Comparison on Community Care and Collaborative Approach in Sweden and Japan.

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本稿はスウェーデン・日本の文化、システム、組織などその長所短所を含めてその理解を促進するための比較研究である。ここで、スウェーデンのシステムをベースにして、日本との間で社会的構造やプロセス、専門職ならびに顧客・クライエントなどの行動や文化の比較を行った。

比較研究の対象としては、サービスの範囲、情報システム、購買過程、クライエント・消費者・患者の権利、利用できる製品やそのサービスなど多くの側面があるが、とりわけソーシャルケアはその焦点にあり、それもその一部にヘルスケア（病院や診療所）を含めるものとしてのソーシャルケアが中心といえよう。したがってヘルスケアとソーシャルケアの相違を比較研究することは非常に重要であると考えられる。

ところで、Vlkarness（1978）は「目に見えない福祉ケア」について論じている。それによるとヘルスケアとソーシャルケアを比較する際、一部目に見える部分と目に見えない部分を持つソーシャルケアと、先進国での目に見えるヘルスケアシステムとを見分けなければならないとされている。

すなわち病院や診療所、医師や看護師、理学療法士などにみられるようにヘルスケアでは専門性が確立され、職業領域が組織化されており、医療分野を基礎とする研究において、科学的な評価を通じて専門性はさらに発展し、国家機能による法的根拠のもとになると規制されている。

一方ソーシャルケアにおける厄介な仕事は表に出ない活動として行われており、その大半は女性が担
Some general comments on comparative research in health care and social care. The differences between the professional areas.

This article has an emphasis the importance of comparative research in order to understand our own system, culture, organization, including strengths and weaknesses. In the comparison, our own system is reflected, with structures, processes, professional and customer/client behavior and culture with another system. There are numerous of aspects, such as the range of services, the information systems, the purchase processes, the power of clients/customers/patients and the products and services available which can be highlighted in a comparative research approach. The focus is the social care, but looking at the social care we have to partly include the health care system – hospitals and clinics. Thus the study of the differences between health care and social care are worthy of note. Waerness (1978) is talking about the invisible welfare care. When we compare health and social care we can identify the visible health care system in the developed countries as well as the partly visible and invisible social care. Hospitals and clinics, professions such as medical doctors, registered nurses, physical therapists, etc are very evidently organized and the area of work is quite fully professionalized. Professionalized, in the sense of research grounded medical work, developed through scientific evaluations, and regulated thoroughly in the jurisdiction of the state and authorities. At the same time the arduous work of social care remains a hidden activity, largely carried out by women and often without remuneration. The social care is still an area where the professional formation is an ongoing process. The social care is above all characterized by its flexible boundaries, by the ambiguity of the tasks involved and the uncertainties over the divisions of labor including an ambiguous dividing line between professional, voluntary and family work. (Anttonen, Baldoch, Sipila, 2003).

The focus is thus the social care for elderly and handicapped persons. In this case it could be relevant to define what we have in mind when discussing social work and social care. I refer to Anttonen et.al’s definition of social care: “social care means giving informal or professional attention to whole persons who need help in their everyday lives.” (ibid, p 7)

Culture plays a central role

In different countries and different cultures there is a considerably substitute between home and in-
stitution and among family, market and state. There is a need to study this subject and these relations more carefully. Does it have any important implications if it is the state, the community, voluntary organizations or professional who deliver the care or the services.

Deep cultural roots have an effect on the development, on what is regarded as normal and expected in shape, formation and creation of the social work. We can identify differences between northern and southern Europe, as well as between Europe and Asia. The same designation or label in different cultures can mean different significations or implications. For example the home help or home service organization in Sweden is the major formal organization in the welfare for elderly. The home service organization is in charge of service houses, service apartments and senior housing. The home helpers serve group homes for people with an intellectual handicap and people with a psychiatric handicap. However it is regarded that at least 70% of the total social care in Sweden is covered by the family. In Japan the major burden of the care is also contained by the family. The content of the family care in Sweden is however different compared to Japan. The main amount of the family care in Sweden is talking, visiting, encouraging, shopping and feeding. Normally the family does not take part in the intimate hygiene activities or the cleaning of the home, or laundry or physical care. All these aspects are normally left to the professional home help staff in Sweden. The family neither takes part in the care for their family members who are hospitalized. Then the family is just visiting the patient at the hospital.

Length of stay in hospital

One socio-economic difference between Japan and Sweden is the length of stay in hospitals. In Sweden the inpatient time in hospitals is extremely short compared to many other countries, especially compared to Japan (figure 1). According to Ikegami (1997) nearly half of all patients in Japanese hospitals are 65 years or more, and nearly half of this group had an length of stay over six month and one third over one year. Future scenarios says that an essential share of the health insured care will shift over to the Long Term Care Insurance covered care in the home (Ikegami 2004). These is a big difference with the incitement for hospitals and social care compared to the Swedish situation. In Sweden the hospitals have a concept guiding the timing of the discharge of the patients. The concept is “medically finished treatment” or “clinically finished patients”. The meaning is that the doctor has finished the medical treatment and now there is “only” the care process or the nursing process remaining. Compared to Japan this seems to be a tough and sometimes inflexible way to handle the cost containment of the hospitals. However there is a distribution of the responsibility between

![Average length of stay in hospital](source: Economic & Social Data Rankings, www.dataranking.com)
health care and the social care in Sweden. The county councils are responsible for the hospitals and most of the primary health care and the municipalities are responsible of the eldercare as well as care for the handicapped. When the medical treatment for a patient, who is 65 +, is “clinically” finished at the hospital the municipality has to start paying the cost for the patient’s stay at the hospital. This regulation puts a pressure to arrange the care for the old person at the regime of the municipality instead for the comparably expensive care at the hospital and thus hasten the discharge of the old patient.

**Short stay in hospital — the Hip bone fracture example**

One example of a rather common diagnosis for old people in Sweden is the hip bone fracture. Hip bone fracture is a serious public health problem for old people. At the age 50 and later in life the risk to get a hip bone fracture is 23 % for women and 11 % for men in Sweden. This is one of the most expensive diagnoses in Sweden. The number of falling accidents for old people has increased by 9 % during the last five years (SvD 2007). However the length of stay is diminished from 19 days 1988 to less than 10 days 2005. Around 50 % of the patient can live in their ordinary home after treatment.

Of the patients 72 % are women and 28 % men. The average age has increased up to 84 years old. Half of the patients are living in single households. This tendency is so far not increasing during the 90s.

In the figures below we can see that more than half of the patients (56,3 %) live in their own home after the fracture. Below 30 % live in some kind of sheltered housing. The good thing is that people are not bed-bound after surgery. Few are staying in acute hospital after 20 days.

The majority of the patients go back to their own home after finished medical treatment and recovery.

![Figure 2](image2.png) **Figure 2** The patient’s housing situation 20, 60 and 120 days after hip fracture

![Figure 3](image3.png) **Figure 3** The patient’s housing situation 120 days after hip fracture

![Figure 4](image4.png) **Figure 4** Walking ability four months after fracture

Most of the patients need rehab exercise also 120 days after fracture. More than 80% of the patients need some kind of technical equipment after a hip fracture. In Sweden the most common tool is the rollator. You can see people with the rollator everywhere in shopping areas, in the bank office, at the market place.

More than 200,000 individuals use a rollator today. It is the most common and most important equipment for old people in Sweden. The rollator has become an “old people’s movement” for health (Sveriges Pensionärsförbund, 2006 /faktablad sept 2006). According to the Swedish Pensioners Association it gives security as well as ability and will for a valuable social life. With this tool frail people can visit friends, shops, libraries, etc.

The need for home help is diminishing and the risk for falling accidents is diminishing. The total cost for the rollators in Sweden is 150 million Swedish crowns (¥ 2,500,000,000). If a half percent of the users avoids falling and prevent a new hip bone fracture the delivery of rollators is successfully also from an economic perspective.

The relatively short length of stay in hospitals after medical treatment has of course not only medical explanations. We can find explanations in the infra-structure, the transportation systems, the standards of apartments and buildings, as well as the primary care system, including not least the availability of district nurses. Sweden has no mega-cities. The transportation net-works are rather well developed. Old people who need a rollator can get a transportation allowance, which means...
that they can use taxi with an very low fare. Al-most all apartments and houses have central heat-ing systems. The frail elderly person, or their family, does not have to deal with the heating problems. New apartments have standards for doors, toilettes, bathrooms, elevators, floor−cover-age, etc.

**Housing adjustment**

In order to make it easier for individuals with a function impairment to continue to live into the original apartment, the individual has the possibility to apply for allowance to adjust the apartment. The municipality is deciding the allowance and pays the money. The number of allowances has been increasing during the latest 30 years. The most frequent adjustments were barrier free adjust-ment, modifying of bathroom, installing ramps, widening and changing doors, installing electric timers, etc. Around 50 % of the measures/actions cost less than ¥ 100,000. Only3 % cost roughly ¥ 2,000,000.

**The forms of financing**

One of the most interesting questions on the fi-nancing area is the co−payment of the care receiver. In Linkoping the cost for sheltered housing is approximately ¥ 1,300 per day, ¥ 1,000 per day for day−care, ¥ 750 for the main meal. The cost for safety alarm is ¥ 1,500 per month. The cost for housing service is paid by hour. Housing service includes cleaning, laundry, shopping, and meals on wheels. It is possible to buy up to 8 hours housing service per month in Linkoping. There is a national maximum total fee for the personal care, housing service (cleaning) and alarm set which is fixed to approximately ¥ 27,000 per month.

The cost for the dinner per month is around ¥ 12,000. If the person gets all meals in the shel-tered housing the cost is approximately ¥ 20,000 per month (SOU 2006:24 Beräkningar och prognos).

The old person living in a sheltered housing or with the support of the home help organization has the right to keep a reserve amount of their pension/salary every month after all fees are paid. This reserve amount is around ¥ 72,000 per month for a single person and ¥ 120,000 per month for a married couple. From these amounts the cost for meals are reduced (Sources : Home pages : www.linkoping.se, www.sundbyberg.se)

In Sweden for−profit organizations are allowed in the care. In Linkoping for example maybe 60 % of the care units are run by private companies. However the fee’s for the elderly are decided by the municipality. The service, staffing, and the all−inclusive quality is assessed by the municipality. Every unit must have a quality assessment system in use continuously.

Non−profit organizations in Japan have a larger share of the care market than in Sweden. In Swe-den for−profit companies are acceptable and pre−ferred by half of the population in Sweden (Sifo
Only 34% of the respondents think that the public organizations will provide a better quality according to the same study (ibid).

**Some more comparisons between Japan and Sweden of the social care**

When comparing the social care arrangements between Japan and Sweden the table below could be useful (Anttonen, Baldock and Sipilä 2003). In the columns of basic organizers of the care, informal, voluntary, commercial and the state, we can do some general remarks of differences between the two countries. If we compare the first column — the Informal care — we can identify some similarities and some differences between the two countries. In Japan, if I dare to say anything without any deeper knowledge, in Japan there is a long tradition of family caring for the old person and even giving a helping hand in the hospitals. Traditionally there were heavy expectations and burdens on the children, especially on the oldest son. According to my information the expectations were so powerful, so the old person could even feel ashamed for her/his family, if they did not take care of their parents.

In Sweden the family also has an important role in the care for their old family members. Though the pressure on the children has gradually diminished parallel to the development and extension of the quality and the quantity of the social care.

<table>
<thead>
<tr>
<th>Rationale or motive</th>
<th>Informal</th>
<th>Voluntary</th>
<th>Commercial</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agency</strong></td>
<td>Household, family, friendship, neighbourliness</td>
<td>Voluntary organizations, charities, churches, communities</td>
<td>Firms, professionals, independent care workers and contractors</td>
<td>Central and local government bureaucracies</td>
</tr>
<tr>
<td><strong>Recipient</strong></td>
<td>Member of household or family, friend or neighbour</td>
<td>Person defined as object of charity</td>
<td>Customer or client</td>
<td>Entitled citizen</td>
</tr>
<tr>
<td><strong>Carer</strong></td>
<td>Unpaid member of household or family, friend or neighbour</td>
<td>Volunteer, employee or contractor</td>
<td>Employee or professional</td>
<td>Civil servant, public sector worker</td>
</tr>
</tbody>
</table>

*Figure 9 A typology of social care arrangements*  
(Source: Anttonen, Baldock, Sipilä, 2003, p. 13)
The actual content of the family’s care or achievements of the family members is not practical at first hand. It is more visiting, communicating, comforting, coffee drinking than involvement in the personal care. The family’s most hands on activity is shopping. This is of course rough generalizations of typical characteristics in the society.

When it comes to voluntary organizations Japan seems to have a very impressive voluntary sector. Shakai Fukushi Kyogikai for example has had a widespread organization with deep influence in the Ministry of Health (Labor & Welfare but also the opposite – the MHW had/has a great influence on "Shakyo" (Adachi, 1993). In Sweden the voluntary organizations in the eldercare are local and rather fragile. The majority of people who are engaged in these organizations are often pensioners. There is one national lobby group – the Swedish National Pensioner’s Organization (PRO) founded 1942. PRO’s task is “to look after the interests of pensioners in various social issues and to run self-reliant operations from which the members can take pleasure and gain fellowship” (www.pro.se). This is by far the largest pressure group in Sweden with around 25 % of all people 65 years and older as members. The main activity of the PRO is not involvement in the practical care, but in debate and lobby work.

The commercial sector has had an increasing share of the Swedish eldercare since the Ådelreform 1992. At that time the welfare sector opened up for subcontracting commercial companies in the social care for old people. Today the companies have a considerable segment of the subcontractors in many municipalities. For example in Linkoping around 60 % of the care units are run by commercial companies. It is important to note that Swedish municipalities have a rather substantial freedom when it comes to organization and financing of the welfare. The cost for the eldercare varies in different municipalities from about ¥ 500,000 to ¥ 1,000,000 per person ≥ 65 years old (Socialstyrelsen, 2004). The smaller municipalities appear to have the highest cost per old citizen.

In Japan, the private sector has been steadily expanding its role in recent years especially since the Long Term Care Insurance was inaugurated 2000. One example with slow change in Japan is the situation for the part time employed. The model of employment for part timers in Japan differs substantially compared to Sweden. Part time employed in Japan seems to have a very unprotected form of employment. In Sweden the part time employed normally has the same formal status and terms of employment as a full time employed. This is an important advantage when the municipality try to recruit staff to the social care.

A slow development in Sweden

Sweden has a long tradition of building a social security network for people in need of care. Sweden reached 10 % of population ≥ 65 years already 1945 as one of the first industrialized nations. So when Sweden and Japan has the approximately the same percentage of 65 + in the population the demographical process has been totally dissimilar. Around the year 2000 both countries had a population of roughly 17 % 65 years and older. The demographic development in Sweden between 10–17 % 65 + of population took some 55 years, while in Japan the same development took only 20 years. This gives of course huge differences when it comes to time for construction of a service system, gradual development
of the legislation, rules and regulations. There has been an opportunity for trial and error, experiments as well as an ongoing improvement of systems for quality measurement and quality development in Sweden.

The figures 10 and 11 illustrate the slow but steady growth of the number of people 65 years and older in Sweden. Figure 11 shows also the fast expansion of the old population in Japan compared to Sweden.

Figure 12 illustrates the very intensive escalation of the older population in Japan. Sweden has a much more slow growth. Almost all countries in the industrialized part of the world have an increasing percentage of population aged 65 and over. However Japan seems to be one of the most
exposed countries for this development (Figure 13).

**Ideological concepts in Sweden**

There has been links between care for handi-
capped people and elderly when ideologically
founded principles were discussed and created.
The concepts of normalization, integration and par-
ticipation have links to handicapped people with
strong lobby groups. These ideological concepts
became guidance in the whole welfare sector, i.e.
both the health care and the social care.

The concept of normalization was firstly devel-
oped in Sweden during mid 20th century (Nirje,
2003). The explanation of normalization principle
means “making available to all ... people patterns
of life and conditions of everyday living which
are as close as possible to the regular circum-
cstances and ways of life in society”(Nirje, 1982).
The needed people should have power and influ-
ence over their daily lives. Normalization has
made a significant influence on the way services
have been structured in the Swedish welfare sys-
tem. It has led to a new conception of ageing,
disability and loss of functions and abilities in
daily life as not simply being a medical subject,
but as a social situation (ibid).

In concrete terms, it was developed through six
connotations:

1. The rhythm of the life should be respected.
The elderly should become aware of the
pace of the day (meal and sleep timetable),
of the week (weekdays/weekend), of the
year (season, holidays, special events ...)
and still with a high degree of individual
freedom.

2. The service house, group home or semi−in-
istitution should be physically integrated in
the community. The reception facilities of
the service conveniences should be located
close to the social life of other people. Prefer-
ably it should be situated near a shopping
center and/or a supermarket.

3. People who live in their own home should
be able to use a cheap transport service,
taxi with a discount fare in order to be in-
tegrated in the society.

4. The elderly should be able to meet other
generations. This is the principle of func-
tional integration. For example, they can
share some facilities with a school where
they can use the same cafeteria/restaurant,
hobby rooms, leisure center, gym etc.

5. Normalization proposes that elderly and
handicapped people should be socially inte-
grated. That is to be involved in decision
making of the personal service and care but
also engaged in the organization of for ex-
ample the personal home service organiza-
tion, the quality control, how the organiza-
tion is managed. This puts a demand on the
layout and content of the information to the
service receiver. The staff must be able to
adjust the language to be understood by the
client/patient.

6. Normalization also suggests demands upon
the receiver of service or care. They (or
their family) have to sign a contract of the apartment they rent in the semi-institution or in the group home. The old person is formally and economically regarded as a tenant.

7. The apartment in the sheltered housing or the room in the group home should be furnished and decorated as a home. Normally the old tenants or the handicapped persons bring their own furniture and their own decorations. The tenant, handicapped or old person, should be able to think “my home” about her/his apartment.

The number of persons receiving home help increased strongly from 1960 to the beginning of 1980s when almost ¼ of all pensioners got some kind of home help during the year. Thereafter the number of home help receivers has diminished. At the same period the number of persons 80 + has been tripled. 1980 14 % of the age group 65–79 years received home help or sheltered housing, compared to 5 % 2005 for the same age group. An improved health is the explanation. The same circumstances is valid for people 80 +. 1980 34 % of people 80 + received home help compared to 20 % 2005.

A majority, around 94 %, of people 65 + lives in their ordinary housing. Approximately 6 % lives in sheltered housing and most of these are more than 80 years old. The number of old people living alone has been rather stable on 37 %. In Sweden only 1 % of married old couples live together with a child and 1 % of single persons.

94 % of married couples had been married more than 40 years. Around 14 % of all old people

![Graph](image)

**Figure 14** Number of home help receivers living in ordinary housing, Number of individuals in sheltered housing and Number of people 80 +. Total population between 1960 and 2005 increased from 8 milj. to 9 milj. inhabitants in Sweden.

(Source: Äldrecentrum, Stockholm Rapport 2006 : 9)

<table>
<thead>
<tr>
<th>Year</th>
<th>Living alone</th>
<th>Living with spouse</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988/89</td>
<td>36,8</td>
<td>51,5</td>
<td>4,4</td>
</tr>
<tr>
<td>2002</td>
<td>37,1</td>
<td>53,8</td>
<td>2,3</td>
</tr>
</tbody>
</table>

(Source: Socialstyrelsen, 2004

| Table 1 Housing and living patterns for old people in Sweden 1988/89 and 2002 in %.)
had no spouse and 9% had no children. 79% of the elderly had grandchildren, on an average 4–5 grandchildren. Around 59% of the old people with children lived less than 20 minutes drive from the children, 25% had their nearest child on walking distance (12 minutes walk). 67% 1988/89 and 57% 2002 met their child (children) at least once a week. 12% said the felt alone "sometimes" (1954 the same figure was 14%). Men feel alone now so often as women. The explanation is they more often have a spouse, while the women lives longer than the men and thus are left alone more often.

Quality assessment and quality development

The quality of the care has been a very important concern in the entire Swedish welfare sector. It is mandatory for every department and every unit in the care to contain an active quality assessment system and quality improvement implements. It is of course important to discuss the implication and the sense of the quality in the social care. One definition: Quality is defined and measured by the attributes which people (customers/old people) talk about. This definition takes the customer’s perspective and as a matter of fact most literature on quality takes the perspective of the customer or client (Anbäcken & Park Dahlgaard, 2005). One famous definition is used by Juran (Bergsman & Klefsjö, 2003): "Fitness for use". This quality definition gives an association to the commercial production of supplies or services. But in a figurative sense this definition can also serve as a definition from a symbolic perspective: it should be easy for the client, the family and/or other involved actors to understand and use information, documents, fill in a form, understand the decision process and the logics of the rules throughout the whole care process. Even a simple, lean organization and a flexible management of a care institution combined with close customer relations could be important for the customer, the old care receiver and her/his family (Axelsson & Bergman, 1999). There are structural or configurational aspects of the quality – for example physical resources, competence of the staff, documentation routines, security manuals, forms of decision making. Another bearing is the process aspect of the quality – for example the course of assessment of the customer’s needs, the appropriate timing or scheduling of the care process, the client’s experience of politeness, friendliness, integrity protection during the care. In the literature we find some more dimensions of quality in the care (Bergman & Klefsjö, 2003)

- Tangibles, which refers to the physical environment in which the service is presented, i.e. the organization, the equipment and the personal and their clothing
- Reliability, which is the consistency of performance and dependability, e.g. punctuality and the correctness of service, information and invoice procedures
- Responsiveness, which is the willingness to help the customer, and answers the question "Does the performance meets expectations. This includes communication, which is the ability of talking in a way which is understandable to the customer
- Competence, which is the possessing of the required skills and knowledge to perform the service
- Courtesy, which refers to the supplier’s behaviour, e.g. politeness, consideration and kindness. This is related empathy, which deals with the interest and possibility of becoming acquainted with the role of the customer
• Credibility, which means trustworthiness, believability and honesty of the service provider. Equity of service in one aspect but one “distinctive feature of service quality is the ability to treat people both equitably and uniquely” (Morgan & Murgatroyd, 1994, p.127)

• Security, which means freedom from danger and risk. According to two paragraphs in the Social Security Act and the Health Care Act, the Lex Sarah and Lex Maria, all deviating situation from the normal and all risk situations in the care must be reported. Any staff person have this responsibility. The background is a staff nurse, Ms. Sarah Wagnert who reported deficient and poor care in an old age home in Stockholm. She alarmed the Social Security Agency and after some time this special act of the duty to alarm misbehaviour and poor care was inaugurated (Socialstyrelsen, 2003).

• Access, which is the ease of making contact with the social service.

Of course there are more perspectives on quality and quality development both from political and economical standpoints. Concepts like ideology, justice, access, cost efficiency, leadership, professionalism have a great impact on quality issues. The most important challenge for the political and professional leadership of the social care institutions is to create an ongoing constructive development of the quality in a deeper sense. It implies to generate and to establish an awareness of possibilities to employ an environment, systems, structures and processes, which gives opportunities to live a good life also I later life.

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www.linkoping.se
www.pro.se
www.sundbyberg.se
www.volaris.se

Äldrecenterum, Stockholm Rapport 2006: 9
APPENDIX 1

THE VISION FOR ELDERLY IN LINKOPING MUNICIPALITY

The elderly shall have the opportunity of maintaining good health and good living conditions until late in life.

Elderly people in the Municipality of Linkoping shall be able to live an active life and have an influence on society and over their own everyday life. They shall be able to feel safe as they get older – retaining their independence and being met with respect at the same time as they have access to good care. We shall endeavour to give them great freedom of choice.

Elderly people shall be encouraged to partake in formulating concrete efforts to promote good health in Linkoping. Cooperation with and support given to societies and voluntary organisations that work for the good of elderly citizens shall be reinforced and developed.

An increase in the knowledge of how good health can be promoted among the elderly shall be included within activities financed by the Municipality. Special attention shall be given to the needs of the elderly.

This work shall aim to:

improve preconditions for the elderly, so that they feel that they are an important part of the community and that they are a part of a meaningful context.

This shall be achieved by seeing to it that:

• the experience, competence and knowledge of elderly people is taken advantage of by different sectors of the community.
• social contacts and association over the generation gap are promoted.
• support is developed to encourage societies and voluntary organisations that work with and/or for the elderly.
• opportunities for social contacts are furthered.

Preconditions for the elderly to live independent lives shall be improved.

This shall be achieved by seeing to it that:

• all those over the age of 75 are offered the opportunity of receiving annual home visits to discuss questions of health and information about activities that promote good health.
• preventive measures are taken to minimize injuries due to defects in the homes of the elderly and in their direct surroundings.
• access to public transport is improved.
• good everyday service (commercial, communications, etc.) is easily available in the close vicinity of elderly people.

Preconditions for physical activity and good catering for the elderly shall be improved.

This shall be achieved by seeing to it that:

• all elderly persons living in homes for the elderly have close access to green belts, giving them the opportunity of getting some exercise, stimulus, association and relaxation.
• all elderly persons that receive help at home or that live in homes for the elderly in the Municipality are stimulated and given the opportunity of spending time outdoors regularly.
• activities arranged by societies and voluntary organisations that promote good health are stimulated.
• all elderly persons that live in homes for the elderly are given nutritious food in a quiet and pleasant environment.
• elderly persons, their close relatives and personnel are informed of the importance of food and physical activity for good health.

1 Resolution decided by the Linkoping municipal-parliament