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Quality and cost-effectiveness in long-term care and dependency prevention



POLICY BRIEF

Long-term care policy in Finland

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INTRODUCTION

This policy brief summarizes recent and emerging policy developments in Finland related to long-term care (LTC) provision. We also summarize some scientific evidence related to the impact of care integration on the quality and costs of long-term care in Finland. Finally, this policy brief shortly describes the ongoing health and social care reform which is expected to have wide-ranging consequences for the organization of long-term care provision in Finland.

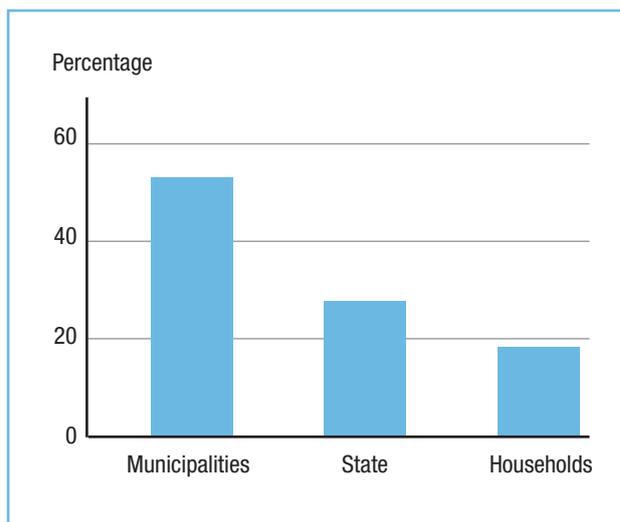
THE FINNISH LTC SYSTEM

The Finnish LTC services are part of the universal health and social care system which provides services to all citizens in need of care. In the current Finnish system, responsibility to provide adequate LTC services falls upon municipalities. In practice, municipalities can provide these services through own service production, in cooperation with other municipalities, or purchase the services from the state, other municipalities or from private providers. Municipalities may also grant vouchers to service users, who can use these vouchers to purchase services from preferred private providers.

The two most important funding sources of long-term care in Finland are the state government subsidies and municipal taxation (Figure 1). The state government allocates state subsidies to municipalities. These state subsidies are typically not earmarked. Thus, municipalities have a large discretionary power to finance the provision of health and social care services through the returns from municipal taxation, state subsidies and user fees. The maximum user fees that municipalities can charge are regulated by decree. The maximum user fees are generally means-tested and home care fees depend on the size of the household to which the service user belongs.

Quality recommendations on old age care have been issued in Finland in 2001, 2008 and 2013 by the Ministry of Social Affairs and Health and the

Figure 1: Funding sources of long-term care in Finland



Source: Seppälä and Pekurinen, 2014.

Association of Finnish Local and Reginal Authorities. They aim at ensuring both healthy and capable ageing and effective and high-quality services for the older population (Sosiaali- ja terveystieteiden tutkimuskeskus ja Kuntaliitto, 2013). Recommendations are wide-ranging and relate to inclusion, living environment, securing healthy and capable ageing, quality and coverage of services, on personnel, informal care and management. For example, it is recommended that 91–92 per cent of the population older than 75 years should live in their own homes and 2–3 per cent of the population in the same age group should be in institutional care by 2017 in Finland.

POLICIES TO SUPPORT INFORMAL CARE

Policy measures supporting informal care in Finland have been targeted to develop informal care support, which is a formal social service to support informal caregivers and cared-for persons. It consists of the caregiver's allowance, care leave and services provided for both the compensated informal caregiver and cared-for person. The provision of the service is steered by the law on informal care support (Laki omaishoidon tuesta,

937/2005) which was introduced in 2006 to remedy concurrent deficiencies in the community care. The law dictates about the eligibility to the informal care support, caregiver's allowances, care leaves, municipalities' responsibilities to arrange respite care, about care plans and contracts between compensated informal carers and municipalities.

The law on informal care support was reformed in 2016 to include physical examinations, education and training for caregivers. The law enacted in 2016 also extends care leaves to at least two days a month for all compensated informal carers (HE 85/2016). In case of demanding and binding care duties, compensated informal carers are eligible to three days of care leave a month. The government bill (HE 85/2016) evaluated that the cost of the reform would cost Finnish municipalities €90 million in 2017, but that savings due to the reduced use of formal services would outweigh the costs. Although the existence of the substitution effect might be realistic, the magnitude of savings hinges on how much the 2016 reform will increase the provision of compensated informal care in Finland.

PREVENTION

Primary prevention which seeks to prevent the onset of important chronic health conditions by risk reduction has been a prominent health policy focus during the last few decades in Finland. Preventive healthcare typically has more general aims than the prevention of institutionalized long-term care, but coincides with the policy aim to support independent living among older people and reduce the use of institutionalized long-term care services. The implicit assumption is that investments in preventive healthcare and services will promote health and reduce dependence in the long-term.

The preventive health care in Finland is directed and guided by the Ministry of Health and Social Affairs. However, the implementation of health promotion programs is a municipal level responsibility.

Municipalities, in turn, often collaborate with non-governmental organizations which are funded through the state owned gaming monopoly and membership fees. The large number of organizations that are quite independent from the governmental guidance and their non-governmental nature makes the preventive health care system agile to react to arising health and social concerns, but at the same time leads to fragmentation and short-lived project-based prevention with little evidence about the effectiveness of these preventive care models. A non-exhaustive list of preventive care programs targeting elderly population includes preventive projects to curb alcohol consumption among the elderly, to prevent downfalls and broken hips among the elderly, to increase physical capacity and to offer life-style counseling

The need for institutionalized long-term care in Finland is strongly associated with Alzheimer's disease. It has been estimated that 80 percent of the elderly people living requiring institutionalized care have Alzheimer's disease (Einiö, 2010). Despite the increasing emphasis on preventive care and clear policy targets for the proportion of people aged 75 and over living at home, there is a serious lack of reliable evidence about the costs and effectiveness of alternative preventive care programs and models.

A notable exception to the sparse evidence about the effectiveness of prevention among the elderly is provided by the Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER). In contrast to the results from many single domain prevention trials, this study investigates the effectiveness of a multi domain approach including nutritional guidance, physical exercise and cognitive training. The results from this two-year randomized controlled trial suggest that multicomponent interventions could improve or maintain cognitive functioning in at-risk elderly people from the general population (Ngandu et al., 2015).

TECHNOLOGY TO IMPROVE OUTCOMES OF THE ELDERLY

The use of modern welfare technology is still quite modest among the elderly in Finland. The most common technological solutions are panic alarm phones and devices to help walk and hear, but more advanced technology, like ICT technology, is still in limited use among the elderly clients. This has not stopped the technological solutions to assist the elderly to cope with their LTC needs. Over the past 20 years, more than 50 development projects have developed welfare technology for the elderly in Finland.

Besides the decree to grant assistive devices for disabled individuals, laws dictating the use of LTC services are silent about the use of welfare technology. Quality recommendations, however, take a clear stand on the use of technology. According to quality recommendations, physical liberty is a pre-requisite for social inclusion and access to cultural and social and health care services and, moreover, physical liberty can be supported by assistive devices and physical arrangements helping older people to move (e.g. ramps and walkers) and hear (e.g. hearing aids). This has developed into the local policies where municipalities often provide assistive devices supporting independent living of the elderly.

CARE INTEGRATION AND THE 2019 REFORM

Integration of health and social care services for the elderly has taken place in Finland particularly in home care services. Integration of home care has been viewed as an instrument to increase the possibilities for independent living of the elderly. Integration on home services (social care) and home health care (health care) started in the beginning of the 1990s. The process has gradually continued in the Finnish municipalities until now and it has taken place in parallel with a trend to integrate health and social care more generally. One important step in this process was the 2004 temporary law on the

structural integration of health and social care (HE 221/2004), which removed the final legal obstacles to integrate home services and home health care into home care.

The Finnish research literature aiming to evaluate the impact of coordinated/integrated care provision includes mostly descriptive analyses based on stakeholder interviews and questionnaire studies conducted among care-givers and patients. The literature on long-term care largely focuses on documenting patients' and their relatives' perceptions about the quality of long-term care overall with some notable exceptions aiming to understand the consequences of policy changes towards more coordinated care provision. There is hardly any evidence about the cost-effectiveness of implemented coordination policies.

The most common practice aiming to increase care coordination is structural integration where municipal home care units are organizationally merged with health and welfare departments. Based on available evaluations, the care coordination has led to more integrated management processes with some potential impact on actual care-taking practices or quality of care among home-dwelling and institutionalized patients.

Paljärvi et al. (2011) find that homecare quality has remained largely at the same level between the years 1994 and 2009, despite organizational mergers in health and social care service production. Overall, many of the questionnaire based evaluations assessing the quality of integrated care provision in Finland do not focus on the consequences of integrated practices but aim to identify the most critical factors contributing to the perceived quality of care. Across the published studies, the most common concern among the long-term care patients seems to be the haste associated with care-giving and high turnover of care-givers.

The more convincing evidence about the impact of coordinated care provision comes from three randomized controlled trials (RCTs) which aim to

evaluate the consequences of certain aspects of coordinated care provision. However, these RCTs focus on the effectiveness of coordinated care provision in relatively specific domains and patient groups. Kinnunen (2002) investigates the effectiveness and costs of individually planned and intensified packages of health and social care on patient institutionalization. The study finds that the need for institutionalized long-term care was significantly lower in the treatment group than in the control group during a two-year follow-up period (41% of the patients in the intervention group and 64% in the control group had ended up into long-term institutionalized care within the two years after the initiation of the trial). However, the initial difference between the treatment and control groups vanished during the post-trial follow-up. There was no effect on mortality.

Hammar et al. (2009) report results from a cluster randomized trial aiming to investigate the effects of integrated home care and discharge practice on the functional ability and health-related quality of life of home care patients. The aim of the integrated practice was to increase the coordination of care and make written agreements between the hospitals and home care units. The study does not find differences in functional ability or health-related quality between the intervention and control groups. However, the care-givers involved in the study reported that the intervention helped to standardize and integrate care provision.

Eloniemi-Sulkava et al. (2009) investigate the effectiveness of a multicomponent care coordination intervention where dementia patients living at home with their couples are provided a family care coordinator, a geriatrician, support groups for caregivers, and individualized services. The study finds that a larger proportion of patients in the control group were in long-term institutional care than in the treatment group at 1.6 years after the initialization of the care coordination. However, there difference was statistically not significant after two years after the commencing of the care coordination program. There is some evidence based on the

study that a tailored coordinated care program for dementia patients may lead to cost savings due to delayed transition into long-term institutional care and fewer days spent in acute hospital care.

Overall, the Finnish long-term care policies have witnessed many changes during the last decade. The effectiveness and economic consequences of these system wide changes in care provision have not been systematically evaluated. However, existing longitudinal studies report that the quality of long-term care has not changed during the last decade. Despite the relatively widely spread public skepticism about the quality of long-term care and publicity of some prominent and widely reported problems in care provision, the quality of care, as measured using questionnaires among the patients and care-givers, has stayed on satisfactory level over the years. The most common concern among the long-term care patients seems to be the haste associated with care-giving and high turnover of care-givers (Tepponen, 2009).

The most recent activities to integrate and coordinate services for the elderly are taking place as part of the current health and social care reform planned to be implement at the beginning of 2019. According to the planned reform, responsibility for providing health care and social services will be assigned to 18 autonomous regions instead of 311 independent municipalities. In the projected service system, regions (or counties) are responsible for organizing and integrating health and social care services provided for clients into larger wholes and coordinating with municipalities, state government and other services providers at regions. At the same time, the existing multisource financing of healthcare and social welfare is planned to be simplified as part of the reform package. In addition to integrated services and reformed finance, another central tenet of the reform is to increase patients' freedom to choose their preferred care provider and encourage progression towards a multi-provider model where private and third sector services will increasingly be available in addition to public sector health and social services.

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