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## **Social and Health Care Services Network Meeting Report**

**Oulu, 27-28 November 2019**

**Kindly hosted by Caritaslaiset and Oulu Deaconess Institute**

After a devotion by our Finnish hosts, Laura Rayner from Eurodiaconia opened the network meeting with a look at **long-term care in an EU context**. The subject of demographic change is increasing in visibility and importance in Brussels and there is greater discussion around the challenges of preparing the EU for the impact it will have. She went over the possible implications but also the specific challenges for the EU in terms of policy-making on this subject due to the complexity of long-term care provision (the mix of health and social care, lack of coordination between the two, mix of formal and informal care) and monitoring difficulties due to informal nature of most long-term care services, the absence of EU-agreed indicators and comparable data. She then outlined the most recent activities at EU level on this subject, including the tasks given to the new Commissioners and the work of the Social Protection Committee. Finally, she outlined what needs to happen at EU level on this topic: for instance, full implementation of the European Pillar of Social Rights; discussions around financing; more focus on the provision of quality services; greater integration of social and health care policies and services; adequacy of pensions; better opportunities, skills development and salaries for the long-term care workforce; and more effort made to tackle the gender gap in this sector.

This was followed by a presentation of the **long-term care sector in Finland and other Nordic countries** by Petteri Viramo, CEO of Caritaslaiset. He outlined the current demographic situation in Finland (highlighting the low unemployment rate, the very low population density of the country, life expectancy and, currently, the lowest fertility rate on record in the country) along with a useful comparison of the situation in other Nordic countries and the EU as a whole. He went on to explain that institutional care is a major issue in Finland and that long-term care is mainly a business of elderly people. Nevertheless, 42% of people receiving long-term care in Finland are under the age of 80. In all Nordic countries, the number of beds in care facilities, social housing facilities and hospitals have diminished dramatically but home-based long-term care is common in Finland.



Photo: Petteri Viramo, CEO of Caritaslaiset, addressing the group

Scandinavian countries are often characterised as ideal welfare states. There is an ideological belief in equality of all people regardless of limitations, affordability of care for all, solidarity with fellow vulnerable citizens, an accessible society and a government that guarantees that people can receive good care and can participate in society. As a result, long-term care expenditure is high. It is usually financed through municipal taxation (around 60%), then governmental subsidies (around 31%), then user charges/out-of-pocket payments (around 9% and mostly income-related). Nevertheless, there is a general trend of increasing private financing in all four Nordic countries.

Petteri Viramo continued his presentation with an outline of the system of governance of the long-term care system in Nordic countries, emphasising that local governments play a considerable role in healthcare in terms of finance and content, and they are fully responsible for delivery. In Finland, there are only two nationally-run institutions for healthcare which are specifically for prisoners, and 60% of long-term care facilities are run by municipalities. These municipalities can contract out for services to providers like our members in Oulu: Oulu Deaconess Institute and Caritaslaiset. To conclude, Mr Viramo explained that the functional independence of the elderly is not improving quickly enough to compensate for the increase in the number of very elderly, i.e. the expectancy of disabled life years is growing faster than that of well-functioning years. In order to predict the service needs and costs for the long-term care sector in 2035, the three most important factors are the following: the increasing number of people aged 85+, an increase in end-of-life morbidity and the development of mortality. The biggest reason for uncertainty on this point is changes in morbidity.

Nonetheless, the Nordic welfare system has proven to produce significant health and happiness benefits in terms of life expectancy and with reasonable costs, but the low fertility rate threatens the future of the system and will lead to a lack of personnel.

Following the two presentations, the group then held a discussion and exchange of practice on long-term care and integrated care pathways, focusing on current challenges and changes in long-term

care; how successfully - or not - are care services being integrated across the EU, and what recommendations would we make to policy makers? We were joined via web-stream by Dr Musta from our member in Timisoara who outlined their telemedicine project, which takes medical care to those living in remote areas who may be unable to travel to towns or cities to seek medical advice due to finances, lack of infrastructure or ill health. There was a wider discussion on health and social care data and the necessity to try and find common indicators in order to provide comparable data. Our Finnish members highlighted the recent efforts by the Finnish government to create a digital platform to bring together all data. Other topics addressed were the move away from institution-based care towards more home-based care, the increasing number of for-profit long-term care providers, the challenge of public procurement rules prioritising lowest cost over quality and the difficulties posed by the shortage of staff willing or able to work in the care sector and the need to improve the attractiveness of working in that field.

During the lunch break, those who wished to were able to take a short tour of the care facility of Caritaslaiset where our meeting was being held. We were given an explanation of the accommodation provided there, including the sheltered living apartments and the fitness facilities, and able to meet a group of residents taking part in an activity organised by Caritaslaiset.



Photos: Taking a tour of the facilities of Caritaslaiset

In the afternoon we were joined by Niina Viikas, the interim CEO of Vivago MOVE, to begin our discussion on **integrated care pathways**, specifically addressing transforming digital health into smart care. She began by outlining the megatrends in healthcare – the ageing population, increasing digitalisation and artificial intelligence – and underlining that increasing digitalisation does not need

to be a threat but is a way of improving care provision. The benefits of this increased digitalisation are: better quality of care; follow-up of effectiveness of care and medication; high standards and reliability; decrease of accidents and acute care; optimisation of the care processes; support for the entire care chain; resource allocation (cost savings); and personalised care with preventative information.



Photo: Niina Viikas, interim CEO of Vivago MOVE, discussing integrated care pathways

Through the wristwatch that Vivago provide, it is possible to track in real-time a person's health status and get information on health condition, diseases, medication, treatment and genetics. It provides precise, algorithm-based, individual data to improve a person's health and preventative care. This service is useful for medical care (rehabilitation, discharge, telemedicine and chronic diseases etc), wellbeing and safety (elderly and disabled, home care etc), institutional living (hospitals and assisted living) and clinical and reporting. Main customer groups are the elderly who live on their own, hospitals (especially rehabilitation and discharge) and professional clinics and laboratories.

The benefits to professionals are the provision of real-time, objective and reliable measurement of a person's health status and wellbeing, objective information on the effectiveness of care, faster response to a change in a patient's physical condition, large-scale overview of patients' condition in an organisation and support for decisions in healthcare and care planning. And, for the patients, it provides a feeling of safety and helps to provide timely and proactive care based on individual needs, as well as allowing support from family and relatives with the Vivago health app and allows for the wearer to be immediately located if required.

Continuing the theme of integrated care pathways, we were next joined by Jan Finell, the Chief International Customer Officer of Raisoft, to outline the **Residents Assessment Instrument (inter-RAI)** in the context of long-term care of geriatric and disabled people. He began by giving us an overview of the history and development of the inter-RAI suite, explaining that they had over nineteen years' experience in implementing solutions in elderly care, mental health, youth mental health,

disability care and rehabilitation. Their main customer bases are in Finland, Switzerland, Spain, Singapore, Australia, New Zealand and South Africa. He then outlined what inter-RAI is: a holistic assessment of elderly, disabled or person with mental health or intellectual disabilities in every phase of the care chain. It points out issues and problems but also possibilities, opportunities, and individual strengths and does so in a universal language across different settings, providing a solution whereby assessment results can guide the client smoothly through the continuum of care. The data that is provided is a useful tool for clinicians (individual care planning), management (resource planning, quality monitoring) and government (policymaking, quality assurance and reimbursement payment).

Mr Finell then went on to outline the collaboration of inter-RAI in Switzerland where, for fifteen years, they have been working with Q-Sys AG. Over 650 nursing homes in Switzerland are using inter-RAI. The keys to their success are: a generalized financial solution of the Resource Utilization Groups (RUG) which is generated directly from the assessment; uniformed documentation and training; and the same software solution is used in all homes (RAIsoft). The collected data is used in studies to improve care and provide new solutions in order to benefit the whole country.

Q-Sys AG provides each nursing home with an annual report (a print-ready report is fully automated and produced by the RAIsoft tool) which shows detailed information for the individual nursing home but also gives the nursing home an overview of the situation in comparison to the canton and the whole country. Furthermore, a total of thirty quality indicators have been developed, consisting of both national indicators specified by Swiss government and also those developed by Q-Sys AG and InterRAI.

Following these presentations, we were able to visit **Oulu Health Labs at Oulu Hospital** and learn about the work they do there, providing a unique, integrated health test for the development of new products that add value to patient care from home to hospital. Oulu Health Labs offer a user-centric innovation platform for products in the development phase. Feedback from the healthcare professionals in the development phase ensures that solutions become more user-centric. In close collaboration with the industry, Oulu University Hospital also uses the laboratory to develop its processes and to model and simulate building projects for the Future Hospital Programme.



Photo: Project Manager Timo Alaläykkölä at Oulu Health Labs

We were given an outline of Oulu CityLab, operated by the city of Oulu, which is a test environment where the end users are at customers' and patients' homes and in all social and healthcare services. The City of Oulu opened a technology healthcare centre in 2008. In addition to usual patient care, this healthcare centre contributes to the development of city's technology-enhanced processes and provides companies with a basic healthcare environment for product testing and development. Oulu CityLab testing operations extends to cover other social and health services in the city as well, including home care.

We were able to visit the simulation laboratory of Oulu Health Labs, a versatile simulation and studio environment, which is used as a learning environment for health and social professional education. This can be used as a testing and development environment in the product innovation of health technology and welfare services, covering bioanalytics, nursing and emergency nursing, optometry, oral healthcare, radiography and radiation therapy as well as rehabilitation.



Photo: Oamk SimLab, part of Oulu Health Labs with Project Manager Timo Alalääkkölä

Our final visit of the day was to **ODL Vesper**, a care home belonging to the Oulu Deaconess Institute. This home is the oldest of all the ODL facilities, having been running for more than fifty years. After a very insightful discussion with staff (with many questions from the members visiting regarding staffing, financing, activities and the organisation of elderly care in Oulu, amongst others), we were also able to make a short tour of the facilities, seeing the rooms and common areas as well as greeting some of the residents.

The last engagement of the day was a wonderful dinner organised by our hosts in Oulu, complete with a private performance of Christmas carols by the Oulu Chamber Choir.

Our final day in Oulu began with a devotion led by our hosts. The focus of the morning thereafter was on **the health economics of long-term care** in the EU and Nordic countries. We were joined by Dr Sanna Huikari D.Sc., a postdoctoral researcher in Health Economics from Oulu Business School, University of Oulu. She began by outlining why it is important to look at health and healthcare issues through the lens of an economist: via healthcare we can (at least partly) modify the incidence and impact of ill health; the availability of healthcare can determine the quality of our lives and our prospects for survival; healthcare is one of the most costly welfare services that governments deliver; decisions about how healthcare is funded, provided and distributed are strongly influenced by the economic environment and economic constraints; evidence on productivity, efficiency and value for money are increasingly the norm in modern healthcare systems.

She went on to outline that currently most healthcare systems are a complex mix of private and public sector activities. Government involvement in the finance and provision of healthcare is common. Within this, there are important criteria to be considered:

- Efficiency: Allocation of scarce resources that maximise the achievement of aims;
- Equity: Fairness in the distribution and finance of health and healthcare between people;
- Effectiveness: Whether or not healthcare “works”;
- Ethics: Concerns strong value judgment widely held in healthcare.

With healthcare systems under financial pressure and with increasing public debt ratios, fiscal adjustments have already been done in many advanced economies but more are needed. Over the next 20 years, public health spending is projected to rise in advanced economies by an average of three percentage points of GDP. This increase is due to population ageing (diseases of old age are very expensive to treat not just medically but also in terms of formal and informal care), the development of health technology (new treatment methods and drugs are often very expensive) as well as due to expectations (people have more information and may have more demands for treatments and examinations. It may also become increasingly difficult politically to decline new treatments for patients) and defensive medicine.

Dr Huikari went on to outline the situation regarding demographic change and healthcare spending in Finland and in Oulu in particular. According to research, 10% of the population in Oulu uses around 80% of all public health spending.

She went on to talk about the necessary ingredients of successful healthcare reform in advanced economies; for instance, that whilst reforms are needed to control spending, these reforms must also be equitable, protecting access to basic healthcare for all who need it, especially the poor; most advanced countries have achieved universal access to basic health services, and health reforms should respect this safety net; and that experience suggests that effective reforms combine a mix of both macro-level instruments to contain costs and micro-level reforms to improve the efficiency of spending.

To conclude, Dr Huikari explained that it appears that there is a clear role for the government in the financing and, to a lesser extent, in the organisation of long-term care services. However, the introduction of some redistributive public funding designs can pose a threat to the financial sustainability of such systems, especially in the longer run. On the whole, publicly funded systems fare better on equity of access. Similarly, the organisation of long-term care indicates that the not-for-profit status of an organisation and the degree of hospital autonomy influence service delivery to a large extent.

The final part of our meeting was dedicated to a **discussion** amongst all participants of the main challenges they face in the care sector, what specific recommendations they wish to give to policymakers in Brussels and what Eurodiaconia could do to help them in their work. Laura Rayner from the Eurodiaconia secretariat led the discussion.

Much of the focus was given to issues around staffing. All members present found that they had difficulties with staff, whether in terms of shortages, the migration of trained staff to other countries, the lack of dedication of some working in this field due to the generally low pay, lack of progression,

lack of prestige etc. They felt that more could be done to increase pride in working in this sector, as well as providing more funding for schools to provide properly trained staff.

There was also a worry that demographic change and the difficulty to recruit professional care workers will put more pressure on informal carers. Therefore, the idea of a Carers' Guarantee was discussed and positively received, as well as an emphasis placed on providing and supporting an ecosystem which allows for more flexibility in mixing formal and informal care. This led to a wider exchange on the ideas around the Economy of Wellbeing, in particular on the importance of supporting families who are very often those called upon to provide informal care.

The discussion then widened to talk about the trends and challenges that our members working on long-term care currently face. Most members felt that the lack of funding for service provision was adding increasing pressure on them. Furthermore, the demand for a 20% co-financing rate on Commission funding opportunities was felt to be too high for some smaller organisations to be able to participate. Many felt that the difficulty of completing applications due to the complexity and the time required was also a deterrence.

Some members also mentioned the tendency in their countries to move away from big institutions towards home-based care or smaller care centres. There is also a related issue in some member states that, due to the housing crisis, some people choose to move to a nursing home because it is a cheaper option than continuing to pay rents or mortgages on their own homes. They do not, however, necessarily require the level of care that a care facility provides, thereby blocking beds which may be needed for other patients.

Finally, and reflecting on the previous day's presentations about the growing use of technology in long-term care, members outlined how they are now using technology in their work. This changing environment was largely welcomed by members who tended to view technology as a useful tool to make care provision more efficient, more personal, more cost-effective and more accessible. They also felt that the data gathered in the field of healthcare or long-term care would also provide a useful evidence base for policymakers about the realities on the ground. The development of EU-level indicators used to measure and assess developments in the care sector was a topic upon which it was felt it would be valuable for Eurodiaconia to be engaged in at the European level.

The meeting was closed by Laura Rayner with very grateful thanks to our kind hosts in Oulu and good wishes for safe journeys for all those travelling back to their own countries.