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Home Nursing in the Nordic Countries

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Danish Health Authority
Islands Brygge 67
2300 Copenhagen S

www.sst.dk

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Summary

In the recent decades, general challenges within primary health care shared by all Nordic countries and self-governing territories have become evident. But it has also been established that there is a lack of knowledge about the organization and role of home nursing in relation to this. To be able to meet the identified future challenges, it is thus necessary to establish a greater understanding of home nursing in the Nordics.

Therefore, the Nordic Council of Ministers has granted Denmark funds (under the auspices of the Danish Health Authority) to prepare this report which focuses on nursing tasks in the primary health care system.

The aim of this report is to establish a basis for a Nordic discussion of the extent to which home nursing is equipped for the coming challenges and the extent to which there is a need for adaptation of organization and professional tasks and competencies.

It is important to emphasize that this report is not a complete overview of all existing initiatives. As there are many differences between each municipality and region in each country and self-governing territory, there will be nuances that it has not been possible to include in the report.

Approach and scope

The Nordic countries included in the report are Denmark, Finland, Iceland, Norway, and Sweden and the self-governing territories Åland, Greenland and the Faroe Islands.

The report is based on documents collected from desk research, and interviews with 27 key informants from the eight countries and self-governing territories. The respondents represent both state and municipal authorities, professional experts as well as nursing organizations.

The surveys and comparisons have been carried out as a supplement to VIVE's report from 2020[1] thereby adding to the existing knowledge base. Avoidance of repetitions has been in focus.

In the report home nursing is defined as nursing provided outside the hospitals. There might be smaller variations in what is included across countries and areas because of differences in organization and structure. Nursing tasks provided specifically for new-borns and smaller children (‘sundhedspleje’ in danish) are not included in the analysis.

[1] Larsen, A. T., Klausen, M. B., Højgaard, B. 2020. Primary Health Care in the Nordic Countries - Comparative Analysis and Identification of Challenges. VIVE – The Danish Center of Social Science Research.

The current organization

Many similarities but also differences can be found in the ways in which the Nordic countries have chosen to organize the services within home nursing. In the report the structural organization of the area is examined both in terms of the regulatory framework, the division of responsibilities, and the capacities that carry out the tasks. Below is an overview of the key elements.

RESPONSIBILITIES AND REFORMS

In most Nordic countries and self-governing territories, **the responsibility of nursing tasks in the primary sector lies within the municipalities**. Exceptions from this are Iceland, Greenland, and Stockholm municipality where regional health centres perform most tasks, and Åland where Åland Health Care supplies home nursing through their three districts.

Still, there seems to be **a movement towards more centralization** of the services with the resent or ongoing reforms in several countries. In Finland 22 wellbeing services counties are being established which will take over from municipalities, in the Faroe Islands municipal cooperation areas are required by law to ensure a sufficient population base, and in Norway 19 new health communities have been established to focus on the most vulnerable patients.

NURSING HOMES

Nursing homes and long-term 24-hour care are **primarily used for elderly people with extensive need of daily care**. For permanent residents it is the final place of residence, and the typical length of stay is only a few years. Exceptions from this are Greenland and the Faroe Islands where the housing structure and to some extend geography means that nursing home stays generally are significantly longer.

All countries and self-governing territories **aim to reduce the use of nursing homes** and many measures are being taken to postpone the need for institutional care. Alternatives like sheltered housing, senior communes, and other elderly friendly housing are used for this, just like efforts are being made to increase treatment and care in the citizen’s own home.

Nursing homes and similar institutions are **most often both the responsibility of and owned by municipalities** (sometimes in cooperation), but they can also be privately owned, or organised as a housing association with the users themselves as owners. They are **typically staffed by a mix of registered**

nurses, practical nurses, nursing assistants, and uneducated staff. In smaller areas such as Åland and Greenland not every institution employs health care staff and instead home nursing personnel handles these tasks.

HOME NURSING

In most places, the services provided by **home nursing, home care and other related functions are separated into independent units** that have historically been established to handle tasks corresponding to the different legislations. But in some areas, such as Finland and Reykjavik municipality in Iceland home nursing and home help have been integrated both to make it more efficient and to make it more comfortable and secure for the citizens.

Each responsible entity **decides for itself which nursing task can be performed by which professional groups**. This often means, that there are different organisational practices across the same country, as the different areas have approached home nursing differently. Common for all is that citizens' use of **home nursing must be substantiated by a professional assessment** which is done through visitations by either a nurse or a doctor.

Home nursing is **primarily staffed by registered nurses and practical nurses** and to some extend supported by nursing assistants. With few exceptions home nursing is free of charge in all countries and self-governing territories.

BEDS FOR TEMPORARY STAYS

Local nursing beds for temporary stays e.g., acute care, rehabilitation, stabilization, etc. **exist in some form or another in all countries and self-governing territories**. For example, in Norway it is required by law to have municipal acute care units (KAD), but they vary considerably in both organization and size.

The beds for temporary stays have **often been established as part of the existing nursing homes** and some areas have experienced that it has been difficult to adjust the number of beds to the actual need, why they often end up being used for permanent residents.

Some countries use **specialized teams** (separated from home nursing) to take care of rehabilitation after hospitalization. These teams are typically manned with nurses, therapists etc. and are used for shorter and intensive periods of time. Mobile acute care teams are used in e.g., Sweden, Denmark, and Finland to take care of elderly and fragile patients at home to prevent hospitalization.

Changes in tasks and competency requirements

An increased focus on prevention, early detection and response, and rehabilitation exists in all countries and self-governing territories. There is a growing attention on ensuring preventive measures and activities in primary care. In many of the countries preventive home visits are determined by law, usually aimed at the 75+ year olds.

To promote further focus on early detection and to prevent or postpone the need for extensive care and nursing, several initiatives are focusing on rehabilitation of elderly people with initial loss of functional levels. The aim is for them to become more self-supportive and able to handle tasks at home, hence reducing or postponing the need for home nursing and home care. In some areas this is supplemented with rehabilitation teams focusing on the transition from hospital to the citizen's own home. It is typically nurses, physiotherapists and occupational therapists who are responsible for this in collaboration with nursing assistants. Nevertheless, there are still a rather broad variety of rehabilitation approaches among the Nordic regions and municipalities.

Across the Nordics the overall strategy for the health care area seems to be that citizens can stay in their own homes for as long as possible, as well as receive a more person-centred and integrated treatment. A slow and incremental shift has been seen from hospitals towards municipal health care solutions. Institutional care has been reduced for a long time, making home care the primary form of care with an emphasis on more treatment at home. The development has been a clear political desire, and many citizens also prefer to be treated at home. However, this presents new challenges for home nursing, as it raises the demand for both healthcare and nursing capacity and competencies on the local level – primarily in the municipalities – as well as for a new and integrated approach to delivering care and healthcare.

As a response to this, a variety of specialized local/municipal care services have emerged, including 24-hour acute care units, more specialized short-term units, and in-home care teams with special expertise in handling specific patient groups (e.g., persons with dementia) or providing specific services (e.g., palliative care and rehabilitation). Intermediate units have also been established in some countries in cooperation between the regional and municipal levels.

Lastly, some countries note that social complexity takes up more space now than in the past, in addition to the clinical and organizational complexity of home nursing. These

challenges require a wide range of specific and general competencies that go beyond the purely clinical ones.

Cooperation and transfer of functions and tasks

Cross-sectoral and interdisciplinary cooperation, and coherent citizen/patient pathways are key words when it comes to ensuring that services in home nursing and home care are provided seamlessly and based on the individual needs. The citizens' needs are put in focus by placing new and higher demands on cross-organizational and structural cooperation.

Throughout the countries it is recognized that there is a need to break with the compartmentalization and instead achieve a higher degree of interdisciplinary collaboration between different professions in different sectors. E.g., between home care/home nursing and specialised health care such as hospital treatment, and between hospital specialist doctors/general practitioners and home nurses**.**

On a practical level there are examples of different types of coordinator functions having been installed on the municipal level primarily staffed by specialised and experienced registered nurses. And initiatives such as 'everyday rehabilitation' takes place in an interdisciplinary collaboration, where the user sets the goals for rehabilitation, and the health team works together to achieve these.

However, a shortage of skilled healthcare staff is a huge challenge in all the Nordic countries. Only Åland reckons that home nursing is seen as such an attractive job, that it would be possible to recruit the needed nurses if the budget allowed for it.

Delegation from doctors to nurses is not used consistently across the Nordics. In e.g., Denmark, Iceland and the Faroe Islands the legislation is relatively open to delegation, while in Finland and Åland it requires special training for the nurses to take over tasks. And since most municipal nurses are not specialised, delegation is seldom a possibility. But even if the legislation makes it possible, there is no guarantee that the opportunities will be exploited. Some point to the fact that the agreements on the remuneration of general practitioners may have unfortunate incentives. Instead, there is a tendency for practical nurses and nursing assistants to take over more of the nursing tasks, as there is a general shortage of registered nurses. And many places practical nurses are also in scarce supply, shifting their tasks towards nursing assistants and unskilled personnel.

Structurally many governments have prioritized resources to increase the capacity for education of both registered and practical nurses. But as the demography is a general issue, the success of recruiting more people to these educations has often been less successful than hoped.

Welfare technology

Throughout the Nordic countries welfare technology and digitalization has been highly prioritized for several years on national, regional, and local levels of government. It is typically the municipalities that are responsible for implementing the welfare technology solutions in home care and home nursing. However, the strategies can be both national and managed by each municipality or association of municipalities.

The technology is expected to support and facilitate the work of employees and in part substitute it. Robotics can help reduce the working time and workload e.g., when lifting and moving patients. Also living at home is increasingly supported by technologies for mobility, localisation, tracking (monitoring included) and alarms. As for digitalisation a general topic is implementation of common journaling systems and/or systems for data sharing between sectors and units. A specific theme of special relevance for home nursing is technologies supporting dispensing and administration of controlled drugs in home nursing. Also, **t**elemedicine and virtual nursing visits plays a huge role these days with Covid-19 working as a catalyst making the use of video consultations/medical contacts increase significantly.

Patient and relative involvement

The involvement of patients, citizens, and relatives both on individual level and on organizational level has been high on the strategical agenda in all countries and self-governing territories. Strategies on involvement are developed and implemented, and there is a consensus on recognizing patients and relatives as a resource.

Third sector, which includes charities, social enterprises, voluntary groups, and other non-profit organizations, only plays a small part in relation to home nursing and their contributions typically focuses on care and social initiatives. There are exceptions though, for example in Iceland where some nursing homes are owned by third sector entities.

Both welfare technology and patient involvement will require new competencies from the nursing staff both in understanding and using the new tools and aids but also being able to apply a supportive and inclusive approach to the citizens.

1. Introduction

Home nursing is organized and managed in various ways across the Nordic countries and self-governing territories due to differences in e.g., geographical conditions, structuring of the health and welfare systems, political positions, and former traditions within home nursing.

In the recent decades, general challenges within home nursing shared by all Nordic countries and self-governing territories have become evident. Some of these challenges are described in the publication 'Primary Health Care in the Nordic Countries - Comparative Analysis and Identification of Challenges' by VIVE[2], and are as follows:

1. an **increase in numbers and share of elderly citizens**, resulting in an unequal distribution of younger people (potential caregivers) and elderly people (to be taken care of)
2. an **increase in incidence and prevalence of chronic diseases**, leading to a need for increased primary health care capacity
3. a **continuous reduction in length of hospital admissions**, hence increasing the amount and complexity of the nursing tasks to be handled within the primary sector
4. a **challenge in recruiting primary health care professionals**, putting pressure on the capacity, and making it difficult to ensure the continuity of care.

Due to the size and severity of these challenges, there is a need for fundamental new solutions and ways of delivering both healthcare and in particularly nursing now and in the foreseeable future. In general, there is a consensus across the Nordic countries and self-governing territories on changing the balance of the system by moving more tasks to the primary healthcare system with more homebased nursing and care delivery. However, as there is only limited cross-country knowledge on how home nursing is organized and how the countries deal with or intend to deal with the challenges, there is a profound need to gather knowledge for a cross-country overview.

The aim of this report is to establish a basis for a Nordic discussion of the extent to which home nursing is equipped for the coming challenges and the extent to which there is a need for adaptation of organization and professional tasks and competencies. The intention of this report is to showcase insights, that can be used both by the individual country to adapt to the future challenges, as well as knowledge on a cross-country level for the purpose of mutual learning and inspiration. It is important to emphasize that this report is not a complete overview of each country's and self-governing territory's initiatives, as it is based on knowledge gathered through interviews and desk research. The eight Nordic

[2] Larsen, A. T., Klausen, M. B., Højgaard, B. 2020. Primary Health Care in the Nordic Countries - Comparative Analysis and Identification of Challenges. VIVE – The Danish Center of Social Science Research.

countries included in the report are: Denmark, Faroe Islands, Finland, Greenland, Iceland, Norway, Sweden, and Åland.

This analysis is conducted on behalf of the Nordic Council of Ministers in the period June–November 2021.

1.1. Approach and scope of the report

The surveys and comparisons in this report have been carried out as a supplement to VIVE's report from 2020[3] and thus adds to the descriptions made there. Therefore, no emphasis will be placed on structures and organization that have already been elaborated previously. An exception to this, however, is in cases where relevant changes have subsequently taken place, or where it is deemed necessary for understanding the actual structure of home nursing.

The report is based on both documents collected from desk research, and interviews with key informants from each country and self-governing territory. 22 interviews of approximately one hour each have been conducted from the 31st of August until the 13th of October 2021. The interviews include a total of 27 participants who represent both state and municipal authorities, professional experts as well as nursing organizations. An overview of which persons and organisations participated in the interviews can be found in the appendix.

As there are differences between each municipality/local level and region/regional level in each country and self-governing territory, there will be nuances that it has not been possible to include in the report. Therefore, some municipalities and regions are highlighted while others are not mentioned. This is partly because some municipalities/regions have a significantly different structure of home nursing than the rest of the respective country/self-governing territory. In addition, the chosen focus also depends on the access to information, as the report is based on a limited number of documents and interviews with selected informants.

The selection of informants is made with an aim to include insights from both the angle of the authorities and as seen by the professional organizations. The experts within home nursing have assisted with details and references to relevant research, etc. For this reason, the chosen informants do not necessarily have a detailed know-how of how specific geographical areas within the respective countries or self-governing territories have chosen to organize home nursing but have instead possessed knowledge on a more general

[3] Larsen, A. T., Klausen, M. B., Højgaard, B. 2020. Primary Health Care in the Nordic Countries - Comparative Analysis and Identification of Challenges. VIVE – The Danish Center of Social Science Research.

level. Therefore, there may certainly exist further challenges and examples of good practice from the eight countries and self-governing territories, than those highlighted in this report.

Finally, a few definitions of some general terms used in the report are elaborated in the following. The first of these being the definition of home nursing which is shown in box bellow.

Definition of home nursing

In the report home nursing will be defined as the nursing care provided outside the hospitals.

Since these nursing tasks can be differently organized in each of the Nordic countries and self-governing territories there might be smaller variations in what is included across countries and areas. This will be described in more detail in the sections on each of the areas' structure.

Common to all areas is that nursing tasks provided specifically for new-borns and small children (‘sundhedspleje’ in Danish) are not included in the analysis.

The next definition concerns the nursing groups that take care of the home nursing tasks, these are shown below.

Definition of nursing groups

All countries and self-governing territories employ both nurses with a longer formal education and assistants with different levels of training and education. Especially the latter group differs between areas, both by name and scope. To make the comparison easier the report will use the following terms to describe the levels of employment, even though they are not 100 percent comparable:

Registered nurses ('sygeplejersker' in Danish) - approx. 4 years of academic education and authorization

Practical nurses ('social- og sundhedsassistenter' in Danish) - approx. 2-3 years of formal education

Nursing assistants ('social- og sundhedshjælpere' in Danish) - approx. 1/2-1 year of formal education

Uneducated staff - has received training in basic nursing tasks

1.2. Structure of the report

The first chapter describes the background, approach, and scope of the report while chapter 2 summarizes the organizational landscape of primary care nursing in each country. Chapters 3-6 examine a number of selected themes, each of which poses a possible challenge to future nursing services outside the hospital sector. Focusing the data collection on these themes ensures that the report builds on existing knowledge. The weighting of the themes and the available knowledge may vary between countries and self-governing territories, nevertheless it has been chosen to maintain alphabetical order in all sections. Finally, a few concluding remarks are made in Chapter 7.

2. The current organization of primary nursing care

2.1. Denmark

While the specialized healthcare and General Practices are the responsibilities of the five regional authorities, home care, home nursing and nursing homes in general are the responsibilities of the 98 municipalities. (In Denmark the national level has very limited operational capacity or responsibility.)

The municipalities can freely organize and structure their model for the above-mentioned areas within the legislative framework of the municipal governing act ('Kommunestyrelsesloven'), the welfare service act ('Serviceloven') and the health care act ('Sundhedsloven'). For example, many municipalities have chosen an organizational integration of home care and home nursing while many others have chosen a separated structure.

In general, the Danish municipalities with variations have the following types of capacity in which they deliver (home) nursing:

Nursing homes are primarily for elderly people with extensive need of daily care. The average length of stay is 2,4 years which illustrates the nursing homes' role as the final place of residence. The staffing of the nursing homes varies but is typically staffed primarily with practical nurses with fewer registered nurses while a decrease in the number of nursing assistants and uneducated staff has been seen. This tendency is under pressure due to high demand of educated staff. Over the last years many nursing homes have made contracts with general practitioners to be permanently associated to enhance the ability to administer treatment on the spot and to empower the staff on the nursing homes to take care of more needs and healthcare issues of the residents in the nursing home. Hence avoiding unnecessary and burdensome hospital admissions. While some municipalities are opening and closing nursing homes in almost direct relation to the demographic development others are trying to reduce the need for cost intensive nursing homes by 'transferring' capacity to less cost intensive home care and home nursing.

Home nursing is authorized under the health care act and is staffed primarily by registered nurses and practical nurses. In 2019 app. 7.000 registered nurses (1.2 per 1,000 inhabitants) and many practical nurses were employed in home nursing in the municipalities.[4] Each municipality decides for itself which nursing care can be performed by which

[4] Data from KRL (Municipals and Regions Salary Registry).

professional groups. This is called decentralized competence assessment. A statement from the country's second largest municipality shows that over 40 percent of nursing is provided by practical nurses and assistants and nursing assistants.[5] The most frequent task of the home nurses is handling of medication, but home nurses cover a broad range of nursing functions and tasks related to complex healthcare needs.

A growing number of municipalities are seeing home care as a central part of healthcare while others mainly see it as a service function which leads to rather different strategic and organizational choices concerning competency levels, integration of functions etc. In general, it is acknowledged that the link between home nursing and home care is critical for delivering sustainable healthcare on the local level.

Some specialized nursing functions e.g., wound care, diabetes care, dementia care, neurorehabilitation, are typically organized as part of home nursing. The growing need for specialized nursing competencies in the municipal context is directly derived from mentioned challenges and trends.

Nursing clinics are primarily staffed by registered nurses and secondarily by practical nurses. The clinics are established by a lot of municipalities to provide nursing to citizens in need but still able to transport themselves. The clinics' purpose is to reduce the time nurses spend on transport to deliver nursing in citizens homes.

Local nursing beds for temporary stays with stabilization and/or rehabilitation in focus. All the municipalities in Denmark have capacity for temporary stays. A mapping from 2019 showed that the capabilities and the staffing of this capacity differs very much. Going from specialized beds staffed primarily with registered nurses trained to take care of unstable patients with rather complex medical conditions after hospital stays or as an alternative to hospital admissions to nursing home-like capacity for people with need of care around the clock.

Local acute functions covering typically mobile nurses' teams staffed almost exclusively with registered nurses with specialization and training in acute nursing and hence former employments in the hospital's acute wards. In some municipalities the acute teams are part of the home nursing organization while other municipalities have separated the function on an organizational level. There are also examples of three to four municipalities joining forces and running a common acute nurse's function together. The Danish Health Authority have a set of specific quality requirements for the municipalities, that have chosen to have an acute function. The acute function consists typically of a mobile nurse's team and/or a number of beds equipped and staffed for patients with acute needs.

[5] Vive.dk. Available: https://www.vive.dk/da/udgivelser/hvad-er-de-kommunale-sygeplejersker-paa-vej-til-at-blive-15037/ [2020, 15-11-2021].

2.2. Finland

The organization of the primary health care services in Finland is rather well described in the VIVE report[6], including the use of health centres which will not be further elaborated here. But a reform has been initiated, that will mean significant changes in governance.

An overhaul of the structures of the social welfare and health care services system has been taking place in Finland for several years. The ageing population and financial capacity have been among the reasons for the reform as small and financially weak municipalities have encountered significant difficulties in organising and producing the needed services.

Autonomous areas for organizing social welfare and health care services have been outlined by the Finnish Government. The objective of this operation is not only to create financially more viable bodies as service organisers, but also to achieve complete horizontal and vertical integration of social welfare and health care services.

Therefore, Finland has a huge health and social services reform[7] in progress where the responsibility for the organisation of health and social services in 2023 will be transferred from the 310 municipalities to 22 regional authorities (Wellbeing Services Counties) and at the same time the content of the offered services is being redeveloped. All healthcare and social welfare personnel and their tasks will be transferred from municipalities and joint municipal authorities to the employment of the wellbeing services counties. School social workers and school psychologists working in the education sector in municipalities will also be transferred to the employment of the counties.

The counties are self-governing areas, and the residents of counties will have the right to vote in county elections, where representatives will be elected to the county's highest decision-making body, the county council. Provisions on the administration of counties will be laid down in an act (Counties Act).

The activities of the counties will be funded mainly by central government and partly from user fees. The funding will be divided among the counties based on factors related to service needs and conditions. Some of the funding will be based on population numbers and some will be determined by criteria for health and wellbeing performance. In 2020 the legislation on user fees was changed. Before municipalities could choose their own user fee – now it is the same fee across the country.

In Finland home nursing primarily takes place through the following types of capacity.

[6] Larsen, A. T., Klausen, M. B., Højgaard, B. 2020. Primary Health Care in the Nordic Countries - Comparative Analysis and Identification of Challenges. VIVE – The Danish Center of Social Science Research.
[7] Soteuudistus.fi. Available: https://soteuudistus.fi/en/frontpage [11-11-2021].

Nursing homes and long-term 24-hour care in Finland is only used, when justifiable grounds for it exist and the person cannot live at home even when supported by intensive home care.[8] Institutional care for older people is either short-term rehabilitating care or long-term care. Short-term care is also called respite care and the purpose is to prevent the need for permanent institutional care. The decision of long-term care is made on medical grounds and older people in long-term care usually have several illnesses, and they need nursing and help from more than one carer at a time in their daily lives. In institutional care, all older persons have a primary carer, who also keeps in touch with their families. In short-term care, a fee is usually charged for each day spent in care. The fee for long-term institutional care is based on how much the person can pay.[9]

An alternative to nursing homes is sheltered housing. Ordinary sheltered housing is intended for people who need help in their everyday lives but who do not require institutional care. In extra care sheltered housing, there is service personnel available around the clock. Public homes for people with memory loss are an example of sheltered housing.[10]

Home nursing in Finland employs registered nurses, practical nurses, and nursing assistants (can have different educations and can assist in different areas). Practical nurses do most of the nursing in home nursing, but since there is a shortage of practical nurses, focus is now on how to transfer more tasks to the nursing assistants.

Finland is generally aiming at ensuring that a smaller number of health care professionals are included in the individual treatment of each citizen – both fewer professions and a smaller number of persons in general – to make it more comfortable and secure for the citizen. Therefore, home care for the elderly is one service that encompasses home help, home nursing and support services. Home help are help with day-to-day activities, such as washing and dressing oneself and eating. Home nursing is nursing and rehabilitation that takes place at home and referral comes from a doctor. Support services includes meals, cleaning, shopping, security, and transport services. Regular home care is subject to an income dependent fee while temporary home care has the same cost for everyone.

Short term rehabilitation units are also used, based on either social or health care legislation. Furthermore, there are specialized teams (separated from home care) who visits patients after hospitalization. These teams are staffed with nurses, therapists etc. and are used for shorter and intensive periods of time. If the client still needs care, the patient will be referred to home care services instead. The different professions work as a team, and they have access to the same client system which makes information sharing easy. The

[8] Thl.fi. Available: https://thl.fi/en/web/ageing/older-people-services-undergoing-a-change [2021, 11-11-2021].
[9] Suomi.fi. Available: https://www.suomi.fi/citizen/social-security/services-for-the-elderly/guide/a-new-home-for-an-older-person/institutional-care-for-older-persons [2020, 11-11-2021].
[10] Ymparisto.fi. Available: https://www.ymparisto.fi/en-US/Housing/Housing_for_special_groups [2019,11-11-2021].

precise organization depends on the size of the municipality, where small municipalities can have teams who also works with home care.

Acute care units are also used and is often called hospital-at-home. In home hospitals there is a specific doctor as part of the team whereas in home care there is typically no specific doctor related to the care (some municipalities have doctors working only in home care, while in other municipalities the care teams must contact the patient's own GP). Home hospital is not compulsory by law, and it is arranged by the municipalities but can be both private (by tender) or public. An example is 'At-home hospital care in Helsinki'[11].

2.3. Faroe Islands

From the 1st of January 2015 elderly care in the Faroe Islands has gone from being a national issue to being a municipal area of responsibility. Since the spring of 2012, an outsourcing process has therefore been underway, which has now resulted in the Act on Home Services, Elderly Care, etc.[12] ('Ældreloven'), a new law on municipal cooperation areas[13] and the Act on the Transfer of Staff[14]. Furthermore, new decrees have been issued that regulate the municipal area.

The purpose of 'Ældreloven' is to provide a coordinated comprehensive service to citizens who, in the sense of the law, need help. The service must be implemented in collaboration with the citizen, and the family must be involved as much as possible. 'Ældreloven' is currently being evaluated and changes can be expected both in terms of requirements for services and financing.

Municipal cooperation is required to ensure a sufficient population base to maintain efficient operation. The law on municipal cooperation areas for home services, elderly care, etc. requires an area of cooperation to have at least 3,000 citizens, and the area must be coherent both geographically and in terms of transport. Today there are seven municipal cooperation areas and an independent municipality (Thorshavn Municipality)[15] that are responsible for home services, elderly care, etc.

In the process of outsourcing, the municipalities have made agreements on how they will jointly manage home services, elderly care, etc. The municipal cooperation areas were free to cooperate on an equal footing or choose one of the municipalities to be the host

[11] Suomi.fi. Available: https://www.suomi.fi/services/at-home-hospital-care-city-of-helsinki/74a83019-f792-4fcf-b9e4-ef0e6cf8d210 [2021, 11-11-2021].
[12] Logir.fo. Available: https://logir.fo/Logtingslog/19-fra-07-04-2014-um-heimataenastu-eldrarokt-vm [2014, 11-11-2021].
[13] Logir.fo. Available: https://logir.fo/Logtingslog/20-fra-07-04-2014-um-kommunalt-samstarv-um-heimataenastu-eldrarokt-vm [2014, 11-11-2021].
[14] Logir.fo. Available: https://logir.fo/Logtingslog/31-fra-14-04-2014-um-um-avis-starvsfolkavidurskifti-ta-heimataenastan-eldrarok-tin-vm-verdur-logd-til [2014, 11-11-2021].
[15] Kf.fo. Available: http://www.kf.fo/kommunurnar/samstoerv/bu-og-heimataenastur [11-11-2021].

municipality. All cooperation areas have chosen to work together equally, and each municipality finances the costs based on its own number of elderly people. Since the elderly legislation is a framework legislation, the municipalities are largely free to determine their own strategy. However, there is some collaboration between the municipal cooperation areas at the professional level, even though the areas are independent units.

Nursing homes, cohousing for the elderly (senior communes) or their own home are the typical places to live for the elderly citizens. In the Faroe Islands, there is a tradition of living in a privately owned house for most of one's life, and a study from 2010[16] showed that this applied to 92% of retired citizens. And today, there is room for about 640 elderlies in either nursing homes or cohousing. This number is high compared to other Nordic countries[17].

Alternative forms of housing such as rental housing is seldom an option. This means that nursing home stays are generally significantly longer than seen in, for example, Denmark. In general, the infrastructure is well developed in the Faroe Islands, except on the very small islands, which are only accessible by boat or helicopter. Therefore, older people on these islands often move earlier into nursing homes, as the opportunities to get help in their own homes are fewer.

However, change is on the way as a national housing policy was announced in 2012, 'Bústaðarpolitikkur Landsins'[18], which states that the housing pattern in the Faroe Islands is too uniform and that the possibilities for alternative forms of housing must be expanded. As a result, the public housing company 'Bústaðir' has expanded the market by more than 500 rental homes in the period 2012 to 2020[19]. The coalition agreement from 2019 also highlights an expansion of alternative forms of housing in both the public and the private sectors.

In some areas the nursing services are integrated, so that nurses work both as home nurses and in nursing homes. As a rule, the municipalities do not employ doctors, but recently the Faroese parliament has passed a law on permanently affiliated doctors in nursing homes. However, this law has not yet entered into force.

Home nursing includes prevention, nursing, rehabilitation, outreach activities and public health care guidance, according to 'Ældreloven'. Home nursing services are free of charge, while home care and other services are subject to an income-related user fee.

[16] University of the Faroe Islands (Fróðskaparsetur Føroya - Søgu- og samfelagsdeildin), 2010. Í triðja aldri ráða vit yvir degnum - ein kanning av livikorum hjá fólkapensionistum.
[17] Rostgaard, T. Worm, V. H., Sigurjónsson, J. A., Næs, J. T., Finne-Soveri, H., Österlund, M., Sigurdardottir, S.H., Ouren, T., Granberg, K., 2015. Projekt: Kvalitet i ældreomsorgen - Ældreomsorg i Norden. Nordens Välfärdscenter
[18] The Faroese Ministry of Health, The Faroese Ministry of Finance, 2012. Bústaðarpolitikkur Landsins.
[19] Bústaðir, 2020. Ársfrágreiðing 2019.

In the Faroe Islands all provisions on health services for the elderly must be substantiated in a professional assessment. This means that elderly people who turn to the municipality for help are met by a visitator. The visitation is most often carried out by a nurse who refers the citizen to other professional groups if it is deemed necessary. In some cooperation areas, the visitation is thoroughly interdisciplinary, where the visitator, who is a nurse, visits the citizen together with an occupational therapist, a physiotherapist, or a dementia coordinator.

There are also **beds for temporary stays** in nursing homes, such as relief beds and rehabilitation beds. It is also possible to use these as **acute care beds**, but staff shortages have meant that some of the beds have had to be closed.

In 2021, the Faroe Islands Economic Council released a report on welfare workers for the next 10 years[20]. Their report shows that by October 2020, there were 284 registered nurses, 293 practical nurses, 770 nursing assistants and 4 pedagogues working in the elderly area (including home care), a total of 1,351 people. Employees without health care education are included in the number of nursing assistants, where they account for almost 50 percent, and they account for about 30 percent of the total number of employees. However, the proportion of untrained employees varies greatly between municipalities. About 51 percent of the employees in the elderly area are over 50 years old.

2.4. Greenland

Greenland is divided into five health regions (corresponding to the five municipalities) and the state is responsible for the health care system. This centralization was justified on the grounds that it would e.g., lead to less expenditures within the health care area, as more health functions could be concentrated in a regional setting.

Nursing homes are the only exception (beside some basic nursing tasks provided by home care), where the municipalities provide the health care services. Formerly, nursing homes only included a residential function, but today nursing tasks are also covered by the nursing homes**.** In Greenland, there are both nursing homes and a slightly less institutionalized version (retirement homes). Citizens receive care and nursing services at both facilities, however there are a higher number of staff per citizen at the nursing homes. In this report, both will be referred to as nursing homes[21]. They are staffed by a mix of registered nurses, practical nurses, nursing assistants, and uneducated staff – it is, however, not at every nursing home that all the above-mentioned professions are employed, and the number of educated staff varies as well. Some nursing homes receive all nursing services from a nearby health centre instead of providing the services themselves.

[20] The Faroese Economic Council, 2021. Temafrágreiðing - Starvsfólk á vælferðarøkinum komandi 10 árini.
[21] The Greenlandic Ministry of Social Affairs, Family and justice, 2020. Status på boligmassen på ældreområdet 2020.

Home nursing is delivered by staff employed at the regional hospitals in each health region as well as Queen Ingrid's Hospital in Nuuk. Home nursing is provided by registered nurses in four of the health regions and by a practical nurse in the remaining region. The largest number of home nurses are to be found in Nuuk, where four registered nurses provide nursing services at citizens' homes. The four home nurses in Nuuk are employed by Queen Ingrid's Health Centre and are as such part of the health region. There are approx. 19,000 citizens living in Nuuk, and the four home nurses provides home nursing for approx. 250 clients. Thus, home nursing is not a service provided by Greenland's municipalities but are instead the responsibility of the health regions.

In some parts of Greenland, there are **beds for temporary stays** at some of the nursing homes. This is however a heavy financial burden for the municipalities. There are only a few functions that handle either acute medical tasks and/or nursing tasks provided outside normal work hours within a primary health care setup. If patients living at home have acute medical needs, these are often handled at the larger health centres or regional hospital instead.

Other out-of-hospital facilities are alternatives to home nursing in the more rural areas where the population is sparse and the distances between cities and settlements are large. Citizens in need of nursing services in the rural areas either receive these from the health centres, health care stations, and settlement health care consultations – all provided by the government:

- Health centres are established across Greenland – both smaller and larger centres depending on the area. All health centres have employed health care professionals such as registered nurses and medical doctors. It is only the larger health centres which are staffed 24-hours, while the smaller health centres redirect citizens to larger health centres or regional hospitals outside opening hours[22].
- Larger settlements and smaller cities have health care stations providing nursing tasks. These have either a registered nurse, one-two nursing assistants and/or a health worker/uneducated staff employed as well as access to medical knowledge sharing through phone or virtual contact. The health care stations are visited four-eight times a year by specialized health care professionals[23].
- The settlement health care consultations handle simple nursing tasks and facilitates contact to other parts of Greenland's health services e.g., regional hospi-

[22] Ingemann, C. and Larsen, C. V. L., 2018. Evaluering af Grønlands Sundhedsreform – Oplevede og målbare effekter 2017. The Danish National Institute of Public Health (NIPH) and The University of Southern Denmark (SDU).

[23]Ingemann, C. and Larsen, C. V. L., 2018. Evaluering af Grønlands Sundhedsreform – Oplevede og målbare effekter 2017. The Danish National Institute of Public Health (NIPH) and The University of Southern Denmark (SDU).

tals. The settlement consultations thus have a gatekeeping function for the citizens of the settlements and the rest of the health care services where e.g., medication can be ordinated from medical doctors or registered nurses via virtual contact[24]. Nursing tasks at the settlement health care consultations are handled by uneducated staff who has, at most, received training in basic nursing tasks or preferably taken a health worker education. Two-four times a year, specialized health care personnel visit the consultations to provide medical assistance and knowledge sharing[25].

As nursing tasks are often performed at one of the abovementioned health care facilities instead of at citizens homes, citizens are offered transportation to and from the facilities.

Because of the organization involving both municipal nursing homes, regional hospitals, and the different health care facilities it has proven difficult to determine the exact number of personnel employed in home nursing. But as described the health care professions involved in home nursing in Greenland include registered nurses, practical nurses, and nursing assistants as well as uneducated staff. And through the health care facilities Greenland's citizens have access to this variety of professionals despite geographical distances and sparsely populated areas – either physical at the facilities or by phone/virtual contact enabled by the health care facilities. Further information on the different professions employed at facilities within the health region can be obtained in the report 'Evaluering af Grønlands Sundhedsreform' (Evaluation of Greenland's Health Reform) by the Danish Institute for Public Health[26].

2.5. Iceland

The health care sector in Iceland is run by the government. Iceland is divided into seven health regions each responsible for providing home nursing to their respective areas. There is a health care organization in each health region, which provides health services through different health care centres across the region.

Nursing homes in Iceland covers a wide range of nursing tasks e.g., palliative care. A designated government body evaluates and recommends whether a nursing home placement is the best option. In Reykjavik, it is also possible for citizens to get offered elderly friendly housing (sheltered housing), however this is only a possibility for citizens with low income. There is wish in Reykjavik to create an awareness among the politicians on the importance of citizens with a higher income to get offered sheltered housing as well, to

[24] Hansen, H. L., Noahsen, P., 2020. Sundhed og sundhedsvæsen i Grønland år 2020.
[25] Ingemann, C. and Larsen, C. V. L., 2018. Evaluering af Grønlands Sundhedsreform – Oplevede og målbare effekter 2017. The Danish National Institute of Public Health (NIPH) and The University of Southern Denmark (SDU).
[26] Ingemann, C. and Larsen, C. V. L., 2018. Evaluering af Grønlands Sundhedsreform – Oplevede og målbare effekter 2017. The Danish National Institute of Public Health (NIPH) and The University of Southern Denmark (SDU).

prevent more of the elderly to move to nursing homes. This is an issue which is debated during the current election.

Home nursing in Iceland is run by the government, but in Reykjavik, home care and home nursing are integrated and referred to as 'home services'. Reykjavik is subdivided into three health care sections, where each section has their own home service-department that run things differently from one another. Health care professionals providing home nursing tasks are registered nurses, practical nurses, nursing assistants, and uneducated staff. There is not one common organisational practice of home nursing across the country, as the different regions have approached home nursing differently. Reykjavik as an exception has been responsible for providing all welfare services within primary care since 2009, where the municipality agreed upon a contract with the government to provide all home welfare services incl. home nursing. New initiatives in Reykjavik targeting home nursing are often partly or solely financed by the government, while Reykjavik has a say in terms of how future initiatives are carried out. Primary healthcare' oversees 1/3 of Reykjavik's home nursing. There are resp. 65 registered nurses, and 35 practical nurses employed in home nursing in Reykjavik[27].

In some parts of Iceland, specialist **day-stays** (both independent and as part of the nursing homes) are an additional service to home nursing for the elderly. These services are provided during daytime with the aim of a bigger part of the elderly population to stay at their own homes if it is the best option for their health and general wellbeing. Reykjavik provides both **beds for temporary stays** as well as other alternative services such as day-stay centres, where nursing tasks can be performed. There is a wish to increase the number of day-stay centres so that more tasks can be performed here instead of by the home nursing teams.

2.6. Norway

The Ministry of Health and Care Services has chief responsibility for health policy, public health, health services, municipal services for the elderly and disabled, health legislation and parts of social legislation in Norway. The municipalities are responsible for providing reasonable, high-quality health care and social services to everyone in need of them, regardless of age or diagnosis. The state is responsible for ensuring equal framework conditions through legislation and financial frameworks. In addition, the state carries the responsibility of exercising supervision and control. The Act relating to municipal health and

[27] Lilja Petra Ólafsdóttir, L. P., Víðisdóttir, B., 2020. Ársskýrsla Heimahjúkrunar 2020 - Heimahjúkrun í Reykjavík. Reykjavíkurborg Heimaþjónusta Reykjavíkur.

care services, etc. ('Helse- og Omsorgstjenesteloven')[28] regulates all health and care services that are offered or provided by the municipality or private companies that have an agreement with the municipality.

In recent years Norway has launched several reforms in the areas of elderly care and healthcare. One of these is the quality reform Live Your Whole Life[29] ('Leve hele livet'), which will help elderly people master their lives longer and make sure that they get good help when they need it, that the relatives can contribute without being overworked, and that employees can use their competence in the services. The background for the reform is a recognition that the good solutions exist locally, but that they can be spread to an even greater extent to others. And the starting point is five focus areas with a total of 25 solutions and several hundred examples from the municipalities. A 'Live Your Whole Life' handbook[30] has also been created to inspire municipalities and help as many as possible to implement the reform. The reform period was originally set for 2019-2023, but it has been decided to extend it to 2024. Funding is not as such part of the programme – however, in some cases municipalities can seek project funds.

19 health communities[31] was establish in 2019, based on an agreement between the Norwegian government and the Norwegian municipal sector organization, KS. The aim is to get the hospitals and municipalities to cooperate better around patients. The health communities must focus on the most vulnerable patients, and four patient groups are to be prioritised: children and young people, people with serious mental disorders and substance abuse, frail elderly, and citizens with multiple chronic conditions. Each health community includes a health administration with associated municipalities. The governance of the health communities is organised at three levels:

- At the partnership meeting, the top management in the municipalities and hospitals meets annually and decides on the overall strategic direction.
- At the next level, the strategic collaboration committee, the administrative and professional management meet and decide on the specific patient processes and how the services are to be developed.
- At the level below are the professional collaboration committees, which are the working groups that work with proposals for the specific procedures and patient courses.

[28] Lovdata.no. Available: https://lovdata.no/dokument/NL/lov/2011-06-24-30#KAPITTEL_1 [2021, 12-11-2021].
[29] Regjeringen.no. Available: https://www.regjeringen.no/no/tema/helse-og-omsorg/innsikt/leve-hele-livet/id2547684/ [12-11-2021].

[30] Helsedirektoratet.no. Available: https://www.helsedirektoratet.no/tema/leve-hele-livet-kvalitetsreformen-for-eldre [12-11-2021].
[31] Regjeringen.no. Available: https://www.regjeringen.no/no/aktuelt/avtale-mellom-regjeringen-og-ks-etablerer-19-helsefelleskap/id2674825/ [2019, 12-11-2021].

It is representatives from hospitals, municipalities, general practitioners, patients, and users who plan and develop the services together to find good local solutions. There are local agreements in each health community to ensure better processes, provide guidance on how this can be done, etc. This means that both agreements and definitions can be very different e.g., due to the size of the individual health community.

Nursing homes are for the elderly and other individuals in need of 24-hour health and care services. The stay may be of longer or shorter duration, this is determined based on the individual's needs. In 2020 there were 39.241 beds in Norwegian nursing homes, and a little more than 80 percent of these were used for long-term stay.[32] Care homes include various types of accommodation which is adapted for people with special needs in terms of support and/or services. Care homes can be owned by the municipality themselves, organised as a housing association or co-ownership with the users themselves as owners, or in other ways. For example, the housing might be linked to municipal areas and/or adapted for 24-hour health and care services.

Home nursing includes help with medicines/medication management, nursing care, such as wound care and observations by a healthcare professional. Other home healthcare services include physiotherapy, occupational therapy (including facilitation around the home), mental healthcare, and rehabilitation pathways. In 2020 there were 102.883 users of home nursing only and 62.761 users of both home help and home nursing.[33] Home nursing, occupational therapy, and conversational therapy (e.g., with a psychiatric nurse) is free, while there is a user fee on physiotherapy.

Anyone who needs it can apply for healthcare services in the home. The municipality will then review the individual's needs regarding assistance and will decide in consultation with the citizen whether services should be offered in the form of healthcare services in the home. Typically, nurses conduct a home visit to collect the necessary information about the applicant. When doing this, nurses use a standardized assessment form, which all municipalities in Norway are required to use.

In Norway home nursing is provided by registered nurses and practical nurses while the more practical assistance (home care) is provided by practical nurses and nursing assistants and includes help with personal and instrumental activities of daily living.

Municipal acute care units (KAD) have been required by law since 2016. The goal of KAD is to relieve hospitals and provide people with an offer closer to home. Today, there are over 200 such offers in Norway, and they vary considerably in both organization and size. Many small municipalities have created one KAD bed at the local nursing home, while the largest KAD units often are inter-municipal collaborations with a double-digit

[32] Ssb.no. Available: https://www.ssb.no/en/helse/helsetjenester/statistikk/sjukeheimar-heimetenester-og-andre-omsorgstenester [12-11-2021]

[33] Ssb.no. Available: https://www.ssb.no/en/helse/helsetjenester/statistikk/sjukeheimar-heimetenester-og-andre-omsorgstenester [12-11-2021]

number of beds at the health centre or in connection with after-hours services. There must always be a nurse available at the KAD. The larger units often have their own KAD doctors present around the clock, while in smaller places it is often nursing home doctors or GPs who constitute the medical resources. Earlier evaluation showed that on a national basis, the occupancy rate at KAD has been low, only 42 percent, and a research group at the Centre for Care Research, NTNU in Gjøvik, a currently studying the benefits of KAD[34].

2.7. Sweden

Sweden is divided into 21 regions and 290 municipalities and has a decentralized health care system with a shared responsibility between regions and municipalities. Previously, the regions were solely responsible for providing health services but with the Swedish elderly reform in 1992, home nursing, special housing, and nursing homes became the responsibility of the municipalities, and the regions' long-term facilities were instead closed.

Nursing homes are the responsibility of the municipalities (also in Stockholm). However, some municipalities outsource the management to other parties. The staff include a mix of registered nurses, practical nurses, and nursing assistants.

The Health Care Act allows agreements between regions and municipalities on the transfer of responsibility for home nursing except for services delivered by medical doctors. Thus, municipalities and nursing homes are responsible for providing both health care and social services – just not services provided by medical doctors. The regions are responsible for offering services provided by general practitioners and other medical doctors affiliated with nursing homes and home care/home nursing.

Home nursing is a responsibility of the municipalities, as it was transferred to the municipalities throughout a period from 1992-2014, where agreements were reached on the transfer between regions and their respective municipalities. The only exception is Stockholm, where home nursing is provided by the region’s health centres (home care is municipal responsibility also in Stockholm).

When the municipalities became responsible for home nursing, there was no framework for what exactly was to be handed over. The regions and the respective municipalities had to find solutions and negotiate what would be included in the agreement based on the local conditions. Therefore, every region and municipality have unique agreements for home nursing which requires different solutions. Thus, it is difficult to give a common picture and draw up the general tendencies within home nursing in Sweden.

[34] Omsorgsforskning.no. Available: http://www.omsorgsforskning.no/nyheter/kommunale_akutte_doegnenheter2 [2021, 11-11-2021].

The Health Care Act regulates obligations for regions and municipalities. In some areas, the regions and the municipalities have joint responsibilities e.g., collaborating on providing certain health care professionals in cases, where the municipality cannot provide the services themselves. The collaboration and joint responsibilities differ across Sweden due to the various agreements between regions and municipalities. There is no user fee on home nursing services, while there is a user fee on services provided by home care.

Acute care beds and other kinds of nursing **beds for temporary stays** are not an official requirement in the Swedish primary sector and so far, there has not been debate on a general implementation of such initiatives. But some current projects exist that may be able to affect this in the longer run. An example is the project 'Hälsostaden Ängelholm'[35] which is a collaboration between Ängelholm Municipality, primary care, and hospital-based specialist care in Region Skåne. An existing older hospital has been developed into a unique local hospital, a health centre with a focus on both care and health. Several different components aim to create a cohesive care chain, with all three involved actors gathered in a single organization. E.g., a mobile acute care team takes care of elderly and fragile patients at home instead of sending them to the emergency department at the hospital, there is a rehabilitation ward under municipal auspices at the hospital for patients who are going home after inpatient care, and Primary care in Ängelholm offers a joint weekend and evening clinic for all the municipality's health centres, public as well as private, which relieves the hospital's emergency department.

In 2018, 135,000 practical nurses (13.3 per 1,000 inhabitants) and 77,000 nursing assistants (7.6 per 1,000 inhabitants) were employed within home care and special housing for elders (SÄBO) – employed either by the municipalities or private providers. Of those would approx. 35,000 of the practical nurses and 11.000 of the nursing assistants reach the retirement age during 2019-2028[36]. Also, in 2018 13,869 registered nurses (1.4 per 1,000 inhabitants) were employed in care of the elderly in Sweden. The number of registered nurses has decreased with 481 nurses since 2015[37].

2.8. Åland

The services included in elderly care on Åland are mainly regulated in the Social Care Act[38] and the Elderly Act[39], but many of the provisions that are to guarantee the quality of the services are found in the Act on the Client's Status and Rights[40].

[35] Halsostaden.se. Available: https://www.halsostaden.se/ [12-11-2021].
[36] The Swedish National Board of Health and Welfare, 2021. Vård och omsorg för äldre - Lägesrapport 2021.
[37] The Swedish National Board of Health and Welfare, 2021. Vård och omsorg för äldre - Lägesrapport 2021.
[38] Regeringen.ax. Available: https://www.regeringen.ax/alandsk-lagstiftning/alex/202012 [2021. 12-11-2021]
[39] Regeringen.ax. Available: https://www.regeringen.ax/alandsk-lagstiftning/alex/20209 [2021. 12-11-2021]
[40] Finlex.fi. Available: https://www.finlex.fi/sv/laki/ajantasa/2000/20000812 [12-11-2021]

Åland Health Care (ÅHS) is responsible for the entire public health service on Åland, including home nursing, while it is the municipalities that handles home care/home service, both in the citizens' own home, in service housing etc. There are also two private suppliers on Åland, these only handle care tasks and not nursing.

Nursing homes/institutions are typically owned by associations of municipalities, while almost all municipalities have senior/service housing – in total there are approx. 500 care places for the elderly on Åland. In institutions, citizens are typically quite weak and mostly bedridden, while senior housing are for those who are healthier. The waiting times for institutional places are generally short.

Home nursing is divided into districts. Mariehamn is an independent unit, while home nursing in Geta, Finström, Saltvik and Sund handles Norra Åland, and home nursing for Lemland, Lumparland, Jomala, Eckerö and Hammarland handles Södra Åland.

It is the nursing staff or doctors who assess the need for home nursing, and ÅHS has the medical responsibility, which includes medication and nursing tasks. It is largely free for citizens to receive home nursing, however, there is a deductible of a certain amount per year, which also applies to materials.

Home nursing in Åland mostly includes elderly citizens and is very much about palliative care, there are not that many young people who receive home nursing. Home nursing also handles tasks at nursing homes and institutions, as there are typically no staff employed for this in the municipalities.

There are a number of **local nursing beds for temporary stays** (periodic beds) in the municipal sector, but these are mostly used for respite care – and as it is difficult to adjust the number to the need, they often end up being used for permanent residents. It is seen as unclear who will oversee transitions and beds for temporary stays in the future, and informants find that it would be good to have more cooperation both between the municipalities as well as between the municipality and the hospital.

It is perceived as a challenge that there are so many organizations and associated organizational boundaries – the overall perspective is missing. At the same time, the use of different forms of financing increases complexity, resulting in lost efficiency. However, this is expected to improve with the new Social Services Act and the new Elderly Act, both from 2021, cf. the section on cross-sectoral cooperation.

At present, about 25 people work with home nursing in Åland (registered nurses, practical nurses, and nursing assistants), corresponding to approx.0.83 per 1,000 inhabitants.

3. Trends regarding changes in tasks and competency requirements

With the increasing life expectancy of the population and the ever-improving treatment options, there will also be an increased number of people living with chronic diseases and/or consequences of serious illnesses. This must be presumed to lead to more treatment-related tasks in home nursing, just as it requires that primary care can handle the more complex needs and treatment with polypharmacy.

Therefore, an increased focus on prevention and early detection of signs of illness and disability has long been one of the most significant development trends in the healthcare system. The same applies to an increasing awareness of the potentials of a rehabilitative strategy in efforts for citizens living in their own homes or in 24-hour staffed facilities. In addition, the primary sector is gradually becoming responsible for more-and-more acute care tasks and tasks outside normal working hours, which also increases the competence requirements when handling more unstable citizens and having a central role in identifying, investigating, and advising on signs of deterioration in the condition of the citizens.

3.1. Increased focus on prevention, early detection and response and rehabilitation

The **Danish** Health Authority published new recommendations in 2017 for early detection of impaired health conditions and impaired functioning of the elderly citizens in contact with home nursing and/or home care. [41] The guidelines specify the implementation of the tools UCLA 3 and TOBS. UCLA 3 can be used by municipalities to detect loneliness and social isolation in older people, and TOBS can be used to measure vital parameters such as heart rate and temperature. Both tools can be used to qualify the observations that employees make of citizens in everyday life. Based on the early detection, the municipalities can then assess the individual citizen and initiate relevant initiatives. These guidelines are one of the efforts to raise the quality of the home nursing and home care in municipalities and thereby reduce the need for more cost-intensive healthcare solutions and raise the life quality of the elderly citizens. The level of implementation on the municipal level is currently unclear.

[41] Danish Health Authority, 2017. Tidlig opsporing af forringet helbredstilstand og nedsat funktionsevne hos ældre mennesker

To promote further focus on early detection and to prevent or postpone the need for extensive care and nursing as of 2014 the Danish municipalities are obligated to deliver intensive rehabilitation to empower the citizen to the fullest potential and reduce the need for permanent home nursing and home care. The legislation (§83a in the Law of Social Service) was drawn up primarily based on experiences from a successful project in Fredericia Municipality. There is still a rather broad variety of the rehabilitation approaches across the 98 municipalities.

As of 1996 the municipalities were obligated to deliver preventive home visits (typically by an experienced registered nurse or a therapist) to contribute to increased safety, well-being, and health of the citizen by preventing or solving any problems before they develop. For example, by informing the citizen about voluntary organizations' offers for the elderly, municipal offers of both health and social professional nature and how social networks can be strengthened, supporting the citizen in utilizing their own resources in the best possible way, master self-care and thus strengthen autonomy and maintain the level of function for as long as possible or if possible, improve this.

In 2020 the **Finish** National Programme on Ageing 2030 was published[42] as a reaction to the ageing population. The programme recognizes the need for long-term and cross-administrative development to address the challenges and the need to push and accelerate use of both new solutions and the full implementation of the known solutions as well as underlining that short-term development of the service system is not enough.

The ongoing reform in Finland specifically includes a shift in the focus of social and health services towards more basic services and the early prevention of diseases and the development of health issues. In the publication ‘Quality recommendation to guarantee a good quality of life and improved services for older persons 2020–2023: The Aim is an Age-friendly Finland’[43] examples of good practices can be found. These includes, amongst others:

- The FINGER Model[44] where primary health care targets lifestyle counselling to persons at risk of memory disorders as an important measure to maintain and improve the functional capacity of the elderly. The model will be introduced throughout the country as part of the future health and social service centre programme.
- The IKINÄ operating model[45] for the prevention of falls where a number of tools created for fall risk screening and informing evidence-based preventive

[42] The Finnish Ministry of Social Affairs and Health, 2020. National Programme on Ageing 2030 - For an age-competent Finland.
[43] The Finnish Ministry of Social Affairs and Health & The Association of Finnish Local and Regional Authorities, 2020. Quality recommendation to guarantee a good quality of life and improved services for older persons 2020–2023 -The Aim is an Age-friendly Finland.
[44] Kulmala, J., Ngandu, T., Kivipelto, Mi., 2018. FINGER-modellen: ett åtgärdsprogram för livsstilsförändring hos äldre personer i riskzonen att utveckla minnesproblem. The Finnish Institute for Health and Welfare.
[45] Ukkinstituutti.fi. Available: https://ukkinstituutti.fi/en/products-services/kaatumisseula-tools-to-prevent-falls/ [2021. 12-11-2021].

measures make it possible for NGOs and non-professionals to co-operate with professionals.
- The TOIMIA database contains assessed functional capacity indicators for various purposes as well as recommendations for measuring and assessing the functional capacity.

Municipalities are obliged[46] to draft a plan on their measures to support the well-being, good health and functional capacity of the elderly population and their ability to cope independently, and for organising and developing services and informal care required by elderly people.

Over the years there has been a general increase in the focus on prevention in **The Faroe Islands**. More services offering 24-hour rehabilitation, training, and activities during the day have been developed, all of which typically take place in joint teams with physiotherapists and occupational therapists. These professional groups are also part of actual rehabilitation teams that come both to the citizens' homes and to the nursing homes. Overall, most municipalities prioritize services such as rehabilitation and maintenance training to help senior citizens live in own homes for as long as possible.

Preventive home visits are determined by law for the 75+ year olds. The visit is conducted by a nurse and the purpose is to discuss the citizen's health, the possibilities of receiving help at home, etc. However, a large proportion of citizens turn down the offer, again with varying extent from area to area.

In **Greenland**, there are several initiatives to promote preventive measures. A political agreement which focusses on preparing the elderly to remain independent of professional help for as long as possible, has been agreed upon. The agreement implies that elderly citizens during hospitalization receive training in taking care of themselves.

In Nuuk, elderly citizens who are at risk of needing home care and/or home nursing are also trained in providing as many caring and nursing tasks for themselves as possible before they are approved for home care and/or home nursing services.

Another example of preventive measures are lifestyle cafés at some of the health centres where citizens are trained in e.g., prevention of lifestyle diseases and disease management.

In 2019, the Ministry of Health in **Iceland** published a health strategy for 2030. The health strategy highlights seven key challenges necessary to address to strengthen the Icelandic health care system before 2030. To implement the strategy, five-year plans with

[46] (§ 5) Finliex.fi. Available: https://finlex.fi/fi/laki/ajantasa/2012/20120980 [2012, 15-11-2021].

both specific goals and benchmarks are developed and revised annually. An area in focus in the strategy is health prevention and health promotion especially within the primary health sector[47].

Generally, there is a growing focus on ensuring preventive tasks and activities in primary care – primarily targeting the elderly population on the national and local levels. Inspired by experiences from the Danish Municipality of Fredericia, Reykjavík in 2014 started a pilot project with the same name ('As long as possible in one's own life') focusing on initial rehabilitation of elderly people with initial loss of functional levels for them to become more self-supportive and handle tasks at home and hence lower or postpone need for home nursing and home care. The project was made permanent and supplemented with a rehabilitation team focusing on the transition from hospital to citizens own home but the same focus on initial rehabilitation to lower the need for home nursing and care.

In **Norway** prevention is primarily the responsibility of the municipalities and in 2016, the Ministry of Health and Care Services launched the 'Escalation Plan for habilitation and rehabilitation (2017 - 2019)'[48] to strengthening rehabilitation in the municipalities.

One specific initiative is obligatory preventive home visits conducted by an experienced, registered nurse is a strong national recommendation, but it is up to the individual municipalities if and how it is done. This results in great variation in both approach and organization. For example, the municipality itself determines the age limit, which is why some have raised this from including citizens over 75 years to citizens over 80 years. The service itself could also be more long-term in its approach, as an informant puts it. The focus is to prevent the need for support by preventing the onset of reduction of functional level. The Norwegian Directorate of Health is considering whether to make an actual strategy in the area, to work with information campaigns, etc.

In **Sweden**, a national strategic goal is to reduce the length of hospital stays and one tool to reach this has been to focus on early rehabilitation and health promotion delivered on the municipal level. It is typically nurses, physiotherapists and occupational therapists who are responsible for this in collaboration with nursing assistants.

In 2017-2020, the Swedish Government appointed an inquiry on 'Good care close to the citizen' [49] ('Samordnad utveckling för god och nära vård') with the aim of *supporting regions, affected authorities and organizations in the work of coordinating the development of a modern, equal, accessible, and efficient health care with a focus on primary care* (p. 19). The inquiry resulted in several concrete proposals which together contribute to a re-

[47] The Icelandic Ministry of Health, 2019. Sundhedsstrategi - Strategi for det islandske sundhedsvæsen frem til 2030.

[48] The Norwegian Ministry of Health and Care Services, 2016. Opptrappingsplan for habilitering og rehabilitering (2017–2019).
[49] The Swedish Government – The Swedish Government's public investigations (Statens offentliga utredningar), 2020. God och nära vård - En reform för ett hållbart hälso- och sjukvårdssystem.

form with a strong and adequately resourceful primary care as a basis. A part of the inquiry is focusing on 'from reactive to proactive' health care measures with the aim of stimulating more preventive tasks.

As of 2020 an agreement between the Swedish Government and SKL (The Swedish Association of Regions and Municipalities) put even more focus on the collaboration between regions and municipalities to ensure relevant care is provided closer to citizen's homes. A part of the agreement concerns preventive measures, early detection etc., which are highlighted as areas that should be in focus for the years to come.

Preventive home visits are also implemented in **Åland**, where the municipalities visit all citizens aged 75+ to identify their needs for help and support at home. Home rehabilitation is also offered including training in coping with everyday activities.

There used to be a rehabilitation ward at Åland Central Hospital where patients could be before they were discharged from the hospital. However, this has been discontinued and there is no equivalent at present. There is also no geriatric specialty on Åland, so it is unclear who is responsible for rehabilitation. Thus, it will be up to the municipalities to solve deliver rehabilitation, but according to a respondent the necessary specialized knowledge is not available on this level.

3.2. More treatment-related tasks in home nursing

In **Denmark** a slow and incremental shift has been seen from hospitals towards municipal health care solutions due to the reduction in lengths of hospital stays to some extend because of a deliberate reduction of hospital beds and at the same time a demographic induced rise in number of patients. This shift has raised the demand for both healthcare and nursing capacity and competencies on the local level – primarily in the municipalities – as well as a new and integrated approach to delivering care and healthcare.

The home nursing area in Denmark has seen a growth in specialized functions staffed primarily by registered nurses with special experience, education and/or both focused on taking care of patients with special or complex needs in nursing homes and especially in their own homes or as supporting specialist for other staff in nursing homes, in home care or in home nursing. Examples of these special functions are complex wound care, incontinence, neurorehabilitation, and dementia.[50]

[50] Implement for Ministry of Health, Ministry of Finance and KL, 2019: Results from survey of all Danish municipalities and depth cases from 20 Municipalities

By 2017 the need for a more fast responding and acute medical competencies on the municipal level was acknowledged on the national governmental level which led to the legal demand that every municipality was to establish and run an acute function with specified acute nursing capabilities as also described in chapter 2.1.

As a further response to the changing role of the home nursing field, a new formal specialist education (post school training) for registered nurses was introduced in Denmark by 2018 to create specialists in 'nursing close to the citizens'. The purpose of the specialist nurses is to deliver: 1. Clinical nursing close to the citizen, 2. Interprofessional and cross-sectoral coordination and cooperation, and 3. Quality development, teaching and guidance.[51]

According to **Finland's** Government Programme, home care is the primary form of care in Finland. Institutional care has been reduced for a long time, and the Elderly Care Act and its amendments have continued to accelerate this change.

The National Programme on Ageing 2030[52] has focus on more treatment and care at home and the same goes for the 'Quality recommendation to guarantee a good quality of life and improved services for older persons 2020–2023: The Aim is an Age-friendly Finland'[53] which was published in 2020. The quality recommendation is primarily intended for decision-makers and managers in municipalities and local government co-management areas as a tool for developing, evaluating, and implementing their services for the elderly.

The Finnish social welfare and health care reform[54] which is currently on its way, responds to structural and organisational changes and improvements. For example, the entire structure of social and health care will be redeveloped, just as structural and organisational actions will be taken in The Future Social and Health Centre Programme. Examples of the increase in treatment related tasks at home is the use of specialized rehabilitation teams and the hospital-at-home acute services (both described in chapter 2.2).

In the **Faroe Islands** the overall strategy for the area is that citizens can stay in their own homes for as long as possible, as well as receive a more person-centred and integrated treatment. The Faroese have a high life expectancy in a Nordic context, especially women, mainly due to healthier ageing. In addition, the Faroese remain in the labour market until an old age[55] and about 50% of all people aged 65-75 are working[56].

[51] The Danish Legal Notice nr. 1199 of 18th of October 2018, Danish Health Authority.
[52] The Finnish Ministry of Social Affairs and Health, 2020. National Programme on Ageing 2030 - For an age-competent Finland.
[53] The Finnish Ministry of Social Affairs and Health & The Association of Finnish Local and Regional Authorities, 2020. Quality recommendation to guarantee a good quality of life and improved services for older persons 2020–2023 -The Aim is an Age-friendly Finland.
[54] Thl.fi. Available: https://thl.fi/en/web/social-welfare-and-health-care-reform [12-11-2021].
[55] Hagstova.fo. Available: https://hagstova.fo/en/society/labour/labour-force [12-11-2021].
[56] Statistics Faroe Island.

The length of stay per patient in the Faroese hospitals is, as in other countries, significantly shortened. From 1985 and up to 2010, the average length of stay has been shortened by 2/3, since then, it has remained stable around 5 days on average. This, and the demographic shifts where there are more elderly people, especially 80+, compared to the rest of the population, means that after discharge to their own homes, the treatment of citizens often continues in the primary sector, leading to greater complexity and placing greater demands on nursing services.

In accordance with studies in Denmark[57], social complexity takes up more space now than in the past, in addition to the clinical and organizational complexity of home nursing. These challenges require a wide range of specific and general competencies that go beyond the purely clinical ones.

Continuity is sought in elderly care, which is why the elderly often receive services from the same (group of) caregivers. However, due to the size of the Faroe Islands, the professional staff knows the citizens and vice versa, and it can quickly become very personal, which can sometimes lead to ethical dilemmas.

There are no formalized acute care teams in the Faroe Islands, but there are several examples of good collaborations between the elderly area, municipal doctors, and the hospital system, especially in connection with palliative care, but also other illnesses.

In **Greenland**, there is a tendency for citizens to be offered permanent residence in a nursing home at an earlier age compared to many of the other Nordic countries (stated by one of the informants). The same tendency appears for earlier admissions to hospitals instead of receiving nursing at home. This tendency is assumed to be partly due to:

- Lack of health care professionals who can visit the citizens at home
- Large geographical distances
- Harsh weather conditions with cold temperatures as well as challenging geographical conditions

One of the informant states that, paradoxically, some of the settlements in the more rural areas of Greenland do not experience a higher rate of hospitalization among the elderly population compared to the cities, despite providing fewer opportunities for home nursing and other medical tasks handled outside hospitals. Instead, citizens living in the settlements often stay at home for longer, which is explained with a tendency among the smaller communities to be more tolerant of who handles home nursing tasks. It is e.g., common for uneducated staff who have received training in basic care and nursing tasks to provide some of these tasks. Thus, it is more common in the settlements to use resources on qualifying uneducated staff in providing nursing tasks rather than sending the elderly to nursing homes straight away – which also benefits the settlement-communities

[57] Vinge, S., 2018. Kompleksitet i den kommunale sygepleje - En analyse af sygeplejerskernes perspektiver på kompleksitet i sygeplejen. VIVE – The Danish Center for Social Science Research.

as it provides income opportunities for citizens who are unemployed. An example of the health-related initiatives, which helps to reduce institutionalization in the settlements are the settlement health care consultations. At these, uneducated staff assist the citizens with health-related problems. The staff provides guidance on health issues, as other health initiatives in the rural areas are sparse.

There are different housing initiatives located across Greenland for the elderly population. One type of special housing located at some the settlements are 'mini-nursing-homes' (sometimes referred to as elderly communes), which are usually not staffed 24-hours a day but mainly during daytime. In some parts of Greenland, mini-nursing-homes have been established in all settlements in that specific area, while other settlements do not have it nearby. One of the informants assume that the pattern of which settlements have mini-nursing-homes might be traced back to the former municipal setup in Greenland and reflects the different priorities within the former municipalities. There is furthermore elderly friendly housing across Greenland, which are less institutionalized than the nursing homes.

In Sermersooq Municipality they aim at providing more housing opportunities for the elderly, which accommodates the municipality's increased need for services for the elderly. In Nuuk, there are already a few of such housing options, though there remains a need for providing more. Elderly-friendly homes in Nuuk are located at a close distance to nursing homes to create a sense of belonging between the elderly-friendly housing and the nursing homes. It is also the intention to establish (within two-three years) a unit for inpatient care with affiliated home nurses. The aim of the unit is to ensure that more citizens can receive nursing services around the clock to avoid citizens being admitted to hospitals when possible.

Every year in **Iceland**, the government publishes a health care plan with areas of focus for the year to come. In 2021, the health care plan revolves around services targeting the elderly – and the focus of the plan is especially on providing more services at citizens own homes.

There is a new tendency towards an increasing proportion of the elderly to stay at their own homes for a longer part of their lives instead of living at nursing homes and other 24-hour staffed services. This can be explained by both the increase in the number of elderly citizens (and the associated costs) as well as by the fact that the country hospital has difficulties with transferring patients to institutions in the municipalities, as there is a general shortage of available beds. However, there is still a shortage of both home nursing and home care personnel as well as different service facilities such as elderly friendly homes. Before it becomes possible for an even larger part of the elderly population to stay at their own homes, it is necessary to solve some of these pressing challenges in home nursing and home care. In Reykjavik, there is a focus on lowering the numbers of elderly staying at nursing homes by e.g., increasing both home nursing and home care staff in the evenings and weekends as well as establishing multidisciplinary rehabilitation teams.

In the northern region of Iceland, there are initiatives where the elderly can stay at a nursing home either by day or night, if they have a need for it. There are some spare rooms at the nursing homes, where the elderly can ‘rent a room’ or come spend time at the common areas while still having their own homes where they live most of the time. The program was initiated to avoid a ‘one size fits all’ model to ensure more of the elderly population to stay at home if it suits their health and wellbeing. There is a wish for expanding the program to more regions in the future. Another pilot project revolves around the establishment of flexible day-stays for the elderly. The intention of the project is to reduce the number or at least percentage of citizens permanently living at nursing homes. The project has had a lot of positive results and national attention, as a similar model is seen as a way of enabling the elderly to stay at home for as long as possible and ensuring that the need for costly capacity expansions at nursing homes are reduced.

In **Norway** there is also an overall political desire for citizens to be able to stay longer in their own homes and already with the Coordination Reform in 2012, a change took place, so that citizens are in the hospital for a shorter time, and the number of care institutions has been reduced. To achieve the goals of the reform, medical and care responsibilities were moved from hospitals to primary care, but the change created challenges for municipalities e.g., handling the citizens who are too healthy for hospital, but too sick to be at home. So, a variety of specialized municipal care services has emerged, including 24-hour municipal in-patient acute units, larger and more specialized short-term units in nursing homes, and in-home care teams with special expertise in handling specific patient groups (e.g., persons with dementia) or providing specific services (e.g., palliative care and rehabilitation). Intermediate units have also been established, i.e., units run by the municipality with doctors available, where patients come as a transition between hospital and their own home – or to avoid hospitalization. An example of this is Drammen Health Centre which has temporary beds for acute care, rehabilitation, palliation, and ordinary short-term stays.

In the rural areas, housing policy makes it difficult to have the right services (elderly housing/care housing) and thus there are greater demands on home care. In addition, elderly housing is seen as the citizens' own home, and municipalities typically choose to have them serviced by home nursing and home care. However, these citizens are relatively demanding and often need permanently attached staff around the clock.

When and if citizens are offered special housing in **Sweden**, is decided by the municipalities. There are different formal housing initiatives with institutionalized surroundings e.g., service housing, and they are seen as preventive measures for avoiding either hospitalization or transfer to nursing homes. Acute and temporary stays might not be an official requirement, but they are still common in Sweden, and they are provided by the municipalities as a mean to shorten hospital stays.

In Sweden, there is a growing tendency for more of the elderly to stay longer at own homes/regular housing instead of moving to special housing. This is partly because there in recent years have been fewer available vacancies in special housing. However, this

tendency possesses future pitfalls as there is 1) shortage of staff – both due to recruitment and retainment issues 2) shortage of staff with the right competencies in both home nursing and home care.

There is a national aim for providing more nursing tasks at home to shorten the number and the length of hospitalization. This transformation requires more qualified staff and better technological solutions within home nursing and home care. Some initiatives have already been implemented to ensure fewer hospital visits. A few examples are:

- In some parts of Sweden, mobile teams have been established with the aim of treating more citizens at home. As the project have had positive results, it is currently being investigated at national level to improve existing initiatives in mobile care as well as implementing more mobile units. This is to ensure that care can be provided at citizens' homes at all times of the day and at weekends.
- A project has been established where the ambulance force helps treating citizens at home instead of transferring them to the hospitals.

Other initiatives at both regional and municipal level targeting more treatment related tasks provided at home (for both elderly and children) can be found at SKR's homepage[58].

It is the municipalities of **Åland** that are responsible for planning and carrying out the care tasks, i.e., also the care for the elderly. According to the Social Welfare Act, care must primarily take the form of activities which make it possible to live independently and which create the economic and other conditions for coping with day-to-day functions on their own.

It is therefore a clear political desire that citizens should be able to stay at home for as long as possible, and many citizens would also prefer to be treated at home. However, this presents challenges for home nursing, which does not have the necessary resources to perform the tasks e.g., handle pump treatment, establish and supervise drips, etc. At present, there are too few employees per shift, and these often must cover large geographical distances.

Home nursing is staffed 24 hours a day, but not all districts have employees on duty in the evenings, at night and on weekends. Instead, the task is shared across districts, so that, for example, Mariehamn covers several areas. This sometimes presents logistical challenges when one employee has to manage a large geographical area and hence have lots of time bound to transportation.

[58] Skr.se. Available: https://skr.se/skr/halsasjukvard/utvecklingavverksamhet/naravard/exempelpanaravard.29764.html [12-11-2021].

3.3. Short summary

In all the countries and self-governing territories covered in this report, there is continually and increasing focus on prevention, early detection and response, and rehabilitation. The means and strategies differ only to a small extend mostly due to differences in geographies and population size.

The focus on early detection and prevention is focal in everywhere as it is seen as the most important tool to postpone the need for extensive care and nursing along with rehabilitation of elderly people with initial loss of functional levels. The aim is for them to become more self-supportive and able to handle tasks at home, hence reducing or postponing the need for home nursing and home care.

In some areas this is supplemented with rehabilitation teams focusing on the transition from hospital to the citizen's own home e.g., in Denmark, Finland, Iceland, and Norway. It is typically nurses, physiotherapists and occupational therapists who are responsible for this in collaboration with nursing assistants. Nevertheless, there are still a rather broad variety of rehabilitation approaches among the Nordic regions and municipalities.

Across the countries and self-governing areas there is consensus on the possibilities of bringing the competencies of registered nurses more into play in early detection, but there is no clear and effective solutions as the demand for registered nurses exceeds supply in except in Åland.

Across the Nordics the overall strategy for the health care area seems to be that citizens can stay in their own homes for as long as possible, as well as receive a more person-centred and integrated treatment outside of hospitals. This presents new challenges for home nursing, as it raises the demand for both healthcare and nursing capacity and competencies on the local level as well as for a new and integrated approach to delivering care and healthcare.

As a response to this, a variety of specialized local/municipal care services have emerged, including 24-hour acute care units, more specialized short-term units, and in-home care teams with special expertise in handling specific patient groups (e.g., persons with dementia) or providing specific services (e.g., palliative care and rehabilitation). Intermediate units have also been established in some countries in cooperation between the regional and municipal levels.

Lastly, some countries note that social complexity takes up more space now than in the past, in addition to the clinical and organizational complexity of home nursing. These challenges require a wide range of specific and general competencies that go beyond the purely clinical ones.

4. Trends regarding cooperation and transfer of functions and tasks

It has been a pronounced expectation from the political, professional and user side for several years, that the individual intervention must not be planned in isolation from other interventions but must be seen in connection with a broader citizen/patient pathway. Thus, much more cooperation is expected both within the individual sectors and between the sectors, which will demand organizational competencies to achieve better coordination and strengthened collaboration across professional groups, organizational units, and sectors.

Several factors are important for changes in the composition of competencies in primary nursing care; this applies to recruitment opportunities; the development with more nursing tasks that require increased competencies; and changes in the education system. Staff shortages have increased the pressure on nursing staff to take over tasks previously performed by doctors, just as fewer registered nurses (and practical nurses) have led to the transfer of tasks to nursing assistants.

4.1. Cross-sectoral and interdisciplinary cooperation, and coherent citizen/patient pathways

In **Denmark** coherence in patient pathways has been a priority for more than 25 years and a lot of initiatives, projects and research has been done.

The National Quality Program commenced in 2015 has among several others a clear strategic goal of bringing leaders across the regional and municipal healthcare sectors together on creating better coherence and quality with a clear understanding of value-based healthcare.

On a practical level several types of coordinator functions have been installed on the municipal level e.g., neurorehabilitation and dementia, to support patients and their relatives in navigating the healthcare system. These functions are primarily staffed by specialised and experienced registered nurses.

On the structural level obligatory agreements of cooperation between the regional and municipal level must be done covering a four-year period to promote coherence and clarity on responsibilities and transitions in the patient pathways.

There is also a formal meeting structure between each hospital and the surrounding municipalities to support efficient coordination and cooperation especially around hospital admissions and discharges. The level of cooperation differs across the country, but it is evident that the number of efforts put into the coordination and cooperation has significance for the level of coherence in the patient pathways.

It is expected that more specific demands for the municipalities will be part of an announced and expected healthcare reform in the late 2021/early 2022 as well as a new organizational structure of health care clusters ('sundhedsklynger'). The aim of the clusters is to bring the regional and municipal level together with a focal point in the hospitals with acute functions. The organizational structure is based on a joint population responsibility to ensure a more cost-effective, quality- and value-based management of the increasingly scares human resources across the capacities in the regional and municipal sectors.

In **Finland** health and social services are to be improved during the current reform as part of the Future Health and Social Services Centres Programme. The purpose is to ensure that services are provided seamlessly and based on the individual needs. Additionally, the programme will improve the client-oriented approach by introducing digital and mobile services and by expanding weekend and evening service times. Clients will be served by multi-professional teams and the staff in health and social services centres will receive support from specialists and from new operating models that utilise digitalisation. Implementation of the programme is supported by discretionary government funding.

In the **Faroe Island** it is a priority to break with the compartmentalization and instead achieve a higher degree of interdisciplinary collaboration. In home care and home nursing in the Northern Islands, for example, a clinical development nurse has been employed, who must focus on safeguarding and raising the competencies among those who perform nursing tasks with a lower competence level and strengthen the interdisciplinary collaboration in the organization.

In the current system with municipal doctors (equivalent to general practitioners), there are problems with filling all the positions. In some areas the result is that it is difficult and takes a long time to get medical visits both for people living in nursing homes and the elderly living at home. The hope is to counteract some of this with a new law on permanently affiliated doctors to nursing homes.

In **Greenland** registered nurses employed in home nursing have a delegated authority to initiate treatment themselves based on visitation criteria and standard treatment forms under the supervision of a doctor.

Some of the advantages recognized by the informants in terms of Greenland's current system, where home nursing is delivered from the regionalized health care sector, is that it is easy to get in contact with the citizens' own medical doctors as well as access their

hospital patient records. As such the home nurses are fully integrated in the regional setting. Some of the disadvantages that is mentioned are on the other hand, that the collaboration between home care and home nursing and between the other regional health services and the nursing homes is difficult.

Beside this, there are challenges with sharing citizens records across sectors when a citizen is transferred from health centres or hospitals to municipal services**.** In some parts of Greenland, arrangements have been established where staff is shared between the health service and the municipalities e.g., the staff working night shifts or physiotherapists, and this enables better cooperation.

In Nuuk physical co-location of the offices of the regional home nursing and the municipal home care are taking place to enhance collaboration. The aim is to utilize the resources used on home services optimally as well as heighten the competencies, especially in home care. However, some of the home nurses fear that they will lose their current direct access to medical assistance and knowledge sharing from the medical doctors employed at Queen Ingrid's health centre, as they will no longer have their base in that context.

A full transfer of home nursing to the municipal level (in Nuuk only) is being considered, but reluctance due to fear of falling ability to recruit and retain registered nurses in the municipal setting – as well as a disintegration and loss of coherence between home nursing and the other regional health services.

In **Iceland**, there are challenges ensuring collaboration between medical doctors and home nurses, as there has been cases where general practitioners have resisted against working together with home nursing teams. Although possible solutions to increase collaboration are being discussed extensively in Reykjavik, only few possible ways of promoting collaboration have been identified as the general practitioners are not employed by the municipality.

A pilot program called SELMA with the aim of strengthening collaboration between general practitioners and home nurses has been initiated. The overarching aim of the project is to lower the number of people getting hospitalized. During the project, registered nurses have gotten daytime access to general practitioners when in need of medical assistance. When the project was initiated, it was difficult to recruit general practitioners to the project. Instead, a contract was made with a private company to deliver medical support. The results of the first six months in service was evaluated medio 2021 and showed a great satisfaction with both the usefulness and the utilization. The initiative is considered an important addition to the services provided and subsequently the budget has been doubled to strengthen the project even further[59].

[59] Guðnadóttir, M., 2021. SELMA - Mat á árangri fyrstu sex mánaða í þjónustu 16.11.2020 – 16.5.2021. Reykjavik City – Departement of Welfare.

The achieved integration between home nursing and home care in Reykjavik is referred to as a strength. It ensures a better collaboration and delegation of tasks between home care and home nursing as well as getting rid of the silos. The special setup in Reykjavik is highlighted as something that could be implemented on a national level in the future.

Some of the common areas of concern in connection to the collaboration between home nursing and home care both in Reykjavik and at a national level is the different ways of thinking, different legislation, differences in staff and competencies, different data (e.g., patient records) in home care and home nursing – these are all barriers for enhancing the collaboration. One informant states that the abovementioned barriers are deemed less of a problem in Reykjavik than in the rest of the country due to experiences with integration of home nursing and home care.

As for **Norway**, in 2015, the Primary Health Service Report showed that many health and care services were good individually, but they were too fragmented, and the coherence was missing. This particularly affected citizens with complex needs. Against this background, a national guide for the follow-up of people with high and complex needs has been developed[60], which, among other things, describes methods and tools for quality improvements as well as the need for competencies and the planning of these. In addition, national pilot projects have been launched for structured multidisciplinary follow-up teams[61] and primary health teams[62], with the latter also testing new funding models.

Work is also being done on 'Everyday Rehabilitation'[63], which is an extended rehabilitation service in the home and local environment for people with disabilities, especially the elderly. The everyday rehabilitation takes place in an interdisciplinary collaboration, where the user sets the goals for rehabilitation, and the health team works together to achieve these. Many municipalities express that they have good experiences with the initiative. There is a great deal of enthusiasm and several local resources, tools and aids have been developed. The available research points in the direction of positive results for users and municipalities, while underlining that the long-term effect seems to require continuous maintenance or repetition[64].

Cross-sectoral collaboration and strengthening of competencies in home nursing are recognized areas for improvements in **Sweden**, as some of the challenges in home nursing concerns both shortage of staff and a need for more specialized health care competencies.

[60] Helsedirektoratet.no. Available: https://www.helsedirektoratet.no/veiledere/oppfolging-av-personer-med-store-og-sammensatte-behov [2017, 15-11-2021].
[61] Helsedirektoratet.no. Available: https://www.helsedirektoratet.no/om-oss/forsoksordninger-og-prosjekter/pilot-for-strukturert-tverrfaglig-oppfolgingsteam [2019, 15-11-2021].
[62] Helsedirektoratet.no. Available: https://www.helsedirektoratet.no/om-oss/forsoksordninger-og-prosjekter/primaerhelseteam-pilotprosjekt [2019, 15-11-2021].
[63] Helsebiblioteket.no. Available: https://www.helsebiblioteket.no/omsorgsbiblioteket/hverdagsrehabilitering [15-11-2021].
[64] Helsebiblioteket.no. Available: https://www.helsebiblioteket.no/omsorgsbiblioteket/nyheter-og-aktuelt/ny-norsk-studie-om-effekter-av-hverdagsrehabilitering [2019, 15-11-2021].

It is recognized that there is a need for integration and collaboration between different professions in different sectors. E.g., between home care/home nursing and specialised health care such as hospital treatment. As an incentive for more medical doctors to be affiliated with home nursing, the government has established a fund for regions, which employ a greater number of medical doctors to support home nursing/home care and health care centres.

At national level, work has been going on for several years with the Coordinated Individual Plan ('Samordnad individuell plan'), which aims at ensuring cross-sectoral collaboration for patients receiving both health care and social services that need to be coordinated. The plan is especially important for patients who are transferred from regional to municipal care[65].

In Borgholm, the municipality have entered into an agreement between the health centres, municipal home care/nursing and the ambulance staff. Patients in municipal home care/nursing are offered a permanent contact with a medical doctor from a health centre, who is involved in all parts of the patients care and nursing services, and who make home visits when needed.[66]

The project 'Hälsostaden Ängelholm' is a project with the ambition to take on the experienced organizational shortcomings and try a new level of integrated solutions to improve health and healthcare in the borderland between regional level and municipalities. The aim was and is to offer patients seamless health and medical care to make everyday life easier for the most ill elderly in Ängelholm Municipality. The goal is also to contribute to accessibility, care, and care at the right level, and a better flow for the people who need services from primary care, hospitals, and municipalities. The project has shown very good results and has been further prolonged and expanded.

In 2021, both a new social law[67] and an elderly law[68] have taken effect in **Åland**, and this new legislation has a clear emphasis on solutions that put the citizens needs in focus by placing new and higher demands on cross-organizational and structural cooperation. The law requires cooperation between the social service providers including home care and nursing and the specialised healthcare providers (primarily hospital service) formalized in 'cooperation agreements' between each of the municipalities and the national health service (ÅHS).

Åland is continuously looking for projects that can save time and staff resources. For example, a collaboration has been established between home nursing and the palliative

[65] Skr.se. Available: https://skr.se/halsasjukvard/kunskapsstodvardochbehandling/samordnadindividuellplansip.samordnadindividuellplan.html [2021, 15-11-2021].
[66] Regionkalmar.se. Available: https://regionkalmar.se/samarbetsportalen/uppdrag_samverkan/nara-vard-2/projekt/hemsjukhuset-borgholm/ [15-11-2021].
[67] Regeringen.ax. Available: https://www.regeringen.ax/alandsk-lagstiftning/alex/202012 [2021, 15-11-2021].
[68] Regeringen.ax. Available: https://www.regeringen.ax/alandsk-lagstiftning/alex/20209 [2021, 15-11-2021].

wards, so that patients can stay longer at home, among other things, using more advanced instruments at home. Work is also under way to establish closer cooperation between doctors and home nursing, including better opportunities to connect with doctors in treatment situations.

4.2. Lack of health personnel and changed composition of competencies

The number of vacant positions within the different kinds of nursing are high and growing in **Denmark**. Over the last decade the growth in the number of people with nursing needs and the development in health care needs in general has driven a lot of changes in the division of tasks. Both as unintended task and function creep and as more deliberate task and function transfer between the various groups of staff, including doctors, registered and practical nurses, therapists, and nursing assistants.

On the structural level the government has prioritized resources to increase the capacity for education of both registered and practical nurses. As the demography is a general issue, the success of recruiting more people to these educations has been less successful than hoped.

Another initiative to recruit more people to the nursing profession (and to raise the quality in healthcare in general) was done by updating the education curriculum for practical nurses with the ambition to attract people not interested in the education as a registered nurse but still interested in nursing. It is still unclear what the effect of this updated education and hence the abilities of the 'new practical nurses' will be. But it is expected that more functions and tasks previously and currently being done by registered nurses soon will be delegated to practical nurses.

There is a general shortage of both doctors and nurses in **Finland** as well. An informant stated that previous studies have shown that by 2030 there will be a need for as much as 30,000 new nurses (incl. hospitals) if nothing else is changed. Delegation from doctors to nurses is possible in Finland, but it is very regulated and there are strict requirements for education. Doctors can only delegate to specialised nurses e.g., nurses specialised in dispensing medicine. However, most municipal nurses are not specialised, so delegation is seldom a possibility.

In Finland there are specific requirements for the number of employed registered nurses based on the allocation of home nursing hours to deliver on the assessed needs in a given area. In the Elderly Care Act reform in 2020 the ratio of registered nurses was raised in long-term care, the job descriptions were specified, and the ratio between direct and indirect patient time were specified to secure quality of care.

By far the biggest challenge in the **Faroe Islands** is the shortage of skilled healthcare staff. Presently it is more attractive to work in home nursing than in other parts of the healthcare sector, so the recruitment of registered nurses is currently less of a problem,

but it is acknowledged that it will be a serious issue in the time to come – and a common challenge for the healthcare sector in general. As of 2021 the number of educational positions for nurses have been doubled as a somewhat late response to the demographic development as one respondent states. Another general set of initiatives are aimed at creating more legitimacy and status in working with the elderly in home care and home nursing, as this traditionally have been perceived as low status.

Delegation hardly exists in the primary sector, except for a few medical practices where municipal doctors delegate tasks to nurses. It is legally possible (same rules as Denmark), but the agreements on the remuneration of general practitioners may have unfortunate incentives. Nevertheless, the shortage of nurses in nursing homes now means that a shift in tasks for the practical nurses is underway which is supported by practical nurses being offered training in, for example, administration of medication. It is also recommended that the municipalities employ nurses with a master's degree in advanced clinical nursing for geriatric patients with multiple diseases and polypharmacy.

In **Greenland** the situation is different in Nuuk compared to the rest of the country because of the geography and structure of home nursing.

The number of home nurses in Nuuk is acknowledged as too low in relation to both the growing population residing in Nuuk and the increased complexity of home nursing tasks. The focus hence is on continuously expanding the competencies of the four registered home nurses employed by the municipality as needs emerge. This is done by following training courses in the specific disease and treatment. In addition, the nurses also receive supervision in instances where they need further professional guidance. The home care unit performs more simple nursing tasks such as eye dripping – after receiving training. It is also common for the home nursing unit to delegate other basic nursing tasks to home care. This requires continuous training of the home care staff when they are delegated new nursing tasks, which is prioritized to ensure to that the home nursing team can focus on more complex nursing tasks.

Health care personnel e.g., registered nurses, practical nurses, and medical doctors, are employed at the health centres. The medical doctors are employed in temporary positions (apart from Nuuk), why it is not always possible to meet the citizens medical needs with a medical doctor at the centres [69]. At the settlement health care consultations, the staff is either uneducated and has only received a little training in basic nursing tasks or has undertaken an ‘health worker education’ (22 weeks) aimed at common nursing tasks

[69] Hansen, H. L., Noahsen, P., 2020. Sundhed og sundhedsvæsen i Grønland år 2020.

in settlements or smaller cities. There are some difficulties motivating the staff at the consultations and health care stations to undergo the health worker education, as it often requires them to leave the settlement and their families during the education[70].

At many of the nursing homes in Greenland, there has previously been invested less resources in the facilities compared to other Nordic countries e.g., Denmark, which is still visible today. Nursing homes also generate large financial costs for the municipalities, making it hard for the municipalities to increase investments and resources for nursing homes. In nursing homes, uneducated staff make up most of the personnel, and these are responsible for most of the care and nursing related tasks. In addition, nursing homes experience challenges with recruitment of new staff. The recruited registered nurses usually have no or only a few years of experience but are assigned with responsibilities that either surpasses their competencies or capacity. It is not uncommon for newly graduated nurses to be employed as managers of uneducated staff at nursing homes despite their limited work experience and competencies in management.

To accommodate the recruitment challenges embedded in the nursing homes, continuing educations have been made for practical nurses and nursing assistants to raise their competency levels. In some instances, the health services take over some parts of the nursing tasks at nursing homes when needed e.g., ordination of medication.

As for **Iceland** there is a tendency for practical nurses and unskilled personnel to take over more of the nursing tasks, because there is a general shortage of registered nurses. In Reykjavik, they are trying to overcome this problem by specializing home nurses and delegating more of the general nursing tasks to practical nurses. They are currently working on finding other professions, who can provide some of the nursing and/or caring tasks as well. They have a 'specialization principle', where they are aiming at registered nurses to become more specialized, practical nurses to deliver more general nursing tasks and other personnel and unskilled staff to take over some of the tasks that practical nurses are usually responsible for.

Delegation is common both between medical doctors and registered nurses and between registered nurses and practical nurses – in accordance with the legislation. Medication can, however, only be ordinated by registered nurses and medical doctors. During COVID-19, there was a shift towards utilizing the nurses' resources for more complex tasks, leaving more of the basic nursing services to be provided by other professionals e.g., pharmacists vaccinating citizens.

It is recognized as a problem that there are not any national initiatives specifically aimed at utilizing resources better within home nursing – when initiatives are initiated, it is often due to a specific need instead of a forward-looking plan. The different organization of home nursing in Reykjavik is highlighted as a strength in periods where a shortage of

[70] Ingemann, C. and Larsen, C. V. L., 2018. Evaluering af Grønlands Sundhedsreform – Oplevede og målbare effekter 2017. The Danish National Institute of Public Health (NIPH) and The University of Southern Denmark (SDU).

registered nurses is more pressing, as it is easier to relocate staff from home care to basic nursing tasks.

It is, however, challenging in Reykjavik to get the home nursing teams to provide services for citizens who are mentally ill, have alcohol addictions etc. They are trying to overcome the taboo around these patient groups by implementing special teams with combined competencies from social services and home nursing.

The biggest challenges in home nursing in **Norway** are also recruitment and competencies. The problem seems to be enhanced due to the structure with 356 municipalities with very different sizes from the smallest with only app. 600 inhabitants. The small municipalities are the most challenged and vulnerable, but even larger municipalities are struggling hard with the lack of especially registered nurses.

New initiatives have been commenced as a reaction to the situation. All healthcare and care personnel are being trained in observation and assessment as to make early intervention less dependent on specific groups like registered nurses. Registered nurses must also to a greater extent be willing to give up more responsibility/tasks and allow the less specialised professional groups to help.

The ambition is to be more specific on the optimal use of the competencies of the different groups, especially to reserve the scares resource of registered nurses to the right types of tasks and transfer more ordinary functions to other groups. One solution would be to become better at defining and describing nursing tasks as well as making a specified assignment distribution. There is a standard, but it is not considered to be detailed enough, as one respondent states.

As recruitment challenges also covers general practitioners (‘fastleger’), the rules of delegation are under scrutiny. Delegation has up until now been the practice in selected areas, as specialist training (master's degree as a clinical nurse) is required, if nurses are to take over specific responsibility from doctors. There is ongoing discussion about whether to change this e.g., with a system for delegation as in Denmark, but this meets resistance among doctors. Instead, collaboration is being attempted in teams of doctors, nurses, and assistants to replace the need to delegate tasks. It is possible to book cooperation hours with the doctor (special rate for this), where the nurse can talk to the doctor without the patient needing to be present. However, this is used very little, since time is not devoted to this in the daily programme in home care and home nursing.

The Norwegian Government’s plan for recruitment, competence, and professional development in the municipal health and care service is outlined in ‘Competence boost 2025’.

The plan also outlines initiatives within user involvement, service development and interdisciplinary collaboration as key components of meeting the challenges.[71]

In **Sweden** there is especially a shortage of personnel who can take care of the more complex and specialized tasks within home nursing as well as ensuring the proper competencies within home nursing in general. As there is no specific education for nursing assistants, they have different backgrounds and competencies. This is recognized as an area in need of unification, as the quality of services provided by nursing assistants varies from person to person. There is an aim at national level to regulate the level of education of nursing assistants to ensure a certain level of qualification. Attempts are currently being made to address the issue at national level e.g., there is a national council for health care competence which works at strengthening collaboration between universities, regions, municipalities as well as relevant national agencies. The regional councils are also aware of the issue, as they support collaborations in the regions with the aim to improve planning of education for nurses, medical doctors, and other healthcare professionals.

Transfer of functions is common in Sweden, particularly due to the lack of health care professionals. It is especially common for registered home nurses to delegate nursing tasks to employees within the social services teams (practical nurses, nursing assistants, and other personnel). Delegation in Sweden is allowed if it is in line with the requirements for the safety of patients**.**

To support and accelerate the movement from care and treatment being delivered in an institutionalized context to in much larger extend being delivered in patient's home and in close vicinity of patient's own home – and to promote high quality in care in general – a leadership programme is being rolled out nationwide: 'Ledarskapsstöd Nära vård'.[72] As of autumn of 2021, more than 2,000 leaders will have participated, and the programme will continue.

In **Åland**, home nursing is experiencing large savings requirements, which makes it difficult to hire as many employees as could be desired. It is seen as an attractive job, so it would be possible to recruit the needed nurses, if the budget allowed for it. Home nursing in Åland is extensively acquiring and using students, which is viewed as an important part of making the jobs attractive and well sought.

The access to medical doctors is on the other hand a general challenge for home nursing specifically when it comes to administration of medication and the need for delegation and decision making. Initiatives are being taken on dose dispensing[73], which has been

[71] Regjeringen.no. Available: https://www.regjeringen.no/no/tema/helse-og-omsorg/helse--og-omsorgstjenester-i-kommunene/kompetanseloft-2025/id2830273/ [15-11-2021].

[72] Skr.se. Available: https://skr.se/skr/halsasjukvard/utvecklingavverksamhet/naravard/ledarskapsstod.34757.html [2021, 15-11-2021].

[73] Ålands hälso- & sjukvård, 2021. Dosdispensering för patienter vid ÅHS hemsjukvård.

introduced everywhere to be able to treat very sick citizens at home. There has been some resistance to this, but it has been necessary to counteract the shortage of doctors.

Though the municipalities are responsible for home care and the national level for home nursing there is close cooperation and a flexible boundary between the tasks of home care and home nursing. In principle, after-care is performed in the home by the home nursing (wounds, blood tests, etc.), while the home care is responsible for help in daily life, small-scale training, etc. Reviews have been made of who-do-what and what-is-done-together, which has led to formulation of new guidelines and instructions. Increasingly, work is being done on 'coherent home care', where the municipal home care must be able to perform certain simpler nursing tasks (e.g., wound care, insulin dosing, some medicine). However, this presents certain challenges, for who has the responsibility for the treatment when home care performs these tasks?

Åland has the same system of delegation as Finland i.e., specific competencies and training of the delegate are required. This constitutes a practical problem, as there are very few nurses with the skills and hence few can train the practical nurses and nurses assistants.

4.3. Short summary

Cross-sectoral and interdisciplinary cooperation, and coherent citizen/patient pathways are focal in the strategies across the Nordics. The citizens' needs are put in focus by placing new and higher demands on cross-organizational and structural cooperation.

It is recognized that there is a need to reduce suboptimization and compartmentalization and instead achieve a higher degree of interdisciplinary collaboration between different professions in different sectors. The ubiquitous reduction of length of hospital stays has especially driven a need for a higher level of collaboration and integration of hospital specialist doctors/general practitioners and home nurses.

On a practical level there are examples of different types of coordinator functions having been installed on the municipal level primarily staffed by specialised and experienced registered nurses. However, a shortage of skilled healthcare staff is a huge challenge in all the Nordic countries. Only Åland reckons that home nursing is seen as such an attractive job, that it would be possible to recruit more nurses easily if the budget allowed for it.

Delegation of functions and tasks from doctors to nurses is not used consistently across the Nordics. In e.g., Denmark, Iceland and the Faroe Islands the legislation is relatively open to delegation, while in Finland and Åland it requires special training for the nurses to take over tasks and therefore seldomly a possibility or exploited.

Across the Nordics there is in a general tendency for practical nurses and nursing assistants to take over more and more of the nursing tasks from registered nurses. As practical nurses are also in scarce supply almost everywhere, shifting their tasks towards nursing assistants and unskilled personnel is seen as well.

Structurally many governments have prioritized resources to increase the capacity for education of both registered and practical nurses. But as the demography is a general issue, the success of recruiting more people to these educations are in general not corresponding to the needs.

5. Trends regarding welfare technology

There is a constant progress in the introduction and use of welfare technology solutions, although the development is relatively slow in some respects. The technology must support that nursing tasks can be performed more efficiently by requiring fewer staff resources and enabling citizens to stay longer in their own homes. At the same time, a digital development is taking place where many citizens acquire devices and programs that they (or their relatives) expect the nursing staff to know. This will require that the staff can use and guide the citizens in the use of these new technological aids and tools.

5.1. The use of welfare technology and digitalization

In **Denmark** welfare technology and digitalization has been highly prioritized for several years on the national, regional, and local levels of government. The level of digitalization in Danish healthcare is commonly acknowledged as being very high. And though there are still many possibilities to be pursued, the preconditions for fast roll-out (access to the technology) and implementation (application of the technology as standard operation procedure) of technologies delivering on productivity, coherency, effectivity, and quality and of late especially on 'manual labour extensivity' are to a large extend in place.

As for supporting and relieving the pressure on nursing functions there are several national and local initiatives, demonstration projects, and implemented solutions supporting nursing functions. The COVID pandemic enhanced the implementation of video solutions which was previously met with some reluctancy. Another specific theme of relevance for nursing is technologies supporting dispensing and administration of controlled drugs in home nursing. The Association of Local Governments (KL) are maintaining an overview of 'The use of welfare technologies in the social area and the health & elderly area'.[74]

Examples of projects and initiatives in Denmark:

TeleCare North has tested the effect of telemedicine home monitoring for chronic obstructive pulmonary disease patients from 2002 to 2015. Cooperation across sectors and uniform task solution has been an important part of the project. Joint operations and services have been developed and implemented, including design of a model for allocating responsibilities and solving tasks. Initially the solution was implemented in Northern Jutland and in 2016 it was decided to expand the solution nationally and

[74] Videncenter.kl.dk. Available: https://videncenter.kl.dk/viden-og-vaerktoejer/teknologilandskabet-overblik-og-redskaber/det-velfaerdsteknologiske-landkort/#/ [15-11-2021]

broaden the scope to other disease areas. In 2020 a common national infrastructure for telemedicine was established making further implementation of solutions possible.

Virtual home nursing has been spreading fast across the 98 Danish municipalities and before the COVID pandemic more than ¾ of them had experiences with the technology. During the pandemic virtual home nursing was spread even wider and intensified in usage. Experiences suggest that a balanced use will be a more fixed part of home nursing in the future, and it is obvious that abilities and competencies to exploit the possibilities of virtual technology in nursing can and must be developed to support optimal implementation.

Finland's cross-administrative age programme[75] plans for welfare technology to be implemented as part of the health and social services reform. It also opens for financing the projects by government grants.

The technology is expected to support and facilitate the work of employees and in part substitute it. The working time and workload of care workers can be reduced by using robots for tasks such as lifting and moving patients and to support the patient's own mobility (exoskeletons and walking robots). Robotics may also replace the indirect time spent on patients, such as time spent on moving devices, transporting meals and some aspects of medical care. Robotics may be used for administrative duties as well.

Living at home is also increasingly supported by technology. Various solutions and services related to safety and the sense of security have increased. Technologies for mobility, localisation, tracking (monitoring included) and alarms have increased. The protection of privacy and ethics are essential considerations when using technology which supports living at home.

In the development of electronic services for public administration, user-orientation and digital skills have been prioritised. A more extensive implementation of digital services and technologies requires a reinforcement of employees' competencies, a change in working methods and technical support in the working community. The suitability of the technology to the user should also always be ensured.

Examples of projects and initiatives in Finland:

The 2018 'Well-being and Health Sector Artificial Intelligence and Robotics Programme', also called the **#hyteairo programme**[76] was launched by The Ministry of Social Affairs and Health to support and accelerate the utilisation of AI and robotics. As part of the programme, the establishment of home technology piloting environments has been prepared along with the creation of national operating models. This includes

[75] The Finnish Ministry of Social Affairs and Health, The Association of Finnish Local and Regional Authorities, 2020. Quality recommendation to guarantee a good quality of life and improved services for older persons 2020–2023 -The Aim is an Age-friendly Finland.
[76] Thl.fi. Available: https://thl.fi/en/web/thlfi-en/research-and-development/research-and-projects/the-well-being-and-health-sector-s-artificial-intelligence-and-robotics-programme-hyteairo- [15-11-2021].

a model to assess the effectiveness of AI and robotics solutions and to issue recommendations.

Technology supporting smart ageing and care at home programme (**KATI**)[77] is a governmental program that implements Hyteairo's home living measures and is part of The National Programme on Ageing.

In the **Faroe Islands** the strategy in this area is managed by each association of municipalities. Several different welfare technology solutions are being considered e.g., projects related to monitoring and communication. This is particularly to increase the quality of citizens' care. It is also likely that the welfare technology solutions can be utilized, for example, for the elderly on the small islands, so that moving to a nursing home can be postponed. The general view is that health technology cannot replace the nursing staff, but it can be a help in e.g., heavy tasks. There is a clear expectation that more and more solutions will come, but that it will be as supplements. In addition, it is often expensive and needs to be maintained, which will challenge implementation and application.

The same medical record system (Cosmic) is being implemented for the entire health care area in the Faroe Islands. Hospitals, general practices, pharmacies, and others in primary care have been using it for many years, and now the elderly area is joining them (expected to be implemented in 2-3 years). It will be a great strength and increase the security of transferring data with the same system so that everyone can access the relevant information quickly and easily.

Examples of projects and initiatives in the Faroe Islands:

Nemlia[78]– a Faroese company that has developed software where they can collect alarms from various systems and send them to the care staff's telephone, to relatives, etc. The system has given the staff of a large nursing home, where they use alarms, great peace of mind in relation to the fact that they do not have to look after some of the residents as often as before. Nemlia has also developed something similar for citizens living at home.

Project on dementia and welfare technology from the EU, **RemoAge**[79]. The project's purpose was to tackle the challenge of supporting people with dementia and other frail older people to age at home in remote and sparsely populated areas of the northern periphery of Europe (Sweden, Norway, mainland Scotland, the Western Isles, the Shetland Islands, Faroe Islands and Northern Ireland). It tested the use of technology to provide: education for citizens, their relatives, and the wider public; access to detailed information; more joined-up communication between supporting organisations; remote access to specialist services. The service innovations developed, tested and in many

[77] Thl.fi. Available: https://thl.fi/en/web/thlfi-en/research-and-development/research-and-projects/technology-supporting-smart-ageing-and-care-at-home-programme-kati- [15-11-2021].
[78] Nemlia.com. Available: https://nemlia.com/en/home/ [15-11-2021].
[79] Remoage.eu. Available: https://remoage.eu/ [15-11-2021].

cases implemented during the project continues to live on in the participating communities.

In **Greenland**, the government has increased investments in welfare technology solutions especially telemedicine in the recent decades as this is seen as a way of ensuring consistency in treatment even in the rural areas. One of the key areas of focus in Greenland's health care reform from 2011 was increased investments in telemedicine to ensure better access to health care services for citizens living in rural areas. As a result of the reform, telemedicine units were established around the country at settlement health care consultations, health care stations and health care centres[80].

However, these investments in welfare technology have been exclusively in the health care system and do not apply to solutions integrated in the citizens' own homes (neither in home nursing in Nuuk nor home care). It is e.g., only a small number of the elderly population in Nuuk who have emergency calls installed in their homes. Since many senior citizens have some challenges using technological solutions there will also be a need for education in the use of technology, should technological welfare solutions be implemented in citizens' homes in the future.

Examples of projects and initiatives in Greenland:

A part of the vision of the **Steno Diabetes Center Greenland** is to develop and increase the technological solutions to ensure that a larger part of the population get access to the preventive initiative provided at the centre. This specifically includes strengthening and developing the telemedicine infrastructure as Greenland's geography and sometimes challenging weather conditions require using telemedicine to ensure equal access for everyone in the country, also citizens living at more rural areas[81].

This form of communication must be able to embrace both the highly specialized doctor and the unskilled health worker in the settlement. Therefore, an important part of the work is to ensure continuous competence development in technical and communicative matters regarding the use of telemedicine.

Welfare technology is somewhat used in elderly care in **Iceland**, but there is still more to be achieved. The Icelandic government has recently acknowledged the need for implementing more welfare solutions, but an informant states that the financial structure and financial incentives are not providing much room for innovation and investments in welfare technology solutions.

There is great interest from multiple parties involved in elderly care such as nursing homes and day-stay centres to increase the use of welfare technology in the future. Also,

[80] Ingemann, C. and Larsen, C. V. L., 2018. Evaluering af Grønlands Sundhedsreform – Oplevede og målbare effekter 2017. The Danish National Institute of Public Health (NIPH) and The University of Southern Denmark (SDU).
[81] Steno.dk. Available: https://steno.dk/en/centres/steno-diabetes-center-greenland/ [15-11-2021].

there is a wish to accommodate some of the challenges embedded in home nursing with welfare technology e.g., it can be challenging for home nurses to get access to the patient's homes – this could be avoided if digital locks were installed in the houses of the elderly receiving home nursing.

Iceland used to have a national plan for welfare technology integrated in the health care services, but the responsibility of welfare technology in primary care has been moved to social services instead. In Reykjavik, a Welfare Tech Centre has been established financed both by the government and Reykjavík. The Welfare Tech Centre was initially established because the Nordic Council of Ministers encouraged the Nordic countries to establish welfare technological Centres. A part of the responsibility of the Welfare Tech Centre is to test possible welfare technology solutions.

Examples of projects and initiatives in Iceland:

Some regions are using medicine dispensers/**medicine robots**. In Reykjavik, 25 medicine robots have been installed at citizen's homes.

New nursing homes are currently under construction. A part of the plan for the nursing homes is to incorporate more welfare technology to minimize some of the staff's tasks, so that the saved time can be used on other nursing and caring tasks.

Reykjavik have employed **nurses close to retirement and nurses on sick leave/** have somatic challenges that make it difficult for them to perform the daily work in the patient's home. These nurses are employed in positions, where they are responsible for virtual contact with patients.

Norway invests heavily in welfare technology, both nationally and locally[82]. Thus, a welfare technology programme was introduced as part of 'Omsorg 2020'[83] (Care 2020), which was the government's plan to strengthen the quality and competence in the field of care in 2015–2020.

The program, which is a collaboration between the Norwegian Directorate of Health, the Directorate for eHealth, and KS, has given recommendations for welfare technology solutions in the municipalities. This includes: Electronic medicine dispensing, Localization technology (GPS), Digital safety alarms, Digital supervision, and Logistics solution for more optimal driving routes and better quality of services.

The recommendations are based on gain realisation reports from tests conducted in 2013-2015[84]. There are now app. 300 municipalities that have participated in the pro-

[82] Helsedirektoratet.no. Available: https://www.helsedirektoratet.no/tema/velferdsteknologi [15-11-2021].
[83] The Norwegian Ministry of Health and Care Services, 2015. Omsorg 2020 – Regjeringens plan for omsorgsfeltet 2015-2020.
[84] Helsedirektoratet.no. Available: https://www.helsedirektoratet.no/rapporter/gevinstrealiseringsrapporter-nasjonalt-velferdsteknologiprogram [2017,15-11-2021].

gramme and have implemented welfare technology as a general part of their service offerings for citizens living at home. A new report has been prepared which describes the gains in more detail, but this has not yet been published (expected to be published soon).

The Norwegian Government has decided to continue the programme for 2022-2024, where technology for children, young people, and adults with congenital or acquired disabilities as well as digital home follow-up for the chronically ill are priority areas.

It is the municipalities that are responsible for implementing the welfare technology solutions in home care. Several municipalities have therefore established key areas of responsibility for technology, where dedicated employees work with the area.

Examples of projects and initiatives in Norway:

Testing of technology for **children and adolescents with congenital or acquired disability** was performed from 2017-2020 with very good experiences[85]. Based on the experiment, national professional recommendations have been prepared, and from 2021, the use of technology for this target group has begun to spread to several municipalities.

In 2015-2018 **medical distance follow-up/digital home follow-up** was tested. Based on the experience[86], a further test was initiated from 2018 to 2021 to gain knowledge to make national recommendations. This test is followed by researchers who have provided sub-reports along the way[87]. The final research report will be published in December 2021.

The usage of welfare technology in **Sweden** is the responsibility of both regions and municipalities. An increasing focus is and will be on the use of technological solutions that can help monitor elderly living at home. Welfare technology has been commonly used within elderly care but not to the same extent within home nursing. Some of the solutions already implemented in home nursing and home care are e.g., alarm systems, calls and cameras installed in patients' homes.

There are several national agreements and investments to ensure development in welfare technology within primary care. The Swedish government and SKR has settled on an agreement in 2020-2022, which aims at ensuring that the municipalities get the proper

[85] The Norwegian Directorate of Health, 2020. Velferdsteknologi til barn og unge med funksjonsnedsettelser – erfaringsrapport fra 4 års utprøving.
[86] The Norwegian Directorate of Health, 2019. Oppsummering underveis om utprøving av medisinsk avstandsoppfølging i primærhelsetjenesten.
[87] The Norwegian Institute of Health and Society – University of Oslo, Oslo Economics and the Norwegian Centre for Rural Medicin, 2021. Evaluering av utprøving av digital hjemmeoppfølging, delrapport II.

resources to develop better activities in elderly care through digitalization and technology[88]. As a part of the agreement, SKR established a Welfare Technological Competence Centre ('Kompetenscenter välfärdsteknik') to support the municipalities in digitizing their services[89]. The government and SKR has furthermore agreed on 'Vision eHealth 2025' with strategies towards enhancing e.g., digitization, information flows and management. The goal is for Sweden to become a leading country in the world when it comes to use of health care technology and digitization before 2025.[90]

An elaborated list of welfare technological and digital solutions used by the municipalities and regions are listed in the report 'Uppföljning av omställningen till en mer nära vård 2020' by the Swedish Authority of Social Services '. In the follow-up report of the agreement, different digital solutions such as virtual consultations are mentioned as initiatives, which have increased collaboration between regions and municipalities[91].

Examples of projects and initiatives in Sweden:

A research project focused on user involvement targeted **citizens diagnosed with dementia and their partners**. A part of the project revolved around developing an app where citizens could find information on dementia, disease management and other relevant virtual courses to increase the citizens' competencies.

There is national consensus on the need for better transfer of information between sectors. There is already arranged a project to deal with **how health information is shared between different parties**, but there are still various issues in this regard. These issues include: How information is organized and structured; How to secure that information is shared the proper way; How to educate staff especially in home care and nursing homes (due to lack of technological competencies).

Work has been initiated to develop a common journaling system for **Åland**. This has been necessary, even though there is a national IT system in Finland, because this does not match Åland's structures, and not all relevant information can be accessed. In Finland, there is also a new system on the way for the social area, but again it does not fit well with Åland. So, at present there is no system that can be used across units and sectors, but work is underway to develop this.

Like many other places, the use of video consultation/virtual medical contact has increased significantly as a result of Covid-19.

[88] Skr.se. Available: https://skr.se/skr/integrationsocialomsorg/socialomsorg/aldre/overenskommelsealdreomsorg.31534.html [2021, 15-11-2021].
[89] Skr.se. Available: https://skr.se/skr/integrationsocialomsorg/socialomsorg/aldre/overenskommelsealdreomsorg/kompetenscentervalfardsteknik.34196.html [2021, 15-11-2021].
[90] The Swedish National Board of Health and Welfare, 2021. Uppföljning av omställningen till en mer nära vård 2020 - Utvecklingen i regioner och kommuner samt förslag på indikatorer.
[91] ibid.

5.2. Short summary

Throughout the Nordic countries welfare technology and digitalization has been highly prioritized for several years on national, regional, and local levels of government.

Technology and digitalization are expected to support and facilitate the work of employees and in part substitute it. E.g. robotics can help reduce the working time and workload, when lifting and moving patients, and living at home is increasingly supported by technologies for mobility, medicine administration, localisation, tracking (monitoring included) and alarms as well as video supported nurses visits.

The biggest issue across all countries is the ability to change and really implement the solutions in large scale and realise the potentials fully.

6. Trends regarding patient and relative involvement

In recent years, there has also been an increasing awareness of the demands for and a recognition of the value of patient and relative involvement. This means that the individual senior citizen and any relatives must be involved in planning, deciding, and setting goals. At the same time, there is a significant development in citizens' access to information about health and treatment, which will require competencies among the employees to apply a supportive and inclusive approach to the citizens.

Furthermore, several so-called third sector organizations delivers services that helps to improve people's wellbeing. This is organizations that are neither public sector nor private sector and they include voluntary and community organizations (charities, associations, self-help groups and community groups), social enterprises, and other non-profit organizations.

6.1. Patient and relative involvement

In **Denmark** involvement of patients, citizens, and relatives both on individual level and on organizational level has been high on the strategical agenda on all levels.

The most visible national strategic initiative is part of the above-mentioned Quality programme, where involvement among the primary focus areas covering PRO, ‘common decision making’, and organizational involvement of patients as partners in the development of healthcare.

Regions, hospitals, departments, and municipalities are individually developing and implementing strategies on involvement, and there is consensus on, that high quality and relevant development of the healthcare sector requires both individual and organizational patient involvement. As for the latter, methods like ‘Co-creation’ (in Danish: ‘Samskabelse’) and ‘Service Design’ are finding its way into healthcare.

In **Finland** the citizens' right to participate in their own care and to promote their functional capacity is strongly governed through many laws and programs. This goes for the Constitution, the Act on the Right to Self-determination, the Elderly Care Act, the Social Welfare Act, the Act on the Status and Rights of Patients, the National Programme on Aging, and the Quality Recommendation. And soon the Autonomy Act will be updated and, among other things, the rights of people with memory disorders will be strengthened.

On top of this, there is the unofficial care, where focus currently is on how to provide the relatives with enough knowledge on care. Technology could be an answer, but work is still being done on finding the right solutions for educating unofficial care givers. Voluntary work is also important for the care of elderly in Finland e.g., for lonely elders. The voluntary part typically aims at social care and not health care. Informal care is part of the Future Social and Health Centre Programme while voluntary work is developed in projects related to the National Programme on Ageing and in the Quality Recommendation. The Ministry of Justice is responsible for developing voluntary work in Finland.

Relatives generally take on a large role in home care in the **Faroe Islands**. Although it is not formulated in the law itself, the resources of the family and other relatives are considered in connection with the visitation for municipal services. However, it is also seen that when the citizen finally goes to a nursing home, the family often withdraws because they are so exhausted from the process. Families should step in when they can, but they shouldn't take full responsibility – and as time goes by, there are also fewer and fewer relatives who have the opportunity to do so (due to their own working situation, distance, etc.). Paid relative care is a possibility, but this is most often seen in palliative care situations and the number of relatives using this arrangement is declining. The Faroese spending a lot of time on their own family, may also be the reason why it is difficult to recruit volunteers. Because due to its size the third sector does not play a significant role in home care, except for Red Cross visiting friends.

In **Greenland** there is no regulation on relatives providing nursing and/or caring tasks and thus no formal opportunities for relatives to receive compensation or a reduced number of working days if they take part in treatment and care. Relatives' involvement in nursing do however occur and it has increased the recent years – especially regarding patients who receive palliative care. Furthermore, it has become less taboo for relatives to state the challenges that they experience when they take part in treatment and care (as stated by one of the informants).

In general, relatives do not play a major role in home nursing. Often relatives live far from each other in different parts of Greenland. The great traveling distances combined with the fact that travelling in Greenland is rather expensive, makes it less likely for relatives to take part in the nursing tasks. It has also become more common for the Greenlandic population to expect the health care system to be responsible for providing home nursing where it was formerly considered the responsibility of the relatives. There are some general differences between settlements and cities in terms of how families are structured. In many settlements, it is more common for family members of different generations to live together under the same roof or perhaps at close distance to each other compared to the cities. Thus, the living conditions in the settlements require greater involvement of relatives in care and nursing tasks – especially in settlements with a shortage of health care professionals to take care of care and nursing tasks at home. For citizens residing in Denmark who wish to return to Greenland, this is only an option if the citizens themselves can handle the daily tasks that occur in connection with their treatment. An example is citizens with peritoneal dialysis, who must be able to handle the daily dialysis themselves**.**

In Greenland, third sector only plays a small part in relation to home nursing. It is not the norm among the Greenlandic population to take part in volunteer work. However, it has partly gained ground during COVID-19 e.g., in relation to the vaccination programs where citizens volunteered.

In **Iceland**, there is some legislation on reimbursement for relatives providing nursing and/or care tasks. It is only spouses, who can receive reimbursement, while children, friends or other family members cannot receive reimbursement.

One of the seven key challenges within the Health Strategy for 2023 is involvement of citizens in own health promotion and treatment. Both easier and more secure digital access to own health records is emphasized as essential, as this is required by law. The Directorate of Health has currently implemented a health portal called 'Heilsuvera', where patients can access their records no matter what sector and institution, they have received services from. The aim of the portal is to promote user involvement in the citizen's own treatment e.g., by the digital overview of relevant health information, access to own health records as well as the possibility of communication with health care professionals[92].

Third sector is another part involved in providing caring or nursing services in Iceland. For example, some nursing homes are owned by 3rd sector entities. During COVID-19, this tendency increased, where some organizations provided services free of charge e.g., 'Call a friend' for lonely elderly citizens.

Relatives are one of the target groups in the ongoing quality reform in **Norway**, just as the so-called Dementia Plan 2025[93] builds on the experience of previous plans. In this way, municipalities across the country have received grants for schools for caregivers/relatives and discussion groups for relatives of people with dementia, as well as for schools for users and discussion groups for people with dementia. The municipalities have also been given a clearer obligation to make an independent assessment of the relatives' needs and make decisions on measures through a separate provision in the Health and Care Act. A new caregiver strategy and action plan for 2021-25 have also emerged. The objectives of the strategy include recognizing relatives as a resource and the strategy defines and includes relatives in a broad sense. Caregivers are close relatives – both family and friends – of people who are ill, have disabilities or substance abuse problems.

Volunteers are considered in many Norwegian initiatives, typically when it comes to mobilizing and making citizens active. All municipalities have one or more volunteers' centres for which the municipality can apply for grants. Their task is to establish cooperation with companies, other associations, etc., i.e., they act as a kind of 'umbrella organizations'. Some competition may exist between volunteers' centres, but they are a small but very

[92] The Icelandic Ministry of Health, 2019. Sundhedsstrategi - Strategi for det islandske sundhedsvæsen frem til 2030.
[93] The Norwegian Ministry of Health and Care Service, 2020. Demensplan 2025, 2020.

central part of care work. However, their role varies greatly from municipality to municipality. Additionally, a strategy for the 3rd sector was drawn up in 2015, but this has not been renewed. In some areas, these organisations are very strong e.g., dementia, which leads to many offers and initiatives in the local areas.

An aim of the **Swedish** Government's inquiry of 'Good and proximity care' was to raise the involvement of both civil society as well as the patients and relatives in relation to home nursing and home care. Involvement of civil society is an area of focus. One of the informant's states that there is no dominant Swedish culture of involving others than health care professionals in the care of citizens outside hospital.

When relatives are involved in care, it is often the partners of the patients, who provides some of the care/nursing tasks at home. The type of relatives involved in care beside partners depends on the geographical distances between the patient and the relatives. Care and nursing tasks provided by relatives are somewhat regulated. It is in some instances possible for relatives to get paid for the care while reducing their working hours at their jobs. This is, however, most common for patients in palliative care. During the COVID-19 pandemic, relatives involved in nursing care became more common.

The Swedish regions are currently using an initiative called 'Patient contracts' as a way of ensuring patient involvement in their own treatment. The aim of the contracts is to ensure care centred around the patient's personal needs and wishes. They are contracts between patient and care providers but are however not legally binding – only an informal agreement between the two parties. The contracts are also supposed to ensure consistency of care personnel and collaboration between the different professions and units involved in the care and nursing tasks of the patient[94]. There is a tradition in Sweden for working organization-based, but at government level focus is shifting from organizations to patients with the hope of a more person-centred approach to care. At SKR, they are focusing on patient and user influence in home nursing services as well.

Third sector involvement in nursing and care services is not that common in Sweden. When third sector is involved, it is often related to activities free of charge e.g., preventive, or social initiatives.

Åland also has a system for 'Closely related care' – where relatives can receive financial support (from the State Pension Institution) to care for a citizen. As part of this, municipalities are obliged to organize periodic respite care, etc. If you participate in the scheme, certain forms of home care will be discontinued, while nursing care can always be received. The scheme is widely used and requires citizens to be screened to become part of it.

[94] Skr.se. Available: https://skr.se/skr/halsasjukvard/utvecklingavverksamhet/naravard/patientkontrakt.28918.html [2021, 15-11-2021].

Dose dispensing[95] is an initiative that involves both healthcare professionals, relatives, and the citizens themselves. ÅHS has thus decided to introduce mechanical dose dispensing for its patients in home nursing. This means that citizens get their medicines in pre-packaged doses from the pharmacy, where they must be picked up every 14 days. The purpose of this is to improve patient safety so that the citizen gets the right medication, at the right time, and at the right dose. At the same time, it makes it possible for the patient or a relative to handle the medication thereby becoming independent of the home care staff. But it also implies that the patient must find a way to pick up the medicine as this is no longer provided by home care. It is the doctor who decides whether the medicine is suitable for dose dispensing. If this is the case, dose dispensing can in principle not be deselected. If the citizen does not want a dose dispensation, he or she is referred to private home care, which in that case distributes the medicine.

Finally, there is some involvement of volunteers and the third sector. More private suppliers are also beginning to emerge, but this mostly applies to home services and care tasks.

6.2. Short summary

The involvement of patients, citizens, and relatives on individual level and to a lesser extent on organizational level has been high on the strategic agenda in all countries and self-governing territories.

Third sector, which includes charities, social enterprises, voluntary groups, and other non-profit organizations, only plays a small part in relation to home nursing and their contributions typically focuses on care and social initiatives.

Finland and Sweden are examples of countries who have formalized involvement and activation of patients and their relatives in legislation.

To capitalize fully on patient involvement it is recognized, there is a need for new competencies from the nursing staff as to apply a supportive and inclusive approach.

[95] Ålands hälso- & sjukvård, 2021. Dosdispensering för patienter vid ÅHS hemsjukvård.

7. Concluding remarks

Four challenges were identified and outlined in 'Primary Health Care in the Nordic Countries - Comparative Analysis and Identification of Challenges'. In this report, focusing on the nursing functions outside hospital (home nursing), it seems clear, that there is also a common challenge to create the necessary speed in the transformation of healthcare and care delivery systems as to meet the present and emerging challenges.

What seems to be creating the biggest differences between the Nordic countries' ability to react and make the necessary changes when it comes to home nursing seems to be the geographical prerequisites and population density.

This means that some countries have been forced to e.g., transfer functions from doctors to registered nurses, and from registered nurses to other groups, earlier and to a larger extend than others. The same trend can be seen when it comes to the implementation level of digitalization and welfare technologies. Yet, there seems to be a potential across the countries for fast and full implementation of technologies already pilot tested and evaluated with positive results in other countries or smaller geographies.

The biggest problem may come from the combination of the challenge of shortage of nurses and the challenge of the growing complexity of the nursing tasks to be handled within the primary sector. There is no obvious one solution to this problem, and it is clear there is a need for a coherent set of different actions and transformations enacted within a very short time span. It is also clear that the challenges cannot be met without cross-sectorial actions from the primary and secondary healthcare sector.

Appendix

Key informants interviewed from each country and self-governing territory

COUNTRY	RESPONDENT	ORGANISATION
Denmark	Karen Marie Myrndorff	Local Government Denmark
Denmark	Steen Dalsgård Jespersen	The Danish Health Authority
Denmark	Elsa Martha Eriksen	The Danish Health Authority
Denmark	Helle Winther Dahl	Danish Nurses Organization
Denmark	Annelise Norlyk	Department of Public Health Aarhus University
Faroe Island	Æna Reinert	Faroese Nurses Association
Faroe Island	Óluva í Gong	Faroese Nurses Association
Faroe Island	Sunnuva á Lakjuni	Klaksvík Municipality
Faroe Island	Per Johannessen	Klaksvík Municipality
Faroe Island	Marna Ellingsgaard Jensen	Klaksvík Municipality
Finland	Anna Haverinen	Association of Finnish Local and Regional Authorities
Finland	Seija Viljamaa	Ministry of Social Affairs and Health
Finland	Marjaana Pennanen	Ministry of Social Affairs and Health
Finland	Teija Hammar	The Finnish Institute for Health and Welfare (THL)
Greenland	Henrik L. Hansen	The National Board of Health/ Landslægeembedet
Greenland	Inuuti Fleischer	Region Sermersooq
Iceland	Sigurjón Norberg Kjærnested	The Icelandic Nurses' Association
Iceland	Berglind Magnusdottir	Reykjavik Municipality
Iceland	Ásthildur Knútsdóttir	Ministry of Health
Norway	Liv Tveito	The Norwegian Directorate of Health
Norway	Siw Helene Myhrer	The Norwegian Directorate of Health
Norway	Ingvild Konttorp Haugen	The Norwegian Directorate of Health
Norway	Abiel Øvrebø	Lier Municipality (+representative in the Norwegian Nurses Organization)
Sweden	Iréne Nilsson Carlsson	National Board of Health and Welfare
Sweden	Lena Karlsson	Swedish Association of Local Authorities and Regions
Sweden	Ingrid Hellström	Professor at Linköping University
Åland	Magnus Sandberg	Åland Municipal Association
Åland	Ann Forsbom-Greiff	Åland Health Care (ÅHS)

Danish Health Authority
Islands Brygge 67
2300 Copenhagen S

www.sst.dk

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