



Innovating care for people with multiple chronic conditions in Europe

Caring for people with multiple chronic conditions in Finland: policy and practices

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Key points

- Chronic diseases have been on the political health agenda in Finland for many years.
- Recently, multimorbidity has become a policy and management issue, for example in the hospital districts.
- Joint provision and budgeting of health and social care in Finland create possibilities for integration of care, both at a local and national level.
- Some care development programmes have addressed the importance of integration of services and collaboration between diverse actors regarding the care of multimorbidity patients.
- A care pathway and a care model for patients with multimorbidity have been developed.



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1. Multimorbidity: a challenge for care delivery

Until recently, multimorbidity — the occurrence of more than one chronic disease within an individual — has not received much attention from European policy-makers. However, this seems to be changing, now that it has become clear that the number of people with multimorbidity is rapidly increasing. Currently, an estimated 50 million (mostly older) people in the European Union live with multiple chronic diseases¹, which deeply impacts their quality of life in many ways (physically, but also mentally and socially). This implies an increasing demand for multidisciplinary care that is tailored to the specific health and social needs of people with multimorbidity.

Yet interdisciplinary collaboration across sectors (e.g. primary care, hospital care, social care, home care, community services) is often hindered by differences in organisational and financing arrangements between sectors. Moreover, most care delivery models are based on a single disease approach, which could bring about fragmentation, gaps or overlap in care delivery for people with multimorbidity with negative consequences for the quality of care, patient outcomes, efficiency and costs.

Integrated care models have the potential to overcome these problems by taking a holistic approach while making efficient use of resources. Such models are characterised by proactive patient-centred and well-coordinated multidisciplinary care, using new technologies to support patients' self-management and improving collaboration between caregivers. The **ICARE4EU** project (see Box 1) explores new models and care practices aimed at delivering integrated care for people with multimorbidity in 30 European countries. This factsheet describes how policy and practices are developing in Finland.

2. The challenge of multimorbidity in Finland

In 2011, among a total population of almost 5.4 million inhabitants, 17.0% of people were aged 65 years and older, and 4.8% were 80 years and older². Among the total EU-27, similar percentages of older inhabitants were found (65+: 17.6%; 80+: 4.8%).

Of the population aged 16 to 64 years, an estimated 37.2% reported to have at least one long-standing illness or health problem³. Figure 1 shows the estimated prevalence rates of some major chronic diseases in Finland.

In 2011, Finland spent 9.0% of its Gross Domestic Product (GDP) on health care. In comparison with 1998, when 7.4% of the GDP was spent, this represents an increase of 21.6%⁴. A similar increase was found across the total EU, where expenditures on health care raised from 7.9% to 9.6% GDP over the same period (+21.5%)⁵. See Appendix 1 for some general characteristics of the health and social care system in Finland.

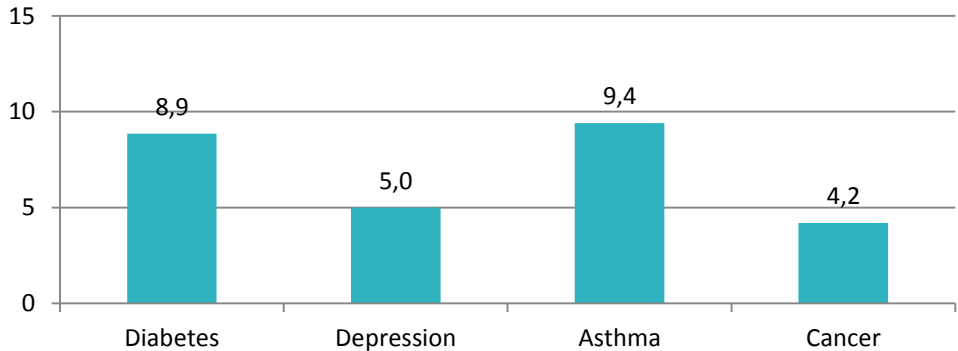
Box 1 The ICARE4EU project

The ICARE4EU project aims to identify, describe, and analyse innovative, integrated care models for people with multimorbidity in 30 European countries, and to contribute to more effective implementation of such models.

For this purpose, country experts have been contracted (one for each country) to identify programmes at a national, regional or local level in their country that focus on providing care for adult (or older) people with multimorbidity, or contain specific elements for this target group. Multimorbidity is defined for this project as *the presence of two or more medically (somatic or psychiatric) diagnosed chronic (not fully curable) or long lasting (at least six months) diseases, of which at least one is of a primarily somatic nature*. Programmes should involve a formalised cooperation between two or more services, of which at least one medical service, and they should be evaluated — or have an evaluation planned — in some way. For each eligible programme, the country expert or the programme manager completed an online questionnaire. In addition, country-level data were provided by the country experts and partly collected by the project team from European databases.

Based on all data available, good practices will be identified and studied in the second half of 2014. For this purpose, additional qualitative data from different perspectives (e.g. management, care providers, patients) will be gathered by site visits. Analysis of the good practices will result in knowledge about the characteristics and conditions for successful implementation of multimorbidity care practices in various European countries. For more information: www.icare4eu.org.

Figure 1. Prevalence of some major chronic diseases in Finland in 2011-2013 (percentages based on various sources), estimations of the total population reporting (or diagnosed with) these diseases⁶



3. The Finnish response to the challenge of multimorbidity

In order to respond to the increasing number of chronically ill citizens, Finland has formulated policies to adapt the care system and care practices to meet the people's needs. However, the implementation of policies is still in process and the focus has not been on patients with multimorbidity.

Policy on multimorbidity care

Finland outlined its national policy on chronic illness care in 2001⁷. However, no specific policy on multimorbidity management has been formulated, though integrated care in general has been a subject of national steering for decades. The policy on integrated care had been initiated by national legislation documents, like the Health Care Act.⁸ Apart from the Ministry of Health and Social Affairs, other actors involved in the development of this kind of policy are municipalities, patient/informal carers organisations, development organisations, trade unions and other different interest groups. Altogether, integration of different sectors, like health and social care, and primary and specialised care, have had quite a strong consensus in Finnish policy⁹, but care processes are still often unit- and sector-specific. It seems that integration of structures, political decision-making and financing systems at different levels of society enable more integrated care processes for patients, but real actions on patient level are connected to the success of multi-sectoral and multi-professional collaborations.

Care practices addressing multimorbidity

Based on expert information and snowballing, 13 care practices or programmes⁹ addressing multimorbidity patients or focusing on multimorbidity management were identified in the first half of 2014 in Finland^h. From five of these programmes we obtained information about their objectives, characteristics and results so far (see Box 2). Presented below are some results of the survey, as reported by either the country expert or the programme managers.

The programmes

Two of the programmes described in Box 2 can be characterised as comprehensive programmes [1,5], two of them [2,3] are integrated in the regular healthcare system, and one [4] as a small scale project. All programmes operate on a regional and local scale, two of them [1,5] also as part of a national project. All programmes operate both at the policy/managerial level and at the level of daily patient care. The POTKU programme [1] is a

⁹ This term refers to care programmes, projects and interventions that have been developed or adapted for use in (a certain region or municipality of) this country, and are actually running in 2014 (e.g. as a pilot/project or already more structurally implemented), start in 2014 or had been finished in 2013.

^h We do not assume that all available (eligible) care practices or programmes in Finland were identified.

large programme based on the Chronic Care Model, comprising many local sub-programmes. One of the sub-programmes (PIRKKA-POTKU [2]) is also included in this report because of its particular focus on developing and implementing a care pathway for patients with multimorbidity. In one of the programmes the main focus is on a model for patients with multiple diseases in primary care [3]. Both the care pathway and the model are available online (in Finnish). Two of the programmes emphasise professional competencies [4,5].

Multimorbidity orientation

Most programmes [1,2,4,5] focus on chronic diseases and multimorbidity in general. In the Chronic Care Model for Patients with Multiple Diseases in Primary Care programme [3] multimorbidity is defined more narrow to include diseases such as cardiovascular (diabetes, blood pressure), dementia asthma/COPD, rheumatoid arthritis, depression, atrial fibrillation and chronic arthritis.

Objectives

Main objectives of the programmes are to improve patient involvement, improve care coordination and integration of services. Improving professional knowledge on multimorbidity serves to achieve these objectives. Preventing and reducing over-use or misuse of services, and thus reducing health care costs, are secondary aims of the programmes. Programme-specific objectives are described in Box 2.

Target groups

Two of the programmes [1,2] directly target patients with multimorbidity or chronic diseases. Three of the programmes [3-5] do not have patients as a direct target group, which means that individual patients are not participating in the programme. However, all programmes described aim to develop the services for patients with many chronic diseases. One of the programmes [1] stated informal carers as a target group. None of the programmes specifically address older people/frail elderly and their family members/informal carers. However, the fact that older people often have multiple diseases is recognised in the background information of all programmes.

Most of the programmes state care providers as a target group of the programme [1,3-5]. Thus the focus in these programmes is on the management perspective, i.e. integration and coordination of services and implementation of organisational changes to improve care delivery to people with multimorbidity.

Level of integration of care sectors and disciplines

Care providers, organisations and disciplines involved in the programmes are described in Box 2. All programmes have enhanced integration of care in particular through increasing the awareness of professionals of the importance of collaboration between different organisations, units and disciplines. Establishment of multi-professional development groups (either within one organisation or between different organisations), in which diverse professionals develop care practices, have been one efficient way to enhance integration and collaboration at practical level.

Experiences and results

The majority of the programmes described in Box 2 have been evaluated internally and will be evaluated again later (four programmes are currently running [1-4]). Several indicators are monitored, so that quality information will become available for evaluation purposes. For most programmes this mainly applies to indicators on the level of the process of the programme. So far, country experts and programme managers have the impression that these programmes have succeeded in enhancing the development of services for patients with multiple chronic diseases, both from the perspective of patients and organisations providing the services. In practice this means, for example, that the quality of chronic illness care is better and more patient-centred than before the programme: personal care plans have increased and health care visits have decreased [1]. The traditional organisation-centred model of care pathways has been reformed into a patient-centred model. The pathway developed in particular for patients with multimorbidity [2] describes a service system that is tailored to the clients' needs while at the same time is clear, effective and cost-efficient. Accordingly, the care model for patients with multiple diseases in primary care [3] includes all essential guidelines, check-lists for professionals and other basic information materials for health service providers, patient information and self-care in a same place. In two of the programmes [4,5], professional expertise related to multimorbidity issues has been enhanced in particular in primary care. In the ASVA programme a case manager model on multimorbidity is developed and implemented and includes Case Manager training. In addition, all programmes have produced concrete tools (forms, instructions, descriptions, documents) which support patient care in a practical way.

Box 2 Characteristics of programmes addressing multimorbidity in Finland and results

ID NR	Programme	Main objectives	Target group	Care providers / organisations	Results
1	<p>POTKU programme – Patient at Driver’s Seat</p> <p>A large ‘parent’ programme including several regional and local sub-programmes</p>	<p><u>Process</u> Promoting evidence-based practice, improving professional knowledge on multimorbidity, improving care coordination, improving integration of different units (within an organisation), improving integration of different organisations, increasing multi-disciplinary collaboration, improving patient safety</p> <p><u>Patient outcomes</u> Decreasing/delaying complications, decreasing morbidity, decreasing mortality</p> <p><u>Utilisation and cost</u> Preventing or reducing over-use of services, preventing or reducing misuse of services, reducing hospital admissions, reducing emergency/acute care visits, reducing (public) costs</p> <p><u>Patient centeredness</u> Improving patient involvement, improving involvement of informal carers</p>	<p>Patients with (multiple) chronic diseases, informal carers, medical and non-medical care providers and management.</p> <p>In particular patients whose</p>	<p>University hospital, general hospital, primary care practice, health centre, nursing home, home care, informal care, pharmacy.</p> <p>General practitioners, cardiologists, pharmacists, physiotherapists.</p>	<p>Evaluated internally and externally; the objectives mainly reached.</p> <p>The programme has improved in particular collaboration between care providers, patient centeredness and patient involvement. Also competencies of care providers and involvement of informal carers seem to be improved.</p> <p>Cooperation and communication between professionals at different areas (including about one million inhabitants) is stated to be very good — they learn from each other. Now care is patient-centred, but there is still work to do to improve professionals’ attitudes, which are mainly organisational-based.</p>
2	<p>PIRKKA-POTKU incl. care pathway for patients with multimorbidity</p> <p>A regional sub-programme of</p>	<p><u>Process</u> Improving care coordination, improving integration of different units (within an organisation), improving integration of different</p>	<p>Patients with multimorbidity or patients who use a lot of services of many organisations or clinics.</p> <p>In particular patients whose</p>	<p>Health centre, patient organisation.</p> <p>General practitioners, informal carers, district/community nurses,</p>	<p>Evaluated internally; the objectives mainly reached.</p> <p>The programme has supported integration of care services,</p>

	POTKU (see above) in Pirkanmaa area	<p>organisations, increasing multi-disciplinary collaboration, improving patient safety</p> <p><u>Patient outcomes</u> Improving functional status</p> <p><u>Utilisation and cost</u> Preventing or reducing over-use of services, preventing or reducing misuse of services, reducing emergency/acute care visits, reducing (public) costs</p> <p><u>Access</u> Reducing inequalities in access to care and support services</p> <p><u>Patient centeredness</u> Identification of target group patients, improving patient involvement, improving involvement of informal carers</p>	needs are not met by the services, who need proactive care planning or who need long-term care.	physiotherapists/exercise therapists.	<p>collaboration between care providers, competencies of care providers, patient centeredness, patient involvement, involvement of informal carers, use of e-health tools and cost-effectiveness.</p> <p>The development and implementation of the care model has had the following results: for example, closer collaboration between public health care and patient associations and patients are now included in the development of care.</p>
3	Chronic Care Model for Patients with Multiple Diseases in Primary Care	<p><u>Process</u> Promoting evidence-based practice, improving professional knowledge on multimorbidity, improving care coordination, improving integration of different units (within an organisation), increasing multi-disciplinary collaboration, improving patient safety</p> <p><u>Patient outcomes</u> Improving early detection of additional/comorbid diseases, improving</p>	<p>Patients with multiple chronic diseases included are patients with cardiovascular diseases (diabetes, hypertension), dementia, asthma/COPD, rheumatoid arthritis, depression, atrial fibrillation, osteoarthritis, etc.</p> <p>(However, individual patients do not participate in the programme.)</p>	<p>Primary care practice, health centre, patient organisation.</p> <p>General practitioners, many medical specialists, district/community nurses, physiotherapists/exercise therapists, dieticians, psychologists/psychotherapists.</p>	<p>Evaluated internally; the objectives mainly reached.</p> <p>The programme has promoted integration of care services, collaboration between care providers, competencies of care providers, patient-centeredness and patient involvement. Also the use of e-health tools and cost-effectiveness have stated to be improved.</p>

		<p>functional status, decreasing/delaying complications, decreasing morbidity, decreasing mortality</p> <p><u>Utilisation and cost</u> Preventing or reducing over-use of services, preventing or reducing misuse of services, reducing hospital admissions, reducing emergency/acute care visits, reducing (public) costs</p> <p><u>Access</u> Reducing inequalities in access to care and support services, improving accessibility of services</p> <p><u>Patient centeredness</u> Identification of target group patients, improving patient involvement</p>			<p>The care model is a useful tool for staff. From one portal the professionals can find everything they need to follow up with a patient with chronic diseases. The model is multidisciplinary and provides patient empowerment.</p>
4	ASVA programme: developing Case Manager Model	<p><u>Process</u> Promoting evidence-based practice, improving care coordination, increasing multi-disciplinary collaboration</p> <p><u>Utilisation and cost</u> Preventing or reducing over-use of services</p> <p><u>Access</u> Reducing inequalities in access to care and support services, improving accessibility of services</p> <p><u>Patient centeredness</u> Identification of target group patients, improving patient</p>	<p>Patients, medical care providers and management.</p> <p>(Individual patients do not participate in the programme.)</p>	<p>Primary care practice, health centre, patient organisation.</p> <p>General practitioners, district/community nurses, hospital nurses/specialised nurses.</p>	<p>Internal evaluation is planned for 2014.</p> <p>The strengths of the programme seem to be client centeredness, process development and trained case managers as final outputs.</p>

		involvement			
5	RAMPE programme: 'Iron' (super good) professionals for primary health care	<p><u>Process</u> Improving professional knowledge on multimorbidity, improving care coordination, improving integration of different units (within an organisation), improving integration of different organisations, increasing multi-disciplinary collaboration, improving patient safety</p> <p><u>Utilisation and cost</u> Preventing or reducing over-use of services, preventing or reducing misuse of services</p> <p><u>Access</u> Improving accessibility of services</p> <p><u>Patient centeredness</u> Improving patient involvement</p>	<p>Medical care providers, management, clinical teachers and educational staff.</p> <p>(Individual patients did not participate in the programme.)</p>	<p>General hospital, primary care practice, health centre, ICT department, government, educational organisation.</p> <p>General practitioners, district/community nurses, physiotherapists/exercise therapists.</p>	<p>Internal evaluation has been done; the objectives partly reached.</p> <p>The programme promotes in particular the competencies of care providers, integration of services, collaboration between care providers, patient centeredness, patient involvement and the use of e-health tools.</p>

Appendix 1 Some characteristics of the health and social care system in Finland

Health and social care

The parliament of Finland together with the Finnish government set the objectives for health and social security at the national level, and municipal parliaments at the local level. Care provision is based on a tradition of a tax-based financing system. The parliament nationally and municipal parliaments locally set the total budget for public health and social funds¹⁰. Thus, typical for Finland is the strong integration of health and social care nationally and locally, both in provision and financing. Municipalities can provide services themselves but they can also purchase social welfare and health care services from other municipalities, organisations or private service providers. Nowadays political steering supports stronger centralisation of care provision than during the previous decades.

Health care

Health care in Finland has been divided traditionally into primary care and specialised care. The Finnish health care system has been quite decentralised; more than 300 municipalities have had a large role in organising and producing health care. Hospital districts organise specialised medical care, but it is financed by municipalities. Some specialised medical care services are organised on the basis of special responsibility areas of university hospitals. Based on characteristics of its structure and delivery of care services, the strength of the primary care sector in Finland was labelled as strong in a European comparative health systems study¹¹.

As in many other European countries, the total population of Finland is covered for health care costs. Benefits are comprehensive, though clients' fees have increased during the last years. As in most European countries, patient cost sharing is applied to limit public expenditures. In 2011, 66.2% of the total health expenditures were paid from public sources of funds, leaving 33.8 to be paid privately by patients or from external sources¹². Cost sharing is generally applied for primary care visits, specialist visits, inpatient care and outpatient prescription drugs¹³. In 2009, about 75.5% of health care was publicly and 24.5% privately provided in Finland when evaluated by annual costs.¹⁴

Social care, home care and care for the elderly

In Finland, municipalities have the responsibility for social care, home care and long-term care for the elderly, although those services can be provided by either the public or private sector. In 2009, 69.7% of social care was publicly and 30.3% privately provided in Finland when evaluated by annual costs¹⁵. In 2012, 73.5% of the total institutional care for the elderly and 77% of home care for the elderly were paid from public sources of funds (state or municipalities), leaving the rest to be paid privately by clients.¹⁶ In Finland, as in many other countries, care at home, self-care and continuity of care have been political and managerial targets for care provision. This has increased the need to find new ways to provide care in home settings, like new technologies and mobile services. In addition, the need to increase support for family/informal carers has been put on the political agenda.

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- ² Eurostat 2011
- ³ Eurostat 2011
- ⁴ WHO Regional Office for Europe 2013 (in: van Ginneken et al. Health Systems in Transition. Trends and patterns in EU28 health systems and Iceland, Norway and Switzerland (pp 79). World Health Organization, Copenhagen, 2015 (under review).
- ⁵ WHO Regional Office for Europe 2013 (in: van Ginneken et al. Health Systems in Transition. Trends and patterns in EU28 health systems and Iceland, Norway and Switzerland (pp 79). World Health Organization, Copenhagen, 2015 (under review).
- ⁶ Sources of Figure 1: Diabetes Atlas 2013, http://www.idf.org/sites/default/files/DA6_Regional_factsheets_0.pdf, Finnish Cancer Registry 2012, <http://www.cancer.fi/syoparekisteri/tilastot/>, Asthma 2012. <http://www.kaypahoito.fi/web/kh/suosituksset/suositus?id=hoi06030>
- ⁷ Health 2015, Public health programme. http://www.stm.fi/en/health_2015
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