報告（出國類別：考察）

105 年度「國際健康產業佈局規劃案」北歐考察團

服務機關：衛生福利部

姓名職稱：林奏延部長、王宗曦主任秘書、趙偉翔科長、郭威中技正、楊俊佑院長、白明奇教授、陳亮恭主任、周明岳主任、梁志光醫師、甄瑞興主任、洪大川主任、徐文俊主任

派赴國家：瑞典、芬蘭

出國期間：105 年 07 月 31 日至 08 月 10 日

報告日期：105 年 10 月 31 日

行政院及所屬各機關出國報告提要

報告名稱：105 年度「國際健康產業佈局規劃案」北歐考察團

出國計畫主辦機關：衛生福利部醫事司

出 國 人：林奏延部長、王宗曦主任秘書、趙偉翔科長、郭威中技正、楊俊佑院長、白明奇教授、陳亮恭主任、周明岳主任、梁志光醫師、甄瑞興主任、洪大川主任、徐文俊主任

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出國地區：瑞典、芬蘭

報告日期：105 年 10 月 31 日

內容摘要：

本考察係衛生福利部為配合國家發展長期照護政策之推動方向，以「提升臺灣整體醫療品質，加值台灣長期照護服務」為目標，向國外學習如何於長期照護服務產業落實預防醫學之策略規劃與做法，以因應我國未來可預見之人口老化、失能人口數上升及高扶老比等議題。同時，本計畫亦希望吸引國外先進長期照護機構來台與國內健康產業進行合作，包括人才交流、技術合作、投資或通路開拓等，為我國健康產業加值、促進產業轉型、帶動經濟成長。

今年 7 月 31 日至 8 月 10 日規劃前往北歐 2 國 2 城市（瑞典首都斯德哥爾摩及芬蘭首都赫爾辛基），由衛生福利部林奏延部長率團考察該國的長期照護服務產業發展現況，以其產業發展與相關政策推展經驗作為我國未來醫療與長期照護銜接、及長期照護產業發展之規劃方向參考；另外也透過參訪相關機構及官方單位，藉以學習國外中央與地方政府與照護機構合作配套之措施、與國外長期照護機構運作及品質管理之機制，並發掘其與台灣醫院或照護業者進一步合作的可能性。

本考察實際參訪 8 家長期照護相關機構、2 家醫療機構、1 家高齡輔具廠商及 3 個政府單位。瑞典及芬蘭等國家針對社會福利及高齡照護等領域之發展一向有口皆碑，其中又以兩國首都地區之長期照護資源與能量最為充沛。本次參訪之兩城市擁有良好之長期照護品質管理，且地方政府與照護機構間彼此相互鏈結合作，並充分利用民營機構服務補足公營機構不足之處。

因此，本考察除學習瑞典、芬蘭兩國政府針對長期照護領域之政策規劃與配套措施、長期照護經營之 know-how 與瞭解當地醫療與長期照護產業間如何進行價值鏈結或國際合作外，也針對台灣與瑞典及芬蘭雙邊照護機構、企業間合作之可能性進行探討。且透過面訪之洽談方式，更能直接深入瞭解產業鏈中每個角色的功能與職責，對於未來台灣長期照護發展之策略擬定與規劃能有更明確之走向。

報告大綱

表目錄

圖目錄

壹、 目的

一、 緣起

因應老年化和少子化時代的來臨，以及醫療費用的逐年高漲，預防醫學及高齡照護已成為未來重點發展之趨勢。我國政府自 2006 年以來，持續大力推廣健康促進政策，並強化衛生局與轄區醫療院所間的夥伴關係，整合健康促進、預防保健及長照服務之資源。2015 年，我國政府更進一步將健康照護產業列為經濟發展願景四大新興產業之一，將視推動健康照護產業之發展為國家發展重大政策。為協助國內健康照護產業發展完備、並具備與國際接軌之產業基礎，學習其他國家之健康照護產業規劃與發展、及政府與民間之合作模式建立將為重要關鍵。

本考察係衛生福利部為配合國家發展政策推動方向，進行國際健康產業佈局規劃，以提升臺灣整體健康照護產業之發展，並進一步帶動臺灣醫療服務高附加價值化，擬向國外學習健康照護產業佈局規劃，同時吸引國外長期照護機構與照護相關產業業者來臺並與臺灣健康照護相關機構業者進行合作人才交流、技術、投資或通路等合作契機。

北歐國家是福利制度建置最完善之國家。瑞典一向以其「從搖籃到墳墓」的社會福利保障制度聞名。據歐洲經濟合作暨發展組織（OECD）資料顯示，瑞典是歐洲投入最多資源於長期照護服務的國家；且為加速行政流程，瑞典係由各地方政府依照各自財政能力調整長期照護之負擔。此外，由於長期照護服務需要大量之人力，瑞典對於公私營長期照護服務機構、甚或家庭照顧者皆有完善的照顧品質管理與津貼制度。芬蘭的高齡照護則更為強調高齡者自主獨立生活之能力。為維持高齡者身體機能，芬蘭各地方政府提供場域及資源予高齡者的復健運動，並提供居家訪視、送餐及清潔等居家服務。

過去台灣各地方政府單位曾陸續前往北歐各國考察當地之健康照護服務，其中又以瑞典斯德哥爾摩及芬蘭赫爾辛基此兩個照護產業發展較為完善之城市最受青睞。過去參訪主要著重健康照護機構運作機制與模式之了解，今年則更進一步學習瑞典與芬蘭中央及地方政府對於長期照護產業之政策規劃、地方政府與照護服務機構間之配套合作、當地醫療與照護服務間之串聯模式、及照護機構針對照護品質之管理機制。爰此，本次北歐二

國二城市之參訪，除了瞭解健康照護機構之運作與品質管理模式外，另一重點即為學習將預防醫學概念整合長期照護，藉以擬定完善之長期照護相關政策，為台灣的健康照護產業奠定未來良好之市場運作機制。

二、 參訪對象概要

本次北歐參訪團總共參訪 14 處不同之健康產業業者與機構，以深入了解瑞典與芬蘭兩國高齡照護實際運作模式與政策配套機制，包含 8 家照護服務相關機構、2 家醫療機構、1 家高齡輔具業者、以及 3 家與照護服務或高齡政策規劃與執行相關之政府單位。

三、 參訪目的

(一) 了解並學習北歐社會福利制度及其針對高齡或長期照護之政策規劃與合作配套措施之長處，供作台灣政府未來長期照護政策擬定方向之參考。

(二) 了解北歐國家地方政府與照護機構間之運作及品質管理機制，及其針對家庭照顧者之配套措施。

(三) 了解北歐高齡輔具業者與研發機構最新之產品研發狀況，從中尋找適合台灣廠商參與之製程環節與產品。

(四) 發掘北歐健康照護業者/機構產品與台灣醫院或照護業者進一步合作或導入台灣的可能性。

貳、 出國人員名單及行程表

以下為本次出國人員名單。

姓名	服務機關	服務單位	職稱
林奏延	衛生福利部		部長
王宗曦	衛生福利部		主任秘書
趙偉翔	衛生福利部	醫事司	科長
郭威中	衛生福利部	醫事司	技正
楊俊佑	國立成功大學醫學院附設醫院		院長
白明奇	國立成功大學醫學院附設醫院	神經學科	教授
陳亮恭	臺北榮民總醫院	高齡醫學中心	主任
周明岳	高雄榮民總醫院	高齡醫學中心高齡整合照護科	主任
梁志光	高雄榮民總醫院	高齡醫學中心	醫師
甄瑞興	臺北市立聯合醫院	仁愛院區專任內科系醫療部	主任
洪大川	台灣基督長老教會馬偕醫療財團法人馬偕紀念醫院	醫務部暨淡水社區醫學中心	主任
徐文俊	長庚醫療財團法人長庚紀念醫院	林口總院神經內科系失智症科	主任

下表為本次整體行程概要。

表 1　北歐參訪團整體行程概要

天數／日期	行程概要
第一天 8 月 1 日	中午：12:10 抵達瑞典斯德哥爾摩
	下午：參訪 Swedish Quality Care
第二天 8 月 2 日	上午：參訪 Villa Agadir 及 Famntaget Omsorg
	下午：參訪 Capio Östermalms Vårdcentral
第三天 8 月 3 日	上午：參訪 Capio Geriatrik 及 Nacka Kommun
	下午：參訪 Attendo Kampementet Elderly Care Facility
第四天	上午：參訪 Sveriges Riksdag（瑞典國會）

8 月 4 日	下午：移動至芬蘭赫爾辛基
第五天 8 月 5 日	上午：參訪 Roihuvuori Comprehensive Service Center 及 Wilhelmiina Elderly Care Center
	下午：參訪 HUR（於 Auron OMT Keskus Citycenter）
第六天 8 月 6 日	上午：University of Helsinki（校園參觀）
第七天 8 月 7 日	上午：Helsinki Smart City（智慧城市參觀）
第八天 8 月 8 日	上午：參訪 Attendo Mommulat
	下午：參訪 Finnish Wellbeing Center
第九天 8 月 9 日	上午：參訪芬蘭衛生福利部
	下午：於 14:05 由芬蘭赫爾辛基出發，於荷蘭阿姆斯特丹轉機返台，抵台時間為 8/10 下午 2:45

參、 內容說明

一、 參訪機構及參訪流程說明

參訪機構共有 8 家照護機構、2 家醫療機構、1 家高齡輔具廠商及 3 個政府單位，其名稱詳下表所示：

表 2　參訪機構名單

照護機構	Swedish Quality Care
	Villa Agadir
	Famntaget Omsorg
	Attendo Kampementet Elderly Care Facility
	Helsinki Roihuvuori Comprehensive Service Center
	Wilhelmiina Elderly Care Center
	Attendo Mommula
	Finnish Wellbeing Center
醫療機構	Capio Östermalms Vårdcentral
	Capio Geriatrik
高齡輔具廠商	HUR
政府單位	Nacka Kommun (Nacka 市政府)
	Sveriges Riksdag 瑞典國會
	芬蘭衛生福利部

於照護機構與廠商的參訪重點在於瞭解該參訪對象的服務及運作模式現況；品質管理的運作機制與模式；其對台灣國際健康產業進行合作交流的意向；及是否有適合導入台灣之制度。而在政府單位的參訪中，則著重於了解對方政策制度及配套措施的規劃；中央及地方政府間的分工及資源分配；地方政府與照護業者間的溝通、監督及獎勵機制；以及針對家庭照顧者的訓練及補貼規劃。

在機構及政府單位參訪的流程上，首先由訪問對象以簡報方式，說明其服務或產品內容、運作及品質管理的機制與模式，以及其在當地或海外事業的拓展現況與未來方向；再由衛生福利部介紹台灣長期照護目前或未來可能面臨之課題、及欲向訪問對象學習之重點。在雙方初步掌握彼此狀況後，再互相提問以促進雙方更進一步之瞭解。透過此種直接進行意見交流之方式，使衛福部更瞭解北歐國家於高齡或長期照護服務的運作模式，作為未來台灣健康照護產業佈局規劃政策的研擬方向參考。

表 3　參訪行程執行方式

當日流程
1. 雙方介紹及交換名片
2. 參訪對象簡介業務內容
3. 衛生福利部說明台灣長期照護發展現況與未來政策方向
4. 雙方針對兩國健康照護制度架構及未來政策佈局規劃進行意見交流
5. 贈送禮品及紀念照片拍攝
6. 企業/機構參訪

二、 照護機構參訪

本次北歐參訪共拜訪八家照護及其相關服務機構，依據參訪時間順序分別為 Sweden Quality Care、Villa Agadir、Famntaget Omsorg、Attendo Kampementet Elderly Care Facility、Helsinki Roihuvuori Comprehensive Service Center、Wilhelmiina Elderly Care Center、Attendo Mummolat、及 Finnish Wellbeing Center。以下就八家照護及其相關服務機構之背景與參訪結果要點分別進行介紹。

(一) Sweden Quality Care (SQC)

1.背景概要

Swedish Quality Care（SQC）曾為瑞典貿易委員會及瑞典殘疾研究所擁有，於 2007 年轉為私營家族企業。SQC 與瑞典當地各照護機構、學校及政府單位形成緊密網絡，著重高齡照護、殘疾照護、孩童照護、及醫療照護等領域，提供客製化之社會福祉及醫療照護之教育與諮詢服務。SQC 除提供系統性之瑞典高齡照護發展與介紹，並協助安排如高齡住宅、失智照護中心、居家照護、高齡日照中心等之參訪。

日照中心

護理之家

輔具體驗 – 照護機構

圖 1　Swedish Quality Care 提供之服務

2.參訪概要

本次參訪 SQC 主要由擔任 CEO 的 Björn Wigström 向參訪團介紹瑞典高齡照護體制與架構。

相較於台灣目前長期照護發展側重於失能失智者之服務，瑞典的高齡照護制度則強調讓所有高齡者都有獨立自主生活的能力（是住民，不是病人），著重對全民高齡的照護服務：針對健康的老人著重身心健康之延續，減少其對醫療資源之依賴；對亞健康及失能失智老人則強調病人“能做到什麼事情”，而不是“什麼事情無法做”。

瑞典 80 歲以上佔人口 5%，人民平均稅率達 30%，為降低醫療財政負擔，注重發展居家照護、社區化健康養老的概念，也是台灣與瑞典制度上相同之處。然瑞典透過行政分級劃分醫療及照護：縣市政府負責醫療服務、區鄉鎮公所主管照護及社會福利服務、中央政府主掌法令制度之規範。而照護服務之財源則由區鄉鎮公所主要負擔，透過地方稅收支援（地方稅 71%，中央稅 16%，自付 3%，個人保險 10%）；台灣則是規畫透過中央稅制支援。

瑞典政府透過減稅方式鼓勵企業投入長期照護服務，並以 National Quality Registry 的機制掌控公私營照護服務之品質管理，此為台灣發展長照政策可參考之模式。此外，台灣目前的高齡住宅經營主要模式為針對健康高齡者提供養生村、對失能失智的老人則是提供像是大型病房的安養院；而瑞典的養老住宅概念則是包含失智失能者之生活照護，強調以群體安養住宅方式提高失能失智高齡者之身心健康。

表 4　Swedish Quality Care 參訪情形

	
衛福部林部長奏延(左)與 SQC 執行長 Mr. Björn Wigström 握手會面	SQC 執行長 Mr. Björn Wigström 對衛福部參訪團進行瑞典照護制度概要簡報說明

衛福部林部長奏延(右一)暨參訪團全體成員於 SQC 會議室交流後留影紀念

衛福部林部長奏延(左)致贈 SQC 執行長 Mr. Björn Wigström 禮物

衛福部參訪團全體合照

(左起：高雄榮總周主任明岳、高雄榮總梁醫師志光、長庚醫院徐主任文俊、台北仁愛醫院甄主任瑞興、衛福部王主秘宗曦、衛福部林部長奏延、成大醫院楊院長俊佑、台北榮總陳主任亮恭、成大醫院白教授明奇、馬偕醫院洪主任大川、衛福部趙科長偉翔、衛福部郭技正威中)

(二) Villa Agadir

1.背景概要

Villa Agadir 成立於 1999 年，提供客製化的退休及失智住宅照護服務，為 Vardaga 集團旗下之高齡照護住宅系列之一。Vardaga 為瑞典最大的私營高齡住宅集團之一，在瑞典 80 個地方皆有提供高齡住宅服務，集團亦有提供居家照護及日照中心等服務。截至 2014 年止，集團員工人數約 7,000 人，營收約 1.6 億美元。

針對照護住宅的品質管理，Vardaga 集團採用品質控管系統 Qualimax 作為旗下各機構服務品質之控管。Qualimax 針對各機構的管理目標、評估、改善及文件記錄等四大面向及其下的 21 個指標作為評測項目，總分位於 0~2 之間，每兩年更新一次。Villa Agardir 於 2016 年 6 月的 Qualimax 總分為 1.98，高於 Vardaga 集團整體平均的 1.86。

Vardaga 集團並使用 Qualimax 作為品質目標設定，鼓勵旗下照護機構針對該目標的實行做評估、改善及記錄，亦即品質管理持續改進之 PDCA（Plan-Do-Check-Action）模型的運用。

圖 2　Villa Agadir 生活環境

2.參訪概要

本次參訪行程主要由 Villa Agadir 的主管 Mrs. Pia Henriksson 向參訪團概要介紹瑞典高齡住宅分配以及運作機制，並帶領參訪團成員參觀 Villa Agadir 住宅與周遭環境。

瑞典的高齡住宅建物多半由當地政府或物業公司擁有，經營權則是由各私營照護事業向當地政府承包，斯德哥爾摩約有 80 個高齡住宅，由政府決定入住順序，政府依入住機構人數與天數，給付得標公司費用。經營模式強調在符合住戶本人意願之下，滿足住戶對“家”的 需求；因此雖同一住宅內依據失智需求有特別規劃失智居住區，也不會強迫入住普通居

住區但後來發生失智病症的住戶搬遷。同時也強調住戶為住宅的主人，員工應適應住戶，並協助住戶無論身體健康狀況及疾病，皆能感到生活是有意義、有價值的，並希望能夠活得更好。

高齡住宅的分配由 65 歲以上的需求者向市政府提出申請，可自行選擇指定要住在轄區內哪一間住宅，再由區鄉鎮政府評估其入住之必要性後，再分配直接入住或排隊登記。原則上每個老人可自由選擇要住哪個住宅，政府都會滿足。各區鄉鎮政府提供之高齡住宅因地方稅收不同，其所提供之照護住宅服務也略有差異。風評較佳的機構 waiting list 長，參訪所見的老人都 80 歲以上。

由 Vardaga 營運之 Villa Agadir 高齡住宅內有 6 個單位，每個單位包含 9 間房間，共用 1 個開放式廚房。人員配置方面則每單位早上 7 點至晚上 9 點間有兩位護士負責，其餘員工包含護佐、照護員、復健師等，會依據住戶需求而機動性調整配置。另外每位住戶在入住的第一周皆會與一位政府聘任的外部高齡醫學醫師會面，而此醫師每周會到住宅訪視，之後根據住戶健康狀況分配與來訪醫師的會面頻率，並不是每周都一定會需要見醫師，另有外部值勤醫師（24 小時 on call），處理臨時或緊急狀況。政府以專業培訓的規定管控工作人員的品質，護士具備大學學歷（3 年制）、護佐則為高中學歷；同時亦有常規性到訪考核工作人員是否達到要求，而 Vardaga 公司內部亦有考核機制，定期加強人員的訓練。而在客戶滿意度方面，也定期透過問卷方式詢問“住戶”及其“家屬”對住宅的滿意度，亦有"員工"工作滿意度調查，以此掌握住宅照護服務的品質。

表 5　Villa Agadir 參訪情形

	
Villa Agadir 主管 Mrs. Pia Henriksson 向衛福部參訪團進行聽取說明	衛福部參訪團於 Villa Agadir 交誼廳聽取說明

衛福部林部長奏延(右)與 Villa Agadir 住民進行交流

成大醫院楊院長俊佑(左一)及衛福部林部長奏延(左三)與 Villa Agadir 住民進行交流

衛福部林部長奏延(右二)與 Villa Agadir 暑期工讀學生交換心得

衛福部林部長奏延(左)致贈 Villa Agadir 主管 Mrs. Pia Henriksson 禮品

衛福部參訪團於 Villa Agadir 外全體合照

(後排左起：高雄榮總周主任明岳、高雄榮總梁醫師志光、台北榮總陳主任亮恭、衛福部郭技正威中、台北仁愛醫院甄主任瑞興、成大醫院白教授明奇、馬偕醫院洪主任大川、衛福部趙科長偉翔、長庚醫院徐主任文俊、同行翻譯人員；前排左起：衛福部王主秘宗曦、衛福部林部長奏延、成大醫院楊院長俊佑)

(三) Famntaget Omsorg

1.背景概要

Famntaget Omsorg 成立於 2009 年，為一典型的家族企業，主要提供客製化居家照護服務，包括居家協助、活動參與協助、喘息服務及其他客製化之服務等，尤其擅長失智症患者的居家照護、喘息服務及陪伴。Famntaget Omsorg 的失智症照護受 Silviahemmet 失智症協會之榮譽認證，具一定之品質水準。截至 2016 年止，Famntaget Omsorg 擁有 3 個據點、70 名員工。

Famntaget Omsorg 強調其照護品質管理，採用 Swedish Institute for Quality（SIQ）的商業模型。該模型符合國家政策與客戶之需求。據 Famntaget Omsorg 2014 年的客戶滿意度調查顯示，88%的客戶對 Famntaget Omsorg 員工提供之服務感到滿意。

居家協助　　活動參與協助　　喘息服務

圖 3　Famntaget Omsorg 提供之服務類型

2.參訪摘要

本次參訪主要對象為 Famntaget Omsorg 創辦人及營運長 Mr. Peter Eriksson 及 Mrs. Mari Eriksson 夫婦，進行瑞典的居家照護服務運作模式解說以及雙方意見交流。

瑞典居家照護服務的內容由區鄉鎮政府依據需求者的情況而指派，由私立居家服務公司接受委派提供服務，在斯德哥爾摩地區共有 60 家居家服務公司；另外，需求者也可以根據自身狀況另與居家服務公司簽訂合約，約定提供政府提供範圍外的居家服務。而委任的費用則以小時計費，不因

其為政府委派或自行簽訂之合約而有差異。而需求者可以自行選擇居家服務的公司，若不滿意隨時可向政府提出申請，五天內即可更換服務公司。

居家服務的內容包含個人照護、居家清潔、傷口護理、給藥、購買食物、洗衣服務、社交活動支援、就診陪同、煮飯洗碗等。針對同一個客戶，盡量會安排同一位居家服務員。居家服務單位的成員編制以小組為單位，每組成員除了居家服務員之外還有護士與護佐，此外市政府也編列一個小組，負責支援私營居家服務業者來不及及時處理的突發性事件。而針對接受居家服務的使用者，同時亦可能接受其他不同單位之服務，如醫生、護士、輔具供應機構、裝修工人等，因此居家照護單位也會為每一名服務使用者指派一名護佐專責協調其他服務單位之整合（manager）。

居家服務的人員培訓中，護佐並不一定要拿到學位證照，只要修滿相關課程的 600 學分（基礎護理，心理學，藥物學等課程）即可投入居家服務市場，而其他居家服務員的培訓則強調在初始加入時的服務訓練課程，另外也會讓員工參加失智護理學校的專業培訓課程；對每位小組組長則多提供管理相關課程。此外，居家照護服務受政府法令制度規範，針對作業流程品管嚴格，以受訪的 Famntaget Omsorg 來說，就有 50 多條的工作流程準則，提供居家服務人員在不同情境下的處理準則參考。

表 6　Famntaget Omsorg 參訪情形

	
Famntaget Omsorg 創辦人及營運長 Mr. Peter Eriksson 及 Mrs. Mari Eriksson 夫婦向衛福部參訪團進行簡報	Famntaget Omsorg 創辦人及營運長 Mr. Peter Eriksson 與衛福部參訪團現場議題交流

Famntaget Omsorg 創辦人及營運長 Mr. Peter Eriksson 及 Mrs. Mari Eriksson 夫婦與衛福部王主秘宗曦(右二)、成大醫院楊院長俊佑(右一)及長庚醫院徐主任文俊(左一)合影

衛福部林部長奏延(中)致贈 Mrs. Mari Eriksson 及 Mr. Peter Eriksson 禮物

衛福部參訪團交流會後留影紀念

(左起：翻譯人員、成大醫院白教授明奇、衛福部王主秘宗曦、衛福部趙科長偉翔、馬偕醫院洪主任大川、高雄榮總周主任明岳、台北榮總陳主任亮恭、高雄榮總梁醫師志光；右起：衛福部林部長奏延、成大醫院楊院長俊佑、台北仁愛醫院甄主任瑞興、長庚醫院徐主任文俊、野村總研成員)

高齡住宅 Servicehuset Pilträdet 餐廳外觀

衛福部林部長奏延(左一)與居住於高齡住宅 Servicehuset Pilträdet 住民一起用午餐及意見交流

(四) Attendo Kampementet Elderly Care Facility

1.背景概要

瑞典廠商 Attendo 成立於 1985 年，為北歐大型跨國健康照護集團，主要經營領域為老人及身障照護市場，主要營運項目為安養照護機構或服務的

自營、及政府健康照護服務的承包。2015 年 Attendo 及團年營收達 11.8 億美元、市值達 16.3 億美元，總員工人數約 2.4 萬人，於瑞典、丹麥、挪威、芬蘭擁有超過 500 家機構，服務人次超逾 2.4 萬人。

圖 4　Attendo 服務模型

Attendo 集團旗下企業皆有進行照護品質管理及評測，其採用之內部品質控管系統（AQ16）為 Attendo 自行研發，由總部的品管部門規劃、各國當地機構執行。此外，Attendo 亦於 2008 年開始採用內部品質指數（The Quality Thermometer），針對九大量測面向做級距 1%-100%的評分。Kampementet 最新的品管分數為 90%，較 Attendo 集團平均的 84%為高。

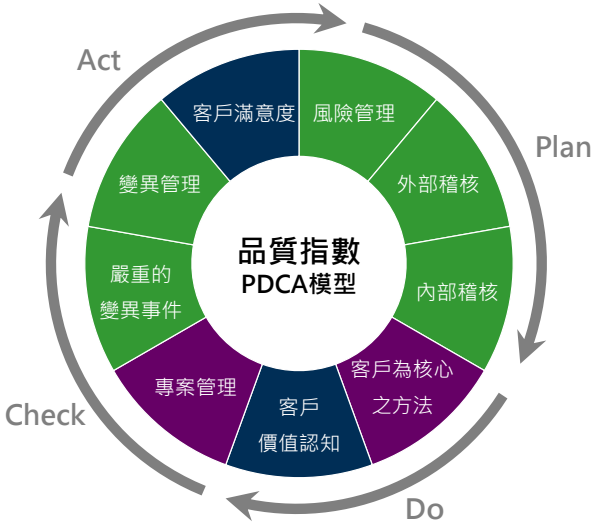


圖 5　Attendo 內部品質指數模型

2.參訪摘要

本次參訪由 Attendo Kampementet 的主管 Mrs. Marie Pihlhjärta 先對參訪團簡要介紹機構概況，然後由兩位物理治療師示範相關輔具運用，再參訪 Kampementet 機構院區。

Kampementet 隸屬 Attendo 集團，位於瑞典中部 Östermalms，為一家提供一般照護及失智照護的退休之家。Kampementet 擁有花園及 96 個房間的六層公寓，其中三層提供一般照護、另三層提供失智者特別照護；每層樓皆被區分為兩大區，每區皆擁有公用廚房、起居室及大陽台。一樓則另設有物理治療與職能治療室、SPA 區、繪畫及活動室。此外，Kampementet 的每位居民皆有其專屬的照護人員及照護經理，並有固定的護士及物理治療師駐點時間，以及針對失智症照護則與 Silvia sister 合作，協助居民及員工進行照護活動。

而針對居住在長照住宅的住戶，瑞典強調鼓勵其自由活動之行動力，不因身體病況限制而降低活動力。在此前提下，對照護人員的健康保護也是瑞典非常強調的：照護人員在移動照護服務使用者時，並不能直接搬運，而是透過各種輔具協助，以不讓照護人員受傷為原則。相較之下，針對長照服務需求者，台灣比較常見的做法還是臥床；而日本則是透過機器人等機械設計，協助照護人員以更不施力的方式搬運長照服務對象。

表 7　Attendo Kampementet Elderly Care Facility 參訪情形

	
衛福部林部長奏延(左一)與 Attendo Kampementet 失智中心主管交換名片	Attendo Kampementet 物理治療師向衛福部林部長奏延(左一)概要介紹照護中心

Attendo Kampementet 物理治療師指導衛福部王主秘宗曦(右)親身體驗輔具之使用

Attendo Kampementet 物理治療師實際操作輔具之使用(衛福部趙科長偉翔(右)親身示範)

福部王主秘宗曦(左)親身操作輔具使用

成大醫院楊院長俊佑(左)親身示範輔具使用

衛福部林部長奏延(右)贈與禮品予兩位護理人

(五) Helsinki Roihuvuori Comprehensive Service Center

1.背景概要

Helsinki Roihuvuori Comprehensive Service Center（Roihuvuori CSC）為 City of Helsinki 旗下的一家整合型服務中心。City of Helsinki 旗下的整合型服務中心主要服務的對象為退休或失業的民眾，服務或設施多數為免費提供，內容包括娛樂及休閒活動如讀書會、技能增進社團等，亦提供郊遊、義工活動、社會與健康諮詢、宗教活動等；最大家的整合型服務中心為 Kustaankartano CSC。

City of Helsinki 致力於預防性老人福利，廣設「健康照護中心」，提供老人物理治療、復健、運動及健康等諮詢，鼓勵老人運動。其並提供市民多樣協助老人獨立生活之高齡服務，包括居家式的家庭照顧者支持與指導、機構式服務、及社區式的日間活動及服務中心等。另外，City of Helsinki 亦提供如居家送餐、安全專線、高齡者專線等服務，並注重家庭照顧者權益，提供指導諮詢、補助及喘息服務等協助。

社工關懷及家庭照顧者指導	協助高齡者維持一定品質的獨立生活；並提供家庭照顧者照護指導
退休及失業者服務中心	免費提供多樣娛樂及休閒團體活動
日間活動	將赫爾辛基市分成東南西北四區，提供不同日間活動
非正式照護（如家庭照顧）支持	由市政府與家庭照顧者簽約，以提供如喘息服務、支薪等服務
居家照護協助	由赫爾辛基健康中心組織護士及照護人員協助居家照護，採使用者付費模式
老人之家及公共服務	由市與業者簽約，提供24小時照護、協助式居家服務、及機構式照護等3種模式
其他服務	記憶障礙診斷、神經科門診、及退休老兵復健等

圖 6　赫爾辛基市 Comprehensive Service Center 提供之服務內容

2.參訪摘要

本次參訪 Helsinki Roihuvuori Comprehensive Service Center 主要對象為主管 Ms. Tuula Mohamud 以及赫爾辛基市政府高齡照護的醫療長 Ms. Harriet Finne-Soveri；由 Ms. Mohamud 簡要介紹此複合服務機構並帶領參訪團參觀服務中心後，由 Ms. Finne-Soveri 介紹芬蘭與赫爾辛基市政府單位如何掌控轄區內高齡照護之品質控管。

芬蘭全國 550 萬人口，65 歲以上佔 1 百萬人，75 歲以上為老老人，長照需求大多發生在 70~85 歲，長照服務佔 GDP 約 2.1%。赫爾辛基市人口約 62 萬，65 歲以上佔 16%。芬蘭與臺灣相同，整合衛生醫療與社會福利組織，於 2013 年 1 月 1 日合併成立衛生福利部（Ministry of Social Affairs and Health），由中央制定法令，提供專科與醫學中心等級的醫療服務，各市政府負責提供居民社福與基礎醫療服務。 赫爾辛基市每年社福預算為 22 億歐元，此次參訪的 Roihuvuori Comprehensive Service Center 每年預算為 200 萬歐元。全市共有 147 高齡照護住宅(含長照與短期照護等)，16 個日照中心，10 個公營的 Comprehensive Service Center，提供居民相關高齡與社福照護服務，然由於全赫爾辛基市約 2 千張公營的長照病床，床位不足的部分則由市政府向私營機構購買床位，與瑞典所採用的“經營權招標”模式不同。

芬蘭人認為繳交高額稅率後，長期照護服務應該是政府的責任，因此由家人照護的比例低，常見獨居老人，因此長期照護政策着重居家照護之配套措施。Comprehensive Service Center 的員工緊密與居家照護服務以及社工單位合作，幫助因短暫需求而住進 Service Center 的高齡居民返家後續之相關照護支援，以早日恢復獨立自主生活能力。目前也在居家照護端導入遠距照護服務，特別是血壓監控以及用藥監控與指示。

芬蘭相較於其他先進國家，在照護服務系統中導入品質管理為發展最好的國家：透過中央政府規範之照護準則，無論公營或私營機構皆須導入此以照護成果證據為基礎的服務品質規範，經由品管模式、品質指標及回報機制的建立，透過芬蘭衛福部五個區域辦公室控管全國照護服務品質；此制度與加拿大法令規範照護機構一定要符合的 evidence index 類似。除此之外，芬蘭各公營的照護機構還會透過 HaiPro 事件回報系統、以及針

對高齡照護相關服務面及環境面等議題的問卷蒐集，持續改善並控管全國高齡照護品質。

表 8　Helsinki Roihuvuori Comprehensive Service Center 參訪情形

 Helsinki Roihuvuori Comprehensive Service Center 主管 Ms. Tuula Mohamud 以及赫爾辛基市政府高齡照護醫療長 Ms. Harriet Finne-Soveri 歡迎衛福部王主秘宗曦(左三)及參訪團到訪	 Helsinki Roihuvuori Comprehensive Service Center 主管 Ms. Tuula Mohamud 向衛福部王主秘宗曦(左三)及代表團成員進行簡報說明
 Helsinki Roihuvuori Comprehensive Service Center 之公共開放餐廳一隅	 Helsinki Roihuvuori Comprehensive Service Center 之公共開放客廳一隅
 衛福部王主秘宗曦(右)致贈 Ms. Tuula Mohamud 禮物	 Ms. Tuula Mohamud 為衛福部王主秘宗曦(中)及長庚醫院徐主任文俊(右)介紹 Helsinki Roihuvuori Comprehensive Service Center

 衛福部王主秘宗曦(中)及成大醫院白教授明奇與 Ms. Finne-Soveri 交換名片	 Ms. Finne-Soveri 向衛福部王主秘宗曦及參訪團介紹芬蘭與赫爾辛基市政府單位如何掌控轄區內高齡照護之品質控管簡報說明
 衛福部參訪團於會議室留影 (左起：衛福部王主秘宗曦、成大醫院楊院長、野村總研成員、台北仁愛醫院甄主任瑞興、馬偕醫院洪主任大川、外館駐芬蘭辦事處黃組長啟民及鄭代理館長素賢、成大醫院白教授明奇、長庚醫院徐主任文俊)	 衛福部參訪團全體合照 (左起：台北仁愛醫院甄主任瑞興、外館駐芬蘭辦事處鄭代理館長素賢、Helsinki Roihuvuori Comprehensive Service Center 主管 Ms. Tuula Mohamud Ms. Tuula Mohamud、醫療長 Ms. Harriet Finne-Soveri、Ms. Finne-Soveri、衛福部王主秘宗曦、成大醫院楊院長俊佑、成大醫院白教授明奇、長庚醫院徐主任文俊馬偕醫院洪主任大川、外館駐芬蘭辦事處黃組長啟民)

(六) Wilhelmiina Elderly Care Center

1.背景概要

Wilhelmiina Elderly Care Center（Wilhelmiina）成立於 1995 年，為私人基金會 Miina Sillanpää 成立的高齡照護住宅集團，提供高齡住宿及其相關衍生服務。Wilhelmiina 於 2015 年營收達 1.43 億歐元，入住 Wilhelmiina 的高齡者人數達 150 名住戶。

Wilhelmiina 提供包括個人房(Rental Apartment)、家庭房(Family Group)、及復健與短期照護（Rehabilitation and Short-Term Care）三種不同服務目的的房間類型。個人房共 37 間，主要提供可自主活動的老人使用；家庭房共 60 間，主要提供的對象為需要護理人員服務的老人，較個人房著重空

間的使用，因此亦較為寬敞；復健與短期照護房則有 54 間，主要提供調養中的老人入住，且調養中的高齡者不分罹患之病症皆可入住。此三種房型被分別獨立設置於三棟大樓中，防止其相互干擾。

此外，Wilhelmiina 設有 Care Service Center，提供所有住戶各項健身設施、康樂設施、餐飲服務等。醫療服務方面則當住戶有需要時，才由照護中心通知醫師前來進行醫療服務。

圖 7　Wilhelmiina 提供的各項生活與醫療服務

2.參訪摘要

本次參訪由 Wilhelmiina Elderly Care Center 的 Managing Director Ms. Minna Saranpää 對參訪團做機構簡要介紹後，帶領團員參訪此民營高齡住宅之環境。

芬蘭在高齡照護上的龐大預算與其他先進國家相比，主要相異之關鍵要素為高水準的專業照護人員：在芬蘭提供照護服務的人員無論在公或民營單位服務，大約 80%皆為受過 3 年訓練、完成 120 學分的護士，目前也積極引進國際人才補充缺口。目前正在規劃中的醫療照護改革，芬蘭也將更強調如何在現有的高服務水準的照護體制下，如何透過居家照護、家庭支援等配套，提升整體照護效率，降低照護服務成本，並落實高齡者在熟悉環境生活的“在地老化”宗旨。

與公營的眾多 Comprehensive Service Center 相同，Wilhelmiina 高齡住宅亦強調高齡者透過日常活動的持續，以及社交人際的維持或強化，達到預防疾病、延緩健康老化的目標。在老人之家的設置標準上，芬蘭與瑞典類似，採取高標準規範，一般老人與失智症患者的照護住宅的基本設計相同，僅有部份針對失智老人的特別設計，防止失智患者走失或迷路。

表 9　Wilhelmiina Elderly Care Center 參訪情形

<table>
<tr>
<td> 
Wilhelmiina Elderly Care Center Managing Director Ms. Minna Saranpää 歡迎衛福部王主秘宗曦(右三)及參訪團成員來訪</td>
<td> 
Ms. Minna Saranpää 與代表團成員介紹照護中心內之餐廳設施</td>
</tr>
<tr>
<td> 
衛福部參訪團成員與 Wilhelmiina Elderly Care Center 住民一同於餐廳排隊取餐</td>
<td> 
Wilhelmiina Elderly Care Center 內 Group Home 之公共開放客廳 Ms. Minna Saranpää 與衛福部王主秘宗曦(左五)及參訪團成員合照</td>
</tr>
<tr>
<td> 
Ms. Minna Saranpää 向衛福部參訪團進行簡報</td>
<td> 
Wilhelmiina Elderly Care Center 內 Group Home 之公共開放客廳一隅</td>
</tr>
</table>

Ms. Minna Saranpää 向衛福部王主秘宗曦(右二)及參訪團進行房間設施解說

衛福部王主秘宗曦(右)致贈 Ms. Minna Saranpää 禮物

衛福部參訪團全體合照

(左起：衛福部郭技正威中、馬偕醫院洪主任大川、外館駐芬蘭辦事處鄭代理館長素賢、成大醫院白教授明奇、外館駐芬蘭辦事處黃組長啟民、衛福部王主秘宗曦、Ms. Minna Saranpää、成大醫院楊院長俊佑、長庚醫院徐主任文俊、台北仁愛醫院甄主任瑞興、衛福部趙科長偉翔)

(七) Attendo Mummolat

1.背景概要

Attendo 集團為北歐最大照護公司，營運據點約 510 個，僱員 19000 人，目前依據集團內發展出的品質控管機制，在芬蘭地區成為私營照護機構市占率最高的公司。

目前 Attendo 於芬蘭經營的事業主要來自於自營照護住宅，占營收約 57%；其次則是承接政府照護住宅營運權，約為 33%；另外一部分則是醫護人員的派遣事業，約為營收之 10%，此亦為 Attendo 進入芬蘭市場初期之主要業務。由於芬蘭醫療服務全為政府提供，在偏遠地區常常缺乏醫護人員，此時多半仰賴私營醫護派遣事業協助。派遣人員以醫生為主，醫師

可在上班以外時間，以論小時計價的派遣方式獲得額外收入，成為偏遠地區醫護人員不足的解決方案。

圖 8　Attendo Mummolat 採用 Attendo 高齡住宅傳統雙 L 型建築

2.參訪摘要

本次參訪芬蘭 Attendo 主要對象為公關主管 Mr. Lauri Korkeaoja、擔任 Press Officer 的 Mr. Vili Lähteenoja、以及 Regional Manager Mr. Simo Saaranen，首先於芬蘭 Attendo 位於 Ruoholahti 的企業總部概要介紹芬蘭高齡照護制度及架構，與芬蘭 Attendo 事業概述。會後由 Mr. Korkeaoja 與 Mr. Lähteenoja 帶領參訪團員移動至 Attendo Mummolat 高齡住宅參訪。

芬蘭目前全國約 7.5 萬老人於自宅接受居家照護服務，其中約 3 萬人接受每日兩次的居家照護服務。超過 4 萬名老人居住於照護機構，其中約 75%為失智老人。與瑞典的老人可以自行選擇入住的機構相比，芬蘭則是由市政府直接決定老人是否可以住進照護住宅、住進哪一間公營或私營的照護住宅，但芬蘭預計未來將導入需求者自主選擇模式，向瑞典模式趨近。

芬蘭各地區老人入住照護住宅的比例不同，在赫爾辛基鄰近的 Vantaa 地區為例，75 歲以上的老人約有 8%居住於照護住宅，其他地區則可能有 15%以上，取決於當地人口結構、照護住宅數量等。過去照護住宅全由市政府提供，但近年人口快速老化，造成公立照護住宅供不應求，因此開放以採購招標方式，納入私營機構提供之照護住宅。由於私營照護事業眾多，因此各機構如何針對照護品質提供良好管理模式，成為招標的重要關鍵因素。

在 Attendo 的 24 小時高齡照護住宅中，平均過世前入住時間約兩年，照護住宅的醫護人力配置以集體住宅(15 間房)為單位，早上 3 位護士、晚上 2 位、半夜 1 位，另有多名照護員；每單位搭配一位專屬醫師，每周拜訪一次，由每位住戶的專屬護士將住戶的身體狀況向醫師彙整報告。在照護人員的培訓上，licensed nurse 為 4 年、practical nurse 為 3 年，caregiver 也需要經過芬蘭衛生福利部擬定的 8 個月培訓課程。

表 10　Attendo Mummolat 參訪情形

 Attendo 公關主管 Mr. Lauri Korkeaoja 及 Press Officer Mr. Vili Lähteenoja 歡迎衛福部參訪團	 衛福部參訪團於 Attendo 芬蘭企業總部會議室與對方進行議題交流
 衛福部王主秘宗曦(左)致贈 Mr. Lauri Korkeaoja 禮物	 衛福部參訪團於 Attendo 芬蘭企業總部外留影(左起：Mr. Lauri Korkeaoja、衛福部王主秘宗曦、成大醫院楊院長俊佑、台北仁愛醫院甄主任瑞興、成大醫院白教授明奇、馬偕醫院洪主任大川、外館駐芬蘭辦事處黃組長啟民、衛福部趙科長偉翔)

Attendo 芬蘭地區照護機構外觀

Attendo 芬蘭地區照護機構內資訊看板

Mr. Lauri Korkeaoja 向衛福部王主秘宗曦(右二)介紹照護機構設施

衛福部參訪團於照護機構住民進行交流

衛福部王主秘宗曦(右一)與住民寒暄問候

Attendo 芬蘭地區照護機構戶外開放空間一隅

衛福部參訪團全體成員合影

(左起：馬偕醫院洪主任大川、衛福部郭技正威中、台北仁愛醫院甄主任瑞興、長庚醫院徐主任文俊、成大醫院白教授明奇、外館駐芬蘭辦事處黃組長啟民、衛福部王主秘宗曦、Attendo Mr. Lauri Korkeaoja、成大醫院楊院長俊佑、衛福部趙科長偉翔)

衛福部參訪團全體成員合影

(左起：台北仁愛醫院甄主任瑞興、馬偕醫院洪主任大川、外館駐芬蘭辦事處黃組長啟民、長庚醫院徐主任文俊、Attendo Mr. Vili Lähteenoja 成大醫院白教授明奇、衛福部王主秘宗曦、Mr. Lauri Korkeaoja、成大醫院楊院長俊佑、衛福部趙科長偉翔)

(八) Finnish Wellbeing Center

1.背景概要

Finnish Wellbeing Center（芬蘭福祉中心，FWBC）由 12 家芬蘭當地的健康科技與服務公司於 2002 年共同組成，致力於照護管理顧問與醫材、輔具、建築設計等服務模式的整體輸出，已協助國內如芬蘭拉赫蒂（Lahti）市，國外如日本仙台、阿賀野市規劃健康福祉中心。

FWBC 以其核心六人團隊為驅動力，重點人物包括擔任 CEO 的 Kari Häyrinen，其亦為前芬蘭貿易投資促進機構之 CEO，以及擁有 30 年日本及芬蘭大型健康照護專案計畫經歷的資深顧問 Hilkka Tervaskari。

FWBC 主要提供之產品為結合高齡服務管理顧問、先端科技(IT 技術)、與無障礙建築設計等動態照護服務模式以及經營複合式居住設施的「服務住宅」，經典個案為 2002 年與日本仙台合作之健康福祉中心。該中心結合輔具研發館與高齡照護設施之功能，使輔具一經研發即可透過高齡照護住宅中的高齡者使用做體驗改良，而高齡者的需求也可為輔具研發館帶來創新研發，兩者相輔相成。該模式隨後於 2005 年運用於日本阿賀野市，阿賀野市的健康福祉中心除提供高齡照護服務，更進一步提供復健服務及社區健康照顧。FWBC 亦分別於 2007 年與 2013 年參與芬蘭拉赫蒂市的市立醫院及福祉中心規劃工作。

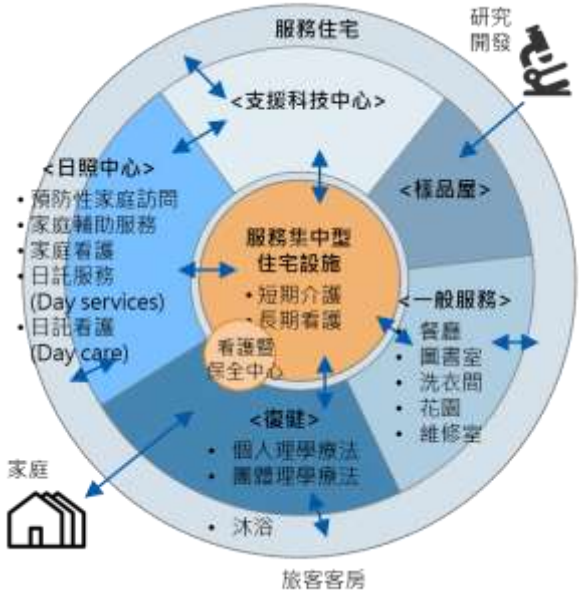


圖 9　FWBC 動態照護服務模式

2.參訪摘要

本次參訪主要對象為 FWBC 的董事長 Mr. Kari Häyrinen、董事會成員 Mr. Mikael Rentto、FWBC 芬蘭的 Managing Director Mr. Ilkka Turunen 為參訪團解說 FWBC 運作模式，之後由各相關合作企業關係人員簡介其產品特色，包括：高齡住宅家具設計商 Martela 的出口經理 Mr. Olli Loikala、復健器材商 DBC Solution 的 CEO Mr. Esa Parjanen、空氣清淨機設備廠商 Geneno 的副總 Mr. Klaus Nissinen、高齡衛浴廠商 Korpinen 產品經理 Mr. Juha Ala-Hiiro。

芬蘭 FWBC 國際照護事業於 2002 年創立，2012 年整套輸出日本，輸出的關鍵為配合當地文化，規劃最適當的照護模式，同時在其照護社區當中，透過使用者的回饋機制，由創新研發中心的生活輔助及醫療器材廠商，針對需求端調整新產品，此次參訪之各類廠商皆經由此團體合作模式，利用 FWBC 照護住宅與創新中心結合特色，將整合性產品輸出國際。然由於目前芬蘭廠商規模較小，雖藉 FWBC 在日本據點可支援其海外輸出曝光機會，考量芬蘭與日本長遠距離，實際進駐 FWBC 日本據點創新中心之廠商並不踴躍，創新中心占用率約四成，且多仰賴芬蘭外貿協會資源支持；然而廠商仍認為此合作模式對產品研發有極大助益，值得台灣發展長照體系的同時，以此機制為參考，進一步支援臺灣相關輔具產業創新研發。

表 11　Finnish Wellbeing Center 參訪情形

	
FWBC 的董事長 Mr. Kari Häyrinen 及與會相關成員向衛福部參訪團進行簡報	衛福部王主秘宗曦(右)致贈 FWBC 董事長 Mr. Kari Häyrinen 禮物

復健器材商 DBC Solution 的 CEO Mr. Esa Parjanen 親身示範該公司產品

衛福部王主秘宗曦(左)親自體驗復健設施

FWBC 展示空間一隅

FWBC 展示空間一隅

衛福部參訪團與 FWBC 代表成員全體合影

(左起：衛福部趙科長偉翔、台北仁愛醫院甄主任瑞興、馬偕醫院洪主任大川、DBC Solution CEO Mr. Esa Parjanen、Korpinen Mr. Juha Ala-Hiiro、成大醫院楊院長俊佑、長庚醫院徐主任文俊、外館駐芬蘭辦事處黃組長啟民、成大醫院白教授明奇、FWBC 董事長 Mr. Kari Häyrinen 衛福部王主秘宗曦、FWBC 董事會成員 Mr. Mikael Rentto、FWBC 芬蘭 Managing Director Mr. Ilkka Turunen、Martela 的出口經理 Mr. Olli Loikala、Geneno 副總 Mr. Klaus Nissinen、衛福部郭技正威中)

三、 醫療機構參訪

本次北歐參訪共拜訪兩家醫療機構，依據參訪時間順序分別為提供基礎醫療服務的 Capio Östermalms Vårdcentral，以及於 Nacka 市提供高齡醫學門診的 Capio Geriatrik。以下就此兩家醫療機構之背景與參訪結果要點分別進行介紹。

(一) Capio Östermalms Vårdcentral

1.背景概要

Capio 於 1994 年成立瑞典 Gothenburg，為歐洲知名的醫療健康品牌，主要以提供一般初級醫療服務為主，亦有提供專科、復健及精神科治療等服務。截至 2015 年止，Capio 共有近 1.2 萬名員工，提供瑞典、挪威、法國及德國等四個國家約 460 萬名病人醫療服務，年營收達 16.2 億美元。

表 12　Capio 於歐洲提供之服務內容

國家	服務提供內容
瑞典	• 1 家急救醫院 • 2 家地區醫院 • 30 家專科診所 • 18 個精神科治療據點 • 75 個一般診所
挪威	• 8 家醫療中心 • 2 家專治飲食失調和物理治療的專科診所
法國	• 8 家急救醫院 • 11 家地區醫院 • 3 家從事復健及精神科治療的專科診所
德國	• 5 家綜合醫院 • 4 家靜脈手術專科診所 • 1 家復健照護醫院 • 7 家一般門診

Capio 於瑞典之經營重點為降低成本的「豐田生產模式」及「管理創新」，經典案例為自斯德哥爾摩郡議會接管的急救醫院 St Göran´s Hospital。在

St Göran´s Hospital 中 Capio 採取著重流動與質量的「精益化管理」，減短病人在醫院停留的時間，並提供病患入院準備及出院後續的協助。

Capio 並提出 Capio 醫療照護服務模型（Capio Model），強調品質、同情心、照護三大核心價值，並透過滿足病患需求與持續改善實現良好的財務成果。

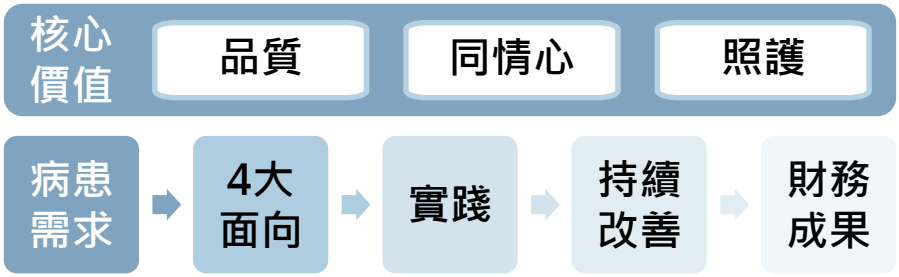


圖 10　Capio Model

2.參訪摘要

本次參訪對象為 Capio Östermalms Vårdcentral 的 GP 兼主要管理者 Dr. Kenneth Jacobsson，以及護理長 Ms. Susanne Wellander。由 Dr. Jacobsson 為參訪團概要介紹瑞典基礎醫療以及照護服務合作與銜接機制、基礎醫療體制與架構，再由護理長協助帶領參訪團員於診間中參觀。

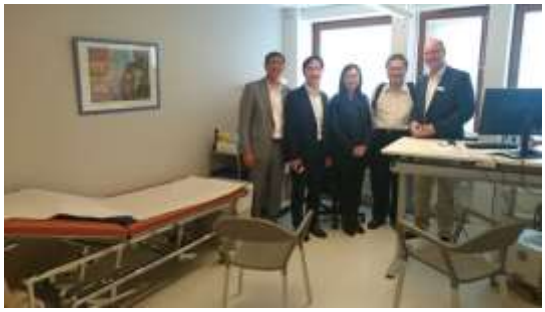
瑞典在醫療照護體系上最基本的概念是，所有人都有自由選擇他所接受服務之提供者的權利。因此，瑞典省級政府主要掌管的醫療服務系統，多半委由民營醫療服務 業者營運，透過自由市場機制互相競爭，提供國民優質的醫療服務。其中，位於醫療服務第一線把關的基礎醫療，更是強調如何在病人第一次就診的時候，就把所有事情做對做好，以降低病人再度造訪的頻率。和台灣健保制度不同的是，瑞典民眾至基礎醫療就診時，每次需支付約 25 元美金的費用，每年度則為約 140 美元的上限，超過的部分則由市政府稅收負擔，此制度推算出斯德哥爾摩地區民眾在基礎醫療上的部分負擔僅為 4%。而醫院每年能夠接受的病人數有限，每診次大約五位病人，每人約看診 30 分鐘，每位醫師每週工時不超過 40 小時。

針對國民的健康促進，瑞典基本概念是透過讓國民有良好的生活習慣，例如藉基礎教育的體育課程從小養成良好運動習慣、將運動復健納入醫療

處方等制度，潛移默化間達到全民健康促進的效果，進而降低高齡人口的醫療資源負擔。

表 13　Capio Östermalms Vårdcentral 參訪情形

Capio Östermalms Vårdcentral GP 兼主要管理者 Dr. Kenneth Jacobsson 向衛福部參訪團進行簡報



衛福部王主秘宗曦(中)於 Capio Östermalms Vårdcentral 與 Dr. Kenneth Jacobsson 合影

Capio Östermalms Vårdcentral 電話諮詢服務中心一隅

衛福部林部長奏延(左二)致贈 Dr. Kenneth Jacobsson 禮物

衛福部參訪團全體成員合影

(左起：Louise Bystrom、Ms. Susanne Wellander、Dr. Kenneth Jacobsson、SQC CEO Mr. Björn Wigström、長庚醫院徐主任文俊、台北榮總陳主任亮恭、衛福部林部長奏延、成大醫院楊院長俊佑、衛福部王主秘宗曦、衛福部郭技正威中、成大醫院白教授明奇、馬偕醫院洪主任大川、台北仁愛醫院甄主任瑞興、衛福部趙科長偉翔、高雄榮總梁醫師志光、高雄榮總周主任明岳)

(二) Capio Geriatrik Nacka

1.背景概要

Capio Geriatrik Nacka 為 Capio 集團的其中一員，其與斯德哥爾摩市政府簽訂委任契約，提供市民以下三種醫療照護服務：Capio ASIH Nacka（重症醫療服務）、Capio Palliative Care（緩和醫療服務）及 Geriatric Care（高齡醫療服務）。Capio ASIH Nacka 提供所有年齡層的重症病人相關居家照護服務；Capio Palliative Care 提供無法治療之重症患者安寧療護服務；Geriatric Care 則提供服務予高齡者或慢性病人。

圖 11　Capio Geriatric Nacka 所在之 Nacka Local Hospital 外觀

此外，Capio 相當注重醫療照護的品質，旗下機構皆使用品質控管模型 Quality Performance Inicator（QPI），將醫療照護分為三部分作品質控管：醫療結果回報（CROM），參數包括病患抱怨頻率、復原情形；病患結果回報（PROM）包含治療後的生活品質提升；病患經驗回報（PREM）則為上述兩者的綜合經驗。Capio 並提出品質預算（Quality Budget）的概念，認為針對醫療照護應設定可量化的過程及目標，以達工作模式的改善與發展。

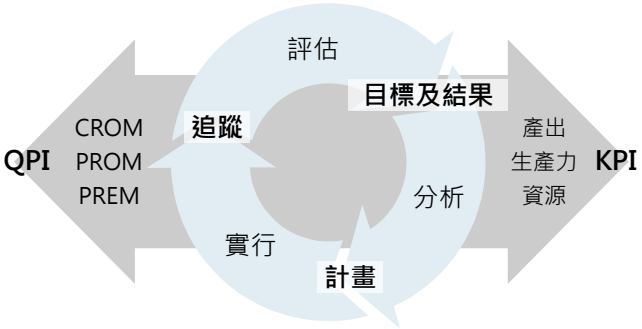


圖 12　Capio 品質控管模型

2.參訪摘要

本次參訪對象為 Capio Geriatrik Nacka 的護理長兼管理者 Mr. Björn Sjögren 以及高齡醫學主治醫師 Dr. Nathalie Morén，由兩位對參訪團解說瑞典醫療體系公私營合作機制以及醫療與照護體系銜接模式，會後再帶領參訪團簡單參觀高齡醫學病房。

1992 年瑞典醫療改革，將醫療服務歸省議會，照護服務則為社會福利領域而由市政府主掌，促使醫院減少病床數，鼓勵在自家的住院照護。目前醫療服務之物業 由省議會的地產公司擁有，營運內容則全部由政府劃分為不同專項公開招標，讓各家私營業者競標經營，然而經費透過總額給付制度限制，並不依投標廠商規格而有差異，因此更強調由可確實提供良好醫療服務品質之廠商承辦，同一間醫院裡可以有多家業者負責不同醫療服務。承包業務主要契約為四年，續約 時間為三年，最後還可延長一年，但在第八年後即須重新招標。

由於鼓勵在自家的住院照護，原本由省議會管轄之醫療端提供服務的病人將轉接到由市政府主管之照護端提供服務，因此在醫療與照護服務的銜接上，瑞典透過 Care Manager 制度的引入，在病人住院的第二天起即與醫護人員、病人家屬溝通協調，將病人回自家住院照護前就把所需之措施與硬體設備準備好，達到醫療照護 無縫銜接。

瑞典醫療支出經費依據 DRG 給付，更逐年下降 2%，同時醫院並沒有拒絕病人的權利，依照省議會的醫管單位評核決定病人是否可以於此醫院就診，因此各家私營 醫療承包廠商單位會更嚴格控制提供服務之品質，提高醫療服務效率以降低病人待在醫院的時間。本次參訪之 Capio Geriatrik 專責 Nacka 市醫院的高齡醫學科，每年由 DRG 給付之病人數為 2,500 人，平均病人住院天數為 9.1 天。

表 14　Capio Geriatrik Nacka 參訪情形

	
Capio Geriatrik Nacka 代表 Mr. Björn Sjögren 及 Dr. Nathalie Morén 歡迎衛福部林部長奏延(右二)	Capio Geriatrik Nacka 代表向衛福部參訪團進行簡報

<table>
<tr><td> 
Mr. Björn Sjögren 及 Dr. Nathalie Morén 與衛福部參訪團進行意見交流</td><td> 
衛福部林部長奏延贈(右) Mr. Björn Sjögren 禮品</td></tr>
<tr><td> 
衛福部林部長奏延(左二)與 Capio Geriatrik Nacka 院內老人寒喧問候</td><td> 
衛福部林部長奏延(右)與 Capio Geriatrik Nacka 院內老人寒喧問候</td></tr>
<tr><td> 
Capio Geriatrik Nacka 院內護理站內一隅</td><td> 
Capio Geriatrik Nacka 院內會客室一隅</td></tr>
<tr><td colspan="2"> 
衛福部參訪團全體成員合影
(左起：長庚醫院徐主任文俊、成大醫院白教授明奇、馬偕醫院洪主任大川、台北仁愛醫院甄主任瑞興、成大醫院楊院長俊佑、衛福部林部長奏延、衛福部王主秘宗曦、台北榮總醫院陳主任亮恭、高雄榮總梁醫師志光、高雄榮總周主任明岳、衛福部趙科長偉翔)</td></tr>
</table>

四、 輔具企業參訪

本次北歐參訪拜訪一家高齡輔具廠商，HUR。以下就其機構之背景與參訪結果要點分別進行介紹。

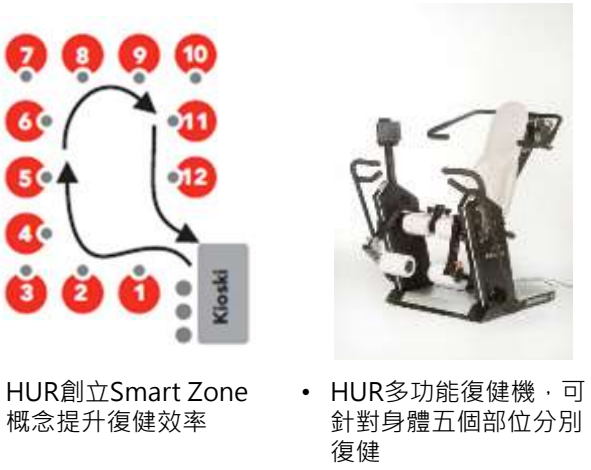
(一) HUR

1.背景概要

HUR 名稱源於 Helsinki University Research 簡稱，成立於 1989 年，為一家透過與赫爾辛基科技大學合作設立 HUR Lab，結合學術理論和不斷臨床實證研發出適合高齡者及病人用的「氣壓式肌力復健器材」的輔具廠商。氣壓式肌力復健器材針對高齡者、病患、脊髓損傷者研發，利用空氣壓縮當阻力，取代傳統鐵片及管線；此外，該產品並可連接網絡與導入使用者回饋機制，透過智慧系統記錄使用情形以協助產品選購及製造改良。

HUR 於澳洲、加拿大、德國、俄羅斯、美國均設有分公司，全球共 30 國經銷網絡、5 千多家機構使用其產品。台灣亦有引進 HUR 的產品，經銷商為普達康公司。

HUR 的產品於亞洲之實績包括 2014 年與新加坡退休村 ASPIRE55 合作，於其創新實驗運動中心進行，針對 37 位 55-78 歲的退休村會員進行為期 10 周、每周 2 次的 60 分鐘訓練，發現 80%的參與者平均增加 25%的手臂及腿部強度，腿部彎曲度最高增加兩倍、所有參與者增加 34%腹部強度、單腳平衡時間增加 1.25 倍。



• HUR創立Smart Zone 概念提升復健效率

• HUR多功能復健機，可針對身體五個部位分別復健

圖 13　HUR 服務及產品

2.參訪摘要

本次參訪首先由 HUR 的營運長 Mr. Mats Manderbacka 與亞洲區經理 Ms. Midori Shimada 協調其產品使用場域 Auron OMT 復健中心，為參訪團成員展示 HUR 產品使用情形，以及由 Auron OMT 之復健師 Ms. Nina Leppänen 為參訪團解說芬蘭復健照護制度。參訪後 Mr. Manderbacka 再藉參訪團員下榻飯店會議室，與團員們討論與台灣進一步合作契機。

關於芬蘭復健治療的投入部份，如持有醫生的 prescription ，政府補助每次 45 分鐘 6 歐元的固定費用。但近年因政府財政困難，醫師處方箋的開立標準趨嚴，未來也將往復健治療無補貼的方向進行改革。本次參訪的 Auron OMT 復健中心為芬蘭最大的高齡健身連鎖店，其經營核心價值在於同時結合老人健身與復健。

HUR 健身儀器透過整合雲端平台，可輔助管理師投過雲端管理，協助使用者達到最佳的復健效果。復健與生理資料彙整的平台服務，更為 FINGER Project 裡追蹤高齡者使用後成效的重要關鍵。此外，HUR 器材目前配備的電子平版核心零件係來自於台灣的廠商，但目前亦積極與潛在合作廠商討論在亞洲製造之可能。

表 15　HUR 參訪情形

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<td> 
衛福部王主秘宗曦(右一)與 HUR 營運長 Mr. Mats Manderbacka 交換名片</td>
<td> 
Auron OMT 復健師 Ms. Nina Leppänen 向衛福部王主秘宗曦(左二)及參訪團成員介紹復健設施</td>
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<td> 
衛福部王主秘宗曦(中)親自體驗復健設施</td>
<td> 
成大醫院白教授明奇親自體驗復健設施</td>
</tr>
</table>

衛福部參訪團全體成員合影

(左起：Mats Manderbacka、Nina Leppänen、長庚醫院徐主任文俊、馬偕醫院洪主任大川、衛福部郭技正威中、成大醫院白教授明奇、外館駐芬蘭辦事處黃組長啟民、衛福部王主秘宗曦、外館駐芬蘭辦事處鄭代理館長素賢、台北仁愛醫院甄主任瑞興、、衛福部趙科長偉翔)

HUR 營運長 Mr. Mats Manderbacka 向衛福部參訪團進行業務簡報

衛福部王主秘宗曦(中)致贈禮物與 HUR 營運長 Mr. Mats Manderbacka

五、 政府單位參訪

本次北歐參訪共拜訪三個政府單位，依據參訪時間順序分別為 Nacka Kommun、Sveriges Riksdag 瑞典國會及芬蘭衛生福利部。以下就三家機關機構之背景與參訪結果要點分別進行介紹。

(一) Nacka Kommun

1.背景概要

納卡市(Nacka Kommun 或稱 Nacka Municipality)為瑞典斯德哥爾摩省(Stockholm County)內之地方政府，位於首都斯德哥爾摩市(City of Stockholm)區之東邊。2015 年底居住人口為 97,986 人，全市平均年齡為 38.5 歲，雖

然較瑞典全國平均年齡 40.3 歲低，但自 2006 年以降人口老化速度每年年複合成長率約 4.2%，至 2015 年底 65 歲以上人口佔總人口數已達 15.8%。根據統計，納卡市內工作人口(20-64 歲)平均年收入 409,000 克朗，較全國平均年收入 348,000 克朗高。納卡市內老人住宅(Special Housing)數約 1,300 戶佔全市總戶數之 3.22%。

圖 14　Nacka Kommun 外觀

Nacka Kommun（Nacka 市政府）成立於 1971 年，負責統籌 Nacka 市內社會福祉相關之活動，包括義務教育、照護與支持、在職訓練、住宿環境協助、都市發展、交通建設…等。其中，在照護與支持服務項目中，Nacka Kommun 提供包括孩童與青少年、家庭、高齡者、殘疾者、家庭暴力受害者、藥物濫用者之照護與支持。而在高齡者照護與支持服務中，Nacka Kommun 提供高齡安養照護的措施與補助、教育與在職訓練、甚至是假期的交通運輸、高齡疾病預防宣導等，以達「讓市內老人皆可過著身心舒適、有尊嚴且有意義的生活」之最終目標。

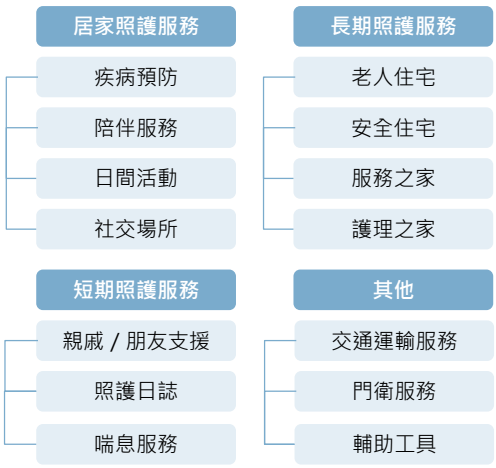

圖 15　Nacka Municipality 提供之高齡照護服務

Nacka 市的高齡照護目標是以「尊重」為基本的出發點，希望每個老人都能自己作主，按照自己希望的方式受到照護及過生活。其並設有委員會負責針對老人安養措施與斯德哥爾摩省議會、斯德哥爾摩省老人中心／基金會進行合作。在這樣的氛圍下，Nacka Kommun 的高齡照護與支持帶有「高品質、高影響力、個別化及安全」的服務特色。

2.參訪摘要

本次參訪主要對象為 Nacka 市政府照護服務組長 Ms. Charlotte Haggren 以及組員 Ms. Lotta Österlund，為參訪團員概述瑞典各地方市政府營運及控管轄區內居民照護服務機制與模式。

根據參訪單位表示，瑞典老人照護服務主要依循中央政府訂定之 Social Service Act 及第三級政府自行訂定的 Guildline 來執行。本次參訪 Nacka Kommun 負責規劃與統整 Nacka 市內的老人照護措施、教育與在職訓練及其補助金額。高齡照護服務項目可分為 Support(包含 Home help、Companion、respite care、social alarms、nursing grants)、Accommodation(包含 Special accommodation、Short-term、relief and respite)、Contribution to housing adaptation(包含 Repair、the need cease)、Daytime activities(針對居家照護之失智者提供之日間照護活動服務)、Vacations(包含 Transportation service、national mobility 及 parking)及 Prevention(包含 Outreach、Tryggve、proper nutrition、physical activity 及 social interaction)等六大項。申請程序上，如需求者申請服務僅包含 Cleaning、Laundry、Shopping、Social alarm 或 food distribution，則可透過政府網頁線上申請並依電話聯繫即可簡化申請作業程序。如需求者有長期高齡照護(elderly care)或 Special accommodation 之需求，則需依一定申請作業流程向政府提出申請後，並由 Assistance officer 進行評估審查的程序後，依審查結果通知予申請者。審查程序包含：1) 聯繫 Assistance Officer、2) Assistance Officer 提供相關資訊、3) 需求者提出正式申請書、4) 審查作業、5) 審查決定、6) Aid decision、7) 評估結果執行等步驟。第一次審查多透過與 Assistance Officer、到家拜訪會面或 Care planning 方式來進行。如審查結果為不同意(Refusal)，申請者仍可向 Administrative Court 提出議異。

Nacka 市內目前約有 21 個 Care manager，平均每人負責 117 個人的使用者之照顧管理。相較於亞洲國家在 Care planning 上多倚賴許多統計資訊應

用工具來判斷使用者的照護需求程度，瑞典則是高度倚賴專業評估者本身累積之經驗與知識 Know how。

民間照護機構於瑞典照護體系亦扮演相當重要之角色。第三級政府與民間照護機構關係為政府僅負責 Care management 業務，實際執行端則透過公開競爭方式由民間企業參與投標以獲取經營權利，並提供服務與使用者。政府委外民間提供之居家服務協助項目包含分為兩大部分：1)個人生活照顧：如著裝、淋浴、如廁、飲食、行走等協助；2)生活服務(Service Operations)：如清潔、洗衣、購物及庶務處理。Homecare 服務給付費用於開始第一個八小時內單價為 150 SEK/小時，一個月上限為 1772SEK。使用者如有照護需求可以透過 Security alarm，Monitoring center 在收到警示後，即會進行後續之作業，每個月費用為 188SEK，使用次數未有限制。Nacka Municipality 與民間業者 Samhall 合作來提供使用者送餐服務，每餐費用為 51 SEK。外出護送部份使用者不需付費，原則以每周三個小時為計。喘息服務亦為居家照護服務的項目之一，每周也有三個小時 。

除居家服務外，使用者亦可到與政府有合作簽約之日照中心使用相關服務，費用根據使用項目分別計算。另外，當居家照護服務之項目無法因應使用者需求時，亦可以到照護功能較完善之 Special accommodation (Special housing)。於短期照護(Short term accommodation)部分，特別規定僅限有長期照護需求者，每日費用為 177SEK(含餐及照護服務)。交通服務協助亦是照護服務範籌，然與前者不同的是，使用者申請審查為第二級單位，審查前亦必須經過醫生確認並取得證明書。瑞典政府照護服務範為亦包含照顧者津貼(Care Contribution)，包含先生/太太/照護夥伴皆可以申請，以降低照顧者的負擔。目前與 Nacka Municipality 市政府有契約合作之高齡照護服務業者約有 40 家，相關資訊由政府端提供予使用者，由其自己選擇適合公司。

表 16　Nacka Kommun 參訪情形

	
衛福部林部長奏延(右二)與 Ms. Charlotte Haggren 及 Ms. Lotta Österlund 交換名片	Nacka 市政府照護服務組組員 Ms. Lotta Österlund 向衛福部參訪團進行業務簡報

<table>
<tr>
<td> 
衛福部林部長奏延(中)贈與禮品予 Ms. Charlotte Haggren 及 Ms. Lotta Österlund</td>
<td> 
衛福部參訪團全體成員合影
(左起：高雄榮總周主任明岳、成大醫院白教授明奇、衛福部王主秘宗曦、長庚醫院徐主任文俊、衛福部林部長奏延、成大醫院楊院長俊佑、台北榮總醫院陳主任亮恭、台北仁愛醫院甄主任瑞興、馬偕醫院洪主任大川、高雄榮總梁醫師志光、衛福部醫事司趙科長、衛福部醫事司郭技正)</td>
</tr>
<tr>
<td> 
斯德哥爾摩養老院 vintertullen 餐廳外觀</td>
<td> 
衛福部林部長奏延(左一)及衛福部王主秘宗曦(右二)與養老院 vintertullen 住民一起用午餐及意見交流</td>
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</table>

(二) Sveriges Riksdag 瑞典國會

1.背景概要

瑞典國會（Sveriges Riksdag）實行一院制，由 349 名國會議員構成，是瑞典的國家立法機關，是瑞典最高決策機關，也是最重要的民主議會，負責辯論、制定和通過瑞典所有法律。Sveriges riksdag 最早的歷史可追溯回 1435 年瑞典貴族的聚會；於 1527 年瑞典現代史上首名國王古斯塔夫·瓦薩修改了聚會架構，使國會包含來自四個等級：貴族、神職人員、資產階級和農民的代表。瑞典一直實行「國民等級代表制」，直至 1865 年才廢除

舊有的四院制國會。然而，瑞典於 1917 確立議會制時，瑞典議會才正式成為現代意義上的議會。

圖 16　瑞典國會外觀

2.參訪摘要

本次參訪由瑞典國會議員 Mrs. Caroline Szyber 帶領參訪團員參觀國會，並於參訪行程中，就瑞典目前社會福利與醫療照護議題與參訪團員進行意見交流。

瑞典近年所面臨的挑戰有二，一是住宅問題，主因是近年歐盟接受中東難民(一年約 3 萬)，原社會住宅轉為提供難民安置，後續衍生國內所需社會住宅供給不足。二是就業問題，10%以上的失業率(含青年失業)為瑞典政府與國內民眾關心的重大議題。

有關醫療照護系統，目前民眾滿意度偏低，民眾最不滿意的部分就是等待時間過久。相較於台灣醫療照護的高可近性與即時性，瑞典就醫所需等待時間都高達數天至數週，即使急診平均至少也要等待超過三個小時以上，民眾認為既然已繳交高額稅率給政府，醫療體系卻提供如此漫長等待的服務，是民眾最不滿意的部份。

為改善民怨與改善醫療資源分配效率，政府透過強化衛生教育，提升民眾對緊急醫療優先順序的認知，教育民眾珍惜醫療資源與就診輕重緩急的優先順序，把資源優先提供給真正有醫療需求的人即時就醫。

表 17　Sveriges Riksdag 參訪情形

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<tr>
<td> 
衛福部參訪團於 Sveriges Riksdag 合影留念(左起：外館駐瑞典辦事處黃參事瑞龍、成大醫院白教授明奇、台北仁愛醫院甄主任瑞興、長庚醫院徐主任文俊、衛福部林部長奏延、外館駐瑞典辦事處廖處長東周、衛福部王主秘宗曦、成大醫院楊院長俊佑、馬偕醫院洪主任大川)</td>
<td> 
瑞典國會議員 Mrs. Caroline Szyber 向衛福部林部長奏延(左)介紹國會設施</td>
</tr>
<tr>
<td> 
瑞典國會議員 Mrs. Caroline Szyber 向衛福部林部長奏延(右)介紹國會會議室設施</td>
<td> 
瑞典國會議員 Mrs. Caroline Szyber 向衛福部林部長奏延(左三)介紹國會會議投票設施</td>
</tr>
<tr>
<td> 
瑞典國會議員 Mrs. Caroline Szyber 向衛福部林部長奏延(右一)解說議會議事運作程序</td>
<td> 
瑞典國會議員 Mrs. Caroline Szyber 向衛福部林部長奏延(左二)解說議會議事運作程序</td>
</tr>
</table>

衛福部參訪團於瑞典國會合影
(左起：衛福部王主秘宗曦、成大醫院白教授明奇、野村總研成員、衛福部趙科長偉翔、衛福部郭技正威中、馬偕醫院洪主任大川、台北仁愛醫院甄主任瑞興、長庚醫院徐主任文俊、成大醫院楊院長俊佑、外館駐瑞典辦事處廖處長東周、衛福部林部長奏延、外館駐瑞典辦事處黃參事瑞龍)

瑞典國會議員 Mrs. Caroline Szyber 向衛福部林部長奏延(左二)介紹議會議事廳

衛福部參訪團於瑞典國會留影
(前排左起：衛福部王主秘宗曦、瑞典國會議員 Mrs. Caroline Szyber、衛福部林部長奏延、外館駐瑞典辦事處廖處長東周；中排左起：成大醫院楊院長俊佑、台北仁愛醫院甄主任瑞興、成大醫院白教授明奇、馬偕醫院洪主任大川、衛福部郭技正威中；後排左起：長庚醫院徐主任文俊、外館駐瑞典辦事處黃參事瑞龍、衛福部趙科長偉翔)

(三) 芬蘭衛生福利部

1.背景概要

芬蘭衛生福利部（Ministry of Social Affairs and Health）原名為社會福利部，為 1917 年為了協助戰爭傷者與社會議題而成立。其後逐漸演變為主管社會福祉、保險、社會與健康服務、收入安全、工作與生活、性別平權等領域之專責機構。

芬蘭衛生福利部於 2013 年全年度支出 632 億歐元，其中社會福利支出佔 31.3%之 GDP，針對高齡者服務之支出金額則高達 250 億歐元，顯示芬蘭衛生福利部對高齡者照護與服務的重視。

由於芬蘭實施「分權管理政策（decentralized public administration）」，芬蘭的社會衛生福利相關之國家層級政策與法律規範主要由衛生福利部制定，再由地方政府根據上位準則，決定如何提供各種服務。舉例而言，衛生福利部於 2000 年提出之「國家高齡高品質服務框架(National Framework for High-Quality Services for Older People)」明確定義長期照護服務內容的衡量標準，再由芬蘭各市政府單位執行及管理。「國家高齡高品質服務框架」以居家照護及復健為終極目標，建立長照服務內容的衡量標準以維持國民照護品質。

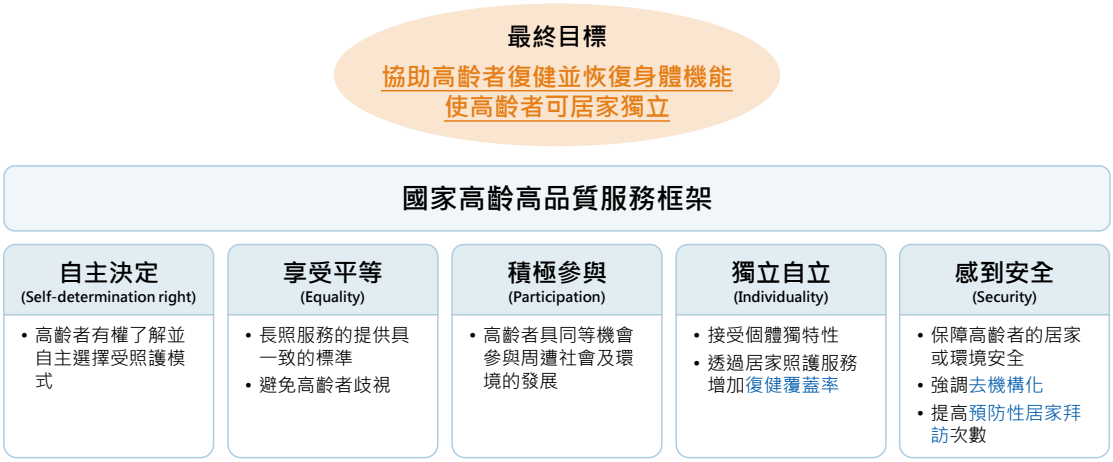

圖 17　國家高齡高品質服務框架 (2008 年修訂版)

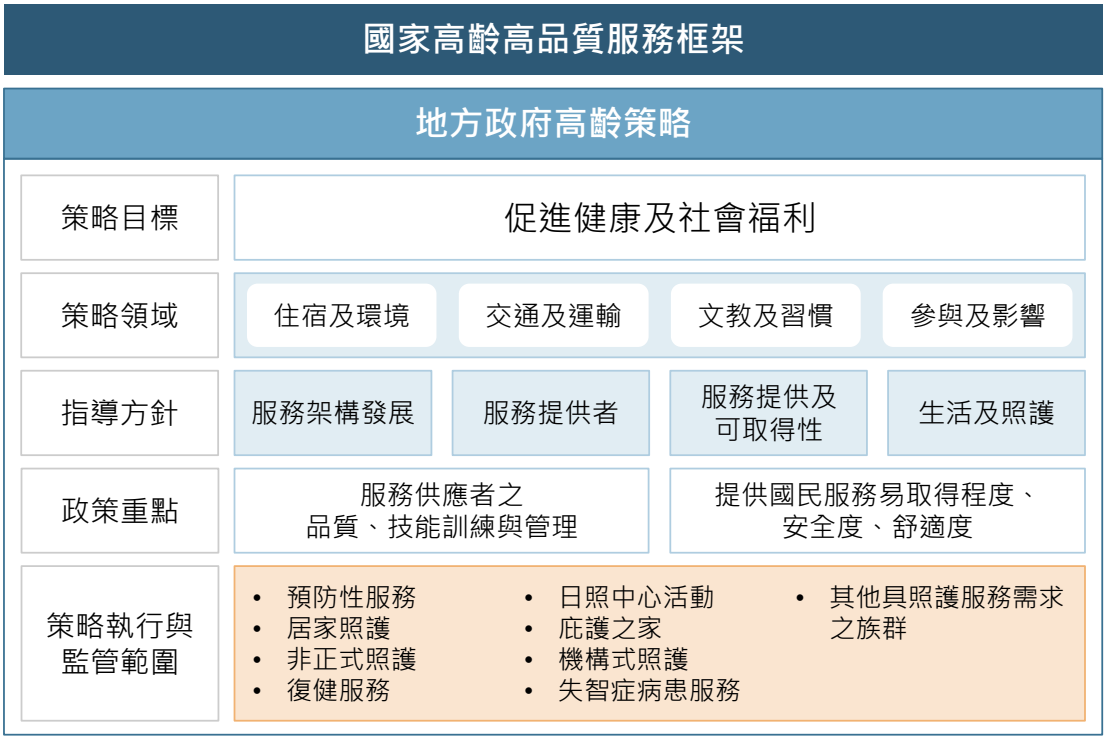

圖 18　芬蘭地方政府高齡策略執行方針

此外，芬蘭衛生福利部和芬蘭地區協會（Association of Finnish Local and Regional Authorities）亦透過共同公布高齡者品質服務建議，以保障老年人持續參與公民生活為前提，提升他們生活的品質，以及透過「品質建議」影響高齡的社會和健康照護服務需求提供者。

2.參訪摘要

本次參訪對象為國際事務組長 Mr. Pasi Korhonen、負責智慧醫療的資深專員 Mr. Teemupekka Virtanen、負責照護服務的專案經理 Ms. Anja Noro，由 Ms. Noro 先對參訪團員概要介紹未來芬蘭照護與醫療體制改革方向與規劃，再由 Mr. Virtanen 介紹芬蘭推動智慧醫療歷程、未來發展，以及智慧醫療於全民照護服務以及產業推動之效益。

在芬蘭所謂的長期照護服務主要指的是針對高齡者的照護服務，在 1970、1980 年代主要專注於機構式照護服務，然而由於人口結構變化，快速高齡化的社會需 求，自 1990 年代以來逐漸強調非機構式以及居家照護服務。芬蘭相信讓高齡者在自己熟悉的家中接受親友的照護服務是維持與促進其健康最好的方式，因此針對高齡者親友等非正式照護員工，依據其提供之照護服務性質，每個月可以獲得最低 300 歐元、最高 1500 歐元的

非正式照護津貼，以彌補其因為需要提供家人照護服務而無法上班的薪資收入。目前在芬蘭提供非正式服務的人員約 50%為照護需求者之配偶、約 50%為照護需求者之子女。目前於 2016 至 2018 年進行中的 Government Key Project 將更強調高齡者的居家照護，以及非正式照護之強化。

目前規劃中之社會福利與衛生改革期望改善現行 300 多個市政府各自不同的照護系統，藉由合併為 18 個縣政府，找到更有效率及更節省經費的照護體系，同時也 希望能維持與強化對全體人民擁有平等得到照護的權利。為求合併體系順利進行，目前芬蘭政府特別提撥預算，藉由未來同屬一個縣的各市政府在維持現行 系統之下，另外合作進行整合照護系統之示範計畫，藉此評估體制改革的成效。

芬蘭於 2007 年通過法令，要求所有公立醫療機構將病人醫療紀錄電子化，並規定電子化病歷統一儲存於中央政府管轄之醫療資料庫；目前公立醫療體系 100% 使用電子病歷，且超過 75%之處方為電子處方箋，在全國約 550 萬人中已有 400 萬人的病歷資料統一儲存於中央。芬蘭目前規劃之 eSocial and eHealth Strategy 2020 將更強化電子病歷與醫療照護紀錄之普遍化，讓每位公民都能掌握自己的醫療照護資訊，配合相關衛教資訊，提升國民自我健康促進之意識，進而降低國民 進入醫照護體系之機率。除此之外，芬蘭社會福利與衛生部更嚴格規範醫療資訊之應用，再透過 innovation hub 的服務，提供去識別化與資訊彙整之後之國民醫療健康資訊讓產業使用，既不侵犯個人隱私也能促進產業創新。

表 18　芬蘭衛生福利部參訪情形

衛福部王主秘宗曦(左二)向國際事務組長 Mr. Pasi Korhonen 介紹成大醫院楊院長俊佑(左一)

國際事務組長 Mr. Pasi Korhonen 向衛福部參訪團進行簡報

	
衛福部參訪團於芬蘭衛生福利部內會議室合影(前排左起：長庚醫院徐主任文俊、Mr. Teemupekka Virtanen、衛福部王主秘宗曦、Mr. Pasi Korhonen、成大醫院楊院長俊佑、成大醫院白教授明奇、Ms. Anja Noro；後排左起：外館駐芬蘭辦事處鄭代理館長素賢、外館駐芬蘭辦事處黃組長啟民、台北仁愛醫院甄主任瑞興、馬偕醫院洪主任大川、衛福部郭技正威中、衛福部趙科長偉翔)	衛福部參訪團於芬蘭衛生福利部外合影(左起：衛福部趙科長偉翔、外館駐芬蘭辦事處黃組長啟民、成大醫院白教授明奇、台北仁愛醫院甄主任瑞興、長庚醫院徐主任文俊、衛福部王主秘宗曦、衛福部郭技正威中、成大醫院楊院長俊佑、外館駐芬蘭辦事處鄭代理館長素賢、馬偕醫院洪主任大川)

肆、 心得與建議

本次透過參訪瑞典與芬蘭高齡照護相關主管單位與業者，了解北歐兩國長照制度架構、推行政策，以及未來改革方向，作為政府持續推動長期照顧與規劃相關政策之參考。

本次北歐參訪團總共參訪 14 處不同之業者、機構與機關，其中照護服務部分共參訪八家照護相關機構，分別為一家照護服務培訓機構、四間高齡照護住宅、一家居家照護服務業者、一家複合式照護服務中心、及一家照護服務國際輸出業者；而醫療服務方面，則參訪兩間醫療機構，分別為一家基礎醫療診所及一家高齡醫學中心；在輔具廠商參訪方面，共參訪一家高齡輔具廠商；另亦參訪了三個政府單位，分別為決定醫療照護相關制度法令是否核准通過的國會、主掌地方照護服務執行的市政府，以及控管全國醫療照護服務的衛生福利部。針對各參訪對象之心得與建議分述如下。

一、 心得

瑞典、芬蘭兩國為著名之社會福利北歐國家，對於高齡者之照護服務強調所有人民平等享有，而非我國過去較為著重的針對失能失智者之長期照

護服務，此全人全健康的醫療照護概念亦為我國未來衛生福利政策目標；而為達成此服務宗旨，相較於臺灣目前偏重由中央單位控管資源，瑞典及芬蘭在醫療與照護服務的銜接上，主掌服務執行之各地市政府皆有較強主導權，在居民對照護服務產生需求的初期，即導入相關配套機制，同時更充分槓桿私營單位資源以強化公營事業不足之服務，此模式亦與我國長照十年計畫 2.0 在部分項目上運用民間資源之概念吻合。此外，瑞典與芬蘭兩國在提供完善醫療服務之餘，亦透過嚴格品管機制，監管公民營照護事業之服務與照護品質，確切為全民把關，此為目前我國在發展長期照護服務上較為缺乏之機制，值得未來政策規劃參考。上述各項心得詳細內容如下：

(一) 全民平等的醫療照護服務，尊重高齡自主意識及尊嚴：

瑞典和芬蘭兩國皆強調對全體國民高齡的照護服務，而並非僅針對失能失智者提供照護。在提供高齡照護服務時，無論需求者是否失智或失能，皆強調對高齡者意願之尊重，依據其意願安排照護服務、居家環境、生活作息等，如瑞典高齡居民可以自由指定希望入住的高齡住宅，抑或改善居家住宅環境後，由居家服務體系提供照護。而目前芬蘭高齡照護系統雖主要仍由地方市政府指定安排，預計在 2019 年的醫療照護改革後，也將導入瑞典的國民自由選擇制度。而不管是居住於高齡住宅內，或使用居家照護服務，皆為高齡者的「住家」，因此照護提供者必須要適應照護需求者的生活習慣與作息，而非要求高齡者配合服務提供者之標準程序與時刻表。透過此核心思維之建立，瑞典和芬蘭的高齡者在接受照護服務同時，仍能感覺自己活得有尊嚴、有價值。

而瑞典、芬蘭兩國皆有活到老、動到老的概念，鼓勵高齡居民維持日常活動，無論是否失能，皆透過居家服務協助其外出活動，或以輔具支援高齡者移動，透過此制度之建立，強調讓高齡者以最大限度自主生活，以減輕照護人員以及相關資源負擔。相較之下，臺灣目前較為普遍的機構式長期照護服務，住戶居住其中皆須按照機構流程管理，較僵化的作息以及照護服務，往往忽略了高齡者個別的獨特需求，也缺乏鼓勵其自主活動之配套機制，導致國人對於進入高齡長照系統所能獲得之照護服務及生活品質具有較為負面之想法。

此外，在高齡人口醫療資源支出方面，除了吻合居家與在地照護概念下更著重 GP 制度外，也利用 capitation 制度控管醫療資源支出，將醫療資源消耗用在更有需要的病人身上。而臺灣目前健保制度，許多高齡者進入醫院其實並不是真的對醫療資源有需求，反而浪費了醫藥資源以及加重醫療支出負擔，未來應參考各先進國家 capitation 的制度管控醫療支出。

(二) 落實地方主掌制度，以個案管理師完善控管醫療照護銜接：

瑞典與芬蘭針對高齡照護服務皆以各地方市政府擔任主導角色，中央單位僅提供共同的法規與政策擬定，實際執行以及資源分配仍由各市政府全權負責。為求提供轄區內居民完善照護服務，瑞典各地市政府內皆有專案管理單位，以掌控與分配高齡照護資源，同時並在病人進入醫療體系內有住院需求時，導入個案管理師協助家屬與醫護人員安排出院後續照護服務相關事宜，此制度能保障病人獲得延續性照護，落實醫療端與照護端無縫銜接。而在使用居家服務體系時，每位客戶皆有一位專責個案管理師負責協調各相關單位事項，包含醫護人員、居家服務員、輔具提供廠商等，在此制度下各民營與公立事業之個案管理專員皆能有密切聯繫配合，才能真正落實全民連續性照護之目標，實為臺灣未來政策推動可參考之典範。

(三) 利用民營服務強化公營事業體系：

瑞典與芬蘭在推動長期照護政策時，亦意識到國人健康照護需求並非僅靠公營事業可以滿足，同時考量公立單位成本控管與服務效率較民營事業不佳，因此制定相關法令開放民營單位透過承包招標公營服務（瑞典），或是以主管單位採購服務（芬蘭）等機制，槓桿民營事業資源，提供國人更完善的照護服務。此制度由於各民營事業於開放市場中自由競爭，彼此間為求經營效率及營收，鼓勵各事業體創造完善的品質管理制度，提升整體國民照護服務品質，同時亦解決公營事業在偏遠地區人力資源不足之困境（芬蘭），使國人所接受的照護服務有更多的彈性，值得臺灣未來政策推展參考。

(四) 品質管理規範，有效掌握國民醫療照護品質：

在確保國人獲得平等醫療照護服務之餘，瑞典與芬蘭更強調品質的控管，因此兩國分別透過 National Quality Registry 以及 Resident Assessment Instrument 等以實證為基礎（evidence based）的品質控管制度，以確保國人獲得優質的醫療照護服務。而臺灣目前僅針對醫療服務透過評鑑機制管控

品質，針對長期照護服務則尚未建立系統性品管機制，因此在推動長照政策同時可納入品質管控系統，進行服務的監管。此外，為達成高品質的照護服務，瑞典與芬蘭亦強調照護專員的訓練及保護。照護服務專員雖傳統各國皆以護士為主軸，然由於照護住宅以及居家照護的需求大增，瑞典與芬蘭兩國除了在各單位配置受傳統護理轉業訓練的護士及護佐外，更納入一般照護員為照護服務主力，亦針對一般照護員規範了專業照護訓練學程，經過培訓後的人員才能進入照護服務系統。同時，並針對特殊技能提供專業訓練課程，如失智症照護、管理課程、心理輔導等，確保照護員的持續進修與職涯發展。此外，瑞典與芬蘭在鼓勵高齡者活動之餘，更重視對於照護人員的保護，因此導入各式移動輔助器材協助照護人員，使其不需要面臨因為支援高齡者活動而造成過度生理負擔與職業傷害。有鑑於瑞典、芬蘭兩國制度,臺灣目前照護人力嚴重缺乏,除需專業訓練課程的導入外，亦需思考的是如何持續保障照護人員的職涯發展以及相關配套措施導入，以提高照護人員進入長照服務體系意願，也才能確保我國照護需求者獲得穩定且良好的照護服務。

二、 建議

藉由本次參訪，可分別由政策面、制度面與產業面出發，給予國內相關產業發展政策與制度給予建議，其內容分述如下：

(一) 政策面

1.強化 A-B-C 三級照護體系權責劃分，落實醫療照護銜接

依據長照十年計畫 2.0，未來國內長照制度將劃分為 A 級社區整合型服務中心、B 級複合型日間服務中、與 C 級巷弄長照站等三級服務點規劃，提供國人多元的照護服務，此三級由 A 級服務中心擔任主導，對 B 級與 C 級提供督導與技術支援，以結合區域醫療資源銜接照護服務。參考北歐模式，未來在推動三級照護服務分層下，應更強化國人專屬個案管理師角色，建立同一高齡者享用三級不同照護服務支援下的整合性。同時並應在高齡者進入醫療系統時，以個案管理師即早參與及規劃後續照護服務，才能真正落實醫療照護銜接機制，達到全人全健康照護的目標。

2.靈活應用民間資源，並加強非正式照護體制之導入

目前長照十年 2.0 計畫規劃簡化核銷流程，導入民間資源來強化照護服務之彈性與多元性，此亦為北歐模式經典，建議應更進一步導入品管機制，才能更擴大民營照護事業之發展，提供國人更多自由意願選擇的選項。此外，參考北歐逐漸導入之非正式照護者制度，配合國人傳統居家照護概念，應擴大對於親友家屬提供照護服務的補助與支援，如：依照提供之照護服務項目不同而給薪、抵稅優惠、提供喘息服務等，才能有效落實在地老化，使國人能在自己熟悉環境中安老的願景。

3.以全民高齡照護為目標，強調全民自主健康發展

隨著我國快速邁入高齡化社會，未來我國應由長照政策擴大至高齡照護政策，將重點聚焦在於日常生活之協助，以高齡居家服務為主，擴大居家服務項目包含運動及肌力強化輔具支援，鼓勵國人在自家環境維持健康活動與健身運動，以延長健康壽命，才能有效減緩高齡化社會的沉重醫療照護資源支出。

(二) 制度面

1.運用現有照護服務網絡落實品質管理

目前我國已針對糖尿病及腦中風兩項高長照需求之疾病項目建立糖尿病共同照護網及腦中風登錄系統，然而目前僅發揮醫護人員培訓以及病歷資料登錄等功能，並無延續擴及至照護服務體系之實質追蹤以及品質監管。而我國由於健保 IC 卡導入多年，每位國民相關醫療病理資訊已有電子病歷存檔，可供長期照護效果追蹤，足以建立我國專屬的以實證為基礎的品質管理制度。本此既有照護網絡資源以及資訊系統架構，可於長照計畫規劃同時，透過專案計畫先示範建立糖尿病及腦中風照護品質控管機制，未來再擴大至高長照需求之其他疾病項目品管系統導入。

2.服務人員培訓發展

目前我國照護服務人員嚴重缺乏，主要提供照護服務者為缺乏專業訓練之外勞，抑或在家照顧親友的家人，對於這些非正式照護者，應提升其相關專業訓練，抑或可參考保母訓練課程，建立類似照護認證制度，在提供自家高齡者照護服務同時，也可成為居住社區中的高齡照護服務主力。此外，針對專業照護人員，可參考北歐、日本等照護先進國家，建立起以被照護者為中心的培訓課程，透過符合其意願與需求的照護方式，鼓勵被照護者生活自主，以減輕照護人員不足的負擔。然而，目前我國照護人員不足尚有一重點因素

在於薪酬制度缺乏誘因，此將待未來輔以專業照護服務認證課程之導入，並提升照護服務專業人員之薪酬，以吸引更多人員投入照護市場服務。

3.健康促進資訊

目前我國雖以導入電子病歷多年，也提供多樣衛教資訊與國人，然而由於我國病歷皆由醫學專有名詞註記，對缺乏專業知識的一般民眾來說，病歷的可理解性不高，同時亦缺乏便利且完善的平台供國人自己讀取醫療紀錄，因此在整合自身健康狀況以及活用衛教資訊上，目前我國尚欠整合機制鼓勵國人注重自身健康促進。而參考瑞典與芬蘭，此兩國的智慧醫療平台不但能讓國人容易取得可理解的自身就醫資訊，同時輔以豐富醫療保健資訊，即可使民眾輕易理解自己健康狀況、需要加強或改善的項目，以及如何加強或改善，藉此達到國人健康促進之效益。建議未來應本著既有豐沛電子病歷資訊，考量如何轉換為可簡易存取、可理解的健康資訊，讓非具專業醫療知識之國人對自身病理狀況有感，才能活用衛教資訊，達到自主促進之目標。

(三) 產業面

1.充分槓桿民間資源，將健康照護效益發揮最大化

如同前述政策面建議，未來應考量在符合共同品管機制監管之下，擴大納入民間資源，補足公立照護單位服務，包含居家照護服務、日托、輔具提供、交通運輸等，既能提升國人的照護服務品質，更能創造相關產業機會，藉以吸引更多廠商投入資源。

2.電子健康紀錄創造產業研發契機

參考芬蘭福祉中心（FWBC）模式，整合前述制度面之照護網絡品管機制與電子病歷資訊，在我國既有傳統電子產業與體外監測式醫材優勢，將能促進電子產業與醫材產業跨業結合，運用照護服務所取得之使用者應用產品回饋機制及品管分析，成為產業研發更符合使用者需求之新產品基礎，藉此將能擴大我國智慧健康穿戴式裝置產業發展，並達到鼓勵國人健康促進之效果。

伍、附件

一、SQC-SE Health Care Sytem 簡報資料

SQC
Swedish Quality Care

Swedish Health care system

Björn Wigström , CEO

www.swedishqualitycare.com

Swedish Care Philosophy

- Sweden has long possessed unique competencies in the care of elderly people, disabled people and children.
- A holistic Swedish healthcare philosophy has evolved, bringing together staff training, assistive technology, medication, architecture, rehabilitation and respect into one integral whole.
- Citizens not Patients
- Active and Independent
- No more help than needed

SQC
Swedish Quality Care

SQC
Business Model

- Based on the Swedish welfare models
- Unique networks in Asia and Sweden
- Cooperation between Swedish municipalities, care providers, producers of technical devices and universities
- Deliver hardware, know-how, training and services
- Full service & hardware provider to care companies in Japan
- Japan, China, Korea and elsewhere



SQC Academy

- Dementia Care
- Salutogenetic approach
- Palliative approach
- Haptic Therapy
- Music Therapy

- Programs in Sweden

SQC Core Values

- The individual's self-determination
- The individual's independence and freedom
- Normalization. (able to live the same way as others)
- Individualized care

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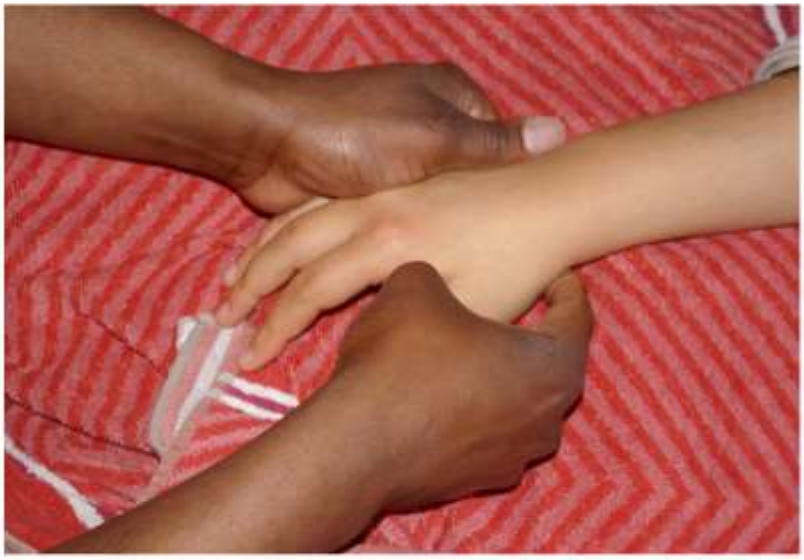
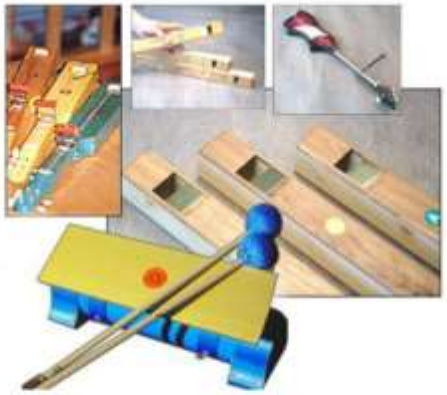
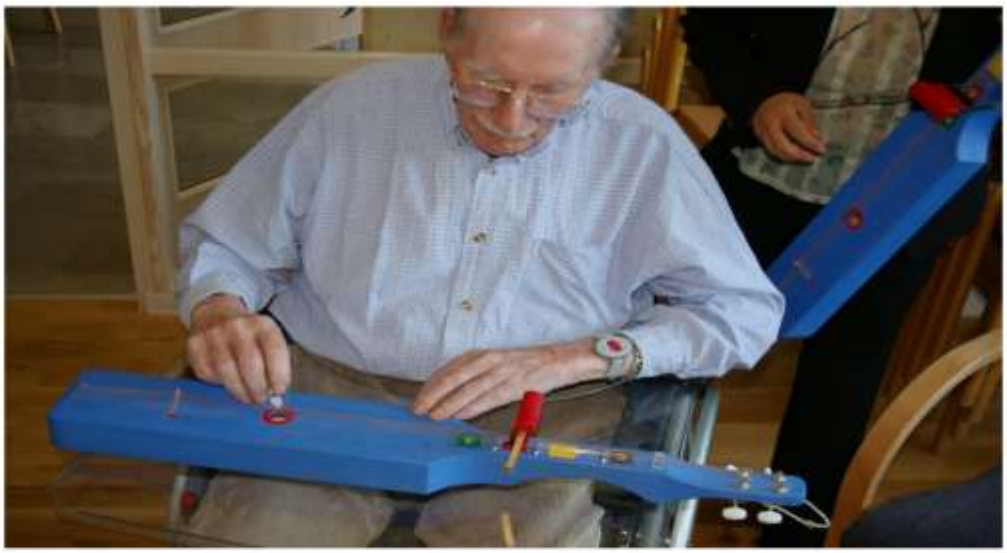
Haptic Therapy



Music Therapy (Bunne Method)





www.swedishqualitycare.jp

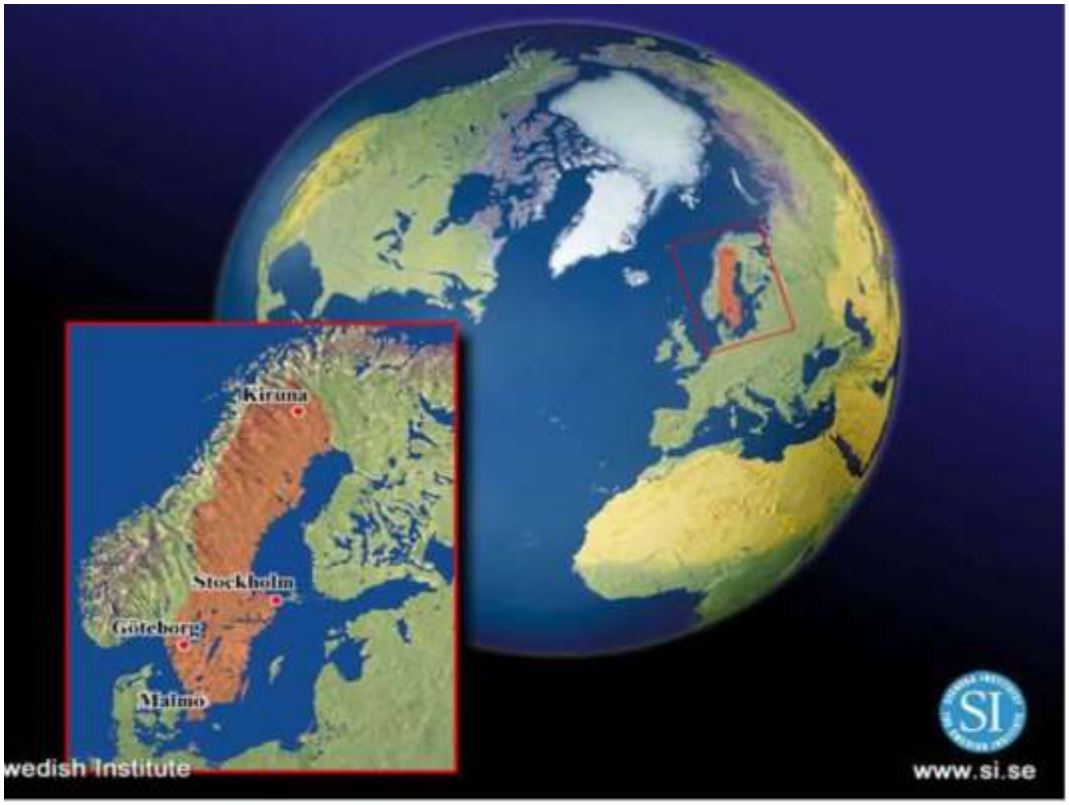
ポータルサイトの活用

スウェーデンとの連携が与えるイメージ
高いQOL
スタッフのモチベーションの向上
利用者の安心感
スウェーデンとの情報交換

ポータルサイトの内容

日本の福祉・医療情報
メンバー紹介
キャリアーフォーラム
スウェーデンの情報
SQCの会社案内
イベント情報

SQC
Swedish Quality Care
スウェーデン・クオリティケア



Sweden

- Established round year 1200 ad
- Modern Sweden begins 1521 with a central government and a new king
- Sweden has always played an important role in the Baltic area
- Today a modern democracy and one of the most social developed country in the world
- Early start with welfare legislation began with old-age pensions in 1911

Sweden

- Economic prosperity after world war II enabled Sweden to pioneer in public health, housing, and job security programs.
- 44 years of Socialist government ended in 1976. A liberal/conservative government took over for 8 years.
- Sweden joined the European Union I995
- The export share of the GNP is 50 %

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Sweden - differences north and south

2/3 of total area

1/3 of total area.

Main population area

SWEDEN	TAIWAN
9 million inhabitants	23 million
Size: 450 thousand km^2	36 thousand km^2
20 persons / km^2	710 p / km^2

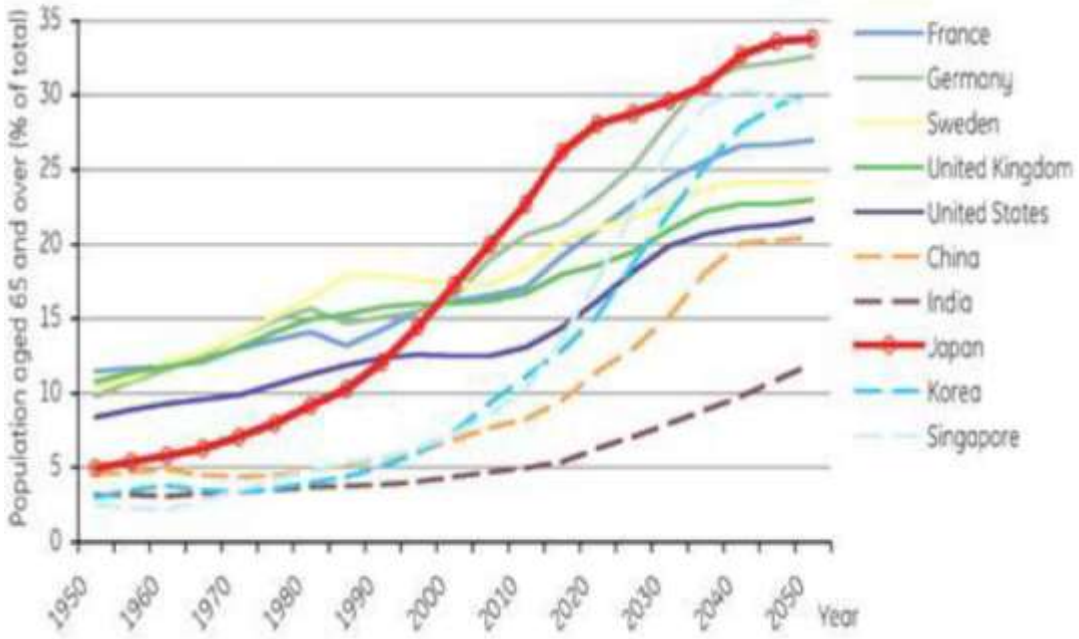
- 54% forested,
- 16% mountainous,
- 8% agricultural land
- 9% water

Length: 1574 km
Width: 499 km
Highest peak: Kebnekaise 2111 metres.

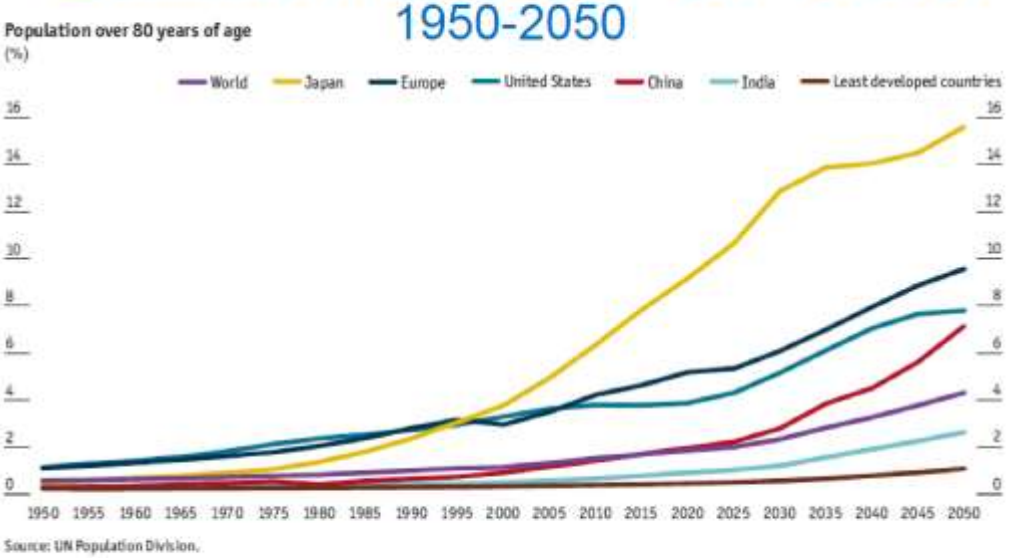
Swedish Export

VOLVO
ERICSSON
AstraZeneca
H&M
SKF
IKEA
Electrolux
Spotify
skype

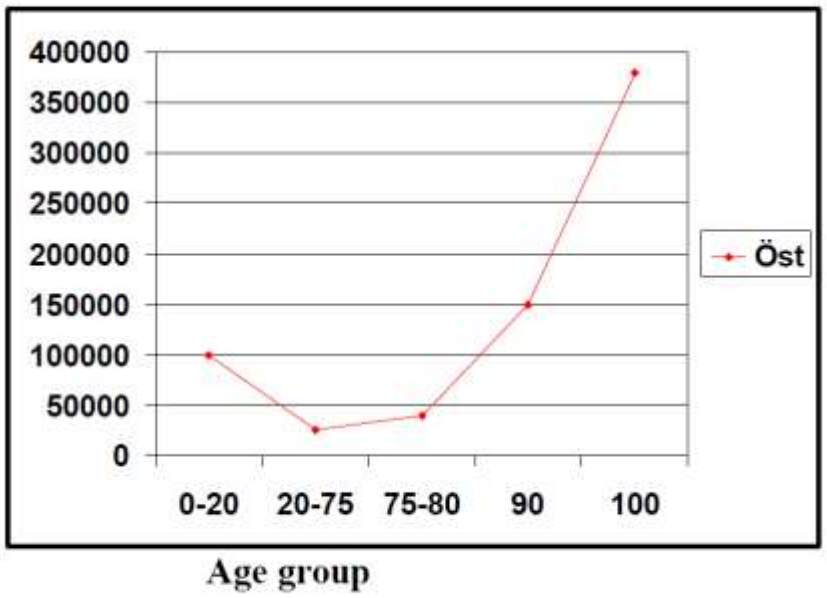
Pace of aging by Country (1950-2050); Growth of elderly (>65 yrs) as percentage of total



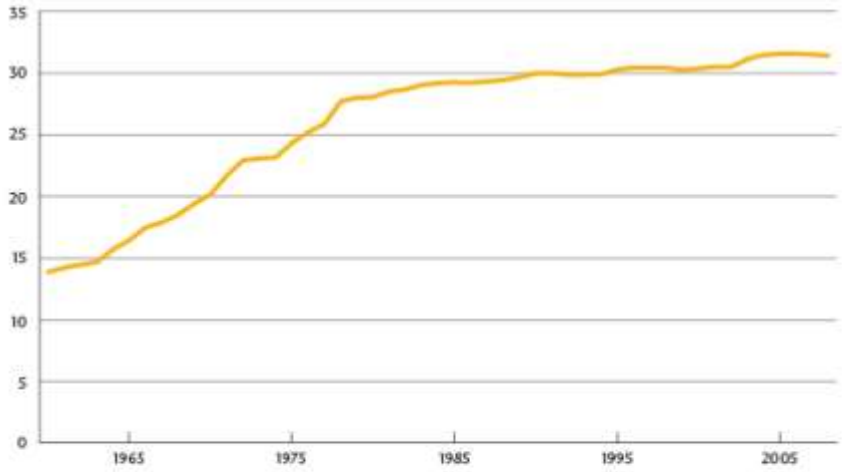
Estimated population 80+ years
1950-2050



Cost / person / year



Average tax rates, 1960–2008



Average tax rates 1960–2008.

Trends

- Life expectancy of the Swedish population continues to rise.
- 80 years for men and 84 years for women.
- Falling mortality risks for both heart attacks and strokes.
- 5 percent of the population is 80 years or older
- Chronic diseases place high demands on the system

Challenges

- Demographic changes
- Medical and technological advances
- Citizen's expectations , being a demanding and well-informed healthcare co-actor
- Financial resources allocated to healthcare are not expected to increase

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Swedish Quality Care

What will happen

- The ageing of the population will continue – but at a lower speed
- The reduction of the original families have already made its impact
- Existing Long Term Care system is already exhausted
-

Obstacles

- Restricted access for individuals
- Focused resources
- Lowered ambitions

has meant a narrower area of public responsibility

Increasing problems

- To recruit and to retain care personnel
- To promote geographic equality

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Solutions

- Improved diagnostics
- Staff training programs
- The private home a place for living and also a place for caring and rehabilitation
- Elderly remain in their private homes longer
- New structure for caring at home
- Development of different kind of assistive devices for caring at home
- Differentiated living subject to needs and wishes i.e. group living homes, service homes, secured living
- A retirement age of 72 instead of from 61

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The Swedish Model

- Public, subsidised services for children and for frail elderly persons are widely available.
- The same services are used irrespective of socioeconomic status
- Service production is the responsibility of local governments, who have a high degree of independence including the right to levy taxes

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- Equal access to health care services.
- Government-funded and heavily decentralized.
- System performs well, with good medical success in relation to investments and despite cost restrictions.

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Swedish ”Ädel” Reform

- 1992
- Evaluted 1997
- Transfer of the care for elderly and disabled from Countys to Municipalities

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Swedish ”Ädel” Reform

- The princip of closeness
- Homes instead of institutions
- From medical aspect to social

- Less medical competence
- Looser connections with doctors
- Finance problems in small municipalities

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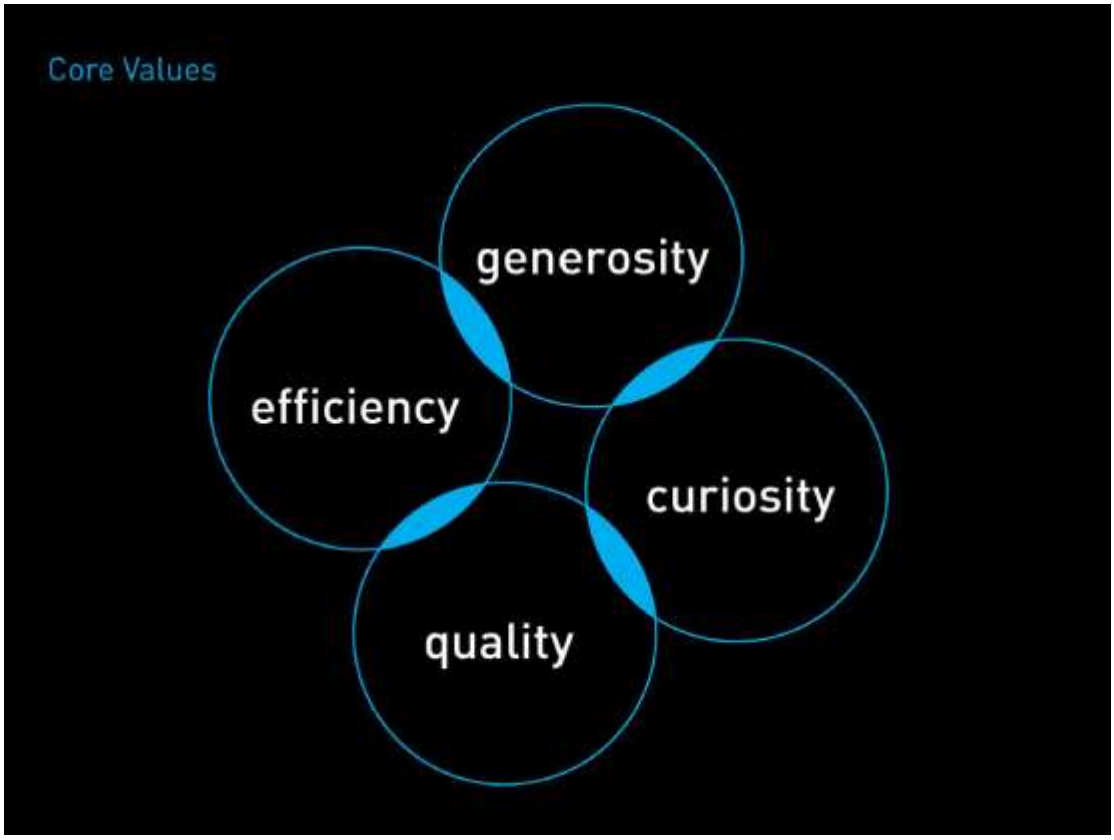
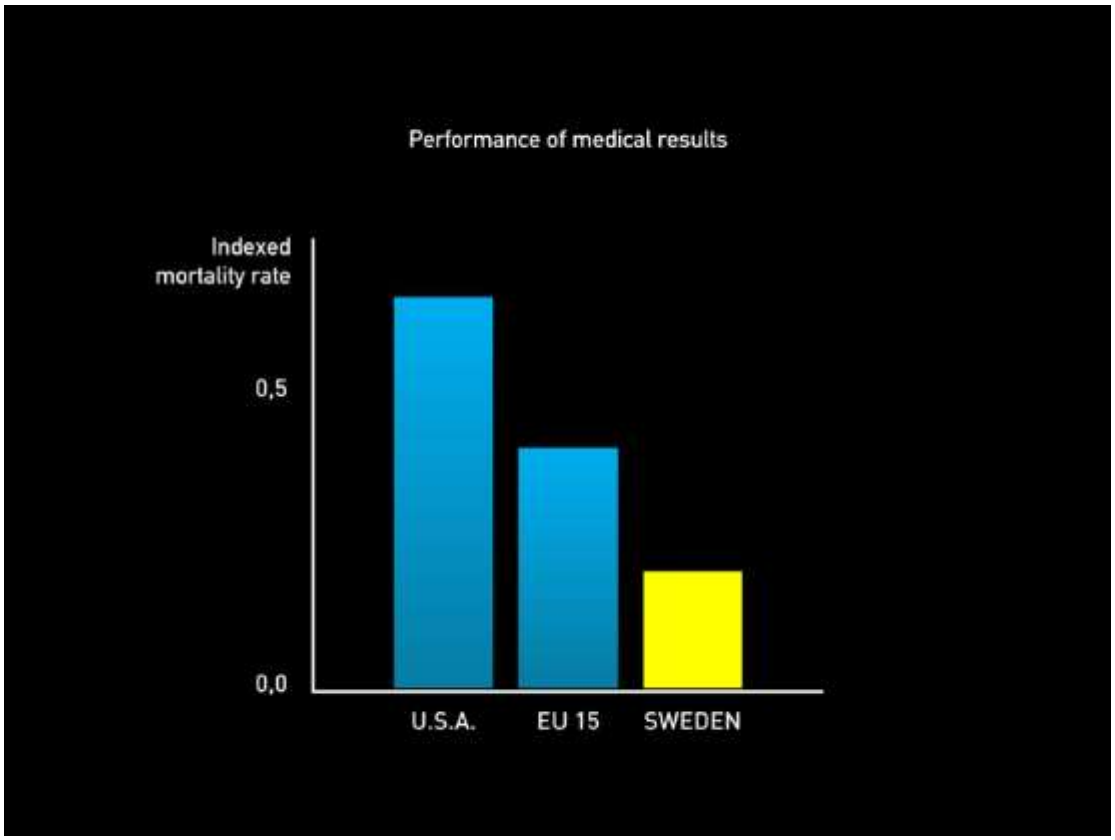
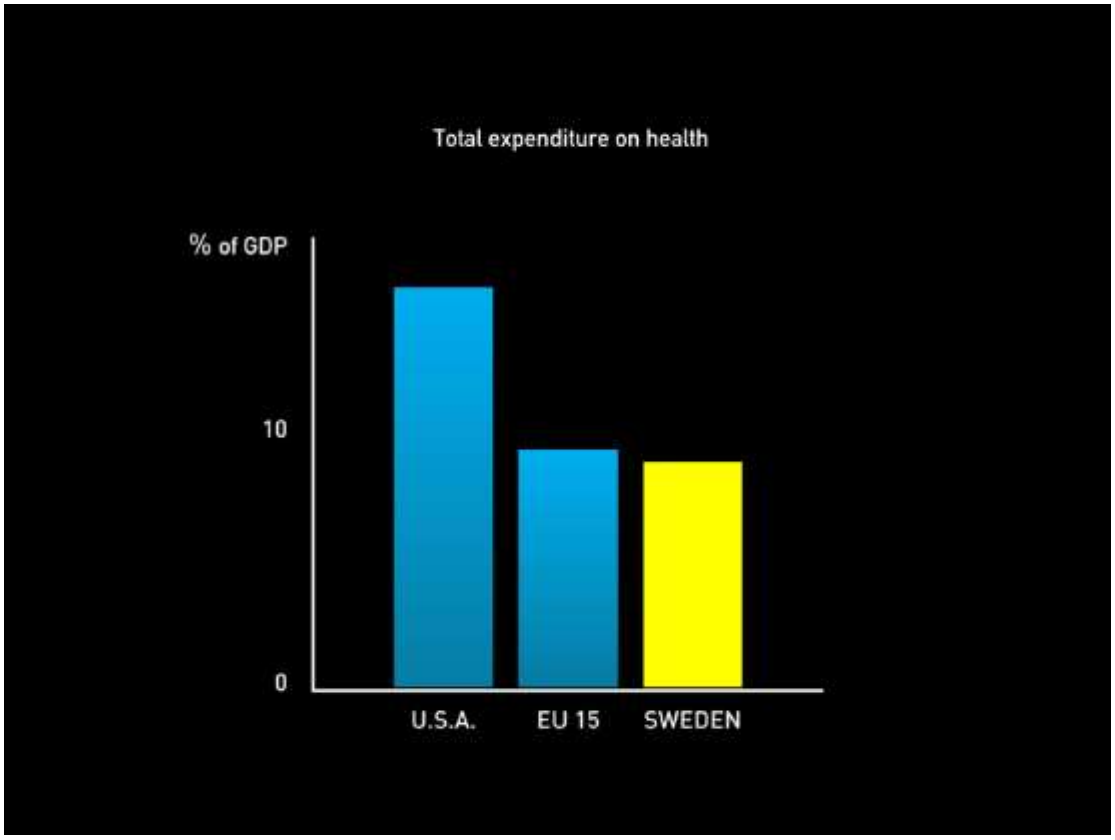



Performance of medical results
Indexed mortality rate
0,5
0,0
U.S.A.
EU 15
SWEDEN


Total expenditure on health
% of GDP
10
0
U.S.A.
EU 15
SWEDEN

Organisation of Elderly and Health Care

Three Levels

- Municipalities (290)
  (Elderly care and care for people)
- County councils (20)
  (Health care)
- Central government
  (Legislation)

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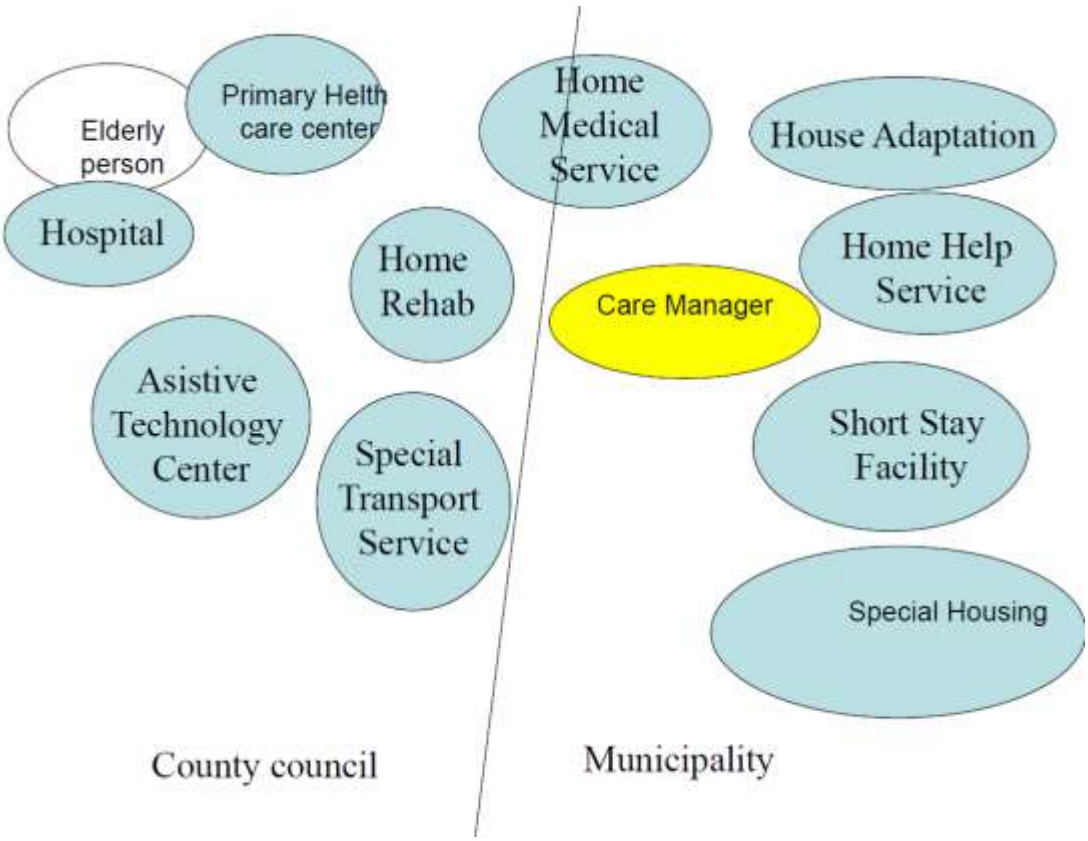

Central government expenditure

Transportation and communication	4%
Justice	4%
Health and medical care, social services	**5%**
Education & academic research	6%
Defence	6%
Interest of central government debt	7%
Guarantee pention, survivers pension	7%
Child allowance, parental insurance	**7%**
General grants to local governments	9%
Unemployment benefits, activity support	**9%**
Sickness benefit, activity compensation	**17%**

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Stockholm county council

2,1 Million inhabitants

26 Municipalities

6.500 square kilometers

Smallest county council
60 000 inhabitants

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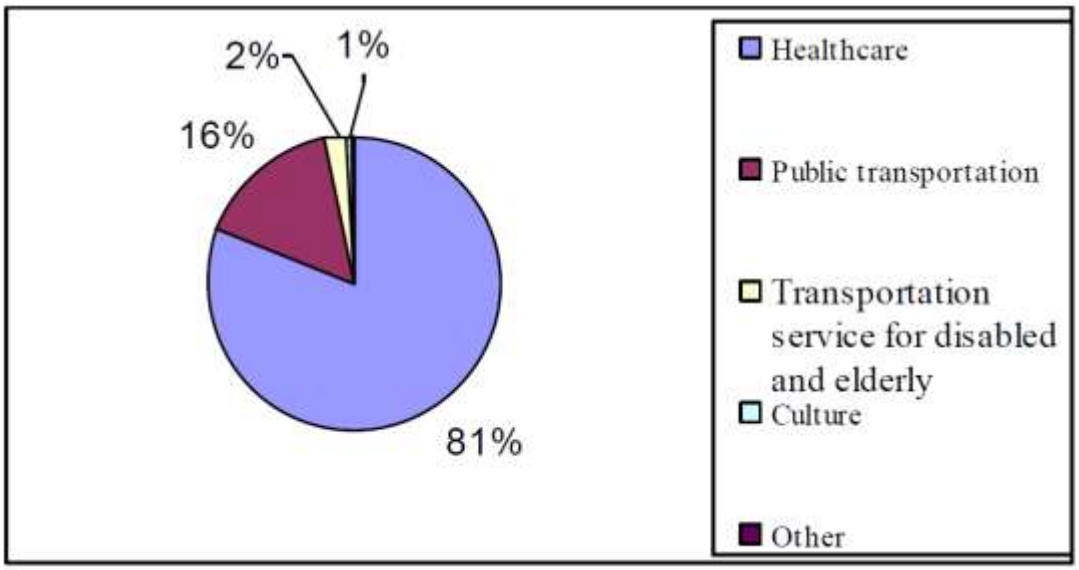
County council expenditure



Deliveries

- Assistive technology Centers
- Health centers
- Special clinics
- 8 University Hospitals
- 70 Hospitals with specialist care
- 1 000 Primary Care Centers

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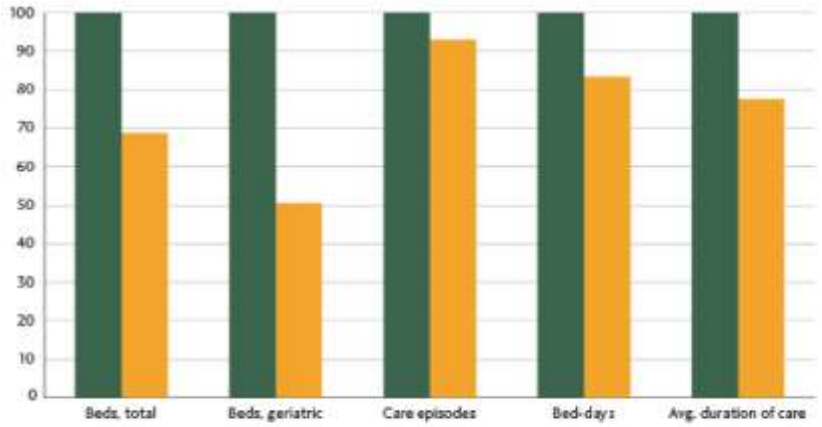
Development trend in the healthcare system, 1996–2006



Development trend in the number of beds, care episodes, bed-days and average duration of care in 1996–2006. Index 1996 = 100.

1996
2006

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New Karolinska Hospital

Start of healthcare activities begin 2015-16

600 inpatient care beds. 125 intensive care beds. 100 day care beds 100 beds in the patient hotel.

The flow 1,600 visits per day.175 are acute,

6,000 work colleagues

1,000 researchers and students

Total area of 450,000 m2.

Costs

- Costs for health and medical care amount to approx 9 percent of Sweden's gross domestic product (GDP)
- Stable since the early 1980s.
- 2010, care and services including subsidization of pharmaceuticals, cost SEK 200 billion (USD 23.5 billion)

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Provision of Assistive Technology

- Free of charge
- Must be prescribed
- Central system for testing and procurement (SHI)
- Decentralized system for distribution and prescription

Result:

High quality assistive devices at low prices

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Financing

- 71 % through local taxation
- State contribution 16 %
- Patient fees 3 %
- Purchaser provider system
- 10 % carried out by private health care providers

Patient Fees

- **Patient fees**

Fee for hospital stay is SEK 100 per day.
For primary care between SEK 100 and 300
For specialist visits, maximum SEK 350.

- **High-cost ceiling**

After SEK 1,100 within 12 months, medical consultations are free of charge.
Prescription medication, maximum SEK 2,200 in a given 12-month period.

Rapid Recovery

- Efficient rehabilitation at home
- Good contact between community and County
- Protocol and following up
- Primary Care centers
- Responsible contact person
- Digital patient journal

Rapid Recovery 2

- Day surgery is performed in almost 2 million patients per year.
- Protocol and following up
- Primary Care centers
- Responsible contact person

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Socialstyrelsen
THE NATIONAL BOARD OF HEALTH AND WELFARE

- The National Board of Health and Welfare (Socialstyrelsen) is a government agency in Sweden under the Ministry of Health and Social Affairs.
- Work to ensure good health, social welfare and high-quality health and social care on equal terms for the whole Swedish population.

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- Collect, compile, analyse and pass on **information**.
- Develop **standards** based on legislation and the information collected.
- Exercise **supervision** to ensure that the standards are observed, and to minimize risk and improve patient safety.

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City of Stockholm

- Population: 860 000 inhabitants
- Area: 209 square km (of which 21 is water)

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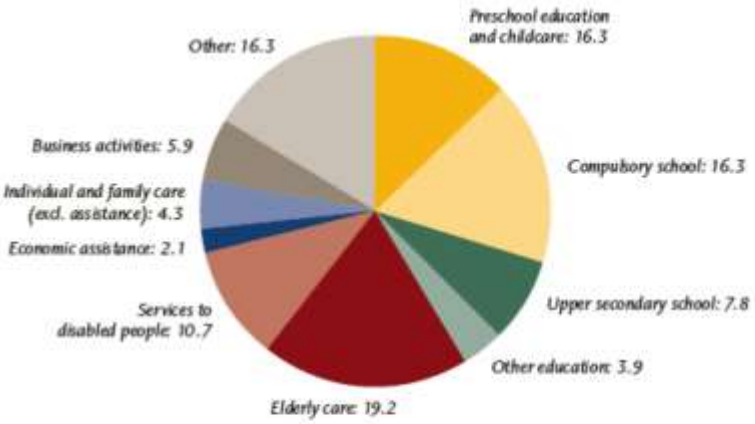
Municipals costs, 2015



Distribution of local authority costs for operations in 2007 (SEK 452 billion). Percentage.

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Deliveries

- Medical treatment
- Rehabilitation
- Transportation service
- Home care services
- Housing adaptation
- Short stay facilities
- Special housing

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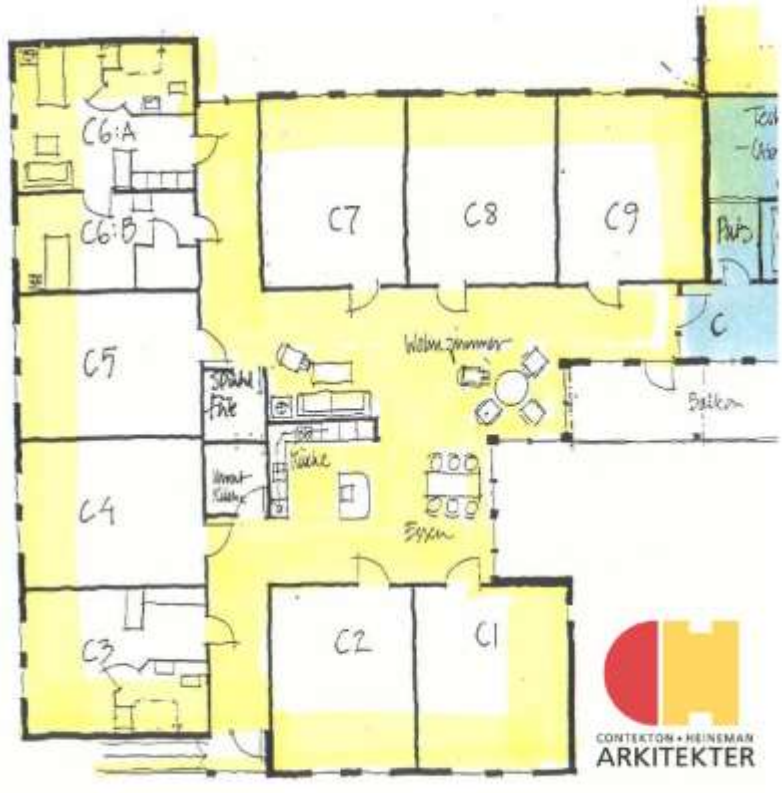
Elderly Persons



Staffing

- Day time: 2-3 care workers,
- Evening: 2
- Night:1

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Patient Fee

- SEK 1700 for the care
- SEK 6 000 to 7 000 rent for the room
- SEK 3 000 for food

- Rental cost follow the average rental cost
- If not possible for the inhabitant to pay there are different kind of social contribution to get

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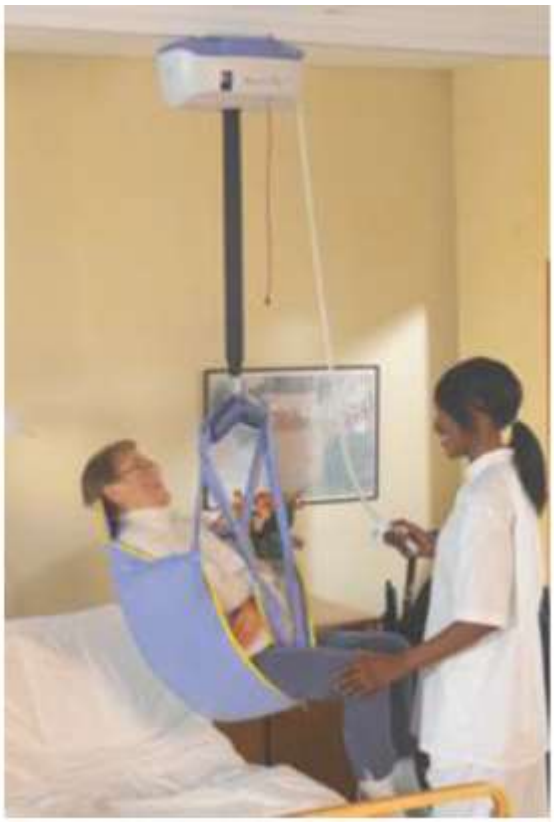

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"Walkers have become a public health booster"

二、Capio Primary Care 簡報資料

Capio

Capio Proximity

First line service oriented healthcare with high quality based on modern medicine and kind treatment

Capio Närsjukvård
August, 2016
Executive version 1.0

Capio

Introduction / Background

What is Capio Proximity?
Underlying business logic…

Statutory freedom of choice in Primary Care

- Sweden have statutory freedom of choice within primary care since 1 January 2008.
- "The reform means that all healthcare providers who meet certain basic requirements may set up at a geographical location of their choice within the county council area, and that the choices made by patients govern the reimbursement paid to the provider." (http://vardanalys.se/)
- A majority of the 21 regions in Sweden have a capitation based model for remuneration of primary care healthcare.
- All 21 models differ and have slightly different underlying business logic. Majority use number of listed patients adjusted with various indexes as a base for their models.

Primary care Remuneration

- Stockholm is the most different model, with a historical production based remuneration model. ie. "paid-by-visit". This model is now under change during 2016 with more alignment to a more capitation based model.
- Capitation is based on the number of listed patients, ie. patients that have chosen us as their primary care provider.
- Remuneration often adjusted with indexes:
  - Age / Gender
  - ACG (Adjusted Clinical Groups) - "predictive health risk"
  - CNI (Care Need Index) – socioeconomy
- Capitation comes with high level of cost responsiblity (lab, radiology, pharmaceuticals, bought care etc..)

"The reform means that all healthcare providers who meet certain basic requirements may set up at a geographical location of their choice within the county council area, and that the choices made by patients govern the reimbursement paid to the provider."
(http://vardanalys.se/)

What is Capio Proximity?

- Capio Proximity provides primary care to patients. Primary care is the initial care level in Sweden and provides healthcare a large number of patient needs. ie. patients not requiring hospital technical and medical resources
- Patients come to our proximity units for:
  - Medical treatment
  - Rehabilitation
  - Prevention and
  - Regular checkups of chronic diseases, such as diabetes, asthma/copd* etc.
- Approximately 20% of our units also provides out-patient specialist care in addition to the primary care offer – ex. Gynecology, Urology, Endoscopy, Cardiology, Psychiatry etc.
- Our doctors sets the diagnosis and Patients are either treated immediately or may be referred to a another care setting for further treatment or diagnosis.

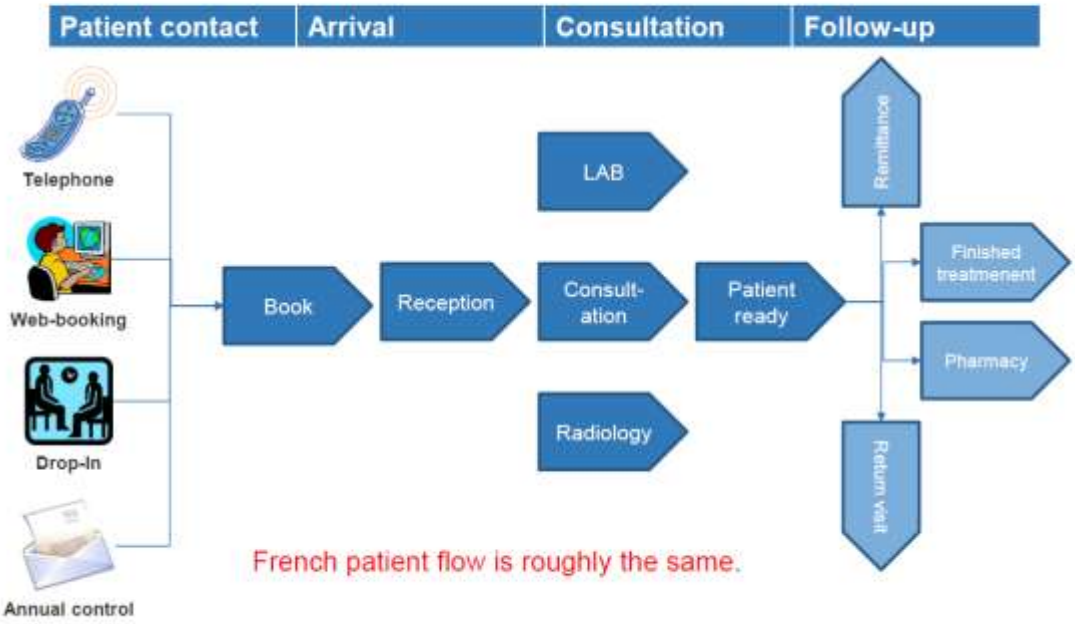
*Chronic obstructive pulmonary disease

Capio Proximity - Staff & Management

- **Typical proximity staff in our units:**
  - Doctors
    - Majority are specialists in general medicine but other specialists exits (see previous)
  - Nurses
    - Often with certain medical specialist
  - Psychologists
  - Physiotherapists

- **The unit manager is a medically trained person and most often a nurse**
  - Works often part-time clinically
  - No formal financial education

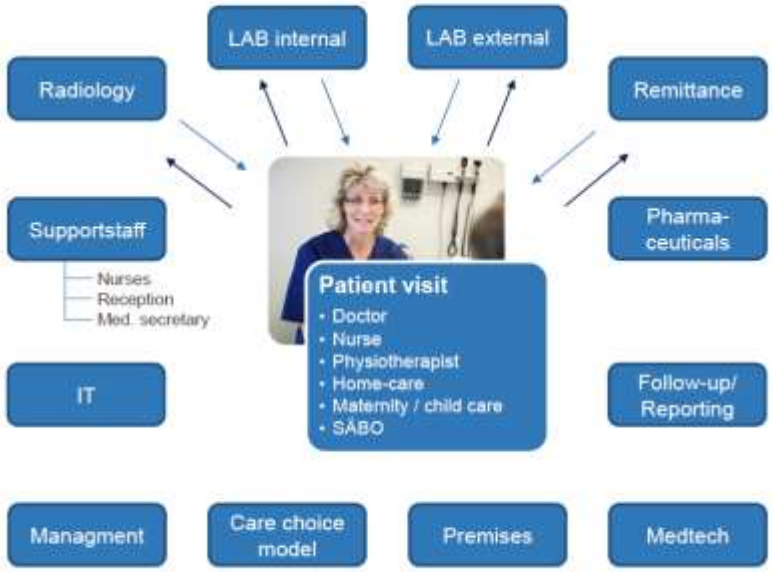
Primary care – overall patient flow



Availability

High Efficiency

- How to get the patient flow as efficient as possible

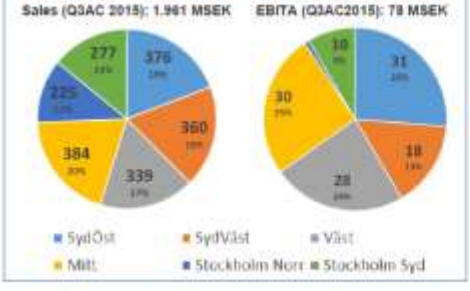


Capio Proximity - Market leading footprint

Market situation

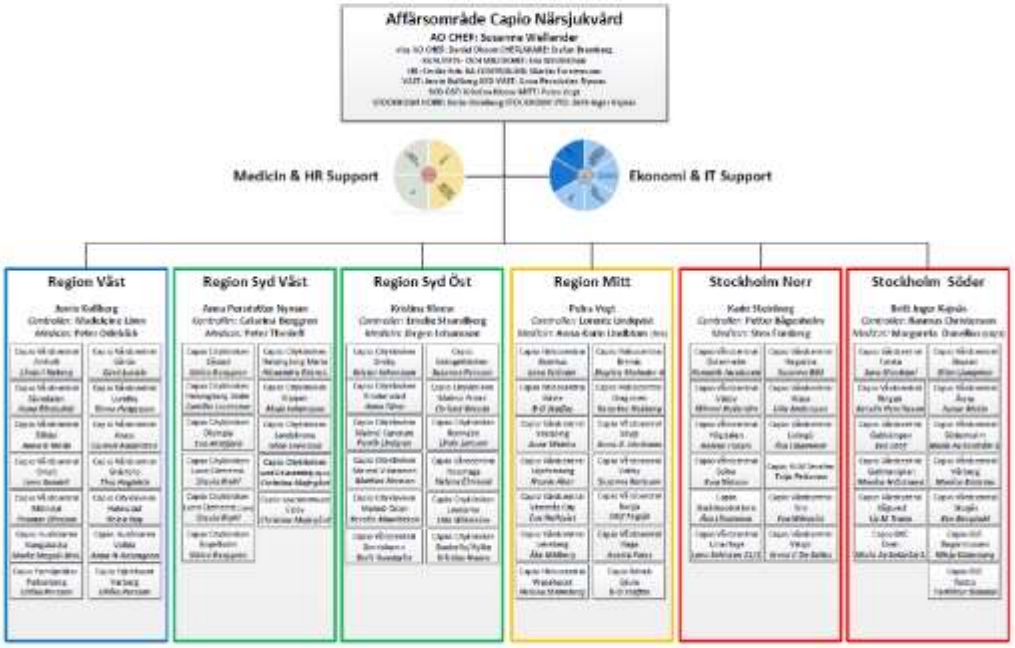
- 75 Units
- In 12 counties with 76% of Sweden's population
- 9% market share of total care centers in these 12 counties
- 22% market share of private care centers in these 12 counties
- 12 different remuneration models, majority capitation based

Regions (% of sales) (accumulated Q3 figures)



Footprint

Proximity Organization 2016



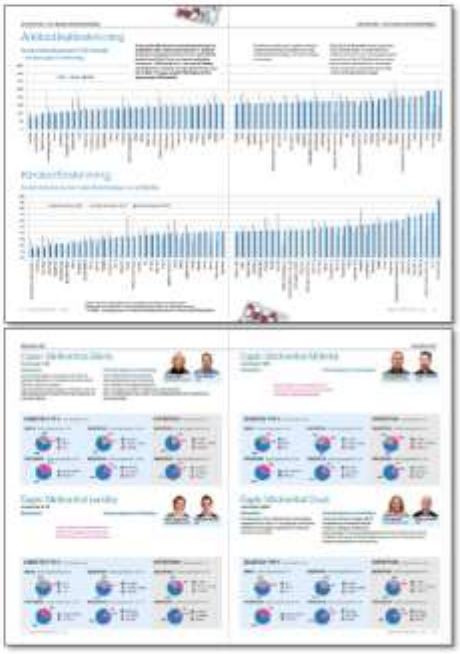
Capio Proximity Overall Strategy 2014-2018

1. Retain current and attract new listed patients
2. Internal efficiency will increase productivity ("Internal LEON")

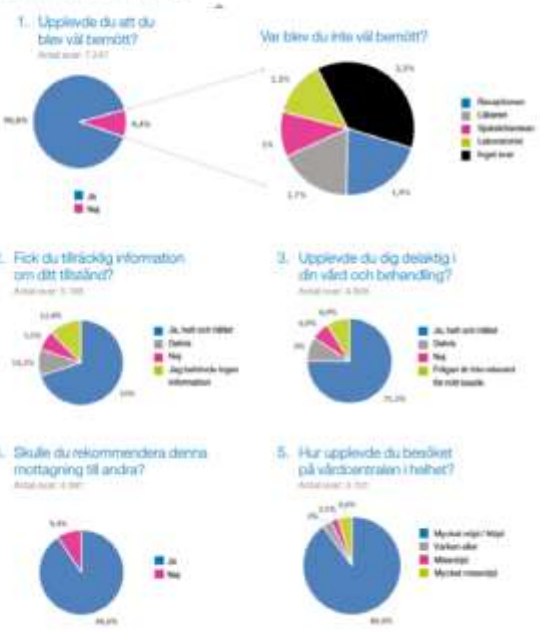
"…By building on an already strong platform and focus on high availability, continuity and patient satisfaction we will achieve further growth and improved financial performance…"

3. Measurable & Transparent Quality Performance Indicators
4. Develop our current, and attract new, skilled staff

Transparency - Quarterly Quality Report



Transparency
- Patient Reported Experience Measurement



Capio

Capio Proximity Business Logic

Different logic in different parts of Sweden

15

Capio Proximity Business Logic - Stockholm

# Listed Patients	# Age 1 # Age 2 # Age 3	Age 1 price / listed patient / month Age 2 price / listed patient / month Age 3 price / listed patient / month	* CNI Index	Capitation revenue
# Doctor Visits		Price / Doctor Visit Patient self pay / Doctor Visit		Doctor visit revenue
# Nurse Visits		Price / Nurse Visit Patient self pay / Nurse Visit		Nurse visit revenue
# Home Care Visits		Price / Home Care Visit		Home care visit revenue
+ Quality Goal related revenue (from 0 to Maximum 2.3% * Total Revenue)		% of Quality Goals Reached		+ Quality Goal revenue
+ Children care (BVC)	# Listed Children * Price per listed child 0-5 years			+ BVC revenue
+ Fotsjukvård		# Price / fotsjukvård visit		+ Fotsjukvård revenue
+ # Vaccinations + # Insurance visits	Revenue related to Vaccinations (travel & work-related) Revenue related to patients with own health insurance			+ Vaccination revenue + Insurance revenue
+ Other revenue	Interpreters, care coordination, other…			+ Other revenue
= Total Revenue				= Total revenue

Capio Proximity Business Logic – Stockholm

The Total Revenue should cover cost **only controlled by us** but price per patient does not consider our listed patients health- or sociodemographic status.

Category	Contains
Total Revenue	• See previous slide for details…
- Direct staff cost	• Doctors cost • Revenue driver staff cost • Other clinical staff cost • Non-clinical staff cost
- Direct Material & Services Cost	• Radiology (20% of cost) • Lab
- Other Direct Cost	• Cost of Premises • Support & maintenance • Support Services • Depreciation • Other Direct cost, other
= Gross Result	
- Overhead (OH)	• OH Staff cost • IT cost • Premises rel. to OH
= Operating result (EBITA)	

Capio

Susanne Wellander
Susanne.wellander@capio.se
www.capio.se

三、Famntaget 簡報資料

Famntaget
Omsorg

" The Embrace
Care"

Eriksson family

- The company is owned by the family
- Mari Eriksson
Executive director
- Peter Eriksson
Development
manager
- Johan Ericsson
Communications
manager

Facts about Famntaget Omsorg

- Start of business in December 2009
- 200 customers today
- Servicies 24 hours every day
- 70 employees
- 90% of all employees are nurses

Facts about Famntaget Omsorg

- Operations in Stockholm 's inner city
- 3 officies in different parts of Stockholm city
- Specialist dementia and cognitive impairment
- 70% of all customers have dementia or cognitive impairment

MISSION

Famntaget Omsorg shall provide services to municipalities, other organizations and private individuals

- Our operations are based on customer needs. There are a clear set of values, high continuity and well- established relationships

- We are working with a rehabilitative approach to strengthen the individual's self-esteem

- We design the services individually together with the clients. The services will be developed in dialogue with the clients

Famntaget Omsorg

VISION

Famntaget Omsorg has an individually designed home care,

performed with heart and warmth, to give an active and meaningful life

Famntaget Omsorg

OUR CONTRACT

- Agreement with the municipality of Stockholm
- Fixed compensation per hour
- Customer choice LOV

OUR ORGANISATION

- **Business plan with Goals and action plans**
- **Management team**
- **A separate team that manages the alarm at night**
- **Independent teams**
- **Preparedness**
- **Security Hotline**
- **2 cars (alarm at nights)**
- **Staff travel by public transport or walking**

THE EMPLOYEE

- Occupational health services
- Introduction of new employees
- Training, courses
- coaching
- wellness
- A sense of being part of a context

CONTENT OF HOME CARE

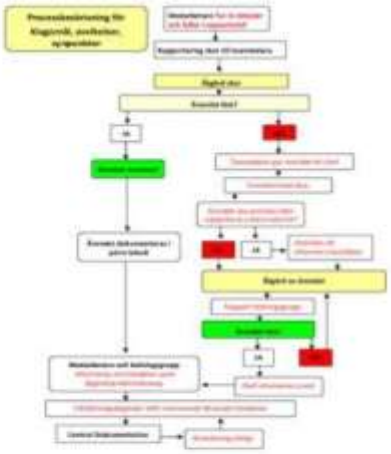
- Personal care
- Cleaning
- Treating wounds
- Give medication
- Food shopping
- Wash clothes
- Activities
- Hospital visits, etc
- Cook and wash dishes
- Terminal care

CRITICAL FUNCTIONS & SITUATIONS

- Key management
- Handling of cash
- Clients unavailable
- Alarms
- Cooperation between different actors
- Relation to client' s relatives

PROCESSES AND PROCEDURES

- We follow the laws and regulations in home care.
- Approximately 50 processes or instructions on how employees should behave in various situations



13 BASIC VALUES

1. Customer- oriented approach
2. Learning from others
3. Committed leadership
4. Employee involvement
5. Continuous improvement
6. Process Oriented
7. Long- term thinking
8. Social Responsibility
9. Cooperate with other
10. Preventive activities
11. Fact- based decisions
12. Act quickly
13. Develops Skills

VALUES THAT GUIDE THE WORK

Client shall:

- have a dignified life
- well- being
- feel secure
- feel meaningfulness
- continuity
- have activities

THE UMBRELLA SYSTEM

- **ParaGå – Smartphone application**
- used by our employees.
- used for time registration visiting clients
- using GPS technology
- writing journals and making work notes
- Invoice data

Applications used by administrators

- ParaSol – accept orders
- ParaGå Web – accept the work
- ParaInn – managing users
- Äldreomsorg – invoice and reports

OUR TOOLS/SYSTEMS

- **Laps Care** –Scheduling software (clients)
- **Rebok**–Scheduling software (employees)
- **MailerLite** – Newsletter tool
- **Survey Monkey**
- **Grant Thornton**- economy
- **ToDoist** – Task management.
- **Snow fire** - home page

IMPROVEMENT WORK

- Incident reporting:
  - serious incidents
  - complaints
  - comments
- Improvement board
  - ideas
  - activities
- Staff meetings
- Projects

STAFF REPORTS PROJECT "HAPPY CUSTOMER"

All teams present their work in the project "Happy customer"

Another project has led to an own cookbook

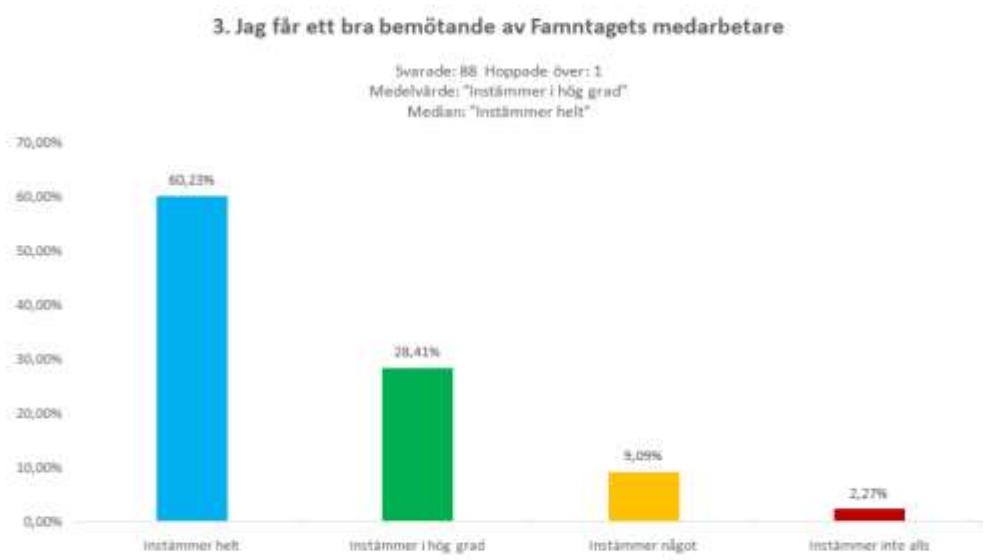
OUR WAY TO SUCCESS

- Person- centered care
- One employee with client contact responsibilities.
- Interaction with many ”players”
- Constant development of the business. Systematic quality work
- Continuous monitoring of activities (follow up)

SOCIAL MEDIA

FACEBOOK, BLOG, INSTAGRAM, TWITTER & HOME PAGE

CUSTOMER SURVEYS



NEWSLETTER

Famntaget Omsorg

Nyhetsbrev Mars 2015

För dig som är kund eller närstående i Famntaget

Famntaget är ditt vård- och omsorgsbolag. Vi har verksamhet i Stockholms innerstad och kontor på Östermalm, Norrmalm och Södermalm. Famntaget har en individuellt utformad hemtjänst som utförs med hjärta och värme för att aktivt och meningsfullt liv.

Öppet hus imorgon!

Vårt kontor på Eastmansvägen, Norrmalm fyller ett år. Detta firar vi genom att bjuda in till Öppet hus!

Onsdagen den 18 mars kl. 17:00-19:00
Eastmansvägen 21 (klicka för karta)

Anhörigkonsulent Kristina Ericsson kommer att vara på plats och berätta hur hon kan hjälpa dig som är närstående.

Vi bjuder på fika.

Varmt välkomna!

Läs om anhörigkonsulentens uppdrag...

CSR CORPORATE SOCIAL RESPONSIBILITY

"A better world"

- Safer and happier world
- Environment, animals and nature
- Knowledge of dementia
- Public perceptions of home care
- Relationships and networks
- Social activities

CAFÉ FOR THE ELDERLY

- A social meeting place for older people
- A collaboration with the Alzheimer Foundation
- Coffee and cake are free for the elderly

FAMNTAGET OMSORG WAS AWARDED "THIS YEAR'S GAZELLE" OF THE REPUTABLE NEWSPAPER MAGAZINE "TODAY'S INDUSTRY" 2014 AND 2015

-A Gazelle has:

- An annual turnover exceeding 10 million
- more than ten employees
- at least doubled its turnover, when comparing the first and the last financial year
- increased its turnover every year for the past three years
- an operating profit for the four financial years is positive
- in everything essentially grown organically

四、Capio Geriatrik Nacka 簡報資料

Welcome to Capio Geriatrik Nacka

Nathalie Morén
M.D, Consultant Geriatrics

Björn Sjögren
R.N. Vice CEO

- Acute geriatric care and rehabilitation on behalf of County Council of Stockholm
- Capio won competitive bidding in 2013
- "Quality competitive bidding" = fixed price + description of how to achieve best quality
- Strong drive for patient safety and good work environment

Capio Geriatrik

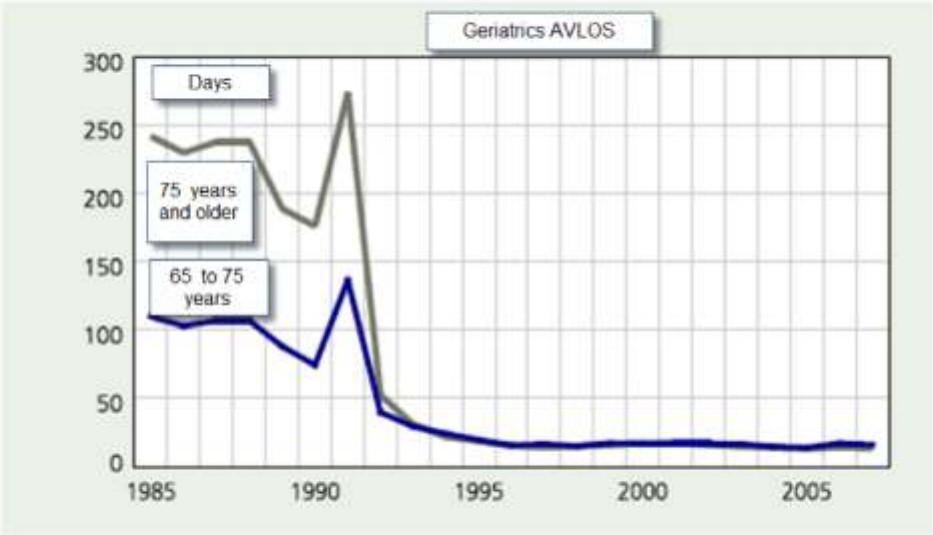
Brief introduction to our context

- Income from DRG-system ➡ shorter AVLOS
- Income solely from County Council (not private insurance or private)
- Lower income per DRG-point from County Council every year -2% after indexation

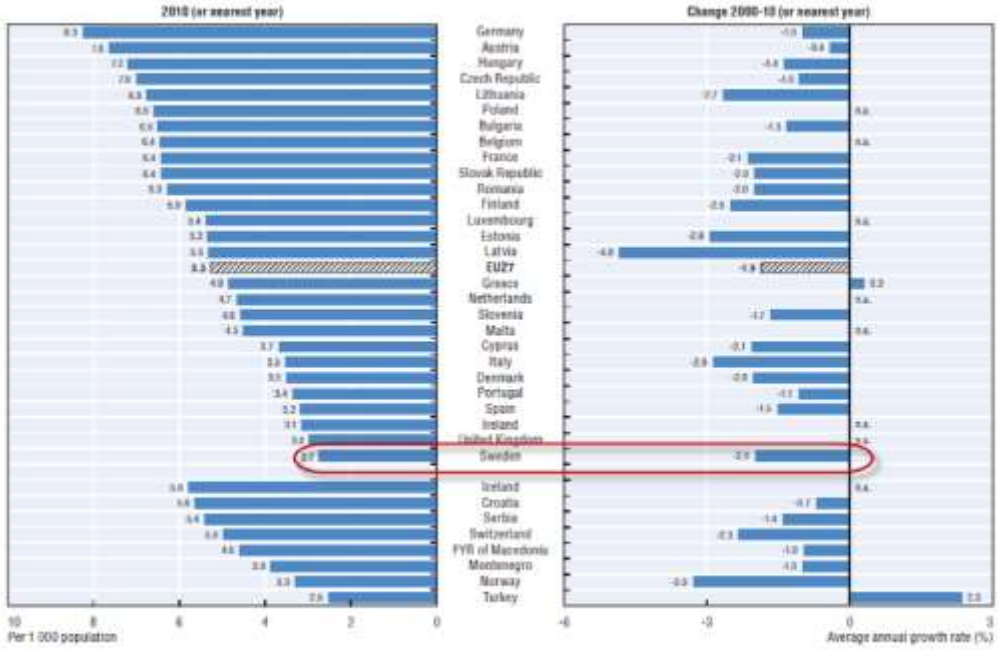
Need for efficiency improvement

Need to expand business

Capio Geriatrik



3.5.1. Hospital beds per 1 000 population, 2010 and change between 2000 and 2010



Source: OECD Health Data 2012; Eurostat Statistics Database; WHO European Health for All Database.

Capio Geriatrik Nacka

GERIATRICS:
4 wards 17 beds each
(68 beds in total)

Advanced Medical Homecare
~ 100 patients

Policlinic
(Diagnostic of dementia)
~220 year

Palliative ward 12 beds

Capio Geriatrik

Admission to in-patient care 24/7/365

Ambulance
6 %

ER
29 %

Primary Health Care
18 %

Follow up and/or rehabilitation after care at Acute Hospital
47 %




Capio Geriatrik

Target group for in-patient geriatric care

Patient who

- is biologically aged with functional impairment **and**
- is dependent on others in Activities of Daily Life **or** have multiple health problems

and that has

- a deterioration in State of Health **or**
- need of rehabilitation **or**
- need for continued care after care in acute hospital

and whose condition requires

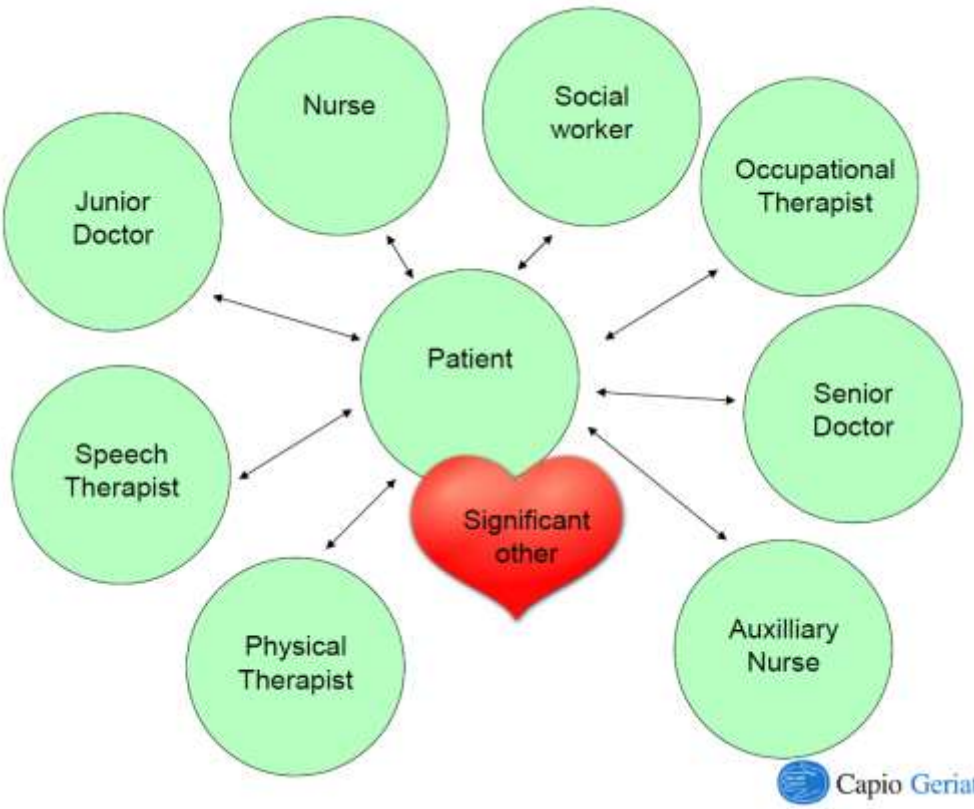
- a geriatric multi professional team work


Capio Geriatrik

Geriatric Care

- 4 wards 60-68 beds
- No longer only patients ≥65 years
- Rehabilitation (eg hip fracture, stroke)
- Acute geriatric care (eg Heart failure, COPD, infections)
- Palliative Care

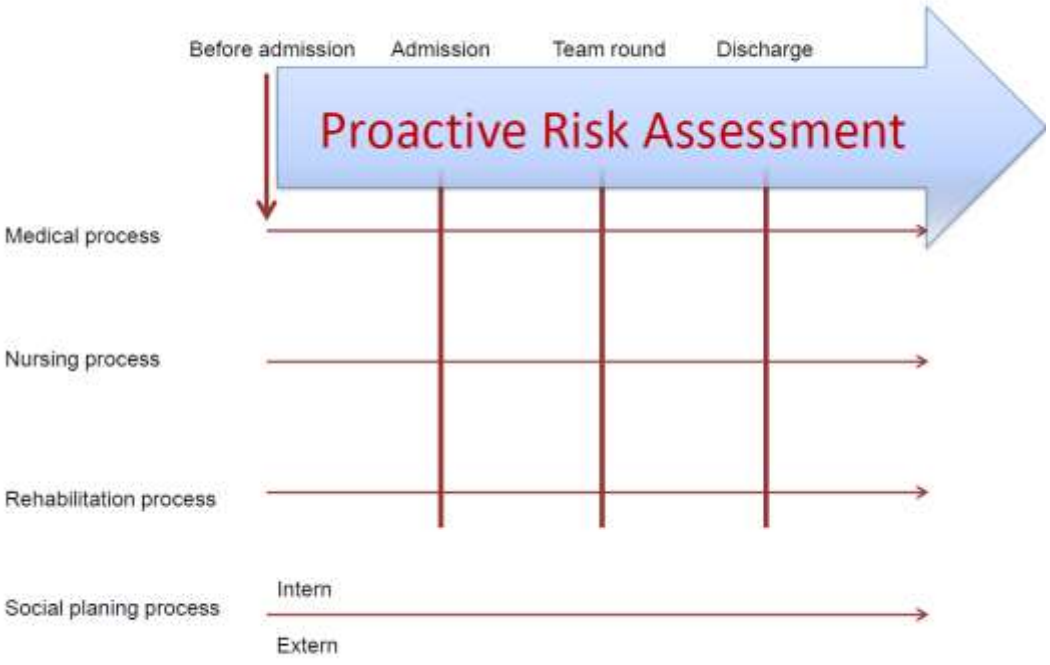
Capio Geriatrik



Capio Geriatrik

The geriatric patient´s path through Capio Geriatrik Nacka

Capio Geriatrik



Capio Geriatrik

Capio Geriatrik

Risks associated with hospitalization

• Pressure ulcers	➡ Standardized Care Plan
• Falls	➡ Early detection of Risk
• Obstipation	➡ Standardized Care Plan
• Infections	➡ Strict Routine
• Urine retention/KAD	➡ Early detection of Risk
• Poor symptom relief for dying patients	➡ LCP – Liverpool Care Pathway
• Malnutrition	➡ Standardized Care Plan

14

Capio Geriatrik

- AVLOS = 9.1 days
- Readmissions within 30 days = 19 %
- Patient survey – top results
- Employee survey – top in Stockholm

15

Capio Geriatrik

Early discharge

Acute hospital (8 %)

Dead (1-3 %)

- Home Rehab
- Neuro Team
- Primary Home Care
- ASIH or Palliative ward
- Home Help
- Care Facility
- District Nurse
- House call

16

Capio Geriatrik

capiogeriatrik.se/nacka
capioasih.se/nacka
capiopalliativvard.se/nacka

nathalie.moren@capio.se
bjorn.sjogren@capio.se

Capio Geriatrik

How it was and how it became

- Big wards with 32 patients
- 1 head nurse
- 1 assistant head nurse
- > 55 nursing staff
- 5 physicians
- 3 physiotherapists
- 3 occupational therapists
- 1 social worker

- Small wards with 16-18 patients
- 1 head nurse
- no assistant head nurse
- 27 nursing staff
- 3 physicians (2,5 FTE)
- 2 physiotherapists (1,5 FTE)
- 1,5 occupational therapists
- 1 social worker (0,5 FTE)

五、Nacka Kommun 簡報資料

NACKA KOMMUN

The Elderly Unit

Assistance officer infomation

The Elderly unit

Contact with the assistance officer

Homecare and other interventions in the home

Selection of homecare

Daytime activities

Special housing, short term accommodation

Transportation service, national mobility

Care Contributions and Tryggve

How to make a contact with the elderly unit?

Contact from hospitalization and care planning.

Phone calls from the elderly person.

Phone calls from relatives.

The first contact is usually done through the meeting with the assistance officer, either through home visits or care planning.

What is a care planning?

Takes place in the department of the hospital you are enrolled in. Department staff are involved and the assistance officer, patient and family.

Care Planning takes about an hour and aims to plan going home with necessary assistance .

What is a home visit?

Assistance officer and you agree a time for home visits. Family members are also welcome.

Home visit takes about an hour and together they talk through the current need for assistance.

Need for help

The need for help is always assessed individually but based on the Social Services Act and Nacka guidelines established by the political committee. Deviations from the guidelines is made if there are special reasons, it can mean that aid is more or less extensive.

Where assistance officer makes a decision it is communicated to the applicant if the aid has been granted or refused.

A refusal can be appealed. The appeal is sent to the assistance officer who then forwards it to the Administrative Court. The appeal shall state why the decision is considered wrong and what changes are required.

What help can you get home?

Homecare

Security alarm

Meals on Wheels

Escorting

Relative Relief in the home

Homecare

Homecare can mean that you get help with:
Personal care in the form of assistance with ex.

- dressing,
- shower,
- toilet,
- eating,
- walking etc.
- Service Operations in the form of cleaning, laundry, shopping and errands.

Homecare fee

The fee for homecare is 150 SEK per hour for the first eight hours. Maximum fee is 1772 SEK per month, no matter how much homecare that has done.
Those who have low income and / or high housing costs in some cases have their fee reduced.

Security alarm

Security alarm is an alarm that can be used to call for help from the emergency squad.
By pushing a button on a special alarm clock, which is worn around the wrist or neck, you come into contact with a monitoring center that is open around the clock.
The alarm can only be used in the home.

Security alarm costs 188 SEK a month whether the alarm is used or not.

Meals on Wheels

Nacka municipality has an agreement with a company named Samhall who is delivering food once a week home to home. The food is vacuum packed and stored in the refrigerator and it is suited to older people's nutritional needs.
It is possible to order special diets and vegetarian options.

The food costs 51 SEK per lunch box and you decide how many boxes a week to be delivered.

Escorting

Granted for cultural activities for people who can not get out on their own, for example the visually impaired.

Normally granted three hours a week.

Escorting is free of charge

Relative Relief in the home

The caring for a dependent can receive help from the homecare while he / she is doing errands and other chores. Homecare is i with the person who needs care.

Normally granted Relative Relief is 3 hours per week. Extra time granted for attendance at meetings for relatives.

Relatives Respite care in the home is free of charge.

Selection of homecare

Nacka Municipality customers choose their homecare, which means that the customer can choose which home care business to carry out the help. Nacka Municipality currently has state contracts with approximately 40 homecare companies.
Assistance officer can inform about the various companies, but will not recommend any company. If you do not want or can choose for yourself is always a "non-choice options," which is one of the existing companies.
Once the customer has chosen home care companies are sending aid officer an order to the home care company. They will then contact the customer and / or its relatives.
The customer and home care companies decide the details of assistance, such as which day of the week the purchase will take place.
Home care and assistance officers are in contact when necessary, for example when changing assistance needs. The customer is always welcome to contact the assistance officer if any changes in the need for assistance.

Daytime activities

There are several day centers around the municipality of Nacka.
There are two different orientations in daytime activities, one social and one for people with dementia.
Jointly planned taxi fares to and from the day center are included in the cost if you find it hard to take you there.
You can choose how many days a week you want to go but you always go on certain days of the week.
On the day center serves breakfast, lunch and snacks, and you can participate in various activities.
Daytime activities costs as one homecare hours at each visit. In addition, and a fee for lunch.
If you want to try out the daytime activities you just contact any of them and schedule an appointment.

Special accommodation for elderly

Special housing means housing with services and care around the clock.
The accommodation provides all the assistance that you need in daily life.
Health care interventions and nursing care is included.
Doctors regularly visit the accommodation.
Costs associated with living in special housing is, rent, fee for care and service, and the fee for food.
Investigation about the need to move done by the assistance officer. When the help at home is not enough, it can be up to date with special housing.

In Nacka there is also a customer choice for special accommodation.

Short term accommodation

A short-term accommodation is a casual place where you get help and cared around the clock. These places are special sections on some of the special housings.
To be granted a short-term place requires that the individual has large care needs which cannot be met in the home with home care.
The cost is 177 SEK per day for food and care.

The purpose of a stay of short-term housing is often:
to allow for recovery from illness or injury.
to provide relief for relatives who provide care in the home.
to investigate whether it is possible to return to their own homes after a hospital stay.
to meet the nursing care while waiting for space in special care homes.

Transportation service

Transportation service applies to travel within Stockholm County and is for those who can not ride public transport.

It is the county council which decides who gets the transportation service, but older unit assists with the investigation.

If you want to apply for transportation service, you must first see a doctor who looks at the need and write a medical certificate. The certificate is then sent to the legacy device.

National transportation service

National transportation service can be made for trips outside of Stockholm.
The trips are designed for people who, because of the large and long-term disability must travel in a specific costly way. The trip can be done by train, taxi, boat or plane. You may not select the mode yourself.
If you need an escort during the trip, you can, if necessary, at no cost, bring a person.

Contact the elderly unit at least three weeks before to plan the trip.
A Customs fee is charged depending on the journey length.
Normally awarded two return trips per year.

Care Contributions

Care Contributions can be made to the person cared for by husband / wife / partner in your home.

The resident should have a substantial and sustained needs of personal care, that is, at least 5 hours per day.

The aim is to give an incentive to people whose families carry a significant additional burden in the form of care.

Nursing allowance is 2200 SEK / month. The grant is tax-free.

The grant can be combined with home care or other efforts to support families.

”Tryggve”

As part of efforts to create a safe and secure municipality the Rescue Service in Nacka introduced the service "Tryggve".

The service is free and is aimed at preventing falls and offer help with things that can be risky for many elderly people to carry out by themselves.

Tryggve helps you with chores involving heavy lifting, climbing ladders and the like.

Hello my name is KURT

Kurt is 84 years old and lives alone in an apartment of four rooms and a kitchen. Kurt manages to take care of himself.

On March 3, Kurt had a fall in his home and he breaks the hipbone and was taken by the ambulance acutely to the Södersjukhuset.
Kurt cannot return to the home as the leg is in plaster, he needs to recover / rehabilitate in Nackageriatriken where Södersjukhuset sends him.

In Nackageriatriken they look at Kurts needs of outside support from the medical perspective with the help of an occupational therapist, physiotherapist and nurses and doctors.
When geriatric medicine manager decides that Kurt is rehabilitated / medical- finished to return to the home they call the assistance officer through web care, (electronic system) to participate in a so called care planning for further planning before Kurt is going home.
In the care planning the following persons are involved: Kurt and Kurt's son, Goran, occupational therapist, physiotherapist, nurses and the assistance officer.

Hospital officials describe Kurt's medical status and the assistance officer asks questions about how it looks in Kurts home and ask about the needs of customization and any devices.
Kurt and occupational therapist describes that Kurt is not capable of showering, put on trousers and underwear and do grocery shopping, clean the apartment and do clothes washing.

Assistance officer informs Kurt that he now must choose home care providers from a directory where there are about 40 companies that are quality controlled and authorized by the municipality of Nacka.
Kurt call the next day and announced to the assistance officer which home care business he has chosen. The assistance officer writes a report and makes decisions about the help that Kurt is in need of and sends the order to the homecare company that is now coming to visit Kurt same day he comes home from Nackageriatriken. Kurt has now also applied for a home adaption grant and he will have thresholds removed in his apartment and handles mounted in his bathroom.

Kurt pays a subsidized fee for using the help for an amount of 150 kr per hour.

The municipality compensate companies with the remaining 250 kr per hour for the help in the home.

The homecare company will receive compensation with 400 kr per hour, regardless of the type of help, and once the help is performed the company will bill those hours worked to the municipality's compensation administrator.

Kurt's decision now show that he has the help of about 30 hours per month, which means that Kurt reached over the

so called maximum rate which is 1772 kr per month regardless of the number of authorized hours.

六、HUR 簡報資料


HUR
The Active Ageing Company
WCAA 2016, Melbourne
What does Science tell us about Senior
Exercise and the practical implications.
Mats Manderbacka. HUR Chairman of the Board


Finland
The Falls Prevention Country...

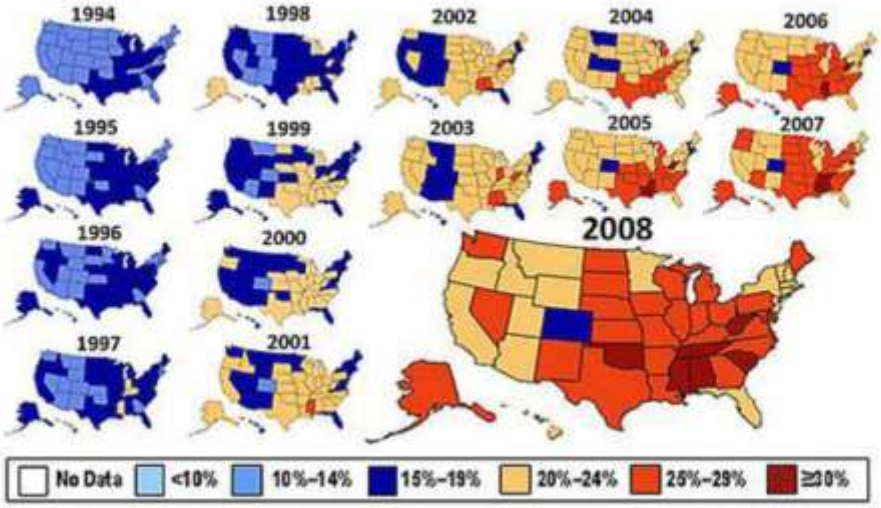
Paradigm shift 2007:

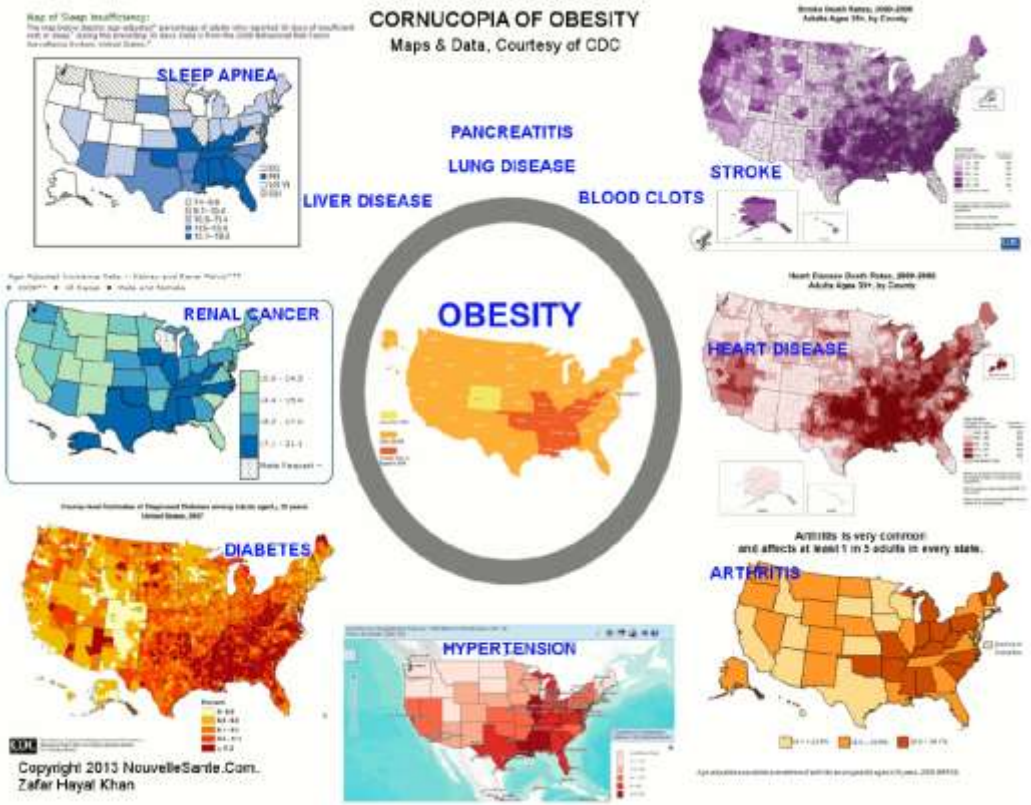
ACSM & AHA Recommendations

AHA Position Statement:

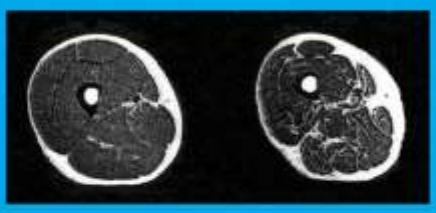
.." The benefits of strength training for older adults are extensive. It reduces the risk of **cardiovascular disease, stroke, hypertension, type 2 diabetes, osteoporosis, obesity, colon cancer, breast cancer, anxiety, incontinence and depression.**

Of particular importance to older adults, there is substantial evidence that physical activity reduces risk of falls and injuries from falls, prevents or mitigates functional limitations and is an **effective therapy for many chronic diseases**.."


1994
1998
2002
2004
2006
1995
1999
2003
2005
2007
1996
2000
2008
1997
2001
No Data
<10%
10%–14%
15%–19%
20%–24%
25%–29%
≥30%


CORNUCOPIA OF OBESITY
Maps & Data, Courtesy of CDC
SLEEP APNEA
PANCREATITIS
LUNG DISEASE
LIVER DISEASE
BLOOD CLOTS
STROKE
OBESITY
RENAL CANCER
HEART DISEASE
DIABETES
HYPERTENSION
ARTHRITIS
Arthritis is very common
and affects at least 1 in 5 adults in every state.
Copyright 2013 NouvelleSante.Com.
Zafar Hayat Khan

THE PROBLEM

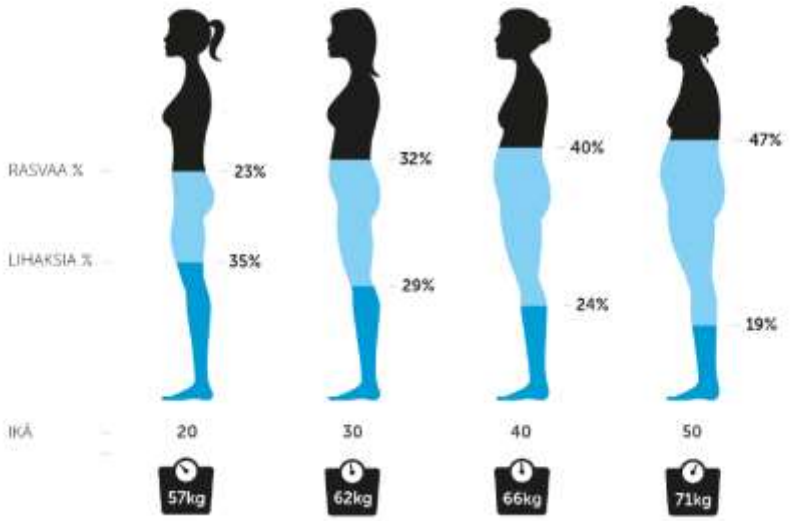


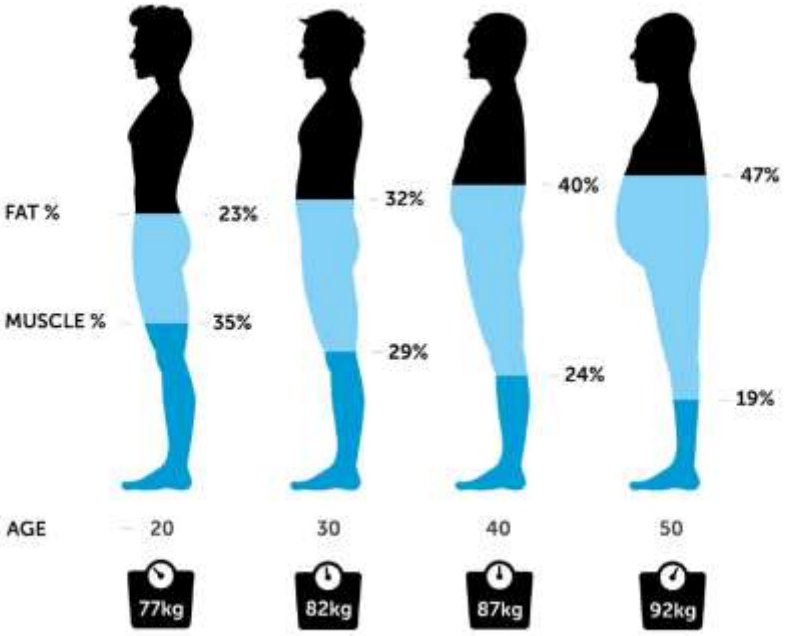
Too little muscle mass

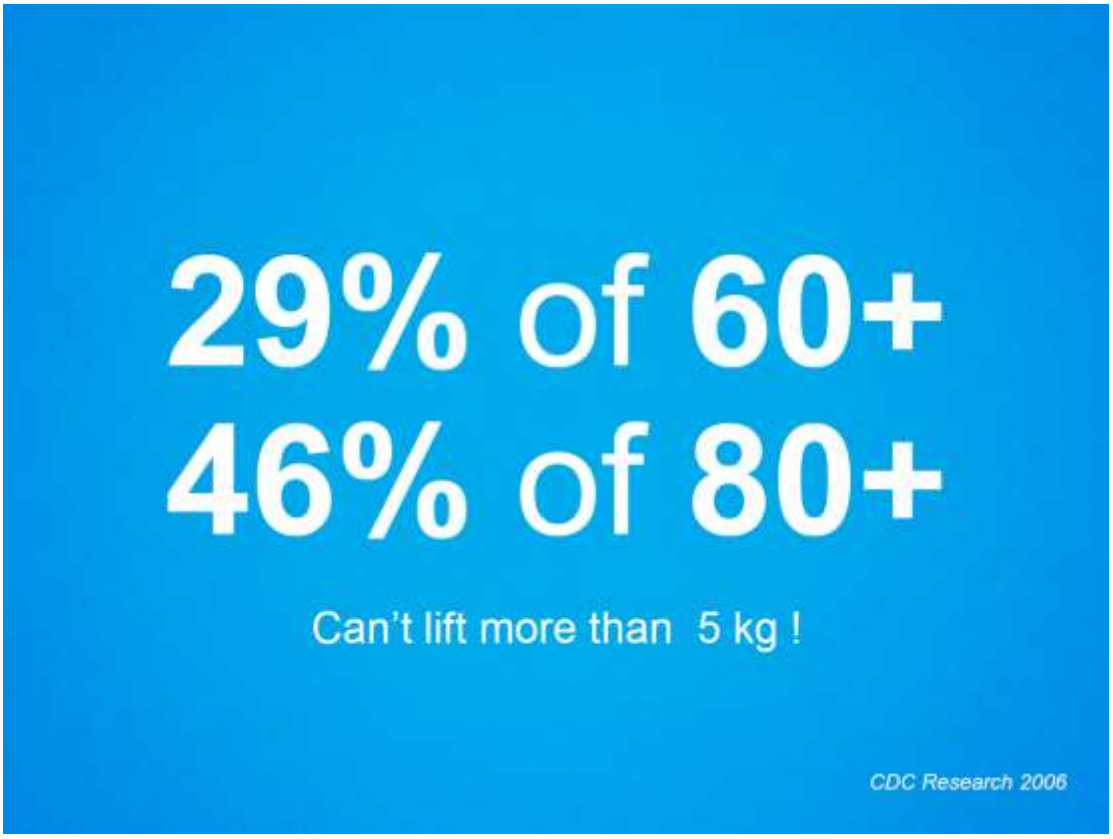
.means lower strength and metabolic rate..

which leads to **reduced functional abilities** and **accumulation of fat**

ADULTS LOSE **6 POUNDS OF MUSCLE** PER DECADE.

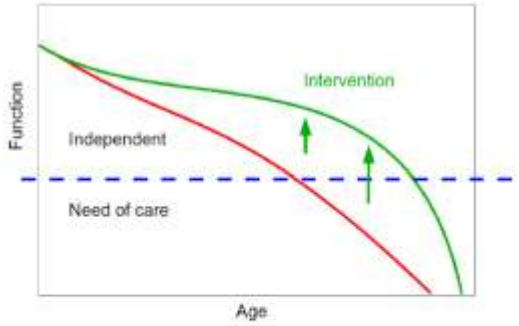


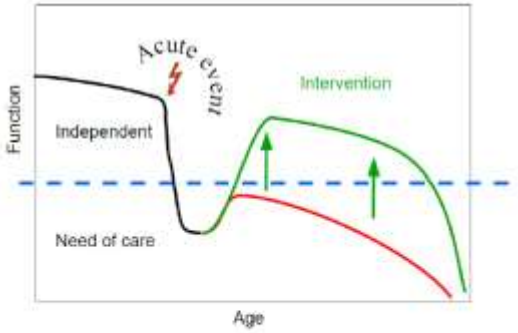

FAT %
MUSCLE %
AGE
23%
35%
20
77kg
32%
29%
30
82kg
40%
24%
40
87kg
47%
19%
50
92kg


29% of 60+
46% of 80+
Can't lift more than 5 kg !
CDC Research 2006

Immobilization cause a loss of **25%** of strength **every week**!

"Performance in physical functions is the most important explanatory factor of elderly care costs"





HUR
For Lifelong Strength

ACSM & AHA:

"Eight to Ten Strength Training Exercises, 8-12 repetitions of each, twice to three times per week"

..to maximum effort

Strength Training reverses aging!

6 Months of Strength Training in older adults reversed the genetic fingerprint for mitochondrial function to levels seen in younger adults

(Melov & Tarnopolsky)


Opera singer
Hannu Ilmolahti
Hannu before
Hannu after


The Strength You need for the life You want!
Thank You for your attention
HUR
MONARK


HUR
FOR LIFELONG STRENGTH

THE HEART OF HUR

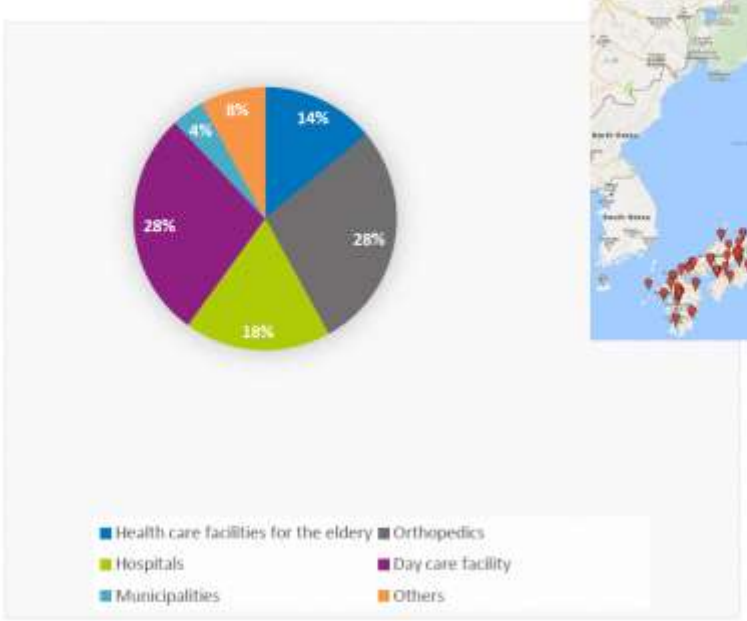
As the world-leading supplier of **exercise solutions to active ageing, rehabilitation and the inclusive wellness markets**, the mission of HUR is to provide the best concepts and products for *lifelong strength*.

By providing professionals with the best solutions and framework to do this – HUR is also a part of the solution for the big socio-economic challenges arising from aging society.

" Give them the strength they need,
for the life they deserve"

OVER 25 YEARS.
5 CONTINENTS.
10.000 INSTALLATIONS

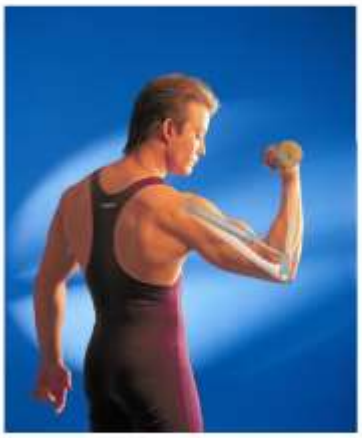
SEGMENT - EXAMPLE

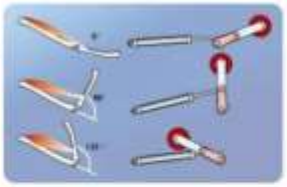


NATURAL TRANSMISSION

1. Based on the research in the University of Technology, Helsinki
2. The resistance changes according to the human movement
3. No matter how fast you do the training, you can do it very safely and effectively

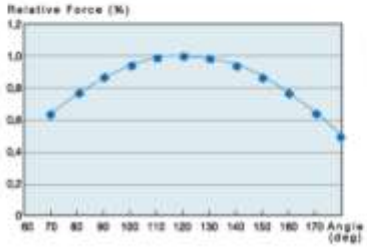
NATURAL TRANSMISSION





Air cylinder is placed according to muscle contraction.Training can be done in accordance with natural movement of muscle. **No inertia** because of using air pressure.

No affects of the speed, always natural movement (Torque curve-always same shape)



Stable Torque curve (safe and effective)

NATURAL TRANSMISSION

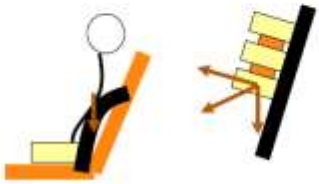
1. Safety & Efficiency
   - Smaller joint impact, efficiency
2. Light weight, silent units
3. Fast Movements possible
   - Seniors, sports, rehab
4. User Friendliness
   - SmartTouch

SAFETY

1. Excellent Back Support: Decrease the pressure on stomach
2. Bucket seat: Keep stable position of the trunk during the training
3. Fast speed/Low resistance
4. Range limiter (Premium line, for rehabilitation use)
5. Possible to put resistance by 100g
6. International standard is applied to machine parts, easy to do the maintenance.

SAFETY – BACK SUPPORT

No support area, 100% resistance to the stomach (2 support points → 75% resistance)



If supportarea is large, stomach area gets only 20% resistance

Double structure seat
= Body fits better

If you train your upper body (ex. Push up/Pull down) WITHOUT high-quality back support, pelvis of seating face get too much resistance. Moreover, keeping stable trunk position causes to put much resistance on stomach and the blood pressure can be easily go up.

SAFETY –BACK SUPPORT

SAFETY – ACCESSORIES

Ergonomic pillow matches the shape of cervical spine

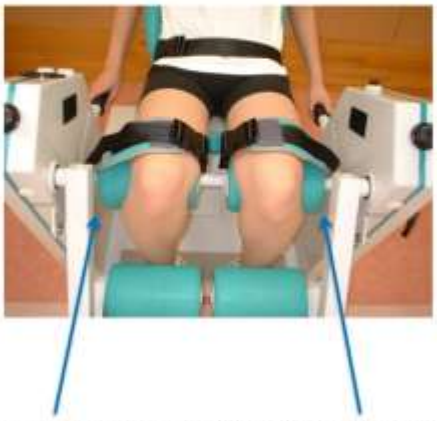
By increasing support area, back support
Lead the arms to the side, supporting the lumber spine

Seatbelt keep stable position of trunk, prevent falling off from the seat

SAFETY

If the knee joint support cushion is fixed, you may have pressure on the knee when extending and joints can be easily damaged.

If the support cushion for articular fossa is roller-shaped, roller rolls when you extend the knee, which avoids stress on tendon.



This cushion support the knee joint and they roll according to the movement.

RESEARCH : GERIATRICS

RESEACH TOPICS

- Cardiovascular Fitness
- Falls Prevention
- Lower Extremities Strength
- Memory disease
- Role of technology in terms of motivation and adherence

RESEACH TOPICS

5. Geriatrics: Lower Extremities Strength

Effects of Strength and Endurance Training on Thigh and Leg Muscle Mass and Composition in Elderly Women (1995)

Effects of strength and endurance training on isometric muscle strength and walking speed in elderly women (1996)

Effects of strength and endurance training on muscle fibre characteristics in elderly women (1997)

Quantitative ultrasonography of muscle: detection of adaptations to training in elderly women (1996)

Asymmetrical Lower-Limb Muscle Strength Effects of Strength Deficit in Older People (2008)

The Effects of Muscle Strength and Power Training on Mobility among Older Hip Fracture Patients (2008)

RESEACH TOPICS

3. Geriatrics: Cardiovascular Fitness
Improving Cardiovascular Fitness by Strength or Endurance Training in Women Aged 76-78 years (2002)

4. Geriatrics: Falls Prevention
4.1 Comparison of Balance and Some Other Physical Characteristics between Elderly Fallers and Non-Fallers (2008)

4.2 Does progressive resistance and balance exercise reduce falls in residential aged care? Randomized controlled trial protocol for the SUNBEAM program (2014)

4.3 Strength-balance supplemented with computerized cognitive training to improve dual task gait and divided attention in older adults: a multicenter randomized-controlled trial (2014)

HISTORICAL TURNING POINT - STRENGTH TRAINING FOR THE ELDERLY

Sarianna Sipilä

Professor in Exercise Gerontology
Gerontology Research Center, Department of Health Sciences,
University of Jyväskylä, Jyväskylä, Finland

Sipilä S, Suominen H. Effects of strength and endurance training on thigh and leg muscle mass and composition in elderly women. J Appl Physiol. 1995 Jan;78(1):334-40

Abstract

The effects of 18 wk of intensive strength and endurance training on knee extensor, knee flexor, and lower leg muscle mass and composition were studied in 76- to 78-yr-old women. Muscle cross-sectional area (CSA), lean tissue CSA, and relative proportion of fat were determined using computed tomography. The strength-trained women increased their total muscle lean tissue CSA of the thigh (1.5%; P = 0.035), quadriceps CSA (4.5%; P = 0.021), quadriceps lean tissue CSA (5.8%; P = 0.009), and mean Hounsfield unit of the lower leg muscles (11.2%; P = 0.035) compared with the changes that occurred in the control group during the experiment. The change in quadriceps lean tissue CSA because of the strength training was also significant compared with that in the endurance group. The relative proportion of fat within the quadriceps muscle decreased due to the strength training compared with the changes that occurred in the endurance group. The results show that intensive strength training can induce skeletal muscle hypertrophy in elderly women and thereby also reduce the relative amount of intramuscular fat, whereas the effects of endurance training are negligible.

Sipilä S, Multanen J, Kallinen M, Era P, Suominen H. Effects of strength and endurance training on isometric muscle strength and walking speed in elderly women. Acta Physiol Scand. 1996 Apr;156(4):457-64

Abstract

The separate effects of 18 weeks of intensive strength and endurance training on isometric knee extension (KE) and flexion (KF) strength and walking speed were studied in 76- to 78- year-old women. Maximal voluntary isometric force for both KE and KF was measured in a sitting position on a custom-made dynamometer chair at a knee angle of 60 degrees from full extension. Maximal walking speed was measured over a distance of 10 m. The endurance-trained women increased KE torque and KE torque/body mass after the first 9 weeks of training when compared with the controls. when comparing the baseline, 9 week and 18 week measurements within the groups separately, both the endurance- and strength-training groups increased KE torque, KE torque/body mass and walking speed. Individual changes in KE torque/body mass before and after 18 weeks of training averaged 19.1% in the strength group, 30.9% in the endurance group and 2.0% in the controls. This study indicates that in elderly women the effects of physical training on muscle strength and walking speed occur after endurance as well as strength training. The considerable interindividual variation in change of muscle performance is also worth noticing.

LATEST STUDIES

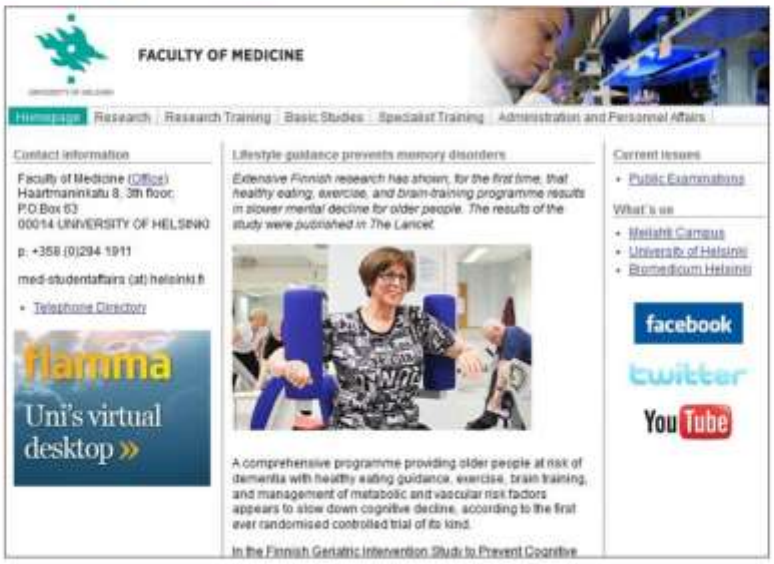
6. Geriatrics: Memory disease

Lifestyle guidance prevents memory disorders (2015)
Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER) , National Institute for Health and Welfare, The University of Eastern Finland, the University of Helsinki, the University of Oulu and the Karolinska Institutet

Research Description: A total of 1,260 Finnish elderly participants were randomly divided into two groups, one of which was given standard lifestyle advice and the other intensive guidance. Intensive guidance included dietary instruction and participation in exercise activities and memory training, as well as support in managing the risk factors of cardiovascular diseases. All of the study participants were deemed to be at risk of dementia, based on standardised test scores. After two years, study participants' mental function was scored using a standard test, the Neuropsychological Test Battery (NTB), where a higher score corresponds to better mental functioning.

http://www.hur.fi/en/know-how/research

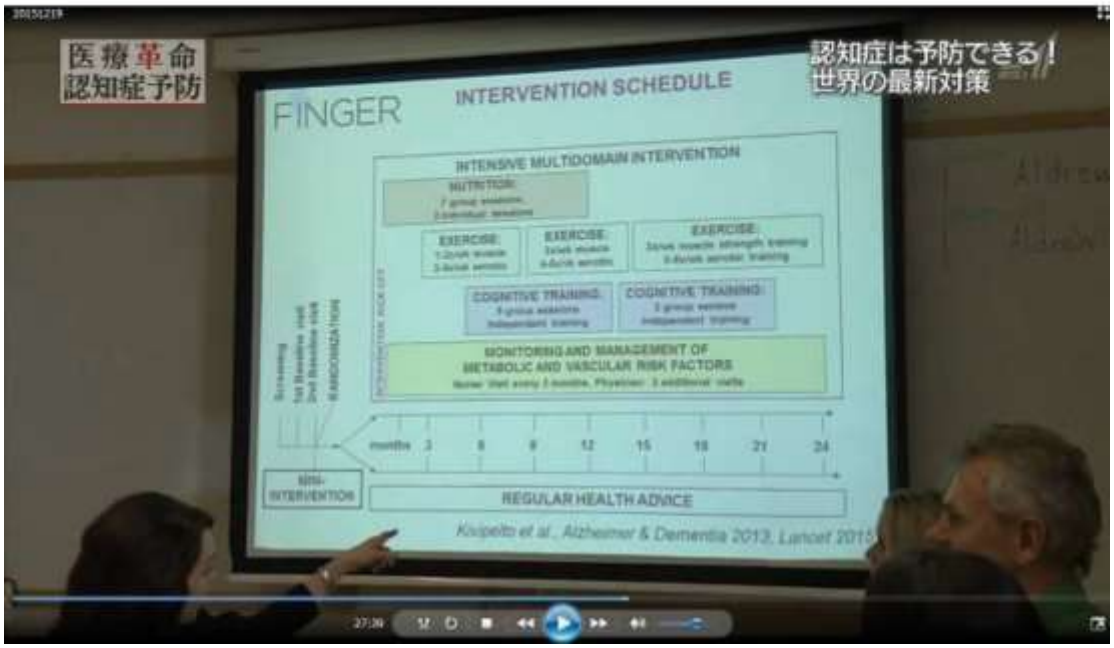
FINGER
FINNISH GERIATRIC INTERVENTION STUDY TO PREVENT COGNITIVE IMPAIRMENT AND DISABILITY



http://www.hur.fi/en/know-how/research

INTERVENTION SCHEDULE

Information from NHK – Japan National Broadcasting comapny



LIFESTYLE GUIDANCE FOR THE PREVENTION OF MEMORY DISORDER

http://www.hur.fi/en/know-how/research

http://www.hur.fi/en/know-how/research

KNOWLEDGE IN TO ACTION
BUILDING THE CONCEPT

KNOWLEDGE IN TO ACTION
CARDIAC REHABILITATION

Japan
- Nagoya University
- Sakakibara Heart Institute
- Nakatzugawa City Hospital
- The 2nd Red Cross Hospital
- Nagoya Heart Center
- Kameda hospital

China
- Shangahi Tongji Hospital

France
- Gousssonville Private Hospital

Singapore
- Singapore General Hospital, National Heart Center

Germany
- Cardiology and Sports Medicine, Department of Preventive and Rehabilitative Sport and Exercise Medicine at the German Sport University Cologne

UK
- Alton Cardiac Rehab Centre

NAGOYA HEART CENTER

SAKAKIBARA HEART INSTITUTE

MULTIFUNCTION 4X & 5X

CARDIAC REHAB SEMINAR

BEIJING, CHINA : HOSTED BY INTERREHA

第 2 届中日心脏康复讲习会工坊日程设计

时间	
[illegible]	英文：Opening
[illegible]	英文：Opening
9:00~10:10	英文：General Guidance for Cardiac Rehabilitation
10:00~12:00	英文：Emergency Management and Safety Control for Exercise Test — Yutaka Kimura
13:00~13:45	英文：Cardiopulmonary Exercise Test and Its Physiological Background
14:00~14:50	英文：Procedure of Exercise Prescription — Yutaka Kimura
15:00~16:00	英文：Role of Physical Therapist in the Cardiac Rehabilitation

This training course provides the attendees with the appropriate methods for the exercise testing, the data analysis, and determining the optimal level of the

CARDIAC REHAB SEMINAR

HEACR

International HEACR in Cooperation with the Institute for Cardiology and Sports Medicine, Department of Preventive and Rehabilitative Sport and Exercise Medicine at the German Sport University Cologne. www.heacr.com

REFERENCES WITH SCIENTIFIC BACKGROUND

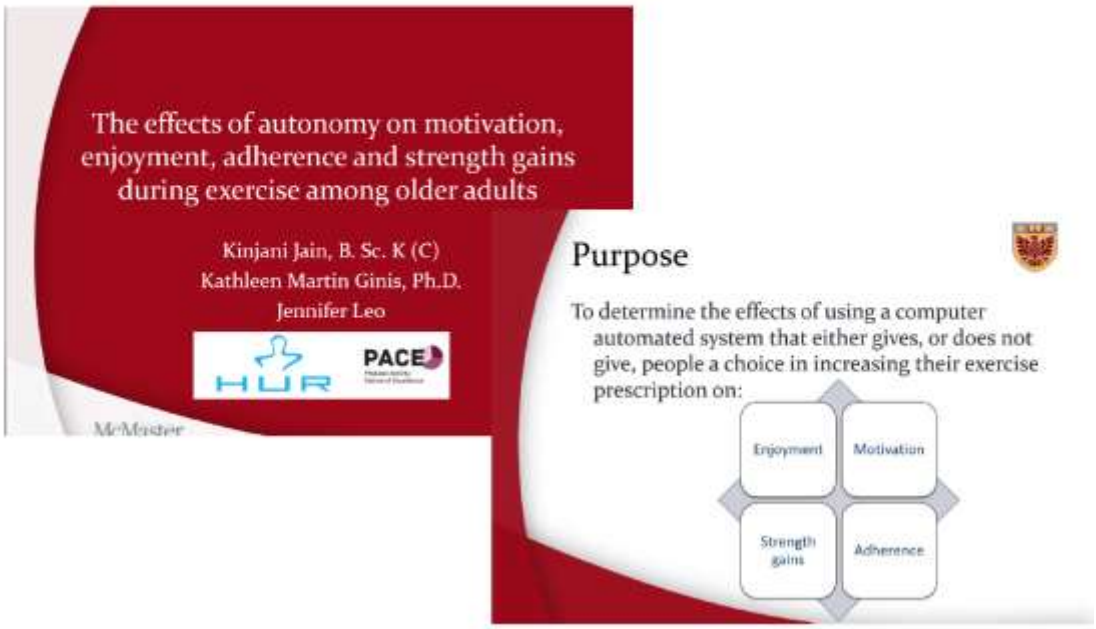
MCMASTER
UNIVERSITY, CANADA

PACE

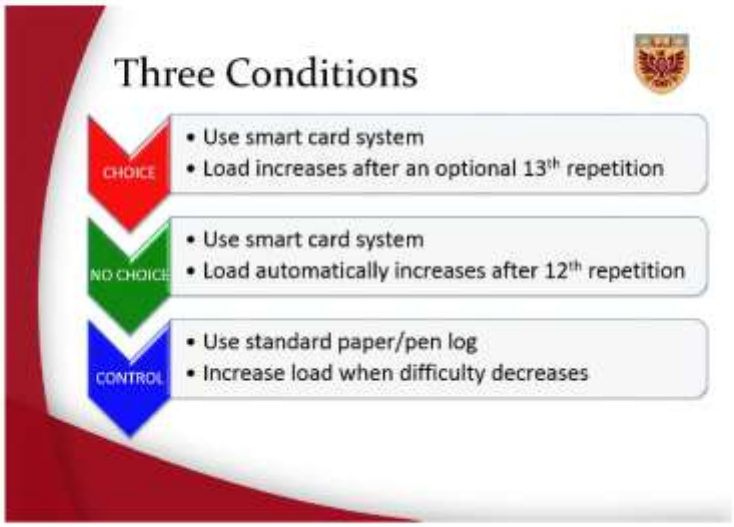
The PACE (Physical Activity Centre of Excellence) is housed in the Department of Kinesiology, in the Ivor Wynne Centre and the Ivor Wynne Centre East buildings.

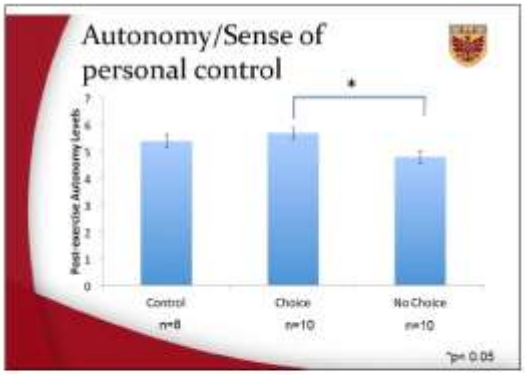
The McMaster Cardiac Rehabilitation and MacSeniors Programs operate in a bright and airy, 4000 square foot fitness facility. Program members have access to over 75 pieces of exercise training equipment including treadmills, stairmills, arm ergometers, recumbent stationary bicycles, and upright stationary bicycles. For a full body workout, our Centre features HUR strength-training machines; these easy- to-use machines are ideal for seniors and beginner exercisers who want to get stronger.

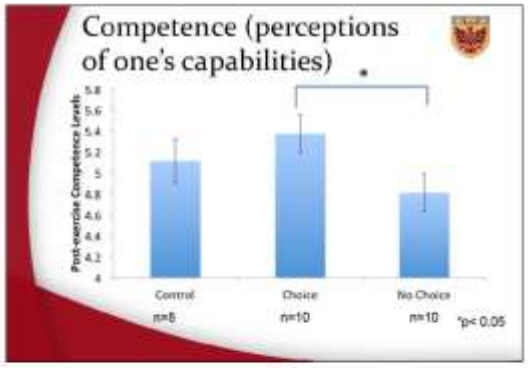
RESEARCH

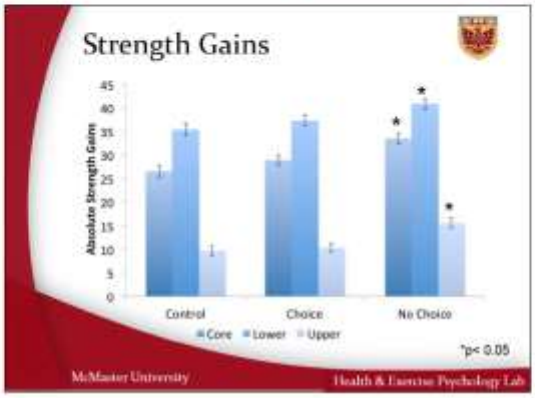


RESEARCH









HUR

Discussion

- Choice group felt more competent and more in control of their exercise than no choice group.
- No choice group got stronger than the other groups. However, in the open-ended questions, it was clear that this group did not enjoy the exercise program.
- Choice group had better adherence than control group—Adherence may be improved by use of Smart Cards.

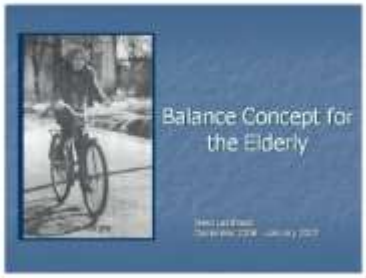
KNOWLEDGE IN TO ACTION
BUILDING THE CONCEPT

UNIVERSITY OF JYVÄSKYLÄ
KOKKOLA UNIVERSITY CONSORTIUM
CHYDENIUS

HUR
The Active Ageing Company

WELMED™

WELMED
HEALTH ASSESSMENT SYSTEMS



WELMED

- **WELMED** is a laboratory and a product concept for continuous quality improvement in health care with a focus on physical function and preventive health.
- The WELMED concept has been developed by the *University of Jyväskylä, Kokkola University Consortium Chydenius* and its business partners. WELMED offers new tools and models to service providers, and the public sector, for promoting health and continuous quality improvement.
- The WELMED consortium represents a new type of partnership between research, business enterprises and service providers in developing innovative health and wellness services.
- Welmed Concept brochure: http://www.welmed.fi/WELMED_concept_270312.pdf
- Profy +65 project - Preventive Fitness Check Up: http://www.welmed.fi/profyA4presentation_en.pdf
- http://www.welmed.fi

WELMED

- Published Research

  "Comparison of Balance and Some Other Physical Characteristics between Elderly Fallers and Non-Fallers (2008)"
  http://www.hur.fi/en/know-how/research#004

- Related videos and articles

  -WELMED LABs, Case Faller
  https://www.youtube.com/watch?v=Ac8rFRtGUpo

  -Gym Tonic introducing Exercise-As-Medicine concept in Singapore:
  http://www.hur.fi/en/news/gym-tonic-introducing-exercise-medicine-concept-singapore

  -Elder-friendly gym machines for active ageing:
  http://www.hur.fi/en/news/elder-friendly-gym-2000-senior-citizens-singapore#

FYSIOGERIATRIA – SPECIALIZES IN MEMORY CARE

http://www.fysiogeriatria.fi/en/

FysioGeriatria®

FYSIOGERIATRIA

- **Fysiogeriatria** specialises in geriatric physiotherapy and comprehensive rehabilitation for the elderly, people with memory disorders and veterans at home, at nursing homes and at rehabilitation centres.The goal is to increase quality of life and happiness, regardless of the customer's age or situation.
- *"We have been using the computerized HUR equipment for rehabilitation of seniors and people with dementia since 2010. Our physiotherapists and our customers really appreciate the benefits and possibilities of HUR products - they are safe and easy to use – and they provide us with important data for client follow-up and motivation"* Katja Sohlberg, CEO, Suomen Fysiogeriatria
- New facility opened in May 2015, applies HUR SmartTouch system
- Facility website: http://www.fysiogeriatria.fi/en/
- See the facility layout: http://www.hur.fi/en/cases/hur-senior-exercise#memory-care

Research project:

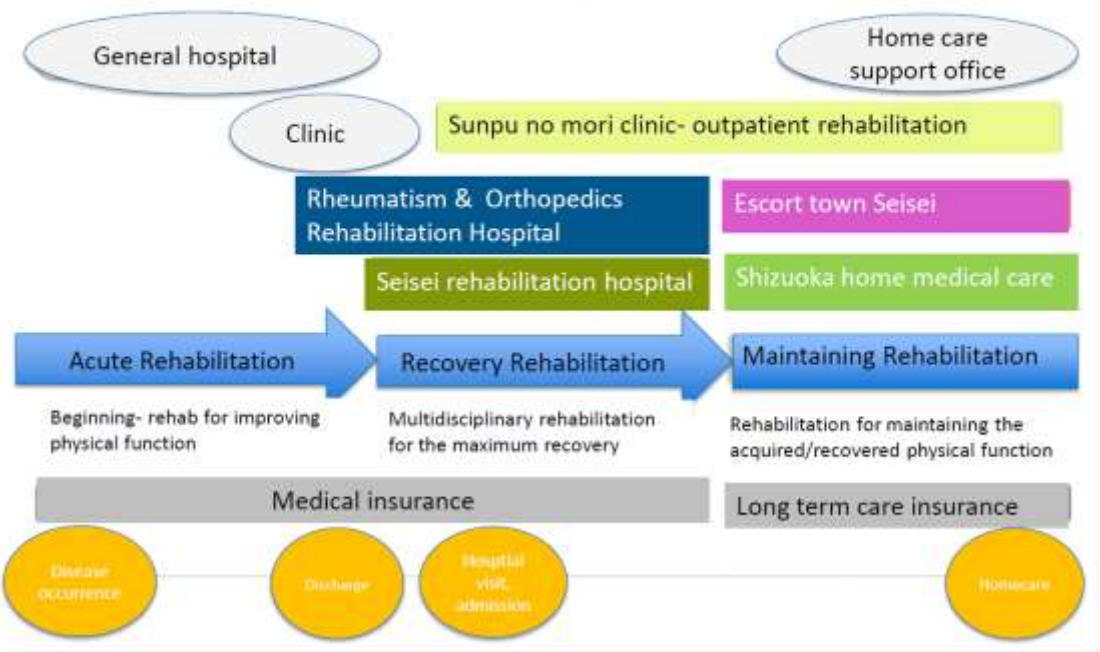
- "Effectiveness of physical rehabilitation for older people with memory disorder -Randomized controlled trial." *The Social Insurance Institution of Finland, Studies in social security and health*
- Exercise May Help People With Alzheimer's Avoid Nursing Homes http://health.usnews.com/health-news/news/articles/2013/04/15/exercise-may-help-people-with-alzheimers-avoid-nursing-homes
- Workout Helps with ADL in Alzheimer's http://www.medpagetoday.com/neurology/alzheimersdisease/38462

SPURTTI – HUR CLUB

SPURTTI – HUR CLUB ACTIVITY BASED ON RESEARCH

- The chairman of Spurtti company, Ms. Tuire Rinta participated in a study on the influence of equipment employing pneumatic resistance and smart technology on 50+ users starting an exercise program, as well as the related motivational factors, provides insights into this.
- The study covered the customers of three gyms in Finland that utilize Smart Card technology and Spurtti was one of three gyms.
- At first glance, the idea of smart technology at a gym specializing in senior exercise may seem far-fetched. However, the study conducted by Tuire Rinta in the Degree Programme in Sport and Leisure Management at the Haaga-Helia University of Applied Sciences shows that this might not be so. A total of 210 exercisers (141 women and 69 men), most of whom fall into the age group of 51-60 years, participated in the study.
- Read more about research from: http://www.hur.fi/en/news/gym-equipment-employing-smart-technology-and-pneumatic-resistance-influences-motivation
- Facility website: http://www.spurtti.fi/
- Facebook: https://www.facebook.com/spurttiliikuntakeskus

R&O SEAMLESS APPROACH



Thank you for your attention ☺

Enjoy the active life
NOW AND IN THE FUTURE

七、Roihuvuori Comprehensive Service Centre 簡報資料

City of Helsinki
Department of Social Services and Health Care

Wellcome to Roihuvuori comprehensive service centre

Mari Sairanen
Director of Roihuvuori comprehensive service centre
Tuula Mohamud
Service Manager
5.8.2016

City of Helsinki
Department of Social Services and Health Care

Helsinki residents

- 624 000 inhabitants
- Residents with some other mother tongue than Finnish, Swedish or Sami language 13.5%
- 1.87 residents/household
- 25% lived alone
- Two thirds of the population were working age
- Over 65-year-olds 16%
- Under 18-year-olds 16%
- Life expectancy of a new born baby
  - women 83.5 years
  - men 77.8 years

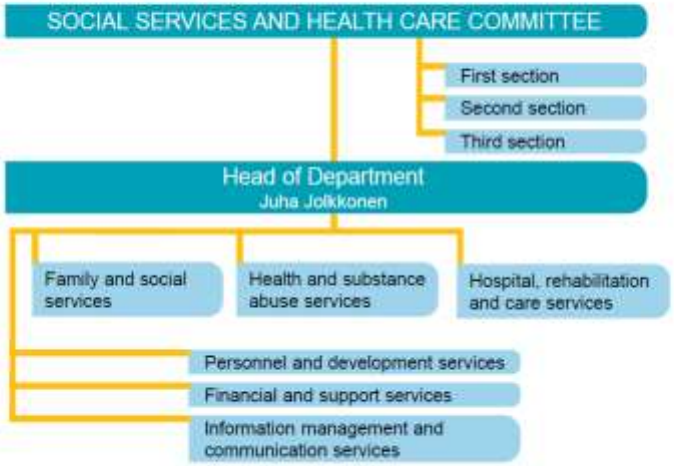
City of Helsinki
Department of Social Services and Health Care

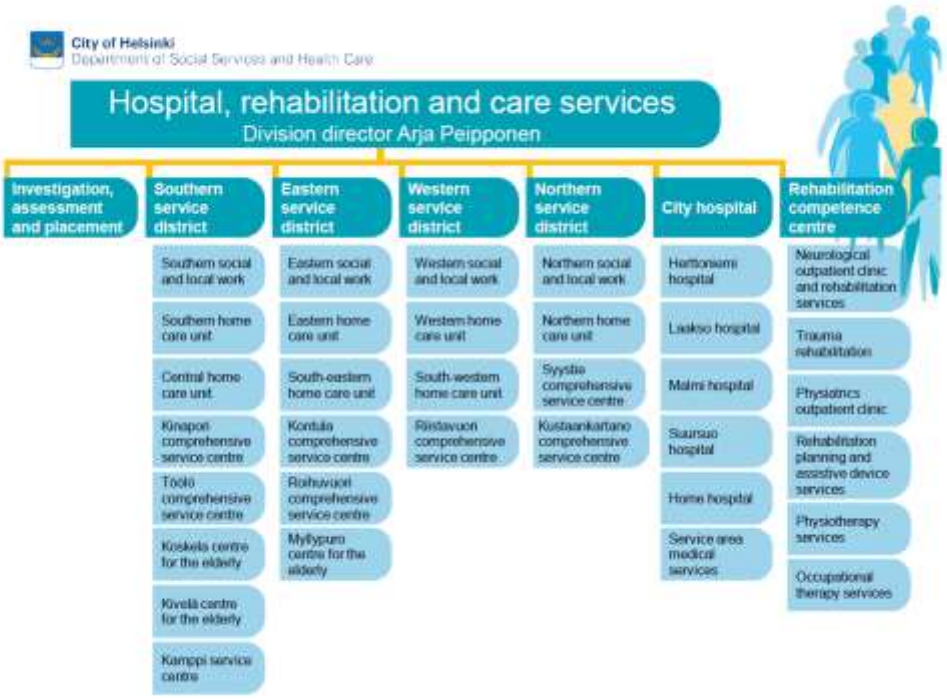
Helsinki's social welfare and health care services in a nutshell

- The City organises and primarily produces social welfare and health care services for 624,000 residents
- Governed by a political board composed of 13 members
- The Department of Social Services and Health Care 1 January 2013 ->
- 16,000 employees
- 133 customer service points around the city
- Budget EUR 2,2 milliard

City of Helsinki
Department of Social Services and Health Care

Organisation of the Department of Social Services and Health Care 2013





Services for Elderly People in Helsinki

To support those elderly people who live at home

- Social work
- Local and community work
- Home care
- Comprehensive service centre
- Service centers
- Day care for elderly
- Support for family caregivers

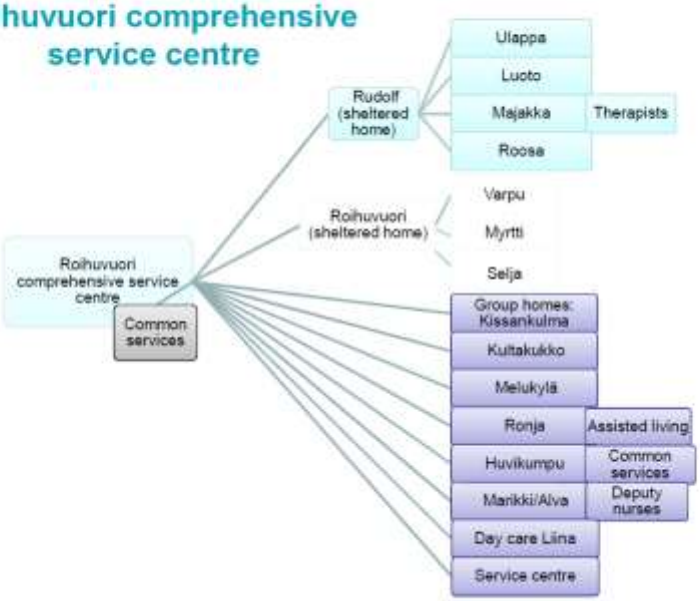
Sheltered housing (residential home care) and Institute services (nursing home care) for those elderly people who need constant care that can`t be provided at home.

And also

- Primary care in Health centre
- Acute medical care in city hospitals

City of Helsinki
Department of Social Services and Health Care

Roihuvuori comprehensive service centre



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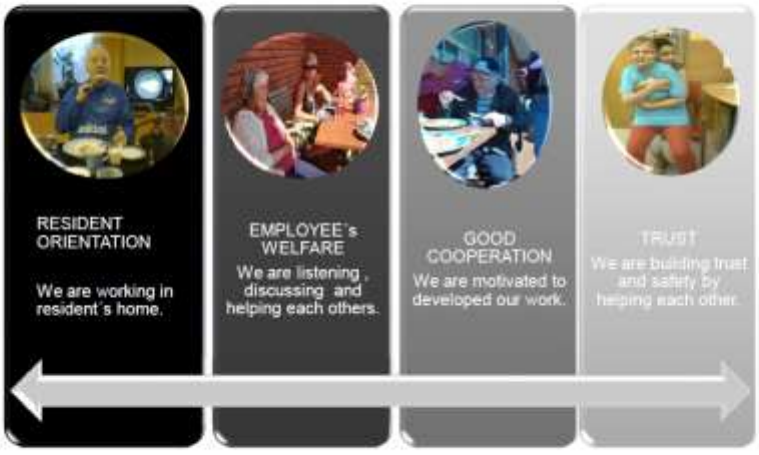
Values



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Principles and nursing practices

- Community care/nursing, sense of community
- Homelike environment and activities
- Primary nursing , every residents has their own nurse
- Multiple activities for enhancing rehabilitation processes & sustaining physical ability

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Staff

- approximately 150 people, nursing staff per resident 0,7
- staff on wards
  - nursing managers
  - registered nurses
  - practical nurses
  - nursing aides
  - physical therapist
  - social counsellor
  - occupational therapist
  - Other members of care team
  - physician
  - social worker
  - activity instructor
- Other staff
  - administration & secretaries
  - support jobs for unemployed people
  - students, trainees

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Roihuvuori comprehensive service centre

Group Homes (A total of 147 placements)
- Long Term Care LTC (104)
- Short Term Care STC (12)
- Assesment and rehabilitation (31)

Day Care (16 places)
- stimulating and rehabilitative activities for people with memory imparement

Service Centre (appr. 2000 visits/month)
- for all elderly residents in Helsinki and for unemployed residents
- goal is to prevent the social isolation

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Group homes

- Four group homes for residents with dementia
- One group home for residents with psychiatric diseases
- One group home for physically disabled residents
- One unit for assessment and rehabilitation
- One unit for short-tearm care

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Grouphomes for residents with dementia

Kissankulma
Kultakukko
Marikki
Alva

- Taking care of dementia people is important to us
- Resident-orientation
- No hurry – memory ill residents day builds his own life rhythm
- Presence – this moment is important!
- Cooperation with relatives
  - Relatives are welcome at any time!
  - Relatives information is valuable
  - Relatives are part of our community

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Grouphome for psycho-geriatric residents

Ronja 18 places + 6 support homes:

We are working with residents together doing things what they usually would like to do if their are living in their own homes including therapeutic relationship work

Residents illnesis:

Psychosis, schizophrenia, delusional disorder, major depressive episodes, mania heavy substance abuse background; brain injury, behavior disorders mood disorders; depression, bipolar disorder, anxiety disorder

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How much does it cost to residents to live in group home

- **Rent** 16,42 euro / m2
- **Basic payment** 74,20 euro /month (group home)
- **Meal payment** 421,40 euro /month (all meals included)
- **Service payment** 2611,00 euro /month
  - includes maximum nursing care / medical care
  - cleaning of the room + linen

- Residents have to have 20 % left from their income and at least 254 euro/month

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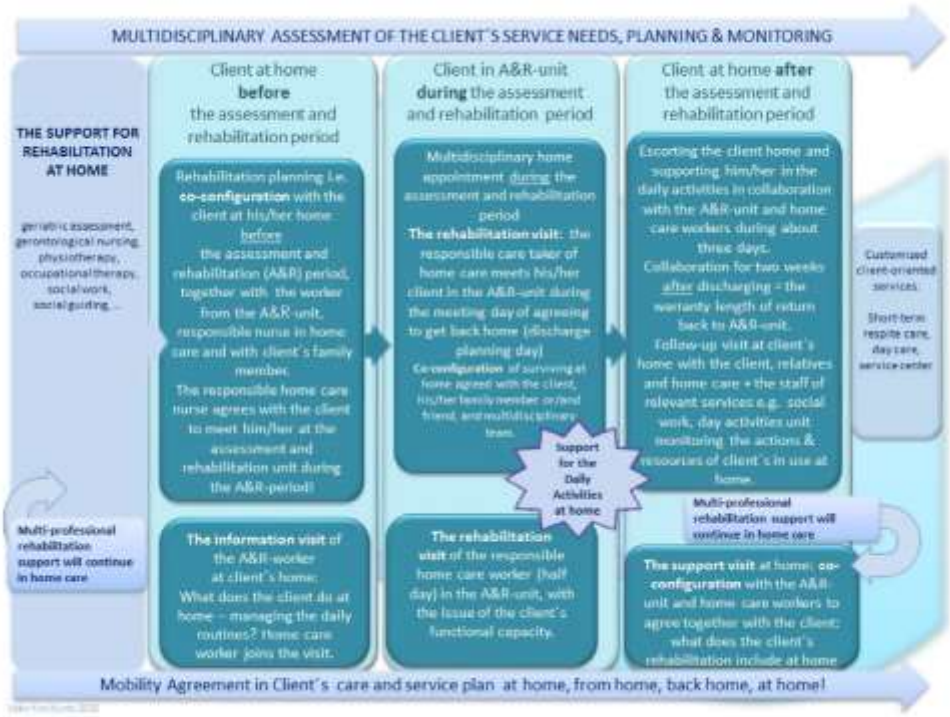
Grouphome for evaluation and rehabilitation

Melukylä (31 places)

- The most important thing is safety discharge to own home!



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Day Care

Day care Unit Liina has a 16 day-time places for elderly people with memory disability who are living at home in Helsinki.

Priorities: rehabilitative approach, multi-professional teamwork, support for caregivers, the development of regional co-operation

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Service centre

- The service center is open to the activities of Helsinki pensioners and the unemployed.

  Focus areas:
  Regional networking
  Exercise
  Support to substance abuse and mental health targeted customers
  Culture

- One social worker also involved in building support for housing pilot.
- Support group for clients who is going back to home from Melukylä.

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The Main Goals of the Service centers

- To maintain mental, physical and social functionality and wellbeing.
- To enable independent functional living of the senior citizens.
- To prevent or delay the need of other healthcare services, such as home care or nursing home.
- To arrange **peer support groups.**
- To offer versatile and high quality services.

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Support for eldery people who are socially isolated organized by Service centers

- **Peer groups:**
  Loneliness, substance abuse, widowed, depression, memory disorders
- Individual **support conversations:**
  Social instructor activates, give help to fill in forms, and gives support
- **Group activities for immigrants:**
  Gymnastics, conversation, peer groups and other support from the social instructor for example cultural issues in Finland

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Supported housing in Roihuvuori

- Roihuvuori comprehensive service centre started in the year of 2012 a new kind of support for the elderly who need psychiatric support or have substance abuse.
- Co-work with home care units, social and local work, geriatric psychiatry counseling unit
- 6 support flats situated in an appartment house nearby Roihuvuori comprehensive service centre
- Low-bureaucracy service

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Quality control in comprehencive service centre

- RAI = Resident Assesment Instrument
  - Two times a year
  - Quality model, indicators, reports
- Incident reporting system– HaiPro
  - Reporting risk of events what happens to our residents
- Queries
  - To residents, stuff, relatives for example satisfaction of services, working environment and wellfare
- Staff training
  - 3 days a year at least

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Current issues

- **The service network is developed**
  - Customers' and patients' needs and expectations have changed.
  - The tightening economy in connection with the population's changing age structure requires more efficient services.
  - The City Council has set a goal for integrating the social and health care services.
  - -> requires changing the service structure and developing the contents of the services
  - Service network
    - Health and well-being centres
    - Family centres
    - Comprehencive service centre
- Aging-in-Place, solutions are searched to create opportunities for the elderly to live in their homes in familiar living environments.

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How to find and provide care and welfare to socially isolated senior citizens?

- **Improving co-operation with social and health services**

→ care management for those elderly who visit doctor/nurse in health stations. Health stations reach aprx.80% of people over 75 years and they quite often would need more comprehensive support than just health care.

→ improving preventive work

- Community work: authorities visit and organize action/services there, where people live and spend their days → strengthen the communities and activate local people to exchange services (neighbor help)

- Peer groups for elderly people (for example lonely, widoved,substance abusers)

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- Co-operation with voluntary organizations and church

- Co-operation regionally with other institutional organizations like schools, libraries, cultural centres etc. For example in the Roihuvuori area there is cooperation with local youth centre:Young people can apply for a summer job helping elderly -> change of attitude

- Welfare advanced house calls are offered annually for age class 75 and 85.

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Quality control in elderly long-term care - a municipal point of view

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Outline

- Definitions
- Facts about aging Finland and Helsinki
- Quality Control in Long-term Care, Finland
- Quality Control in in Long-term Care, Helsinki
- Summary

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DEFINITIONS

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Long-Term Care (LTC)

Box 1. What is Long-term care?

A range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are dependent for an extended period of time on help with basic activities of daily living (ADL). This ***personal care*** component is frequently provided with basic medical services, ***nursing care***, prevention, rehabilitation or palliative care. LTC services can also be combined with lower-level care related to help with so-called instrumental activities of daily living (IADL) (e.g., domestic help, help with administrative tasks, etc).

LTC can be
- permanent
- Temporary

LTC can be delivered
- At home
- Institution

Source: Colombo, F. et al (2011), *Help Wanted? Providing and Paying for Long-Term Care*, OECD Publishing www.oecd.org/health/longtermcare/helpwanted

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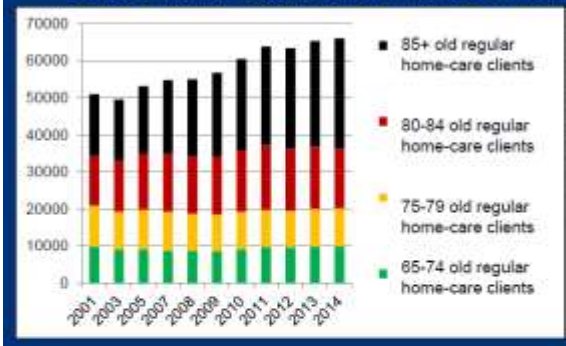
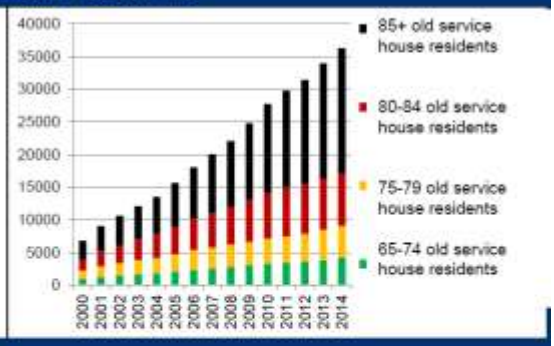
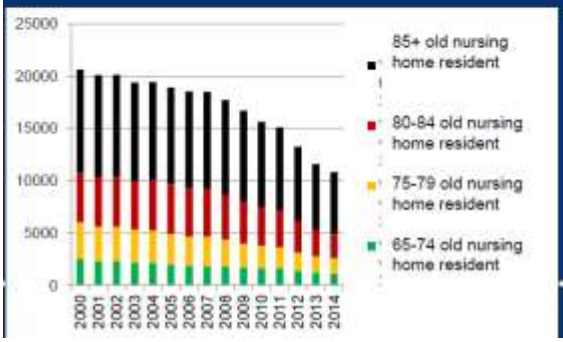
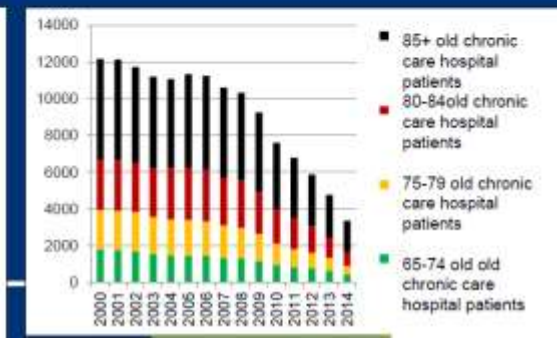
Clients (n) in elderly care services from 2001-2014

Source: National register, National Institute for Health and Welfare (THL)









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FACTS ABOUT AGING FINLAND / HELSINKI – IN THE NUTSHELL

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- Population, Finland 5,5 million in 2016
- More than one million of the population is aged 65 +
- Need of help starts approximately between the age of 80-85
- Official statistics use 75+ for figures for "older people"
- Governance of Finland has traditionally (by legislation) based on decentralization.
- - In 2010 we had 410 independent municipalities
- - In 2019 we will have 18 regions

FACTS ABOUT AGING FINLAND / HELSINKI – IN THE NUTSHELL

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Long-Term Care (LTC)

Figure 1. LTC users as share of the population, 2008 or latest available year

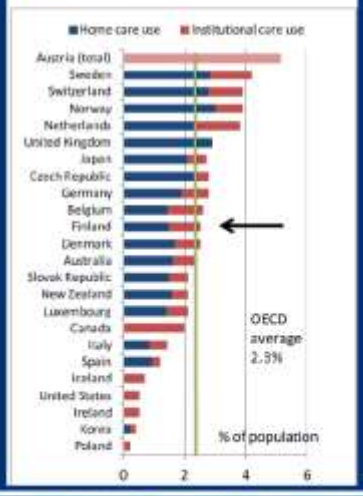
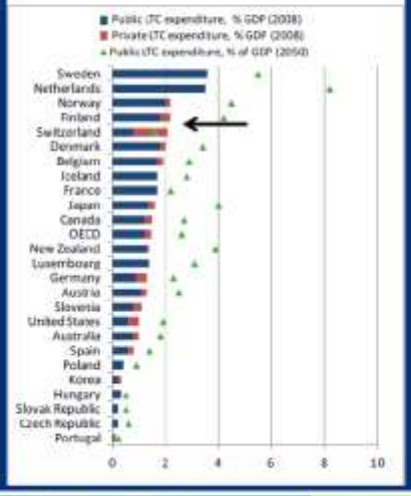


Figure 2. Public and private LTC expenditure in the OECD, 2008 and 2050



In western countries

- Appr 25% of the 80+ people need some kind of help
- Appr 1/10 of the 80+ people need help 24/7
- Disability shifts closer to end of life
- Population ages more rapidly than disability shrinks

Source: Colombo, F. et al (2011), *Help Wanted? Providing and Paying for Long-Term Care*, OECD Publishing www.oecd.org/health/longtermcare/helpwanted

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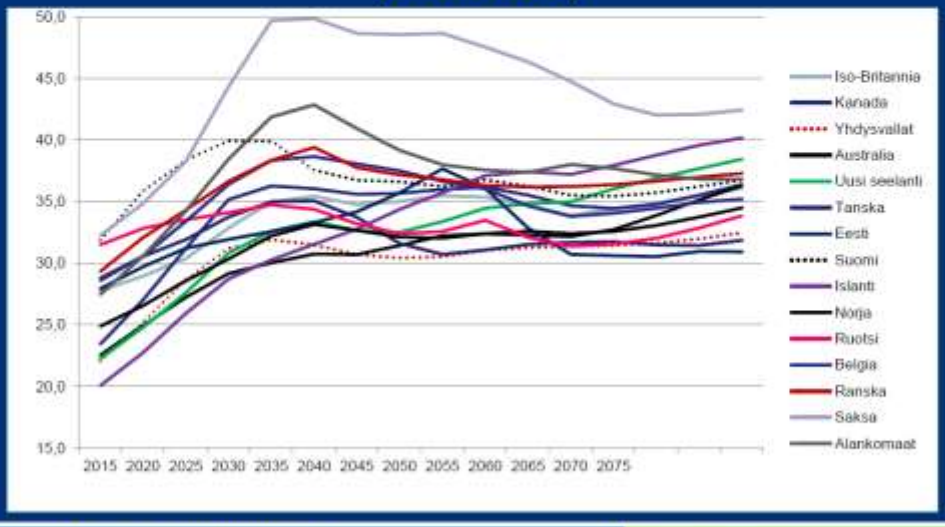
Old Age Dependency Ratio

(Source UN)



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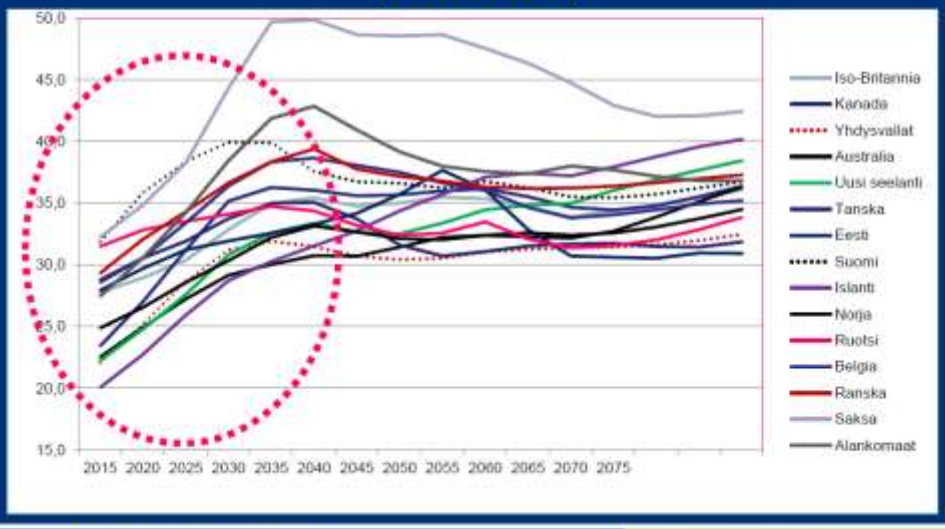
Old Age Dependency Ratio

(Source UN)



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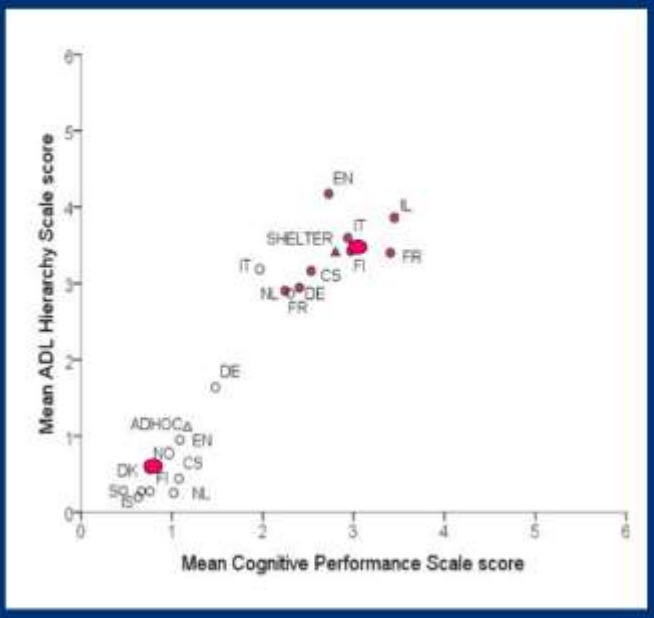
European variation



Functional Capacity of the Long-term care patients, in Europe according to country

The cognitive and physical capacity crosstabulated
From two EU funded studies

SHELTER 2009-2011
- 7 EU-counteries and Israel
- Institutional LTC

AD-HOC 2001-2003
- 11 EU countries
- Home Care

Sources:
1. AD-HOC and SHELTER databases
1. Onder et al.

SHELTER adC Soutce: Onder et al 2012 www.interrai.org

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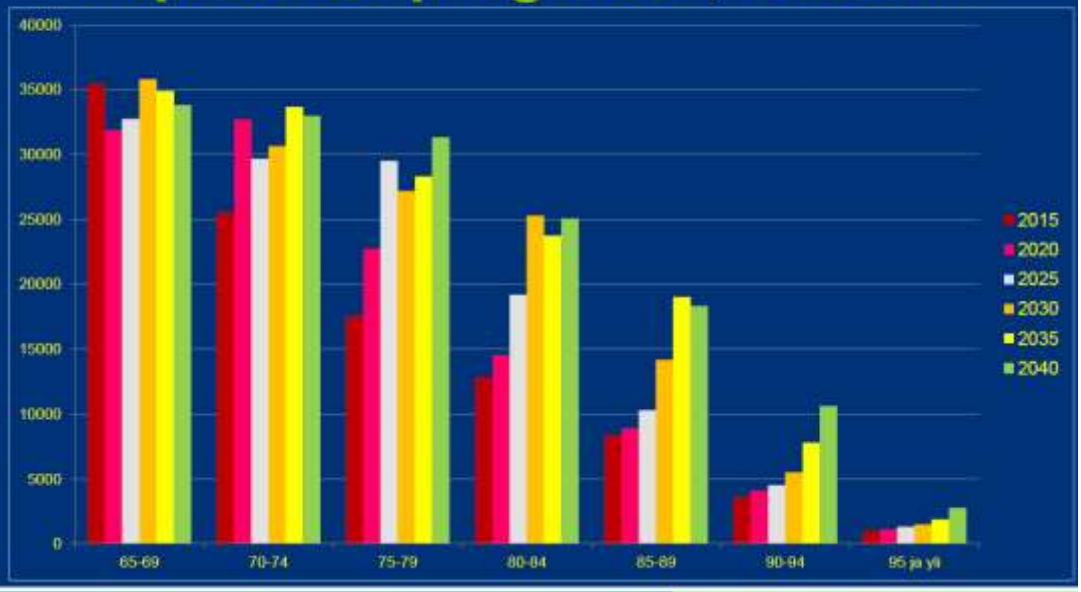
Source: Statistics, Finland

Population prognosis, Helsinki



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QUALITY CONTROL , LONG TERM CARE, FINLAND

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Social and health policies to

1. Increase and prolong health and independence with or without disability
2. minimize need for other people's help
3. enhance and maintain social contacts and quality of life
4. Minimize unequity

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Valvira
National Supervisory Authority for Welfare and Health

Quality control of the long-term care, Finland

1. Legislation
2. MOH
   - Valvira http://www.valvira.fi/web/en/front-page:
     - Guidelines / criteria
     - Quality of professional staffing etc
   - 5 Regional officies (under the ministry of internal affairs)
     - Accrediation of private institutions, complaints,
3. Municipalities
   - Quality development
   - Self auditing

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Resources meet needs in Finnish LTC care on the cost/quality ladder

(Source National Institute for Health and Welfare RAI data-base 2011)

Step 6 Health center wards
- ADL=4.1 (range 0-6, where 6 is totally dependent)
- Cognition=3,6(range 0-6, where 6 is very severe dementia)
- Mood=1,8 (range 0-14, where 3 or more is depression)
- BPSD=one or more BPSD 44%
- Staffing ratio 0,69 carers per client

Health center wards

Nurse (RN)	32,5%
Nurse (LPN +)	53,5%
Others	14,0%

Step 5 Nursing Homes
- ADL=4.4 (range 0-6, where 6 is totally dependent)
- Cognition=3,8(range 0-6, where 6 is very severe dementia)
- Mood=1,9 (range 0-14, where 3 or more is depression)
- BPSD=one or more BPSD 51%
- Staffing ratio 0,64 carers per client

Nursing homes

Nurse (RN)	21,9%
Nurse (LPN+)	68,0%
Others	10,0%

Step 4 Sheltered (assisted) living with 24/7 care available
- ADL=2.9 (range 0-6, where 6 is totally dependent)
- Cognition=3,2 (range 0-6, where 6 is very severe dementia)
- Mood=2,1 (range 0-14, where 3 or more is depression)
- BPSD=one or more BPSD 51%
- Staffing ratio 0,62 carers per client

Sheltered Living

Nurse (RN)	14,7%
Nurse (LPN +)	76,3%
Others	9,0%

Step 3 Sheltered (assisted) living w/o 24/7 care available
- ADL=1.1 (range 0-6, where 6 is totally dependent)
- Cognition=1,8 (range 0-6, where 6 is very severe dementia)
- Mood=1,5 (range 0-14, where 3 or more is depression)
- BPSD=one or more BPSD 21%
- Staffing ratio 0,3 carers per client

Sheltered Living

Nurse (RN)	13,4%
Nurse (LPN+)	80,2%
Others	6,5%

Step 1&2 Regular home care (visit at least once a week)
- ADL=0.6 (range 0-6, where 6 is totally dependent)
- Cognition=1,4 (range 0-6, where 6 is very severe dementia)
- Mood=1,0 (range 0-14, where 3 or more is depression)
- BPSD=one or more BPSD 14%
- Staffing ratio 0,15-0,16 carers per client

Regular home care

Nurse (RN)	13,8%
Nurse (LPN'+)	57,0%
Home helpers	15,9%
Home assistants	6,2%

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Quality control of the long-term care, Helsinki

Organizing care is based on legislation

- 14 a § (30.12.2014/1351) providing long-term care
  - Priority is home / home care
  - Appr 9 000 home-care recipients
  - Appr 4000 lives at different types of care homes, financed by the client, national Insurance Institute, and the municipality of Helsinki
- § 15 assessment of needs
- § 16 care planning based on assessment of needs

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interRAI tools for quality development in long-term care

- www.interrai.org

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interRAI tools in long-term care, Helsinki

- Since 2000 in Helsinki, computerized
- Trained nurses perform the RAI assessment at admission + minimum x 2 annually and every time when the condition of the client changes
- Care plan created based on the assessment
- Copies of the assessments are sent to the Institute for health and welfare -> feedback received x2 annually
- Care plans and training of the staff based on the reports

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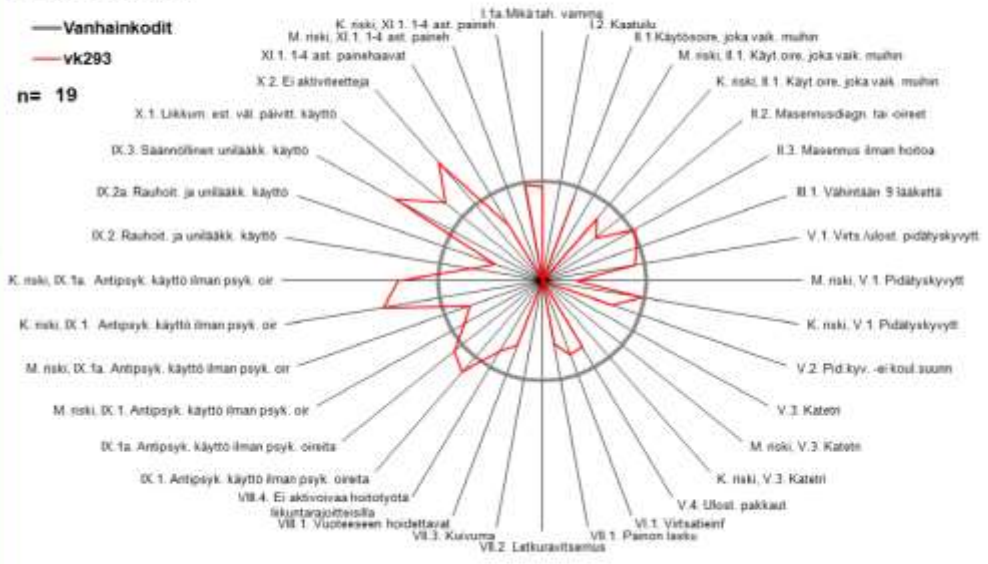
Benchmarking quality of professional care –semiannual report

Semi-annual feed-back report: **Category = nursing home, prevelence indicators**

The smaller the red figure, the better the care. Indicators outside circle=to be improve

(example from spring 2011)



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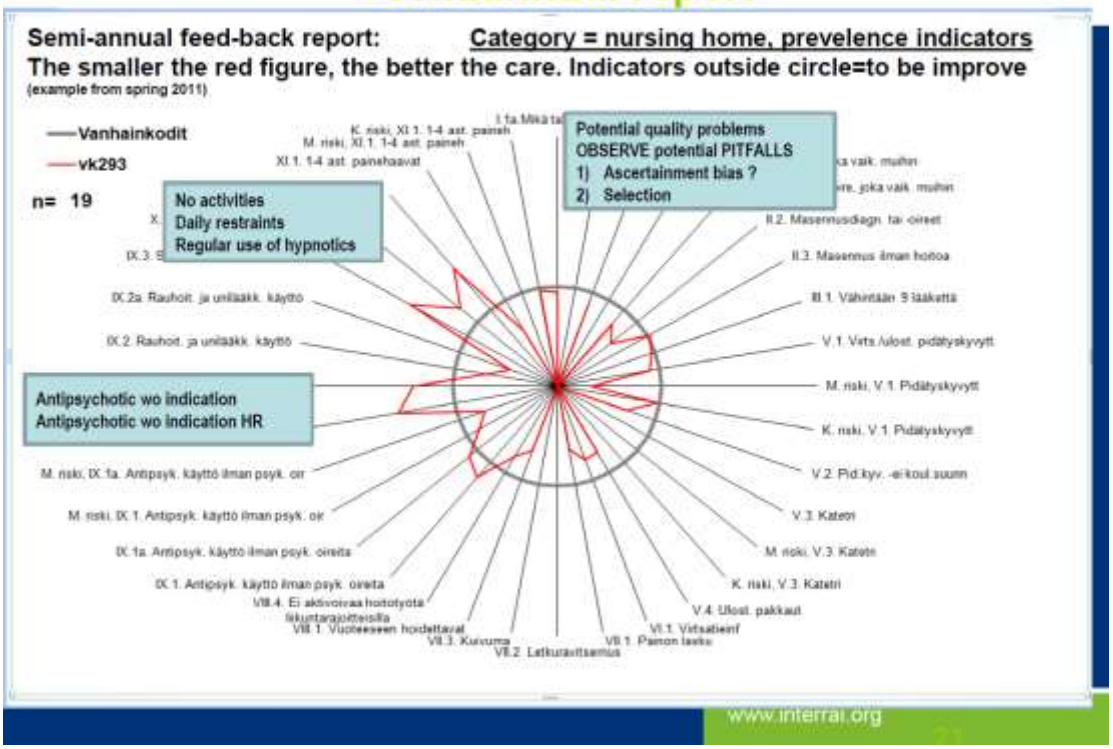
Benchmarking quality of professional care
–semiannual report



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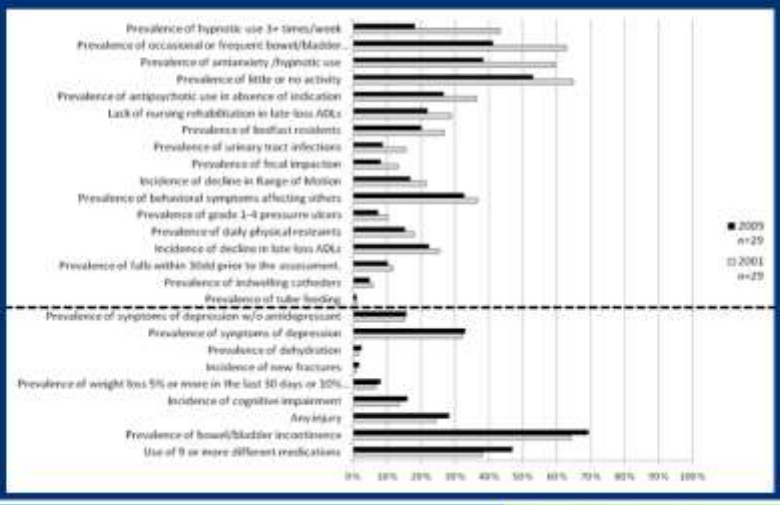
Source :
Finne-Soveri et al Eurohealth (WHO) 2010

Examples of the use of RAI
- Quality indicators



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Source : Finne-Soveri et al. 2014

Laatuindikaattori tai tunnusluku prosentteina asiakkaista tai keskiarvona	1.10.2005–31.3.2006	1.10.2010–31.3.2011	1.4.2013–30.9.2013
Mitä tahansa vammia, %	41,9	13,7	8,8
Uudet murtumat, %	2,7	2,0	1,7
Kaatuilu, %	13,4	9,3	7,3
Käytöoire, joka vaikuttaa muihin, %	40,6	39,0	34,0
Masennus, %	35,3	27,3	21,4
Masennus, ei hoitoa, %	11,6	9,0	8,7
Yhdeksän lääkettä tai yli, %	45,9	39,5	47,3
Uusi avojen vajaatoiminta, %	10,7	11,3	9,5
Päätyskyvyttömyys, %	74,6	62,4	76,7
Pidätyskyvyttömyys, ei WC-ohjelmaa, %	22,0	10,3	9,5
Virtsakatetri, %	2,6	3,4	5,0
Ulosteen pakkautuminen, %	11,1	2,2	1,5
Virtsainfektiot, %	13,4	4,6	5,0
Painon lasku, %	7,2	6,6	6,3
Lantiurvitsemut, %	0,0	0,2	0,5
Kuivuma, %	2,1	2,0	0,5
Vuoteeseen hoidettavat potilaat, %	6,6	3,2	3,5
Pitkään säilyvien taitojen hiljattainen heikkeneminen, %	23,0	16,6	16,0
Nivelten toiminnallisen liikelaajuuden menetys, %	13,8	13,6	12,2
Aktiivisen hoitotyön vähäisyys liikunnarajoitteisilla, %	7,9	6,0	12,2
Psykoosilääkkeiden käyttö ilman psykoottisia oireita, %	30,9	19,7	24,0
Rauhoittavien ja unilääkkeiden käyttö, %	44,1	27,5	27,2
Unilääkkeiden säännöllinen käyttö, %	13,4	9,5	8,8
Päivittäinen liikkumista rajoittavien välineiden käyttö, %	8,7	7,3	8,0
Vähän tai ei lainkaan aktiviteetejä, %	88,3	23,9	12,0
1-4 asteen painehaavat, %	8,3	6,4	4,2

Examples of the use of RAI - Quality indicators

- 8 years follow up at the Kustaankartano centre for the aged
- Sustainable improvements in the quality of care and quality of life

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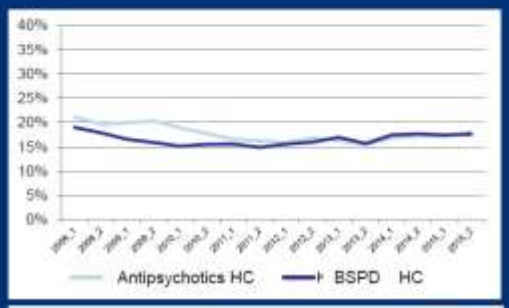
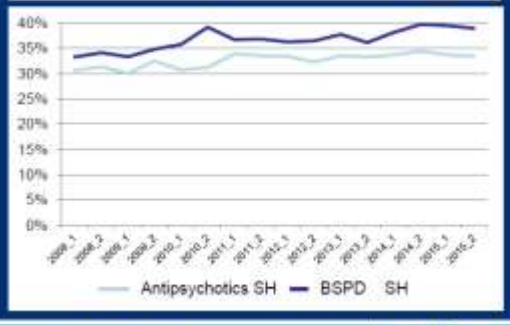
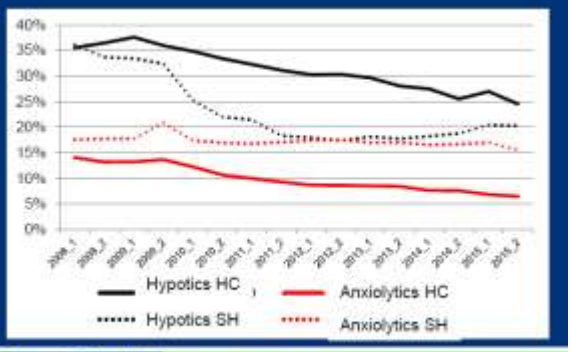
Use of psykopharmaca Helsinki home care and service houses in 2008-2015





- Examples of follow-up of the use of psychopharmaca in home care and in service housing



7.5.2016 harriet Finne-Soveri@hel.fi www.interrai.org

interRAI

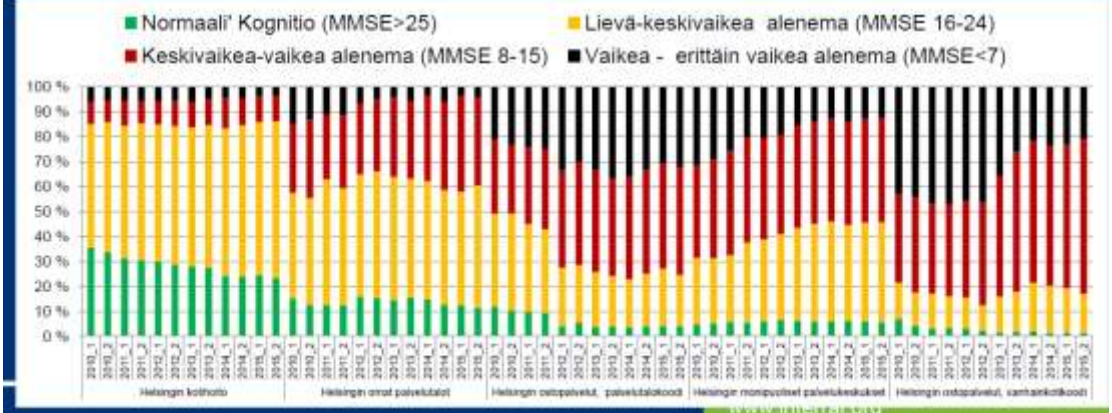
Examples of the use of RAI clientele – interntional comparisons

- Mean 82v
- Mean 3-4 diagoses
- mean 3 drugs per dg
- Declined ADL - severe in 30%
- Incontinence 90%
- Pain 15 %

interRAI

Examples of the use of RAI clientele – Clientele / eligibility

- Cognition in the elderly care recipients in 2010-2016

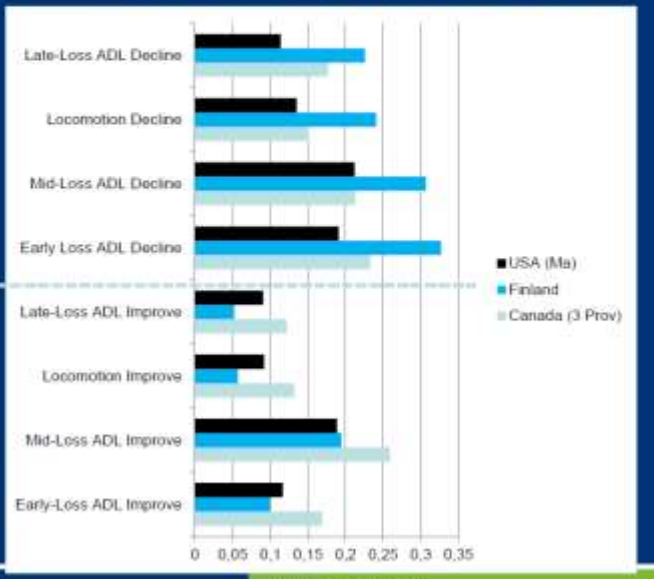


International benchmarking

QI comparisons

- In Finland ADLs get worse in more individuals compared to Massachusetts and Canada
- In Finland ADLs get better in fewer individuals compared to Massachusetts and Canada

International comparisons



interRAI

Summary

- Quality work pays off
- Systematic approach in the lines of Comprehensive Geriatric Assessement (CGA) and rehabilitation pays off
- Training of the staff pays off
- International comparisons pay off
- Centralized guidelines and follow-up pays off


interRAI
AGING LEADS TO DIVERSITY
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八、Wilhelmiina 簡報資料

Welcome to Wilhelmiina

- A Home with care and services, where you decide how you live.

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www.wilhelmiina.fi | Taavetti Laitisen katu 4, 00300 Helsinki

Basic facts about elderly in Finland

- In 2015 20% of the Finnish population was over the age of 65. The share of people aged 65 or over in Finland was the sixth highest in EU). In 2050, 27% of the Finnish population will be over the age of 65 and 11% of the population will be over the age of 80.
- Long term care spending as a share of GDP is higher than the average OECD countries. Finland's public expenditure for long term care was 2.1% of GDP in 2010 (OECD average 1.6%).
- Older people are the main consumers of health and social care services in Finland, same as they are in most European countries. With population aging, need for care increases; however, older people may often depend not on a single source of support (family/public/private) but on a combination of several sources.

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Challenges for the Elderly Care

- The amount of elderly people is growing rapidly
- Elderly people are living alone
- The situation of economics (Finland vs EU)
- Growing amount of elderly with illnesses of memory
- Lack of trained nurses (interest to study or work in elderly care & early retirement of nurses)

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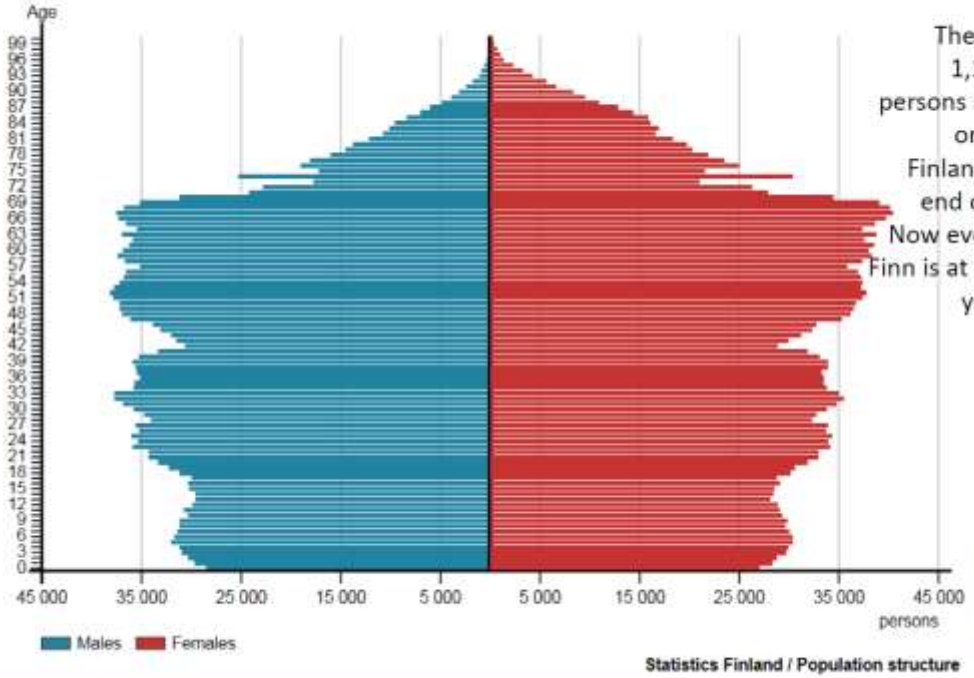
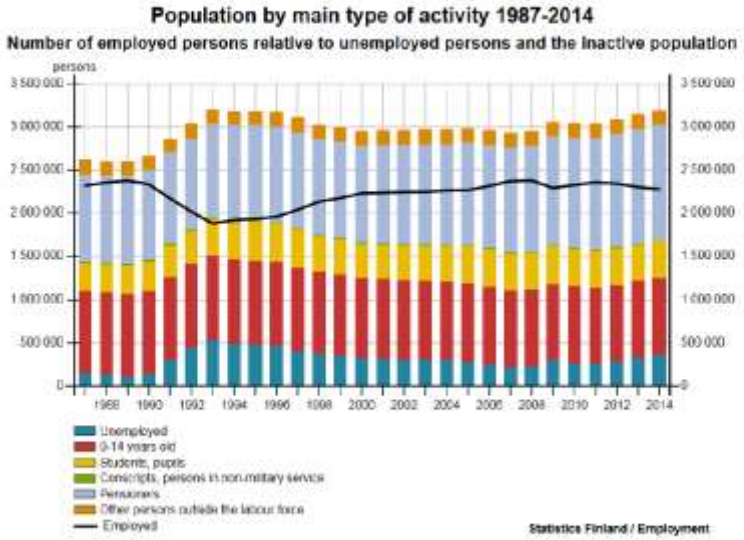
Population according to age (1-year) and gender 31.12.2015



There were 1,123,103 persons aged 65 or over in Finland at the end of 2015. Now every fifth Finn is at least 65 years old

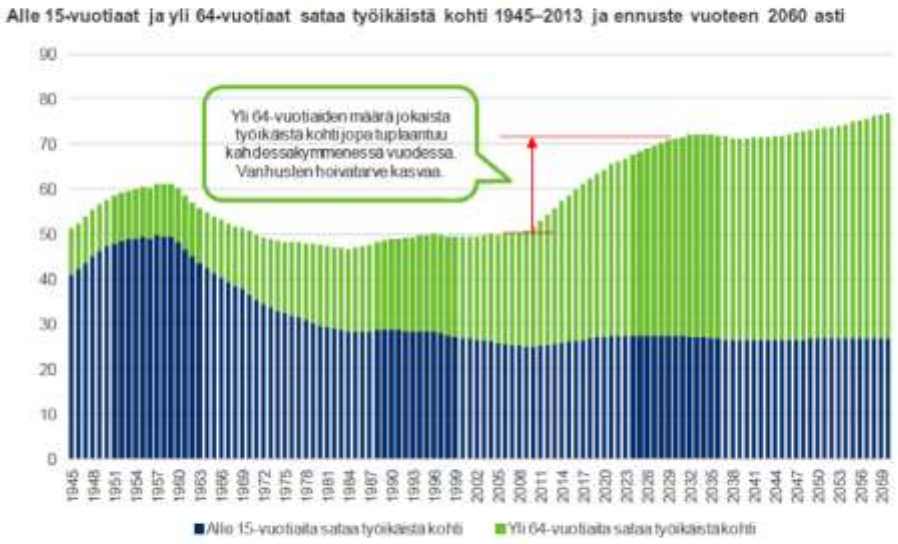
Statistics Finland / Population structure

Economic dependency ratio



In 2014, there were 141 non-employed persons per one hundred employed persons,

Economic dependency ratio growth



Lähde: Tilastokeskus

The social care system for elderly in Finland - The Role of State

- Finland is one of the few OECD countries to have a national quality framework for care of older people. The framework specifies key dimensions of quality of care such as prevention and early intervention, comprehensive assessment, and workforce, and standards to be met.
- Guidelines for elderly care published by the Ministry of Health and Social Affairs help municipalities monitor attainment of a set of targets for elderly care and reduce variation in quality across municipalities.
- There is also a National Curriculum for long-term care workers with a vocational education programme lasting three years.
- The Ministry of Social Affairs and Health in Finland is responsible for general planning, legislation, guidance and supervision of services aimed at older people

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The social care system for elderly in Finland - The Role of State

- National legislation concerning provisions for home care services:
    - In the Constitution of Finland (731/1999) basic rights and liberties of inhabitants are defined. E.g: the principle of equality , the right to life, personal liberty and integrity, the right to social security.
    - Everyone is guaranteed by an Act the right to basic subsistence in the event of illness and disability.
    - The Social Welfare Act (710/1982) defines social welfare: social services, social assistance, social allowance and related measures intended to promote and maintain the social security and functional ability of the individual, the family and the community.
    - This Act also defines municipalities' responsibilities in organising services (home-help services, support for informal care).
    - In the Social Welfare Decree (607/1983) the way that home-help services are organised is defined: 1) assistance, personal attendance and support provided at home by a trained home helper for house aid for an individual or a family and 2) auxiliary services (meals on wheels, maintenance of clothes, bathing, cleaning, transportation and services promoting social interaction).
    - In the Act on the Status and Rights of Social Welfare Clients (812/2000), it is stated that clients' wishes and opinions must be taken into account in planning and providing social welfare. If a person cannot participate in planning because of their illness, family carers' opinions should be used in order to determine clients' will.
    - Law for Elderly care (2013) supports the well-being of elderly. It also specifies requirements for the municiplaities for organising elderly care services.
- In Finland, all inhabitants are legally obliged to have social insurance. This obligatory social insurance is intended to cover everyone for the financial impact resulting from old age, work disability, sickness, unemployment and death of dependents.

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The social care system for elderly in Finland - The Role of municipalities

- Municipalities are responsible for organising services for their inhabitants. Tax revenues finance service provision/organisation in municipalities
- There are around 450 municipalities, which are independently responsible for providing social and health care services in Finland
- By tradition, the municipalities offer social care services to their residents with some complementary support from nonprofit organizations.
- **At present,** alongside the municipality, a large number of for-profit and a non-profit organizations are actively involved in providing a wide range of care support for older people. Transition from publicly provided services to privately produced or provided service can be observed following the recession of the early 1990s.
- The size of the social services market is today between 10 – 11 mrd. €, of which around 33% is produced by the private sector → the private sector is growing and is particularly important in the field of housing services
- Each municipality can organise services independently. The services consist of:
  - home help,
  - housing services: assisted/sheltered living
  - support for informal care (elderly linving in their homes with the help of relatives get some financial support and services)

The social care system for elderly in Finland - The Role of municipalities

- The way that services are organised vary. The municipalities can provide services:
  - independently themselves,
  - they can organise/provide services together with another municipality,
  - or they can buy services from the private service provider or
  - provide a voucher to service users so they can buy services from a private service provider
- According to the Act on Planning and Government Grants for Social Welfare and Health Care (733/1992), municipalities receive financial support from the Government in order to organise these services.
- Financial support is dependent on the municipality's age structure and the size of its population. However economic constraints dictate the level of service provided. There are areas/municipalities, especially in eastern and northern Finland where local authorities are experiencing financial difficulties (because of migration, age structure in the municipality and tax revenue).
- The costs of the services provided by municipalities for their clients are determined by their income.

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Division of the social services market

Sosiaalipalvelujen tuotos tuottajittain 2012 (miljoonaa euroa)

- Public sector 68%
- Private sector 32% → and growing:
  - Companies 17%
  - Third sector 15% (associations, foundations e.g.)

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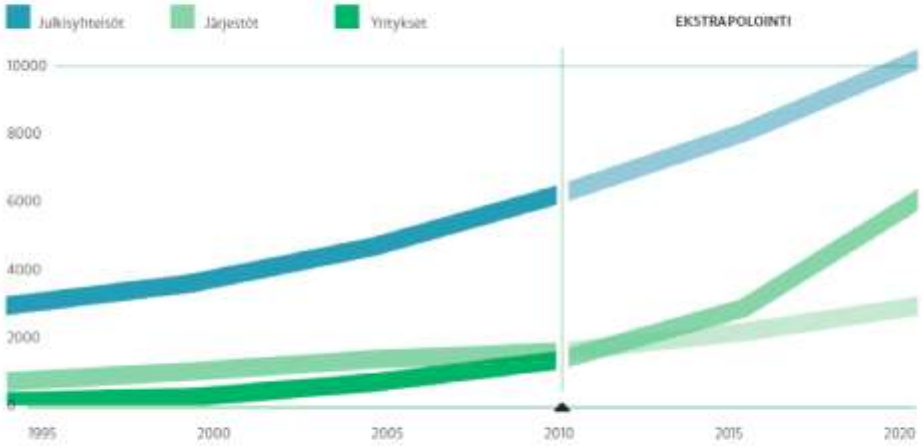
Division of the social services market- future developments



Kuva 12:
Sosiaalipalvelujen tuotos (tuotettujen palvelujen arvo) tuottajasektoreittain vuosina 1995, 2000, 2005 ja 2010. Vuosien 1995–2010 luvut perustuvat tilastoihin ja vuosien 2015 ja 2020 datapisteet on ekstrapoloitu tilastoista. Kasvuprosenttina on käytetty todellisten lukujen keskiarvoa. (Lith 2012), ekstrapolointi T-Media Oy)

wil
www.

Professionals working in elderly care

- Practical nurses (upper secondory education)
- Nurses
- Bachelors of Health Care and Social Work (Elderly Care, geariatrics)
- Social workers, fysiotherapists,
- Doctors
- Care assistants (training 9 months, not exam)

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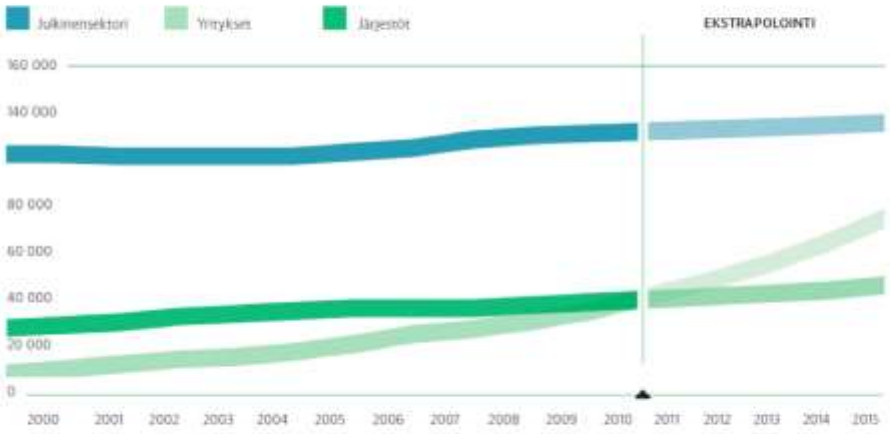
Personel in the social services market- future developments

Henkilöstön kasvu sosiaalialalla



Kuva 14.
Jos henkilöstömäärien kasvu jatkuisi vuosina 2010–2015 samana kuin mitä se oli vuosina 2007–2009, olisi julkisten sosiaalipalveluiden henkilöstömäärä vuonna 2015 noin 137 000, yritysten noin 70 000 ja järjestöjen noin 40 000. (THL 2012, ekstrapolointi: T-Media)

The Social Services Reform

- Health, social services and regional government reform is one of the biggest ever administrative and operational overhauls in Finland. The reform impacts the jobs of hundreds of thousands of people and affects the services of every citizen in the country. It also has an effect on the financial resources, steering and taxation of healthcare and social services. The aim is to transfer the organisation of healthcare and social services and other regional services to counties as of 1 January 2019.
- The health, social services and regional government reform serves to modernise services and to improve the sustainability of general government finances. The reform creates the conditions for a future model for health and social services in Finland. The new counties will adopt the most efficient and effective practices, so that services can be produced efficiently and cost-effectively. The aim is to narrow down the differences in people's wellbeing and to curb growing costs. The services will be integrated in a customer-centred way based on people's needs. The scope of integration of services in the reform is very ambitious by international standards.
- On 29 June the Government published draft bills on reforming health and social services and on establishing counties. The main legislative acts governing the reforms are the Counties Act, the Act on Organising Health and Social Services, the Implementation Act and the Act on the Financing of the Counties.
- The Acts will pave the way for a reform where 18 autonomous counties will be established in Finland. As of 1 January 2019, the counties will be responsible for all public health and social services, rescue services, environmental healthcare, the duties of the regional councils and selected other municipal and regional state administrative duties.

Wilhelmiina Home

- Wilhelmiina Home was founded in 1995
- It offers homes, rehabilitation and other services for elderly people
- We offer homes for 150 inhabitants (both with independet living and intensive care)
- Wilhelmiina is 100% owned by Miina Sillanpää Foundation
  - → The non-profit ownership base enables our profits to be used to promote and develope residential and other services for elderly people
- Our services are provided by our multi-professional staff and also co-operation partners.
- We have around 120 health and elderly care professionals of whom around little over 70 people work in our regular staff and others on part-time/hour bases.

Our background and heritage

"Every human being has a right to wellbeing, humane working conditions and respect for humanity"

- The Miina Sillanpää Foundation organises, promotes and supports:
  - rehabilitation services for working-age and elderly populations
  - residential and other services for elderly people
  - research and development that promote public health care.
- The Miina Sillanpää Foundation itself is a non-profit organisation. The companies owned by the Foundation provide care, rehabilitation and well-being services for adults.
  - Wilhelmiina Services Ltd. offers homes, rehabilitation and other services for elderly people and
  - Avire Ltd. provides services on promoting well-being and work ability.

Miina Sillanpää
(1866–1952)

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Our Mission

We want to enable a meaningfull life.

"Every human being has a right to wellbeing, humane working conditions and respect for humanity"

- Miina Sillanpää

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19

Our Values

We respect the uniqueness of every human being.

Jokaisen ihmisen arvostaminen, yhdenvertainen hyvä kohtelu ja ihmisistä huolehtiminen Miina Sillanpään arvojen mukaisesti ovat kaiken toimintamme lähtökohta. Palvelemme jokaista hänen omista lähtökohdistaan ja hänen omien tavoitteidensa pohjalta, rinnalla kulkien ja omatoimisuutta tukien.

Together we will succeed.

Kehitämme, jaamme ja yhdistämme osaamistamme kumppaneidemme, asiakkaidemme ja heidän lähiverkostojensa kanssa. Ihminen ja hänen elinympäristönsä ovat toimintamme keskiössä. Opimme toisiltamme ja autamme toisiamme onnistumaan.

We are courageous and responsible.

Toimimme yhteiskunnassa aktiivisesti ja vastuullisesti. Olemme aloitteellisia ja ennakkoluulottomia. Ennakoimme toimintaympäristömme muutoksia ja vaikutamme edelläkävijänä toimialojemme tulevaisuuteen. Kokeilemme ja arvioimme suunnitelmallisesti uusia toimintatapoja.

Wilhelmiina Home's Ideology

Maintaining and promoting everyday involvement and performance

Constant development of our know-how and services - based on the needs of our inhabitants and customers

Enabling Meaningfull Life
"Every human being has a right to wellbeing and respect for humanity"

Our basis are in involvement, sense of community and self-determination

Home amongst services and with services


Wilhelmiina - summary
Daily activities:
art and music, events,
excercise, parties
Inhabitant's forum.
A Home, where:
You decide how you live.
You get help and service's
you need.
Individual rehabilitation
and activation plan for
everyone.
A named care person.
Multidimensional
services.
wilhelmiina
www.wilhelmiina.fi | Taavetti Laitisen katu 4, 00500 Helsinki


Kiitos!
Thank You!
Contact information.
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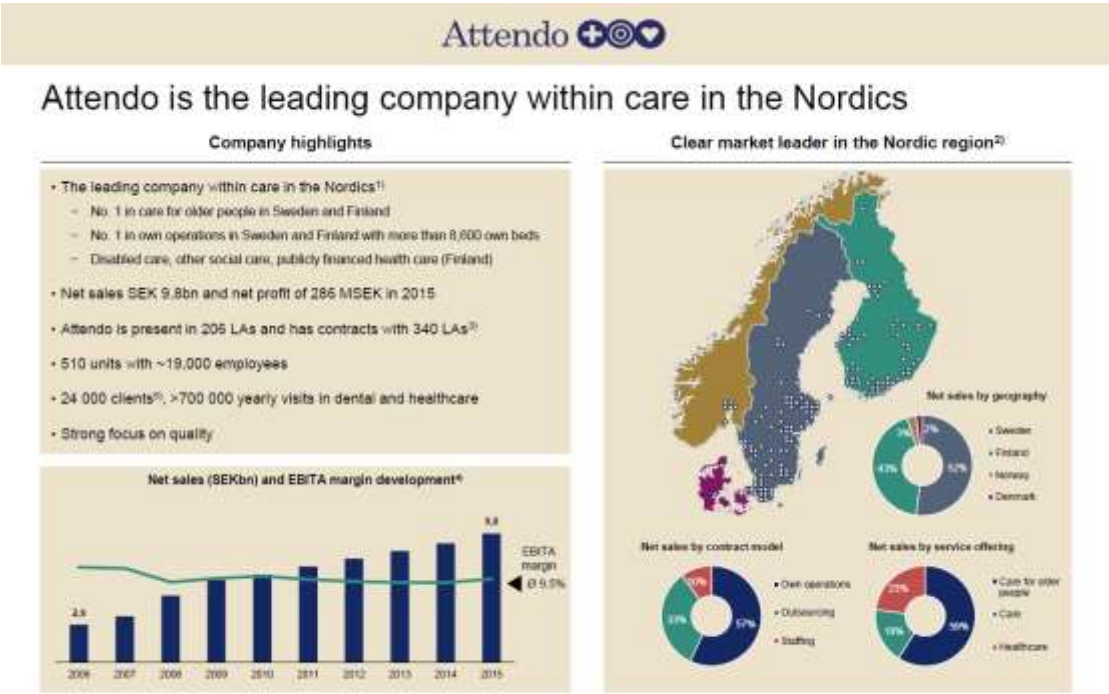
九、Attendo Finland 簡報資料



1) Attendo analysis. 2) In terms of net sales 2014. 3) LA = Local authorities. 4) Annual reports: 2005-2012 Attendo Utveckling AB (prior Group holding company), 2013-2014 Attendo AB. 2005 excludes the divested Business Areas Systems and Response. 2006 and 2007 have been annualised and calendarised. During 2013 Attendo AB acquired Attendo Utveckling AB. According to accounting principles for acquisitions under common control the figures for the years 2011 and 2012 were restated in the annual report 2013. 5) Home care clients and beds in care units

2

Attendo

The "Mummola" concept – Grandmother's house

- Unique concept of service housing for the elderly
- Most of the houses subsidized by the ARA (Governmental Housing finance and development center – Absorption principle applied to rents)
- 41 Built, 7 under construction and 8 with positive decision from ARA

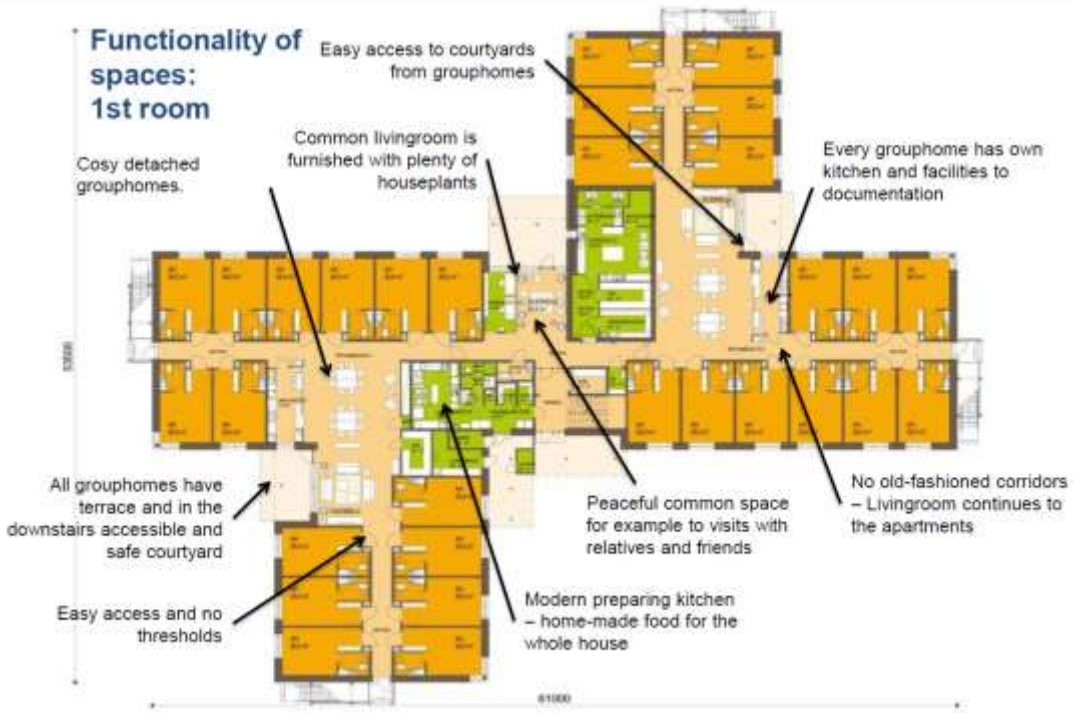
Attendo

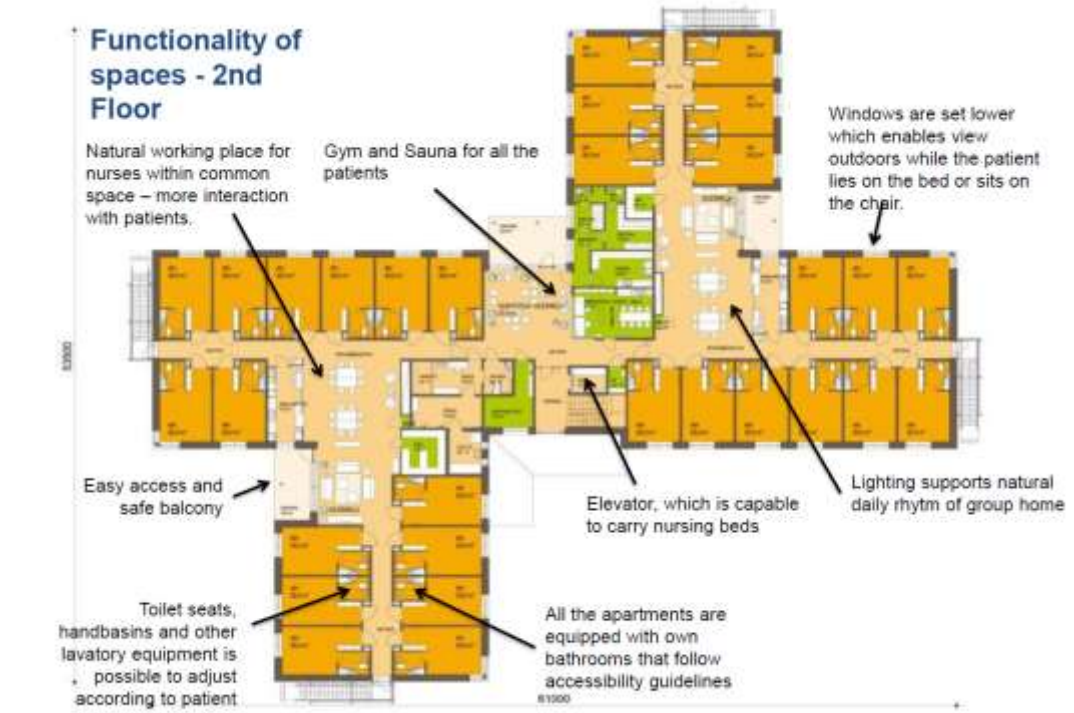
Attendo Mummola

A safe and comfortable home for the last years

We provide:

- nursing and care
- meaningful daily life and stimulating activities
- an own nurse
- a private room
- home-made and nutritious food


Functionality of spaces: 1st room
Easy access to courtyards from grouphomes
Common livingroom is furnished with plenty of houseplants
Cosy detached grouphomes.
Every grouphome has own kitchen and facilities to documentation
All grouphomes have terrace and in the downstairs accessible and safe courtyard
Peaceful common space for example to visits with relatives and friends
No old-fashioned corridors – Livingroom continues to the apartments
Easy access and no thresholds
Modern preparing kitchen – home-made food for the whole house


Functionality of spaces - 2nd Floor
Natural working place for nurses within common space – more interaction with patients.
Gym and Sauna for all the patients
Windows are set lower which enables view outdoors while the patient lies on the bed or sits on the chair.
Easy access and safe balcony
Elevator, which is capable to carry nursing beds
Lighting supports natural daily rhytm of group home
Toilet seats, handbasins and other lavatory equipment is , possible to adjust according to patient
All the apartments are equipped with own bathrooms that follow accessibility guidelines

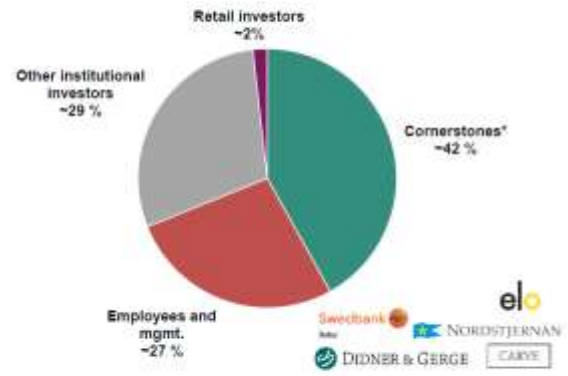
Attendo

Attendo's senior hybrid

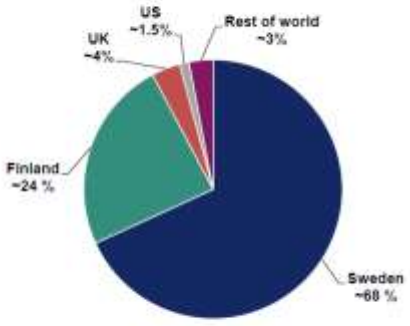
Attendo

Attendo has a new long-term, diverse and broad ownership base

Ownership per investor



Ownership per geography



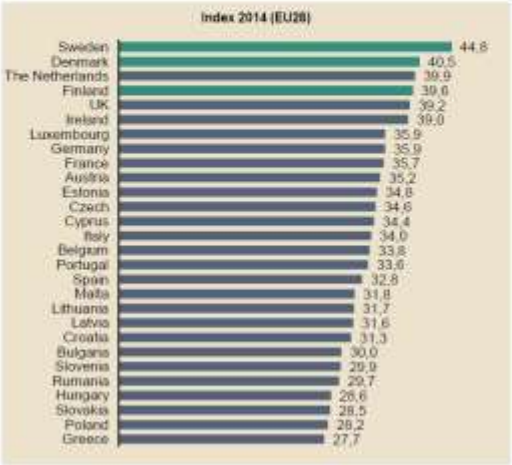
Approximately 30,000 investors participated in the IPO of Attendo

Note: Approximate ownership distribution
* Includes Nordstjernan (16 % of the total number of share outstanding), Swedbank Robur (9 %), Didner & Gerge (8 %), Carve Capital (6 %) and ELO (3 %)

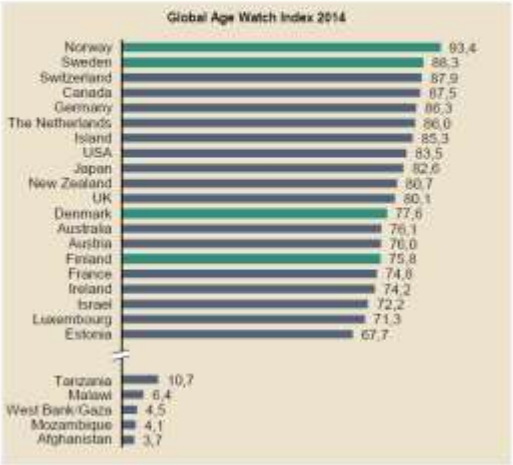
Attendo

The Nordic countries are leading in quality and consumer satisfaction

UNECE Active aging index



Help age international

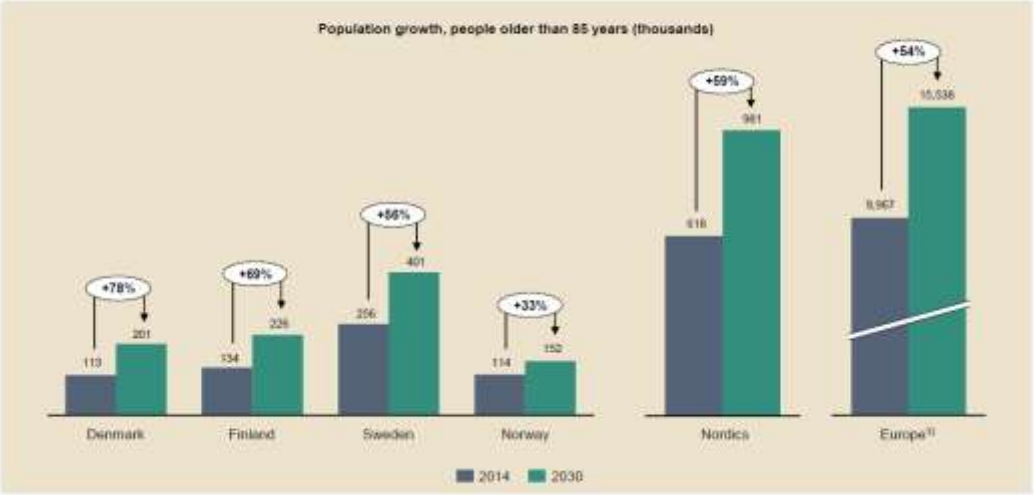


The Nordic countries are leading in high quality

Source: United Nations European Commission for Europe, Help Age International

Attendo

Growing older population increases pressure on care and healthcare systems

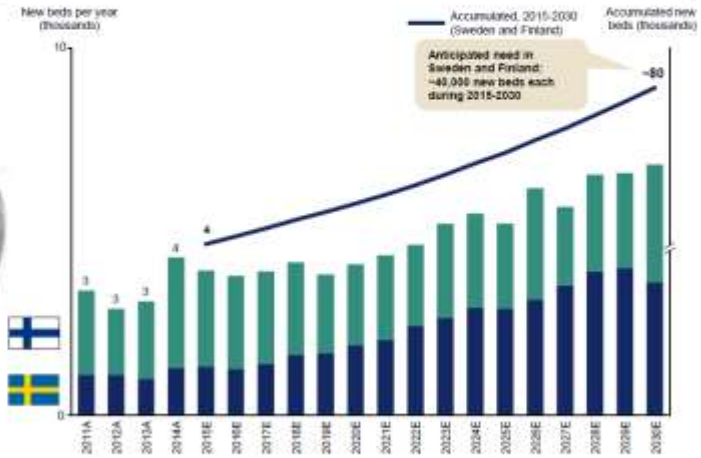


Source: National statistics databases, Eurostat, National boards/authorities of Health and Social welfare, National ministries of finance/economy, Frank Knight, Liang & Burston
1) Europe illustrated by countries deemed most relevant as seen above – GER, UK, FRA, SWE, SUI, ITA, SPA, NOR, AUT, FIN, DEN, BEL

Attendo

~80,000 new beds in nursing homes are anticipated to be required in Sweden and Finland in the next 15 years to meet demographics

Anticipated need for new nursing home beds for older people in Sweden and Finland



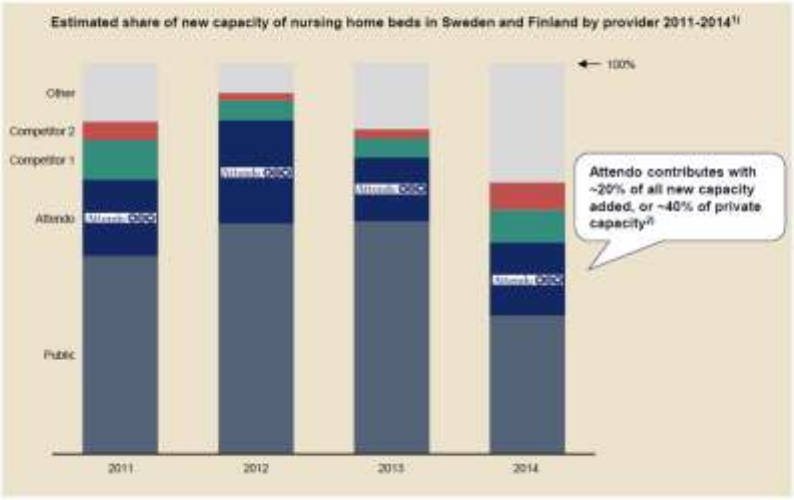
The expected ~40,000 new beds in Sweden alone, is estimated to cost SEK 60-90bn to build and approximately SEK 25bn annually to run

Source: SCB, Socialstyrelsen, Attendo analysis

Attendo

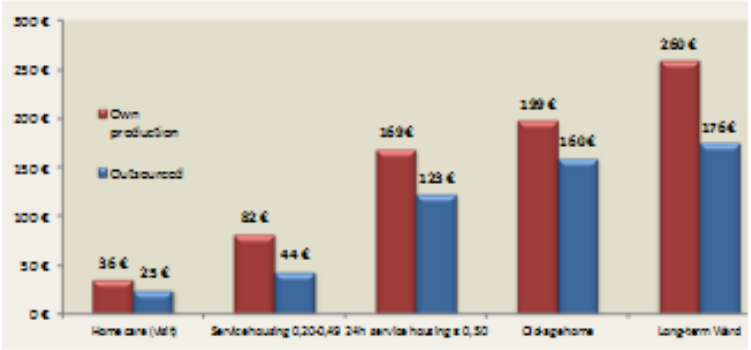
Private sector important in the Nordics with Attendo as the no 1 player in developing new nursing homes

Selection of new nursing homes



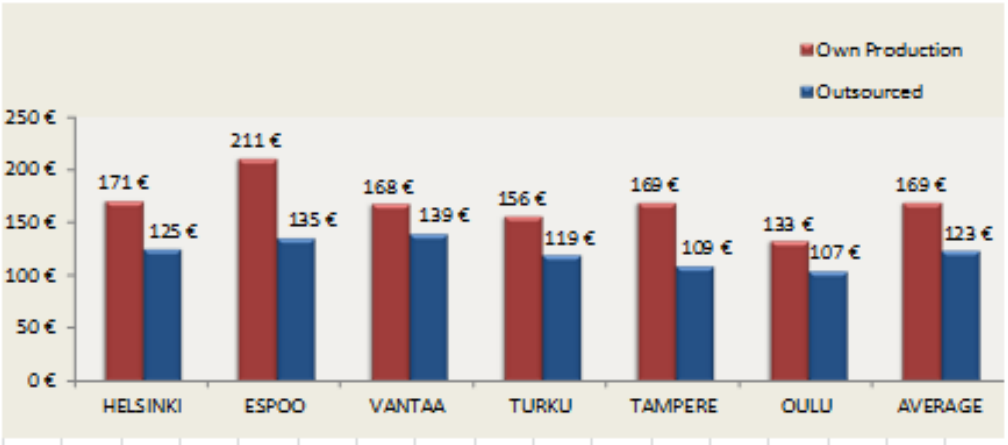
Source: Attendo analysis
1) Sweden: care for older people, Finland: care for older people and people with disabilities; 2) Weighted average 2011-2014

Cost per day of elderly care in six biggest cities



- Kuusikko - working group follows the development of Finland's six biggest public services. Question is significant for Welfare state's future – at the end of year 2014, there was 272 000 inhabitants over 65 years in these cities, which is 20,7 % more than 2010.

24 h service housing cost per day in six biggest cities in Finland (own production and outsourced)



Source: Kuusikkokunnat (Six biggest cities in Finland), 6/2015, page 74

- If Six biggest cities would have purchased all the services outsourced, they would have saved 40 million € per year. Merely Helsinki would have saved 26 million €.

Attendo

Proven Attendo model developed and refined over the years

GREAT PEOPLE IN A DECENTRALISED ORGANISATION	STRONG CULTURE	SHARED TOOLBOX AND CURIOSITY TO LEARN
	Vision – Empowering the individual  Values – Competence Commitment Care	
→ Drive and attitude → Local responsibility → Flat organisation	→ Vision and values in everyday work → Action focus and passion for growth → Take pride in what we do	→ Share best practice and innovations → Local teams get access to Attendo's skill base

13

Attendo

Strong culture

Vision – Empowering the individual

- Attendo's aim is to always put focus on the individual
- An individual who is offered Attendo's services should:
  - ✓ Feel involved and listened to
  - ✓ Feel treated with respect and warmth
  - ✓ Feel supported to independence
  - ✓ Feel safe and secure
  - ✓ Feel a positive effect on quality of life

Values – Competence Commitment Care

Attendo

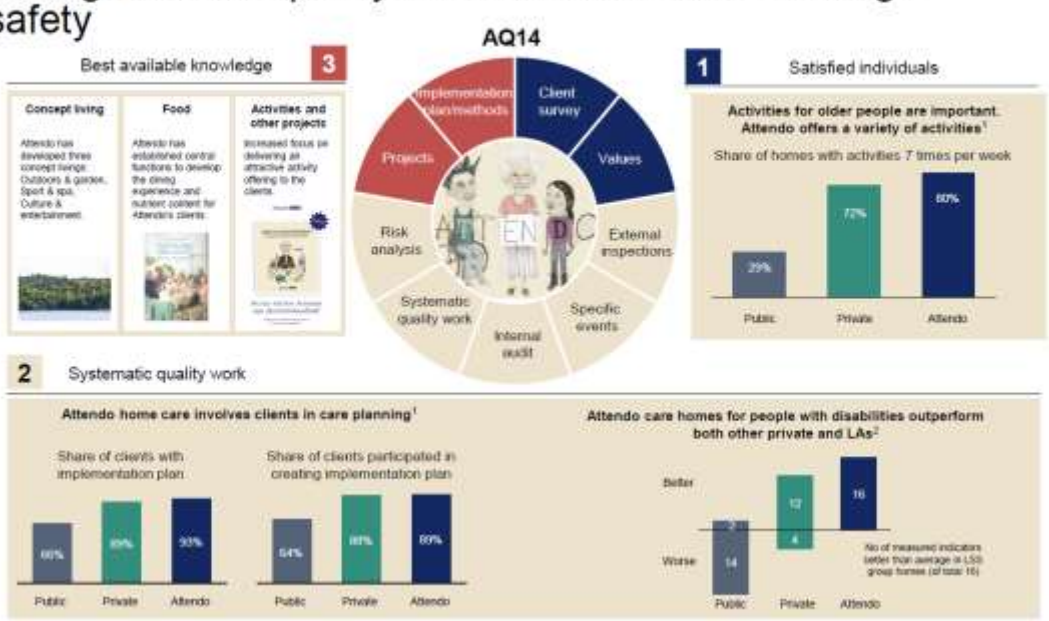
Vision and values in our everyday work

- Client first – "we spend less time in meetings and more with the client"
- Action focus – "act quickly when something can be improved"
- Competitive – "passion for growth, we enjoy winning new business as it enables us to can serve new clients"
- Continuous improvement – "we can always get better, if we relax we fall behind"
- Take pride in Attendo and the work we do – "we are ambassadors for Attendo and our industry"

14

Attendo

Strong focus on quality with satisfied clients and high safety



Källa: 1) Socialstyrelsen, kommun- och enhetsundersökningen 2014; 2) SKL Öppna jämförelser Stöd till personer med funktionsnedsättning, 2014

15

Attendo

The listing gave Attendo a broader ownership base and support for the company's long-term development

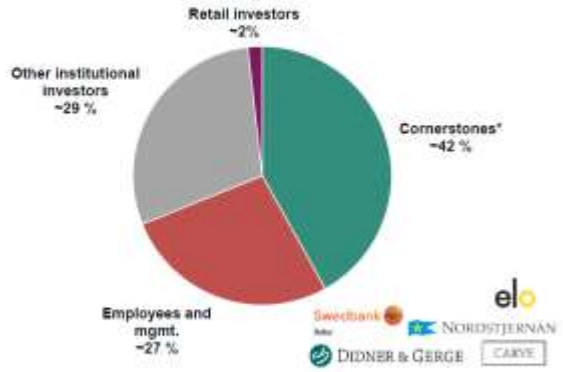
- The stock market listing was a natural next step for Attendo
  - Supports the company's long-term development and expansion
  - Gives access to Swedish and international capital
- More than 30,000 new shareholders were added at the time of the listing, of which ~1,000 are Attendo employees
- Five cornerstone investors with experience in long-term ownership
  - **Nordstjernan** – one of the top family owned long-term investment companies in Sweden, owned by Ax:son-Johnson. Over 100 years of experience in investing in Swedish companies.
  - **Swedbank Robur** and **Didner&Gerge**. Two well-known mutual fund managers, Swedbank being no 1 on the Swedish market and Didner&Gerge runs the most popular fund in the Swedish PPM-system
  - **Carve** – a part of Brummer, a hedge-fund investor seeking stable income
  - **ELO** – one of the biggest occupational pensions managers in Finland (comparable to AMF Pension in Sweden)
- Other notable long-term investors
  - **AP2, AP3** – 2 out of 4 of the big Swedish long-term state pension funds
  - **Norges Bank investment management** – the Norwegian oil fund
  - Swedish investment managers **SEB, SHB** and **DnBNor** (Sweden)
  - **Ilmarinen, Aktia, Pohjola** – mutual pension funds & investment managers in Finland
  - **Fidelity, JPMorgan, UBS, Lazard** and **TT** International investment managers

16

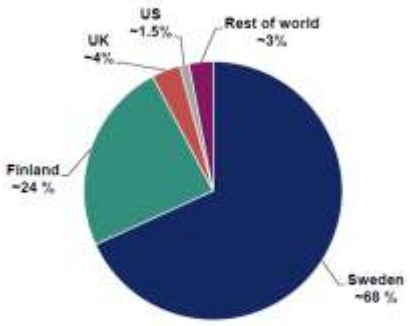
Attendo

Attendo has a new long-term, diverse and broad ownership base

Ownership per investor



Ownership per geography



Approximately 30,000 investors participated in the IPO of Attendo

Note: Approximate ownership distribution
* Includes Nordstjernan (16 % of the total number of share outstanding), Swedbank Robur (9 %), Didner & Gerge (8 %), Carve Capital (6 %) and ELO (3 %)

17

Attendo

Experienced management team with broad industry knowledge

Henrik Borelius, CEO
- Born: 1971
- Employed: 2008
- Background: CEO since 2003, BA Director 2000-03, Kunskapsskolan, McKinsey & Co

Ammy Wehlin, Business Area Director
- Born: 1962
- Employed: 2000
- Background: BA Dir. since 2003, Regional Dir 2000-03, Social services City of Malmö
- Business Area: Care for older people, Southern and Western Sweden, Denmark and Norway

Margareta Nyström, Business Area Director
- Born: 1971
- Employed: 1993
- Background: BA Dir. since 2003, Regional Dir and Sales, Mkting Quality Dir. 2000-03, various positions 1993-00, Vasteras Distr. Hosp
- Business Area: Care for older people, Central and Northern Sweden

Cecilia Addamshill, Business Area Director
- Born: 1965
- Employed: 2000
- Background: BA Dir. since 2016, Regional dir AB, Malmö municipality
- Business Area: Care for people with disabilities and individuals and families, Sweden

Pertti Karjalainen, Business Area Director
- Born: 1969
- Employed: 2000
- Background: BA Dir. since 2007, founder Attendo Finland 2000-07
- Business Area: Care for older people and people with disabilities, Finland

Antti Ylikorkala, Business Area Director
- Born: 1974
- Employed: 2002
- Background: BA Dir. since 2007, founder Attendo Finland 2002-07
- Business Area: Health care, Finland

Tomas Björkstén, CFO
- Born: 1969
- Employed: 2001
- Background: CFO since 2007, Fin. Dir Scandinavia 2006-07, Group Controller 2001-05, General Electric, E&Y

Fredrik Mossberg, Business Development Director
- Born: 1977
- Employed: 2009
- Background: BD Dir. since 2007, bus. developer 2006-07, Bain & Co

Ingalill Östman, IR (acting)
- Born: 1956
- Employed: 2015
- Background: IR manager since 2015, SVP Group Communications & Gov. Relations at SKF 2008-14, SVP Communications at ABB 2003-07

Source: Attendo

18

Attendo

Social- and healthcare reform 2019

- Politicians want to reform our system for budgetary and ideological reasons
- The official goal is to integrate social services and healthcare services in an unprecedented way to improve care and cut costs (3 b€ per year)
- Ideologically the reform is about empowering citizens to become active actors instead of passive objects of public social- and healthcare

19

Attendo

Social- and health care reform: Freedom of choice and new organizing structure

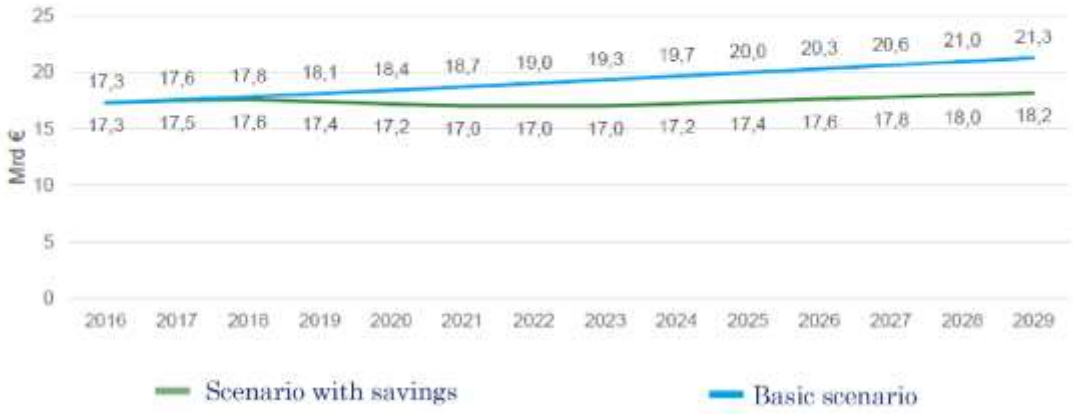
- Public social and health care is today arranged and funded by appr. 300 municipalities.
  - In order to get "wider shoulders", the arranging and funding is proposed to be transfered to 18 counties and one-channel funding shall come from the state
- Public primary health care is produced by public sector with approximately 95 % share and by private sector by 5%.
  - After reform, citizen is able to choose the health care station where he/she gets the public health care
- Public service housing is produced by private / public sector 50/50, the private sector prices are tendered by the municipality
  - After reform, citizen gets a voucher and is able to choose the nursing home he/she wants

Plats för Sidfot - [Infoga - Sidhuvud/sidfot]

20

Attendo

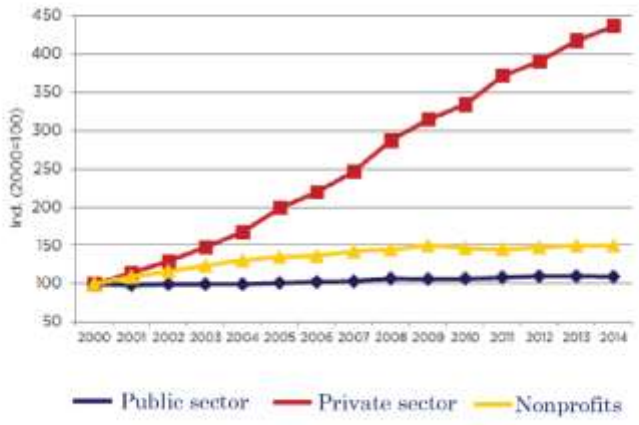
Public social- and healthcare spending scenarios 2016-2029



21

Attendo

Social services (NACE:T 87-88) volume change by producer sector
2000-2014, index 2000=100



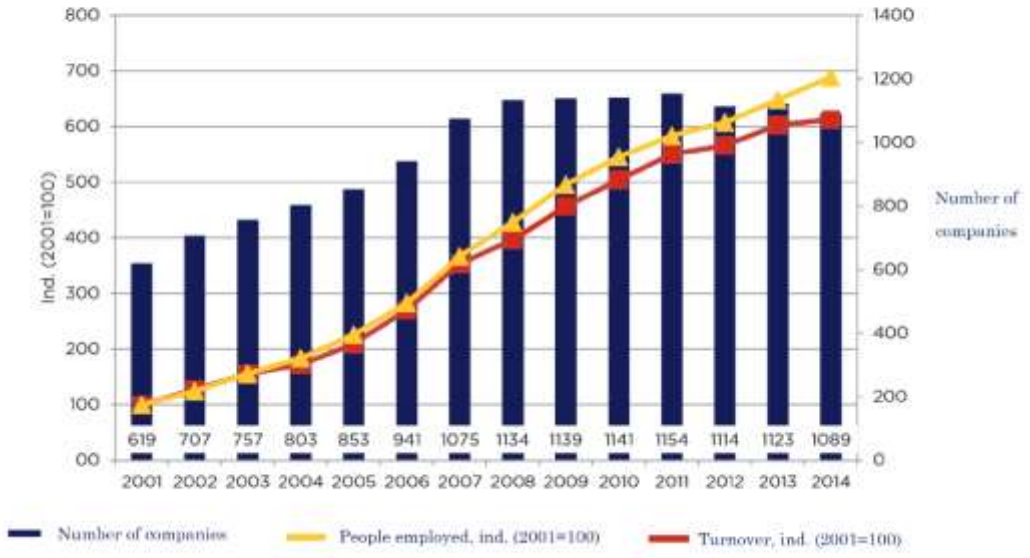
Attendo

Social services (NACE:T 87-88) total production in Finland 2013-2014

	Total	Public sector	Private business	Nonprofits
Social services produced 2013, billion €	10,850	7,241	1,858	1,753
Social services produced 2014, billion €	11,093	7,342	1,984	1,767
Change %	2,2%	1,4%	6,8%	0,8%

Attendo

Labourforce, amount of companies and turnover change in social services which include housing (NACE:T 87) 2001-2014




Attendo
ATTENDO
30
1985 - 2015
25

十、Ministry of Social Affairs and Health 簡報資料

Key Project: Home care for older people will be developed and informal care enhanced in all age groups

Anja Noro, PhD, Adjunct Professor, Research Professor

Project manager, Department for Social and Health Services, Ministry of Social Affairs and Health

GOVERNMENT KEY PROJECT

Overview

- Policy trends and legislation
- Some facts about Finnish Social Welfare and Health Care
- Trends in use of services
- Government key project

POLICY TRENDS AND LEGISLATION

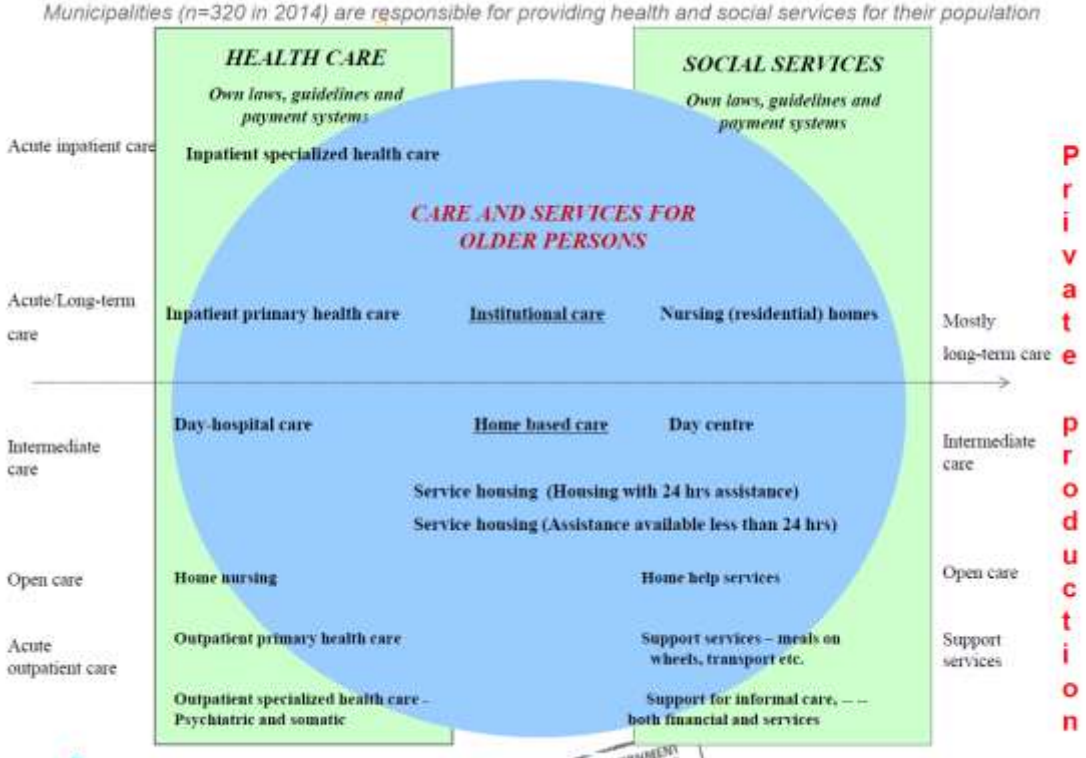
Policy trends and legislation…

- Decentralized decision making and provision of services since 1993
- Quality guidelines for older persons care (2000, 2008, 2013) have been used as a national tools for information guidance
- The Act on Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Services for elderly people (980/2012) came into force in 1st July 2013 in Finland.
- Since 1990's policy focus has been on home care and deinstitutionalization

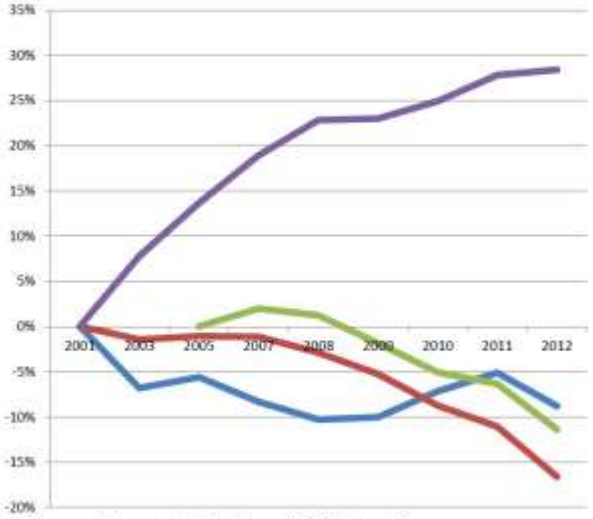
The Finnish municipal model for service provision

FACTS ABOUT FINNISH SOCIAL WELFARE AND HEALTH CARE

Municipalities (n=320 in 2014) are responsible for providing health and social services for their population



History: Trends in use of long-term care services during 2001 – 2012, (reference year 2001, in support services year 2006).



Source: Noro et al. THL Report 13/2014, p. 27

Age adjusted rates of coverage indicate that long-term institutional services have decreased during last decade, as well as home care and support services.

Use of services is accumulating in older age groups, especially among women. The only increasing type of service is statutory informal care.

GOVERNMENT KEY PROJECT

GOVERNMENT KEY PROJECT, 2016-2018:
Home care for older people will be developed and informal care enhanced in all age groups

Government has 26 key projects of which five are in Ministry of Social Affairs and Health

Increasing health and wellbeing

1. Client centered services

2. Promotion of health and wellbeing

3. Program for renewal of services to children and families

5. Way to work life to those partly fir for work

4. Program for renewal of home care services for older people and enhancing informal care for all aged carers

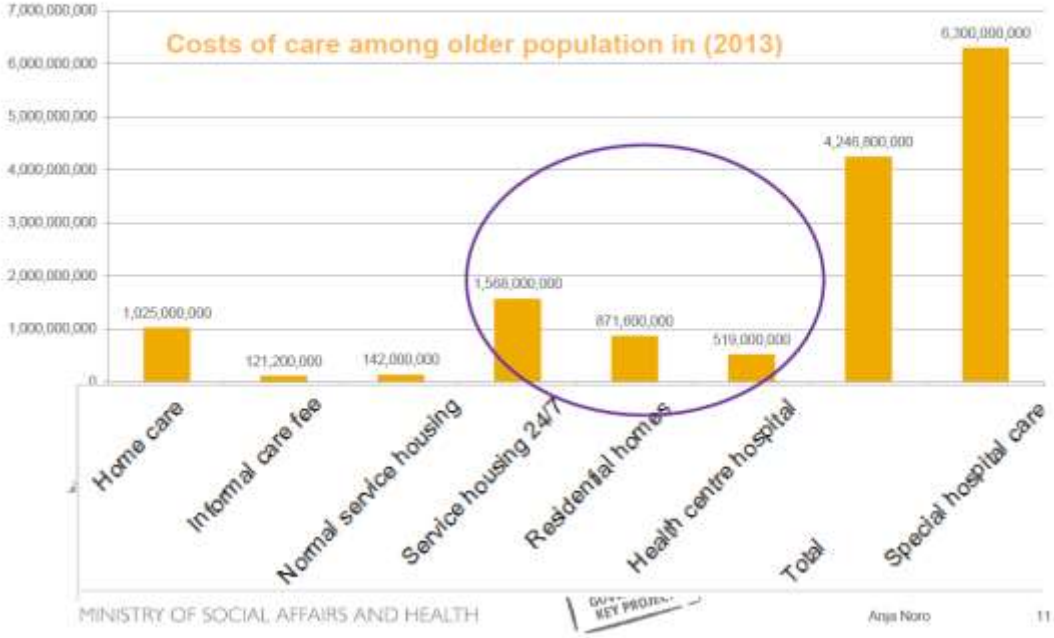
130
m. euros

Actions needed because

- Services for older people are scattered, structure has not evolved fast enough or according to national aims, dispersion of best practices has been slow, regional differences are vast
- Similar patterns have been found concerning informal care

The growth of costs can be controlled

a) by changing service structure; b) by developing contents of home care & c) by strengthening informal and foster care



Equal, well-coordinated and cost-effective services for older persons and all aged informal carers

More action and multidisciplinary rehabilitation to ensure healthy and active ageing

Improved service allocation and home care for older persons

Established practices to support the health and wellbeing of informal and foster carers

Testing and implementing best practices

The key project aims

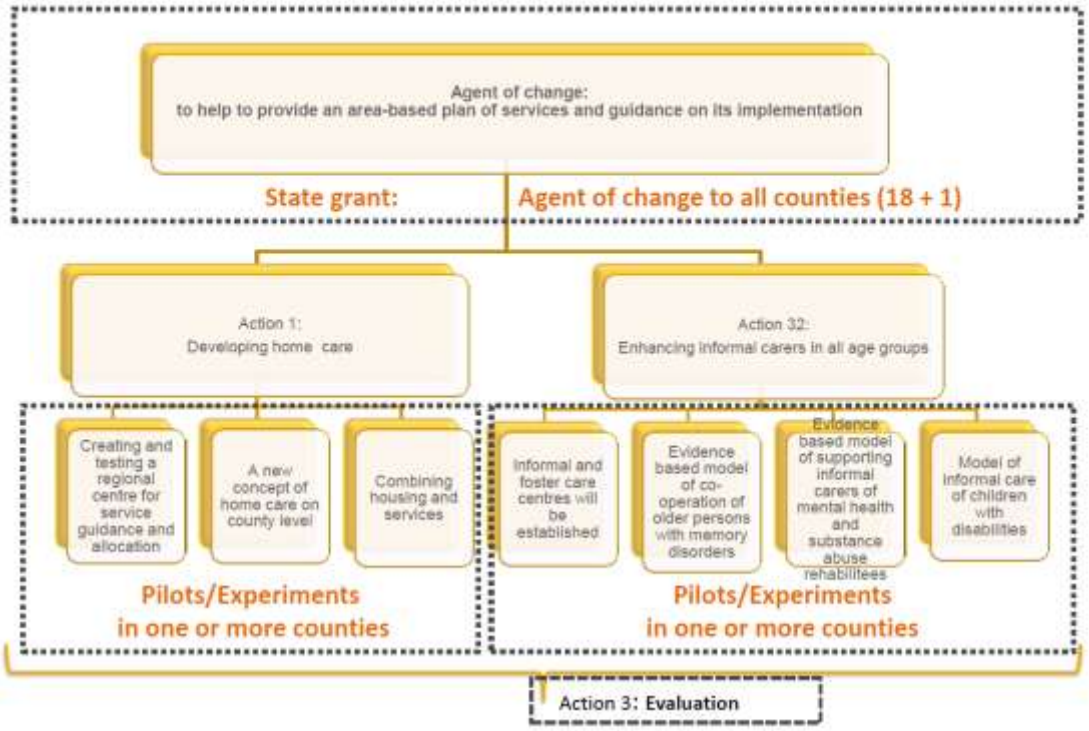
- to increase equality among older persons and among all aged informal carers,
- to more efficiently coordinate services for them,
- and to cut the increase of health and social care costs in coming years.
- In the new system, home services and services accessible from home are preferred.

Criteria for grant applications (30 million euros)

1. Relevance: in area of interest based on theoretical and evidence based modeling
1. Size: big areas, counties with all or almost all of their municipalities
2. Participants: Municipalities, public and private providers, organizations, companies etc.

Application period: 10th May to 31st August 2016, pilots / experiments start in October

Tasks of the I&O key project in 2016-2018



Follow-up 2016-2018

- Statistics, registers, research
- Follow-up of the Older Care Act (2013, 2014) continues 2016, 2018
- In each pilot/experiment, follow-up information will be collected
- Whole project - a review at the end

More information

- Director Päivi Voutilainen
- Project manager Anja Noro
- Consulting official Satu Karppanen
- Consulting official Anne-Mari Raassina
- Assistant Tarja Slant-Storti

»ikioma.karkihanke@stm.fi

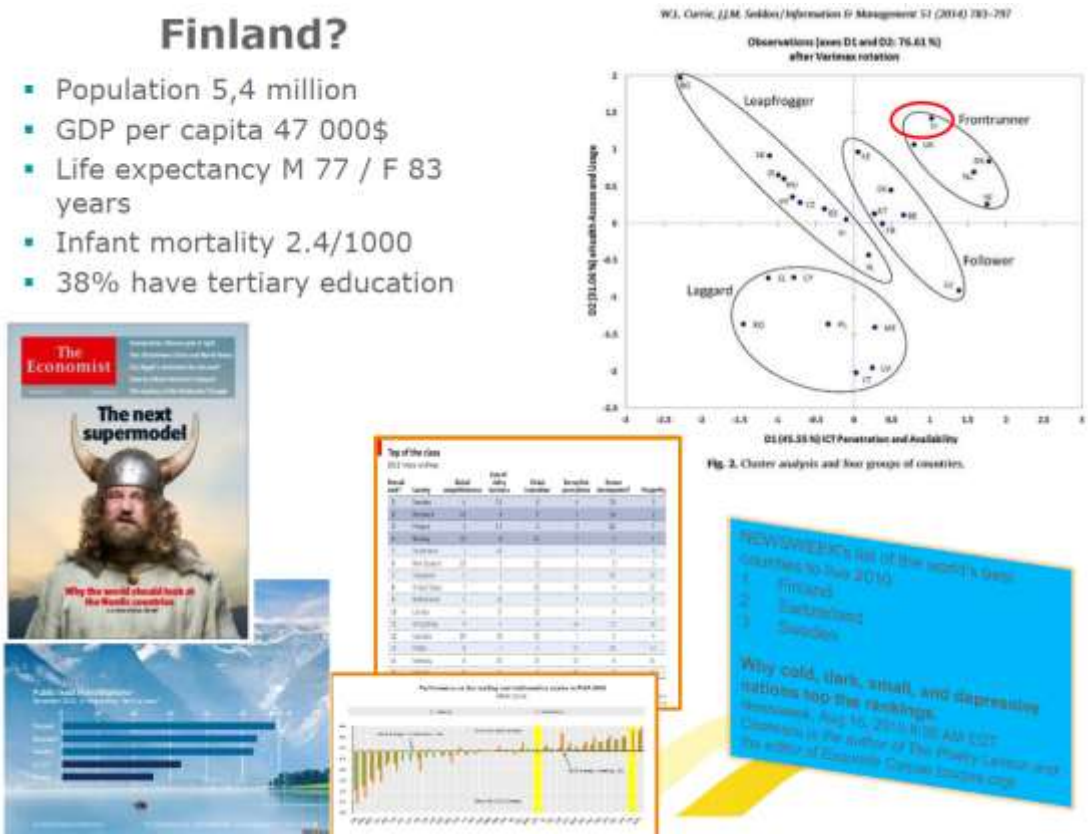
»# IKIOMAT

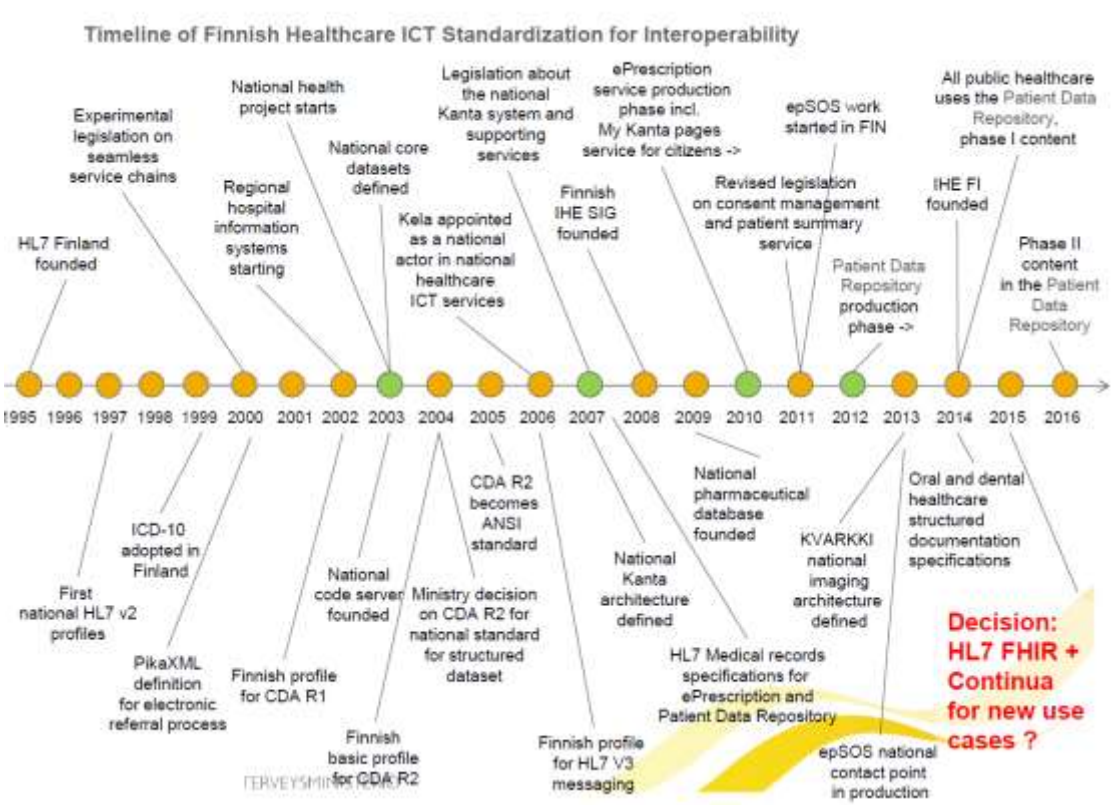
» http://stm.fi/hankkeet/koti-ja-omaishoito

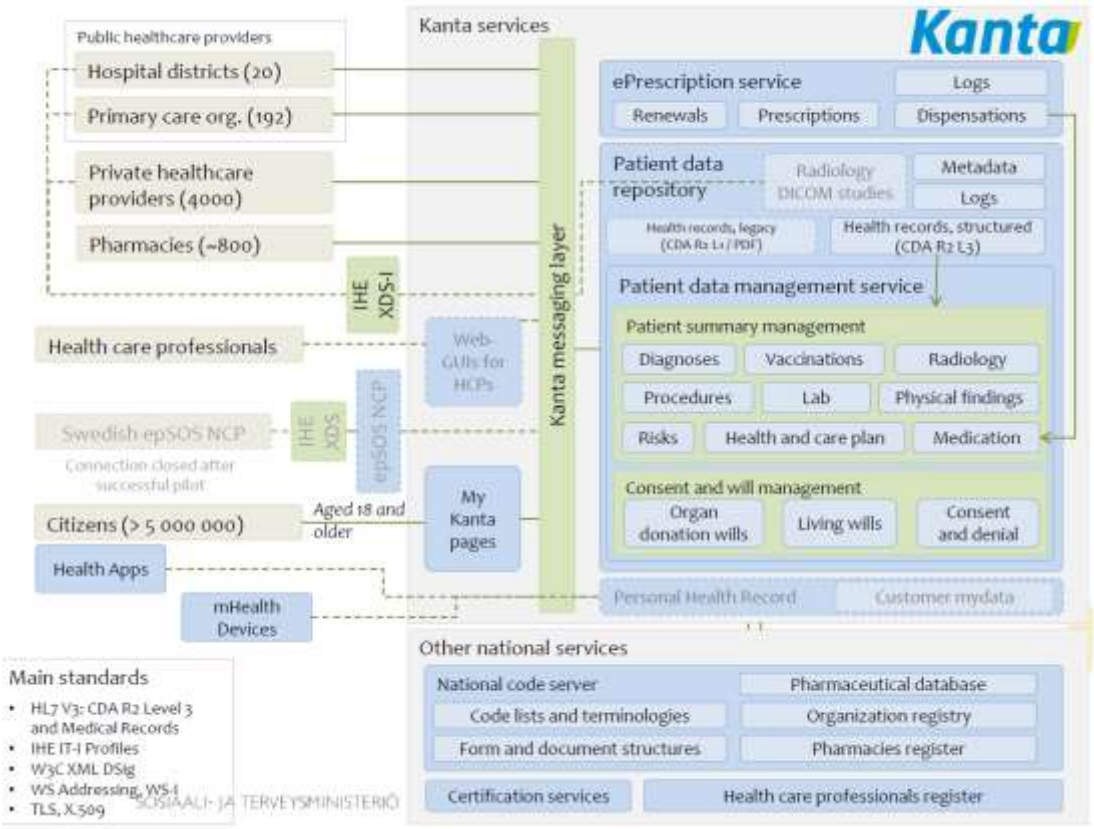
Thank you!

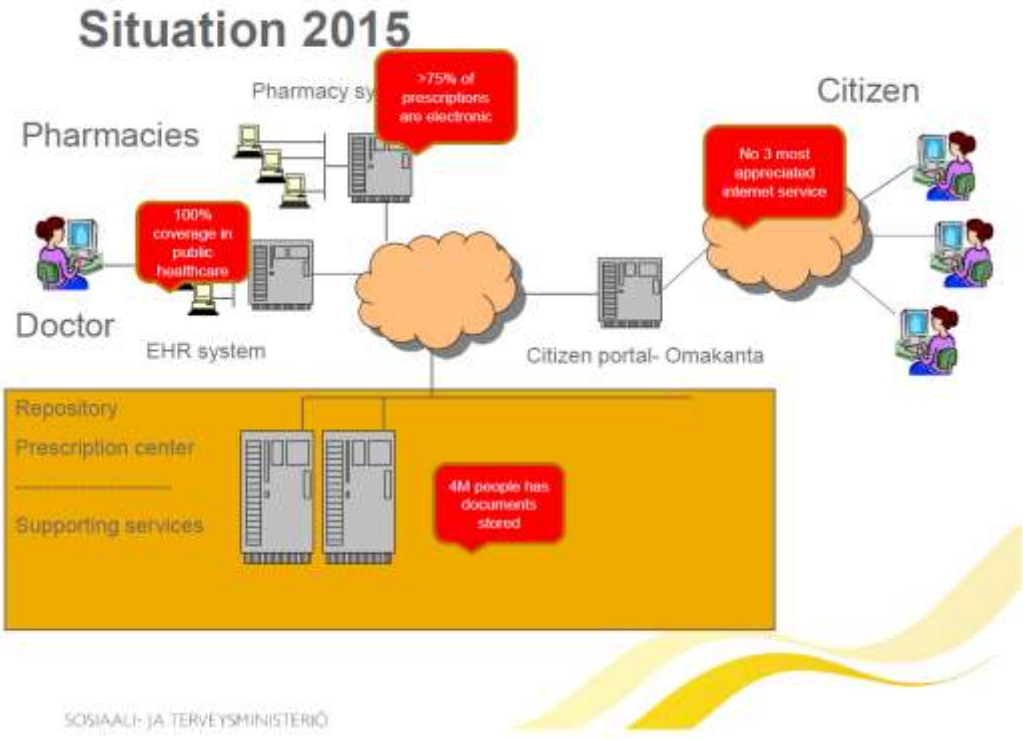
Finland?

- Population 5,4 million
- GDP per capita 47 000$
- Life expectancy M 77 / F 83 years
- Infant mortality 2.4/1000
- 38% have tertiary education

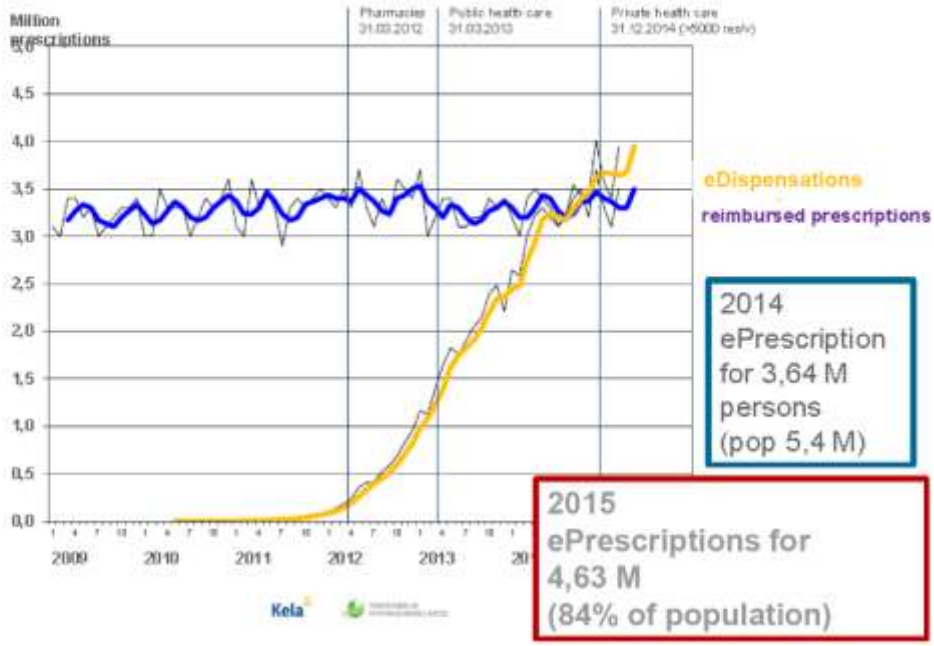




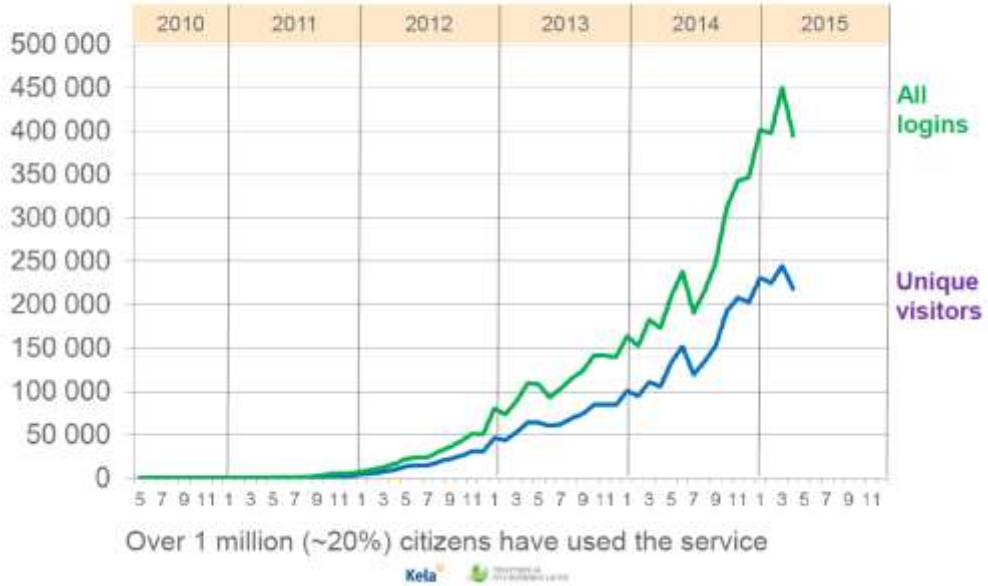

Public healthcare providers
Hospital districts (20)
Primary care org. (192)
Private healthcare providers (4000)
Pharmacies (~800)
IHE XDS-I
Health care professionals
Web-GUIs for HCPs
Swedish epSOS NCP
IHE XDS
epSOS NCP
Connection closed after successful pilot
Citizens (> 5 000 000)
Aged 18 and older
My Kanta pages
Health Apps
mHealth Devices
Kanta services
Kanta
Kanta messaging layer
ePrescription service
Logs
Renewals
Prescriptions
Dispensations
Patient data repository
Radiology DICOM studies
Metadata
Logs
Health records, legacy (CDA R2 L1 / PDF)
Health records, structured (CDA R2 L3)
Patient data management service
Patient summary management
Diagnoses
Vaccinations
Radiology
Procedures
Lab
Physical findings
Risks
Health and care plan
Medication
Consent and will management
Organ donation wills
Living wills
Consent and denial
Personal Health Record
Customer mydata
Other national services
National code server
Pharmaceutical database
Code lists and terminologies
Organization registry
Form and document structures
Pharmacies register
Certification services
Health care professionals register
Main standards
HL7 V3: CDA R2 Level 3 and Medical Records
IHE IT-I Profiles
W3C XML DSig
WS Addressing, WS-I
TLS, X.509
SOSIAALI- JA TERVEYSMINISTERIÖ

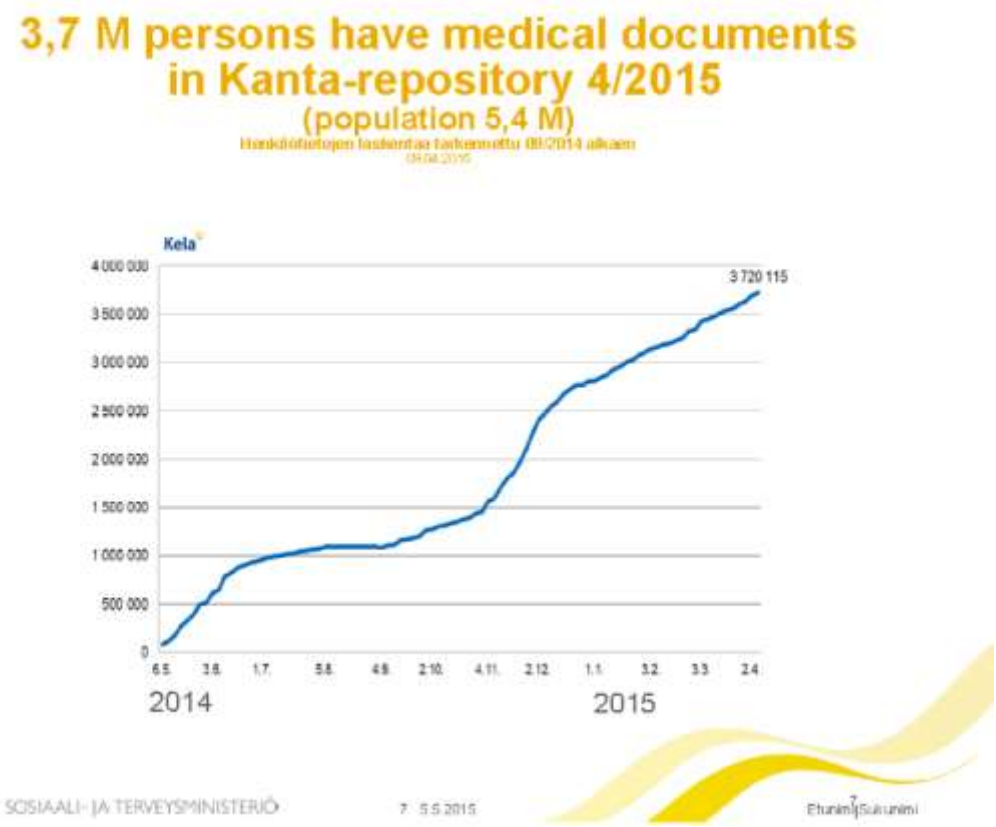

Situation 2015
Pharmacies
Pharmacy sy
>75% of prescriptions are electronic
Citizen
No 3 most appreciated internet service
100% coverage in public healthcare
Doctor
EHR system
Citizen portal- Omakanta
Repository
Prescription center
Supporting services
4M people has documents stored
SOSIAALI- JA TERVEYSMINISTERIÖ

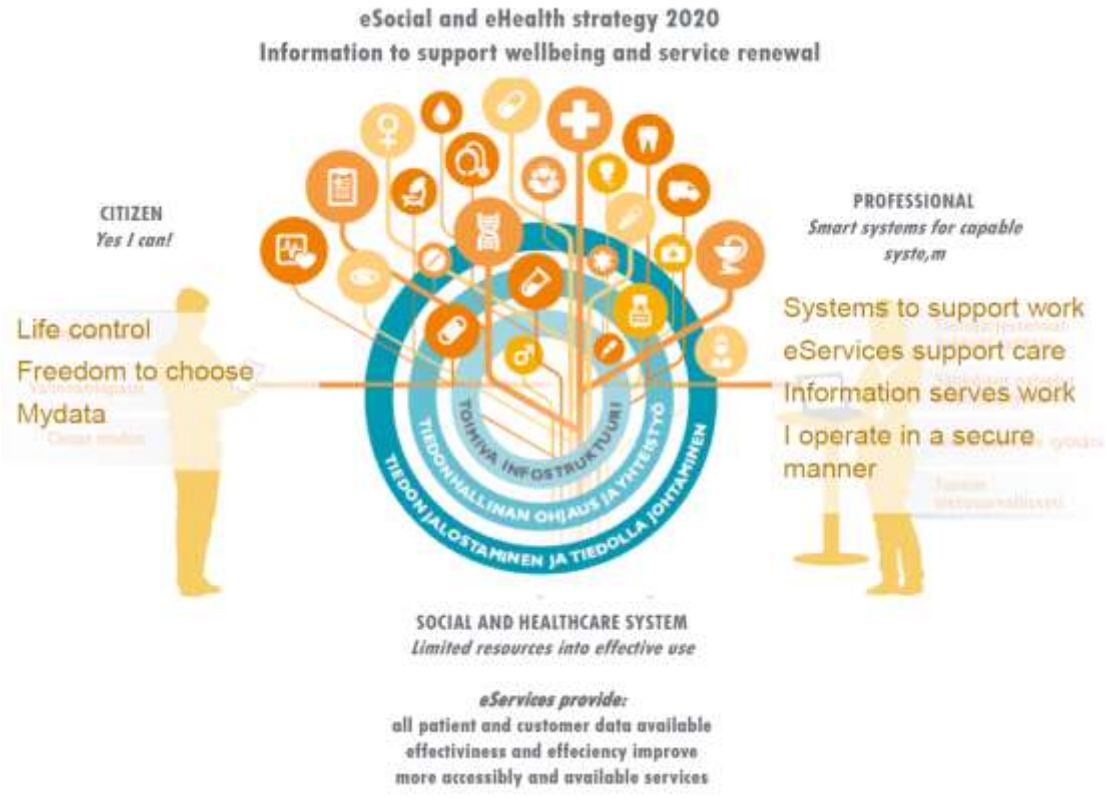
eDispensations from pharmacies compared to reimbursed prescriptions years 2009–2015

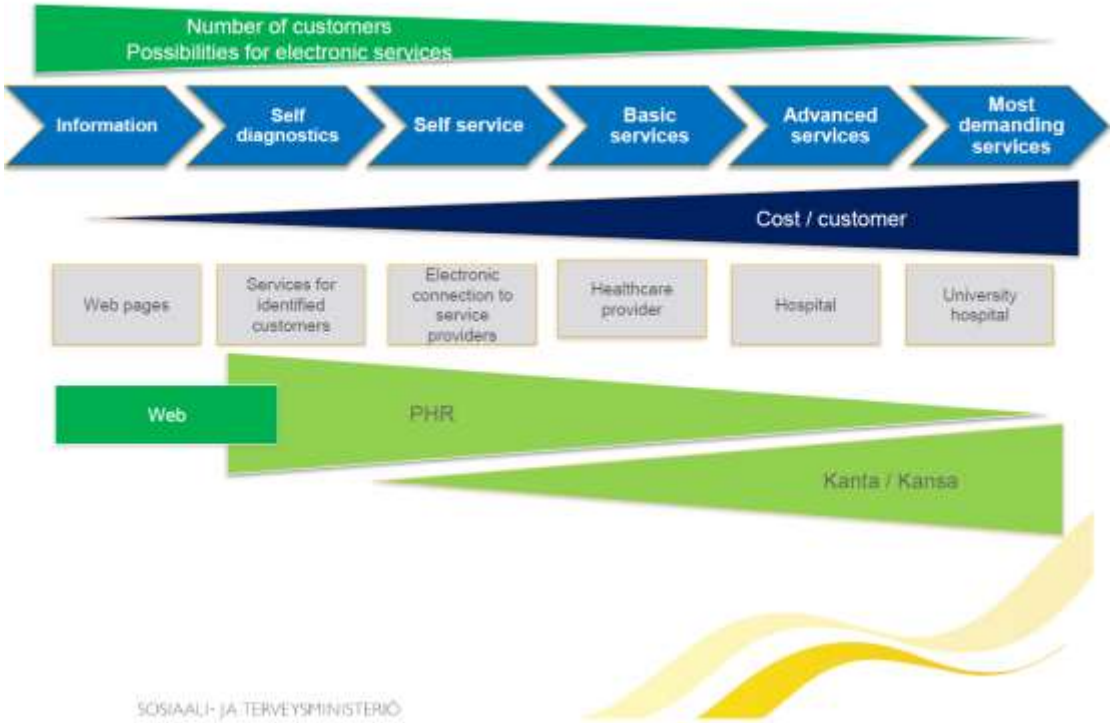


Omakanta (patient portal, my Kanta pages) logins and unique visitors monthly 05/2010–04/2015




3,7 M persons have medical documents
in Kanta-repository 4/2015
(population 5,4 M)
Kela
4 000 000
3 500 000
3 000 000
2 500 000
2 000 000
1 500 000
1 000 000
500 000
0
3 720 115
6.5.
3.6.
1.7.
5.8.
4.9.
2.10.
4.11.
2.12.
1.1.
3.2.
3.3.
2.4.
2014
2015
SOSIAALI- JA TERVEYSMINISTERIÖ
7 5.5.2015
Etunimi Sukunimi


eSocial and eHealth strategy 2020
Information to support wellbeing and service renewal
CITIZEN
Yes I can!
Life control
Freedom to choose
Mydata
PROFESSIONAL
Smart systems for capable
syste,m
Systems to support work
eServices support care
Information serves work
I operate in a secure
manner
TOIMIVA INFOSTRUKTUURI
TIEDONHALLINAN OHJAUS JA YHTEISTYÖ
TIEDON JALOSTAMINEN JA TIEDOLLA JOHTAMINEN
SOCIAL AND HEALTHCARE SYSTEM
Limited resources into effective use
eServices provide:
all patient and customer data available
effectiviness and effeciency improve
more accessibly and available services


Number of customers
Possibilities for electronic services
Information
Self diagnostics
Self service
Basic services
Advanced services
Most demanding services
Cost / customer
Web pages
Services for identified customers
Electronic connection to service providers
Healthcare provider
Hospital
University hospital
Web
PHR
Kanta / Kansa
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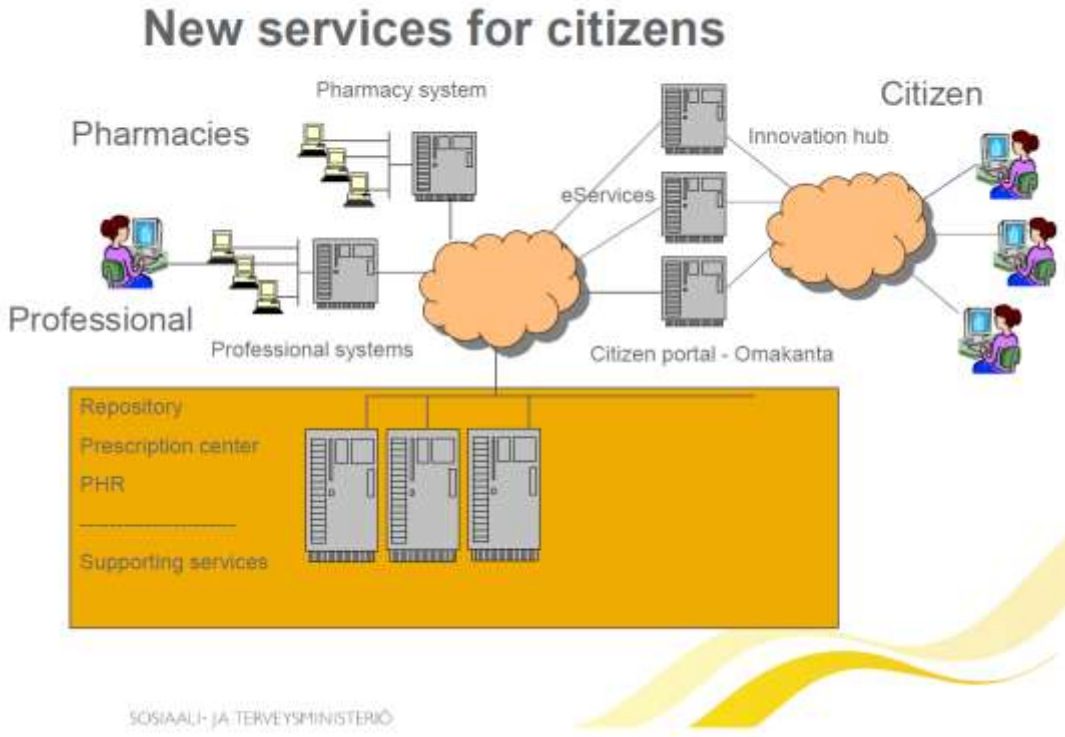
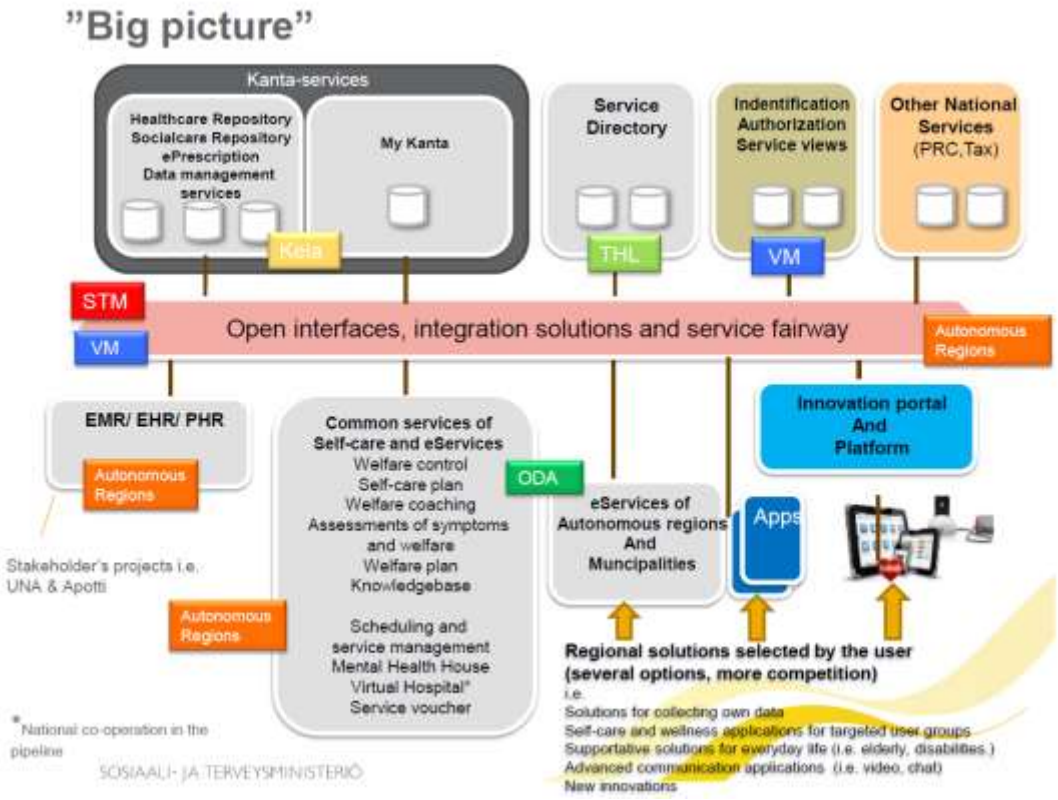

New services for citizens
Pharmacy system
Pharmacies
Citizen
Innovation hub
eServices
Professional
Professional systems
Citizen portal - Omakanta
Repository
Prescription center
PHR
Supporting services
SOSIAALI- JA TERVEYSMINISTERIÖ


"Big picture"
Kanta-services
Healthcare Repository
Socialcare Repository
ePrescription
Data management services
My Kanta
Kela
Service Directory
THL
Indentification Authorization Service views
VM
Other National Services (PRC,Tax)
STM
VM
Open interfaces, integration solutions and service fairway
Autonomous Regions
EMR/ EHR/ PHR
Autonomous Regions
Stakeholder's projects i.e. UNA & Apotti
Autonomous Regions
Common services of Self-care and eServices
Welfare control
Self-care plan
Welfare coaching
Assessments of symptoms and welfare
Welfare plan
Knowledgebase
Scheduling and service management
Mental Health House
Virtual Hospital*
Service voucher
ODA
eServices of Autonomous regions And Muncipalities
Apps
Innovation portal And Platform
Regional solutions selected by the user (several options, more competition)
i.e.
Solutions for collecting own data
Self-care and wellness applications for targeted user groups
Supportative solutions for everyday life (i.e. elderly, disabilities.)
Advanced communication applications (i.e. video, chat)
New innovations
*National co-operation in the pipeline
SOSIAALI- JA TERVEYSMINISTERIÖ


Do I need to worry?
What can I do myself ?
Present
Future
1.
2.
3.
4.
5.
6.
Test
Digital health & wellfare check
Patient data (EMR)
Mydata
Data from Health&wellf are apps
Results
Weightindex
Cholesterol
Alhocol consumption
Functioning / Disability
Recomendations
Looking good!
Life expectancy/ healthy years
82/75
Decision support for change
Goals
Citizen's own goals
Interactive health & care plan
-10kg / year
-More everyday physical training
Better balance of own economy
Risks/reminders
Right service contacts (for self care support)
Guidance & support
Personal health & welfare guidance
Tracking & support
Personal health & wellfare coaching supported by mHealth solutions

The new eSocial and eHealth strategy

- Citizens must be enpowered
  - National PHR
  - New type eServices provided by social and healthcare providers
  - New type of eServices provided by companies
- Better systems for professionals
- New ways to provide services
- Better co-operation between service providers

New electronic public services - ODA

- The new platform to build electronic services for citizens
- Well connected to public health providers
- Social services and primary healthcare
  - Reliable information delivery
  - Tools for self analyse and guidance based on the result
  - Reliable communication between customer and professional
  - Wellness plan
- Based on experiences in one city

Gateway for other providers - Innovation hub

- A platform or a gateway that makes possible to store and retrieve information to/from PHR
  - Device manufacturers
  - Analyse providers
  - Mobile services
- Security and privacy requirements but no medical evidence required
- Business based services
- Possibility to get proof of medical advance

Questions - Discussion