ESPN Thematic Report on Challenges in long-term care

Finland

2018

Laura Kalliomaa-Puha & Olli Kangas
February 2018

EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

Contact: Giulia Pagliani

E-mail: Giulia.PAGLIANI@ec.europa.eu

European Commission
B-1049 Brussels

EUROPEAN COMMISSION

European Social Policy Network (ESPN)

ESPN Thematic Report on Challenges in long-term care

Finland

2018

Laura Kalliomaa-Puha & Olli Kangas

Directorate-General for Employment, Social Affairs and Inclusion

2018

The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

For more information on the ESPN, see:
http:ec.europa.eusocialmain.jsp?catId=1135&langId=en

Contents

Summary

Social protection for older people consists of income security and services in kind, arranged as a part of social and health care. Entitlement to long-term care (LTC) services in Finland is based on residence in a municipality. Services are granted on the basis of an individual needs assessment. There is a wide range of in-kind benefits such as home care, sheltered homes, more intense institutional care, and health care centres; as well as cash benefits such as care allowance, tax deductions for services, and informal care support. Municipalities can provide in-kind services themselves or buy them from other municipalities or from private service providers. Therefore most of the costs of private service providers are also paid for by the municipalities. Municipalities may also give vouchers for the elderly to buy services themselves from private service providers. Most of the costs are covered by taxes even though client fees are collected. In 2014, clients paid 18.5 % of the costs of services for the elderly.

The problems lie perhaps more in take-up rates, rather than coverage. The system is so complicated that many clients cannot cope in the web of multiple services and service providers. Therefore, families may not always find the services they need the most. Access to services should be made simpler and more transparent for clients. Instead of strictly defined service packages, care workers should be left with wider discretion to decide which service is really needed by the family in question. This method has worked in child welfare services, and the model could be applied in LTC as well. Allocating elderly people with their 'own' social worker is also needed as a way to help them find and coordinate services – especially those who do not have family members to help them.

Even though LTC is a public responsibility, families play an important role – not only as guides to find services, but also as helpers and carers. Maintaining the carer's well-being is important if they provide full-time care to a family member, since it affects not only the carer but also the quality of care they provide.

Thus, Finland's care regime is a mixed one, combining public, private and individual provision. A characteristic of this care regime is a strong gender bias in care obligations, and hence gendered employment patterns.

The whole Finnish social and health care service system – including LTC – will be totally changed under the social and health care reform (SOTE), which is planned to come into force in 2020. Instead of the municipalities, 18 counties will organise care. Furthermore, the SOTE reform will open more room for private for-profit service providers to operate. There are already many private service providers offering 'service housing' (i.e. housing for people who need some help but not institutional care) and home care but freedom of choice will be expanded by introducing individual care budgets and additional vouchers. The opponents of the SOTE reform fear that international companies will dominate the care market and eat up small-scale local enterprises and not-for-profit third sector providers that traditionally have had an important role in Finland. For the time being, nobody knows what the eventual outcome of the SOTE will be.

1 Description of the main features of the country's long-term care system(s)

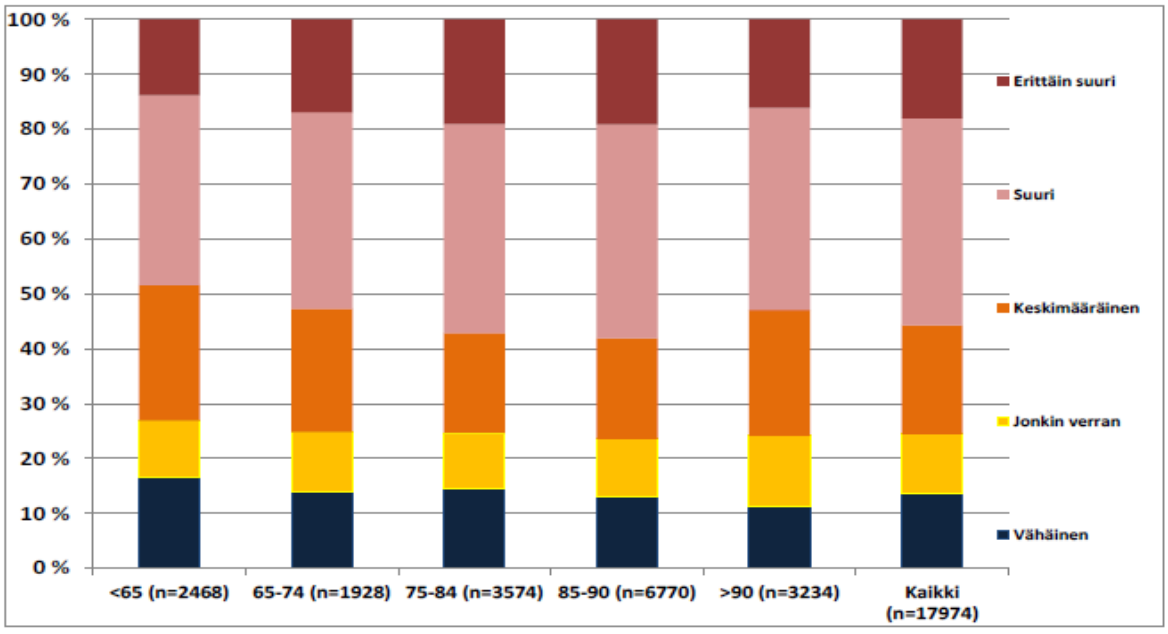
1.1 Municipalities are in charge of LTC services but cash benefits come from municipalities and Kela

Long-term care (LTC) is provided by municipalities, private entrepreneurs and – most often – by families. However, heavy care needs are most often taken care of by public provision, either in whole or in part.

Entitlement to public LTC services is based on residence in a municipality. Services are granted on the basis of an individual service needs assessment. There are various indicators used to measure a client's dependency and autonomy,[1] but according to legislation the assessment should not build solely on those but on an overall assessment. Most of the costs are covered by taxes even though client fees are collected. In 2014, clients paid 18.5% of the costs of elderly people's services (Seppälä & Pekurinen 2014). Social protection for older people consists of income security and services in kind, arranged as a part of social and health care. Municipalities can provide the services themselves, or buy them from other municipalities or private service providers. Municipalities may also give vouchers for the elderly to buy services themselves from private service providers. After the SOTE reform[2] the counties will be in charge of this.

Public LTC services can take the form of **home services**. In many municipalities home services and home nursing are combined as home care. The publicly expressed target is to enable people to continue to live at home in spite of their LTC needs. Many of the elderly people cared for at home are increasingly frail and the need for services is vast: the need was considered heavy for 55% of clients in 2014 (Figure 1).

Figure 1: The need for services of clients of home services by different age groups



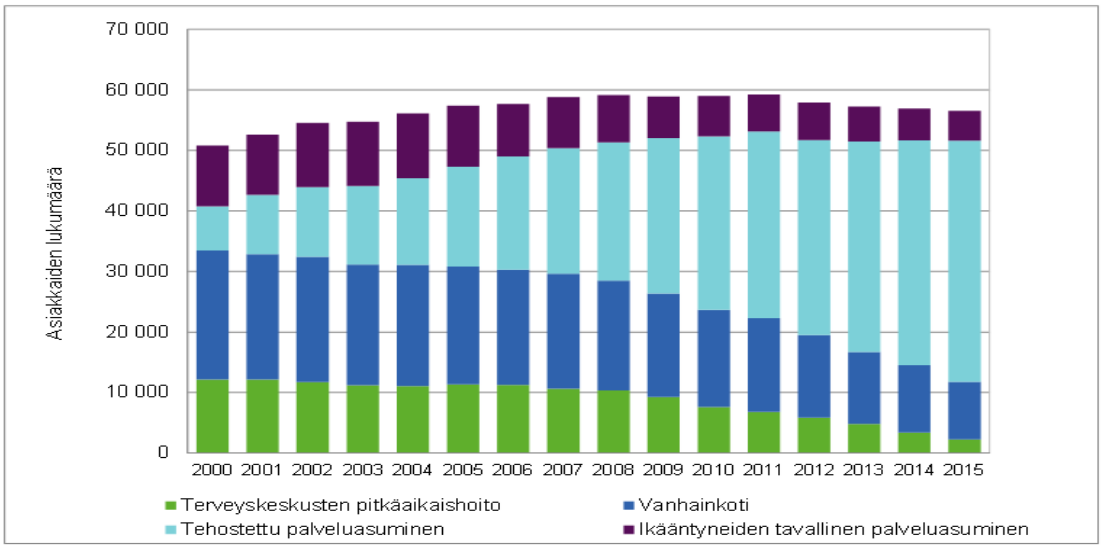
[1] For example the RAI-system, see Chapter 3.

[2] A big reform of social and health care is about to be finalised during spring 2018, see www.alueuudistus.fi.

Legend: vähäinen = little; jonkin verran = some; keskimääräinen = average; suuri = heavy; erittäin suuri = very heavy.
Source: RAI-tietokanta 2015, Noro et al. 2015.

There is also **day care** for the elderly and the services of day centres and **service centres**. Even though services supporting care at home are the priority, sometimes **sheltered housing, intensive sheltered housing or institutional care** is needed. Institutional care provides round-the-clock treatment in an institution for people who would not be able to manage at home using other services. This may comprise long-term, short-term or periodic care. Another option is '**family care'** (perhehoito), which is provided at the carer's home.[3]

Figure 2. The development of care given in hospitals, old people's homes, intensive sheltered homes and regular sheltered homes (number of recipients)



Legend: terveyskeskusten pitkäaikaishoito = long-term care in health centres; vanhainkoti = old people's home; tehostettu palveluasuminen = intensive sheltered homes; tavallinen palveluasuminen = sheltered homes.
Source: THL 2016.

These services are benefits in kind. On the other hand, **informal care support** is a combination of a benefit in kind and a cash benefit. Informal care support is paid to a relative who provides care at home for an elderly person, or a person with a disability or a chronic disease. Municipal informal care support demands a contract between the municipality and the caregiver. The amount of the support is linked to the intensity of the care needed. If the caregiver is unable to work due to heavy care obligations, the minimum amount is EUR 774.98 a month, and in the case of less intensive care the minimum is EUR 387.49 a month. The support is treated as taxable income and it accrues pension rights. This informal care benefit also includes municipal services for the care-receiver needed to make care at home possible. These can consist, for example, of help with washing, medical care or meals on wheels. In addition, these official informal carers are insured for accidents and, most importantly, get days off. A carer doing demanding care work gets three days off per month. Municipalities may also offer institutionalised care at intervals, in order to give the informal carers some rest. Some carers space out their time according to these intervals. Since 1 July 2016 municipalities have also been encouraged to arrange social and health services for informal carers in order to support their work. From 1 January 2018 informal carers are provided with

[3] See the Acts on Elderly Care (vanhuspalvelulaki 980/2012), Social Welfare (sosiaalihuoltolaki 1301/2014) and Family Care (perhehoitolaki 263/2015).

coaching related to their caring duties. There are approximately 40,000 informal carers at the moment, out of which approximately 60% are pensioners (Tillman et al. 2014).

There is also a care allowance for pensioners, a cash benefit paid out by the Social Insurance Institution (Kela) intended to make it possible for pension recipients with an illness or disability to live at home, as well as promoting home care and reimbursing pension recipients for the extra costs caused by illness or disability. The care allowance for pensioners is payable at three rates, depending on the level of need for assistance, guidance and supervision, in addition to special expenses. The middle rate is EUR 153.63 per month in 2018. Kela also pays the same amounts of care allowance to persons in institutional care.

Provision of LTC is a growing business. Already by 2010 elderly care was the biggest line of private social services: one fifth of the companies in this field provided sheltered housing (812 firms) and the second biggest line was provision of home services for the elderly and disabled (694 firms) (Yksityiset sosiaalipalvelut 2010). This trend is about to accelerate, and will mostly be paid for from the public purse – for example the city of Oulu has decided to cover all increases in need by buying services from private companies. At the moment, half of LTC services are provided by the city itself in Oulu, and half is bought from private companies (Haverinen 2018). Most probably, the share taken by private providers will expand as the forthcoming SOTE reform opens up more possibilities for choicee between public and private providers. The personal care budget also will expand the use of private care providers.[4]

1.2 Municipalities are in charge but families have their roles

In Finland there is no legal obligation to take care of one's relatives, except for one's children under 18 years of age and one's spouse (married or registered). In spite of this, Finns do care for their family members and friends, and this also goes for working people: 28% of working people take care of their old, disabled or ill relatives and friends in need of care, which means over 700,000 people (Silfver-Kuhalampi & Kauppinen 2015). Family care is supported by different forms of cash-for-care schemes such as informal care support or care allowances.

People can also have a ***tax deduction for the expenses of caring*** for their or their spouse's children, parents or grandparents. The tax credit for domestic help or household expenses (*kotitalousvähennys*) reduces taxes directly. After one's own liability of EUR 100, the maximum credit is EUR 2,400 per person per year. This has not been a very popular option – only 3% of the deductions were used for care in 2011 (Häkkinen Skans 2011).

As a rule, the care-giver is a female relative – a wife, mother or daughter. In addition to the general trend in favour of non-institutional LTC, the centre-to-right Juha Sipilä government (nominated on 29 May 2014, consisting of the Centre Party, the True Finns and the Conservative Coalition Party) wants to develop the informal care option in particular, since it is less expensive than various forms of institutional care.

Table 1 summarises various alternatives for organising LTC in Finland.

[4] For more information on LTC, see (for example) www.stm.fi or ASISP country document 2013 Finland.

Table 1. Summary table of the Finnish long-term care system and the main providers of care

In-kind services
- Health care centres (mainly municipal)
- Old people's homes (municipal or private)
- Intensive sheltered homes (municipal or private)
- Sheltered homes/services homes (municipal or private including family care)
- Home services (municipal or private)
- Day care/service centres

Cash services
- Informal care support (municipal)[5]
- Care allowance for pensioners (Kela)
- Tax deductions for services (tax authorities)

2 Analysis of the main long-term care challenges in the country

2.1 Assessment of the challenges for long-term care

2.1.1 Financial sustainability

In the coming two decades the Finnish population will be greying more quickly than populations in the other EU Member states.[6] Needless to say, this will inevitably increase age-related social spending. Since social spending is already about 30% of GDP and the public sector budget is in deficit, there are limited possibilities for increasing public spending on LTC. Within public social spending there may be a trade-off between services and income transfers. As part of the SOTE reform a personal budget will be introduced, which will accelerate this tendency.

Another problem is that almost all social services are provided by individual municipalities. Due to the sheer geographical size of the country and the relatively small number of inhabitants, the 320 municipalities are very different when it comes to the size and structure of their populations and their economic capacity to take care of all their responsibilities. Average municipal costs for social and health care services are EUR 2,940 per capita. However, the variation is huge. The cheapest bill is EUR 1,980 and the most expensive bill is EUR 4,689, indicating that the magnitude and severity of the problems individual municipalities face vary greatly. The economic problems of municipalities are mirrored in public opinion: as many as 40% of Finns think that in future the quality and amount of old-age care will not be adequate.[7]

The government is trying to solve the dilemmas in LTC by, on the one hand, digitising public services and increasing their efficiency, and on the other hand, placing more emphasis on home care given by relatives. The strategy is double-edged. Home care will diminish public spending but the flip side is that female labour force participation (see below), in particular, may diminish, which in turn is detrimental to the long-term

[5] Informal care support could also be listed as an in-kind service when looked at from the elderly person's point of view – since it takes the form of compensation given to a friend or family member rather than to the elderly person themselves. On the other hand, since almost all informal care-givers are family members, and most of the families have a common purse, informal care support is often used to meet the expenses of the person being cared for (Kalliomaa-Puha & Tillman 2016); thus it might also be listed as cash benefit.

[6] The economic dependency ratio was 142 in 2016 according to www.findikaattori.fi (16 February 2018).

[7] Aalto et al. 2016; see also Lähitapiola (2015) in which 57% shared this view.

sustainability of the welfare state. Short-term budget rationalism conflicts with the long-term national and EU targets to increase employment rates at all ages.

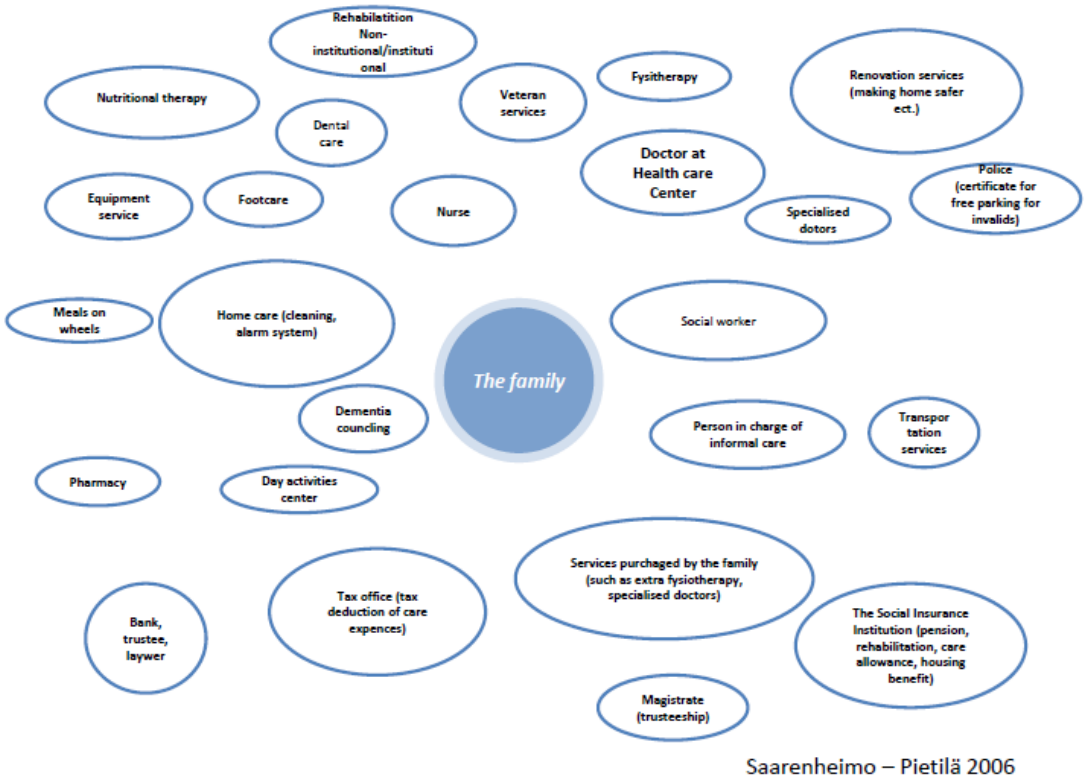
Due to forthcoming changes (the SOTE reform) as well as the need for financial savings, discussion has once again been aroused on the question of liability distribution: that is, what parts of LTC should the public and what should be left for families to cope with. At the moment, the market for private insurance for care is undeveloped, but this may change as more people become worried about the availability of public provision (Kalliomaa-Puha & Kangas 2015).

2.1.2 Access and adequacy

In Finland, there are many benefits available for carers. However, families in challenging situations may not have the resources to find the information they need. The application procedures may be too complicated for the elderly themselves, or even for relatives with low educational attainments. The discretionary nature of the benefits may also cause different outcomes around the country.

The more services provision is scattered, the more difficult it is to have control over it. As Figure 3 indicates, there is a multifaceted service 'cocktail' available for a family needing to care for a person suffering from dementia. Good management skills are needed to cope with all the services involved. At the moment, the family would have to deal with as many different providers as the number of services – perhaps even more with the continuing trend towards fragmented provision. Future plans for personal budgets and additional vouchers will increase the number of different actors around a family. Thus, the problem is not the number of services available but how to coordinate them.

Figure 3. Services of a person living at home and suffering from dementia (the 2006 situation)



Even though there are many services provided, they might not always be just the ones the families themselves think would help them the most. It is hoped that the new Social

Welfare Act[8] will fix that. The idea of the act is that by providing services early, more severe difficulties, and hence also expense, will be avoided. Instead of service packages, care workers might be left with wider discretion to decide which really is the service needed for the family in question. This has worked in child welfare,[9] and it may perhaps also work in LTC. There is also much discussion of one-stop shops and counselling. The Social Welfare Act, as well as the Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons,[10] provide for the municipality to appoint a responsible employee for each older person (omatyöntekijä). These employees should act as project managers for the elderly people concerned. There are also different experiments being undertaken, such as databases or service platforms,[11] designed to assist both citizens and employees. The new Social Welfare Act emphasises co-operation between the various authorities, as well as proper guidance for clients. A needs assessment (*palveluntarpeen arviointi*) must be made for every client and, if necessary, a plan (*asiakassuunnitelma*) made collecting all the services and benefits possible for the client. Municipalities also offer counselling points for social services, including offices, internet and phone services. According to the Administrative Act, authorities must provide the necessary advice free of charge to their customers. Also, the third sector plays an important part. There are associations for the elderly such as The Finnish Association for the Welfare of Older People, as well as for most illnesses; and there are associations for carers, such as The Central Association for Carers in Finland or the National Family Association Promoting Mental Health in Finland. However, despite the wide coverage of support services described above, there remain problems over take-up rates.

2.1.3 Gendered employment

Caring is still a gender issue, whether formal or informal. Cash-for-care has been criticised on the basis that it would lock women into their traditional homemaker roles (Hiilamo & Kangas 2009, 457-475). Even though the gendered roles of caring have changed – especially in informal care (already 25% of recipients of informal care support are men, Ahola et al. 2014) – women still carry a bigger care burden than men: 60% of all working women and 40% of working men provide care on a weekly or daily basis, while 20% of working women and 30% of working men provide care 2-3 times per month. 45-year-old people have the most heavy care burden on average (Silfer-Kuhalampi & Kauppinen 2015). If the plans to increase families' responsibility for LTC are carried out, it will probably mean an increase in the responsibility of middle-aged women. If they decide to cut their working hours or decide to stay at home caring, they might have great difficulties getting back to work when their caring duties come to an end.

In Figure 4, we concentrate on those women whose labour force status is either 'taking care of children or other relatives' or 'inactive'. The data are derived from the EU Statistics of Income and Living Conditions (EU-SILC 2012). The figure displays female care responsibilities along the whole life span from 20 to 65 years of age. As can be seen, whereas in Denmark, Norway and Sweden inactivity spells are negligible and short, in Finland, Iceland, and the UK the most intensive periods of care are concentrated in the 25-45 age bracket. Given the age bracket, this presumably means that carers might be caring for children and adults with disabilities. Southern Europe and the Benelux countries display their own distinct pattern, where family-related care tasks increase substantially with age, and the spells of absence simultaneously become much longer. In the three Scandinavian countries, the absence rates are almost flat over the age range.

[8] Act 1301/2014. Unfortunately, there is no English translation available.

[9] See the Flash report of Finland 2015.

[10] Act 980/2012. There is an unofficial English translation in the database Finlex: https://www.finlex.fi/en/laki/kaannokset/2012/20120980.

[11] See for example www.kymenlaaksonopastin.fi and Olkkonen-Nikula 2018. There are also many legal questions to tackle, see Pohjonen et al. 2017.

In comparison with its Nordic neighbours, Finland is a deviant case – reflecting the gendered impacts of care-related leave, the child home care allowance system in particular. The government's neo-familialistic orientation in LTC may further deepen the Finnish deviance from the 'Nordic' welfare model, with the latter's strong emphasis on public services facilitating care and employment.

Figure 4. Female labour force status 'taking care of family-related care responsibilities' (%); bars represent the duration of care-related absences from the labour market according to age

Source: Kangas, Palme & Kainu 2017.

2.1.4 Welfare of carers

Most informal carers are found to experience positive feelings in their everyday lives. However, the more difficult the care receiver's condition, the more burdened the caregiver naturally is. The more caregivers are supported by their close relatives or the municipalities, the less burdened they are (Juntunen & Salminen 2014.) Various options aimed at helping carers to participate in employment are of great importance for their well-being. Many working informal carers think that working increases their well-being (Tillman et al. 2014).

It has been estimated that 300,000 people provide care for their old, sick and/or disabled relatives. Out of these 300,000 carers, 60,000 even give highly demanding care. There are approximately 40,000 informal carers currently who have made a contract with their municipality and receive informal care support. Thus approximately 20,000 carers would

be entitled to informal care support in addition to those who currently do.[12] The problem with municipal payments is that receipt of the benefit has been more dependent on the economic situation of the individual municipality than the need for help.[13] The Social Welfare Act was amended in 2016 so that those helping an elderly person without a formal contract can also get days off (Section 26a, 512/2016). However, this is only a recommendation, and municipalities are not obliged to comply.

Arranging rest for informal carers is crucial. Only one third of the informal care support receivers use the leave available to them, and one third use fewer days off than they are entitled to – they simply think the substitute care provided is not good enough or not suitable for the care-receiver (Kalliomaa-Puha & Tillman 2016). The problem is well known and a lot has already been done to tackle it. Hiring substitute carers from the family circle seems to have worked well. Since not all families can supply a substitute carer, some municipalities have invented substitute carer pools (*sijaishoitajapankki*) (Mattila & Kakriainen 2014).

Often the most important thing for persons giving LTC is to get some support in daily life activities and to get some rest and leave, in order to cope with their care obligations. Therefore, options for rest and recreation should be guaranteed to care-givers. Even though pension rights accrue for those carers who have signed an informal care agreement, the accrual rate is small. Caring also affects carers' careers. Therefore, caring periods scar the livelihood of working-age carers, often severely. The consequences are quite different in the case of carers already receiving a pension. If combining work and care is not possible, perhaps the combination of services and cash for informal care support should be different as between pensioners and working-age carers.

Those employed in LTC in Finland are usually professionals, and there are steady jobs, career opportunities and education available even though the wage level is not very high. There are around 50,000 professionals working in LTC: about 35,000 people in institutional care and about 15,000 people in home care (Vehko et al. 2017). Even those working in home help are trained personnel: one tenth of them nurses and another tenth trained home-helpers. The problem is thus not the training, but the fact that the number of the staff is smaller than planned and needed. Cash-for-care schemes have at least not yet brought about a black labour market, at least not on a large scale. The well-being of the employees in LTC is good on average. However, the well-being of the employees of home care is diminishing. As the clients in home care are increasingly in poor health, the work involved is getting more onerous (Vehko et al. 2017). Also the number of clients in home care has increased while the number of employees has decreased (Kehusmaa et al. 2017). Employees are worried about the quality of care, do not sleep well and wonder whether they can carry on until their own retirement (Vehko et al. 2017).

2.2 Assessment of reforms: social and health care reform (SOTE) will change the total landscape of services

The whole Finnish social and health care service system – including LTC – will be totally changed when the SOTE comes into force. The whole bundle of laws will be discussed and either rejected or accepted by the Finnish parliament before summer 2018. If it is accepted, 18 counties, instead of municipalities, will organise care. Furthermore, the SOTE reform will open more room for private for-profit service providers to operate. Freedom of choice will also be increased by the additional use of vouchers and the introduction of individual care budgets. There are fears that international companies will dominate the care market and eat up small-scale local enterprises and not-for-profit third sector providers that traditionally have had an important role in Finland. For the time being, nobody knows what the eventual outcome of the SOTE will be and what kind of

[12] Ministry of Social and Health Affairs (2014:14).

[13] Ministry of Social and Health Affairs (2014:14); see also the cases 70 and 71/2011 of the European Committee of Social Rights, which found the discretionary powers of the municipalities too wide.

impact the reform will have upon either the division of labour between different providers, the responsibilities of individuals, or the accessibility and quality of care. A vote on the reform is expected in June 2018 in the parliament. If all the Acts are passed, the reform will take effect from 1 January 2020.[14]

2.3 Policy recommendations

The SOTE reform will probably even out the quality of LTC provision because it will be the responsibility of 18 counties instead of over 300 municipalities. At its best, the SOTE reform may also increase self-determination for those receiving care. The right to self-determination is a self-evident starting point in elderly services, and this is reflected in the legislation. However, in practice it does not always materialise (Kehusmaa et al. 2016, Kalliomaa-Puha 2017). Plans to increase freedom of choice through vouchers and personal budgets could potentially guarantee self-determination. However, this will not happen by itself. According to recent experiments with them, there have been problems with overlapping services and the flow of information between different actors (Vanninen 2018). Allocating elderly people with their 'own' social worker to help them find and coordinate services, as well as deal with the various authorities involved, would increase elderly people's access to justice.

Previous research shows that more know-how is needed in the provision of rehabilitation, dementia care and terminal care at home. There are also not enough home-care services provided during the night time, and the provision is unequally distributed (Noro et al. 2015). It is also clear that institutionalised care will also be needed – probably on a bigger scale than is now available – to secure the safety and well-being of the growing number of fragile people, at least if we want to retain the number of home-care workers. In many situations, home care is simply not possible and the workload for the workers concerned becomes too heavy. Also families may choose to take care of their elderly people themselves if the quality of home care – or institutional care – is considered to be inadequate.

As research shows that combining work and care increases informal carers' well-being, developing the options for doing so would improve not only the finances of caring families, but also their coping skills, and therefore the quality of care.

3 Analysis of the indicators available in the country for measuring long-term care

The Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons obliges the government to monitor the well-being of old people as well as other outcomes of the Act (Section 7). The task was given to the National Institute for Health and Welfare (THL) and Valvira, the National Supervisory Authority for Welfare and Health. THL conducted an exceptionally detailed investigation into LTC in May 2013. All municipalities, almost all home-care units and LTC institutions and most of the private service providers took part in this investigation. The investigation was repeated in 2014 and 2016.[15]

The needs of an elderly person are evaluated by an assessment system – RAI.[16] Legislation requires the use of some kind of assessment system and the RAI system is the most popular one (see Figure 5). Some assessment systems make comparisons

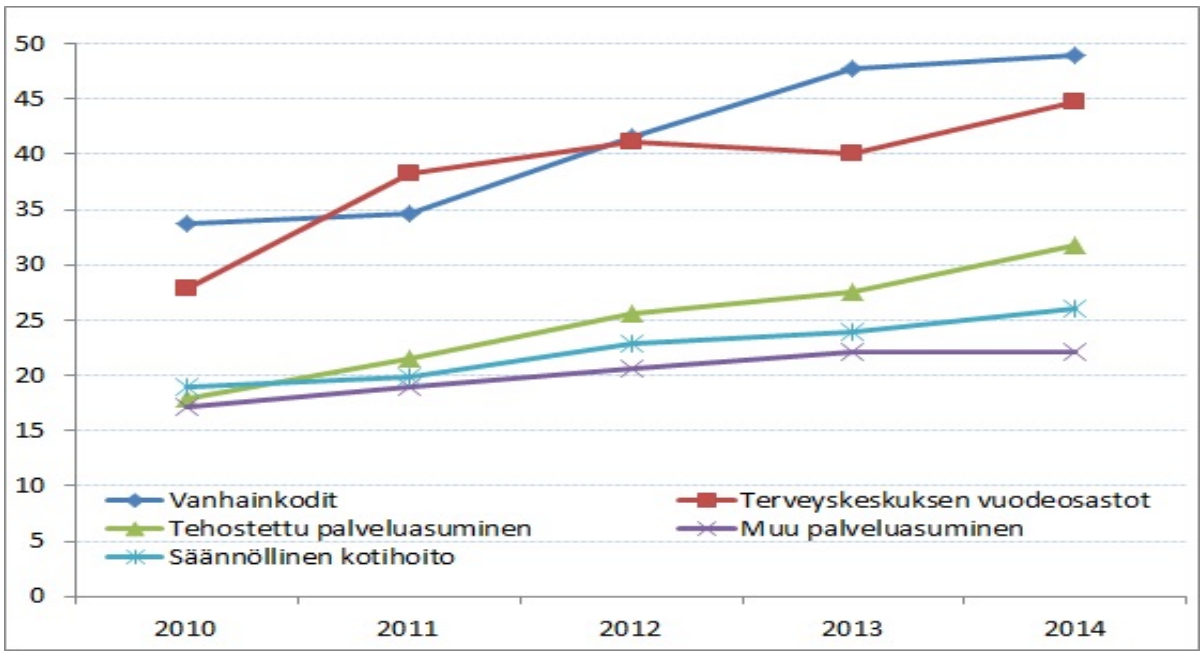
[14] For more information on the SOTE reform, see www.alueuudistus.fi and the latest ESPN Country Report of Finland.

[15] See the latest in https://www.thl.fi/en/-/vanhuspalvelujen-seuranta-kunnat-ovat-kehittaneet-vanhusten-vaativaa-kotihoitoa.

[16] See https://www.thl.fi/fi/web/ikaantyminen/rai-vertailukehittaminen/rain-kaytto-hoitotyossa. See the information of InterRAI consortium http://www.interrai.org/.

possible between the needs of different client groups as well as different areas. Thus, it is possible to do peer evaluation.[17]

Figure 5. The use of the RAI assessment system in different forms of long-term care in Finland since 2010



Legend: vanhainkodit = old people's homes; terveyskeskuksen vuodeosastot = health care centres; tehostettu palveluasuminen = intensive sheltered housing; muu palveluasuminen = sheltered housing; säännöllinenkotihoito= regular home care. *Source: https://www.thl.fi/fi/web/ikaantyminen/rai-vertailukehittaminen.*

Since promoting home care is one of the targets of the present government, the Ministry of Social affairs and Health has an ongoing project on LTC.[18] THL is also collecting information for the purposes of this project.[19]

THL provides statistics on social services for the elderly on the following topics.[20]

- Health and social services used by clients with memory disorders (available only in Finnish and Swedish).
- Social services for older people; municipal survey (available only in Finnish and Swedish).
- Institutional care and housing services in social care.
- Data on institutional care and housing services for older people by municipality. The information is based on the care register for social welfare.
- Regular home care.

[17] See more in https://www.thl.fi/fi/web/ikaantyminen/rai-vertailukehittaminen.

[18] http://stm.fi/hankkeet/koti-ja-omaishoito (Kärkihanke Kehitetään ikä ihmisten kotihoitoa ja kaiken ikäisten omaishoitoa 2016-2018).

[19] http://stm.fi/hankkeet/koti-ja-omaishoito/julkaisut. See also other projects on LTC https://www.thl.fi/en/web/ageing.

[20] See the Annex for more specific information as well as https://www.thl.fi/en/web/thlfi-en/statistics/statistics-by-topic/social-services-older-people; see also https://www.sotkanet.fi/sotkanet/en/haku?g=358.

- Information on the number of clients receiving home care and the services they have received, on the clients' age structure, need for care, required place of care, reasons for the start of service recipiency, and previous places of care.
- Health and social services used by clients with memory disorders.
- Information on the social and health services used by clients with memory disorders, by municipality. Clients with memory disorders include clients who have received a diagnosis for a disease that causes a deterioration in memory or other areas of data processing.
- Social services for older people; municipal survey.
- Every three years, THL collects data from municipalities regarding municipal activities in services for older people, services for persons with disabilities, child day care services, social credit granting, and rehabilitative work experience. This information complements the data in the statistics on municipal finances and activities maintained by Statistics Finland.
- The interRAI includes background information and information on cognitive patterns and health conditions, as well as other relevant clinical information such as medical diagnoses and medications. Outcome measures are, among others: physical activities of daily living (PADL); instrumental activities of daily living (IADL); cognitive performance scale (CPS); changes in health, end-stage disease and symptoms and signs (CHESS); body mass index (BMI); depression rating scale (DRS); pain scale; resource utilisation groups (case-mix index) (RUG-III); and quality indicators.

In order to involve the whole nation in watching over the quality of services for the elderly, the National Broadcasting Company, Yle, provides a free application for monitoring services in every municipality, called *vanhusvahti* ('elderly watch'): https://yle.fi/uutiset/3-9507060#etusivu. The information is based on the statistics of THL.

This is in line with the general idea of involving clients in monitoring the quality of the services that the Social Welfare Act provides. This 'self-supervision' (*omavalvonta*) might not, however, work that well with clients in poor health, not to mention the ones with dementia (Kalliomaa-Puha 2017). In addition, Valvira and six regional state administrative agencies supervise LTC. They can give directions and also provide licences to private social welfare providers. They also process complaints, which might give grounds for investigating LTC more widely than in just the individual case concerned. Under the SOTE reform Valvira and these regional agencies are to become one national agency, Luova.[21]

[21] http://alueuudistus.fi/maakuntauudistus/virasto.

References

Aalto A-M., Manderbacka K., Muuri A., Karvonen S., Junnila M. & Pekurinen M.: Mitä väestö ajattelee sosiaali- ja terveyspalveluiden uudistamisesta?, Tutkimuksesta tiiviisti 4/2016. Terveyden ja hyvinvoinnin laitos, Helsinki.

Ahola E., Tillman P. & Mikkola H.: Omaishoidosta maksettavat palkkiot ja omaishoitajien tulotaso – rekisteritutkimus vuodelta 2012. In Tillman P., Kalliomaa-Puha L. & Mikkola H. (eds): Rakas, mutta raskas työ. Kelan omaishoitohankkeen ensimmäisiä tuloksia. Helsinki: Kelan tutkimusosasto, Työpapereita 69/2014, 46-56.

Hiilamo H. & Kangas O. (2009): Trap for women or freedom to choose? The struggle over cash for child care schemes in Finland and Sweden. Journal of Social Policy 2009:38(3):457-475.

Häkkinen-Skans I.: Kotitalouspalveluiden verovähennykset Suomessa ja Ruotsissa. Helsinki: VATT Valmisteluraprotti 11, 2011.

Juntunen K. & Salminen A.: Mikä omaishoitajaa kuormittaa? Omaishoitajien jaksaminen ja tuen tarve COPE-indeksillä mitattuna. In Tillman P., Kalliomaa-Puha L. & Mikkola H. (eds): Rakas, mutta raskas työ. Kelan omaishoitohankkeen ensimmäisiä tuloksia. Helsinki: Kelan tutkimusosasto, Työpapereita 69/2014, 69-79.

Kalliomaa-Puha L. (2017): Vanhuksen oikeus hoivaan ja omaisolettama. Gerontologia 31(3) 2017, 227-242.

Kalliomaa-Puha L. & Tillman P. (2016): Äiti on aina äiti. Lasten omaishoitajien arjen haasteet. Teoksessa A. H., Ilpo A., Saarikallio-Torp M. & Valaste M. (eds): Laulu 573,566 perheestä. Lapsiperheet ja perhepolitiikka 2000-luvulla. Kelan tutkimus 2016, s. 322-355.

Kalliomaa-Puha L. & Kangas O.: Yhteistä ja yksityistä varautumista – vanhusten hoivan tulevaisuus (Public and private bracing – elderly care in the future). Kalevi Sorsa – säätiö 2015.

Kangas O., Palme J. & Kainu M.: The multifaceted roles of the social investment state in compensating, accumulating and multiplying endowments over the life cycle. In Erola J. & Kilpi-Jakonen E. (eds): Social Inequality Across the Generations: The Role of Compensation and Multiplication in Resource Accumulation. Edward Elgar Publishing, 181-203.

Kehusmaa S., Vainio S. & Alastalo H.: Ikääntyneet palvelun käyttäjät tuntevat olonsa turvalliseksi mutta hoidon suunnitteluun osallistumisessa on kehitettävää. Tutkimuksesta tiiviisti 13, heinäkuu 2016. Terveyden ja hyvinvoinnin laitos, Helsinki. http://urn.fi/URN:ISBN:978-952-302-688-9.

Kettunen, M. (2018): Asiakassegmentointi Kymenlaaksossa. Kokeiluista käytäntöön. Ikääntyneiden palvelut valinnanvapauden kynnyksellä – seminaari 30.2.2018 THL.

Mattila Y. & Kakriainen T.: Kunnan työntekijät arvioimassa omaishoitoa. In Tillman P., Kalliomaa-Puha L. & Mikkola H. (eds): Rakas, mutta raskas työ. Kelan omaishoitohankkeen ensimmäisiä tuloksia. Helsinki: Kelan tutkimusosasto, Työpapereita 69/2014, 10-44.

Mäkelä M. (2018): Palvelukriteereistä tarpeiden ratkaisukirjoihin. Kokeiluista käytäntöön. Ikääntyneiden palvelut valinnanvapauden kynnyksellä – seminaari 30 February 2018 THL https://www.slideshare.net/THLfi/matti-mkel-palvelukriteereist-tarpeiden-ratkaisukirjoihin.

Noro A., Alastalo H., Finne-Soveri H. & Mäkelä M. (2015): Kotihoidon toimintamallit ja henkilöstö vuonna 2014 – Vanhuspalvelulain toimeenpanon seurantatutkimus. Tutkimuksesta tiiviisti 2, Helmikuu 2015. Terveyden- ja hyvinvoinnin laitos, Helsinki.

Olkkonen-Nikula A. (2018): Asiakasohjauksen edelläkävijä Päijät-Häme. Kokeiluista käytäntöön. Ikääntyneiden palvelut valinnanvapauden kynnyksellä – seminaari 30 February 2018 THL https://www.slideshare.net/THLfi/anu-olkkonennikula-asiakasohjauksen-edellkvij-pijthme.

Pohjonen S. & Noso M. (eds) (2017): Kansalainen keskiöön! Näkökulmia sote-uudistukseen. Kunnallisalan kehittämissäätiö. Julkaisu 2, 2017. http://kaks.fi/wp-content/uploads/2017/04/nakokulmia-sote-uudistukseen.pdf.

Seppälä Timo T. & Pekurinen M. (eds) (2018): Sosiaali- ja terveydenhuollon keskeiset rahavirrat. Terveyden ja hyvinvoinnin laitos, Raportti 22/2014. Helsinki.

Silfver-Kuhalampi M. & Kauppinen K.: Tulosten pohdintaa – joukkoustamiskyselyn vastauksia. In Kauppinen K., Myyry L. & Silfver-Kuhalampi M. (eds): Työssäkäynti ja läheis- ja omaishoiva – työssä jaksamisen ja jatkamisen tukeminen. Helsinki: Sosiaalitieteiden laitoksen julkaisuja 2015:12, 177-190.

Tillman P., Kalliomaa-Puha L. & Mikkola H. (eds) (2014): Rakas mutta raskas työ. Kelan omaishoitohankkeen ensimmäisiä tuloksia. Kelan tutkimusosasto. Työpapereita 69/2014.

Vanninen H. (2018): Henkilökohtainen budjetti Keski-Uudenmaan valinnanvapauskokeilussa. Kokeiluista käytäntöön. Ikääntyneiden palvelut valinnanvapauden kynnyksellä – seminaari 30.2.2018 THL. https://www.slideshare.net/THLfi/helene-vanninen-henkilkohtainen-budjetti-keskiuudenmaan-valinnanvapauskokeilussa.

Vehko T., Sinervo T. & Josefsson K. (2017): Henkilöstön hyvinvointi vanhuspalveluissa – kotihoidon kehitys huolehstuttava. Tutkimuksesta tiiviisti 11, keskäkuu 2017. Terveyden ja hyvinvoinnin laitos, Helsinki.

Yksityiset sosiaalipalvelut 2010. Suomen virallinen tilasto. Sosiaaliturva. Terveyden ja hyvinvoinninlaitos. Helsinki. https://www.thl.fi/fi/tilastot/tilastot-aiheittain/yksityiset-sosiaali-ja-terveyspalvelut/yksityiset-sosiaalipalvelut.

Annex: Indicators for measuring elderly care in Finland[22]

Indicators to monitor quality and service structure	Source	Note
Palvelurakenne / Servicestructure (75+, 80+, 85+) • Kotona asuvat, % vastaavanikäisestä väestöstä (living at home, % of corresponding age population) • Omaishoidon tuen hoidettavat vuoden aikana, % vastaavanikäisestä väestöstä (elderly people receiving informal care support, % of corresponding age population) • Säännöllisen kotihoidon piirissä 30.11. asiakkaat, % vastaavanikäisestä väestöstä (clients of regular home care, % of corresponding age population) • Ikääntyneiden tehostetun palveluasumisen asiakkaat 31.12., % vastaavanikäisestä väestöstä (elderly people living in intensive sheltered housing, % of corresponding age population) • Terveyskeskusten asiakkaat, % vastaavanikäisestä väestöstä (clients of municipal health centres, % of corresponding age population) • Vanhainkodeissa tai pitkäaikaisessa laitoshoidossa terveyskeskuksissa olevat 80 vuotta täyttäneet 31.12. % (% of those aged over 80 in old people's home or inpatient ward in health centres, %) • Perhehoidossa olleiden osuus 75+, 80+, 85+ -vuotiaat väestöstä (% of those aged 75+, 80+ or 85+ in family care) • Muistisairaiden osuus eri palvelumuodoissa 75+, 80+, 85+ -vuotiaat täyttäneistä asiakkaista (% of those aged 75+, 80+, 85+ of all clients suffering from dementia)	**Sotkanet, AvoHILMO, HILMO registers** https://www.sotkanet.fi/sotkanet/en/index The Sotkanet.fi service contains over 2,000 indicators on health, welfare and the functioning of the service system. Many international comparisons are also available. Rokotusrekisteri (register for vaccinations)	**Nationwide data**

[22] Information given by 26 March 2018 / Teija Hammar, Iäkkäät, vammaiset ja toimintakyky –yksikkö, THL.

Indicators to monitor quality and service structure	Source	Note
• Influenssarokotteen kattavuus 75+ täyttäneistä (coverage of influenza vaccine of 75+ olds)		
• Arkitoiminnassa vähintään suuria vaikeuksia kokeneiden osuus 75+ täyttäneistä (%) (% of those aged 75+ having had serious trouble coping with everyday life) • Muistinsa huonoksi kokevien osuus 75+ täyttäneistä (%) (% of those aged 75+ experiencing hypomnesia) • Itsensä masentuneiksi kokevien osuus 75+ täyttäneistä (%) (% of those aged 75+ experiencing depression/low spirits) • Terveydentilansa keskitasoiseksi tai huonommaksi kokevien osuus 75+ täyttäneistä (% of those aged 75+ experiencing average or bad health) • Itsensä yksinäiseksi kokevien osuus 75+ täyttäneistä (%) (% of those aged 75+ experiencing loneliness) • Aktiivisesti järjestötoimintaan tms. osallistuvien osuus (%) (% actively participating in organisational or other activities) • Palvelujen käyttö; apua riittämättömästi saavien osuus apua tarvitsevista (%) (use of services: % receiving insufficient services) **Habits of living:** • Alkoholia humalahakuisesti käyttävien osuus 75+ täyttäneistä, % (% of those aged 75+ drinking to get drunk) • Vapaa-ajan liikuntaa vähän harrastavien osuus 75+ täyttäneistä, % (% of those aged 75+ taking little exercise)	Aikuisten terveys-, hyvinvointi- ja palvelututkimus (**ATH–research: nowadays FinSote)** **-** classification of different age-groups possible (63+, 75+, 80+)	Extensive survey by the National Institute for Health and Welfare (THL) carried out every 1-4 years according to national or area needs. Started 2010. **Restrictions** ATH-research is done by **random sampling** of the population aged over 20. The sample size is 10,000 yearly – every fourth year the sample size is 150,000.
• Yhteistyön toteutuminen eri tahojen kanssa (julkinen, yksityinen, järjestöt, srk ym.), % kunnista (%) (co-operation with various units (public, private, NGOs, church etc.), % of municipalities) • Henkilöstörakenne: suunniteltu ja toteutunut henkilöstömäärä ja	**Monitoring the well-being of old people according to The Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons**	Research done in 2013, 2014, 2016; 2018 forthcoming. However, the future of this research is not certain. **Restrictions:** Information on

Indicators to monitor quality and service structure	Source	Note
osuudet palvelutyypeittäin (structure of staff: planned and actual number and shares of personnel in various services) • Asiakkaat: määrä ja osuudet palvelutyypeittäin (clients: number and shares in various services) • Henkilöstömitoitus: suunniteltu ja toteutunut palvelutyypeittäin (number of staff: planned and actual number of personnel in various services) • Koneellinen lääkejakelu suurimmalla osalla toimintayksiköiden asiakkaista käytössä, osuus toimintayksiköistä (automatic distribution of drugs used by most of the clients of the functional unit, share of functional units) • Turvateknologiaa suurimmalla osalla toimintayksikön asiakkaita käytössä; osuus toimintayksiköistä (safety technologies used by most of the clients of the functional unit, share of functional units)		round-the-clock care and home care by functional unit
• Asiakasrakenne: palvelutarve (Maple), fyysinen (ADL, IADL), kognitiivinen (CPS), sosiaalinen (social) ja psyykkinen (DRS) toimintakyky (structure of clients: need of services (MAPLe), physical (ADL, IADL), cognitive (CPS), social (social) and psychological (DRS) capacity) • Lääkehoidon tarkistus vähintään puolivuosittain kotihoidon asiakkailla (checking medical treatment at least every 6 months, clients of home care) • Lääkehoidon tarkistus vähintään puolivuosittain ympärivuorokautisen hoidon asiakkailla (checking medical treatment at least every 6 months, round-the-clock care)	**RAI-järjestelmä (RAI-system)**	**Samples:** 40% coverage of clients of round-the-clock care, 30% of clients of regular home care. Not all functional units use the RAI-system, so there is no nationwide information.
• Lähiesimiesten hyvinvointi (well-being of immediate superiors) • Henkilöstön hyvinvointi: fyysinen, psyykkinen, kokemusoikeudenmukaisesta	**Kuntakymppi (HELA)**	**Erillistutkimus, otospohjainen (Independent study, sample**

Indicators to monitor quality and service structure	Source	Note
johtamisesta ja työn vaatimusten ja hallinnnan tasapaino (well-being of staff: physical and psychological welfare, experiences of fair management as well as coping with demands of work) • Henkilöstön poissaolot ammattiryhmittäin/vuosi (absences of staff by occupational group/year) • Henkilöstön vaihtuvuus ammattiryhmittäin/vuosi (turnover of staff/year)		**study)**