Out-of-hours organization and emergency preparedness schemes in the municipal health, care and child welfare services – English summary

This report discusses the municipal tasks related to out-of-hours emergency primary health care, municipal emergency centers (so-called "KAD-units"), personal safety alarms, preparedness to receive patients ready for discharge, emergency preparedness in the child welfare services outside of ordinary office hours and shelters for victims of violence and abuse. The aim of the project was to document the development in the scope of the municipal' tasks related to emergency preparedness within the health, care and child welfare services, to evaluate the municipalities' costs associated with these tasks, and to provide examples of resource-efficient organization and cooperation between the various emergency preparedness services.

Development in requirements for the out-of-hours organization and emergency preparedness schemes

Within most areas, the requirements for and expectations of out-of-hours (OOH) organization and emergency preparedness schemes have become more stringent in the recent years. The most important changes are:

- More stringent competence requirements for medical doctors participating in out-of-hours emergency primary health care and for the operators of local emergency centers
- Requirement that all municipalities should have emergency centers ("KAD-units") for somatic patients and patients with mental health and substance abuse problems
- Municipalities are responsible for more advanced patients due to shorter hospital stays and earlier discharge, or otherwise pay for "excess bed-days" in hospitals
- Requirement of a formalized emergency preparedness in the child welfare service
- Requirement that the municipalities should have a shelter service for their residents

Due to increasing and more stringent requirements for emergency preparedness, many municipalities struggle to ensure sufficient capacity and expertise in the services they provide.

Costs

Emergency preparedness has considerable costs, and the costs of OOH organization and emergency preparedness schemes vary between the municipalities. This indicates differences in cost-effectiveness. Variation in costs is also linked to economies of scale: Large municipalities and municipalities participating in inter-municipal cooperation have lower costs than smaller municipalities that organize emergency preparedness on their own. This is particularly evident for out-of-hours emergency primary health care. Small municipalities with their own emergency primary health care without inter-municipal cooperation, on average have a cost per inhabitant that is several times higher than that in larger municipalities, or in municipalities that collaborate with others about emergency primary health care.

Organization to ensure resource-efficient schemes within today's legal requirements

No single model exists for the organization of emergency preparedness that appears appropriate for all municipalities. The municipalities are organized differently in the way they deliver emergency preparedness services. The main difference is between municipalities that participate in inter-municipal cooperation and municipalities that organize their emergency preparedness services without collaboration. Which model is most appropriate depends on various factors in the individual municipality and in the neighboring municipalities. The most important factors influencing which

model is most appropriate are the municipal's economic situation, geographical distances (long travel distance/ emergency response time), and capacity and competence to ensure preparedness according to the requirements.

In many of the municipalities, inter-municipal cooperation appears to be advantageous for the organization of a majority of emergency preparedness schemes. This particularly applies to out-of-hours emergency primary health care, reception of personal safety alarms, emergency preparedness in child welfare services and shelter services. Inter-municipal cooperation in these emergency preparedness schemes provide the municipalities with a stable and robust service by bringing together capacity and expertise, and appears to be resource-efficient.

For municipalities with available capacity and competence in their own institution it is advantages to organize "KAD units" within the municipality. "KAD-units" are resource-intensive and the need to use these units may vary. Operation in-house allows for more flexible use of the units and contributes to better utilization of both the expertise and the units. For smaller municipalities that typically lack capacity and competence, it is difficult to take advantage of such benefits.

Challenges for small and sparsely populated municipalities

In general, small, sparsely populated municipalities with large geographical distances have the greatest challenges. For these municipalities, it is difficult to ensure sufficient capacity and competence for the emergency preparedness services. The challenges may be solved through inter-municipal cooperation. For some municipalities, however, geographical distances, challenging travel routes and / or lack of competence and capacity in the neighboring municipality will imply that a collaboration will be difficult or even impossible to establish. These municipalities experience large expenses and challenges in securing the competence to fulfill the emergency preparedness requirements. As small municipalities also often have few cases that require acute response, the emergency preparedness requirements are perceived as costly.

The municipalities find that new requirements and expectations create even greater challenges, especially municipalities that initially have difficulties in recruiting skilled personnel within the relevant services. In particular, the new competence and staffing requirements in the Emergency Medicine Regulations and the requirement for formalized emergency preparedness in the child welfare service represent a challenge.

Opportunities for comprehensive preparedness across OOH organization and emergency preparedness schemes and other agencies

Requirements and expectations are set separately for the OOH organization and emergency preparedness in the various services. This implies that there is no focus on the overall challenge facing the municipalities. Opportunities for organizing efficient and comprehensive preparedness across schemes depend on synergies to be obtained. Synergies can be realized if there are overlapping requirements for capacity and competence in OOH organization and emergency preparedness across schemes.

Opportunities to **coordinate** OOH organization and emergency preparedness schemes across health, care and child welfare services are limited: The various schemes require different competence. A coordinated unit can thus only work if it employs professionals that cover all areas of competence in health, care and child welfare. It is unlikely that a co-organization based on the same resources that is needed today can contribute to great savings. We have, however, seen a potential for more **interaction** (contact and communication between different services) across the OOH schemes and emergency preparedness systems within the health, care and child welfare area, and with other agencies in the municipality.

For emergency preparedness in the *health, nursing and care services*, the potential lies in co-location or physical proximity between OOH emergency primary health care, municipal emergency care and care for patients ready for discharge from hospital, and functions from the specialist health service (e.g. in a health center, local or district medical center). However, the municipalities have

different experiences in interacting with the specialist health care services. Most municipalities find that hospitals discharge patients without considering the municipality's capacity and competence to take care of patients who still need extensive treatment and follow-up.

For the *child welfare service*, important collaborators include the police, out-of-hours emergency primary health care and other health services. Police and health services are often the first to discover acute problems where the child welfare service needs to be involved. Good communication between these bodies is therefore important to deal with cases of violence and abuse at an early stage. In most municipalities, it seems that the communication between the child welfare service and other bodies works well. However, several find that there is room for improvement in the collaboration.

Lastly, for the *shelters for victims of violence and abuse* this report shows that many municipalities lack knowledge of the types of issues and user groups the shelters deal with. As a result, municipalities are to a lesser extent able to develop preventive measures to capture the shelters' user groups. Municipalities with limited contact with the shelters and limited knowledge of the problems and user groups should establish channels for regular communication and information exchange between their administrative management, the shelters and relevant other municipal services.