwD in the community	98	0	98
4	Appoint dementia care coordinator	84	9	93
5	Deliver information package for users	77	21	98
6	Establish early stage support team	74	26	100
7	Improve support for family carers	74	0	74
8	Set up ‘dementia café’	70	9	79
9	More training for professional staff	40	2	42
10	Preventing activities against dementia	33	0	33
11	Individualized counseling and advice	21	0	21

of citizen supporter many times and municipalities responded. In September 2019, we have over 11,900,000 citizen supporter in Japan.

Appointing guardian for PwD is also ‘classic’ program, which started in year 2000. This program is for protecting PwD by legal procedures. But applicants were family carer in many cases.

Finding ‘lost’ PwD program functions as follows. Family carer worried about PwD to go out and lost her way in the community. They registered ‘their’ PwD in municipality where they live, with information like name, photo and telephone number of family carer. When PwD lost her way in the community and family cannot find her, that family will ask for help to the municipality. Municipality will ask for help to the ‘companion’ members by e-mail with registered information. The companion members were registered ones, ordinary citizens, shop clerks or taxi driver for example. When companion find ‘lost’ PwD, they will report to municipality. And then officers of municipality will meet ‘lost’ one and guide her to her house. So this program is serving for the difficult situation of PwD, but applicants were family carer. In my view, this program primary help family carer. This program was invented by some municipalities before year 2010 and spread all over Japan. National government help these expansion.

I think these top 3 and ‘support for family carers’ in seventh position were the ‘traditional’ PwD programs in Japan. These program supported family carer primarily and intended to develop ‘citizen involvement on dementia issue’ and ‘neighborhood support for PwD’.

‘Dementia care coordinator’, ‘information package (dementia care path)’, ‘early stage support team’ and dementia café was proposed by national dementia policy in year 2012. All of them are ‘new wave’ of dementia care. Ideally all of these program focus on PwD, not family carer. But in reality, beside early stage support team, most of them focused on family carer primarily. These four was obligated to all municipality by government and ‘deadline’ was set in year 2018. So most municipality hurried to implement these. And they had implemented some 70 to 80 percent in March 2018. And most ‘not implemented’ municipality wrote that ‘we will implement this program before the end of year 2018’. For some small municipalities, it was not easy to establish early stage team, because this program needs experienced medical doctor

specializing PwD. And it was also difficult for small village（with 5,000 inhabitant）to set up dementia café.

Ninth and tenth position was impressive for me. Training of professional about dementia care was not put high priority. Many municipality wrote one limited program like‘training of medical doctors’,‘training of specialist nurse’,‘training of care workers’ or‘training of care manager and social worker’. Most of them did not mention multi-professional or interdisciplinary training. And most of them wrote only one or two lines about professional training. Most of them had no concrete action plan for this topic.

It was also impressive that one third of municipality implemented some kinds of preventive activity. Most researchers do not believe that we have evidence-based effective preventive activities against dementia at this moment. But many municipalities were aggressive on these programs. May be we have two reasoning for this phenomena. One is that residents（mainly elderly）prefer preventive activities against dementia. So politicians and civil servants in municipality set high priority on this. Whether they are effective nor they has research-evidence are not important.‘My city is doing some programs’ was important. Other is financial matters of Kaigohoken in that municipality. When preventive activities went well, it will give good impacts on the financial management of Kaigohoken in that municipality. This is also nice for politicians and civil servants in that municipality.

Finally I will describe the relationship between Table 1 and national guideline in 2017. We can understand that Table 1 data is influenced by national guideline so much. But we can find one exception,‘more support for younger patients’. In legal basis, responsibility of support for younger patients placed in prefecture, not in municipality. Because numbers of younger patients is not very big, and they needs more specialized services. So in my sample, only two‘delegated cities’ wrote some programs for younger ones.

3. Estimated numbers of PwD and planning the volume of Kaigohoken PwD services in coming 3 years

In their Municipal Kaigohoken Plan, some municipality estimated the numbers of PwD in some years, for example year 2017 or year 2020. Others did not. In fact some 17 municipalities estimated for some year. It occupied about 40 % of 43 municipalities. When municipality estimated the numbers of PwD in year 2017 and 2020, they can recognized the amount of net increase of PwD in coming 3 years. But most municipality did not calculate these numbers.

All of 43 municipalities in Osaka estimated the volume of Kaigohoken services sold in years from 2018 to 2020, because Kaigohoken law required to do so. In Kaigohoken services, two items are served‘only for PwD’. They are（1）group home for dementia（GH）and（2）special daycare for dementia（DC）. So I read‘estimated service sold in coming 3 years’ chapter of municipal plan carefully.

I also spotlighted on another two services in Kaigohoken. They are（3）community based multiple social services unit（SU）[2] and（4）community based multiple nursing services unit（NU）[3]. Both items are rather new in our system. In my view main target user of these services is PwD. We can find same idea in some documents in our national government. Many Kaigohoken professionals（care managers, nurses, care workers and medical doctors）wrote same opinion in their papers and books. These two services aimed PwD to live in their house as long as possible.

SU provide home help, daycare and short stay beds（or respite services）for PwD. It is small size, community based service unit for PwD, which provide multiple Kaigohoken services by one organization.

NU is similar to SU and it provide ‘visiting nurse’ service also. NU have to employ more nurses than SU. And NU can provide better service in ‘the end of life care’, final days of their lives by experienced nurse.

So I had focused on these four items, (1) GH, (2) DS, (3) SU and (4) NU in Kaigohoken services. I read all municipal plan carefully and got data about estimation of services sold in coming 3 years (2018 to 2020). Data I got was classified to five subdivisions as follows.

(A) Plan to expand service capacity (‘Capa’ in short). It means that municipality planned to increase the capacity of service provision. For example, increase the rooms of group homes or add some daycare places.

(B) Estimate more services sold in coming 3 years (‘More’ in short). Municipality do not plan to expand service capacity, but purchase of services will increase in coming 3 years. Municipality think that they has enough capacity for users. For example they had many unused rooms in group homes and participants of daycare was very few. So they think that users of services will increase in years from 2018 to 2020.

(C) Some municipalities put same number in year 2018, 2019 and 2020 for particular services. I named it ‘stagnation’ (‘Stag’ in short). You can understand that when PwD will increase every year and quantities of service sold will be same in coming 3 years, it means ‘reduction’ for residents. It is restraint for them.

(D) One municipality planned to decrease particular service sold in coming 3 years (‘Redu’ in short). This city planned that DS and NU will increase and SU will decrease in years from 2018 to 2020. Priority change or ‘shift’ of services.

(E) Some municipality omitted particular services in their plan (‘Abse’ in short). For example some city wrote ‘We have no NU in our city at this moment. And we do not plan to establish NU in coming 3 years here. We estimate no user for NU in years from 2018 to 2020’.

Results are shown as Table 2 below.

Table 2 Planned volume of PwD services in years from 2018 to 2020

Table 2 Planned volume of PwD services

Name of PwD service	Capa	More	Stag	Redu	Abse	Total
Group home for dementia (GH)	14	15	13	0	1	43
Daycare for dementia (DC)	6	26	2	0	9	43
Multiple Social Unit (SU)	13	20	3	1	6	43
Multiple Nursing Unit (NU)	17	10	2	0	14	43

Table 2 can be summarized as follows. Besides NU, major trend was ‘not so much capacity expansion’. Mainstream was that ‘more service will be sold within service capacity today’. And we can also point out ‘bipolarization’ phenomena among 43 municipalities. We can recognize rather many stagnation, restraint, reduce and even ‘omit or absence’ of some services in coming 3 years. The facts are that restraint and omit were found in smaller cities, below 100,000 inhabitants. And we found so many ‘omit’ among towns and village, which has less inhabitants, below 40,000.

NU is the newest item among our 4 services. It was invented in year 2012. So it is underdeveloped today and rather many cities planned to establish and expand it. But for some cities and many towns, it was

not attractive item. Results on group home was impressive for me. One third was expansion, another one third was increase and the rest（one third）was restraint. DC is very not new item in our system. Most municipalities developed service capacities for many years. But in the field, it is not popular service among PwD. So they have many vacancies in many cities. Some PwD preferred ‘normal’ daycare, not daycare for dementia.

As I wrote, proportion of elderly aged over 65 varies in 43 municipalities, from 23 to 40 %. One assumption is that municipalities with high rate of aged 65 plus will write expansion and increase of services in their plan. But I could not find correlation between them. Another assumption is as follows. Municipal Kaigohoken Tax is set by municipalities every third years. It varied from 5,083 to 7,927 JPY per month in Osaka in year 2018. Municipalities with ‘expensive（high）’ Kaigohoken Tax will restrain, reduce or omit some services in their plan could be an assumption. But I could not find this tendency either.

Finally I should pay attention to the reader that whether volume of expansion or increase written in municipal plan is ‘adequate’ or not. It is not easy issue to judge. But as I wrote, we can not recognize the numbers of PwD, net increase of PwD in coming 3 years and length of waiting lists for each service in most municipal plan. Majority of municipal plan did not mention those data. So we can not evaluate the numbers set are valid or not. And most plan did not state what service is insufficient in that municipality.

Data I collected in Sweden

1. Backgrond

Sweden has 20 regional government and 290 municipalities（Kommune）. Municipality is responsible for social services and part of nursing and rehabilitation services. Regional government is responsible for medical services. National government published comprehensive ‘Guideline for health and social care for PwD’ in year 2010.[4] It had evaluated and renewed national guideline had published in year 2017.

2. Sampling and data collection

Thanks to the great support provided by research partners in Karlstad University, we did study visits and interviews with staff about dementia care in 3 municipalities in August 2018. We did data collection in Karlstad（90,000 inhabitants）, Arvika（26,000 inhabitants）and Kil（12,000 inhabitants）.

Arvika and Kil had comprehensive municipal dementia care plan（Demensplan）. We could not find this in Karlstad. I got ‘Demensplan version 2016’ of Kil before visit, because it is included in web-site of the city. When we completed study visit and interviews, I got Demensplan of Arvika, both 2016-2018 version and 2019-2021 version. But both are not published in web-site of this city.

So, I got 3 municipal Demensplan altogether. They are different documents but structure and format of these 3 plans are similar in many aspects. In this paper I focused in Demensplan of Kil municipality. Because Kil is small municipality and with multiple study visits and interviews with staff, I can comprehend whole picture of dementia care in this city.

3. Contents of Demensplan of Kil municipality

The plan was established in year 2016. This document is 11 pages, with no table and figure. For Japanese researcher, it is impressive because Japanese municipal Kaigohoken plan consist of tons of tables and figures. Japanese Kaigohoken plan is filled with numbers.

To read them through, this document is organized in this structure and can be summarized as follows.

(1) Background and basic information

This municipal policy document is action plan of this city, following national guideline in 2010. Some explanation of important parts of national guideline. Basic information about dementia and dementia care system in Sweden.

(2) Goals of dementia care in Kil city

What this city wanted to achieve in this plan. Focusing and targeting on PwD and their family, carers.

(3) What city is doing for dementia care in year 2016, the current situation

Organizations and service delivery system, responsibilities of each part, who (professional staff) do what. Explanation and evaluation of service items today, day care, home help, respite care residence, special nursing home for PwD, security alarm system, housing adaptation, coordinating practical tools for PwD, support to the family. Collaboration between professionals and interdisciplinary work.

(4) Medical issues

Derailed information about particular medicines for PwD. Effects and side effects. Warring about serious episodes of wrong and over medication, quoting national guideline. BPSD episodes and use of medicines and alternative ways. Support for Frontotemporal Dementia (FTD) patients.

(5) Priorities for coming years

Importance of person centered care in all setting, stages and process. More days and places for day care, invent special home help team for PwD, improve qualities of care in nursing homes for PwD. Better service for minority groups, especially for young people living with dementia and ethnic minorities with dementia. Developing and introducing new technologies for support and care for PwD. Improved support for families, more family meeting and dementia café, more support at night. Overall and comprehensive training for staff in PwD fields.

4. Distinguishing feature of Swedish system – a view from Japanese researcher

Some contents of Demensplan of Kil city are never or seldom written in Japanese municipal Kaigohoken plan which I read. I will describe them in 4 parts.

(1) Importance of person centered care and issues related to physical restraint in care setting were written in very first part in Kil. These are human rights aspects of dementia care. These topics are seldom written in Japanese municipal plans. BPSD itself and developing better services for PBSD patients is not discussed in Japanese municipal plan so much.

(2) Issues of medicine is never written in Japanese municipal plans I read. Wrong medication, over medication and side effects. Demensplan Kil is against wrong and over medication clearly, this is the important goal to achieve in municipal plan. Kil Kommune is not responsible for describing medicines for PwD. But this is important part in municipal plan.

(3) Some items or services listed in Kil is not exist in Japanese system. Special dementia team, Special home help team for dementia and individualized support provided by occupational therapist for 'just diagnosed' patients.[5]

(4) Organization, responsibilities of each bodies, who (professional staff) do what issue is central parts of Demesplan of Kil city. But most Japanese municipal plan did not state this basic information. For example, city will employ or appoint 'dementia coordinator'. But some cities wrote nothing about what coordinator will do for whom in the field.

Discussions

I analyzed 43 municipal Kaigohoken plan in Japan and compared with one municipal dementia care plan in Sweden. Structure and contents of municipal plan in two countries were so different, because they has different care system, with different laws, regulations, national plan and national guideline. In Japan programs for PwD occupied only small part of municipal Kaigohoken plan. Demensplan in Swedish municipality was comprehensive one but not all the municipality established nor publicized it.

In Japan, law set detailed rules about how to create municipal Kaigohoken plan and how they describe. Estimation of services sold in coming 3 years is important, because without these data, municipality can not set Kaigohoken Tax for coming 3 years. So, they concentrated on numbers. National dementia plan and national guideline were also very important for all municipalities in Japan. State asked all municipalities to start some program 'before year XXXX. When you do it, you can get some money from national government', in many occasions. In this case, first priority for municipality was 'start program A before year XXXX'. Contents and qualities of the program would be ignored in worst case. In Demensplan of Kil city in Sweden, they wrote 'we do this program to realize A and B' in many case, the aim and goals of each program with 'how' they implement the programs to achieve goals. In Japanese municipal plans, 'what we want to realize by this program' was not written in many case. Sometime program was implemented but it was perfunctory, formal, empty or 'no contents'.[6]

In my articles in 2013 and 2014, I insisted that the distinguishing feature of Japanese dementia policy was strong emphasis on 'citizen involvement approach' and 'support for family carers' when compared it with Sweden (Yoshihara 2013 and 2014). In 2013 paper, I named Swedish system 'Professional and evidence-based' model, compared with data I got in Japan. I think this is not changed nowadays, and I can add another features today 'person centered, individualized' model for Sweden, after I read though Demensplan of Kil city. After comparison I had done in this paper, it is not surprising for me that 'more training for professional' was not very popular program among Japanese municipalities. As I revealed in this paper they still focused more on citizen involvement and support for family today.[7] In this case person centered care and 'human rights' based approach for dementia care can not be recognized as mainstream idea in Japan.

At this moment in year 2019, we have 'Basic bill on supporting PwD' in Diet (Parliament) in Japan. This bill is discussed in many points today. This bill in Diet has some chapters (articles) about 'municipal support plan for PwD'. We has some municipalities which invented 'municipal support plan for PwD'. Tondabayashi city in Osaka and Fujisawa city in Kanagawa Prefecture are example.[8] Both plans were

influenced by ‘national plan for PwD’ in 2012, 2015 and 2019 so much. Both were some kind of ‘action plan’ of the city to implement national plan for PwD. But these plans has no ‘source of law’ now. We have many unsolved research topic on this issue, both theoretical, empirical and practical. This small paper is a first step for this huge and complicated topic.

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Note

1. I searched previous research by SCOPUS in year 2019. The keyword I set were ‘dementia’ and ‘plan’ and ‘municipality’. I got 18 articles. But none of them wrote about theoretical and empirical finding on comprehensive health and social service planning for PwD in municipality.
2. ‘Shokibotakinougata-kyotakukaigo’ in Japanese.
3. ‘Kango-shokibotakinougata-kyotakukaigo’ in Japanese.
4. You can read brief summary of guideline 2010 written by Swedish researchers. Bengt Eriksson and Åse-Britt Falch（2015）. For Japanese reader, Rumi Fujiwara（2013）.
5. Detailed findings were stated in Yoshihara（2019）.
6. I give you some example. In the summer of 2017, my student did participant observation in some ‘dementia café’ in one city. All of these dementia café were held in the meeting room of the ground floor of nursing home or day care for elderly. This city was so proud that ‘we have many dementia café and XXXX people participated in those café this year’. My student visited café A and found that no PwD nor family participated at that day. In reality it was a kind of ‘preventing activity against dementia’ café. All participant were healthy elderly and their images of PwD were very bad, like ‘Suffering dementia means end of life’. So they were so active and did every preventive effort against dementia in that cafe. It was not dementia café in my view. It was ‘preventive activities against dementia café’ or ‘dementia phobia’ café. Student visited café B the other day. In that café, all participants were PwD, no family participated in that day. It was a calm café. The reality was that all participants were residents with dementia in that nursing home in the third floor. They went down to the meeting room in the ground floor to enjoy coffee and cakes with help of staff of nursing home. In my view this was not dementia café neither. I think that staff in this

city and dementia café did not comprehend the aim and goals of dementia café. Important issue was ‘how many dementia café was established in my city and how many people participated’ for staff of the city and ‘my nursing home started dementia café this year’ for managers of the nursing home.

7. I think both ‘professional’ and ‘citizen involvement’ approach are important. In Japan we accumulated citizen involvement approach so many years and it is well-developed today. I think we need more professional approach in coming years. We should reconsider and change priorities.

8. Both plans are included on the web site of the city.

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基礎自治体が策定した認知症支援計画の日本、スウェーデン比較

―小規模な事例研究

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要　　旨

地域社会を基盤とする認知症の支援システムを改善するためには、地方自治体を基盤として医療や福祉等にまたがる包括的な計画を策定してサービスを運営することが求められる。本稿は、高齢者介護の責任が主に基礎自治体におかれている日本とスウェーデンを、比較研究した。日本では、大阪府の43市町村すべての介護保険事業計画をインターネットを使って集め、分析した。収集したのはすべて第７期計画で、計画期間は2018から2020年度である。収集した計画には、各自治体の認知症支援の事業を掲載することが義務づけられていたので、この部分を分析した。スウェーデンの自治体計画は、主に現地で2018年に収集した。２つの基礎自治体の３つの「認知症支援計画」が得られ、このうちひとつを内容分析した。以上を踏まえ、両国における認知症支援自治体計画の構造や内容を、主に差異を中心に分析した結果を述べた。

キーワード：認知症、基礎自治体、計画、日本、スウェーデン