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National Framework for

HIGH-QUALITY SERVICES FOR OLDER PEOPLE

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ASSOCIATION OF FINNISH LOCAL AND REGIONAL AUTHORITIES

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SUMMARY

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The Finnish Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities first issued a national framework for high-quality services for older people in 2001, when such frameworks were a new form of informative guidance. The present revised framework incorporates current national strategies in old-age policy, assessments of the earlier framework, the latest research findings and recent changes in the operating environment. The current reform of the municipal and service structure in Finland is having a particularly great impact on services for older people. The Ministry of Social Affairs and Health drafted the new framework jointly with the Association of Finnish Local and Regional Authorities and the National Research and Development Centre for Welfare and Health (STAKES).

As the population's age structure changes, the whole of society has to adjust to the needs of a growing number of older people. The framework is designed to help municipalities and cooperation districts to develop their services for older people on a basis of local needs and resources, jointly with the third sector, private-sector service providers, and clients, their relations and other local residents. Municipalities are required to draw up their own old-age strategy to prepare for the demographic change, and integrate it into their municipal budget and budget plan. Implementation of the strategy will be monitored regularly.

It is the aim of the framework to promote the health and welfare of older people and to boost the quality and effectiveness of services. The framework is intended for use by decision-makers and managers in municipalities and cooperation districts as a tool for developing and evaluating their services for older people. It applies to all social and health services used regularly by older people and to efforts more generally to promote their health and welfare.

The Finnish Constitution requires government to ensure the implementation of fundamental and human rights, including the right to equal treatment and essential care. The new framework defines the values and ethical principles guiding the provision of services for older people. It also outlines strategies for boosting quality and effectiveness in three dimensions: (1) promoting health and welfare and developing the service structure, (2) staffing levels and staff skills and management, and (3) old-age living and care environments.

The framework sets national quantitative targets for services for older people that municipalities and cooperation districts can use as a basis for fixing their own targets. It underlines the primacy of promoting health and welfare, of giving priority to prevention and support for home living, and of comprehensive assessment of individual needs. The range of available services must be diversified with the addition of advisory and other preventive services, and health, functional capacity and rehabilitation must be supported throughout. The principles behind the staffing levels used are explained, and recommendations are made for minimum levels in 24-hour care. The importance of increasing employees' well-being at work, gerontological skills and managerial ability is underlined. Improving the quality of older people's living and care environments means investing in accessible, safe and pleasant surroundings. The framework includes monitoring indicators for the collection of local and national data on implementation of the main areas covered by the new framework.

KEY WORDS

Care, care for the elderly, older people, quality, services, services for older people

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Foreword

The Finnish Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities issued the first framework for services for older people in 2001. According to subsequent assessment, those responsible for such municipal services for older people considered the framework a valuable aid to planning and development. The present revised framework takes account of strategies in the Government Programme, the national targets of old-age policy, post-evaluations of the framework, the latest research findings and changes in the operating environment.

The aim of the new framework for services for older people is to promote the health and welfare of older people, to narrow differencies in that health and welfare, and to raise the quality and effectiveness of services provided. The framework will help municipalities and cooperation districts to develop their services for older people on a basis of local needs and resources, in cooperation with clients, other local residents, service users and their relations, NGOs, businesses and parishes.

As the framework is implemented, the targets it sets for service structure changes will help to restrain rising health and welfare costs. If no such changes are made in service structures and operations, it will be difficult to hold down costs in a situation in which the population's age structure is changing rapidly and the need for services is growing all the time.

The framework was drawn up by the Ministry of Social Affairs and Health in cooperation with the Association of Finnish Local and Regional Authorities and the National Research and Development Centre for Welfare and Health (STAKES). During the process, two public hearings were held, opinions were requested, and an opportunity was provided for on-line comments on a draft version of the framework. Numerous experts and representatives of municipalities were also consulted. We offer our warmest thanks to all those who at various stages helped to generate the new framework.

Helsinki, February 2008

Ministry of Social Affairs and Health

Paula Risikko
Minister of Health and Social Services

Kari Välimäki
Permanent Secretary

Association of Finnish Local and Regional Authorities

Risto Parjanne
Director General

Jussi Merikallio
Director

1 INTRODUCTION

Over the next few decades, the Finnish nation will be ageing fast. Municipal councils and managers, particularly, must recognize this trend in their operating environment and ponder ways of providing high-quality services for older people that demonstrate dignity and respect for individual clients while being both effective and financially sustainable.

A framework of quality recommendations has been found to play an important role in the development of services for older people. The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities issued the first such framework for high-quality services for older people in spring 2001, when frameworks were still new tools of informative guidance. Ex post assessments of frameworks indicate that municipalities consider them valuable tools: the more concrete targets for raising quality a framework lays down, the more useful it is thought to be. Assessments specifically stress how important it is to get frameworks implemented. This can be promoted through training and by supporting projects in the municipality working towards achievement of key targets. Systematic collection of data evaluating such target achievement plays an important part in implementation.

The original framework for services for older people has now been updated to take account of Government Programme strategies, national targets for old-age policy, the findings of framework assessments, new research data and changes in the operating environment, where the ongoing reform of Finland's municipal and service structure has a particularly great impact on services for older people. The framework's aim is to promote old-age health and welfare and to improve the quality and effectiveness of services.

The framework outlines strategies for raising the quality of services for older people in three dimensions: 1) promoting health and welfare and the related service structure, 2) staffing and management, 3) living and care environments. Different choices have different effects on older people's welfare and on costs. Modifying the service structure in line with the targets by increasing services that help older people to continue living at home while reducing institutional care will eventually restrain rising health and welfare service costs. If this structural modification is not embraced, it will be difficult to hold down costs in a situation in which the population's age structure is changing rapidly and the need for services is growing all the time (appendix 1).

The framework underlines the importance of careful preparation for changes in the age structure, comprising systematic development of the

service structure on a basis of local old-age needs, action to safeguard the staffing level and skills needed, and long-term planning of suitable housing and facilities. To back up such preparations, drafting of an old-age strategy that will be monitored regularly is recommended. The framework focuses on the dimensions of quality that will further the smooth functioning of processes and produce a good outcome, i.e. a real improvement in the health and welfare of older people.

The framework focuses on those dimensions of quality that will further the smooth functioning of processes and yield good outcomes.

The framework is intended for decision-makers and managers in municipalities and cooperation districts, as a tool for developing and evaluating their services for older people. Under the framework legislation for the reform of Finland's municipal and service structure, municipalities or cooperation districts with a population of more than 20,000 are required with certain exceptions to fulfil social welfare and basic health care functions that include a large proportion of the services used regularly by older people. Thus, municipalities and cooperation districts will carry the responsibility for providing services for older people and be responsible for the quality of the services they themselves provide or purchase from other providers. Municipalities and cooperation districts must also ensure that these services meet the population's needs and are of high quality and cost-effective. Because operating environments vary, solutions that take local circumstances into account are needed.

Using the framework, municipalities and cooperation districts can develop their services for older people in the long term, with consideration for local needs and resources, and in cooperation with NGOs, parishes and private-sector service providers. Indeed, the framework stresses the importance of partnership between the public, private and third sectors, and also underlines that opportunities for involvement by local people, clients and their families should be increased. Implementation of the framework will give the various actors a better chance to participate and exercise influence, and to guarantee effective high-quality services based on comprehensive assessment of the growing service needs of the municipality's older population.

The framework concerns itself with services used regularly by older people, such as home care, support for informal care, sheltered housing, long-term care and care in 24-hour sheltered housing units and residential homes, while also acting to promote the health and welfare of older people. In preparing for ageing of the population, planning must focus not only on services for older people but also on the need for society to adjust more generally to the needs of older people. That means mainstreaming them into all activities. Important decisions need to be made by municipalities not only in social welfare and health care but also in housing, culture, transport and education, and in community planning, the NGO sector and private-sector services. One in

four people over 75 use public social welfare and health care services regularly, and a growing number of older people use services on the expanding private-sector market. All older people, and also other local residents, benefit from a well-functioning and accessible living environment.

The impact of the framework must be monitored and regularly assessed at both the local and national level. The framework provides monitoring indicators that can be used to obtain regular information on progress made in the key areas. In addition, a separate nationwide assessment will continue to be needed to evaluate the impact of the framework and its effectiveness as a tool of informative guidance.

2 Raising service quality and effectiveness

2.1 Values and ethical principles guiding service development

- The Finnish Constitution requires government to safeguard the implementation of fundamental and human rights, including the right to equal treatment and essential care.
- Old age with dignity calls for conscious value choices that are made concrete in operating plans and budgets as quantitative and qualitative service targets.
- The main ethical principles ensuring old age with dignity are:
  - self-determination,
  - resource orientation,
  - equality,
  - participation,
  - individuality,
  - security.

The Finnish Constitution Act (section 25) requires government to ensure the implementation of fundamental and human rights. The rights of particular significance for the content of the services for older people framework concern equality (section 6) and social security (section 19), including essential care and adequate health and welfare services. Because making conscious value choices is the starting point for raising service quality and the basis for evaluating success, safeguarding these rights means developing services and defining the ethical principles and values that should guide the various actors involved. These principles and values take on concrete form in short and long-term operational plans and budgets, and in the quantitative and qualitative targets set for services.

The key fundamental value is respect for human dignity. Everyone must be ensured the right to a dignified old age and good treatment, irrespective of where they live or are cared for and of what their requirements for services may be. The ethical principles safeguarding a life of human dignity are:

- ***the right to self-determination***, which means that older people must be able to make informed choices and obtain the information and other help they need to make decisions. This right can be promoted by identifying, strengthening and utilizing their own resources in accordance with the ***resource orientation*** principle.

- ***equality***, which plays a part in welfare and satisfying human needs. Equal targeting of services means assessing the services needed to ensure the equality of older people and following consistent principles in granting them. Equality also means preventing discrimination, intervening when injustices occur, and accepting difference.

- ***participation***, which can be seen from the viewpoint of both the individual and society as a whole. At the individual level, it means making the participation principle visible in services for older people, maintaining and strengthening their active social capacities, and ensuring social cohesion so that people remain full members of their community even in old age. More broadly, social participation means ways in which people can influence the development of the society and environment they live in.

- ***individuality***, which stresses the importance of seeing people as unique individuals. Decisions made on services must be assessed in terms of how they affect people's ability to see themselves as valuable individuals and feel that their lives are meaningful. Individuality means freedom and choice, but also taking responsibility for one's own life.

- ***security***, which means creating a sense of physical, mental and social safety. The principle is implemented for instance by ensuring the availability and quality of social support and services, and trust between service providers and local people, by ensuring the safety of homes and care environments against fire and other hazards, and preventing accidents, violence and abuse.

The ethical principles of various vocational groups provide professionals with instructions on how to act in situations involving the exercise of power in their professional capacity, and suggest ways of influencing their clients' lives. Such instructions on ethics also underline the importance of responsibility.

2.2 Involvement of local people in service development

- Under the Finnish Local Government Act (365/1995), people living in a given municipality must be given the opportunity to participate in and influence how things are planned and prepared, and to obtain information on all matters currently under discussion and their planning.
- Providing older people with equal opportunities for participation and influence helps to ensure them a successful old age, whether they live at home or in care, and irrespective of their need for assistance.

The Local Government Act requires municipal councils to ensure that local residents and service users can participate in and influence municipal affairs, planning and preparation. Local authorities have a duty to notify residents about matters under discussion, plans concerning them, stages in the handling process, and decisions made and their impact. A municipality can freely decide how to execute this duty in practice. Apart from and in addition to traditional representative democracy, forms of direct participation are being used and developed, such as involvement in preparation, planning and decision-making affecting service provision or one's own district, and in publicity concerning them.

Local people must be given the chance to participate in and influence changes in the strategic focus of old-age policy and action to raise the quality of services. This means taking better account of the different — e.g. political, socio-cultural and financial — resources of older people in the municipality at both the local and a more general level. Active participation and meaningful involvement are also crucial factors in a successful ageing.

Clients and other local people must be given the chance to influence their municipality's old-age policy and service quality.

The various services must ensure that clients can participate in and influence action to raise service quality. At its most active, the client's role involves quality development, i.e. helping to raise the quality of the services they use themselves by setting quality targets, planning service implementation, and assessing service provision as far as their own resources permit. All clients, even those with the least functional capacity, experience this quality and can express their own views about it, for instance through client satisfaction surveys or feedback via relatives. Client feedback must be collected regularly and acted upon.

Local people must also be informed about implementation of their municipality's old-age strategy and efforts to raise the quality of services for older people. Local authorities should also inform people about:

- the services and facilities they can offer their older residents,
- when an older person or relative is entitled to a service and what the criteria are for granting it,
- how older people can have their service needs assessed,
- what the client charges and the principles for them are, and which services the charges cover,
- how living conditions and the quantity and quality of services for older people have improved.

The main ways of providing this information are various bulletins, advisory services, preventive home visits, service handbooks and municipal websites. Other good channels promoting participation are forums for the exchange of views and information, such as residents' nights, collaboration with NGOs, parishes and private-sector service providers, and senior citizens' or older people's councils.

2.3 How a strategy helps to ensure operational quality and effectiveness

- The aim is for every municipality to have an old-age strategy approved by its council, with its implementation integrated into the municipal budget and financial plan.
- The basis for formulating this strategy comprises the different needs and resources of third-age and fourth-age people living in the municipality, and of course local conditions.
- The strategy is drawn up jointly by the various administrative branches, local people, the third sector, business and industry, and other actors.
- The document defines a vision and key strategies for safeguarding services and welfare for older people, with an emphasis on local services.
- As a basis for decisions on key strategies, a preliminary assessment should be made to aid the choice of best options and increase the transparency of justifications for decisions.
- Implementation of the strategy must be monitored and evaluated regularly.

Strategy drafting and content

The aim is for every municipality to have an up-to-date old-age strategy approved by the municipal council. Municipalities forming a sub-region or cooperation district can have a joint strategy. The process of drawing up the strategy will involve representatives of the various administrative branches, local people, service users and relations, and key stakeholder groups such as senior citizens' councils, NGOs, parishes and local business and industry.

An old-age strategy is based on a comprehensive analysis of the current situation regarding services and the local population's health and welfare, and a forecast of future changes in the operating environment. Some older people are active and involved senior citizens, while others need considerable help and services. Some are members of various ethnic, linguistic or other minorities. The strategy must take all the various needs and resources of older people into account.

Municipalities need broad-based old-age strategies founded on a comprehensive analysis of current services and local people's health and welfare.

A comprehensive old-age strategy takes older people into account in all operations, from community planning and transport and housing policy to cultural and recreational policies and the promotion of learning and participation, health and welfare, and services. It defines a vision, i.e. a shared target state, and key strategies, as well as the responsibilities of various actors in making these a reality. A good vision and strategies are founded on active public debate about values in the municipality.

As a basis for formulating a strategy, a preliminary assessment should be made of its impact on older people's health and welfare. The aim of this assessment is to improve the quality of decision-making, that is, to help with the choice of best possible options, to make the justifications for decisions transparent, to increase attention to health and welfare considerations, to further participation and commitment, and to provide opportunities for discussion about values. The assessment moves from an outline of options and identification of impacts to a comparison of and decision-making on these options, and is done by obtaining the necessary facts about projects currently in preparation, consulting with experts and older people, and/or holding joint working meetings. The assessment of impact on people can be quick or thorough. The outcomes of a quick impact assessment are used 'as is' in decision-making and for the purpose of determining whether a thorough impact assessment is required. A thorough impact assessment requires careful planning and resource allocation.

A municipality can produce the services it is responsible for itself or jointly with other municipalities. It can also outsource services from private or public-sector providers or alternatively issue vouchers to service users with which

they can purchase necessary services from the private sector. Municipal federations and parent municipalities produce services in much the same way as independent municipalities. The old-age strategy sets out guidelines to be followed in the service structure and service production. These guidelines are also part of the service strategy followed by the municipality or municipalities concerned.

From the viewpoint of older people, exactly what services are available, and where, is an essential consideration. In terms of availability, services can be divided into local services, regional services and services demanding an extensive population base. Older people need them all, but in their everyday life it is local services that are crucial. Local services are delivered to their home, or are produced close by. They include preventive services, assessment of service needs, home care, support for informal care and gerontological social work. Regional services are needed for instance when special skills are required or their production regionally rather than locally yields other added value. Good examples are special services for those with dementia symptoms, units specializing in old-age psychiatric care, or units that can supply gerontological expertise. In sparsely populated areas, mobile services that visit clients are recommended.

Local services are crucial in everyday life.

The guidelines in a municipality's old-age strategy must be incorporated into its overall strategy and other programmes to promote health and welfare. The guidelines for staff involved in services for older people should similarly be integrated into other personnel strategy.

Implementing the strategy

Implementing an old-age strategy is a long-term process demanding effective leadership, full commitment to achieving the targets, and smooth cooperation between the personnel involved and the municipality's professional managers and elected officials.

The strategy approved by the municipal council should be integrated into the municipality's core processes, such as planning, budgeting, development programmes and ex post evaluation. The most important targets will be counted among the council's specific goals, and it will be the council that allocates the necessary resources. A separate implementation programme can be drawn up for putting the strategy into practice, analysing the targets into concrete sub-targets that will be monitored, clarifying areas of responsibility and the timetables and various steps to be taken, and determining how progress will be evaluated.

Successful drafting and implementation of a strategy demands active involvement by personnel at every stage. The strategy is converted into objec-

tives and action to be taken by the sector, unit, team and individual employee concerned. Development talks between employees and supervisors are an important link in the chain that will lead from strategic targets to day-to-day work. The old-age strategy also guides the choice of development projects. These are one form of change management, and they must be closely integrated into attainment of the strategy's aims. Good communication is essential both for personnel and for local people. Communication must be systematic, for instance involving an annual definition of the main focuses, key events and individuals responsible.

Monitoring the strategy and assessing its implementation

Strategy implementation must be monitored and regularly assessed.

A clear and concise analysis of the current state of services for older people and older people's health and welfare in a municipality is the starting point of monitoring and assessment. It also provides a basis for local debate. Municipal managers need information about development trends and the kind of operational changes that may have to be made. Committees and administrators need to scrutinize outcomes, effectiveness, efficiency and client satisfaction in their respective areas. Supervisors and employees need detailed reports, comparative figures and client feedback in order to plan and assess their own work. Such reporting must concentrate on the most crucial matters for the municipality's future functioning.

The conclusions drawn as a result of this assessment process will guide operations and affect the setting of new targets or adjustment of old ones. At council level, the function of assessment is to point out the adjustments that need making and the places where improvements are needed. Assessment is part of every municipality's core management process and constant development of operations.

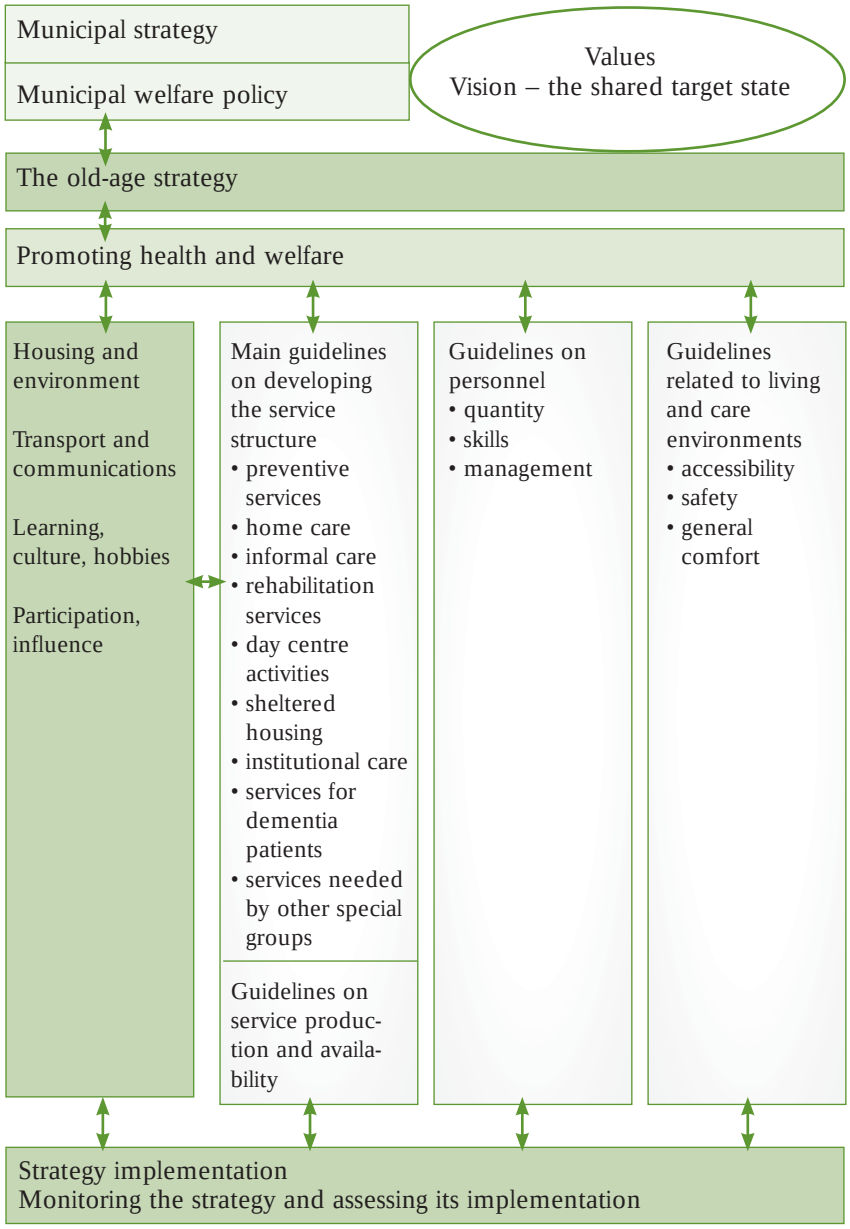
The municipal audit committee assesses whether the operational and financial targets set have been met. The aim here is to report whether operations have been successful from the viewpoint of the municipality but also, and particularly, the viewpoint of local people and service users. An old-age strategy is a long-term programme for ensuring services and welfare for older people. Monitoring the implementation of various strategies also plays a key role in the audit committee's assessment work. At intervals, it can also subject the municipality's old-age strategy and its implementation to closer scrutiny.

The municipality's assessment system not only involves the council and committees but should also link up with the evaluations made in the various operating units. The chain of assessment starts with the council but extends

via the various operational levels to development talks held with individual employees.

Monitoring and assessment of an old-age strategy should employ jointly agreed quantitative and qualitative evaluation methods and indicators, together with suitable comparative data. Monitoring and assessment information should be published annually, ensuring that the data are utilized in setting targets for the next round of planning.

Figure 1. The old-age strategy of a municipality or municipalities.



3 Guidelines for promoting health and welfare and developing the service structure

3.1 Focus on preventive action and promoting health and welfare

- The Primary Health Care Act and Social Welfare Act prescribe mandatory duties for municipalities regarding the promotion of the health and welfare of local people and the safeguarding of related advisory services, while the new framework recommends concrete measures for executing these duties.
- The key elements in promoting health and welfare are:
  - safeguarding successful ageing,
  - promoting a healthy lifestyle and preventing disease,
  - reducing differences in health and welfare,
  - supporting independence and a sense of security,
  - increasing opportunities for exercise to maintain and build muscle tone and a good sense of balance,
  - early intervention in failing health and functional capability,
  - effective treatment and rehabilitation for disease,
  - building up geriatric and gerontological expertise.
- Older people must be ensured ways of getting advice and guidance at low-threshold advisory units.
- Preventive home visits must be added to the range of municipal services and targeted at older people who do not yet need health and welfare services but are considered members of an at-risk group.
- The coverage of rehabilitation must be increased, particularly through services in the home.
- If health and welfare are to be promoted, the various actors in the public, third and private sectors must work together towards shared targets.

Legislation already 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.

It is worth promoting old-age health and welfare and providing necessary rehabilitation because:

- health and welfare have greater impact on the need for health and welfare services, and the latter's cost and the adequacy of available financing, than a rising number of the older people per se,
- boosting old-age health and welfare helps older people to go on living independently and at home, and to function as active members of the community and society in general,
- there is evidence from research to show that prevention, risk management, early intervention and rehabilitation are effective.

The health and welfare of local people can be promoted by firmly rooting response to growing old-age needs into planning and development in every administrative branch. Decisions important for such health and welfare, and for ways of helping older people to live at home, are made not only in health and welfare care but also in housing, culture, sport and physical recreation, transport and aspects of community planning such as zoning and land use.

The basic premise for planning in the various administrative branches must be to allow as many older people as possible to live a full, independent and meaningful life in their own homes and in a familiar environment. An accessible built-up environment and transport system and ready access to public services reduce the need for health and welfare services and thus save on costs. Ensuring older people accessible movement in their surroundings and means of transport is an important element in encouraging them to remain active and play a real role in everyday life. Free or low-priced opportunities for regular exercise are particularly valuable in strengthening muscles and improving balance. Hobbies, recreation, rehabilitation and access to peer support are of enormous value both to older people themselves and to the families caring

All planning must be geared towards making it possible for as many older people as possible to live a full, independent and meaningful life in their own homes.

for them. By working in close association with NGOs, parishes and voluntary organizations, municipalities can draw on their resources too in supporting old-age participation and an active life.

Preventive activities designed to maintain older people's functional capacity can defer their need for services by many years. When there is effective early intervention in declining functional capacity, general state of health and social circumstances, older people can be prevented from sinking into a real capacity deficit, thus avoiding serious aggravation of their problems. Such early intervention will call for wider use of, and thus an increase in, various preventive and rehabilitative working methods and services.

Family, friends and the community play an important role in safeguarding the welfare of older people. With help from this support network, the latter will primarily look after their own welfare, mostly using the same services as other local people. It is the job of the service system to encourage, guide and motivate people to take responsibility for their own health and welfare. Research findings must be drawn upon for maintaining health and welfare.

The main elements in promoting health and welfare are:

1. Securing successful ageing
   - support for participation
   - maintenance of social networks
   - ensuring opportunities for exercise, learning, cultural activities and other meaningful activities
   - advice, guidance and social support in ensuring welfare
   - promoting positive, respectful attitudes to older people in society

2. Promoting healthy lifestyle and preventing disease
   - a healthy diet suited to older people's needs
   - regular exercise and maintenance of muscle power
   - regular health checks

3. Reducing differences in health and welfare
   - recognizing and taking responsibility for the special needs of at-risk groups (those in a weaker socio-economic situation and at risk of exclusion)

4. Supporting independence and security
   - preventing accidents in the home and at leisure
   - use of ethically acceptable technology developed for older people's needs

5. Early intervention in declining health and functional capacity, drug and alcohol misuse, violence and abuse, and other social problems.

6. Effective treatment of disease, and rehabilitation based on a rehabilitation plan.
   - safe pharmacotherapy[1] complying with guidelines laid down in the Safe Pharmacotherapy guide and the municipal bulletin on safe pharmacotherapy for old people.
   - early identification, treatment and rehabilitation of somatic diseases, including oral health, mental health (especially depression) and memory problems.
7. Reinforcement of gerontological expertise, including geriatric expertise.

Advisory centres[2]

Ageing people and their families need advice and guidance on matters related to the ageing process, health and social problems, and where and how they can find help when needed. This need can be met by providing low-threshold advisory centres and services. The aim is for all older people and their relations to have access to information, advice and guidance on exercise and other recreations, the activities of organizations, assistive devices and accident prevention. The range of services provided by advisory units could include assessing and monitoring functional capacity and health, and guidance regarding the use of services. Side by side with independent use of online assistance, it is important to be able to get one-to-one advice. Advisory services can partly be arranged jointly by several municipalities, and in association with NGOs, parishes and voluntary organizations.

Preventive home visits

Preventive home visits enable early intervention in failing functional capability and health and help older people to continue living at home. The purpose

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[1] The following national guides have been issued to ensure safe pharmacotherapy:
- *Vanhusten turvallinen lääkehoito: Kuntien velvoitteet* (Safe pharmacotherapy for old people: Municipal responsibilities; in Finnish). Municipal bulletin 6/2007. Ministry of Social Affairs and Health.
- *Safe Pharmacotherapy. National guide for pharmacotherapy in social and health care* (in Finnish). Guides 2005:32. Ministry of Social Affairs and Health.

[2] The Government's policy programme for health promotion includes creation of a nationwide network of advisory centres for older people. The Ministry of Social Affairs and Health has set up a working group on promoting old-age health and welfare, one aim being the formulation of good practices in such centres' work. The working group's term ends on 31 December 2008.

of such visits is to assess and support independence, to provide information about services, to identify risk factors endangering the person's health and welfare, and to check the safety of the home and surroundings. The likely future need for individual services can also be established.

Preventive home visits should be targeted mainly at older people who do not use health and welfare services regularly. Special attention must be given to risk groups, such as those in a weaker socio-economic position and at risk of exclusion, those with multiple diseases and repeatedly hospitalized, those susceptible to falls and other accidents, the recently widowed and older people living alone. Seeking out at-risk groups is a challenge calling for cooperation between many different professionals and other actors. Once members of an at-risk group have been identified, adequate monitoring must be ensured so that any deterioration in their functional capacity and health can be noted in time, and the necessary services arranged without delay.

Rehabilitation

Rapid rehabilitation and rehabilitative care after acute treatment are effective, and investment in them helps prevent older people from ending up in long-term institutional care. All services for older people should adopt an approach that promotes recovery of functional capacity and rehabilitation, as well as utilizing rehabilitation methods properly. Targeting rehabilitation demands a precise clarification of needs and provision principles if those older people who will benefit from rehabilitation are to get the services they need.

There is a need for more periods of rehabilitation aimed at getting clients back home, and rehabilitation once they get there. After short spells of institutional rehabilitation, a client should return home as soon as possible, with efficient communication between the institution and the home carer.

Organizing rehabilitation demanding special skills in larger units, e.g. regionally, leads to more efficient use of resources, and consequently greater service output. Close cooperation between specialist care, basic health services and welfare services will boost the effectiveness of the rehabilitation chain. Skills learnt in the rehabilitation of war veterans can be utilized in developing services.

3.2 Aiming at a service structure that promotes health and welfare

- The service structure must be developed comprehensively, utilizing everything we know about old-age living conditions, morbidity and functional capacity.
- A comprehensive assessment of the individual's service needs ensures effective and high-quality service. The information generated can be used in planning the municipality's or region's service system.
- The service system must be developed with the main emphasis on services that help older people to live permanently at home.
- The quality and effectiveness of services for home care clients can be ensured by allocating them a specific responsible person or persons (coordinators) and by giving them a better chance to consult sources with expertise in geriatrics or gerontological nursing and social work.
- The needs of clients with dementia symptoms must be given special attention when the service structure is being developed.
- Long-term care must be reformed, aiming at homely residential units that meet older people's wishes, and allowing municipal health centre hospitals to be reserved for acute treatment and rehabilitation.
- All services must incorporate opportunities for older people to get care and assistance that promote their functional capacity and rehabilitation.
- Concrete quantitative targets must be set for service coverage, and implementation monitored using proper indicators.

Services meeting old-age needs must be based on comprehensive needs assessment

Information about their ageing population's functional capacity, morbidity and trends in housing and living conditions will help municipalities to develop services that really meet local needs. The factors specifically increasing the need for services for older people are diseases causing dementia, poor physical condition, deficient local services, living alone, obstacles in the living environment and surroundings, and lack of social networks.

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 (Social Welfare Act 710/1982, section 40a)[3]. The findings of such assessments can also be utilized when the service system of the whole municipality or region is being planned.

Effective, high-quality services presuppose comprehensive assessment of the individual's service needs and effective use of this information at the municipal level.

Good practices[4] 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 reliability[5];
- full understanding of the assessment process, the methods used, analysis of the data produced, and interpretation of the findings.

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[3] The aim is to extend the right to service needs assessment to persons aged 75 years as of 1.1.2009.

[4] The Ministry of Social Affairs and Health has issued a municipal bulletin for the development of good practices: *Ikäihmisten toimintakyvyn selvittäminen osana palvelutarpeen arviointia sosiaalihuollossa* (Assessment of older people's functional capacity as a part of service needs assessment in social services; in Finnish). Municipal bulletin 5/2006.

[5] The National Public Health Institute (KTL) coordinates the work of the 'network of experts on functional capacity measurement and assessment'. It is the goal of the network's section on old-age functional capacity to agree on the specifications for measuring and assessing the functional capacity of older people, to chart what parties are involved in this area in Finland, to create a database on projects, indicators and assessment methods and their usability, and to issue recommendations.

The supply of municipal and regional services must always be viewed as a whole, because the various dimensions interact. The guidelines for developing the service structure set measurable quantitative and qualitative targets for services for older people and the resources available for them, define the action needed to reach the targets, and agree on systematic evaluation of their attainment. In developing the service structure, priority must be given to various services promoting welfare, health and functional capacity, those permitting independence and home living, and rehabilitation services.

Rehabilitative home care

Good home care is proactive. It is based on a comprehensive assessment of the client's functional capacity and reacts rapidly to changes in their health and capabilities. Good home care promotes rehabilitation and responds to the client's physical, cognitive, mental and social rehabilitation needs. A 'rehabilitative approach' means encouraging and helping clients to use their remaining personal resources in their everyday life. Rehabilitation helping older people to live at home emphasizes community and outpatient services such as forms of rehabilitation that can be given at home.

The aim is for home care clients to have access to 24-hour service, provided by evening and night patrols. Clients' and families' sense of security can be strengthened and continuity of home care boosted by appointing a responsible person or unit that can be contacted around the clock as necessary.

Home and family care can also be supported by arranging rehabilitative activities during the day and short-term 24-hour care to maintain clients' functional capacity and allow the carer some respite. Broader adoption of services supporting the discharge from hospital, such as discharge teams formed jointly by various sectors, is also to be recommended if a hospitalized client is to have a real chance of subsequently successfully settling back home.

Older people need not only assistance with basic activities of daily living and nursing care but also help with everyday matters such as household chores and errands. This need can be met by ensuring sufficient diversified home and support services and providing client guidance allowing municipal, private-sector and third-sector services to be combined on a case-by-case basis. If a person seeking services does not meet the particular municipality's criteria or the municipality does not provide the services needed, older people cannot just be left alone with their problems; rather, they and their families must have the other options explained to them. A service voucher is one way of arranging for home services and home nursing and of supplementing what the municipality can offer.

Clients using public services must be given access to guidance and advice on how they can supplement the services available to them by arranging for additional services at their own expense.

The quality and effectiveness of services should be ensured by appointing a responsible person or persons as home care coordinators and assuring them consultation opportunities drawing on adequate expertise in gerontological nursing and social work, and in geriatrics.

Reforming long-term care

The long-term care of older people must be reformed by changing both its structures and its operating methods. Long-term care in municipal health centre hospitals that is not medically justified must be replaced by other options. Health centre hospitals can then focus on flexible and rapidly available acute treatment and rehabilitation.

Long-term care must be arranged to meet clients' own wishes at home or in a homely environment, such as sheltered housing units with 24-hour assistance. Another aim is to create a new form of care[6] to replace the traditional residential home and long-term institutional care in municipal health centre hospitals; this will offer rehabilitative long-term care to meet clients' needs, in which staff are on hand round the clock and a physician is readily available.

Special needs of older people with dementia symptoms

Dementia diseases among older people are one of the main factors increasing the need for services. Provision of care and services for those with dementia symptoms is a crucial element in the planning and dimensioning of services for older people. Sufficient and appropriately allocated social health and welfare services can also help those with dementia symptoms to live at home longer and defer their transfer into institutional care. It is particularly important to safeguard flexible services that adjust to changes in their functional capacity throughout the care and service continuum. Those diagnosed with a dementia disease and their families must be given information and support, have their service needs assessed, have case management and services through every stage of the client's service continuum. This can be made possible by strengthening partnerships in service provision.

[6] The Ministry of Social Affairs and Health has started the development of this new form of care in cooperation with the National Research and Development Centre for Welfare and Health (STAKES), municipalities and other experts.

The service system must be developed so as to place the main emphasis on services enabling and supporting home living. Services requiring special skills should be specified in the municipality's old-age strategy or agreed regionally. A good example of collaboration between municipalities is a service provided by units focusing on severe behavioural symptoms among dementia patients. The old-age strategies of municipalities should incorporate a separate section that specifically addresses the service needs of dementia patients, including those with multiple problems such as intoxicant addiction in addition to dementia.

3.3 Quantitative and qualitative targets of the service structure

Future development and dimensioning of the service structure should be based on a clear vision and old-age strategy concerning services for older people in a municipality or cooperation district. Different municipalities and cooperation districts can produce service packages that respond differently to old-age needs.

The need to expand preventive action to maintain functional capacity is common to all municipalities. Preventive activities and services must be increased, diversified and changed so as to support older people's health and welfare.

The coverage of home care must be increased to match the very clear needs highlighted by research findings. This is also justified because it means more services can be produced at the right time and in a proactive manner. If regular home care and informal care support services are increased, it will also be possible to increase the potential for dementia cases and those with mental health problems to continue living at home.

Improving the living conditions of older people and expanding home care will reduce the need for normal sheltered accommodation, allowing greater concentration on accommodation with 24-hour assistance.

Adequate home care and sheltered housing with 24-hour assistance, together with new types of care service, will reduce the need for long-term institutional care.

Adequate home care and sheltered housing with 24-hour assistance, together with new service concepts, will reduce the need for long-term institutional care.

Achievement of goals set for regular home care, informal care support, 24-hour sheltered housing and institutional care can be assessed using monitoring data from national statistics and registers. There are still no national monitoring indicators on preventive services and day centre activities, but attainment of local targets for these services should be assessed regularly by municipalities.

The national targets to be reached by 2012 are that, of all people over 75:[7]

- 91% to 92% live at home independently or using appropriate health and welfare services granted by assessing their overall needs,
- 13% to 14% receive regular home care,
- 5% to 6% receive informal care support,
- 5% to 6% live in sheltered housing with 24-hour assistance,
- 3% live in old people's homes or are in long-term care in health centre hospitals.

In their own old-age strategies, municipalities and cooperation districts should set individual targets for services based on their old-age needs and local resources. Targets must also be set for services to promote health and welfare, and for day centre activities and periodic care.

Ensuring the quality and effectiveness of services requires well-functioning service chains in social and health care.

Ensuring the quality and effectiveness of services requires well-functioning service chains. To help older people with living at home and managing everyday tasks, a shared service concept is needed in which social welfare, basic health care, specialist care and other service provision all work smoothly together. When care, service and rehabilitation plans are drawn up for health and welfare care, the individual targets must be agreed on jointly, in order to avoid overlapping. In client-oriented care and service, the client's family and friends should be included in service planning, implementation and assessment. The aim is for each client to have a single written plan for care, services and the like, to be followed in smooth collaboration between the various actors, and providing the client with an effective, high-quality service package. When an individual client's plan is drawn up, care must be taken to ensure that the charges made for the services do not create an unreasonable burden for the client (Act on Client Fees for Social Welfare and Health Care, 745/1992, section 11).

Client orientation is the key factor in good care and service. Client-oriented planning and implementation of care and service processes should derive from a careful and thorough assessment of the individual client's needs, resources and living environment. This provides the basis for the goal-oriented provision of activities to promote functional capacity and rehabilitation that must be the pervasive quality factor in all services for older people, from preventive care to long-term institutional care. In all services, clients'

[7] See the definitions of concepts in the section *Terms used in the framework* on p. 49.

functional capacity and rehabilitation should be assessed, maintained and promoted utilizing functional capacity indicators and assessment systems, interviews with clients and family members, and observation. The information must be documented in the client's or patient's records to ensure that they are always up-to-date.

Quality services

- are client-oriented and allow clients and their families to participate in service planning, decision-making and assessment,
- are based on a comprehensive assessment of service needs, living environment and client resources, assessing the individual's physical, cognitive, mental, social, linguistic and cultural needs and resources, as well as environmental factors,
- are goal-oriented and regularly assessed against a single written plan for care, rehabilitation and/or services,
- are based on a working approach that promotes functional capacity and rehabilitation,
- are implemented in cooperation with the client, the various service providers, and relatives and friends,
- are given in a safe and timely manner,
- utilize existing research results and information about good practices,
- are effective, i.e. attain the individual and social targets set for the services.

4 Main strategic guidelines for personnel and management

- The basic premise for deciding on staffing levels is the clients' functional capacity and need for assistance.
- The number of employees in services for older people, the task structure, and attention to occupational safety and well-being at work are elements that must be incorporated into the old-age strategy and overall personnel strategy of the municipality or cooperation district concerned.
- In planning the staffing level and task structure, the qualification requirements laid down in the legislation regarding the competence of professional staff and their licence to practice must naturally be complied with, and attention also paid to the task structure recommendations for professional social welfare staff.
- Staff competence should be ensured by targeting supplementary training to meet the estimated future skills need and by following the supplementary training provisions and frameworks for social and health care.
- The aim is for all those working in services for older people to have completed vocational training in social welfare and/or health care, and also to have gerontological expertise acquired though basic, continuation and/or supplementary training.
- There must be skilled and adequate management of services for older people.
- Occupational safety and staff well-being at work must be promoted.

Staffing levels, skills and well-being at work are the foundation for the quality and effectiveness of services. Strategic guidelines on the amount, skills, well-being and safety of staff working in services for older people should be incorporated into the old-age strategy of individual municipalities and cooperation districts and integrated into their personnel strategies. The premise for these guidelines is that a municipality must have enough trained and skilled personnel, including competent management, to carry out its vision and strategy for future services for older people.

The personnel strategy is drawn up jointly by the personnel concerned, the management and the political decision-makers. If the drafting process is successful, this as such commits the various actors to implementing a strategy anticipating future challenges.

The guidelines on older people in a municipal personnel strategy should cover the following areas:

- Local and regional forecasting of personnel resources,
- A plan for staffing levels and task structure, and implementation of the plan,
- Skills enhancement based on an assessment of future competence needs,
- The promotion of occupational safety and well-being at work,
- A supportive and motivating pay system,
- A multicultural clientele and personnel,
- Plans for developing assessment and management systems so as to safeguard staff skills and well-being at work and achieve the operational goals.

4.1 Staffing levels and task structure

When staffing levels are planned, the focus must be on the functional capacity and the physical, cognitive, mental and social independence of clients. It is vital to consider both clients' rights and the quality and effectiveness targets aimed at. Another challenge in scaling staffing levels is to ensure a well-integrated care and service entity and continuity for clients, while also minimizing staff turnover.

Staffing levels must take account of clients' rights and the quality and effectiveness of targets set for operations.

In planning staffing levels, it is also important to ensure that the outcome is dynamic, i.e. that the system can readily produce substitutes to replace regular staff away for short or longer periods. 'Dynamic' also means that staff can be transferred temporarily to other units when changes in the overall level of client capability require, e.g. in terminal care.

Staffing levels are successful when clients' service and care needs are met and there are enough skilled personnel to guarantee clients services of high quality and effectiveness not only cost-efficiently but also while showing older people proper respect.

The following factors should be taken into account when staffing levels are planned and assessed:

1. Clients' functional capacity and need for assistance
   - clients' need for assistance, established by means of a comprehensive assessment of their service needs,
   - the number of clients requiring special skills, such as dementia clients with behavioural problems and older psychiatric patients,
   - clients' rights to health care and welfare services that meet their needs adequately and in a timely manner.

2. The service structure, production and availability of services
   - targets for the service structure and the coverage of different services in the municipality or cooperation district,
   - ways of producing services (internally, outsourcing, service vouchers) and their availability (local services, regional services),
   - the effects of the various services provided by a given unit, such as rehabilitative short-term care or day centre activities,
   - environmental factors, such as the size, structural functioning and safety of the unit (24-hour care) and distances between local services (home care).

3. Factors related to the personnel and how their work is organized
   - staff potential for producing services for clients appropriate in terms of both quality and effectiveness,
   - the training structure of personnel working with clients, their skills and full use of them,
   - the way operations are organized and carried out, such as taking client needs into account in shift planning, and the possibility of staff sharing when necessary,
   - adequate staffing in unusual situations, e.g. terminal care,
   - indicators reflecting well-being at work, such as short and long sick leaves and high turnover.

When the personnel job structure is planned, note must be taken of the qualification requirements laid down in the acts and decrees on professional staff (Act (272/2005) and Decree (608/2005) on Qualification Requirements for Social Welfare Professionals; Act (559/1994) and Decree (564/1994) on Health Care Professionals; and task structure frameworks for social welfare professionals[8]).

The aim is for all those working in old-age health and welfare services to have a vocational qualification in social welfare and/or health care, and gerontological expertise acquired in basic, continuation and/or supplementary

[8] *Recommendations for the task structure of professional social services staff* (in Finnish). Publications 2007:14. Ministry of Social Affairs and Health.

training. Staff skills must be safeguarded by aiming targeted further training of this kind at the skills expected to be needed in the future, and by complying with further health and welfare care training frameworks and provisions in legislation (Social Welfare Act 710/1982, as amended 50/2005; Primary Health Care Act 72/1972, as amended 992/2003; and Act on Specialized Medical Care 1062/1989, as amended 993/2003; Decree on the further training of health care personnel 1194/2003).

The personnel included in staffing level planning in the various services include employees involved in direct care of clients, such as trained home helps and home care assistants, licensed practical nurses, social welfare counsellors and educators, registered nurses and public health nurses, geriatric nurses and their immediate supervisors, such as head nurses. If, however, there are other staff who lack basic vocational training in welfare and/or health care work involved in direct care work in a unit, e.g. ward assistants, they should be included only insofar as what they do is a direct response to clients' basic needs, such as help with washing, eating and use of the WC. When the work of healthcare assistants or clinical support workers comprises only cleaning, for instance, they should not be included when staffing levels are calculated. At sheltered housing and institutional care units, there are also therapists, physiotherapists and functional therapists who may visit several units or hospitals. They should then be included in terms of the percentage of the total work input represented by their work. If, for instance, a full-time employee spends 20% of his/her time working in a given hospital, his/her work input there is 0.2.

Older people's functional capacity and quality of life can also be greatly boosted by people in fields other than those mentioned above. Good examples are qualified arts and music professionals, whose skills and input can provide older people with interesting and pleasurable activities, self-expression and aesthetic experiences, as well as introducing other staff to socio-cultural work. Socio-cultural work with older people includes all kinds of creative activity, from music, drama and art to literature and creative writing. To ensure resources for such work, it is important to work closely with municipal arts and culture departments and NGOs.

Staffing levels for home care personnel:[9] A Ministry of Social Affairs and Health working group has developed a model for scaling future needs which is currently being tested by various municipalities. The scaling is based on the following factors:

[9] As the quality recommendations were revised also a model for scaling staffing levels for home care personnel was developed. The model will be piloted in an ongoing project at the Ministry of Social Affairs and Health.

- the number of 65 to 74 year-olds and people over 75 in the municipality,
- the percentage of under and over 75s using home care:
  a) The percentage of 65 to 74 year-olds using home care,
  b) The percentage of over 75s aimed at for home care coverage,
- Data on home care intensity (monthly average for recorded hours spent on work with clients and other duties),
- Data on the number of personnel working in home care.

The Ministry of Social Affairs and Health will be issuing national staffing level recommendations for social welfare personnel, including those working in home care, by the end of 2008.

24-hour care: The aim is to ensure good care, the quality and effectiveness of which are assessed. The national recommendation for minimum staffing levels[10] in 24-hour care is 0.5-0.6 employees per client. The higher option (0.6) is recommended when the clients concerned display difficult somatic or behavioural symptoms or when the size of and/or structural defects in the care environment mean more staff are needed. In reality, a good staffing level in 24-hour care is 0.7-0.8. If there are long-term clients needing medical care in health centre hospitals, the minimum level is 0.6-0.7 employees per client, and a good level 0.8. However, it must be kept in mind that staffing levels must always be based on the clients and their particular needs, whatever kind of unit they are in.

The staffing level recommendations refer to real levels, with absent employees replaced by substitutes. A permanent substitution system is therefore a justifiable option, and can also be set up jointly by several municipalities. It is vital to achieve the planned staffing levels from the viewpoint of both client safety and staff welfare. As well as staffing levels *per se*, it is also important to allocate the available personnel to different shifts so that clients can be ensured the chance of normal life and the care they need at all times of day and night.

The availability of doctors must also be safeguarded. Although everyone who needs treatment has access to the local health centre, home care also ensures that clients receive an annual check-up by a doctor. In 24-hour care, it is a good practice for a doctor to visit the unit at agreed intervals. Clients' medical condition and care needs can then be evaluated and suitable action taken, including regular review of their medication. To meet clients' acute needs in 24-hour care, there must be clear and documented practices that all employees are aware of.

[10] In 2005, the national average was 0.46–0.55 in sheltered housing with 24-hour assistance, 0.52 in residential homes, and 0.66 in health centre inpatient care.

4.2 Management of services for older people — the challenge of boosting skills and well-being at work

Management of services for older people is founded on the implementation of old-age and personnel strategy guidelines for services for older people. The aim of all management is that workplace units, organizations and municipalities are able to reach the quantitative and qualitative targets set. Management affects not only staffing levels and skills but also the welfare and occupational safety of personnel. All these things have an impact on service quality and effectiveness. The management function calls for mastery of strategic management, skills management and of course financial management. It is also essential to be able to network effectively.

Management affects not only staffing levels and skills but also the welfare and occupational safety of personnel. All these aspects affect service quality and effectiveness.

At 'shop floor' level, it is the immediate supervisors who carry the responsibility for proper work organization, updating working practices and staff skills, and increasing the welfare and occupational safety of the workplace community and individual employees. Managing the work of professionals demands not only managerial skills but also a high level of know-how about occupational and collaborative matters in the field of social health and welfare care, and special expertise in care of older people and services for older people.

Broad gerontological understanding of older people must be the starting point for all efforts to develop staffing levels, the training structure and individual skills. Older people need a variety of social and health services, depending on their individual situations. Some also need special services, such as those provided in gerontological social work. Managers and supervisors carry the responsibility for recruiting personnel whose overall skills match the targets set for any given service or form of care.

Because staff skills are linked to quality and effectiveness of service, every workplace unit should draw up both a long-term and a short-term training plan covering its entire personnel. Supervisors are responsible for further training and for monitoring and assessing its effectiveness, but individual staff members are also responsible for their own personal development.

Workplace units also need a programme to maintain working capacity. The characteristics of the job and the workplace community have a crucial impact on not only on-the-job learning but also employee commitment to achieving their unit's targets and how well individuals can cope with their jobs. It is up to managers and supervisors to ensure employee well-being at work, for instance by ensuring a reasonable work load. The employer is also

responsible for providing employees with the necessary information on matters affecting their safety, health and other circumstances at work (Occupational Safety and Health Act 738/2002). Individual staff members, too, can promote the smooth functioning of the workplace community by enhancing their collaborative skills.

The aims of management to develop skills, well-being at work and occupational safety are:

- to safeguard an adequate number of skilled personnel,
- to ensure the systematic development of staff skills,
- to make full and varied use of employee skills,
- to encourage steps to make the work more manageable, e.g. by dividing clients and personnel into smaller and more easily managed units, thereby allowing work targets to be defined more clearly,
- to change procedures, e.g. by guiding the workplace culture in a direction favouring open debate, reducing unnecessary routines and increasing general flexibility,
- to identify physical and mental factors threatening well-being at work, such as difficulties with client relations, unnecessary routines, lack of independence, pressure of time and problems in the working climate,
- to seek active solutions to eliminate known negative factors and support the physical and mental welfare of employees and help them to find job satisfaction,
- to treat the personnel fairly,
- to make consistent, justified and transparent decisions in which staff are all treated according to the same principles and the same rules apply today and tomorrow.

5 Quality living and care environments

- The aims are safe, pleasant, accessible living and care environments.

Municipal health and welfare, housing, technical and emergency services should all work together to promote home living and meet future space needs, and

- assess any need to convert and renovate the homes of older clients receiving home care and preventive home visits, focusing on obstacles to movement, fire safety and other security considerations,
- assess the safety and freedom from obstacles of sheltered housing and institutional facilities meant for older people,
- using this assessment data, prioritize renovation needs in home and institutional environments and draw up a programme for upgrading them,
- increase investment in the adoption of client-friendly technology.

In units providing long-term care, the aims are:

- rooms, corridors, communal areas and yards should be safe and obstacle-free,
- each resident should have a single room with en suite washing and toilet facilities unless he or she specifically wants to live with a spouse or another resident who prefers company,
- new units providing long-term care should have only sufficiently spacious single en suite rooms, and when older facilities are renovated, more single rooms should be created whenever possible,
- the general surroundings must take the special needs of dementia clients into account, be safe and clear, and promote easy orientation,
- the dimensioning of facilities must be adequate, promoting their flexible use while ensuring the staff's occupational safety and ability to cope,
- outdoor recreational opportunities for residents should be increased.

5.1 Safe, accessible surroundings promote independence

Most ageing people live in the normal homes that they have chosen for their old age. If the safety and accessibility of these home environments are increased, their occupants' functional capacity can be raised and their health and welfare enhanced. Action to this end means older people can live safely at home longer, enjoying the independence their own resources permit and their own way of life and home customs, while having the freedom to make their own choices and being involved in the community, yet also benefiting from home services provision.

Accessibility means producing an environment friendly to those with a physical or sensory disability. That means having no steps or changes in level that cannot be negotiated in a wheelchair. Accessible planning also involves lighting, choice of colours and materials, and acoustical considerations. Thus, attention must be paid not only to physical obstacles but also to how information and social functions and services are presented. To be accessible, products, information, services and the built-up environment must function well and be easy to use and access. A well-planned accessible environment maintains and promotes physical, cognitive, mental and social capabilities, reduces the need for aids or assistants, and decreases the risk of accidents. That means more independence and equality.

Independence and participation can be furthered with home conversions, assistive devices and gerontechnology.

Safety and accessibility can be promoted through home conversions and use of assistive devices. Gerontechnology, in turn, can help older people to achieve an independent and autonomous life. Various forms of assistive devices and detector systems, such as wrist alarms, beepers and other monitoring methods, allow an older person's health and safety to be watched over without the constant presence of a professional. As 'smart home' technology becomes more common and access to it spreads, older people's potential for controlling their environment will grow. Thanks to e-mail and video phones, contacts with relations and friends that boost participation are already increasing rapidly, and a rising proportion of old-age home services can also be provided online. Support for technology-assisted home living is not restricted to the area inside the home: there are already several orientation, positioning and alarm systems that contribute to safe movement outside the home. A crucial aspect here is always to respect client privacy and ensure that clients, family members and employees are given sufficient guidance in use of the technology to ensure that it really increases, rather than reduces, the user's sense of security.

Particular attention must be paid to the safety of home and care environments. The fire safety and other security of homes, sheltered housing

and institutions must comply with the law and official instructions. Preventing all kinds of accident is an important part of security promotion. The duties of municipal actors with regard to minor and major accident prevention are laid down by law (Primary Health Care Act (66/1972) section 1; Rescue Act (468/2003)). Joint safety planning practices adopted by municipalities provide a good way of intensifying cooperation aimed at boosting safety levels and of furthering security comprehensively. In future, a growing number of homes will also be the working environment of an informal carer or care worker, which means the resident's right to privacy and self-determination has to be reconciled with occupational safety considerations.

Municipal departments of health and social welfare, housing, technical matters and rescue services should ideally assess jointly the repairs and conversion work needed in long-term care units, and in the homes of clients receiving home care, informal care support and preventive home visits, from the viewpoint of obstacles, safety, smooth service provision and future space needs. This will help old people to continue to live at home. On the basis of such assessment, these needs can be placed in order of priority and an improvement programme drawn up which will ensure that adequate advice on refurbishment and related services are available and that client-friendly use is made of modern safety technology and equipment.

5.2 Long-term care units

At long-term care units (sheltered housing with 24-hour assistance, residential homes), the aim is for rooms, communal areas and corridors to be accessible, safe and pleasant. As well as ensuring freedom from obstacles in the physical sense, such units must also ensure that their entire environment is socially and institutionally accessible, and that the older people living there are sovereign individuals despite their limited functional capacities, with a right to self-determination, privacy and participation. Promoting a sense of security is an important element in the work of sheltered housing units and institutions. Responsibility for this security rests with the service providers.

The aim is for all units providing long-term care, including dementia group homes, to be able to provide residents with single en suite rooms unless the resident specifically wishes otherwise. For those in long-term care, their own room is their home, so should be cosy, comfortable and contain personal items of furniture. Single rooms promote high-quality long-term care by ensuring residents privacy and involvement in their own care. In the interests of quality of life and respect for individual privacy, it is important that residents

are not cared for in spare beds or corridors. Single rooms also mean that it is possible to provide terminal care. However, some older people actually feel more secure and contented when they can share a room with someone else, and this option must also be ensured.

People in long-term care must also have access to company and joint activities: they should be able to enjoy a homely setting and share their everyday events, so communal areas must be both comfortable and safe. Balconies and terraces must be large enough to allow those using assistive devices to enter, leave and move around easily and safely, and even allow access for a bed. Being in the open air is important for residents' mental alertness, and can be furthered with yard and garden design. Access to a yard or garden brings contact with nature, and this is a vital element in welfare.

The recommendation is that new long-term care units should primarily provide only sufficiently large single en suite rooms. When old facilities are renovated, the number of single rooms should be increased. By 2015 at the latest, renovations, too, should comprise solely single rooms. The comfort and homeliness of sheltered housing units and of institutional accommodation and care environments should be increased, aiming to produce facilities that function well, meet clients' needs and create a sense of normality.

The main aim is sufficiently large single rooms.

When dementia patients' housing units are built and renovated, attention must be paid to their special needs. If the number of residents in a dementia group home or unit exceeds 12 to 15, it is more practicable to divide it into smaller fairly independent divisions. A small group helps residents to feel secure and in control of their environment, and means staff can become familiar with their individual situations and divide their duties into manageable units. This boosts well-being at work and occupational safety. Facilities must be sufficiently spacious, to make staff feel secure and help them cope with their work. Important features in interior décor are various ways of promoting orientation and identification, such as distinct surface materials and lighting minimizing reflections.

New technology can be utilized in a long-term care unit in many ways. Sensors and alarm systems also increase safety and freedom of movement in accommodation with 24-hour assistance. There are many technical solutions already in use or under development to monitor vital functions and support rehabilitation. Closed-circuit television channels and various interactive multimedia programs can provide stimuli and entertainment.

A well planned and constructed long-term care environment promotes the health and welfare of older people and greatly supports efforts to promote rehabilitation. Safe, pleasant and accessible surroundings further independence

A safe, pleasant and obstacle-free environment encourages independence and furthers participation.

by increasing clients' physical, cognitive, mental and social capabilities and by compensating for other decline in functional capacity. They can also provide opportunities for and encourage participation in recreational activities.

6 Monitoring indicators

Systematic collection of assessment data on attainment of set targets plays a crucial role in implementation of the framework. It allows both local and central government to evaluate development over time and to compare data with the situation in other municipalities and nationwide. The National Research and Development Centre for Welfare and Health (STAKES) SOTKAnet Indicator Bank (www.sotkanet.fi) provides indicators for monitoring and comparing promotion of health and welfare, service needs, service structures and finances.

Indicators of service needs

In terms of practicable factors influencing service needs that can be monitored annually and at the municipal level, the framework covers the following:

- current overall age structure and prognosis, total population and percentage breakdown (SOTKAnet, Statistics Finland),
- number and percentage of those over 65 and 75 living in housing with poor or extremely poor amenities (Statistics Finland),
- number and percentage of those over 65 and 75 living alone (SOTKAnet),
- number and percentage of those over 65 receiving the full national old age pension (SOTKAnet).

The number of older people, especially those over 75 and 85, is a background variable illustrating the need for services and can be used as a benchmark for other indicators. Housing with deficient amenities makes it more difficult for older people with decreased functional capacity to function independently. 'Deficient' here means having no bath/shower room and/or no central or electric heating. 'Extremely deficient' means that there is also no running water, drains, hot water or WC. The number and percentage of those living alone is an important indicator when service provision is planned. Especially if they have memory problems, living alone makes it more difficult for those with declining functional capacity to cope and increases their need for support and services, possibly resulting in demand for 24-hour care. The only people receiving the full national old age pension are those without a sufficiently large earnings-related pension, so the figure and percentage for these recipients also indicate lack of means, i.e. poverty. Poverty, in turn, is a background factor with several effects on morbidity, need for services and the ability to request charged services.

Indicators of service structure

Indicators are available for monitoring attainment of the quantitative service targets set in the framework. They allow local and central government to evaluate development over time and to compare data with other municipalities and nationwide. Data is available in the STAKES SOTKAnet Indicator Bank (www.sotkanet.fi).

Indicators	Targets (as % of over 75s)
Percentage living at home (excluding those in 24-hour care)	91%–92%
Percentage receiving regular home care	13%–14%
Percentage receiving informal care support	5%–6%
Percentage in sheltered housing with 24-hour assistance	5%–6%
Percentage in long-term institutional care (residential homes, health centre hospitals)	3%

At the end of 2006, 90.1% of over 75s were living at home. The calculation excludes all those in long-term hospital care, old people's residential homes and housing with 24-hour assistance. In 2005, 11.5% of over 75s received regular home care and 3.7% received informal care support, 3.9% were living in sheltered housing with 24-hour assistance, and 6.5% were in long-term institutional care.

	Percentage of over 75s living at home and their use of services for older people		
	2000	2005	2006
Over 75s living at home	89.8%	89.6%	90.1%
Over 75s receiving regular home care as at 30 November		11.5%	
Over 75s receiving informal care support during the year	3.0%	3.7%	3.7%
Over 75s living in sheltered housing with 24-hour assistance as at 31 December	1.7%	3.4%	3.9%
Over 75s in residential homes or long-term institutional care in health centre hospitals as at 31 December	8.3%	6.8%	6.5%

There are considerable regional discrepancies, however. (See Table 1, p. 48)

Indicators related to staffing

The various data on staffing levels and training structures published regularly in statistical publications are as follows:

- Number and training structure of municipal personnel by sector, vocational group and region,
- Number of private-sector social health and welfare service personnel by sector and province,
- Number of personnel per 1,000 over 75s in home care and home nursing, old-age sheltered housing, residential homes and health centres,
- Number of personnel by vocational group in municipal and municipal federation home care and home nursing, old-age sheltered housing, residential homes and health centres.

In statistics on the vocational structure, regular nursing staff includes head, registered and public health nurses, social welfare counsellors and educators, licensed practical nurses and other practical nurses, mental health nurses, social welfare carers, home carers and home assistants.

No direct information on the staffing levels of individual municipalities or units can be obtained from national statistics. Separate reports are often produced to illustrate the situation nationwide, using data on municipalities and municipal federations taken from Statistics Finland's figures on local government pay. When this data is combined with information taken from social welfare and health care treatment notification registers on the number of days spent in care and treatment, it is possible to make indicative calculations. In the case of private-sector services, some average estimates on levels can be obtained from STAKES statistics. In other respects, private-sector personnel data is based on Statistics Finland figures on employment levels. In 2005, the national average was 0.46-0.55 employees per client in sheltered housing with 24-hour assistance, 0.52 in residential homes and 0.66 in health centre hospitals.

Other indicators

Indicators of health and welfare promotion

The STAKES SOTKAnet service also includes two groups of indicators related to the promotion of health and welfare, with about 20 indicators specifically concerning the old age. These include:

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

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

Financial indicators

Indicators for financial monitoring and comparison include:

- total running costs of institutional services for older people, EUR 1,000,
- total running costs of home services, EUR 1,000,
- total running costs of other services for older people and people with disabilities, EUR 1,000.

Table 1. Structure and coverage of services for older people by region, 2006.

	Clients over 75 as percentage of total number of over 75s					
	Informal care support*	Regular home care **	Sheltered housing ***	Of this, sheltered housing with 24-hour assistance	Residential home***	Long-term health centre care***
Whole country	3.7	11.5	5.7	3.9	4.1	2.4
Uusimaa	3.2	9.9	5.4	4.9	4.3	2.2
Itä-Uusimaa	3.4	10.1	4.4	2.7	5.6	1.5
Varsinais-Suomi	3.1	10.4	4.4	3.2	4.6	1.9
Satakunta	3.3	9.9	5.4	4.1	5.9	1.7
Kanta-Häme	3.1	11.3	5.4	2.7	5.9	1.7
Pirkanmaa	2.3	10.8	4.4	1.6	6.0	1.8
Päijät-Häme	3.3	9.8	4.7	3.6	1.9	4.5
Kymenlaakso	4.0	10.0	5.4	4.3	3.4	2.7
South Karelia	3.0	11.0	4.4	3.1	3.6	3.1
Etelä-Savo	3.5	15.3	6.9	4.4	3.7	3.1
Pohjois-Savo	3.7	11.9	5.2	3.6	2.9	2.8
North Karelia	2.9	14.0	6.4	2.6	3.2	3.8
Central Finland	4.0	13.7	6.0	3.3	4.3	2.2
South Ostrobothnia	5.7	10.6	7.1	4.0	3.7	2.7
Ostrobothnia	3.3	9.8	7.2	5.1	4.0	2.9
Central Ostrobothnia	5.4	11.9	10.3	7.7	2.6	0.9
North Ostrobothnia	6.2	17.4	6.4	4.5	4.0	1.6
Kainuu	6.8	11.8	8.2	6.8	0.5	2.0
Lapland	5.2	13.3	6.8	5.2	2.3	3.0
Åland	5.3	10.8	9.2	3.0	4.6	2.5

* Clients during year
** Clients as at 30 November 2005
*** Clients as at 31 December 2006

Terms used in the framework

Accessibility is a broad concept referring to the unhampered participation by all in daily tasks, hobbies, culture and studies. It means providing ready access to services and assistive devices, easy-to-understand information and opportunities to contribute to decision-making concerning oneself. An accessible environment means construction and building that is safe, pleasant and accessible to all users. Easy access should be arranged to all facilities and multi-storey buildings. In addition, facilities and their functioning must be as logical and easy to use as possible.

Client-oriented means scrutinizing and classifying services from the recipient client's viewpoint. The activities of a client-oriented organization are planned focusing on the needs and resources of the recipient client, involving the client as far as possible in evaluating service needs, in service planning and implementation and in assessing the impact of the service.

Cooperation districts are regional organizations set up to consolidate collaboration between a number of municipalities. Administratively, a cooperation district can be either a municipal federation or a joint body of municipalities in the area; in the latter case, one municipality is responsible for all the municipal functions in the area concerned.

Gerontechnology is technology designed for older people. Its design combines gerontological and technological know-how.

Gerontology is a discipline that studies ageing and older people. It analyses the changes brought by age and the factors that affect these changes and how they can be influenced. Gerontology studies the consequences of the ageing process on the individual, the community and society as a whole. It includes geriatrics, gerontological nursing in practice and theory, psycho-gerontology and social, cultural and environmental gerontology.

> ***Geriatrics*** is a special field of clinical medicine that broadly utilizes gerontological research and knowledge regarding ageing patients yielded by other clinical specialities.
>
> ***Gerontological nursing*** is a special field of nursing combining nursing values, know-how and methods with gerontological knowledge. The aim of gerontological nursing is to promote and maintain the health and functional capacity of older people, their family and their community, providing help and support with the changes and physical decline

brought by ageing, prevention of disease, and curative, palliative and rehabilitative care.

Gerontological social work is a specialist field aiming to strengthen older people's functional capacity, welfare, living environment and social circumstances and the functioning of communities. Gerontological social work promotes life management and self-determination. It helps clients to get the services they need and support from social workers, and is responsible for related preparatory work and implementation.

Old-age policy means various public welfare policy targets, strategies, operating systems and measures, and legislation maintaining and improving the independent life management potential of older people. Old-age policy is an element in policy covering the whole life cycle which guides the development of various areas of public policy in accordance with trends in the demographic age structure, i.e. meets the needs of an ageing population.

Preliminary assessment in this connection means human impact assessment (HuIA), a prospective (ex ante) process foreseeing the effects of current decisions on the health and welfare of older people. HuIA can be either thorough or quick. Outcomes of the latter are used 'as is' in decision-making and to identify needs for a thorough HuIA. A thorough HuIA calls for detailed planning and resources.

Quality means a service's ability to respond systematically to clients' appropriately estimated service needs both in accordance with the law and cost-effectively. The matters subjected to quality assessment can be divided into structural and process-related factors and outcomes. Structural factors provide the preconditions for operations, and include staffing and its structure, management and supervision practices and care environments, and in general factors that provide the conditions for well-functioning processes and thus effective outcomes. Process-related factors include the whole operating process starting when clients first need services and ending when they no longer do so. The process is assessed by evaluating whether the activities guarantee the client effective and high-quality care and service. Assessment of outcomes means judging whether the targets have been reached, i.e. have the changes aimed at in the client's situation or behaviour been achieved?

Quantitative targets of the service structure (see p. 30) The 'service structure' is the whole system of social welfare and health services provided within a municipality or cooperation district; this framework deals specifically with services used regularly by older people.

Living at home means not being in long-term hospital or health centre care, or living in a residential home, sheltered housing with 24-hour care, or a home or sheltered housing for persons with developmental disability.

Regular home care clients are those receiving some kind of home help and/or home nursing who had a currently valid service and care plan on the calculation date (30 November) or otherwise (without a service plan) receive such services at least once a week. These clients do not include persons who are in institutional care or receive housing services on the calculation date, even if they have a valid service and care plan.

Informal care support means care allowance and services granted to safeguard the care and attendance for an ageing, disabled or ill person at home, as laid down in their care and service plan. The local municipality and carer sign an agreement on the informal care support. All those clients who have received informal care support during the year are counted as clients.

Sheltered housing has never been defined officially. Definitions in social and health service statistics stress that sheltered housing always includes care and attendance services integrated into a lease agreement. Some units are buildings where clients have their own apartments and some for instance group homes for dementia patients. These are divided into ordinary sheltered housing and sheltered housing with 24-hour assistance.

> ***Ordinary sheltered housing*** means that the staff are only on duty during the day.
>
> ***Sheltered housing units with 24-hour assistance*** are meant for older people who may need staff on hand round the clock. They differ from residential homes in that they have, for instance, been approved by the Social Insurance Institution (SII) as open care units, and the client pays separately for the accommodation and any services utilized. Clients living in such units on the calculation date (31 December) are included in the figures.

Institutional care includes all clients over 75 living in residential homes and long-term patients over 75 in health centre hospitals on the calculation date (31 December)

> ***Residential homes*** provide institutional care for older people as a social service.

Long-term care in health centre hospitals means care given in health centre hospitals managed by general practitioners. That includes not only municipal health centres but also certain other municipal or private-sector service providers responsible for health centre activities in a given area. Long-term care means that a decision on long-term care has been made concerning the client, or a situation in which the client has been in care for over 90 days.

Service management is a client-oriented approach stressing the client's interests. It means both individual case management and service coordination at the organizational level. Service management is a working method that harnesses several services to help the client, reducing the disadvantages of a dispersed service system. The aim of service management is to identify individual client needs and provide the services and support required. The main content of service management as it affects the individual is advice, coordination and advocacy, based on a detailed assessment of service needs, planning and resources.

Staffing levels means the computed ratio between personnel and clients/patients. If, for instance, a unit has 20 care workers and altogether 40 clients, the ratio of staff to clients is 20/40, i.e. 0.5.

Third age and fourth age: The third age is the period between retiring from working life and becoming dependent on others, when the fourth age begins. During their third age, people are still independent and free to pursue their personal goals. Typically, the fourth age is marked by frailty and increasing dependence on help and support from others in coping with everyday life amid deteriorating health and declining functional capacity.

Sample calculation of the cost impact of coverage by certain services in 2006—2012

The table on the following page is a sample calculation illustrating the impact of trends in the number of older people and service coverage on changes in the cost of producing certain services between 2006 and 2012.

If the coverage of regular home care, informal care support, 24-hour sheltered housing and institutional care among over 75s were to remain at the 2006 level, the gross cost of producing these services would rise by EUR 318 million by 2012. This increase would be caused by the growing size of the ageing population.

The target set in the framework is that coverage of regular home care at the national level should rise by 2012 to 13%-14% of the total number of over 75s, and the coverage of both informal care support and 24-hour sheltered housing to 5%-6%. At the same time, the coverage of long-term care in residential homes and health centre hospitals should fall to 3% of all over 75s. If the coverage of regular home care, informal care support and 24-hour sheltered housing were raised according to the lower figures (13%, 5% and 5% of over 75s) and institutional care were to fall to 3%, the gross cost of these services would decrease by EUR 49 million. If service coverage were raised according to the higher figures (14%, 6% and 6%) and institutional care were to fall to 3%, gross costs would rise by EUR 199 million between 2006 and 2012.

Sample calculation of the cost impacts of coverage by various services, 2006–2012 (at 2006 prices)

Coverage remaining at the 2006 level				
	No. of clients		Change in no. of clients	Change in costs, EUR million
Coverage (% of over 75s)	2006	2012	2006–2012	2006–2012
Regular home care 11.5 *	45,037	51,839	6,802	113.1
Informal care support 3.7	14,870	16,679	1,809	8.5
24-hour sheltered housing 3.9	15,676	17,580	1,904	63.9
Long-term institutional care 6.5	26,190	29,300	3,110	132.8
Total	101,773	115,398	13,625	318.4
Increases in coverage: lower option				
Regular home care 11.5* =>13.0	45,037	58,601	13,564	225.6
Informal care support 3.7 =>5.0	14,870	22,539	7,669	36.1
24-hour sheltered housing 3.9 =>5.0	15,676	22,539	6,863	230.5
Long-term institutional care 6.5 =>3.0	26,190	13,523	-12,667	-540.9
Total	101,773	117,202	15,429	-48.8
Increases in coverage: higher option				
Regular home care 11.5* =>14.0	45,037	63,109	18,072	300.6
Informal care support 3.7 =>6.0	14,870	27,047	12,177	57.4
24-hour sheltered housing 3.9= >6.0	15,676	27,047	11,371	381.8
Long-term institutional care 6.5=>3.0	26,190	13,523	-12,667	-540.9
Total	101,773	130,726	28,953	198.8

* The data on regular home care date from 2005.

Unit costs (gross) used in the calculation and other assumptions:
– Home care visit average EUR 42 per visit, average 33 visits a month per client,
– Fee payable to informal carers average EUR 4,711 per year per client,
– 24-hour sheltered housing average EUR 92 per day,
– Long-term institutional care in a residential home or long-term health centre hospital average EUR 117 per day, assuming that 36% of the care days are in health centre hospitals and 64% in old people's homes.

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