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

COUNTRY REPORT

Long-term care policy in Finland

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Contents

Highlights

- Long-term care (LTC) services are part of the universal health and social care system in Finland.
- Current policies seek cost savings by reducing the use of institutional care.
- Increasing patients' choice and integration of social and health care services in LTC are currently debated.
- Planned major reforms in social and health care in 2019 are expected to have wide-ranging consequences for LTC provision in Finland.

1 Introduction

This report summarizes recent and emerging policy developments in Finland related to LTC provision. It focuses on key policy developments in coordination of formal LTC, informal care, preventive health care and welfare technology in LTC. It summarizes some scientific evidence related to the effects of care integration on the quality and costs of LTC. The report begins with a brief overview of the current LTC system. It goes on to outline the ongoing health and social care reform which is expected to have wide-ranging consequences for the organization of LTC provision.

2 A short description of the formal LTC system in Finland

LTC services in Finland are part of the universal health and social care system which provides services to all citizens in need of care. LTC services are provided by a network of actors including public and private providers of health and social care services. However, the responsibility for organizing the services rests with the municipalities. Municipalities represent the local level administration and act as self-governing administrative units, and form the majority of public administration in Finland. The legal framework guaranteeing their right to self-governance is codified in the Constitution. As of 2017, there are 311 municipalities in Finland with populations varying from about 1,000 to more than 600,000.

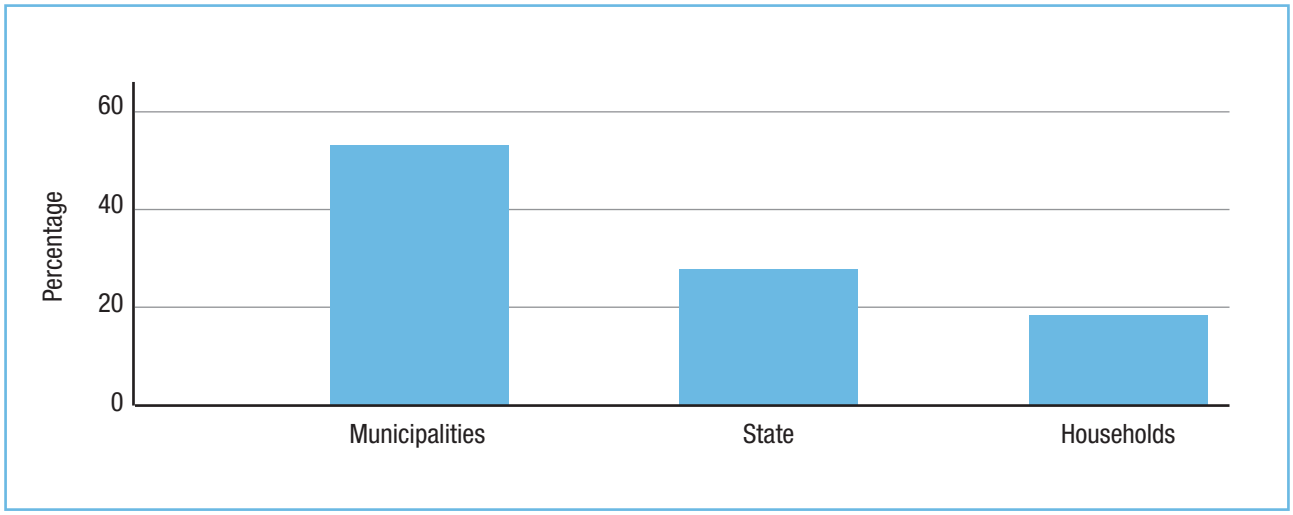
Municipal health and social care professionals assess individuals' needs for social and health care services. After the assessment, the municipality is responsible for drawing up a service plan defining the services required to support the person's wellbeing, health, functional capacity and independent living. The views of the person should also be recorded in the service plan. The municipality makes the final decision about the provision of services.

2.1 Service provision and financing

Municipalities can organize their services in several ways. They can produce services themselves via public facilities, in cooperation with other municipalities, or purchase the services from the state or other municipalities or from private providers. Municipalities may also grant a voucher to a service user, who can use the voucher to purchase the service from a preferred private provider.

The two most important funding sources for LTC care in Finland are the state government and municipalities (Figure 1). The state government allocates state subsidies (or state grants) to municipalities. These state subsidies are typically not earmarked (Seppälä and Pekurinen, 2014). Thus, municipalities have a large discretionary power to finance the provision of health and social care services through the returns from municipal taxation, state subsidies and user fees. The maximum user fees that municipalities can charge are regulated by decree (Asetus sosiaali- ja

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



Source: Seppälä and Pekurinen, 2014

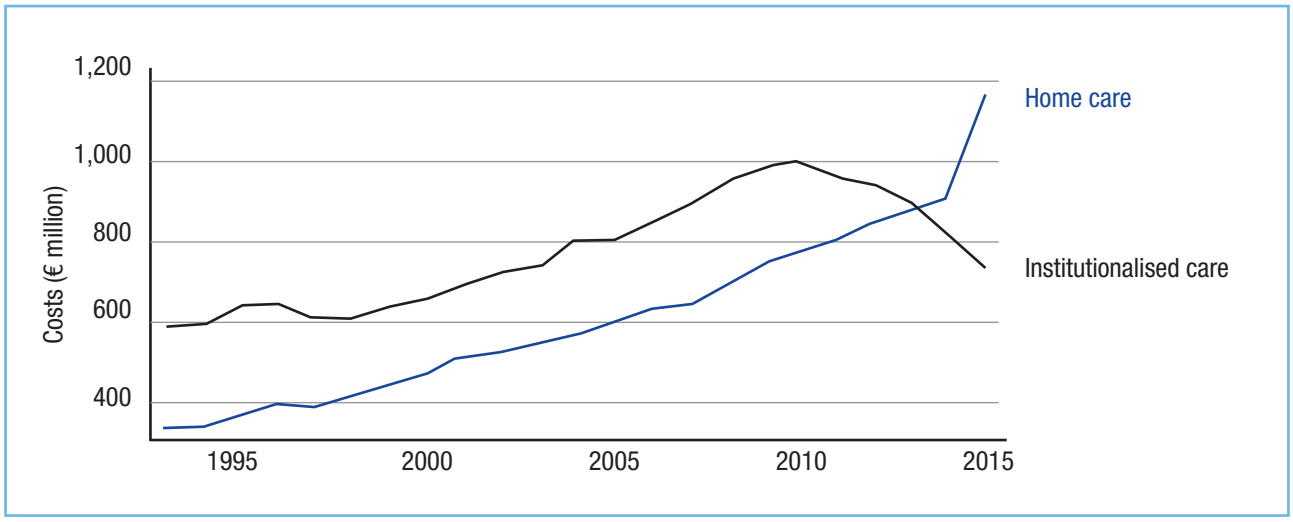
terveydenhuollon asiakasmaksuista, 912/1992). The maximum user fees are generally means tested and home care fees depend on the size of the household to which the service user belongs to.

Formal services can be classified into community care and institutional care (Noro et al. 2014). Community care includes home care, support services (e.g. meals-on-wheels and cleaning) and care provided at day centres, service centres and sheltered housing facilities with and without 24-hour assistance. Community care also includes informal care support for compensated informal carers and cared-for people. Institutional care consists of LTC provision in old people's homes and in primary health care. Sheltered housing with 24-hour assistance is often very similar to institutional care with regard to patients' needs. Thus, the term round-the-clock care (Noro et al. 2014; Colombo et al. 2011) has been adopted. Round-the-clock care is understood to include institutional care and care provided in sheltered housing facilities with 24-hour assistance. In addition to the public provision of LTC services, service users may purchase some services directly from private service providers. These service purchases are fully covered by out-of-pocket payments. There has been a continuing trend to reduce the proportion of elderly people relying on institutional care and cover their care needs with home care services. The major policy rationale for the reduction of institutional care has been an implicit assumption that home care is less costly than institutional care. Figure 2 shows investments in institutional care and home care in Finland by year from 1993 to 2015.

2.2 Legislation and quality recommendations

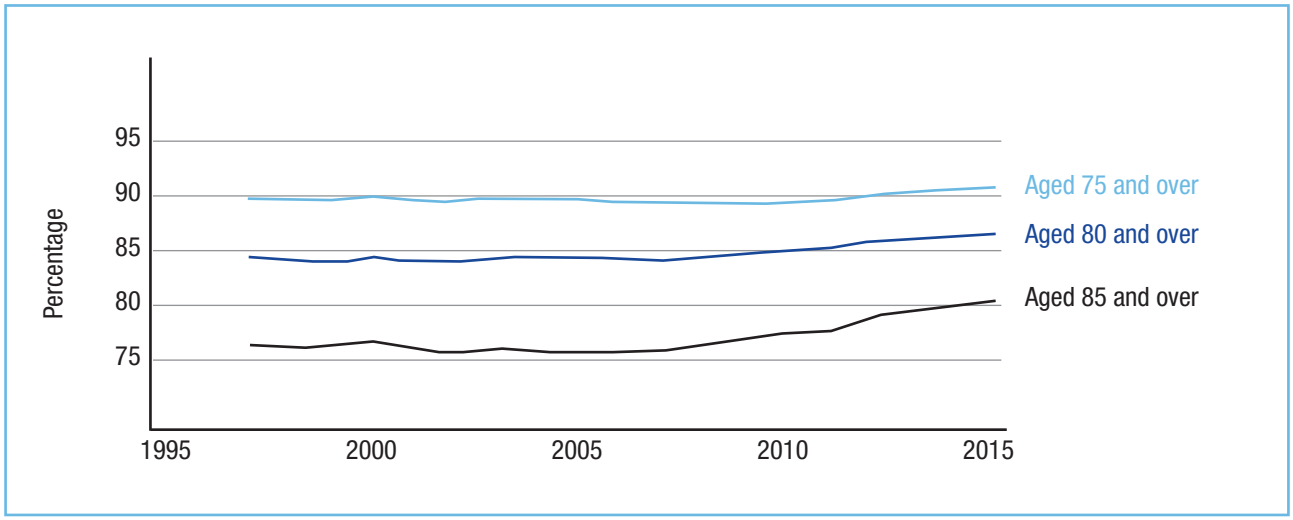
The Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons (980/2012) was introduced in July 2013. The act focuses specifically on health, wellbeing and services among the elderly and complements the existing legislation on organization, pricing and financing of health and social care services (e.g. the Social Care Act and the Health Care Act, 1326/2010). The law regulates the responsibilities of the Finnish municipalities in promoting wellbeing, health, functional capacity and inclusion among the older population, assessing service needs of older people, and responding to these needs by providing high-quality social and health care services. The act also regulates the provision of service quality in units and facilities providing social and health care services for the elderly.

Figure 2: Investments in institutional care and home care in Finland by year from 1993 to 2015



Data source: www.sotkanet.fi – Statistical information on welfare and health in Finland.

Figure 3: Proportion of population living at home in age groups 75+, 80+ and 85+



Data source: www.sotkanet.fi – Statistical information on welfare and health in Finland

Quality recommendations for LTC were issued in in 2001, 2008 and 2013. Recommendations have been developed to support development and evaluation activities in municipalities. They aim to ensure both healthy and capable ageing and effective and high-quality services for the older population (Sosiaali- ja terveysministeriö ja Kuntaliitto, 2013). Recommendations cover inclusion, living environment, securing healthy and capable ageing, quality and coverage of services, personnel, informal care and management. For example, it is recommended that, by 2017, of those aged older than 75 years, 91–92% should live in their own homes and 2–3% should be in institutional care. Figure 3 shows the proportion of the population older than 75 years living at home between 1997 and 2015. Quality recommendations have been considered useful by municipal decision-makers, in particular when they give concrete examples on how to improve the quality of LTC (Sosiaali- ja terveysministeriö ja Kuntaliitto, 2013).

3 Coordination and integration of LTC in Finland

We will begin our discussion about the LTC policy development in Finland by examining the historical and ongoing developments in care coordination and integration. We also briefly discuss the rationales given for integrating health and social care services in home care in Finland.

3.1 Concepts of coordination and integration

The concepts of coordination and integration are often intertwined and the difference between the two concepts is subtle. For example, McDonald et al. (2010) defines coordinated care as follows:

> Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

Thus, care coordination refers to coordinated activities of different stakeholders in health and social care to provide appropriate care for individuals in need of care. Stakeholders can be public, private or non-profit care providers, professionals in health and social care, regulators of health and social care, informal carers, service users or individuals with care needs. Integrated care of the elderly is defined by Tepponen (2009) as follows:

> Integrated care is a well-organized and planned whole of care episodes and services, aiming at responding to complex needs of elderly clients in an appropriate, sufficient and cost-effective way.

Like the definition of coordinated care, the above definition mentions the organization of services needed by patients or clients in such a way that it efficiently meets the needs of patients and clients. This definition of integration does not imply the merger of organizations responsible for the provision of care, as is typically the case when integration is examined in the economics literature (e.g. Varian, 2010). In what follows, we do not make a distinction between the terms coordination and integration, but use them interchangeably.

3.2 Reasons for coordination and integration of LTC services

Several reasons for better integration of social and health care services have been put forward in the literature analysing Finnish LTC (Tepponen, 2009). First, the aging of populations has increased the number of individuals with complex health needs and limited ability to function. This demographic change increases the demand for the coordinated service provision within health and social care sectors, because a growing number of individuals need a combination of health and social care services. Complex health needs and limited ability to function are of course particularly prevalent in the population aged 80 years or older, which is predicted to grow quickly in future years and decades (European Commission, 2009).

Second, the increased diversification of service supply both within and between the public and private sectors has created a need for better coordination of care. For example, several support services, like cleaning, have been outsourced from the public sector to the private sector. At the same time, both the number and variety of professionals providing health care, personal care and support services has grown.

Third, changing health policies may also encourage coordinated care. During times of sluggish economic growth, policymakers emphasize the efficient use of public resources in the health and social care sector. There is a wide belief among policymakers that better coordination and integration of care will improve the quality of care and contain the growth of costs when provided for populations with complex health and social care

needs (HE, 221/2004). Some regional pilot programmes support the hypothesis that the integration of health and social care sectors may succeed in containing the growth of costs (Erhola et al., 2014), but generally the evidence on the positive economic effects of health and social care integration is sparse and weak (e.g. Mason et al., 2015).

3.3 Policy developments in coordination and integration of LTC services

Here we concentrate on the development of integrating/coordinating practices in Finland over past decades. These integrating practices can be various (Tepponen, 2009, referring to Leichsenring, 2004). They can refer, for example:

- the assessment of care needs in multi-professional teams
- common care plans for both health and social care services
- integrated practices of discharging patients from hospitals
- various forms of care management
- one entry/access point for elderly people (providing information about both health and social care services)
- various intermediate services between institutional and community care.

Since the coordination of care is closely related to integrated care, we also discuss coordinating practices, such as negotiating and cooperation practices between health and social care, whenever such practices have applied to Finland. After a description of the general policy development in Finland, we discuss the existing evidence of coordination/integration on costs and outcomes.

3.3.1 General policy development in Finland

Here we take a longer perspective on the policy developments in health and social care integration and summarize Tepponen's (2009) findings about the health and social care integration in the home care for the elderly in Finland. We begin our discussion with the 1950s and 1960s when large home health care centres were set up in large municipalities and population centres (Tepponen, 2009). The first home health care centre was established in Helsinki in 1951 and the second in Hyvinkää in 1962. By 1973, there were 85 home health care centres in Finland. These provided both home help (social care) and home health care (health care) to the elderly population with the aim of supporting independent living at home and preventing or postponing the costly use of institutional care. These centres were early Finnish examples of integrated health and social care services for elderly people.

Home health care centres were directed by a district nurse, administered by a committee, and steered and monitored by a directorate consisting of a medical superintendent, a private doctor, a representative from the private sector, a local director of social welfare services, and a representative from the town or city board. The centres educated home helpers and provided the services of home helpers and home nurses to hospitals, doctors and home care clients. Home helpers and home nurses (who were managed and monitored by the district nurse) received payments directly from clients.

Some support services, such as bathing, cleaning and washing services for the elderly in the community, were developed as a cooperative effort of municipalities and third-sector organizations in the 1970's. One example of such cooperative services was the provision of hot meals for elderly people at home.

The structural integration of home services and health care represented by the home health care centres in the 1950s and 1960s ended in the 1970s at the time of an extensive public health reform in Finland. After the introduction of the Primary Health Care Act (66/1972), primary health care centres were set up in each Finnish municipality and all outpatient health care services were centralized to these centres. Although some primary health care centres

hired social workers (Sinkkonen and Jaatinen, 2003), more often it was the case that social care services, including home help for the elderly, were organized and governed separately from health care services. This trend created a division between home help (organized by social care) and home health care (organized by health care), complicating the implementation of home care for the elderly in practice (Sinkkonen et al., 1977). Although the integration of home help and health care was recommended by the Public Health Care Act, very few municipalities ended up implementing this recommendation in practice (Tepponen, 2009).

Central government agencies in health and social care continued to recommend the integration of home services and home health care during the 1980s. The authorities believed that the integrated services were needed to enable independent living at home for elderly people. Structural integration of home services and health care started again at the beginning of the 1990s in parallel with a more general trend to integrate municipal health and social care committees (Tepponen, 2009), and this integration continues.

One important step in the integration of home care services for the elderly was the temporary law on the integration of health and social care introduced in 2004 (Laki sosiaalihuoltolain ja kansanterveyslain väliaikaisesta muuttamisesta, 221/2004), which concerned the organization of health and social care services in the municipalities. Municipalities were enabled to organize social and health care services for the elderly under a municipal social care or health care organization or an organization specifically developed to develop and manage the provision of elderly care services. This law reform gave legal possibilities for Finnish municipalities to integrate home services and home health care into home care. Although the law was temporary and designated a pilot, it became permanent and the legal obstacles to integrated home care have been removed after the pilot programme.

3.3.2 Other types of integration and coordination in Finnish LTC

According to Tepponen (2009), other integrative practices in the Finnish LTC have been the coordination of workers, multi-professional groups, common care plans and electronic patient records.

Coordinating workers were the predecessors of care managers in the Finnish LTC. Introduced in the 1970s and 1980s, the idea was that an elderly client needs a care manager to liaise with authorities and care providers, ensuring their care needs are appropriately responded to. The current legislation, the Social Care Act (1301/2014) states that elderly care clients should have a dedicated worker ensuring that clients' care needs are met.

Multi-professional or SAS – selvitä/arvioi/sijoita (clarify/assess/place) – groups, introduced in the 1980s, are another form of structural integration in Finnish LTC for elderly people. They assess the needs of elderly clients, implement service provision and evaluate the care provided.

Care plans for home care clients and those in residential care are obligatory by law. They were made mandatory in the 1990s and they also appear in the Act of Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Person (980/2012), which was introduced in 2012. Care plans are drawn up by municipalities after the care needs of an elderly individual have been assessed and define the set of services that is needed to support the wellbeing, health, ability to function, independent living and good care of the elderly individual. There is a requirement for the views of the elderly person and their relatives to be recorded in the plan.

Some municipalities began to use electronic patient records for the home care clients at the end of the 1980s. Although there have been developments in this area, there remain municipalities that do not use electronic patient records in home care (Tepponen, 2009)

3.4 Evidence on costs and outcomes

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

The most common practice aiming to increase care coordination is structural integration, where municipal home care units are organizationally merged with health and welfare departments. Based on available evaluations, it appears that this care coordination has led to more integrated management processes with some potential impact on actual care practices or quality of care among clients living at home and those in institutional care.

Paljärvi et al. (2011) find that homecare quality has remained largely at the same level between 1994 and 2009, despite organizational mergers in health and social care service production. Many of the questionnaire-based evaluations assessing the quality of integrated care provision in Finland do not focus on the consequences of integrated practices but aim to identify the most critical factors contributing to the perceived quality of care. Across the published studies, the most common concerns among LTC patients appear to be rushed care visits and the high turnover of caregivers (Tepponen, 2009).

The more convincing evidence about the impact of coordinated care provision comes from three randomized controlled trials (RCTs) which aim to evaluate the consequences of certain aspects of coordinated care provision. However, these RCTs focus on the effectiveness of coordinated care provision in relatively specific domains and patient groups. Kinnunen (2002) investigates the effectiveness and costs of individually planned and packages of health and social care on patient institutionalization. The study finds that the need for institutional LTC was significantly lower in the treatment group than in the control group during a two-year follow-up period (41% of the patients in the intervention group and 64% in the control group moved into long-term institutional care within two years from the start of the trial). However, the initial difference between the treatment and control groups vanished during the post-trial follow-up. There was no effect on mortality. The author also reports that there was no effect on the total costs between the groups. Notably, patients in the treatment group received more health care services and spent twice the number of days in hospitals than the patients in the control group.

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

Eloniemi-Sulkava et al. (2009) investigate the effectiveness of a multicomponent care coordination intervention where dementia patients living at home with their partners are provided a family care coordinator, a geriatrician, support groups for caregivers, and individualized services. The study finds that a larger proportion of patients in the control group were in long-term institutional care than in the treatment group at 1.6 years after the start of the care coordination. However, at two years the difference was statistically not significant. There is some evidence based on the study that a tailored coordinated care programme for dementia patients may lead to cost savings due to delayed transition into long-term institutional care and fewer days spent in acute hospital care.

Overall, Finnish LTC policies have witnessed many changes over recent years, as documented in the previous section. The effectiveness and economic consequences of these system-wide changes in care provision have not been systematically evaluated. However, existing longitudinal studies report that the quality of LTC has not changed during the last decade. Despite the relatively widely spread public scepticism about the quality of long-team care and publicity of some prominent and widely reported problems in care provision, the quality of care, as measured using questionnaires among the patients and caregivers, has stayed at a satisfactory level. While there is no satisfactory evidence about the consequences of system wide policy changes towards more coordinated care provision, there is some evidence about the impact of coordinated care provision based on highly specialized models of care coordination among certain patient groups. The results from these evaluations suggest that tailored coordination and intensified health and social care before transition into institutional LTC may improve patients' outcomes without increasing the costs of care.

3.5 Incentives for LTC integration

In this section, we discuss specific topics related to the integration of care, including incentives for integration and the management of elderly care. Some of the topics overlap with the description of the general policy development in Finland and hence are treated briefly.

The financing of LTC is characterized by the presence of multiple payers. Financial resources allocated to LTC are collected from multiple sources and channeled to providers through various funders. Currently, 58% of LTC costs are covered by municipalities, 29% by the state, whereas households directly finance about 18% of the total costs (Seppälä and Pekurinen, 2014). Household contributions include income-based payments, fixed payments and co-payments for otherwise publicly-covered services. The maximum co-payments that municipalities can charge are regulated, but municipalities may deviate from the maximum payments and provide services without any direct cost to a recipient. Notably, the coverage of pharmaceutical costs depends on the type of services received. The pharmaceutical costs of community-dwelling individuals receiving homecare services or living in serviced housing are covered by the Social Insurance Institution and patients' out-of-pocket payments, whereas the pharmaceutical costs of individuals living in institutional care are fully covered by the municipalities.

The presence of multiple payers in LTC may introduce conflicting incentives for providers and hinder service integration. While there are relatively few incentives for duplicate care and overtreatment in the Finnish system, the multipayer system may lead to cost-shifting and frequent transitions between the care providers. To counter the conflicting incentives associated with the multipayer system and increase care coordination, municipalities have been increasingly implementing organizational mergers between homecare service units and home health care units and introduced bundled payments for all home care. Moving from individual payments for different services to a bundled payment for a set of services is thought to increase care coordination and reduce patient transitions between different care-giving organizations. However, as the municipalities are responsible for organizing the services, the use of bundled payments and other incentives for care coordination may vary between municipalities.

4 Policy measures to support informal care

Policy measures supporting informal care in Finland have been mainly targeted to develop support systems for informal caregivers. The pool of informal caregivers can be divided into compensated informal caregivers (CIC) and (other) informal caregivers (IC) in Finland. Informal care support (Laki omaishoidon tuesta, 937/2005) is a formal social service allocated to compensate informal caregivers and cared-for persons. It consists of the caregiver's allowance, care leave and services provided for both the compensated informal carer and the cared-for

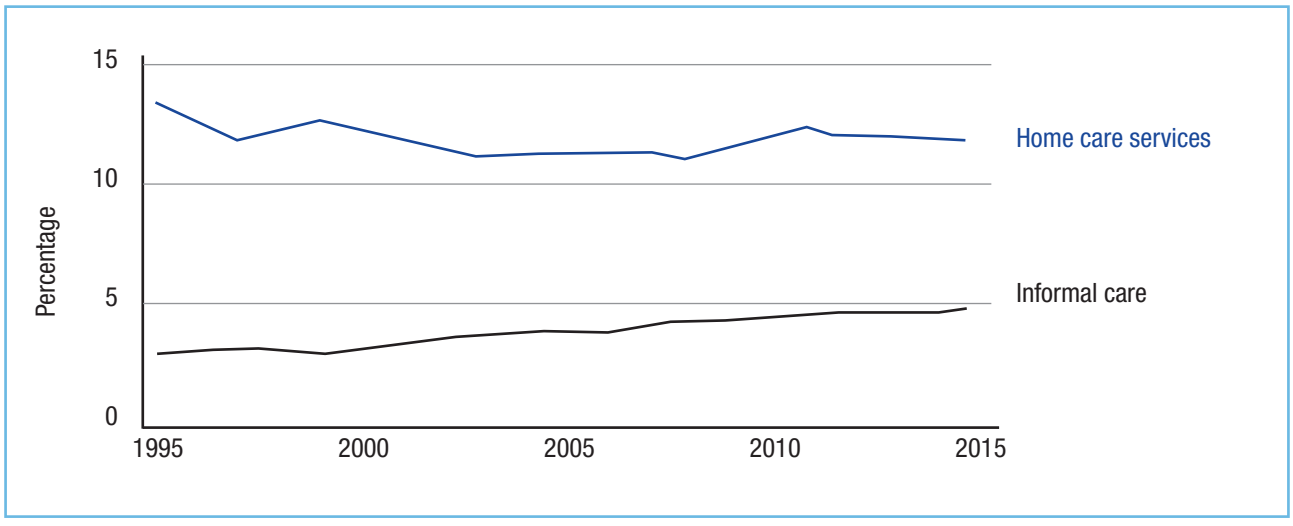
person. A compensated informal caregiver takes care of a relative or otherwise close person typically at his/her home. The care need of the cared-for person may be related to old age, disability or illness. Compensated informal carers pledge to undertake care duties by signing a contract with municipalities (Linnosmaa et al., 2014).

Persons in need of care may apply for informal care support from their municipality of residence. Before the support is granted, the cared-for person's need for support and care, the care-giver's ability (e.g. health status) to take up care duties and the suitability of the living environment are assessed. The caregiver's allowance is determined according to the degree of complexity and dependence of the tasks. The minimum monthly payment is currently €300 per month (Laki omaishoidon tuesta, 937/2005). The law also decrees that the minimum payment is €600 per month for a transitional stage that is demanding and burdensome for the caregiver. Actual caregivers' allowances vary across Finnish municipalities (Linnosmaa et al., 2014). Compensated informal carers are eligible for three days of care leave (respite) a month during the periods when they are committed to the round-the-clock care. Municipalities are obligated to arrange respite care for these days.

In 2015, there were 44,107 compensated informal carers in Finland (Sotkanet, 2016). This includes those caring for people under 65 years old. As 67% of cared-for people are 65 years or older (Sotkanet, 2016), one can calculate that approximately 29,571 compensated informal carers provide care for older people. In total, there were 45,329 Finnish people receiving compensated informal care in 2015 (Sotkanet, 2016), implying that some caregivers provide care for more than one person.

Compensated informal care is provided for care recipients from all age groups in Finland, but most of the care is given to old people. The national survey conducted in 2012 found that 64% of care recipients were older than 64 years. According to the findings of the same study, the amount of care needed was assessed to be high or very high for 68% of the care recipients. A look at the carers' side showed that the narrow majority (52.5%) of compensated informal care-givers were older than 64 years. In addition, most of the caregivers took care of their spouse (58%) or a parent (23%). Around 60% of the caregivers were retired and 17% of the carers were working in 2012. Figure 4 shows the proportion of the population receiving formal home care services and informal care in the age group 75 years and older, for the years 1995 to 2015.

Figure 4: Proportion of population receiving formal home care services and informal care, aged 75 years and older (1995– 2015)



Data source: www.sotkanet.fi – Statistical information on welfare and health in Finland.

4.1 2006 law on informal care support

Laws and decrees regulating the provision of informal care support in Finland have been in force since 1993. Between the years 1993 and 2006, compensated informal care was directed and regulated through the Social Care Act (Sosiaalihuoltolaki, 1301/2014). During that time period, several reforms or improvements to informal care support were made. The length of care leave was set at one day in 1998 and to two days per month in 2002 for those caregivers with binding care duties (providing round-the-clock care). Finally, the length of care leaves was extended to three days for those caregivers with binding care duties at the beginning of 2007.

Fees that municipalities could charge for respite care were capped at €9 per day in 2004, increasing in 2014 to €11.30. Finally, the minimum caregiver's allowance was increased in 2005 to ensure the real purchasing power of the allowance (HE, 131/2005).

Despite these improvements, several issues remained regarding informal care support at the beginning of the twenty-first century. Problems were seen with the amount of support for older, disabled and ill caregivers (HE, 131/2005), the reconciliation of care and work duties as well as care allowance and other social benefits, and cooperation between health and social care. In addition, it was generally thought that old people willing to stay and live in their homes as long as possible should receive more support.

As a response to these shortcomings, a government bill on a new law on informal care support was introduced at the end of 2005 (HE 131/2005). The Finnish parliament accepted the bill, and the law on informal care support came into force at the beginning of 2006, replacing the previous decrees and provisions on informal care in the Finnish legislation.

The 2006 law aimed to strengthen the role of informal care support as part of the community care system, increase the equality of access to services, and support elderly people to live in their homes as long as possible. The law remains in force, although with small modifications over the years. It regulates the eligibility for informal care support, services provided both for compensated informal carers and care recipients, respite care, carer allowance, care plans and the care contracts between compensated informal carers and municipalities.

4.2 Development programme for the years 2014–2020

Informal care support is a discretionary social benefit and its provision is affected by the financial situation of Finnish municipalities. This has been considered to be a shortcoming of the service (Sosiaali- ja terveysministeriö, 2014). In addition, municipalities do not use common criteria in granting the caregivers' allowance.

The Ministry of Social Affairs and Health established a committee in 2012 to draw up a development programme for informal care support for the years 2014–2020. The aims of the programme (Sosiaali- ja terveysministeriö, 2014) were to:

- improve access to informal care support;
- improve equality between compensated informal caregivers and care recipients;
- help caregivers cope with the burden of care;
- develop models to enhance flexible coordination between care and work.

It was expected that the programme would propose measures to achieve these goals, devise an implementation plan, and propose changes to the existing legislation.

The working group responsible for drawing up the development programme did propose several changes to informal care support (Sosiaali- ja terveysministeriö, 2014). For example, it was proposed that informal care should be divided into contracted informal care (with a contract between the caregiver and his/her municipality) and to informal care without such contractual obligations. This would not entail a change in the existing informal care system as such. What was new was that informal care support including a contract (and

the associated caregiver's allowance) should be available only for those caregivers with demanding and binding care duties. It was proposed that other carers would receive services and support to help them to cope with the possible burden of care.

The working group also proposed a new caregiver's allowance scheme where the allowance would vary depending on the level of care provided. The same scheme would be applied nationwide, with three rates of payment, €500, €700 or €1100 per month, depending on how demanding and 'binding' were the caregiver's duties.

In addition, the group suggested that care leave should apply to all compensated informal carers. At the time the development programme was being drawn up, caregivers were eligible to three days of care leave per month if their care duties were binding and demanding. The working group suggested extending the eligibility for care leave to all informal caregivers contracting with their municipality of residence. The development programme also included a proposal for municipalities to arrange physical and wellbeing examinations for informal carers.

4.3 The most recent policy actions

The most recent changes to informal care support, in 2016, reflected proposals appearing in the development programme on informal care support (Sosiaali- ja terveysministeriö, 2014). The law on informal care support (Laki omaishoidon tuesta, 131/2005) was reformed in 2016 to include physical examinations, education and training for compensated informal carers and the extension of care leave to at least two days a month for all compensated informal carers (Hallituksen esitys, 85/2016).

A new article 3a was added to the law on informal care support (Laki omaishoidon tuesta, 131/2005) in 2016. Municipalities are now responsible for providing education and training for compensated informal carers in need of it. In addition, municipalities are required to organize health and wellbeing examinations and services supporting the care duties of compensated informal carers.

According to the current law, all compensated informal carers are eligible for two-day care leave per month. Those carers providing demanding and binding care are eligible for three-day care leaves per month. It was thought that this extension would help working caregivers better coordinate their paid employment and relatively demanding and binding care.

The government bill (Hallituksen esitys, 85/2016) estimated that these most recent reforms would cost Finnish municipalities €90m in 2017. However, the net cost results of the reform were estimated as positive, because the enlargement of informal care support would bring about €113m of savings in 2017. This evaluation is based on the assumption that improving compensated informal care through better care leave and better education would reduce the need for and use of costly institutional care for elderly. On the basis of empirical findings (e.g. Van Houtven and Norton 2002; Bolin et al. 2008), it is realistic to think that such a substitution effect between informal and formal care exists. Whether the magnitude of the net benefit in the government bill is realistic, however, depends on the extent the proposed measures do in practice increase the provision of compensated informal care family care in Finland.

5 Reduction in institutional LTC and promotion of healthy aging

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

the proportion of people aged 75 and over living at home to 91–92% (Sosiaali- ja terveysministeriö and Kuntaliitto, 2013).

While investments in preventive health care and an official policy resolution to reduce the proportion of the elderly population in institutional LTC are occurring at the same time, the implementation of these policy programmes is quite different. The policies to support independent living among older people and set quantitative targets for people living at home are largely driven by top-down policymaking, where public finance aspects are of major importance. On the other hand, the planning and implementation of preventive healthcare programmes is fragmented and includes multiple largely independent actors. Moreover, there is a large variety of preventive health programmes, from large-scale primary prevention (e.g. vaccination programmes) to small-scale programmes with very narrow target groups.

Preventive health care in Finland is directed and guided by the Ministry of Health and Social Affairs. However, the implementation of health promotion programmes is a municipal-level responsibility. Municipalities, in turn, often collaborate with non-governmental organizations which are funded through the state-owned gaming monopoly and membership fees. The large number of organizations that are independent from governmental guidance and their non-governmental nature makes the preventive health care system agile to react to arising health and social concerns, but at the same time leads to fragmentation and short-lived project-based prevention initiatives with little evidence about their effectiveness. A non-exhaustive list of preventive care programmes targeting the elderly population includes preventive projects to curb alcohol consumption among the elderly, to prevent falls and broken hips among the elderly, to increase physical capacity and to offer lifestyle counseling.

The need for institutional LTC in Finland is strongly associated with Alzheimer's disease. It has been estimated that 80% of elderly people living requiring institutional care have Alzheimer's disease (Einiö, 2010). While the international evidence on the role of other medical conditions and quality of housing is largely inconsistent, a study utilizing unique administrative data on Finnish adults aged 65 and over finds Parkinson's disease, stroke, depressive symptoms, other mental health problems, hip fracture, and diabetes are strongly associated with an increased risk of admission into institutional LTC in Finland, after controlling for socio-demographic confounders and co-morbid conditions (Einiö, 2010). Even though the study assessing health-related predictors of institutional LTC does not enable causal interpretation, findings that associate specific health conditions may help to assess the potential of current preventive health care policies to delay and prevent the need for high-cost and intensive institutional LTC.

Given the evidence about the predictors of institutional LTC in Finland, many preventive care programmes have appropriate target populations. These programmes may potentially prevent or delay transition into LTC. Despite the increasing emphasis on preventive care and clear policy targets for the proportion of people aged 75 and over living at home, there is a serious lack of reliable evidence about the costs and effectiveness of alternative preventive care programmes and models. However, useful evidence is provided by the Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER). In contrast to the results from many single domain prevention trials, this study investigates the effectiveness of a multi-domain approach, including nutritional guidance, physical exercise and cognitive training. The results from this two-year randomized controlled trial suggest that these interventions could improve or maintain cognitive functioning in at-risk elderly people from the general population (Ngandu et al., 2015). While the study provides interesting results related to the potential effectiveness of multi-domain prevention, it does not provide clear-cut evidence about the cost-effectiveness of prevention in the elderly population. The robustness of the reported results has also been questioned (Lampit and Valenzuela 2015; Kivimäki et al., 2015).

6 Technologies to improve outcomes for people with LTC needs

Technologies that can support and improve the outcomes of older people range from information and communication technologies (ICT) to assistive technologies and robot care. ICT technologies cover a range of solutions from communication technologies using a computer and internet to telemedicine and sensor technology (Khosravi and Ghapanchi 2016). Assistive technologies or devices help disabled individuals to maintain or improve their functional capability. In what follows, we use the term welfare technology for the elderly to refer to technology and devices that support independent living and social participation and the health and wellbeing of older people.

The use of welfare technologies can have several outcomes (Mäki, 2011). One of the leading arguments for the use of welfare technology has been its support to independent living in home or in a home-like setting. Technological solutions may also be used to help old people to maintain their social contacts, to administer medication and to increase the safety of old people (Khosravi and Ghapanchi, 2016). In addition, technology and devices may mitigate the burden of care for caregivers. Technological solutions are also used in institutional care, where wrist alarms for instance have already been used for some time. Recently robot care has been receiving much attention in the media and in research (Kyrki et al. 2015; Khosravi and Ghapanchi 2016), but wider use of robots in LTC practice in Finland is still in its infancy.

6.1 Policy development in Finland

According to the Act on Supporting the Functional Capacity of the Older Population and on Social and Health Care for Older People (980/2012), municipalities must organize services that support wellbeing, health, functional capacity, independent living and inclusion of older people. However, the act does not specify what kind of services municipalities should provide or whether municipalities should apply welfare technologies to achieve the abovementioned goals. It should be noted, however, that an older disabled person in Finland may be eligible for assistive devices on the basis of the decree on services and support provided for disabled individuals.

Quality recommendations on services for older people (Sosiaali- ja terveysministeriö ja Kuntaliitto, 2013) take a clear stand on welfare technology or gerontechnology. Recommendations state that physical liberty is a prerequisite for social inclusion and access to cultural and social and health care services. According to the quality recommendations, physical liberty can be supported by assistive devices and physical arrangements helping older people with mobility (e.g. ramps and walkers) and hearing (e.g. hearing aids). The use of welfare technologies to promote independent living and inclusion was also mentioned in the previous quality recommendations published in 2001 and 2008 (Sosiaali- ja terveysministeriö ja Suomen Kuntaliitto 2008 and 2001).

Development of technologies and devices to help older people to cope with their LTC needs has been a very active area in Finland. Mäki (2011) finds over 50 Finnish projects developing welfare technologies for older people in 1993–2013, all involving service users aged 75 or more. Development projects cover the application of both assistive devices and ICT technology to help older people, often with dementia, to cope with their care needs.

While most of the development projects have been interested in assessing user experiences of the assistive technologies, some have also evaluated other outcomes (Mäki, 2011). For example, the ENABLE project evaluated whether assistive technologies (e.g. a self-made picture/photo gallery, an electronic calendar, an easy-to-use phone, a search device for mislaid items) can be successful in supporting the wellbeing and functional capacity of demented patients in home and institutional care. Patients were interviewed at the beginning of the intervention and three weeks and three months after the beginning of the intervention. Quality of life and

wellbeing were assessed using the Dementia Quality of Life and Dementia Care Mapping instruments. From this it seems that the assistive technologies do seem to support the wellbeing of dementia patients. For example, one of the findings was that the wellbeing of patients with dementia improved during the time they were using a self-made photo gallery.

6.2 Evidence on the use and cost-effectiveness of technologies

Though there have been a large number of development projects in welfare technology in Finland, ICT technologies are less often used by old people and by LTC service users in particular (Mäki, 2011; Jyrkkänen, 2013). Jyrkkänen (2013) studied the use of welfare technologies among home care users in Finland in 2013. The study was a structured survey on caregivers who answered the questionnaire on behalf of regular home care users older than 75 years, in seven municipalities in the south of the country.

The study found that around 47% (N = 455) of home care users in the sample used a panic alarm phone, while the use of other technological devices was less common. About 2.2% of service users had a meal machine and around 4% had a motorized bed. When the results are assessed from the perspective of potential ICT applications in home care, it is also notable that only 2.2% of the home care users had an internet connection. As expected, the use of (non-ICT) assistive devices was more common among home care users. Almost 77% of home care clients had assistive devices to help with mobility. The most common device was a walker. In addition, 36% of the home care clients in the sample had made alterations to their homes to meet their LTC needs. The most common alteration was installing a grab bar.

In a representative population survey conducted in Finland in 2014, 12% of the respondents had used electronic social and health care services (Hyppönen et al. 2015). The main obstacles to the use of e-services mentioned were that e-services cannot replace face-to-face services, complicated terms of use, and that e-services are not easily accessed by disabled people.

Welfare technologies can be an effective and cost-effective means to support the care of elderly service users (e.g. Khosravi and Ghapanchi 2016; Knapp et al. 2016). A systematic review by Khosravi and Ghapanchi (2016) finds that evidence on the effectiveness of assistive technologies is increasing worldwide. Increasing academic attention in this field has been at least partly due to the need to reorganize service provision and contain the growth of LTC expenditures at a time of population ageing. It is noticeable that most of the research has taken place in the US and Asia; only about 17% of the reviewed studies have been done in Europe. In a Finnish study by Riikonen et al. (2010) health care professionals estimated that risk reduction technologies, assistive technologies and emergency technologies in patients' homes could delay the institutionalization of patients with dementia by eight months. Development projects in Finland have evaluated the effects of assistive technologies on outcomes such as wellbeing and health of the elderly people (Mäki, 2011), but these evaluation studies rarely meet the rigorous criteria to provide reliable causal evidence. Moreover, there is very little evidence on the cost-effectiveness of welfare technologies for elderly people in Finland.

7 Finnish health and social care reform for 2019

7.1 Overview of the planned reform

The current government of Finland plans to implement a large-scale reform to restructure the provision and financing of health and social services. Policy outlines and draft bills have already been issued (see, for example, http://alueuudistus.fi/en/frontpage), describing planned structural reforms in health and social services. A largely overhauled system is expected to be in operation at the beginning of 2019. While the proposals have majority support, the necessary bills have not yet been approved by the Finnish parliament. The most

important aims of the restructured health and social care system are increased availability of services and cost containment.

Responsibility for providing health care and social services will be assigned to 18 autonomous regions instead of the 311 independent municipalities. According to the draft bills (http://alueuudistus.fi/en/frontpage), regions (or counties) will be responsible for consolidating health and social care services provided for clients into larger wholes. At the same time, the existing multisource financing of healthcare and social welfare is to be simplified. Details of the financing of health and social care under the legislation are still to be finalized. At the time of writing, there is a large political consensus that the newly formed autonomous regions (counties) will not have the powers to levy taxes to finance their operations. In the first stage of the reforms, health and social care services will be financed by state grants to the counties.

In addition to consolidated services, another central tenet of the reform is to increase patients' freedom to choose their preferred care provider and encourage progression towards a multi-provider model where private and third sector services will increasingly be available in addition to public sector health and social services. Where there is a shortage of services provided by the private and third sectors, counties will be responsible for meeting the shortfall through their own service provision capacity.

7.2 Potential consequences for LTC

The planned restructuring of health and social care services is likely to have a major effect on the provision of LTC and will increase the integration of social and health care services for the elderly. A substantial proportion of the projected cost containment is planned to be achieved by reducing the number of elderly patients in institutional care and cutting the time elderly patients on average spend in these care settings. Even though a relatively high proportion of people over 75 live in their own homes in Finland, there are grounds to think that costs can be reduced by reducing the length of stays in institutional care. The average time spent in institutional care before death in Finland is 677 days, compared to 365 days in Sweden and in the Netherlands (Kinnula, Malmi and Vaaramo, 2015).

Related to the goal of curbing costs by reducing the time spent in institutional care, Kinnula, Malmi and Vaaramo (2015) argue that different models of rehabilitation may lead to widely differing outcomes in elderly patient groups. The authors refer to a model with six hours of daily rehabilitation activities and argue based on a pilot study that intensive rehabilitation enables the proportion of people 75 and older population living in their own homes to be further increased. A year after beginning the pilot programme, 94% of the population aged 75 and older were able to live at home in the pilot region. Consequently, the pilot region in Southern Karelia has set a new target level: for 97% of the population aged 75 and older to be living at home. Reaching the new target level in the entire country would result in reducing the number of elderly citizens living in institutional settings by about 30,000. It remains to be seen whether the ongoing health and social care reform helps to keep similar numbers of elderly people living at home across the entire country and what this would mean for the quality and costs of LTC.

7.3 Increasing use of vouchers and personal budgets in health and social care

In the current Finnish health and social care system, municipalities can issue vouchers to fund purchases of LTC services. The issuer can set the value of vouchers and the health and social care services that they can be used to purchase. The value of the voucher can be either fixed or earnings-related. If the municipality decides to offer vouchers, it is up to the service user to decide whether he or she wants to accept and use one. The service user can use the voucher to purchase services from the preferred private service provider.

The use of vouchers as a way to organize service provision has lately been increasing in Finland. The

main rationales for the increasing use of vouchers have been to respond to the increasing demand for health and social care services, to diversify the service supply, to promote entrepreneurship, and to increase clients' freedom of choice. Municipalities have used vouchers to provide home and support services (e.g. cleaning and meal services), rehabilitation and respite care for compensated informal caregivers. The capital city, Helsinki, has also given vouchers for older people for buying sheltered housing (Linnosmaa 2012). Interestingly, according to a recent survey study (Seppälä and Vähänen, 2017), the elderly population in Finland seems willing to accept a smaller state subsidy for sheltered housing if this allows them greater freedom for individual choice of service provider.

Volk and Laukkanen (2007) studied the experiences of service users and care providers related to the use of vouchers. Both the providers and service users, who are able to decide about their services independently, were satisfied with vouchers as means of organizing health and social care services. Service users indicated that they were sufficiently informed about the supply of services to make a reasonably well-informed choice. More than half of the service providers in the sample responded that vouchers have increased the demand for their services. Some service users mentioned, as a disadvantage of the voucher system, that vouchers cannot be used to purchase services other than those chosen by the issuer. Service providers responded that vouchers may lead to additional and costly administration.

As part of the general reform of health and social care in Finland, the government bill on the Act of Freedom of Choice aims to facilitate the access to services and improve the quality and cost-effectiveness of services. According to the current plans, freedom of choice is to be implemented through the use of primary vouchers and personal budgets. Primary vouchers are to be used as subcontracting instruments. Health and social service centres and dental clinics may grant primary vouchers to clients and patients, who can use vouchers to purchase services from other service providers. For example, a GP may grant a primary voucher to a patient to purchase physiotherapy from the physiotherapist of the patient's choice. Older people and people with disabilities can be granted personal budgets to arrange service provision that meets their needs. The current government has allocated €10 million to regional pilots to collect information and experiences about the use of new instruments in health and social care.

8 Conclusions

The ageing population is putting economic pressure on the Finnish municipalities responsible for organizing health and social care services for the elderly. Currently, many municipalities are too small to be able to organize episodes of care in a way that is effective, efficient and cost-minimizing. In addition, it is often the case that units responsible for organizing service provision lack information about the optimal ways to organize services.

Reliable information on how to organize service provision is particularly important now as the Finnish government plans an extensive reform in health and social care in 2019. After the reform, newly formed autonomous regions (counties) will be responsible for organizing both health and social care services, opening up not only new possibilities for improved consolidation and integration of services but also for more efficient coordination between the various professionals in health and social care. In addition, new instruments increasing the freedom to choose services and providers are to be made available for the population at large. Decisions on how to make the most of these possibilities should be based on reliable evidence.

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