interlinks

Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Governance and financing of long-term care for older people

National Report Finland

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1 Key contextual factors

In Finland long-term care for older people is provided in four major settings: home care; sheltered housing; residential homes; and health centre inpatient wards. In 2008 about 90% of those aged 75+ lived at home either independently or assisted; 11% received regular home care and 4% received informal home care allowance. Of the institutionalized elderly population 4% lived in 24-hour sheltered housing, 4% in residential homes and 2% were treated in long-term care of health centre inpatient wards.

Increasing the number of older people living independently in their own homes and promoting access to home-based care services have long been among the government's main strategic health policy goals (see Overview 1). These goals are motivated by factors relating both to financial sustainability and ensuring agreeable living conditions for the elderly population. Home-based care is believed to promote better quality of life as well as cost savings by avoiding expensive institutional care. Another critical factor relates to the rapid ageing of the population, and the subsequent weakening of the old-age dependency ratio (the ratio of those aged 65+ to those aged 15-64). In this respect one of the key areas for future reform and policy development will be in providing older people with equal opportunities for participation, promoting health and welfare, and increasing institutional integration and collaboration between health and social care organizations, as well as informal care givers.

Overview 1 Quantitative national targets to be reached by 2012 for older people over 75 years of age: Framework for High-Quality Services for Older People

- 91 - 92% live at home independently or using appropriate health and welfare services granted by assessing their overall needs
- 13 - 14% receive regular home care
- 5 - 6% receive informal care support
- 5 - 6% live in sheltered housing with 24-hour assistance
- 3 - 5% live in old people's homes or are in long-term care in health centre hospitals

Source: Ministry of Social Affairs and Health, 2008.

2 The governance and financing of long-term care services for older people

Finnish municipalities are legally obliged to organize health and social services for their residents. There are currently 336 municipalities with a median size of less than 6,000 inhabitants. Municipal services for the elderly comprise home care, support for informal care, service housing, institutional care, preventive care services and rehabilitation. A municipality can provide the services independently, together with other municipalities or purchase services from private sector providers. The municipality can also admit the client a service voucher eligible to purchase services from predetermined private providers. In addition, private companies offer care services for older people ranging from various types of support services to all inclusive service housing

The funding of health and social services comprises of revenue collected through general taxation and user fees. In addition, the Social Insurance Institute (Kela) collects obligatory social insurance payments for funding the National Health Insurance (NHI) that partly reimburses private sector health services and prescription drugs. Kela also subsidies the older population through various means-tested allowances and benefits.

Until the end of 1992 health and social services were, although locally organized, under comprehensive central government control. In the 1993 state subsidy reform the grounds for determining state subsidies for municipalities were revised, shifting from a system of cost-based grants (earmarked) to one of prospective lump-sum grants (non-earmarked). As an integral part of the reform municipalities were assigned the responsibility to organize health and social services for their residents. However, municipalities were assigned the freedom to decide whether services are purchased from public or private providers. Despite of the freedom of choice of provider, public providers owned by municipalities and hospital districts account for the majority of health and social services.

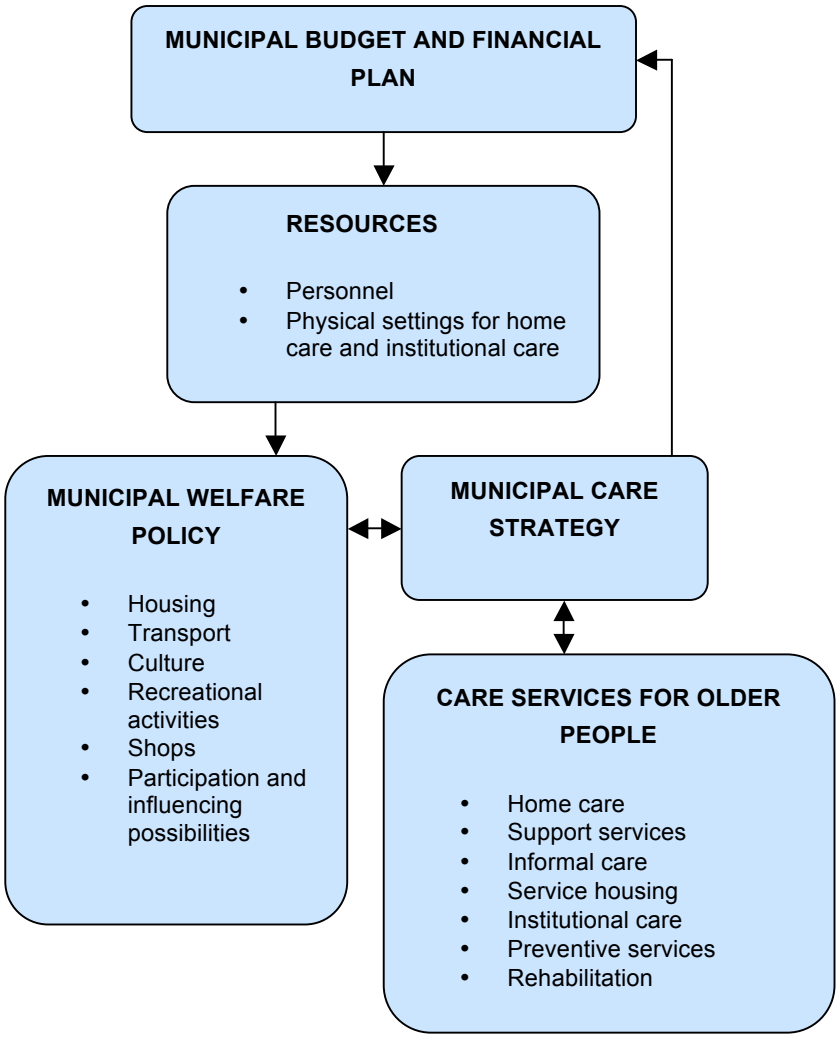
In the Finnish social care system the financing and provision of care services for older people partly overlap with services provided by the health care sector. Long-term health centre inpatient wards are part of the municipal health care system, while most other types of care services for older people are organized under the governance of social welfare services. The majority of residential homes and about half of sheltered housing are owned by municipalities and run by the social services sector. In addition a number of private companies and NGOs provide corresponding services; in 2006 12% of residential services and 57% of sheltered housing services were delivered by private companies. The number of traditional residential homes has decreased since the early 1990s, and the volume of sheltered housing has increased (Teperi *et al*., 2009). The development has been encouraged by increased public sector support for independent living as well as municipalities' financial incentives.

Assisted living without 24-hour service (service houses, also daycentres) is classified as social care and usually have a permanent own personnel, but some of the residents in service housing receive temporary or regular home care from the municipality or the private sector. Short-term and periodic institutional care helps older people cope at home and provides back up for family caregivers. It also prevents the need for permanent care in an institution. Periods of short-term institutional care can be regular, when they alternate with living at home. The fees for short-term institutional care are usually fixed.

People aged 75+ are entitled to a service requirement assessment in non-urgent cases within one week from contacting their local social service or home care offices. In urgent cases the need for services must be assessed without delay regardless of the client's age.

Municipalities are responsible for the implementation of policies for care for older people at the local level. The municipality (or several municipalities jointly) is obliged to draw up a policy strategy that has been approved by the local council. (Fig. 1) The drafting of the strategy should be carried out collectively by representatives of the administration, residents, clients and family members, and central interest groups. The strategy must take into account the elderly population in all aspects of municipal decision-making and activities, such as community planning, housing and traffic policies, cultural and recreational activities, and educational facilities. The execution of the strategy is integrated into the municipal budget and financial plan and monitored on a regular basis for continuous development of care services for older people and related activities (the interactional processes are presented by two-way arrows in Fig. 1). Currently more than 80% of municipalities adhere to care for older people policy strategy (Holma, 2008).

Figure 1 Social and care for older people services in a municipality



Within the framework of nationally set policy targets municipalities can independently decide on the means of service provision, as well as the range of services provided. National recommendations are integrated into the municipal strategies for developing services according to local needs, conditions and resources. At the national level major ongoing policy programmes concerning care for older people either directly or indirectly involve the following frameworks and guidelines.

2.1 The National Framework for High-Quality Services for Older People, 2008

- Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities 2008
- Quality standards for the care of elderly
- Guidelines for decision-makers in planning and evaluating the organization of services for older people at the local level
- Health and welfare services for the elderly focusing on the significance of preventive services and support for independent living at home
- Control the increase in costs of social and health care services in preparation to meet the needs of an ageing population

2.2 Strategies for Social Protection 2015 - towards a socially and economically sustainable society, 2006

- Ensuring the availability and quality of services for older people by adding to the resources available for the services as the number of older people grows. The emphasis is on services provided at home and in the local community. Care and rehabilitation services must be adequate, well-timed and relevant.
- The seamless service chain of primary health care, specialized medical care and social welfare services will be improved further. High-quality social welfare and health care services in community and interval care (short-term care) can enable elderly people to live at home even if they suffer from chronic diseases.
- The use of functional capacity indicators will be developed as an aid in assessing older people's service needs and planning the provision of services and also for the monitoring of service quality
- Social welfare and health care services form a functional entity, and the provision of home services for older people will be increased as a part of this. Older people will be given support in living at home for as long as possible, with a flexible transition to more intensive forms of care.

2.3 Project to Restructure Municipalities and Services (PARAS), 2005

- Restructuring the municipal health and social care system which is highly decentralized and based on small catchment populations
- Primary health care and associated social services are to be provided by a local authority or partnership area with a catchment population of at least 20,000. At the moment only about one-fourth of all municipalities meet this criteria
- Municipal mergers, federations, regional co-operation and governance
- Improving functional co-operation between social services, primary and specialized health care to secure adequate and high-quality services for the elderly

In recent years Finnish municipalities have invested in structural change; preventive work has been encouraged, functional and coping abilities of the elderly have been supported and home-based services

promoted. A remaining challenge concerns differences in service availability, standards of care and quality in various parts of the country. Significant differences across municipalities exist due to variation in financial resources, availability of health professionals and ways in which each population's health and social care needs are perceived by municipal decision makers.

3 Key barriers to joint working

3.1 Structural

In Finland, the ministry of Social Affairs and Health is in charge of the overall functioning of social and health services. It determines the course of the development of these services, drafts legislation and steers reform processes. It monitors the implementation and quality of services via the State Provincial Offices and the National Supervisory Authority for Welfare and Health.

As discussed before social and health services are governed by two partly overlapping administrative sectors with their own financial and legislative administrations. The boundaries between health and social care are often difficult to distinguish, which creates ambiguity in the division of responsibilities and in the planning of intersectional and effective care paths. The present structure of the Finnish social- and health care system creates monopolistic dynamics where municipal payers and public providers do not face true competition for patients. This lack of competition, together with a lack of performance assessment, has likely hindered the speed of innovation and therefore improvement in the models of care delivery (Teperi et al., 2009).

In addition, the fragmented and self-contained municipal structure sets geographical barriers for the achievement of homogenous quality and provision standards of care. Restricted freedom of choice concerns in particular patients in the need of institutional care; in small municipalities non-hospital institutional care is often provided by a single residential home. Moreover, in the absence of an independent evaluation scheme monitoring the quality of care (such as star-rating in the UK), clients are often obliged to accept care by a certain provider without prior information on the standard of care.

3.2 Procedural

In spite of the fact that regional differences in the procedures involving services requirement assessment are likely to exist, Finnish municipalities rather extensively employ standardized instruments in determining the need of care. For example, the implementation of the RAI (Resident Assessment Instrument) in Finnish long-term institutional care started in 2000. Currently the RAI is being used in 25 municipalities in Finland representing nearly 20% of all long-term care beds. The concept for implementing RAI is based on training, professional software, and an internet based benchmarking system. Another widely applied instrument, RAVA, measures the functional capacity of clients in different types of care services. The RAVA instrument is applied in over 40% of the municipalities. The existence of two partly overlapping and competitive instruments has delayed the implementation of a nation-wide system for assessing the need of care of the elderly. When investigating customer's satisfaction and quality of life, some municipalities have done regular follow-ups using CareKeys as a theoretical framework (see Vaarama et al., 2008).

Despite of long-lasting efforts to develop electronic information systems that cover all public health (and social) care providers, little concrete results have been achieved. This has restricted the fluent transmission of patient information between providers of care even within a municipality with several administratively separated health centres. For more intense co-operation between the social and health care sector and better privacy of data, the Parliament passed new legislation in 2006 concerning electronic prescription systems and patient records. According to the Acts, new national electronic databases for patient records and prescriptions will be formed, and the systems are currently under development. All public providers are obligated to maintain their patient record archives in the new system, but private providers are only required to join the system if they already have electronic archives. Concerted efforts are also underway to create a common, national structure for communication between patients and providers over the internet (Teperi et al., 2009; Ministry of Social Affairs and Health, 2008).

3.3 Financial

Financial barriers constraining effective cooperation between health and social care actors exist both in horizontal and vertical dimensions. Horizontally the financial divide of municipal budgets into health and social sector expenditures generates administrative and functional barriers for the collective planning and provision of comprehensive treatment practices (see 3.1).

Vertical financial constraints concern the possibility of cost-shifting between the state and municipalities. Maintaining two parallel and partly overlapping public financing schemes is economically ineffective as it creates incentives to shift costs from one sector (municipalities) to another (State administered Kela, NHI). An example of the consequences of such incentives in the context of care for older people concerns the attempt of municipalities to shift the costs of prescription drugs to the NHI (and to some extent costs of transport services which are reimbursed by Kela).

As residential homes are defined as institutional care settings, financial responsibility for drugs and other services lies solely on the municipalities. In contrast, residents in sheltered housing are entitled to national social insurance benefits similarly to people living/treated at home - drug costs, for instance, are partly covered by the NHI and partly by persons themselves, not the municipalities. Consequently, several residential homes have been administratively changed to sheltered living units, officially defined as independent housing, rather than long-term care facilities. In this way, municipalities have been able to shift costs to the NHI.

3.4 Professional

The roles and responsibilities of various professional staff in the health and social care sectors are rather hierarchically organized as a result of professional and administrative boundaries as well as legislative regulations. In addition the lower social status and unattractiveness of certain occupations impairs the scope for more effective cooperation and division of work, and gives rise to labor shortages at certain areas of the health and social sectors. This tendency will be strengthened in the future by the upcoming wave of retiring health and social care professionals. At the same time there is a growing trend to be employed under temporary assignments instead of entering long-term full-time employment (Kokko, 2007).

3.5 Issues of status and legitimacy

As the municipalities have legislative responsibility to arrange health and social services for its residents, there is no separate legislation concerning services of the elderly within the Finnish social and health care legislation. This has at times given rise to conflicts of interest between the health and social sectors and the associated policy-making processes. A common legislation complicates and slows down the passing of laws that are specific to social or care services for older people only. The provisions applicable to the care of the elderly are found within different laws, of which the most important include the Primary Health Care Act (1972), the Act on Specialized Medical Care (1989), the Social Welfare Act (1982), the Act on the Status and Rights of Social Welfare Clients (2000), and the Act on the Status and Rights of Patients (1992). The first two of these will be combined in 2011 in the new Health Care Act.

4 Key enablers

4.1 Shared vision

Activities towards enhancing the harmonization of views and modes of operation, and which are predicted to reduce expenses effectively, consists of integrated and coordinated organizations of health and social care providers (from public and private sectors) working in close cooperation, and where customers have a more active role. For example, pensioners can be useful in a variety of tasks related to their own professional or other competencies, and such activity should therefore be actively supported and promoted by the municipalities (The Ministry of Social Affairs and Health, 2008; Vaarama, 2009; Teperi et al., 2009; Hartikainen, 2009).

4.2 Clarity of roles and responsibilities

A way to increase cross-sectional segmentation and alleviate shortages in labor supply is to develop new ways for encouraging more extensive multi-professional cooperation between doctors, nurses and social workers, as well as between public, private and third sector actors. In addition to highly trained personnel such as practical and registered doctors and nurses, health or social care personnel is also needed for assisting tasks (such as helping residents to go out or to take care of pressing matters). Further investments in the utilization of volunteer's contribution particularly in the social care sector will be necessary (Hartikainen, 2009). A step towards this direction is outlined in the new HealthCare Act (2011), which combines the Primary Health Care Act and the Act on Specialized Medical Care.

4.3 Appropriate incentives and rewards

Besides ensuring satisfactory and appropriate working conditions for the health and social care staff, motivation for improved joint working between providers of care can be encouraged by introducing standardized performance indicators and systematic feedback mechanisms including actors at all levels of care for older people. In line with the national targets for increasing the number of older people living at their own homes, the public sector has to provide sufficient financial and social means for encouraging home care, particularly for third sector actors

4.4 Accountability for joint working

The National Framework for High-Quality Services for Older People (2008) sets common targets for the standards of care services for older people that municipalities and cooperation districts can use as a basis for setting their own targets. It underlines the primacy of promoting health and welfare, giving priority to prevention and support for home living, and the comprehensive assessment of individual needs. The framework also includes monitoring indicators, as well as principles for staffing levels, gerontological skills and managerial abilities (Ministry of Social Affairs and Health, 2008).

The Ministry of Social Affairs and Health also prepared a draft in 2011 for an act to ensure the right of older persons to care according to their needs. The proposed act aims to support the goals of the National Framework for High-Quality Services for Older People issued in 2008. The carrying idea of the draft is to organize services so that older persons can lead a dignified life.

5 The funding of long-term care services

Financing of health and social services in Finland is mainly based on revenue collected through general taxation. In the system of locally administered service provision municipalities act as autonomous funding pools. Revenue is collected through a mixture of municipal income taxes, state taxes (income and commodity taxes) and user charges. The funds are prospectively allocated through an annual budgetary plan/process to purchase needed health and social services. In addition to the fiscal financing system, the social insurance scheme administered by Kela collects payroll taxes that finance old-age pensions, a range of income transfers and reimbursements for private health services and prescription drugs.

User charges for long-term care in institutions are regulated and related to disposable income (not property); up to a maximum of 85 percent. A monthly disposable amount of 97 Euros must remain for the clients own use.

The monthly fee for home care is calculated as a percentage of the client's monthly income exceeding an minimum income limit. The applied income limit and percentage varies according to household size. In 2010 the lowest income limit for a one person household was 520 Euros and the corresponding percentage 35%. People in temporal home care and assisted living (not night-time services) pay fixed daily charges, which can differ by municipalities and depends on the kind of service-package provided. In short-term institutional care the maximum fee is 32.5 Euros per day and in psychiatric units €15 per day. After reaching the municipal payment ceiling (€633 in 2010) the short-term institutional care reduces to €15. The minimum caregivers allowance in 2009 was €416.25 a month.

As care services for older people are funded from general non-earmarked tax revenue the exact financing shares of various revenue sources are not directly observable. In addition, care services for older people partly overlap with services provided by the health care sector; long-term care in hospitals is administratively classified as health care and funded under the health care budget. However, a broad distinction between revenue from the state, municipalities and clients can be presented. In 2009 a total of 52% of care services for older people were financed by municipalities, 31% by the state and 17% by clients (Fig. 2). The composition of care expenditures for older people by service type is presented in

Figure 3. Expenditures for institutional care constituted the largest share, 38% of total expenditures. The municipalities' financing share of institutional care was 52%, the state's 29% and the clients' 19%. The financing share of municipalities was highest in informal home care allowances (64%) which, however, made up only 4% of total expenditures (National Institute for Health and Welfare, 2010).

With developments starting in the 1990s significant structural changes in the delivery of LTC services have taken place. The number of institutional care clients has decreased while the number of clients in sheltered housing has increased. Consequently the expenditure share of institutional care and long-term inpatient primary health care (> 90 days) has declined. At the same time, expenditure on so-called other services for older people as a proportion of total expenditure has nearly doubled. In 2009, this expenditure (excluded from core health care expenditure according to the SHA) amounted to €1.13 billion. A particularly sharp rise in this category was seen in expenditure on other services for older people purchased by municipalities and joint municipal boards from private service providers, being €684 million in 2009. This category includes, for instance, sheltered housing with 24-assistance, which currently accounts for as much as three fourths of clients in sheltered housing.

Figure 2 Funding of LTC services 2009 (%)

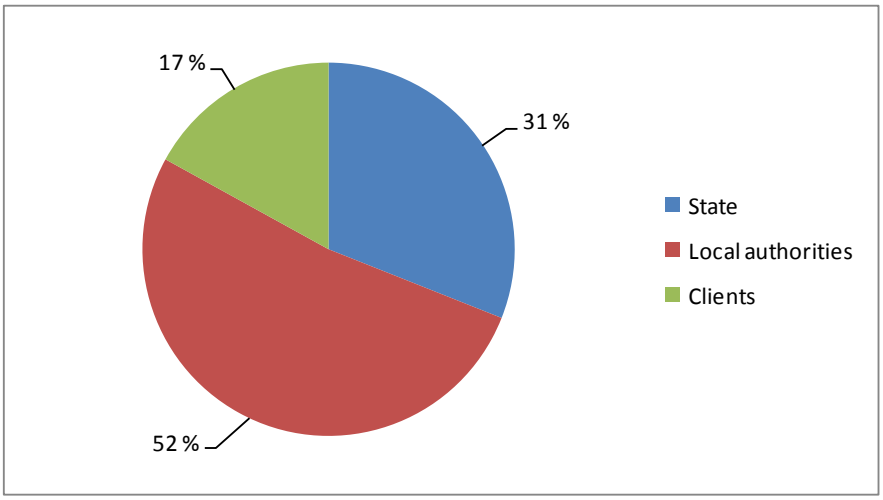
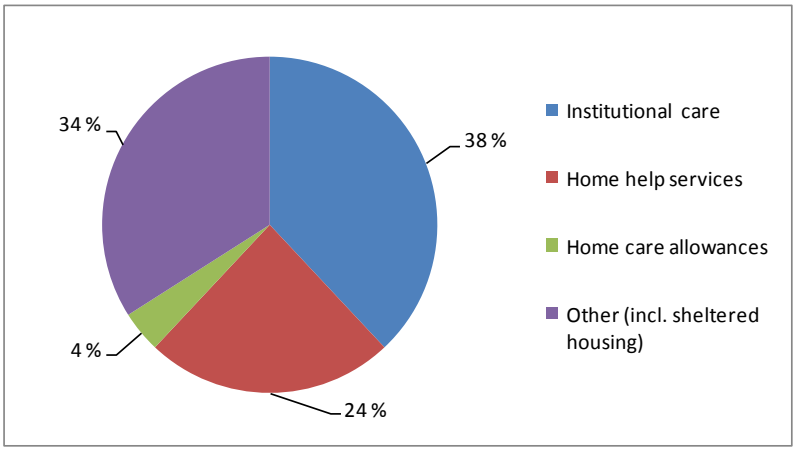


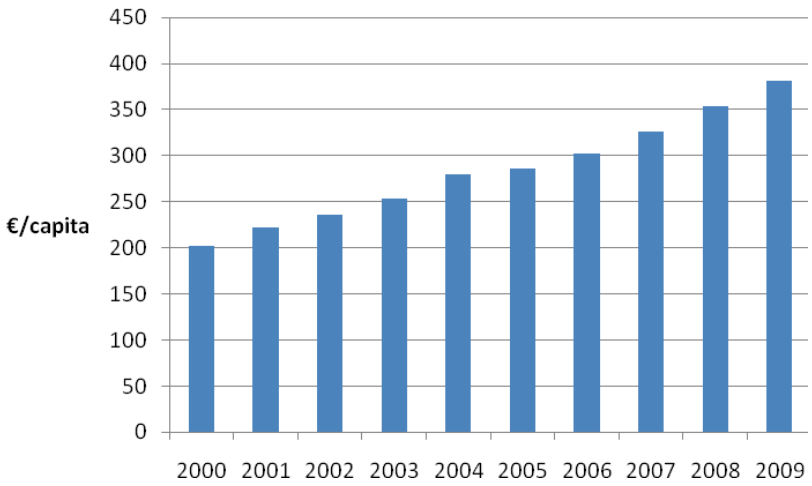
Figure 3 Composition of LTC expenditure 2009 (%)



6 Financial sustainability

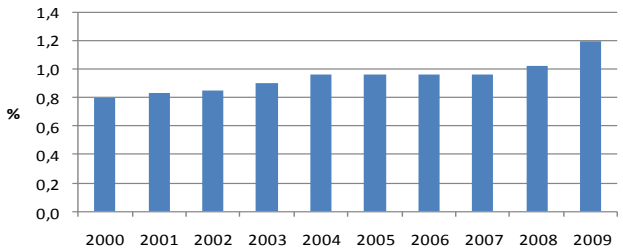
LTC expenditure per capita has steadily increased in the last ten years (Fig. 4). Between 2000 and 2009 LTC expenditure nearly doubled, and was € 382 in 2009. The GDP share of LTC expenditures remained at a level of under one percent until 2008 (Fig. 5). In 2009 the GDP share increased to 1.2 percent.

Figure 4 LTC expenditure per capita 2000 - 2009



Source: National Institute for Health and Welfare 2010, and own calculations.

Figure 5 Expenditure on LTC services as share (%) of GDP 2000 - 2009

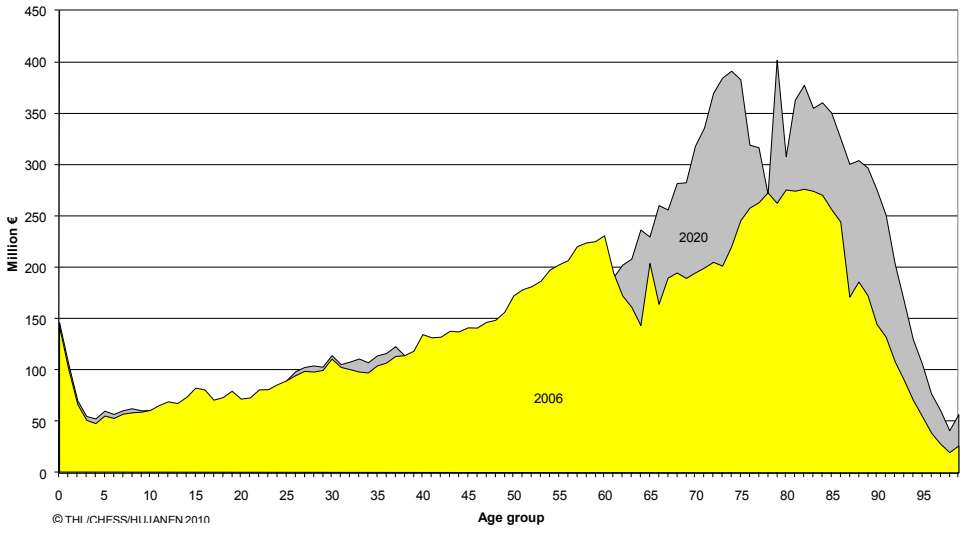


Source: National Institute for Health and Welfare 2010, and own calculations.

Population ageing is considered as one of the most pressing future challenges confronting the financial sustainability of care for older people. Due to the combined effects of increased longevity and ageing of the large post-war population cohorts, the proportion of elderly population will rapidly increase. The share of those aged 75+ will rise from the current 7% to approximately 14% by 2030, and also their absolute number will double.

Taking only into account the change in population age structure, expenditures for health and care for older people were projected to increase by over one fifth (22%), or € 2.4 billion by 2020 (Figure 6) (Pekurinen et al., 2006). More than one third of the increase was attributable to rising care expenditures for older people, about one fourth to primary health care expenditures (27%), and one fourth to specialized health care expenditures (24%). The effect of the increase in the expenditures of prescription drugs was estimated to be 11%.

Figure 6 Total expenditures for health and care for older people by age 2006 and 2020 (€ millions)



The change in the population age structure will affect different services rather differently. The greatest cost pressures are expected to fall on care for older people. Considered individually, real expenditures for care services for older people were projected to increase by some 50% between 2006 and 2020. Primary care expenditures were expected to increase by 29% while the rise in specialized health care expenditures was estimated to be 16%.

Population ageing will substantially change the focus and allocation of health and care resources for older people. If treatment practices and service structures are not accordingly reformed, the bulk of resources will be used on the care of elderly people. In 2006 about half of total health and care expenditures were spent on the care of those over 60 years old. By 2020 the corresponding age is expected to move nine years forward and accordingly half of the resources will be used on the care of those over 69 years old. These developments underline the importance of reforming service structures in a direction where care for older people, primary care and specialized care are considered, designed and provided within more tightly interlinked organizational units. Another key development related to financial sustainability concerns improving the functional capabilities of the elderly and thereby postponing the starting-age of receiving care services for older people, such as home and community care, and in particular cost-intensive institutional care (Räty et al. 2003).

7 Good practice

- The focus of Finnish social and health care policy is in preventive action and promoting health and welfare. This shows, for example, in older people's ensured ways of getting advice and guidance at low-threshold advisory units (senior counselling).
- Steps are taken to improve clients' active participation in the planning of appropriate care patterns as a key member of multi-professional teams.
- Long-term care is under reconstruction where the aim is to provide homely residential units that meet older people's wishes. This includes a variety of rehabilitative activities in addition to the provision of conventional care. Therefore, municipal health centre hospitals can concentrate on acute care and rehabilitation services.
- National electronic databases for patient records and prescriptions will be formed for more intensive cooperation between the social and health care sectors and better privacy of data.

8 Ongoing tensions

From an economic perspective persisting tensions in Finnish care for older people concerns the two-tiered financing system and the high customers' payment share in long-term institutional care. Both generate inequity amongst the elderly population and place high economic burdens on certain groups of older people.

The Finnish public financing scheme is internationally exceptional, as it is not common for social insurance systems to cover alongside another financing source (tax financing) the same types of services for the same population groups. As discussed earlier the existence of two overlapping financing schemes, the municipal and the NHI funded, creates perverse incentives in the delivery of health and care services for older people. Policies of care for older people aim at providing targeted and appropriate care according to the individual needs of the elderly, but the possibility to escape costs may encourage municipal providers to overlook policy principles in the seek of economic savings. While much research on the scope and effects of the phenomenon does not exist, the fact that a large number of municipal residential homes have changed their status to sheltered living units, suggests that such cost shifting takes place. In this sense, it would also be economically profitable for municipalities to restrict and postpone the starting of institutional care of its elderly population in favor of home care, which again would be in line with the national targets of increasing the share of elderly population living at home - given that these decisions would be made with respect to the service needs of the patients.

The shifting of costs from the municipality to the NHI concerns not only the municipal budget, it also bears economic consequences for the users of services. Health care expenditure, particularly costs of medicines, can cause high economic burdens for individuals in the need of care. According to a recent Finnish study, high health care payments in relation to capacity to pay were reversely related to household income. Payments that approached, or exceeded the "catastrophic" threshold (more than 40% of the household's capacity to pay) only occurred in the lowest income quintile. High payment shares were also related to age and mainly concerned elderly households (over 65-years) with high medicine expenditures (Klavus and Kapiainen, 2009)

Compared to municipal health services the degree of cost-sharing in long-term care is substantially higher. The share of total costs paid by the users of long-term care was 22.5%, while in municipal health services the corresponding share was 4.2%. The average payment in the poorest income quintile amounted to 300 €/year compared to 130 €/year in the richest quintile. This reflects the strongly biased pattern of use of municipal long-term care services across income groups. While the long-term care payment constitutes a fixed amount of income at all income levels, and is in this sense proportionally distributed, the use/need of municipal long-term care is higher among elderly in the lower income groups, and consequently gives rise to a highly regressive payment structure (Klavus, 2010).

9 Embedding good practice in everyday practice

- In the last few years the traditional biomedical gerontological approach to elderly health care has been accompanied by a socio-cultural view, which focuses on aging as a psychosocial and cultural phenomenon. This has increased the participation of the elderly in their own care practices, as well as facilitated a number of development projects being started in the wards and working communities. It has also offered multi-professional teams a new approach towards the care of the elderly.
- An increasing number of health care facilities are providing assisted living with night-time services according to the client's needs. Several units are running pilots where night-time services are provided by their own personnel.
- In seek of better cost-effectiveness certain pilot areas have outsourced their home care services to commercial service providers. Constant measurement is undertaken for comparing the cost-effectiveness of private and municipal service provision.
- More attention is paid to easy-access aspects in the planning and construction of residential homes as well as in home care settings.

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