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ANCIEN

Assessing Needs of Care in European Nations

LONG-TERM CARE IN FINLAND

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1. The Finnish LTC system

1.1. Overview of the system

The basic principle for the Finnish LTC system is that it is a publicly funded, universal system which is open for every resident. The Finnish Constitution (section 25) requires the government to ensure the implementation of fundamental and human rights. The rights of particular significance for LTC concern equality and social security (sections 6 and 19 of the constitution). Thus, in Finland, it is considered the obligation of the public sector to provide a decent level of LTC services for the elderly.

In the most recent update of the National Framework for High-Quality Services for Older People the Ministry of Social Affairs and Health has outlined the main ethical principles for how LTC should be produced in Finland (Ministry of Social Affairs and Health, 2008). They are

- *The right to self-determination*, which means that older people must be allowed to make informed choices and obtain the information and other help they need to make choice about LTC.
- *Equality*, which means that consistent principles in granting LTC services should be followed. Equality also means that discrimination should be prevented, and that differences between people should be accepted.
- *Participation*, which means that effort should be so that older people may influence the development of the society and environment in which they live.
- *Individuality*, which stresses the importance of seeing people as unique individuals.
- *Security*, which for instance means that the safety of home and care environment against fire and other hazards should be ensured.

The Finnish public administration system consists of three levels: state, province and municipality. There are two main laws that govern LTC services provision in Finland. They are the Primary Health Care Act and the Social Welfare act. They prescribe that it is the municipalities are the ones that are responsible for public sector production of health care and social services including LTC. However, Finland's municipalities enjoy a very broad autonomy, and state level regulations and steering in health care in general are not very detailed. Thus, legislation is not very specific regarding how municipalities' duties are to be performed in practice. Indeed, it has been argued that public responsibility for health care and social services are decentralised in Finland to a greater extent than in any other country (Häkkinen and Lehto, 2005).

The Finnish LTC system covers the whole spectrum of LTC services. At the one end, there is home care. This type of service consists both of services that have a personal or social focus and to some extent also of home nursing care. At the other side of the spectrum there is institutional care. Institutional care is produced both in nursing homes and in the inpatient departments of health care centres.

In Finland, entitlement to LTC services are based on residence, Thus, if an individual is in need of LTC services, he or she or some relative or friend should contact the local municipality. From that point onwards, the municipality together with the elderly decide on which services that should be provided.

1.2. Evaluation of needs

In the Finnish type of LTC system and in the presence of scarcity eligibility decisions come down to an evaluation of needs. The evaluation of needs usually starts with the elderly person or his or her relative contacting the municipality after which the social services department in the municipality starts the needs evaluation. The result of this evaluation can then be that the elderly receives home care services or perhaps will be admitted to an institution.

As was already mentioned, the Finnish municipalities are responsible for supplying LTC services in Finland. And furthermore, they have a vast degree of decision power over how this is to be done. There is no national definition of “need for care”. This is also the case for needs assessments, with the municipalities being able to a great extent to decide on how needs are to be assessed. However, the Ministry for Social Affairs and Health has issues guidelines for what is to be considered good practice in needs assessment.

According to these guidelines, a comprehensive assessment of service needs at the individual level is very important because it means clients can be ensured effective, high-quality services. In urgent cases, the need for social services must be assessed without delay. In non-urgent cases, persons over the age of 80 and recipients of the Social Security Institution’s highest care allowance are entitled to an assessment of their need for welfare services within seven days of contacting a local authority. The findings of such assessments can also be utilized when the service system of the whole municipality or region is being planned. Good practices for service needs assessment at the individual level are:

- comprehensive assessment of the various dimensions of functional capacity, i.e. physical, cognitive, mental, social and environmental factors.

- performance of this assessment in multi-professional collaboration and in cooperation with the client and his/her family.
- careful choice of the measures used in assessment (indicators of functional capacity), based on sufficient proof of their reliability⁵.
- full understanding of the assessment process, the methods used, analysis of the data produced, and interpretation of the findings.

Because of this vast decision power of the municipalities it is clear that needs assessment and even thresholds for whether an individual will be eligible for care will vary between municipalities. The guidelines that are provided by the MSAH are a good help for the municipalities, but they will not ensure that everybody gets the same services. There are and will be differences depending on municipality.

1.3. Available services

When needs have been assessed several forms of LTC are available. In Finland these form can be classified according to the intensity and coverage of care (STAKES 2006). The basic level of service is home based care. This type of service consists both of services that have a personal or social focus and to some extent also of home nursing care, as many municipalities have merged departments for health services and social services. At the other side of the spectrum there is institutional care. Institutional care is produced both in nursing homes and in the inpatient departments of health care centres. The difference between medical care and long-term care may in this case be somewhat blurred. There may be individuals in the inpatient departments of health care centres that do not require medical care and individuals that live in nursing homes that from time to time require medical care. This medical care could either be in the form of an inpatient period at a hospital or medical care given at the nursing home.

During the last 10-15 years a new type of service that lies in between nursing homes and the inpatient department at the health care centres has been developed – sheltered housing (service homes). This type of service can in turn be divided into two categories, ordinary sheltered housing and sheltered housing with 24 hour service. In 24 hour sheltered housing care and medical facilities are available around the clock. Therefore, the distinction between this type of service home and a nursing home may be diffuse.

There are also other types of services that lie in between the above mentioned. For instance, social services may provide a kind of day-care centre for elderly people, which offers meals and some care and/or medical services.

There is no particular rule for deciding who is eligible for which services. It is up to the municipality to decide whether the elderly is to receive home care services or a place in an institution.

Although the Finnish LTC system mostly is a system based on benefits in kind, there are also some benefits in cash. These benefits are not paid out by the municipalities, but by the Social Security Institution (KELA). The *Care Allowance for Pensioners* is intended to make it possible for pension recipients with an illness or disability to live at home, as well as to promote home care and to reimburse pension recipients for extra costs caused by illness or disability. The mean monthly allowance is around €100. There is also a special *housing allowance* for pensioners. However, it is not entirely clear whether this type of benefit should be accounted for as belonging to the LTC system.

As in the other Nordic countries, the Finnish LTC system is tilted towards formal care. However informal care of course exists. There is also a special home care allowance, which is available for carers. Thus, someone who is staying at home to take care of a relative who can be eligible for a home care allowance. This allowance is given to the carer by the municipality and constitutes taxable income. The amount of support is normally 336 euro per month, but can be up to 637 euro per month if the work to be done is particularly demanding. The home care allowance is taxable income for the recipient. It is the local municipality that administers this type of support. The home care allowance can also be combined with various types of home care.

1.4. Management and organisation

Barring some minor exceptions all of the above mentioned forms of serviced are produced by the public sector, the private sector and not-for-profit organisations. The role of the municipalities is the strongest in the case of home-based care and institutional care. Of the home-based care, the private sector and the not-for-profit organisations produce some 25%. Particularly regarding nursing homes the role of the municipalities is large, as they produce more than 90 % of output. Regarding service homes the public sector's share of production is less than half (STAKES, 2006). It should however be noted that private production mostly takes the form of outsourcing. Private companies operate a service home for instance, and the municipality then purchase services from this provider. Decisions on resource allocation, planning, and organization of LTC are made by municipal health and/or social services boards, municipal councils and municipal executive boards. Budgets are typically based on historical data and allocated without any specific targets or incentives (Vuorenkoski, 2008).

Legislation provides for the promotion of old-age health and welfare and the development of advisory services. The Primary Health Care Act (66/1972) requires municipalities to provide local people with advisory health services and health checks and to monitor trends in their state of health, and factors affecting it, by population group. Municipalities must also take health considerations into account in every aspect of their activities and work with other private and public bodies in their area to further public health. Under the Social Welfare Act (710/1982), municipalities must, for instance, arrange for public guidance and advice and for information on and access to various welfare and other social security benefits. They are also required to improve local social conditions and eliminate any defects (MSAH, 2008).

The regional evaluation of basic services is one of the essential statutory tasks of the State Provincial Office. In total, there are 6 of these provinces in Finland. The aim is to establish the accessibility and quality of basic services within the province. The evaluation conducted by the State Provincial Offices supports national development goals and complements municipal evaluations. It also serves the municipalities in the development of basic services. There is also a nationwide authority, the National Supervisory Authority for Welfare and health (Valvira), which starting in 2010 will be responsible for quality control at the national level. In practice, this authority will deal only with particularly severe problems or cases with an implication for future practice in the field.

Municipalities can produce services it is responsible for itself or jointly with other municipalities. It can also outsource services from private to public-sector providers or alternatively issue vouchers to service users with which they can purchase necessary services from the private sector. Municipal federations produce services in much the same ways as independent municipalities (MSAH, 2008).

1.5. Integration

In Finland, municipalities are responsible both for health care and for implementation of social policy, including long-term care. However, in terms of specialised health care, municipalities are divided into 20 hospital districts.

In many municipalities the responsibility for social services and health care has been merged. Therefore, the distinction between long-term care, for instances home nursing care, and health care services is sometimes no very clear cut.

2. Funding

Finland switched to reporting its health care expenditures according to the OECD System of Health Accounts in 2008. According to this, total expenditure on LTC amounted to 2559 million Euros, i.e. some 1.5% of GDP in 2006. Some 28% of this expenditure was spent on institutional care, some 18% on long-term care by primary health care, some 19% on home-help services, and some 32% on other services. It should be noted that the category other services includes sheltered housing with 24-hour assistance (STAKES 2008b). Out of the total expenditure on LTC in Finland, some 28-29% was provided by the private sector. It should be noted that the Social Insurance Institution of Finland contributes very little if anything to LTC in Finland. Instead, funding is taken directly from taxes and user fees.

Legislation governs the user fees that municipalities are allowed to charge for LTC services (Laki sosiaali- ja terveydenhuollon asiakasmaksuista). For institutional care, fees depend on ability to pay. The maximum user fee can be 82% of the patient's monthly earnings. However, a minimum of €0 per month must always be left for the patient. Monthly earnings comprise of any pensions or capital income such as dividends or rents that the person may have. Also, the earnings of spouses will be taken into account. If a spouse is present, the maximum user fee is 41% of the combined earnings of the spouses.

Ability to pay is also the guiding principle for user fees in home care. User fees depend on income, the type of care to be provided, and size of household. Maximum user fees are always a percentage of income that exceeds a certain threshold. The following percentages apply (table 1).

Table 1: User fees in home based care in Finland

Household size	Income per month	Percentage
1	520	35
2	959	22
3	1504	18
4	1860	15
5	2252	13
6	2585	11

Thus, if the household size is 2, and total household income per month is 1200 euros, 22% of the difference between €1200 and €959 i.e. €241 should be paid. If it is a single person household and

the monthly income is €200, 35% of the difference between €200 and €520 i.e. is the maximum user fee is €38 per month.

In Finland, public LTC services are provided by municipalities. The municipalities collect taxes themselves, but they also get transfers from the central government. The municipal tax is proportional but the state tax is progressive. The sum of the funds from the municipal tax and the state transfers to the municipality forms the funding for the municipal budget. Government transfers are generally not specifically targeted towards specific purposes in municipalities, but municipalities have the power to decide how much is to be spent on for instance LTC. Thus, municipal taxes are not specifically targeted for LTC, but municipalities decide in what way their total budget is to be split between various expenditures.

3. Demand and Supply of LTC

3.1. The need for LTC (including demographic characteristics)

In 2008 the total population of Finland amounted to 5 299 772 people. The population of the age of 65 or over amounted to 875 356 people, or 16,5 % of the total population. In the EU-15, which is a reasonable reference group for Finland, the population aged 65 or over was 17,7 % of the total population. The population 80 or older in Finland consisted of 229 091 individuals in 2008. This amounted to 4,3% of the population. In the EU-15 share was 4,7% of the population in 2008. In 2032, i.e. roughly one generation later, the share of the population in Finland which is 65 or over will have risen to 26,0%. The same number for the EU-15 is projected to be 24,7%. (The total population in Finland in 2031 is estimated to be some 5 568 256 inhabitants) This means that Finland faces a somewhat sharper increase in the population that is 65 or older than what is the case in the EU-15. Regarding those 80 or over, it is projected that this share will rise to 8,7% of the total population in 2032 in Finland whereas the corresponding figure for the EU-15 will be 7,5% (Eurostat, population projection, trend scenario). Thus, also in the case of the population aged 80 or more the rise in Finland will be somewhat sharper than in the EU-15 countries as a whole.

The need for LTC is normally defined in such a way that someone suffering from a given criteria, such as being unable to perform a certain number of activities of daily living (ADL). Out of necessity such data has to be retrieved from population health surveys. There is no data on need for care in Finland according to KATZ or Barthel indices etc. from representative surveys of population health. Data on how many clients there are in nursing home etc. cannot in the Finnish case be used as a measure of need as they are really the intersection of supply and demand. However, there exists

one population survey, the Health Behaviour and Health among the Finnish Elderly published by the National Public Health Institute which contains some population-wide measures of health status for the elderly. If one chooses for instance the non ability to perform heavy household chores without help as measure of need from this household one comes to the conclusion that some 157 000 persons over the age of 65 would be in need of help according to this measure. This amounts to some 18% of the population aged 65 or more.

The best comparative data on Finns' need for LTC probably comes from The European Statistics of Income and Living Condition (EU-SILC) survey. This data provides comparable, cross-sectional and longitudinal multidimensional data on income, poverty, social exclusion and living conditions in the European Union. In terms of self-perceived limitations in daily activities within the past six months, it seem like Finns report somewhat higher prevalence of these problems. For 65-74 year olds, 20,3% of Finns report severe limitations in daily activities, versus 14,3% of individuals in the EU-25 in general. For 75-84 year olds, the corresponding figures are 29,7% for Finns and 23,5% for inhabitants in the EU-27 in general.

The European Commission's Ageing Report reports a substantially larger number for individuals in need of care (European Commission, 2009). In the "AWG reference scenario" of this report, some 274 000 people are assumed to be dependent. This number is projected to rise to 485 000 by 2035. This is a large number both compared to national sources and to projections in the other Nordic countries. The corresponding numbers for Sweden for instance are only marginally higher than those in Finland at 312 000 in 2007 and 485 000 in 2035. However, the total population in Sweden in 2035 is projected to be 10.4 million people, versus some 5.6 million in Finland. Furthermore, as health differences between the two countries are very small it is surprising that the number of dependent people projected for Finland in 2035 is almost the same as that for Sweden.

3.2. Supply and demand for informal care

The LTC system in Finland is heavily tilted towards formal care and benefits in kind. Obviously there is also a lot of informal care but there are no reliable data. A rough estimation of 133 000 people as the number of individuals receiving informal care was provided in the Finnish report from the Euroframecare project (<http://www.uke.de/extern/eurofamcare-de/publikationen.php?abs=2>). This would be some 15% of the population aged 65 or more.

Another way of quantifying informal care is to look at the number of individuals that receive support for informal care. That is, carers who get support. In 2006, some 20 400 persons received this kind of support. The Finnish Eurofamecare report also provide information on the

characteristics of the informal carers. Some 75% of carers are women. Some 39% of carers are themselves older than 65 years, and 43% of carers were spouses to the dependent person.

3.3. Supply and demand for formal care

A public health system or LTC system with subsidised prices is by necessity a system of rationing. Therefore, observed volumes of LTC use cannot really be taken as indications of supply or demand. Nevertheless, they are of course interesting in themselves. In Finland, there is no good information on spare capacity in the LTC system, or information on capacity in general for that matter. However, because the LTC system in Finland for the most part is a tax-financed public sector system with queuing, it is likely that data on use at the same time can be taken as data on capacity, as demand exceeds supply in a system with rationing.

It is clear that waiting times exist in a LTC system of the Finnish type. However, there exist no data on waiting times. The municipalities which are in charge of delivering LTC services are not obliged to collect data on waiting times. In practice, it is likely that there are large differences between municipalities in this respect. There may also be large differences in waiting times depending on the form of LTC. For instance, it may be easier to get home based care than a place in an institution.

In 2006, 18 538 persons (2.1% of the population 65 and over) lived in residential homes. 11 201 persons (1.3% of the population 65 and over) were treated as long-term inpatients in Health centres. 8 692 persons (1.0 % of the population 65 and over) lived in service homes, and 18 064 persons (2.1% of the population aged 65 or over) lived in service homes with 24-hour assistance. In addition to this, some 55 000 persons aged 65 or more received regular home care, and some 20 000 aged 65 or more persons received support for informal care at home. Compared with earlier years, there has been a clear increase in service home living and home care, and a clear decrease in residential home and health centre care (STAKES 2008).

In the Finnish LTC sector in total, some 67 000 people were employed on a full-time equivalent basis. Of these, some 12 000 were employees/care givers in formal home based care. The ratio of nurses to other personnel in formal home based care was about 2, i.e. there were some 8 000 nurses and 4 000 other helpers in formal home based care.

4. LTC Policy

Long-term care in Finland is at least on paper high on the policy agenda. Policy objectives regarding the form of services available, the financing of services, and the supply of carers are mentioned in the programme of Prime Minister Matti Vanhanen's second cabinet.

4.1. Policy goals

The overall policy strategy for the whole of Finnish social protection policy up to 2015 has been set out by the Ministry of Social Affairs and Health (MSAH 2006). This major policy document has four themes, which are “promoting health and functional capacity”, “making work more attractive”, “reducing poverty and social exclusion”, and “providing efficient services and income security”. For two of these, LTC is explicitly mentioned. Under the theme “promoting health and functional capacity” it is mentioned that “new models must be found for boosting the functional capacity of older people and under the theme “providing efficient services and income security” it is mentioned that “the availability and quality of services for older people must be improved”

4.2. Integration policy

Although policy in this relatively high-level document is portrayed in relatively broad terms it is still interesting as it reveals the main line of what is to be done. In terms of boosting the functional capacity of older people the importance of preventive measures is emphasised (MSAH 2006, p. 10). Clearly, it is of interest to policymakers to expand the span of healthy life as much as possible in order to save on LTC costs. Regarding the availability and quality of services of older people some important directions for the future are set out. First the importance of increasing home care and local production of LTC is emphasised. Second, the need to improve the assessment process is mentioned, with an explicit mention of the need for harmonising assessment between producers. Importantly, it is also mentioned that improved service quality would improve peoples' possibilities of living at home even if they suffer from dementia. Furthermore, the possibility of alternative funding models of LTC is also mentioned.

4.3. Recent reforms and the current policy debate

The Finnish LTC system has been criticised for not being particularly equal regarding the amount and quality of LTC person receive in different municipalities. Partly as an answer to this the Ministry of Health and Social Affair and the Association of Finnish Local and Regional Authorities has issued the National Framework for High-Quality Services for Older People (MSAH 2008). This

framework defines the values and ethical principles guiding the provision of services for older people, and outlines strategies for boosting quality and effectiveness. It also sets national quantitative targets for LTC that municipalities can use as a basis for fixing their own targets.

The municipal structure in Finland is undergoing a major overhaul at the moment. The process is called the Paras-hanke (Ministry of Finance, 2009). This overhaul will have substantial implications for LTC services production in Finland. As has been described earlier in this report, it is the municipalities in Finland that are responsible for the bulk of social services in Finland. The aim of this overhaul is to increase productivity in social services production in Finland, including the productivity of LTC. One important policy tool here is to decrease the number of municipalities by municipal mergers. In short, the aim is to make better use of economies of scale. Further, as some remote areas already suffer from a lack of personnel, another aim is to make organisations bigger in order to make them more attractive as employers.

4.4. Critical appraisal

However, guidelines issued by the MSAH or the PARAS-project only may not be enough to sort out some of the problems in the Finnish LTC system or in the Finnish public sector in general. The demographic changes that are facing Finland in the short and medium term pose a challenge in two ways. First the demand for LTC will increase. Second, the supply of LTC personnel will decrease. These two will put serious pressure on public finances in the years to come. Attempts to increase productivity in LTC by reorganisation and potentially more outsourcing may simply not be enough. The Finnish public sector may have to give up financing some services entirely. The debate about what the public sector can be expected to do in Finland in the coming decades will be lively.

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L launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

- 1) How will need, demand, supply and use of LTC develop?
- 2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (<http://www.ancien-longtermcare.eu>).