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

Quality assurance and quality management in long-term care

National Report Finland

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1 Introduction

Quality management of long-term care is an issue that reaches from the individual to the national level. Several acts in Finnish legislation support the achievement of good quality care. In addition to the national level, it is possible to distinguish the municipal level (local), the organisation/service level and the client/patient level. In Finland, the means of steering public services and also health care has shifted from the use of norms to mainly steering through information.

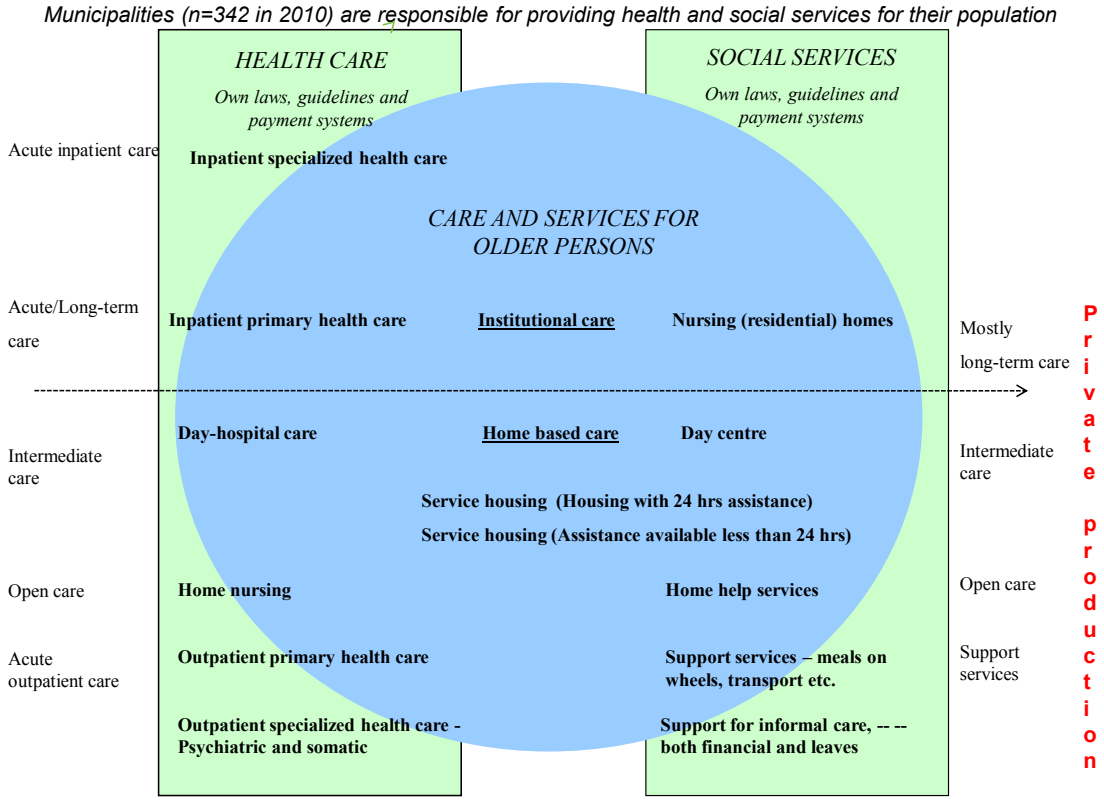
1.1 Definitions and terminology

In this paper, long-term care services for older persons in Finland are discussed. The focus is specifically on ageing and not on the long-term services for other vulnerable groups such as children or adults with intellectual or other disabilities, or persons with mental illnesses.

The terminology of long-term care or the welfare services for older persons is not – as pointed out by Richard Saltman et al. (2006) – homogeneous across European countries or even within nations. For example various terms for the same type of functions are used for old-age homes across nations; conversely, the same terms are used for totally different kinds of functions. In some countries homes for old age are called care homes, in others they are nursing homes, residential homes, sheltered housing, or simply long-term care facilities. In some countries the term nursing home is used only if medical care is present.

In Finland, services for older people are provided both through the social and the health care sectors (Figure 1). They utilize acute hospital and outpatient care, primary health care services, and home nursing. Mainly long-term care is given in health centre hospital wards and in residential/nursing homes. Sheltered/service housing is based on living requirements and there you can receive services and care either 24/7 or during daytime hours. The situation concerning sheltered/service houses varies from area to area. These homes can be operated and/or financed by public municipal organisations, not-for-profit voluntary organisations, or for-profit commercial organizations, while the level of staffing and medical care can range from very modest to highly demanding. Additionally, home help is available if the older person is still living in his/her own home and also additional services like meals-on-wheels, security services etc. Home help, sheltered housing and residential care reflect the services of the social sector. These services are mainly publicly provided and/or financed, but we have a growing sector of private service production (not-for-profit or for profit). In this paper the term home care applies to older individuals living in their original home and receive regular home help (term for mainly home-making help; to keep things running in the home environment). The management of diseases and medications, or personal assistance with clothing, toileting, washing etc. can be included or excluded. Further, there are differences in co-payments when the client is living in a long-term care establishment or is receiving home-based care.

Figure 1 Service structure for older people in Finland



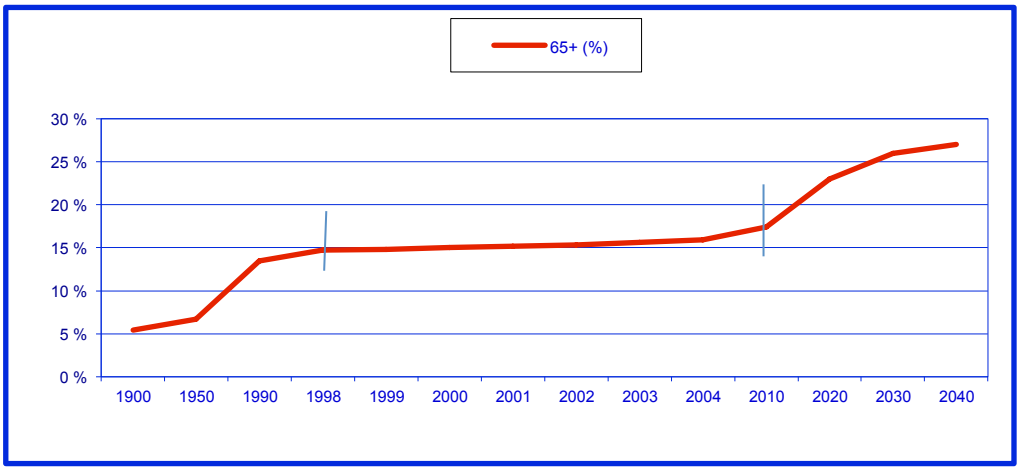
Source: Noro, A. (1998), SVT 2007.

In the context of describing the service, explanations and figures are given to demonstrate the characteristics of the residents or home care recipients and the staffing, including the type of help or care delivered.

1.2 Ageing and its potential consequence

Finland is ageing more rapidly than on average in countries within the EU. By the year 2020, the percentage of the Finnish population aged over 65 years will have risen from its current 16% to an estimated 23% (Figure 2). The percentage of the population over 75 years of age is expected to increase from 7.8% at the end of 2007 to 10% by the year 2020 In Finland, the life expectancy for women in 2007 was 82.9 years and for men, 75.9 years, and there is reason to believe that life expectancy is increasing.

Figure 2 Population prognosis for those aged 65 years or more



Source: Statistics Finland 20th July 2004.

Even though the health and functional capacity of those aged 65 years or more has during the past decades improved in Finland, the trend has been slow. Moreover, population-based knowledge covers the older population only up to 84 years of age (Sulander et al., 2008). Since the mean age of home care recipients is 78 and those residing in institutions is 83 years, the sparseness or lack of information about the needs of the oldest age groups and thus of those needing long-term services has to be taken into account when interpreting study results. Since functional problems and the help needs tend to accumulate in the oldest old, the number of older persons with a disability has been calculated as growing twofold within the next two decades in Finland (Koskinen et al., 2006).

2 Structure of health and social care services for older persons in Finland

2.1 Responsibilities of the municipalities and the state

In Finland, the municipalities, i.e. local authorities (n=342, year 2010) have a legislative responsibility to arrange health and social services for their citizens (including specialist care, primary care and dental care), provide child daycare, welfare for the aged and the disabled, and a wide range of other social services (the Primary Health Care Act 66, 1972; The Status and Right of Social Welfare Clients 812, 2000).

The municipalities perform a wide range of functions and enjoy a relatively strong autonomy that is safeguarded by the Constitution, including the right to levy taxes and make decisions independently. They also have a fairly comprehensive set of statutory duties and the major financial responsibility for securing the welfare of citizens and the necessary technical infrastructure. In Finland, as well as other Nordic countries, welfare services are mainly provided through the noncommercial activities of state, local and joint authorities as well as non-governmental organizations.

The municipalities can provide services to residents in different ways. A municipality might provide the services itself or together with other municipalities. Municipalities often set up a joint municipal authority to establish co-operation on a more permanent basis. Several municipalities can together establish a joint health centre. In addition, a municipality can purchase services from private service providers (profit, non-profit) or give the client a service voucher, which can be used to acquire services from the private sector. The client can then select the service provider from a list of service providers approved by the municipality.

The municipalities are responsible for the direction and implementation of the old age policy at local level. The municipality should have a policy strategy that has been approved by the local council. The strategy can also be a joint strategy of several municipalities together. In 2008, over 80% of municipalities have such a strategy. The drafting of the strategy should be carried out collectively by representatives of the administration, residents, service users and family members. Other central interest groups such as councils for the older people (Leinonen, 2006), non-governmental organizations, parishes and local businesses are also involved in planning. The strategy for old age policies must take into account the ageing population in all aspects of municipal decisions and activities, such as in community planning, the planning of traffic and housing policies, cultural and recreational activities, educational and participatory opportunities, and in the production of services and promotion related to well-being and health. The execution of the strategy is integrated into the municipal budget and budget plan. The implementation is monitored and assessed on a regular basis, and the follow-up and assessment reports are utilized to further develop these activities.

Within their own strategies, the municipalities integrate the national recommendations for high-quality services for older people as they set targets for the development of services based on their own local needs, conditions and resources (The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities, 2008). Recommendations for the quality of services and staffing ratios exist only at the national level, although the quality targets of services are not determined in detail. The municipality can decide the method of quality assurance that they use.

According to the Act on the Status and Rights of Social Welfare Clients (812/2000), each municipality must have at least one official, a properly qualified social worker, who is responsible for services for social welfare clients. In urgent cases, only a qualified social worker can decide on the provision of care and other related action, even without the client's consent. The funding for long-term care has primarily been the responsibility of the municipalities. The Government (state) participates in the funding by paying a state subsidy to the municipalities. Client fees are paid by the service users themselves.

This system has lead to a complicated net of different types of subsidies granted by the National Insurance Institute and/or the local authorities. In addition, service users have had difficulties in distinguishing between long-term care institutions and the extensive services that are also provided in sheltered housing. The balance between different housing types has been subject to change for some period of time.

2.2 Health and social services and long-term care for older persons

Figure 3 presents the quality–efficiency ladder in long-term care together with the payment source. Visible on the top is the most expensive element, *"health-centre-based long-term care"*, which equals to some degree the concept of "*chronic care hospitals"* in Canada or to some extent the "*skilled nursing facilities"* in the USA. However, in Finland the residents reside permanently in these settings. The health centers are governed by health authorities, mainly financed from public funds, while the role of the private sector in this field is very small. In 2007, the residents in health center wards were sicker, more demented and disabled than the residents in other care types, as shown in figure 3. Next level from the top is *"Nursing homes"* or *"Residential homes"*, which correspond with those of Canada both in name and type of clientele. This level is governed by the social sector.

The level in the middle, *"Assisted living"* or "*sheltered housing"* with 24-hour services, resembles the services provided by nursing homes. These usually have a permanent staffing. Funding, however, comes from the federal government via the National Insurance Institute rather than from local municipalities.

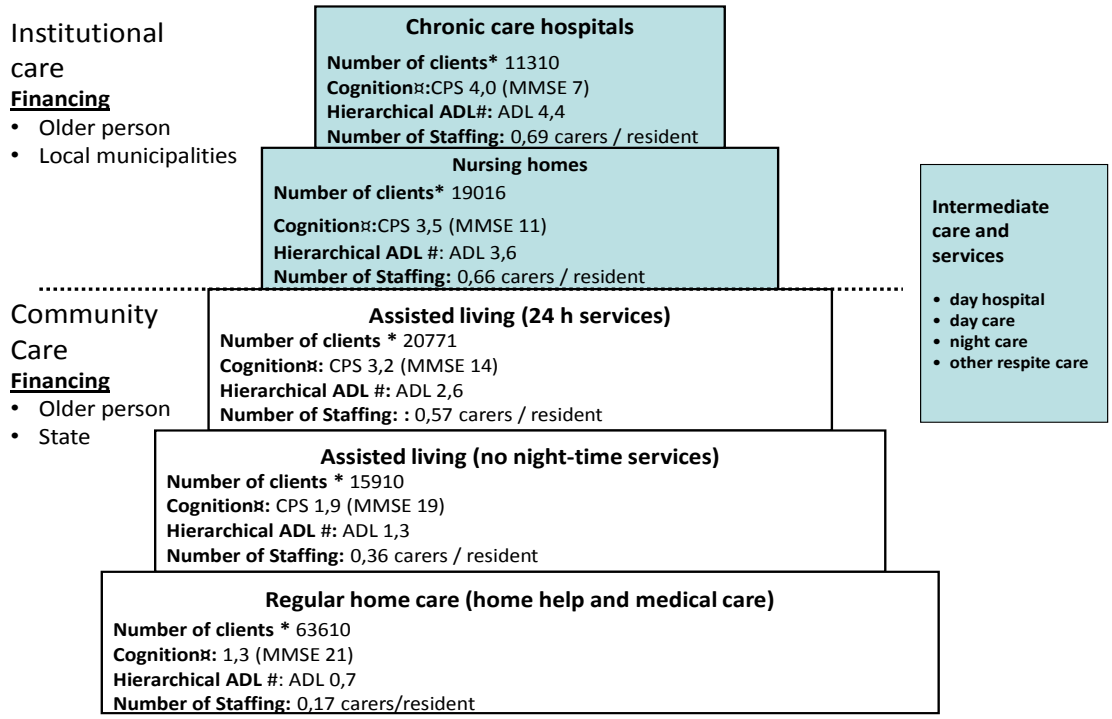
"Assisted living" or "*sheltered housing"* without 24-hour service represents a large variety of accommodation for persons who wish to move to houses or apartments where they can receive help and services according to their need, and where there is a possibility to stay for the rest of their lives. The residents in these houses vary from recently retired and well-off persons to quite severely disabled persons. Some of them receive temporary or regular home care services from the community, other houses have a permanent staffing.

"Regular home care" signifies regular visits from social welfare and/or health care professionals who provide nursing services and assistance in everyday activities for the older people living at home who are ill or have disabilities. It can also include support services (e.g. meals-on-wheels) and transfer services. Home care services are provided by home help units (under social welfare services of the municipalities) and home nursing units (under health care services) either separately or together as a unified home help and home nursing unit (Kauppinen et al., 2003: 21-23). Home care services, especially home help, are nearly always provided as a long-term service. Some of the home care services, particularly health care, are temporary. There is little exact national data on temporary home care services. It is assumed they mainly cover health care services, the assessments of care needs, and service counseling.

In Finland only the two top levels in figure 3 are considered to be institutional care. Other three levels belong to community care. The naming "institution" has been decided rather on basis of the funding source than on the case-mix. In the institutions, the funding - apart from the share of the older person pays - comes from the local authorities.

In community dwelling the older persons end up paying their medications and part of their health care (such as dental and ophthalmological service) themselves. In case of poverty, they can seek subsidies directly from the state trough National Insurance Institute.

Figure 3 The quality-efficiency ladder in long-term care and the division between institutional and community care



Source: Modified from Finne-Soveri et al. 2008 (original: Statistics and RAI database, National Institute for Health and Welfare).

Note: * = National Statistics, National Institute for Health and Welfare RAI-database:

¤CPS = Cognitive Performance Scale, scale 0-6, where 0=normal and 6=very severe cognitive decline

#ADL = Hierarchical ADL scale, scale 0-6, where 0=normal and 6=very severe disability

In staffing figures all those professionals participating in care have been included

According to the annual statistics published by the National Institute for Health and Welfare, in 2009 three out of four of those aged over 75 years were able to live independently at home without any regular care services (Table 1). The exact number of beds in institutions or care homes is not known. However, the statistics reveal the number of users of those services on a given day: reports are made on the last day of the year in the case of care institutions and on the last day of November in the case of home care recipients.

Likewise, Table 1 shows the trend in long-term care: sheltered/service housing care and home care are increasing, while the number of aged persons in long-term care in the health centres is decreasing. In 2007, first time in the history the number of those residing in nursing homes compared to those living the assisted living type of settings was smaller.

Table 1 Long-term care for older persons, at the end of 2010

	Number of persons using services 2010	*+/- compared to 2008 (%)*	*Age 75 years or more*	*Of all 75 years of age or more (%)*
Residential homes: nursing homes*	16,692	-5.8	14,971	3.5
Sheltered / service housing (total)*	32,540	+5.9		
24-hour service not included	6,856	-12.6	1,017	1.4
24-hour service included	25 684	+12.2	3,582	5.1
Regular home care services**	57,495	+ 3.1	48,679	11.4
Residing in Health Centre long-term care unit e.g. chronic care hospitals*	9,079	-12 .5	7,930	1.9

Source: Statistics National Institute for health and welfare 2010.- Notes: * 31st December 2010; ** 30th November 2010

Primary care

Outpatient clinics or offices in the health centers are open for everyone. In addition to health care, older persons can receive guidance for social services and benefits and preventive services tailor made for the aged. In general, services aimed at older persons are part of primary care. For instance, the hospital wards in the health centers (chronic care hospitals) are part of primary care.

Other primary care level services are home making and/or personal care and assistance at home, support services such as cleaning, meals-on-wheels, alarm system (etc.), temporary care in any of the long-term care settings.

Positions for geriatrics have been created in primary health care over the last 15–20 years. The activities associated with geriatrics include the treatment of older patients in health centers and their treatment and rehabilitation in health central hospitals and long-term care facilities. Geriatrics also entails developing and improving preventive measures, the treatment and rehabilitation of older people and providing updated training to other staff.

Specialist care

In Finland, the health services for adult citizens are delivered to everybody regardless of age. Specialist services (in- and out-patient care) are provided by 20 hospital districts. Each municipality is a member of a hospital-district joint authority, which is responsible for organising specialised medical and hospital (secondary and tertiary level) treatment in its own district (Kauppinen et al., 2003). Some hospital districts have created geriatric wards for older persons, for example for case managing purposes or rehabilitation, while others have not.

Social services

Municipalities in Finland are entrusted with preventing social problems, maintaining social security and supporting people's independent living. Social care staff offer guidance, advice and handle problems. They arrange support measures on an individual, family and community basis. Professional social work provides guidance, advice, dealing with social problems as well as arranging support measures. Emergency social services in Finland are available around the clock for handling sudden and acute problems. Social services for older people include home and support services, informal care support and institutional care. Municipalities use service needs assessments to allocate services. The service counselor provides counseling and guidance in matters related to services and social security for the elderly.

3 Quality assurance, assessment and management in Finland

Quality management of long-term care is an issue that reaches from the individual to national levels. Several Finnish legislative acts support the achievement of good quality care. In addition to the national level, it is possible to distinguish the municipality level (local), organisation/service level and client/user level. As a way of steering public services, including health care, Finland has moved from steering through norms to mainly steering through information.

3.1 System Level

3.1.1 Legislation

According to *the Constitution of Finland*, public authorities must ensure the realization of basic and human rights, such as the right to equal treatment and care based on need, and adequate social and health care services for everyone. Respect for human dignity must be the guiding principle for all authorities and activities. The ethical principles ensuring a dignified old age include the right to self-determination, justice, participation, individuality and security.

Health and social care legislation regulates the health and social care system in Finland. The Constitution of Finland stipulates that society must guarantee adequate social, health and medical services for everyone and promote the health of the population. In Finland, the general planning and guidance and monitoring of health and social care services that are governed by legislation are the responsibility of the Ministry of Social Affairs and Health. There is, however, no separate law regarding services for the older people within Finland's social and health care legislation. The provisions deemed applicable to the care of the older people elderly are found within different laws, of which the most important include the Primary Health Care Act 66/1972, the Act on Specialized Medical Care 1062/1989, the Act on the Status and Rights of Social Welfare Clients 812/2000, and the Act on the Status and Rights of Patients 785/1992. The first two of these will be combined in 2011 into a new Health Care Act. The need for a separate law regarding services for the elderly is under discussion.

Elements for providing good care for older citizens can equally be found in the Acts that regulate patient payments, care for disabled persons, substance abuse, and mental health. All these legal procedures aim to guarantee fair services and justice among the care and service recipients irrespective of age.

The duties and qualifications of various health and social care actors are also defined by law (Act on Health Care Professionals 1994/559, Decree on Health Care Professionals 564/1994, Act on Qualification Requirements for Social Welfare Professionals 272/2005).

In addition, health and social care professionals are obliged by legislation to maintain and develop their professional skills. Recommendations for further education relate mainly to the public employer. The recommendations apply to the planning, realization, monitoring and evaluation of further education at the individual, work unit and establishment levels. The employer is responsible for providing and financing further education and training. The recommendation is 3–10 days per year depending on the employee's level of professional education. Further, the employer is responsible for reporting on further education (number of participants, duration, costs) for a national report (maintained by Commission for Local Authority Employers). The employees are responsible for assessing their need for further education and for participation in further education that serves their own job tasks and organisation.

3.1.2 Inspectorate

In Finland, general guidance and monitoring of health and social care services that are governed by legislation are the responsibility of the Ministry of Social Affairs and Health. The agency under the Ministry, Valvira (=National Supervisory Authority for Welfare and Health), is responsible for ensuring the adequacy of services provided by health care professionals and health care operating units through guidance and supervision.

The Regional State Administrative Agencies (previously State Provincial Offices) grant licenses to private providers of social and health services. The Agencies also monitor the quality of services (quality standards to meet in arranged social and health services) and ensure that both public and private services in social and health care comply with legislation.

The municipalities are responsible for monitoring the health and social care services that they have organised. Some municipalities have their own quality criteria for services. The municipal audit committee assesses whether the operational and financial targets have been set are met. In addition, the providing organisations, both public and private, monitor their own performance.

Traditionally the inspection/audit system for providers is sanction led. If a municipality does not meet quality standards when arranging social and health care services then the County Administrative Board can take action against them. The County Administrative Board can impose a fine, issue a public warning, suspend a service until it is brought up to standard, or take it off the register entirely. County councils can order fines in cases where the municipalities fail to obey legislated orders (STM, 2001).

Organizations are also obligated to produce statistical information concerning the population, municipal finances, families, housing, morbidity, medicine use, mortality, service use and inpatient and outpatient health care (Finnish care registers for social welfare and health care (Hilmo), SOTKA-municipal database for social and health statistics).

3.1.3 Accreditation and certification

In Finland, the employer is responsible for checking that employees are registered (licensed) and that they have appropriate qualifications for their duties. The duties and qualifications of various health and social care actors are defined by law (Act 272/2005 and Decree 608/2005 on Qualification Requirements for Social Welfare Professionals; Act 559/1994 and Decree 564/1994 on Health Care Professionals; and task structure frameworks for social welfare professionals). All those working in old-age health and social welfare services should have a vocational qualification in social and/or health care. Gerontological expertise should be acquired in basic, continuation and/or supplementary training.

In the Finnish health care system, nurses have a possibility to specialize in certain fields, for example pain care, diabetes, or wound treatment. These professionals are used in the care of older people as needed. The basic care is mainly given by nurses with 3-year training (lähihoitaja). Further education has been developed for example in the form of Bachelor's programs of Bachelor of Social Services and Health Care (Geronomi): specialists in the field of elderly care and services, and they work in hospitals and home care.

In addition to professional training, certain categories of health care professionals also require official authorization or a license to practice their profession. Authorization and licenses for health care professionals are granted by the Valvira (=National Supervisory Authority for Welfare and Health). **The** Regional State Administrative Agencies (previously State Provincial Offices) license providers of private social and health services and monitor practitioners.

3.1.4 Registration of health care personnel

All health care professionals, irrespective of whether they have taken their degree in Finland or abroad, must file an application with the National Supervisory Authority for Welfare and Health (Valvira, http://www.valvira.fi/en/) for the right to practice their profession in Finland or to use an occupational title of health care professional. Valvira may grant the health care professionals applying for legalization either the right to practice as legalized health care professionals in Finland or, in certain cases, to issue a limited license to practice their profession in Finland. Health care professionals granted a permit or license are registered in the Central Register of Health Care Professionals (TERHIKKI) maintained by the Valvira.

3.1.5 Standards and Guidelines

The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities presented a road map for the whole social and health sector in 1999. The most important approach or perspective was thought to be that of the client's. The challenge of achieving quality care would be met through eight recommendations: 1) to involve the clients, 2) and the leaders in the quality work 3) to realize that good quality can only be provided by competent staff 4) to allocate attention to promotion and prevention 5) to realize that process management is the basis for quality, 6) to use knowledge as a tool 7) to use systematic methods 8) to seek support from individual quality recommendations or quality criteria.

In 2001, the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities jointly published a guideline *the National Framework for High-Quality Services for Older People*. The original framework has been updated in 2008 to take into account Government

Programmes, strategies, national targets for old-age policy, new research data, as well as the assessment of results achieved by the Framework. The ongoing reform of Finland's municipal and service structure has also had a particularly significant impact on services for older people.

The framework is intended to serve as a tool to assist decision-makers and municipal managers in developing and evaluating their services for older people. The framework's aim is to promote health and welfare in older age and to improve the quality and effectiveness of services for older people. The framework emphasizes the need for society and also different branches of administration, to prepare to meet the needs of the ageing population. The framework sets national targets for services regularly used by the elderly. The aim is that services supporting those living at home should be increased and the share of long-term institutional care reduced. The range of services is diversified with the addition of advisory and other preventive services. The framework outlines strategies for raising the quality of services for older people across three dimensions: (1) promoting health and welfare and the related service structure, (2) staffing and management, and (3) living and care environments. The framework specifies the principles behind the staffing levels used and the recommendations for minimum levels in 24-hour care. The framework promotes improvements in the accessibility, safety and comfort of the residential and care environments of the elderly. The aim for units giving long-term care is to be able to provide an adequate number of single-occupant rooms.

3.2 Organisational level

3.2.1 Quality management systems and audits

Monitoring, measurement and evaluation based on reliable information are essential to quality management and an organisation's decision-making. When combined with quality management, evaluation gradually provides support for decisions to be made. Municipalities and organizations are free to choose the method of quality management. One popular way is to adopt Total Quality Management (TQM) type systems, Quality Award standards or Balanced Score Cards that involve the whole organization from top to grass root. There is also a widely used Finnish application of the basic TQM principles.

Many LTC units also apply external audit or certification, where the approval is usually based on a blend of self-assessment and external audit. Certification gives them a basis for achieving their own quality improvement, but it also serves as an advantage in the market of service providers. The Certification in Quality Management can be obtained through procedures and standardisations developed by the International Standards Organisations (ISO) or the European Foundation for Quality Management (EFQM). In the field of long-term care, ISO-standards and EFQM are mainly used by private long-term facility chains.

There are no national obligations or recommendations to adopt any of these systems rather than another.

3.2.2 Benchmarking, monitoring and performance indicators

More than one third of residential, nursing home (LTC facilities), and approximately 25% of regular home care service clients used Residents Assessment Instrument (RAI) in 2009 (www.interrai.org).

Organizations use the RAI indicators for benchmarking purposes to work directly on improving the care and the wellbeing of clients (Finne-Soveri et al., 2008; Noro et al., 2005). RAI -Quality indicators are presented in detail in Section 4.

3.3 Professional level

3.3.1 Technical care quality

Donabedian (1980) identified three components in technical care quality: 1) structure (including material components and staffing) 2) process, and 3) outcome. Øvertveit further adds cost as an additional component (1998).

3.3.2 Structural quality

Material

Structural components, such as the size of the rooms or accessibility to the toilet, its location and size, are officially monitored by county councils. Since inspections or site visits are not carried out on a regular basis but only initiated following complaints, there is no holistic national knowledge of the living conditions of those residing in long-term care facilities.

Some items relating to structural quality are regularly assessed in the context of long-term care RAI projects. Annual assessments are performed that cover staffing ratios and skill-mix in all the participating long-term care formats (roughly 1/3 of long-term care in Finland). Living environment is assessed semi-annually in home care settings and annually in long-term care facilities.

The term ISO stands for *International Organization for Standardization.* There are more than 50 ISO-standards for different health technology fields. In the field of long-term care, ISO-standards are mainly used by private long-term facility chains.

Number of staff, skill-mix and the regulations

Numbers of staff or the skill-mix are not centrally regulated by law. However, the duties and qualification held by various health and social care actors are defined by law (Act on Health Care Professionals 1994/559, Decree on Health Care Professionals 564/1994, Act on Qualification Requirements for Social Welfare Professionals 272/2005, Valtioneuvoston asetus sosiaalihuollon ammatillisen henkilöstön kelpoisuusehdoista 608/2005).

The purpose of the Acts is to promote the safety of clients and the provision of high-quality health and social care services by ensuring that health and social care staff receive proper professional training and are generally qualified and competent to perform their duties. In addition to professional training, certain categories of health care professionals also require official authorization or a license to practice their profession. Authorization and licenses for health care professionals are granted by the Valvira (the National Supervisory Authority for Welfare and Health). A person practicing as a healthcare professional in Finland without a licence can be sentenced to a fine or imprisonment. Valvira is also responsible for ensuring the adequacy of services provided by health care professionals and health care operating units

through guidance and supervision. This includes the processing of complaints, notifications and other supervisory matters related to the adequacy of services which may arise as a result of official requests for opinion.

There are only national recommendations for staffing rations, but the quality of services is not determined in detail. The framework for older people promotes improvements in the accessibility, safety and comfort of residential and care environments for the elderly. The aim for units providing long-term care is to be able to provide an adequate number of single-occupant rooms. Within their own strategies, the municipalities shall integrate the national recommendations as they set targets for the development of services based on their own local needs, conditions and resources. (The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities2008.)

The Ministry of Social Welfare and Health has so far mainly published examples on staffing levels by way of rough descriptions on nursing ratios.

For home care, a working group of the Ministry of Social Affairs and Health has developed a model for scaling future needs for staffing levels for home care personnel. This model is currently being tested by various municipalities. The scaling is based on the following factors:

- The number of 65 to 74 years-olds and people over 75 in the municipality
- The percentage of under and over 75s using home care: (a) the percentage of 65 to 74 years-olds using home care and (b) the percentage of over 75s at which home care coverage is aimed
- Data on home care intensity
- Data on the number of personnel working in home care.

For 24-hour care, the national recommendation for minimum staffing levels in 24-hour care is 0.5–0.6 employees per clients. The higher option is recommended when the clients concerned display difficult somatic or behavioral symptoms or when the size of and/or structural defects in the care environment mean more staff are needed. The good staffing level is set at 0.7–0.8. If there are long-term clients needing medical care in health centre hospital the minimum staffing level is 0.6–0.7 employees per client.

In the examples, no further calculations have been made as to the care burden. The nursing care needs between those with the least and those with the greatest needs have been show to be as much as nine-fold, and in Finland, up to six-fold.

Table 2 presents the development of the skill-mix within all the long-term care facilities. According to this table, the highest percentage of registered nurses is found in hospital-type care and the lowest in housing without 24-hour services.

Table 2 Skill-mix of staff in the long-term care facilities for older persons from 2000-2007

Profession	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*
Health centre wards								
Registered nurse, %	32,0	31,2	33,0	30,5	30,5	34,6	33,8	33,6
Licensed practical nurse/or similar, %	52,7	50,6	51,4	53,3	53,3	53,6	54,5	56,1
Other, %	15,3	18,3	15,6	16,2	16,2	11,8	11,8	10,3
Nursing homes /Residential homes								
Registered nurse, %	23,8	25,2	27,0	26,1	26,1	26,7	22,3	23,9
Licensed practical nurse/or similar, %	53,5	52,4	54,8	58,3	58,3	58,5	61,8	62,3
Other, %	22,7	22,5	18,3	15,6	15,6	14,8	15,9	13,8
Assisted living (24-hour service)								
Registered nurse, %	12,4	9,5	14,0	13,6	13,6	15,0	14,4	15,2
Licensed practical nurse/or similar, %	77,0	78,0	66,9	72,3	72,3	76,1	72,3	71,6
Other, %	10,7	12,5	19,1	14,1	14,1	8,9	13,3	13,2
Assisted living (no 24-hour service)								
Registered nurse, %	-	-	-	-	-	-	-	16,5
Licensed practical nurse/or similar, %	-	-	-	-	-	-	-	71,1
Other, %	-	-	-	-	-	-	-	12,4
Registered nurse = includes all the registered nurses head of the ward								
Licensed practical nurse/similar =includes all the nursing staff other than registered nurses								
Others = no nursing related degree								

Source: Noro et Finne-Soveri, 2009 (original RAI database, National Institute for Health and Welfare).

3.3.3 Processes

It is a common belief that care processes need more attention. According to the RAI-database at the National Institute for Health and Welfare, the patient-specific care times in Finnish institutions have increased from approximately 80 minutes in 1995 to 120 minutes in 2002. This can be explained by increased numbers of staff and/ or a change in care processes in the same time period. The patient-centered care model, where every resident or client had his/her own nurse, was widely implemented.

Due to the different case-mix on the distinct ladders of care, different care models may be needed and need monitoring at each level. For instance, with bedfast residents, regular and systematic turning programs to avoid pressure ulcers are needed for those care levels with the heaviest care burden (two top levels in Figure 3); likewise, programs and processes to prevent falls are needed at intermediate care levels where the residents/clients still have the capacity to move around independently. All the care levels need processes in place to enhance adequate nutritional status and to prevent pain and suffering.

Unnecessary polypharmacy has been the subject of discussion in recent decades, while several somewhat similar “black lists” have been developed in different parts of the world to guide physicians and pharmacists to deliver medications that generally are well tolerated and beneficial and therefore recommended for older persons (Fick et al 2003, Zanh et al 2001).

In Finland, two quality-related programs are available: RAI-systems and a computerized database for those who have to select appropriate medications for older persons (ROHTO).

3.3.4 Outcomes

Technical or professional care quality is based on objective observations, things that are done, things that have happened, which contrasts with subjective statements, interpretations, preferences, or feelings towards received care or services.

RAI indicators for the benchmarking of quality processes and outcomes are presented in Table 3. They are derived from the national RAI-database, located at the National Institute for Health and Welfare. Approximately one third of the residential-, and home care services in Finland in 2009 were using RAI-systems for quality improvement. They assess each resident at least semi-annually and also when there is a significant change in status. A copy of assessments is sent to the National Institute of Health and Welfare. Participants receive a benchmarking feedback report within 1–2 months. The participants can also access a unit-level benchmarking database online.

Table 3 presents the preliminary results for the trends in care quality in those facilities that started RAI programs in 2000 or 2001 and are continued to at least 2008.

The figures show a dramatic drop in the use of psychotropic medications and at the same time, an increase in the number of people receiving more than 9 medications. This clearly indicates that polypharmacy today consists mostly of medications other than psychotropics. Worth noticing is that the use of antipsychotic medications go down without increase in behavioural problems.

A rough estimate of the economic benefits and savings in medications alone among those participating in RAI-activities is of several million Euros. Further analysis is needed on other beneficial consequences, such as prevented falls or pressure ulcers.

Another substantial area in the care of older persons is nursing rehabilitation. The increased awareness about the small events in everyday life – such as getting up from bed and having something relevant to do and participating social life – have been the focus for participating facilities.

The RAI quality indicators used in Finland cover areas such as nutrition, use of various psychotropic medications, rehabilitative care and social interactions (Achterberg et al., 2009; Feng et al., 2009; Noro et al., 2005; Finne-Soveri et al., 2006).

Table 3 Care quality outcomes on the facility level in long-term care facilities (n=29), in Finland during 2001 and 2008

Trend	*Name of the quality indicator*	*Indicators in 2001 (%)*	*Indicators in 2008 (%)*
Deterioration	Use of 9 or more different medications	34,9	41,8
2% or more	Incidence of cognitive impairment	11,1	14,9
	Prevalence of bowel/bladder incontinence	68,2	71,2
	Any injury	25,5	25
	Prevalence of falls within 30dd prior to the assessment.	9,9	8,6
	Incidence of new fractures	0,8	1
	Prevalence of symptoms of depression	34	31,9
No or slight	Prevalence of symptoms of depression w/o antidepressant	14,9	15,6
change (+/-2%)	Prevalence of indwelling catheters	5,6	5,4
	Prevalence of weight loss 5% or more in the last 30 days or 10% or more in the last 6 months	7	7,8
	Prevalence of tube feeding	0,8	1,2
	Prevalence of dehydration	1,7	1,9
	Incidence of decline in late loss ADLs	23	23,3
	Incidence of decline in Range of Motion	17,2	16,8
	Prevalence of grade 1-4 pressure ulcers	9,8	8,8
Improved	Prevalence of behavioural symptoms affecting others	39,8	34,4
2-9%	Prevalence of occasional or frequent bowel/bladder incontinence w/o toileting plan	64,9	49
	Prevalence of faecal impaction	14,3	8,8
	Prevalence of urinary tract infections	14,3	8,7
	Prevalence of bedfast residents	29,5	25,8
	Lack of nursing rehabilitation in late-loss ADLs	28,4	22,3
	Prevalence of antipsychotic use in absence of indication	35,6	27,2
	Prevalence of daily physical restraints	20,3	16
Substantial	Prevalence of anti-anxiety /hypnotic use	58,4	38
Improvement	Prevalence of hypnotic use 3+ times/week	40,8	18
10% or more	Prevalence of little or no activity	65,5	52,1

Source: RAI-benchmarking database, National Institute for Health and Welfare.

The 5-year results from home care as well as the national report on the gatekeeping of services are currently under analysis.

The preliminary RAI-report on home care, which covers five geographical areas (Finne-Soveri et al. 2006), shows that issues of disability and rehabilitation together with isolation and loneliness were poorly addressed. The quality indicators showed more variation than the patient characteristics. Home care clients often used hospital services and there is reason to believe the pathways across settings were not always clear.

A longitudinal follow-up will unveil the trends in home care.

3.4 User level

3.4.1 Informed consent and shared decision making

Clients' / Patients' rights

Clients/patients in Finland are entitled to timely and good quality attention, treatment and services. Clients/patients are entitled to be treated with dignity, their privacy to be respected, and their **individual** and **language** requirements and **culture** taken into account. Treatment and services are provided on the basis of mutual consent between health/social care providers and clients/patients. People must be given the right to **participate** in and influence the planning and implementation of treatment and services intended for them. The patient/client and the service provider jointly draw up a plan that agrees on how the respective treatment, service, care or rehabilitation will be carried out. They are entitled to be told of possible **alternative procedures**, to **receive and examine** all information concerning themselves and are **obliged to give** all relevant information about themselves. Clients / patients are guaranteed transparency of information concerning their health, patient records and waiting periods for treatment. (The Act on the Status and Rights of Patients 785/1992, The Status and Right of Social Welfare Clients 812/2000).

3.4.2 Complaint

If clients or patients in Finland are dissatisfied with the decisions, services, assistance, treatment or behaviour toward them, they can seek a change of decision, file an objection concerning a particular service or treatment procedure to the responsible authority, or complain to the supervising authority. Complaints and objections are handled by a municipal social service ombudsman or health care ombudsman and by **The** Regional State Administrative Agencies (prev. State Provincial Offices) (http://www.avi.fi/fi/Sivut/inenglish.aspx). Complaints in cases of death or suspicion of malpractice resulting in serious disability are handled by the Valvira.

Access to service needs assessment and access to care

The Social Welfare Act (710/1982) secures the access of people aged 75 and older to a social services needs assessment within seven days of contacting their municipality. In urgent cases, the need for services must be assessed without delay regardless of the client's age. The timeframes guaranteeing access to health services are set down in the Primary Health Care Act (152/1990) and the Act on Specialized Medical Care (1062/1989). Non-emergency health care examinations by a physician or nurse are available from health centres throughout Finland within three days of making an appointment. Phone contact and assistance is available immediately during working hours. Non-emergency treatment has to be arranged within three months, and non-emergency specialist treatment within six months. Hospital services are available by referral from a health centre physician, with a three-week timeframe for receiving an examination and a six-month limit for treatment. The age of the patients is not an acceptable criterion for prioritization; rather, the decision regarding care must be based on the individual's specific need and the expected benefit of the care for the patient in question. The decision for care based on a diagnosis rests with the treating doctor or dentist.

3.4.3 Choice

Service users are increasingly being given choice and control over the care and services they receive. For example, the municipalities can give service users a voucher which can be used to buy services from the private sector. The service user is able to select the service provider form a list of providers approved by the municipality. This system of approved providers can help ensure the quality of care provided by services. (Laukkanen & Volk, 2007. Laki sosiaali- ja terveydenhuollon palvelusetelistä 2009/569). The recently launched online Palveluvaaka service (http://www.palveluvaaka.fi) is where people can compare different quality indicators for nursing homes and sheltered/service homes online. The aim of Palveluvaaka is to improve a person's possibilities to compare different services and thus to help the service user make an informed choice about care.

3.4.4 Client satisfaction

On the client level, the views of the care recipient have been surveyed either ad-hoc or data have been collected by regular client satisfaction surveys by the local authorities. There are no nationwide standardized or compatible questionnaires or regular data collections as to the subjective care quality in Finland.

3.4.5 Role of informal and non-formal care

Informal caregivers of the elderly represent a crucial source of support and aid. If a spouse or family member elects to care for an elderly, disabled, or sick person at home, the municipality should provide the necessary support for informal care. In Finland, there is a national policy to help caregivers receive support so that they can lead more normal lives and better perform their caring duties. In Finland there are over 300 000 family caregivers who are providing care for the disabled, long-term ill or an elderly relative or friend at home. About 28 000 carers receive support based on the Act on Support for Informal Care 937/2005. The municipalities are basically responsible both for health care and the provision of social services. The people have no obligation, according to law, to provide care for their disabled, long-term ill or elderly relatives, though many people choose to do so.

Services requiring guaranteed care are determined in a care and service plan made for the cared-for person. In Finland, there is, however, no policy, law or recommendations that dictate the quality of care that informal carers must provide. There are however some criteria for informal caregivers concerning her/his health status and functional ability.

Informal care givers need assistant as well as guidance and information on issues related to ageing, health and well-being, services and facilities, social allowances etc. Further, caregivers must be told where and how to seek the support and services they need. Through co-operation with local organizations, the municipalities have put together service guides and websites as well as establishing service centers, to which the elderly and their caregivers can turn for personal advice and guidance. But there are large variations between municipalities concerning the availability and accessibility of services.

The Act on Support for Informal Care 937/2005)

- Statutory social service
- Can be granted if a person needs care at home because of reduced capability, illness or disability
- Consist of:
  - any necessary services to support both the caregiver and the person being cared for

  - a care allowance and 3 days leave per month for the caregiver
- Average fee about €416.25/month: From the 1st of January 2011, a minimum of €353.60/month and €707.20/month during a transitional period of heavy care load.
- Commission agreement is made between the caregiver and the municipality (not employment).
- About 23 400 persons (over 65) were entitled to informal care in 2009.

4 Quality indicators, users of indicators and financial issues

4.1 Introduction and meta level

Assessments are made from national to client/patient level. On the national level, the performance of municipalities is assessed. Municipalities and organisations monitor their own performance. On the client/patient level, various aspects of quality are surveyed.

The Ministry of Social Affairs and Health assesses how well the recommendations for older people are put into practice (implementation). *The national framework for high-quality services for older people (2008)* set quantitative and qualitative targets of the service structure and for the staffing level on a national level.

Indicators for quantitative targets for the service structure by 2012 are:

Those aged 75+:

- 91- 92% Living at home either independently or assistant
- 14% Receiving regular home care
- 5 - 6% Receiving informal care allowance
- 5 - 6% Living in enhanced care service housing
- 3% Receiving long-term institutional care

Indicators related to staffing at the national level are:

- Number and training structure of municipal personnel by sector, vocational group and region
- Number of private sector social health and welfare service personnel by sector and province
- Number of personnel per 1000 over 75s in home care and home nursing, old-age sheltered housing, residential homes and health centers
- Number of personnel by vocational group in municipal and municipal federation home care and home nursing, old-age sheltered housing, residential homes and health centers.

The municipalities have also set their own targets for the service structure and staffing level. No direct information on the staffing levels of individual municipalities or care unit is obtainable from national statistics.

The National Institute for Health and Welfare (THL) SOTKAnet service includes and gives data on indicators related to the promotion of health and welfare, with about 20 indicators specifically concerning old age. These indicators are:

- Percentage of all over 75s living alone
- Percentage of all over 65s receiving full national old age pension
- Number of over 65s per 1,000 entitled to special refund medication

- Number of over 65s per 1,000 entitled to special refund medication for psychosis
- Percentage of all over 65s hospitalized for injuries and poisoning
- Mortality rate over 65s per 100 000.

Indicators for financial monitoring and comparison are:

- Total running costs of institutional services for older people, € 1000
- Total running costs of home services, € 1000
- Total running costs of other services for older people and people with disabilities, € 1000

The Kaste programme has also set its own targets indicators concerning quality, effectiveness and availability of services. The Kaste programme is the national development plan for social and health services that covers the period 2008-2011 (http://www.stm.fi/en/strategies_and_programmes/kaste). The main aims of the programme are based on the long-term strategic objectives for the social and health administrative sector. The aims are that: (1) municipal inhabitants' social inclusion will increase and levels of social exclusion will be reduced, (2) the municipal inhabitants' wellbeing and health will increase, inequalities in wellbeing and health diminish, and (3) the quality, effectiveness and availability of services for the municipal inhabitants will improve and regional inequalities will be reduced. Target indicators are:

- Feedback based client satisfaction with services will improve
- The defined timeframes for access to health care will be achieved
- The timeframes for a needs assessment for elderly care services will be achieved
- Regular home care according to need is available for 14 per cent of those over 75 years
- Maximum of 3 per cent of the over 75-year-olds in long-term institutional care
- The shortage of physicians and dentists in primary health care will be reduced
- The shortage of social workers will be reduced
- Regional inequalities in the effectiveness of specialised medical care will diminish

4.2 Observed care quality and health-related quality of life

Recently there have been trends to also highlight the ways professionals interact with older persons. Methods such as dementia care mapping (Brooker, 2005) or ELO-D (Salo, 2006) have been introduced, that present tools for observing interactions between staff and the client. In these tools ethical components are strongly highlighted. So far the use of these instruments has been limited to research, but there is reason to believe that they would also be well accepted in clinical practice. The future will show whether these instruments will be defined under structural quality or if they will present a new angle in the quality literature.

In Finland, the health-related quality of life instruments for elderly care that are based on the health and functional status measurement of the older people; for example, the Minimum Data Set 2.0 [MDS 2.0] and the 15D HRQoL instrument are being developed and validated. The Minimum Data Set 2.0 (MDS 2.0) has since 1987 (originating in the USA) been developed as a structured, standardized, systematic national tool for assessing relevant domains of residents in nursing facilities. (Morris, 1990). The 15D is a generic, standardized, self-administered instrument that can be used both to give a profile and a single index score (Sintonen, 1994). The purpose is to develop a crosswalk between the MDS 2.0 and the 15D

and to test its properties and suitability for further use. With this instrument thus created it will be possible to measure and compare HRQoL of the patients in different long-term care institutions, wards and home care cross-sectionally, and over time and to assess the effectiveness and cost-utility of care provided.

4.3 Adopting guidelines, documentation

In Finland care- or best practice guidelines are developed by Duodecim in the Käypä hoito programs (adequate Care) (http://www.kaypahoito.fi/web/english/home). Duodecim is a foundation founded by physicians, which publishes text books for medical care in addition to a Medical Journal. In the recommendations, old age is usually present; however, the special needs of long-term care clients are seldom addressed.

4.4 Research

Research and evaluation of services also plays a part in ensuring quality in care. The National Health and Welfare (THL), the Association of Finnish Local and Regional Authorities, the Ministry of Social Affairs and Health, Universities and other organisations carry out special reviews and studies in order to provide guidance on best practice and to drive improvement. Longitudinal studies about quality of the patient documentation are sparse in Finland.

4.5 Are there quality indicators (or will they be developed shortly) to monitor patient pathways across services?

The trend is moving towards integrating health and social care. The need for co-operation between different professionals and the need for the integration of services is continuously growing. New interventions like a case/care manager/co-ordinator, a discharge and integrated care programme, and multidisciplinary team work have been developed. The aim of the KASTE programme is to achieve the objectives of the programme by ensuring sufficient staff and a strengthening of skills, and by ensuring social and health care services function as an integrated whole and by using effective models of operation. Together with the Association of Finnish Local and Regional Authorities, the Ministry of Social Affairs and Health support the regional networking of primary health care units. This would help to co-ordinate the supply of services, such as emergency functions and daytime acute consultation, and intensify recruitment. Networking could also be utilised when concluding service agreements with specialised. The achievement of the objectives of the action plan will be monitored by the unit responsible for the development of primary health care at the recently formed National Institute for Health and Welfare and the Ministry of Social Affairs and Health, together with relevant NGOs and stakeholders in the field who are responsible for the implementation and evaluation of the action plan.

The beginning of 2004 saw the launch of the Perfect-project (Performance, Effectiveness and Cost of Treatment episodes) which measured the impact and efficiency of care (http://info.stakes.fi/perfect/EN/index.htm).The aim of this project was to develop assessment indicators based on national registers and to enhance the impact, costs and efficiency of the chains of care through different settings for different patient groups. These indicators are presumed to be useful from a care quality point of view, as well.

The aim of the new Health Care Act has been to intensify the cooperation between primary health care and specialised medical care. The action plan is called *An Effective Health Centre* and the plan is under development currently.

In addition the expanding RAI-activities are producing increasing numbers of semi-annual data from acute care and mental health settings. Follow-up mechanisms and indicators are also being developed for transitions between settings.

There is little research and evidence concerning integrated care and its effectiveness and cost-effectiveness. In Finland, the Integrated Services in the Practices of Home care and Discharge (PALKO) -project was carried out between 1997 and 2007. The aims of the project were to develop, implement and evaluate a new approach in the practice of hospital discharge and continuing care at home, called the PALKO model. The content of the PALKO model included clients' self-determination, human-centered care, proactive discharge planning, integration of services across interfaces and organizations, and seamless and continuous transfer of information. The PALKO model decreased the use and cost of services and showed some improvements in health-related quality of life. The results of the PALKO project suggested that by developing the discharge and home care practices according to the PALKO model, municipalities would be able to offer their elderly population services more efficiently (Hammar et al. 2009, Perälä et al. 2004).

There are currently no national quality standards for integrated health and social care.

4.6 Is cultural diversity a subject in quality management?

The aim of the Finnish aging policy is to support all kinds of patients/clients irrespective of their socioeconomic status, race or the municipality in which they live.

According to law (The Act on the Status and Rights of Patients 785/1992, the Status and Right of Social Welfare Clients 812/2000) in both public- and private-sector services, clients have the right to good-quality social welfare and good, non-discriminatory treatment. Further, if a service provider does not speak the client's language, an interpreter must be arranged whenever possible. However, quality management systems aimed particularly for cultural diversity are practically nonexistent.

4.7 Who uses quality indicators and for which purposes?

Existing (and future) quality indicators are used or are planned for use at many levels.

National Level: the Ministry of Social Affairs and Health uses existing indicators for follow-up and monitoring together with developing purposes on the state level. Targets are the municipalities (local governments).The indicators are needed for developing the payment systems and defining the strategies for policy making for the future.

Municipalities: these use the indicators - particularly the RAI-indicators for developing their services particularly in the field of benchmarking. Another area is purchasing services from the private sector or foundations.

Organisations: these use the indicators for benchmarking purposes in order to improve care and the wellbeing of the clients. Other purposes include staff education and resource allocation between units. Other leadership and management purposes include interactions between units, imago, staff recruiting, and information for families and relatives.

Clients: these compare services and service provides. However, currently these functions are more for the future than praxis. The aim is to help the service user to make informed care choices.

Researcher: develops and tests the developed indicators. The scientific properties of the quality indicators should be tested to the same extent as in scales: face validity, other types of validity, sensitivity, specificity prognostic values. In addition, thresholds need to be set.

The National Institute for Welfare and Health (THL)(previously: The National Researcher and Development Centre for Welfare and Health, STAKES) the SOTKAnet Indicator BANK (www.sotkanet.fi) provides indicators for monitoring and comparing the promotion of health and welfare, service needs, service structure and finances.

The RAI-feedback database offers a unit-level RAI-benchmarking database for the participants, where client structure, scales and quality indicators together with staffing ratios and skill-mix figures are provided.

4.8 How financially sustainable are the approaches being adopted?

The municipalities have the main responsibilities for arranging and funding, alongside state subsidies, high-quality social and health care services for their citizens.

5 Critical overview

Quality of care is a complex issue. It has both subjective and professional components (technical quality), each with several dimensions that depend on who is considered to be the client and how she/he/the organization experiences or measures the quality.

5.1 General problems with measuring quality in long-term care settings

Firstly there is a potential conflict of interests in quality measurement in the long-term care setting. In the industrial world the client/patient pays the bill, receives the product and expresses his/her view about the quality of the purchased item in relation to its cost. In the health and social care business the concept of the client/patient is complicated - the person receives the product but pays only a small part of the bill. The other payer (government, taxpayer) never receives the product and their interest may mainly lie in reducing the bill.

Secondly, clients/patients very often suffer from cognitive decline and are sometimes unable to assess their own situation, to recall recent events or perhaps to express themselves verbally.

Thirdly, clients/patients may suffer from one or more incurable diseases that in a short while are fatal, which might make them see things in a darker light.

Fourthly, these diseases may cause aches and pains, and life losses may be a source of sorrow and depression, which makes things worse.

Fifthly, older persons are often deeply dependent on their caregivers and therefore might be unwilling to express any negative statements.

Sixthly, using surrogates bring in a separate problem area that is little studied. If compared with other widely studied subjective measures, such as the experience of pain, there is reason to believe that clients' / patients' own view about care quality is either over-, or underestimated, or not understood at all. There is no consensus on the use of proxies (yet) in these types of surveys in Finland

Seventhly, the positive results of care interventions are difficult to measure in a situation where chronic progressive diseases are present with no actual cure and the clients/patients may experience decline anyway. In these situations “no decline” in a given time period can be very positive result. Often there might be only unfavorable options available and choosing the management with the least side effects or discomfort is a sign of good care. Clients may also want to choose unfavorable options due to individual preferences or beliefs.

5.2 User satisfaction

Client/patient satisfaction surveys are voluntary and are performed sporadically. Local data collections are usually self-made, non-comparable with previous surveys and lack validation or reliability testing.

The psychometric and other properties of these survey questionnaires are generally not known. The value of those surveys is not known.

In institutions, the client/patient satisfaction surveys can, due to degree of dementia, maximally cover 10–30% of the clientele, and among the home care clients up to half of clients. Therefore views will be skewed and biased in favor of those with intact cognition. Interpreting the results of those reviews is problematic if the comorbidity, degree of cognitive decline, or the burdens of uncomfortable symptoms of each of the respondents are unknown. It is unclear yet if they should be included in surveys. In favor of inclusion is the argument for the right of the person with dementia to express their views, where capable of speaking, although deciding who would be the spokesman for those who are not able to talk remain a challenge.

The views stated above might be one reason for the absence of national client/patient satisfaction surveys. Another explanation is the independent role of local governments that possess an endless human passion for inventing unique questionnaires.

5.3 Structural quality

Structural quality is relatively well known and is addressed perhaps because of its clear association to costs. The RAI-based quality-efficiency ladder shows roughly that in general, resources meet the needs and there is little wastage.

In the rural areas, distances are long and living standards are poor. More attention should be paid to this aspect.

Several items relating to structural quality are collected either nationally or among the RAI-participants together with 300–400 item RAI-assessments. It can be argued the national data collection should be more detailed. On the other hand RAI users increase year after year and detailed relatively country representative information is available for national and local level decision-making. Additional monitoring for structural quality might not be needed at the national level. Key questions in long- term care are: how much personnel would be enough and what education do they need to have.

Bowman et al. (2004) investigated medical and dependency characteristics of the “residential type” and “nursing care type” of residents in 244 care homes in the United Kingdom. They found out that medical morbidity and associated disability rather than non-specific frailty and social needs had been the driver behind admission for over 90% of residents. The care needs of people in those care homes were mainly determined by progressive chronic diseases. Similar findings have also been reported from Finland (Noro et al. 2005). Consequently both staffing ratio and the level of nursing education need to be considered when quality is measured.

5.4 Process quality

The process quality needs attention, not only within service settings but particularly across settings. There is a high demand to find relevant quality indicators for integrated care. There are studies that show increased expenditure around “seams” between settings.

For instance, there is reason to believe that laboratory tests are taken at discharge and immediately on admission (often in the same day). Information is lost, functional aids such as glasses, canes or dentures are lost. In addition, several studies have shown that discharging older patients from acute care can place them at risk of malnutrition, functional decline, and readmissions unless special procedures are taken (Ashton et al., 1995; Naylor et al., 1999; Campbell et al., 2004; Cunliffe et al., 2004; Carpenter et al., 2007; Stenvall et al., 2007a; Stenvall et al., 2007b).

Within settings, acute care for older persons is particularly in need of attention. It is a natural partner for long-term care in transitions. Studies show among other things that malnutrition and inadequate rehabilitation lead to failures at discharge (Reuben, 2006). In short, a hospital is a dangerous place for an older person (Jonsson et al., 2006; Jonsson et al., 2008).

Some of the processes are presented in RAI quality indicators, others are embedded in the questionnaires, but are never presented as indicators. The pathway across services need rapid interventions and indicators.

In Finland, the RAI-system includes training for managers twice per year in seminars. The training consists of information on how to use benchmark data in management, in strategic planning and in developing services and by networking.

Finland has also participated in the Care Keys project (EU-project) where one objective was to develop a set of 'key indicators' that could be used to guide care quality management and to take the first steps in developing instruments and tools for practitioners using these indicators (Vaarama et al. 2008). The Care Keys 'Toolkit' includes among others key indicators on quality of life, quality of care and quality of management, and it promises to support efforts to monitor, plan and develop high-quality care for clients in LTC.

5.5 Outcome quality

5.5.1 The complexity of measuring technical quality in long-term care

The outcomes of high quality care in long-term care are not easy to identify in a population with one or more progressive diseases and pessimistic prognosis covering periods ranging from a few days to maybe the next 3-4 years. Rather than expecting improvement, the rectangularization of the deterioration curves for physical and cognitive decline together with decreased numbers/percentages of those expressing symptoms that generally are associated with suffering, can be considered signs of high quality care.

5.5.2 Quality and economical benefit share common interests

The preliminary results from long-term care facilities show that it is possible to improve quality of care even in this stage. Therefore it is urgent to make the enact the same trends BEFORE the client enters an institution.

From the economic and care quality point of view it can be stated that eliminating or diminishing those factors that are known to lead to increased disability, in the short term, are signs of successful and efficient quality programs.

These factors are, according to systematic literature review by Stuck et al. (1999), cognitive impairment, depression, disease burden or comorbidity, increased and decreased body mass index, lower extremity functional limitation, low frequency of social contacts, low level of physical activity, no alcohol use compared to moderate use, poor self-perceived health, smoking and vision impairment. In a well-designed longitudinal study (the Kungsholm project), in Stockholm, Sweden, dementia was the major cause of functional dependence, followed by age, cardiovascular disease, hip fracture and heart disease. However, only age and dementia were associated with a continuous decline in functional capacity (Aguero-Torres et al., 1998).

All these issues can be tangled, however, work must be continuous, and not based on projects that begin and end, giving only a limited view of trends.

5.5.3 Comprehensive geriatric assessment

The best known way to prevent disability and postpone institutional care among older subjects is to perform a thorough comprehensive multidisciplinary geriatric assessment (CGA).

In-home CGA-based intervention programs delay the development of disability, reduce unplanned admissions, and permanent nursing home stays among elderly people living at home (Stuck et al., 1995; Nicolaus et al., 1999; Hubbard et al., 2004). Comprehensive geriatric intervention programs improve health-related quality of life without increasing the overall costs of care (Pitkälä et al., 2008). Outpatient geriatric interventions in older patients with multiple chronic diseases and performed by geriatricians in collaboration with primary care physicians have been shown to increase chronic disease self-management, and physical activity, in addition to reducing the hospitalization risk and total health care costs (Fenton et al., 2006).

The best practices in assessing an older person's care needs include the use of structured health assessment protocols, an integrated multidisciplinary approach, targeting patient groups with intermediate levels of disability and handicap, in-home assessments and carefully structured follow-up mechanisms (Gray and Newbury, 2004).

There are no national recommendations for such assessments. However, within RAI-users, such assessment has been performed biannually for every person receiving long-term care to produce and update individual care plans. Therefore, there was reason to assume that the quality indicators at the unit level would show improvement, and they did. The economic and quality benefits are obvious, if without increasing the number of staffing, the (expensive) psychotropic medications can be abandoned and side effects, such as falls or rigidity, be avoided, while at the same time everyday life develops in a more meaningful direction.

Only three of the benchmarked areas were developing in an unwanted direction. Those were incontinence, onset of cognitive decline, and use of nine or more medications. Deeper analyses are needed to find out the true meaning of these trends. One assumption is selection. Newly admitted persons are already, on admission, sicker, more demented, and disabled than those previously admitted. Since dementia is the driving force, incontinence follows automatically. Every year a greater percentage of residents are beyond any toileting programs due to underlying disease. If this is the case, those figures that show improvement have more value: more falls, restraints, nutritional, and behavioural problems would have been anticipated than seen in 2008.

These preliminary figures show the quality trends in the institutions and in the corresponding housing formats. No knowledge is available on those who are not participating in RAI-assessments to improve care.

5.6 National level

Finland has struggled since 1999 to improve the quality of care for older persons. The recommendations have been – given the legislation – general, broad, and loose with no practical sanctions. In addition the focus is increasingly targeted on promotion and prevention. Therefore the needs of those already receiving long-term care services are only superficially addressed.

At the same time when multiple plans across a broad sector are made to improve and monitor the care for older persons, little is done for the quality of care in institutions. Furthermore, there is a true risk that local governments ignore developing their home care due to the economic depression and at the same time close institutions for the same reasons, without addressing the quality recommendations launched by the ministry of Health and social welfare.

Today the only thing that comes close to a national holistic and comparable quality monitoring system is the RAI.

6 Summary and conclusions: An evaluation of quality management in Finland and an appraisal of where it is heading

In summary, multiple programs are in process both locally and nationally. The impact of the programs, other than RAI, will depend on how standardized the data collecting will be, on how well the municipalities will commit to it, and on how long the economic depression will bite.

These quality programs, other than RAI, will address long-term care only superficially. The economic benefits of the RAI-programs have been be analyzed during 2009-2010.

It will be a challenge to provide health and welfare services in a situation where the population ages, the post-war baby boom generation retires, internal migration increases, and where external economic changes – e.g. in the wake of globalization – will pose serious challenges.

Finnish municipalities have invested in structural change; preventive work with the older people is encouraged, the functional and coping abilities of the older people are supported – enabling them to manage independently for a longer period of time – and the services provided within homes have been increased. The municipalities are also endeavoring to work in co-operation with the Government to ensure the sustainability of funding for these services. One challenge remains the considerable differences in service availability and quality between municipalities and regions. The services are more vulnerable, particularly to the economic circumstances of the municipalities and, in part, to the development of availability in the work force.

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