EUSBSR
EU STRATEGY
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SEED MONEY FACILITY

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INTERGRATED CARE FOR OLDER PEOPLE WITH CHRONIC CONDITIONS

The main international experiences

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1 Introduction

Health services have traditionally seen as their task to solve problems related to diseases that occur and have their impact on human health. The “medical model” starts from the assumption that the human body is a healthy and well-functioning system, which can be invaded or disrupted by organisms or factors leading to disease. The task of the health professionals is to identify the reasons for malfunctioning and/or symptoms, to prescribe or otherwise bring about cure. After these steps the patient may need rehabilitation. A growing number of diseases are nowadays chronic by nature. For chronic diseases, there is usually no cure, but the treatment can return the original balance or at least relieve symptoms. Many chronic diseases would lead to early death if left untreated. Typical of the ways to tackle chronic diseases over the past several decades has been to focus on one disease at a time.

An increase in the number of persons with one or more chronic conditions among the population is a global phenomenon. According to a definition by the WHO, the term “chronic conditions” is used to refer to a health issue that requires constant management through several years or decades (Word Health Organization 2003). Simultaneously occurring risk factors are often behind these illnesses, but, at the same time, increases in life expectancy and improved possibilities to treat diseases also have an impact. However, the majority of older persons with multiple illnesses do not receive sufficient and suitable care for their conditions. It is a challenge to determine how high-quality and cost effective services can be organized to this target group in the future (Nolte & McKee 2008).

The management of persons with different long-term diseases sets similar demands to staff members and organizations. The higher the number of illnesses of a patient, the more important it is to form a comprehensive view of the patient’s condition, to integrate care, and secure continuity of management. In order to reach these goals, the implementation of both functional and organizational changes is often necessary. There is a demand to move emphasis to home care and prevention of diseases, and to strengthen the participation of patients and their family members in the planning and

realization of care. Functions should be more often based on evidence and the evaluation of the need for care should be more proactive. Instead of setting up more hospitals, alternative care sites should be established and possibilities offered by information technology should be utilized. (Nolte & McKee, Ham et al. 2012.)

Care models for managing chronic conditions have been developed since the 1980s. The Chronic Care Model (CCM), developed by Edward Wagner, is one of the most significant representations for treating long-term diseases (Wagner 1998). The CCM is an extensive frame of reference for organizing care of persons with chronic conditions and improving care results. The model includes four components of good care - self-management support, delivery systems design, decision support, and clinical information systems – which are present in a functional health service system and a sufficiently resourced community. The activated patient and proactive practice team lie at the center of the model. The CCM has been applied into service systems in several different countries.

Traditional models of services challenged

Health services have been until recently all about face-to-face contacts between the health professional (usually a medical doctor) and the patient, either in the office or on a home visit. The service has been supplemented and supported by telephone contact.

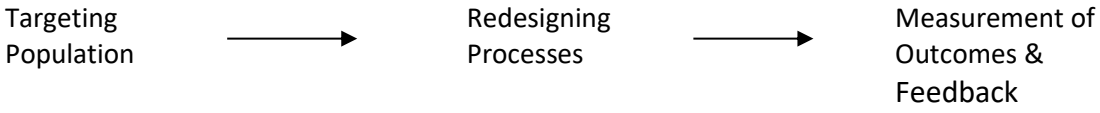
The core process of the encounters in health services has been to find out what lies behind the symptoms that the patient presents. The doctor is expected to establish the diagnosis and prescribe treatment. As the prevalence of chronic illnesses has been increasing, the core process of diagnosis and treatment is no longer often the leading activity. Taking care of those who already have one or several illnesses is a rapidly growing task.

Changes in a service system must be carried out in line with the delivery system design (the second component of the CCM). The new paradigm can be illustrated through the Pyramid Model developed in the Kaiser Permanente

health services (Figure 1, p. 3). The model can be used in two ways: (1) to portray all the tasks of the health service, or (2) to illustrate how individuals with one or several chronic diseases, or their risk factors can be divided into different categories according to their needs and personal capabilities for self-care.

Patients with multiple conditions require coordinated services carried out by a multiprofessional team. This means not only integrating the activities within an organization, but also between different organizations, fields of operation and professional groups, appropriate targeting of resources, and strengthening a shared knowledge base.

This report is about the profound changes that the chronic care model and its implications are having on health systems and in a broader sense on the overall care of older people. The changes are most prominent in primary health care and in those social services that cater for the needs of older people. We have taken an overview of the Nordic countries, the United Kingdom, the Netherlands, but left out of the focus the background development in North America, where the roots of the chronic care model are. This choice is deliberate; the structures of health systems and their funding in the United States are very different from the European systems. Since this review is written for the purposes of providing background material for a development project, we have included descriptions of past and ongoing development projects on care of older people with multiple illnesses in the countries covered.



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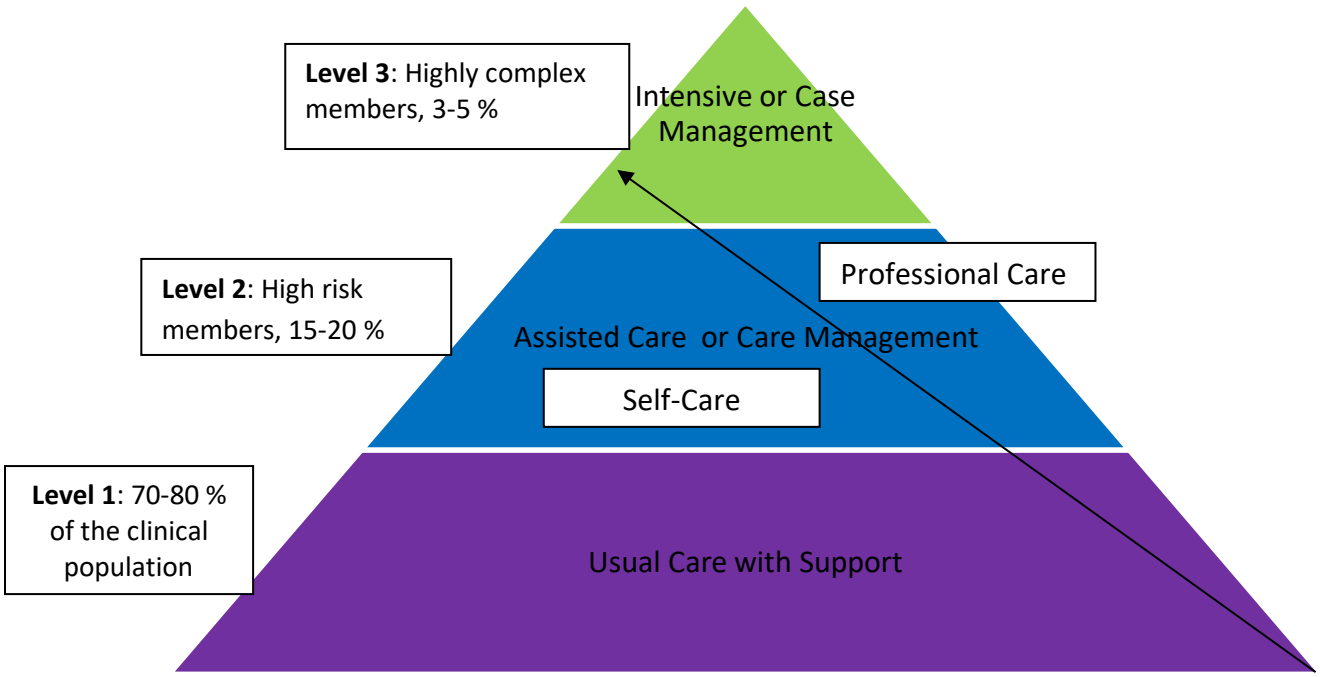


Figure 1. The Kaiser Permanente's Pyramid Model

The Kaiser Permanente's Pyramid Model (Jadad et al. 2010) can help us to understand the different needs of population and target accordingly the health interventions from health promotion to end-of-life care. To identify individuals belonging into categories in accordance with their level of complexity, is the main goal of the model.

At the bottom of the pyramid prevention and early diagnosis are the priorities. Level 1 provides support helping individuals and their caregivers to develop the knowledge and skills, and confidence to care for themselves and their condition effectively. The second level is designed for patients who need regular contact with multidisciplinary team to ensure effective management. Level 3 targets for patients who require more intensive support. A case management approach is used to anticipate, coordinate and link health and social care. (Barceló et al. 2013.)

The purposes of case management described by CMSA are (Powell & Tahan 2008):

1) to interject information where it is lacking in order to promote informed decision making by patients and others
2) to maximize efficiency in the utilization of available resources
3) to work collaboratively with patients, physicians, family members and other health providers to implement a plan of care that meets the individual's needs
4) to make the system work more effectively in order to ensure that individuals receive assistance that is responsive to their needs.

Case management is a complex intervention, generally led by nursing staff, which covers a wide range of interventions including patient identification, the evaluation of problems and needs, planning of care in accordance with such needs, coordination of services, and review, monitoring and adaptation of the care plan.

3 Transforming the health and social care delivery system

3.1 England

In the United Kingdom health and social care services are built on the foundations of the needs of the post-ward population. The National Health Service (NHS) is responsible for providing *health care*, which is publicly funded and services are provided free of charge to all patients. Responsibility for health care is devolved to the governments of England, Scotland, Wales and Northern Ireland. (Sonola et al. 2013.)

In England, community, mental health and general hospital services are provided by statutory NHS organizations, charities, social enterprises and private organizations who provide NHS funded services.

Primary care services (physical and mental health care) are provided by general practioners (GPs), nurses and support staff. They are independent businesses payed through a national contract administered by NHS England.

The majority of people are registered with a GP practice. When required, patients are referred to hospital or other specialist providers. Urgent and emergency care services are available directly through out-of-doors services and hospitals.

In England, general hospital services, urgent and emergency care, mental health and community services are commissioned by clinical commissioning groups (CCGs). The groups are formed from GP practices who assess the needs of the population in their locality and commission services from NHS or other provider organizations.

In contrast, local government is responsible for providing *social care* services (for example for assisted living at home and long-term care). Users can pay for services directly or gain access based on levels of need and ability to pay. Residential and domiciliary care are generally privately provided.

Responsibility for *public health* has shifted to the local authorities alongside the introduction of CCGs in 2013. Health and wellbeing boards have been established to support dialogue and the development of joined strategies between the health and social care system. Jointly funded and delivery services could promote person-centred care co-ordination.

After all, the current health and social care delivery system has failed to meet the needs of an ageing population. While life expectancy has increased, the number of years spent in ill health has also increased (Ham et al. 2012). The needs of people with multi-morbidity present major challenges (Ham et al. 2012, Goodwin et al. 2014, Ham & Walsh 2014).

Prevention is important to ensure that further increases in life expectancy translate into healthy years. Community and third-sector organizations do not have resources enough to this work. Local government may be able to make a bigger contribution to improve population health.

Social care plays an important role in helping older people to live in their own homes. However, poor resources can be used to act early with relatively simple interventions. It is higher risk that people will be admitted to hospitals and care homes without prevention in social care.

Primary care provides a wide range of care. However, the practices are not well coordinated with specialist teams in hospitals and other expertise in the community. It is important to give attention to the work of nurses and allied health professionals in the community, so that their work can be integrated with that of primary care teams. Social care needs to be part of these arrangements.

Changes in how *acute hospitals* work are essential. Older people make up the majority of patients in hospitals though many of them could be cared for elsewhere. Lack of adequate training for staff according older people's needs is clearly to be seen.There is an urgent need to performance of services outside hospital and to bring closer integration between hospitals and services provided in other settings.

In the future, it is essential that patients are working in partnership with professionals to design services and care pathways. Patients are also key members of care teams and take part in shared decision-making. It has shown that people with long-term conditions are enable to take control of their health when they are supported in self-care.

The health and social care system will require staff who are able to adopt their skills to changing patient needs. The roles and responsibilities have to be clear to all team members. Changes to the education and training of health and social professionals are needed to use a wide range of skills and to improve team working.

In the future, people who need care that cannot be provided in other settings, will be cared for in acute hospitals. There will also be increased community-based urgent care and out-of-hours service as alternatives to emergency. Enhanced intermediate-care provision will support rehabilitation and recovery close to home through both beds and new community-based teams. 'Patient

hotels' provide accommodation for patients who do not require intensive hospital-based care but who need to remain within the hospital campus.

New information and communication technologies can also support clinicians to deliver safe and high-quality care for patients. Mobile phones provide health advice. Electronic health communication interventions can help to promote self-management and shared decision-making. Older people can use the internet to manage their health and engage with health and social care professionals. The Comprehensive Health Enhancement Support System provides information and interactive coaching tools, and enables patients and carers to communicate with their clinical team, other patients and their own social support networks.

3.2 Netherlands

In the Netherlands, a major structural health reform was implemented in 2006 (Schäfer et al. 2010). The reform introduced a single compulsory insurance scheme, in which multiple private health insurers compete for insured persons. The role of the government changed from direct steering of the system to safeguarding the process from a distance. The government controls the quality, accessibility and affordability of the health care. Responsibilities have been transferred to insurers, providers and patients. Also in long-term care, increase competition among providers of outpatient services is changing the health system considerably.

Private health care providers are primarily responsible for the provision of services. Preventive care is mainly provided by public health services. The municipalities are responsible for disease prevention, health promotion and health protection. There are 29 municipal health services carrying out these tasks for all municipalities. There are a wide variety of providers in primary care (GPs, physiotherapists, pharmacists, psychologists and midwives). All citizens are registered with a GP practice. GP care is covered by basic health insurance. The GPs have the role of the gatekeeper. GPs can usually be visited within two days. After receiving a referral from a GP, patients can choose the

hospital in which they want to be treated. There are six types of institutions that provide hospital or medical specialist care: general hospitals, university hospitals, categorical hospitals, independent treatment centres, top clinical centres and trauma centres. Hospitals have both inpatient and outpatient departments as well as 24-hours emergency wards. Emergency care can also be provided by GPs - who have a separate telephone line for emergency calls - and trauma centres.

Several tasks of GPs have been shifted towards other primary health care providers. *The practice nurse* has become an important new professional in general practice. Practice nurses take care of specific categories of chronically ill, for instance diabetes, chronic obstructive pulmonary disease and cardiovascular diseases. The physiotherapists are also freely accessible.

Long-term care is mainly provided by nursing homes, residential homes and home care organizations. Nursing homes are especially for people with severe conditions who require constant nursing care while residential homes provide accommodation for people who need less care. The number of people with dementia is increased in nursing home care. Health insurers are responsible for purchasing long-term inpatient care, but they have delegated these tasks to care offices. Patients who want to organize their own care may apply for a personal budget. They may buy care from professional organizations, but also from non-professionals, for instance neighbours, friends and family. There has been an increased focus on the support of informal carers. Since 2007, the support and assistance of informal carers are responsibility of municipalities. Patients can use a part of their personal care budget to pay informal carers.

In future, because of the increase of patients with complex morbidity, an integrated approach of multidisciplinary cooperation becomes necessary. Disease management programmes should be developed. The Minister of Health Welfare and Sport has noted that it has to be clear who is to coordinate the care processes.

3.3 Sweden

In Sweden, the *county councils* manage the health care services, while the *municipalities* manage care for older people. Primary health care is responsible for guiding the patient to the right level within the health system. Choice of primary care provider for the population and freedom of establishment for primary care providers is mandatory in Sweden since 2010. Primary care has no formal gate-keeping role in most county councils and patients are free to contact specialists directly. Team-based primary care facilities with four to six GPs, complemented with other staff categories, is the most common form of primary care practice. (Anell et al. 2012.)

District nurse play an important role, as many first contacts with the health care system are their responsibility. District nurses work both within primary care and within the municipal sector. They are employed by the municipals and involved in home care making regularly work visits, especially to older people.

The competence of paramedic staff has improved over the past decade. There is a person with three years of studying to become a nurse and an additional year of specialist training, in each ambulance in most county councils.

There are also mobile teams composed of different clinical competences making home care visits, especially to people who have an identified greater need of care, such as older people and people with chronic illness.

Specialized care involves health care services that cannot be provided in the primary care settings. Swedish counties are grouped into six medical care regions. There are 7 regional/university hospitals and 70 county council hospitals offering specialized inpatient and outpatient care. Two-third of the county council hospitals are acute care hospitals offering care 24 hours a day and a larger number of clinical expert competences than local hospitals.

The county councils are responsible for patients until the patient no longer requires hospital care. Then the physician, staff from social care services, other outpatient services and the patient develop a care plan and responsibility for the patient is transferred to the municipality.

The municipalities are responsible for the care of older people. The division of responsibilities between medical treatment by county councils and nursing and

rehabilitation by the municipalities requires integrated care and improvement of services for the patients, not at least for the older people. That should mean for instance locally organized and provided services responding to the needs for common preventive and curative services for the population or a new role for smaller hospitals.

With regard to the challenges facing the provision of social services to older people and people with disabilities, the shortage of skilled personnel in the municipal sector is the most important.

Examples of development projects in Sweden

Several county councils initiated *reform projects* in the early 2000s focusing on the development of community services. In 2004, Stockholm County Council (which is responsible for health care services) and the Norrtalje local authority (which is responsible for social care) formed a joined governing committee that is responsible for health and social care for the Norrtalje population (Goodwin et al. 2014).

The governing committee owns and steers a public company that is responsible for purchasing delivering care. The model is characterized by: funding responsibilities for a single population; increased focus on health promotion for the population; common integrated health and social care organization to achieve greater patient and user benefit. There is an emphasis on using case managers and on developing pathways and plans around transitions in and out of hospitals, from nursing homes to hospital.

The objectives of the case study were 1) to support older people to remain in own home, 2) to improve care continuity, quality of life and feeling security, 3) to improve quality of care for people with dementia and at end of life. The target population was older people with complex health and social needs.

In Norrtalje, there was purchaser-provider organization, contract from county council and local authority. The breadth of integration was both vertical (hospital-home) and horizontal (home care). The degree of integration was

fully integrated social and health care provider with integrated funding. Information management was limited (joint medical documentation, moving toward shared records in future).

Providers were specific multidisciplinary teams for home care, home care workers, district nurses and chief physician. The care plan was made and home care workers were care or case managers. Self-management support in home care was essential, but there was not telecare. By home based care the focus was on supporting informal carers.

Primary care physicians worked for and on behalf of the integrated health and social care provider and were integral to the care provided to older people locally. A single chief physician supported a home care service.

As results, information and communication improved among professionals, and access to care was easier and faster.

Nursing home placements among older people reduced. There were lower costs per user for home care than in similar municipalities.

As assigned by the government, the Swedish Association of Local Authorities and Regions (SALAR) has carried out *19 development projects* to improve the care of elderly persons with multiple illnesses in recent years (the Swedish National Board of Health and Welfare (Socialstyrelsen) 2014). Some of these trial operations have utilized scientific methods. The projects have been used to search 1) new organizational models between primary health care, home care and elderly care and 2) suggestions for improving existing practices.

Projects combining staff operating in short-term care providers of different operational fields are worth mentioning as examples of the new organizational models. These projects enabled efficient use of human resources and secured the continuity of care to patients. This integration improved communication and cooperation between staff. The structure of care strategies also improved the level of plans, and the elderly received help sooner.

Different team models have also been developed in the projects. For instance, patients who had returned from a hospital and their family members were

given an opportunity to contact a geriatric team around the clock for 6-8 weeks after hospital discharge. The projects also tested using mobile teams (doctor and nurses), which helped assessing the conditions of elderly persons in home care during home visits and referring them directly to a suitable care unit if necessary. The team members also offered support to home nurses.

Care practices were also improved in the projects without implementing organizational changes. For instance, an individual, integrated electronic care plan was employed and a person was named in charge of coordinating care. The trials also included arranging telephone conferences and regular team meetings, which strengthened team work.

Many of these experiments focused on the patients' transitions from home to hospital care and from the hospital back to home. The aim was to assess situations carefully, e.g., during visits to a nurse or home visits, in order to avoid unnecessary hospital admission.

3.4 Norway

In Norway, the health care system is semi-decentralized. The Ministry of Health and Care Services determines the national health policy, prepares legislation and decides the allocation of funds within the health sector. Addressing social inequalities in health, improving resource allocation and strengthening the role of patients have become more important over the past few years. (Ringard et al. 2013.)

The responsibility for primary care lies with the municipalities. General practitioners act as gatekeepers, referring patients to more complex care. Regarding elective care, the regular GP either makes an appropriate appointment for the patient or provides a referral so that the patient can arrange his or her own appointment. Despite the right ratios of health-care professionals to the size of population, waiting times for elective care are long and cause dissatisfaction among the patients. Municipalities are responsible for provision rehabilitation, physiotherapy and nursing and after hours emergency services.

At the primary care level emergency or acute primary care services are provided by regular GPs and on-call GPs supported by telephone services. They are often organized jointly in an emergency ward at one local hospital. In very sparsely populated areas, pre-hospital EMS may be provided within municipal home nursing facilities with the support of telemedicine. In urban areas there are designated emergency wards by the municipality. Accident and emergency departments (AEDs) are hospital departments where emergency cases are received. They exist in all hospitals that provide emergency care.

The responsibility for ambulance services rests with the RHAs. Increased specialization of ambulance staff is needed, but there are no national requirements for education.

Long-term care (LTC) is provided in three types of settings – patients' homes, nursing homes or sheltered homes – by the municipalities, and it is often administratively integrated with health and social services at the local level (Department of Health and Social Care). These departments have a high degree of freedom in deciding how LTC services should be organized. The goal is that people could stay in their own homes as long as possible. There are for instance short-term rehabilitation departments within the nursing homes where patients can stay after a hospital discharge. In addition, there are elderly day-care centres within nursing homes. However, there is currently a shortage of adequate trained staff. If a person wants to be an informal carer for a close relative, he or she may be paid for the care work at home by the municipality.

The responsibility for specialist care lies with the state (administered by four Regional Health Authorities, RHAs). The RHAs own health trusts, currently 27. Inpatient specialized care – including both somatic and mental health and specialized rehabilitation – are mainly provided by hospital trusts. Hospitals also provide outpatient specialist care.

All RHSs and most municipalities have established designated coordination units in the rehabilitation. The specialist care sector also has a guiding role towards municipal health services. In some areas – for example in geriatric care – specialist mobile teams have been established by the hospitals. They

provide guidance and care to patients at home or in other settings within the community.

At the municipal level, further developments are needed:

1) Introduction of a more binding cooperation between the GPs and the municipalities in order to encourage GPs to assume greater responsibility for services provided to patients
2) Expanding of home care services
3) Both decentralized (groups with chronic diseases) and centralized (technologically advanced treatments)models will be considered
4) The education of health care professionals will have to be adapted to the requirements of the coordination reforms (more process oriented approach, the development of expertise of coordination, a focus on user participation and more emphasis on topics such as preventive care and public health efforts)

3.5 Denmark

In Denmark, the major structural reform of 2007 changed the health system by creating larger municipalities and regions and redistributing tasks and responsibilities (Olejaz et al. 2012). After the reform, *the state* has responsibility for the overall regulatory and supervisory functions, but also for more specific planning activities. *The five regions* are responsible for hospitals as well as for self-employed health care professionals. *The municipalities* (98) are responsible for disease prevention and health promotion.

The five regions are governed by the councils and they are financed by the state and the municipalities. The regions own hospitals and finance GPs, specialists, physiotherapists and others. The GPs act as gatekeepers, referring patients to hospital and specialist treatment. Each region can determine the size, content and costs of hospital activities trough detailed budgets. However, patients can choose treatment in other regions. According to a national study patients prefer treatment close to their place of residence (Birk & Henriksen 2003). Patients, who are not offered treatment at public hospitals within one

month, are free to choose treatment at private hospitals anywhere in the country.

Most public hospitals are general hospitals with different specialization levels. Hospitals have both inpatient and outpatient clinics as well as 24-hours emergency wards. Patients may consult emergency wards without prior referral from GP.

If the patient is in need of rehabilitation, this is established and assessed whether there is a need for additional home care. GPs receive a discharge summary for each patient from the hospital and are responsible for further follow-up. Rehabilitation is provided free of charge at hospitals and in the municipalities. Municipalities offer different kinds of rehabilitation setting: training in the patient's home, in a care centre or in municipality rehabilitation centres. Some municipalities have also an agreement with the regions to provide rehabilitation services as a partnership with joint financing. This type of partnership enables service provision in a professional environment with a group of competent professional. Rehabilitation takes place in both the social and the health sector and therefore there is a guide on rehabilitation for the municipalities published inter alia by the Ministry of Health and the Ministry of Social Affairs and Integration.

The primary sector consists of private (self-employed) practitioners (GPs, specialists, physiotherapists) and municipal health services, such as nursing homes, home nurses and health visitors. Danish municipalities are required by law to offer the preventive home visits to all citizens aged 75 and older twice a year. Home visits are usually carried out by trained nurses who offer advice and support on health and social issues. GPs have also an important role as the first point of contact for patients. Free access to private specialist requires a referral from a GP.

Nursing homes are actually categorized as a social service and, are part of the social and not the health administration. Nursing homes provide both day care and residential services. Nursing home inhabitants are individually registered by a GP. Nursing homes and protected housing are financed by their inhabitants.

It is possible for many chronically ill patients to stay in their homes because of the combination of day care services, an increased number of home nurses, and extensive home help and GP support. Municipalities have developed a wide range of services for older people. These services include care and assistance with cleaning, shopping, washing, the preparation of meals and personal hygiene. Home care can be used to relieve family members for a sick or disabled person. Home care can be either long-term or temporary. Home nurses offer day and night services, and ill individuals can have an emergency or safety phone system installed in their home that provides them 24-hours contact to their public health nurse.

Public services for patients with mental disorders are provided through cross-sectoral collaboration between the health and social care sectors. The regions are responsible for psychiatric health care services, and the municipalities are responsible for the social psychiatric institutions, which are still managed by the regions but financed by the municipalities.

In the Danish health system, patient pathways are criticized for not being coherent, particularly across primary/secondary care. The lack of continuity in patient pathways is often attributed to lack of mutual understanding between providers and inadequate communication systems. In order to strengthen *the coordination* between primary care, secondary care and the municipal services for the chronically ill, the National Board of Health launched a national strategy on chronic disease management and developed a generic model for chronic disease management programmes together with regions and the municipalities.

The described patient pathway in general does not differ across the five Danish regions. The only difference that can be observed is that open emergency wards at hospitals only exist in the large cities. Outside the large cities, minor trauma and acute illness are treated by GPs on emergency call.

3.6 Finland

In Finland, the health care system is decentralized. Municipalities can decide how they organize services. There are three different health care systems, which receive public funding: municipal health care, private health care and occupational system. There is National Health Insurance financing based on compulsory insurance fees and different public financing taxes. (Vuorenkoski 2008.)

Municipal health care is accessible for all permanent residents of the community. Patients can choose their health centre in their own municipality of residence. If the physician in the health centre assesses the need of secondary health services the patient is referred to secondary care in the hospital district. If the discharged patient cannot be transferred home, the patient is taken to the inpatient ward of the health centre. The municipality provides also suitable home care.

There is a wide selection of various health professionals in health centres: GPs, practical nurses, nurses, public health nurses, social workers, physiotherapists etc. GPs provide office-based general medical care, consultation at municipal nursing homes. Physicians and nurses form a team that is responsible for the care of geographically defined area.

Secondary care is provided by the municipality-owned hospital district (currently 20). Each hospital district has a central hospital and depending on the size of the hospital district, other needed hospitals. Five of central hospitals are university hospitals. Primary and secondary care are not always well coordinated. The issue of continuity of care has often been expressed as a seamless chain of care.

In this year, the government parties and the opposition parties have agreed on the implementation of a new social welfare and health care reform. The aim of the reform is to provide seamless and integrated service chains of key welfare and health care services. All social and health care services will be organized by five regional providers (running as of 2017). Both primary and specialized services will be under the same administration and budget. A new administrative model will be a joint municipal authority. Their funding for the regions will be provided by the municipalities. The municipalities will continue

to participate in the provision of services. Local service including health centres, home services for the elderly and social welfare services will still be provided close to home. (Ministry of Social Affairs and Health 2014a.)

The National Development Programme for Social Welfare and Health Care (Kaste) of the Ministry of Social Affairs and Health, confirmed once every four years, has the purpose of renewing Finnish social and health policy. The aim of the programme is to narrow disparities in health and well-being and to organize social and health care structures and services that accommodate customer views. The programmes for the periods of 2008-2011 and 2012-2015 both include sub-programmes for revising the structures and contents of elderly care services.(Ministry of Social Affairs and Health. 2014b.)

The "Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons" (980/2012), hereby referred to as the Elderly Care Service Act, came into effect last year. The act is meant to support the well-being, health, functional ability and independent management of older population. The purpose of the act is to offer aged population a timely and sufficient access to high-quality social and health care services. Municipalities are required to formulate strategies to organize these services and they must establish elderly councils to ensure that older population can impact decision making.

Municipalities must offer consultation services to elderly people and their close relatives and support independent living and management of the elderly by offering health check-ups, appointments and home visits. Individual service needs must be determined immediately as a person seeks evaluation of need for social services, or, if he or she is already a customer of social and health care services, once there has been a significant change in his or her condition. In order to answer to service demands, a *care and service plan* must be formulated in cooperation with social and health care experts and the elderly person and their close relatives. The views of the elderly person must also be reported in the plan. Moreover, if there are many coordinated services and the elderly person needs help in systematizing them, a professional *person in change* must be appointed to handle this task. The follow-up, revision and

evaluation of the realization of the plan are carried out in unison among those involved in drawing up the plan.

According to the act, services offered to homes and home-like living arrangements are also the primary selections when organizing long-term care, and institutionalized care in health centre wards or elderly care homes are only rarely considered alternatives for care. The stability of care arrangement is a guiding principle and, for instance, elderly couples must be offered the possibility to live together. A family caregiver agreement can also be formulated when organizing care at home. (Ministry of Social Affairs and Health, Association of Finnish Local and Regional Authorities 2013.)

Government-funded implementation projects founded according to the Elderly Care Service Act focus on, e.g., improving the premises for elderly people living at home by goal-oriented guidance and service instruction, offering customer-oriented resourcing for the realization of self-directed and effortless everyday life, constructing cooperation networks between those working with the elderly, including close relatives and the elderly people themselves in service development, and enforcing involvement in planning one's own care and in using electronic services.

Development of chronic care and elderly care in Finland

Finland was a very rural country until late in the 1950-60's. Families lived in small farms. This was accentuated by the need to relocate the population of one South-Eastern county (Karelia) as an outcome of the two wars in 1939-40 and 1941-1944.

The 1970's speeded the structural changes in economic life. Young people moved away from rural areas in search for better employment opportunities to cities of Southern Finland. Women took full time employment outside the home or home farms.

Older people stayed usually in their original homes. Many were left without local connections with the members of their immediate family.

During the same time period, Finland had a sad map of an epidemiological burden of diseases typical of that time: cardiovascular diseases, stroke, COPD, depression, muscular-skeletal disorders and also dementia, although diseases leading to dementia were not identified appropriately. This all resulted in growing pressures for both acute and long-term hospital care.

All these developments lead into Finland becoming one of the leading countries in the rate of placing older people with chronic illnesses to long-term institutional care. There were several pathways to this, at least the following should be mentioned

1) Homes for the elderly were modernized and they became places of better quality of life to many, as compared to the remote homes often without the modern facilities and conveniences
2) Psychiatric hospitals were the main pathway of care for old people with psycho-neurological confusion. This often led into neglect of necessary diagnostics and rehabilitation. Instead, old people were often over-medicated by psychotropic drugs. This was often a firm start of passive life in an old-fashioned institution at a stage when there would have been alternatives and pathways to recovery
3) Acute specialist hospitals reported large numbers of older people having become ”bed-blockers”; in other words patients who have received the medical care conceivable but who are not able to return home and who do not have alternative places for care. This lead the government into giving strong imperatives and incentives to building long-term care capacity

Towards less institutional care

Being a leading country in placing citizens into long term institutional care was obviously deeply rooted in the culture and in the public opinion of what constitutes good care. It took a special nationwide project, “Palvelurakenneuudistus” during the first half of the 1990’s to get public support and political acceptance to structural changes. The structural changes

were most profound in psychiatric services, where long term hospital stay was radically reduced and replaced by assisted living in small service homes or even by living in rental apartments with daytime support available when needed. This reform meant also the beginning of dismantling large regional institutions to individuals with learning disabilities. The new alternatives were service home arrangements for a large proportion of the former clients of the institutions. In the services for the elderly, the flagship development was replacement of older facilities under the name of “old people’s homes” with assisted living arrangements. The same replacement started to carve into the capacity of long term care in the health centre hospitals, which had turned into long term care institutions that would in many other countries be called nursing homes; about 70 % of the bed capacity was being used for long term care at the highest peak.

The reform led into fundamental changes in the statistics of long term care. About 8000 long term beds disappeared from the statistics. Simultaneously, the number of clients in 24/7 assisted living units grew from almost level zero to over 20000 in a short period of transition. All growth of capacity now takes place in the provision of this particular service, which has a clumsy name in Finnish – literally translated “instensified service home living”, where the term intensified refers mainly to the presence of paid staff in the premises at all times.

Service home living

The main driver for this transition was in the difference of funding arrangements. If an old person lives in an institution, either “old people’s home” or in the chronic care ward of the health center hospital, the local municipalities are obliged to cover the total costs of the service minus the user charges that are levied to the users on a means tested basis. A typical full service day could cost in 2014 between 120 to 180 euros, resulting in monthly costs between 3600 and 5400 euros. The means tested user charges could cover up to 80 % of the total costs, but this would be possible for only a small

fraction of older people with high pensions. The current generations of older people, born typically in the 1920-30'ies did not earn such pensions even after a long career in working life. The local municipality pays the difference, which can be tens of thousands of euros per month.

Simultaneously, on the other side of the line, in "intensified service home living", the client is expected to pay rent, pay for food, medicines and cleaning and for variable packages of personal services needed. The clients are often eligible for subsistence to rental costs and prescription medicines paid by the National Sickness Insurance. As all costs run through the budget of the client, also family members have their incentive to help with daily activities in order to control the service fee costs. In other words, the service is not very different from what the traditional institutional care offers, but the shares of the various payers are different, and the local municipalities have been keen to organize service home living.

One special feature of intensified service home living is that most of the clients, perhaps more than 90 %, have become clients of this service because they have a significant cognitive impairment, typically Alzheimer's disease. In other words, they have been moved from institutional care to more independent living without really being capable of taking care of themselves.

This replacement of one type of care with another type not very different has captured much attention and resources. Therefore, many critics will still say that development of care that is actually given at home or on an outpatient basis has not been as rapid and radical as it should have.

Home care

In home care, there were for historical development reasons, two parallel sectors and types of service. The social services provided "home help", and the primary health care centers provided home nursing in the sense that this service took special care of health problems, care of chronic illnesses,

medications etc. There were times in the 1980-90'ies when the same household of one or two older people could be served by two separate sets of service providers in different "uniforms" and administrative roofs. This was thought to be wasteful duplication of service. In order to get rid of duplication and the inefficiency it meant, several measures were commonly taken:

- Home help and home nursing were administratively placed under one roof of *home care*
- Joint teams were formed out of the different professionals with different trainings and task profiles
- A new basic training track was created to train professionals called "lähihoitaja", which literally translated means a nurse who works near to you, and takes care of the most concrete needs related to everyday needs, social needs and health needs, for example medication, insulin injections, treatment of leg ulcers etc.
- The two services started using shared information systems that have links to the primary health care records.

The role of legislation and other binding norms

One dilemma in the Finnish services for older people is the question of what level of human resources is needed for the core services. If the number of staff in institutional care or assisted living homes is too low in relation to the number of clients, the service becomes hasty and thin. There have been reports of unacceptable failures to attend everyday needs for hygiene, nutrition or physical activity instead of being restrained in bed or a chair. In home care, the shortage of staff may be seen in shortening of the contacts at home, in splitting the activities by the type so that one service slips in the meals, another enterprise takes care of laundry, another takes the clients to shower and toilet as a part of a routine round.

Currently, the good standard is presented and published as recommendation of good practice. This has obviously improved the overall quality by decreasing the occurrence of examples of truly bad practice. However, the worker's unions and NGOs argue that too often the organizers and payers of services insist on using the bare minimum of staff.

Examples of development projects in Finland

POTKU project

Services answering to the demands of persons with long-term illnesses have been developed in Finland according to the Chronic Care Model in the POTKU project of the Kaste programme. The project has the aim of supporting patients' involvement in planning and realizing their care. The initial phase of the project was realized between 2010 and 2012 and the second between 2012 and 2014. 61 municipalities were involved in the development activities.(Potku 2 project 2014.)

The project has included development work in all of the subsections of the Health Benefit Model (Figure 2). According to the model, *self-management* is perceived as care that is carried out by the patient in accordance with a care plan drawn up together with a health professional based on evidence-based knowledge best suited to their situation. In other words, the patient has the main responsibility for their care. Motivating interviews and peer groups have been realized as interaction models supporting self-care, and information systems have been made available for customers.

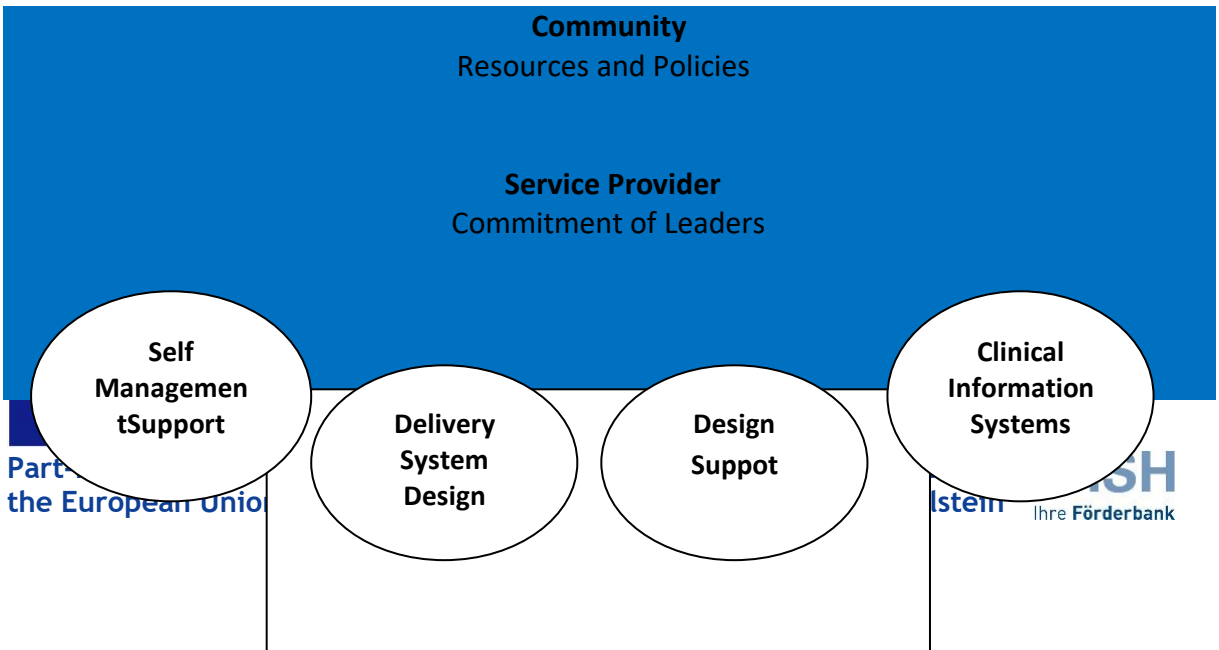
The competences of several different professional groups and a wider *array of services* are needed for preventing and treating chronic illnesses, meaning that offering mere doctor's appointments as care do not suffice. In addition to regular appointments, group appointments have been organized, telephone and online contacts have been developed, and invitation and reminder systems have been utilized.

Case managers are responsible for realizing and coordinating the care of those who need it most. The case manager operational model takes into account patients' overall situation, including their possible need for social services. A case manager begins the process of formulating a care plan and supports the patient in formulating it with a physician. Careful planning of follow-up appointments is an essential part of the realization of care. The case manager model has been applied in both home care and more extensively in the cooperation between primary health care, home care, and specialized nursing.

Decision-making between professionals and patients should be founded on scientific evidence. Measurement data collected through patient care is used to develop treatment. Patients' decision-making can be supported by, e.g., the patient versions of the Current Care Guidelines or Terveysportti ('Health Gate') websites.

An electronic patient record system and the standardization of data recording practices enable the efficient use of *clinical information systems*. The systems allow it to recognize patients using a large number and variety of services and persons with high total risk scores.

The involvement of *the management of service providers* and *the policies and resources of other communities* also have an important effect on care results. In the project, structures of leadership in transition have been developed and multiprofessional education and development plans have been formulated based on the goals of the health benefit model.



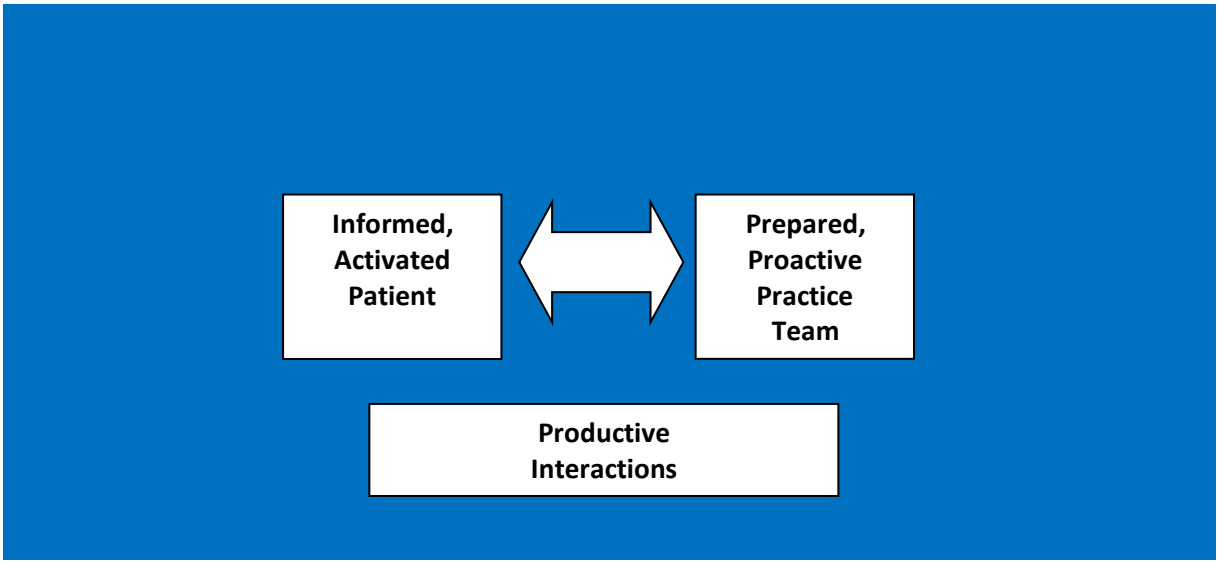


Figure 2. The “Health Benefit Model”

Campus living for senior citizens -project

A report (MSH 2010) by the Ikähoiva (‘Aged Care’) work group set up by the Ministry of Social Affairs and Health brought up suggestions for changing the structures connected to the organization of around-the-clock care for elderly persons. The proposals for changes were founded on the right to live at home and to receive services needed for sustaining functional ability and health. Institutionalized care should be replaced by non-institutionalized living arrangements, i.e., different intermediate residential alternatives.

In effect, service areas have been planned all around Finland to offer different living arrangements to suit different requirements of elderly citizens, such as private apartments, senior homes and group homes, and activities to promote functional ability, health and well-being. In other words, the service areas combine anticipatory actions, possibility for around-the-clock care, and availability of consultation services. The areas broadly apply security and monitoring technology (Tarkiainen 2010).

4 Conclusions

This report described organizing social and health care services especially to older patients with multiple diseases in Sweden, Norway, Denmark and Finland. The operations models from the UK and the Netherlands were included to function as examples of future-oriented viewpoints.

There are similarities in the challenges faced by the examined countries in the future. The countries share questions of integration on different levels and the sufficiency and appropriate targeting of workforce with required expertise. In *Sweden*, questions of dividing responsibilities between municipalities and counties require the development of cooperation in order to guarantee functional service chains. The operations of different teams, electronic care strategy, and the transitory stages of the treatment chain are central development targets. In *Norway*, cooperation with general practitioners and municipalities, expansion of home care, and training staff to be active in preventive operations that are in line with the process have emerged as development targets. The solutions carried out to promote the rehabilitation

of the elderly create a strong foundation for development work. In *Denmark*, the aim is also to enforce coherency of care chains. Preventive home visits have been found useful in predicting service needs. In *Finland*, development activities have been, and will continue to be, conducted in all of the subareas of the Health Benefit Model. Future challenges will include the functionality of service processes in keeping with the social and health care service reform, more efficient utilization of electronic information systems, and questions connected to living arrangement solutions for elderly persons. It is important that the elderly person and their close relatives are equal participants in care planning and get all the support they need for making decisions. In order to make this possible, each elderly person with multiple conditions should be assigned a person in charge of care coordination.

References

Anell A, Glenngård AH & Merkur S. 2012. Sweden. Health system review.Health Systems in Transition Vol. 14 No. 5. European Oservatory on Health Systems and Policies.

Barceló A, Epping-Jordan JA, Ordunez P et al. 2013. Innovative Care for Chronic Conditions. Organizing and Delivering High Quality Care for Chronic Noncommunicable Diseases in Americas. Pan American Health Organization.

Finlex. 2012. The Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012.

Goodwin N, Dixon A, Anderson G & Wodchis W. 2014. Providing integrated care for older people with complex needs. Lessons from seven international case studies. King's Fund.

Ham C, Dixon A & Brooke B. 2012. Transforming the delivery of health and social care. The case for fundamental change. The King's Fund.

Ham C & Walsh. 2014. Making integrated care happen at scale and pace. The King's Fund.

Jadad AR, Cabrera A, Martos F et al. 2010. When people live with multiple cgronic diseases: a collaborative approach to an emerging global challenge. Cranada: Andalusian School of Public Health.

Ministry of Social Affairs and Health. 2014a. Social welfare and health care reform. http://www.stm.fi/en/ministry/strategies/service_structures

Ministry of Social Affairs and Health. 2014b. National Development Programme for Social Welfare and Health Care. http://www.stm.fi/vireilla/kehittamisohjelmat_ja_hankkeet/kaste

Ministry of Social Affairs and Health, Association of Finnish Local and Regional Authorities. 2013. "Vanhuspalvelulaki" - Muistio lain toimeenpanon ja tulkinnan tueksi.

National Board of Health and Welfare (Socialstyrelsen). 2014. Försöksverksamheter och samverkansnätverk för de mest sjuka äldre. Slutrapport från utvärderingen.

Nolte E & McKee M. 2008. Caring for people with chronic conditions. A health system perspective. European Observatory on Health Systems and Policies Series.

Olejaz M, Nielsen AJ, Rudkjøbing A at al. 2012. Denmark. Health system review. Health Systems in Transition Vol. 14 No. 2. European Oservatory on Health Systems and Policies.

Oliver D, Foot C & Humphries R. 2014. Making our health and care systems fit for an ageing population. The King's Fund.

Potku 2 project. 2014. http://www.potkuhanke.fi/

Powell S & Tahan H. 2008. CMSA© core curriculum for case management. Philadelphia: Lippincott Williams & Wilkins.

Ringard Å, Sagan A, Sperre Saunes I & Lindahl AK. 2013. Norway. Health system review. Health Systems in Transition Vol. 15 No. 8. European Oservatory on Health Systems and Policies.

Schäfer W, Kroneman M, Boerma W et al. 2010. The Netherlands. Health system review. Vol. 12 No. 1. European Oservatory on Health Systems and Policies.

Sonola L, Thiel V, Goodwin N & Kodner DL. 2013. Oxleas Advanced Dementia Service. Supporting carers and building resilience. The King's Fund.

Tarkiainen A. 2010. Ikäihminen välissä? Vanhusten asumisen uudet ratkaisut ja asumisen varhainen tuki -hanke 2008–2010. Selvitys ikäihmisten välimuotoisista ratkaisuista Itä- ja Keski-Suomen Vanhus-Kasteen alueella. Joensuun kaupunki.

Vuorenkoski L. 2008. Finland. Health system review. Health Systems in Transition Vol. 10 No. 4. European Oservatory on Health Systems and Policies.

Wagner EH. 1998. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice 1(1), 2-4.

World Health Organization. 2003. Innovative Care for Chronic Conditions: Building Blocks for Action. Geneva: World Health Organization.