How The Coordination Reform's affects the municipal health and care sector

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Report IRIS - 2014/382

This study investigates how municipal financial responsibility for patients cleared for discharge from hospital affects municipal health and care sectors. This is one of the financial incentives introduced by The Coordination Reform.

The data collection and -analysis consist of two parts. The analysis in part 1 is based on registry data and describes developments on some central indicators in the health and care sector during the period 2009-2013. The analysis in part 2 is based on qualitative interviews with a broad sample of informants from twelve municipalities. The indicator analysis draws the big picture, while the interview data add depth and nuance. The indicator analysis is based on central tendencies, and it is important to keep in mind that it may not necessarily provide adequate descriptions of developments in individual municipalities.

Main findings

- **Patients cleared for discharge by hospitals are generally in worse health than prior to The Coordination Reform. They leave hospital with more serious, more treatment-requiring, and/or more complex medical ailments.**
- **The character of the municipal health and care services is changing in the direction of more specialized, short-term, treatment and care. The share of short-term beds and beds dedicated to habilitation/rehabilitation is growing, but this is happening at the expense of long-term beds. Real-term capacity increases are rare.**
- **The threshold for being granted home care or a place in a nursing home has been raised. The development of more specialized services happens at the expense of basic services. This may in turn limit the preventive effects of basic services.**
- **Reducing the number of nursing home residents, as well as the stability of the share of the oldest cohort receiving home care, may indicate that the build-up of short-term treatment- and follow-up services for patients ready to be discharged may have harmed municipalities' ability to provide long-term care for the elderly.**
- **The Coordination Reform does not provide economic incentives for primary preventive health care among the elderly, and few municipal resources are devoted to this.**
- **The reorganization challenges seem bigger in large than small municipalities.**
- **The professional level of ability has improved in several municipalities. This has made the staff's work more interesting, but it is unclear whether the professional level of ability has improved sufficiently to handle the varied needs of patients.**
- **It is unclear whether hospital-municipality coordination regarding individual patients has improved.**

- **Reporting of deviations from the mandatory discharge agreement between municipality and hospital varies. Interviewees in several municipalities say they do not have the time to report deviations, and that reporting has little effect.**

Sicker Patients

There is a consensus that patients reported ready for discharge by hospitals are generally in poorer health, meaning they suffer from more serious, more treatment-requiring, and/or more complex medical conditions, than prior to the Coordination Reform. At the same time, the number of hospital discharges is on the rise, and the discharges are processed faster. The majority of those discharged are older patients well-known to the health and care sectors, as they already are in the system.

Newly operated hip fractures, sores, neurological disorders, intravenous antibiotic treatments, respiratory disorders, blood transfusions, cancer treatment, palliative care and increasing frequencies of multi-morbidity are all brought up by our informants as examples of new challenges in the health and care sector. Patients who previously would have remained hospitalized until the completion of medical treatment are now declared ready for discharge as soon as the treatment is judged to answer and the patient shows signs of improvement. Municipal medical costs have increased significantly, confirming the notion that hospitals discharge sicker patients.

The Changing Nature of Municipal Health and Care Services

The nature of municipal health and care services appears to be changing, towards more short-term and specialized treatment. Short-term bed capacity in municipal nursing homes remains a critical factor in order to ensure that patients ready to be discharged receive quality care close to home. A high capacity may facilitate seamless transfers between hospitals, municipal institutions, and the home care services. The main function of short-term bed capacity is rehabilitation, treatment, examination, and support. The share of short-term and rehabilitative bed capacity is increasing, but it does so at the expense of long-term treatment capacity. Real-term capacity increase at municipal institutions happens to a limited degree.

Some processes are clarified and amplified as a result of The Coordination Reform. This includes the increase in short-term and (re)habilitation capacity, and the number of nurses per institution. Medical costs, particularly in the home care services, have increased with the implementation of the reform. These are most likely the areas where the reform's effects are the most immediate, and they particularly pertain to the transfer and treatment of sicker patients.

Other processes of change have persisted over time, with the rate of change subsequent to the reform being much what it was prior to it. These include the increasing number of attending physicians in nursing homes, the capacity of user-focused services, and the share of qualified nurses in the home care services. The informers say that this is due to rising demands for medical treatment, developments in part believed caused by The Coordination Reform.

Other important areas have seen less change following the reform. Among these are the number of residents per institution, and receivers of home care services among the oldest age cohort. It is unclear if and how this relates to the reform. The positive, but less probable, explanation is that the reform has had a preventive effect and reduced the demand for services. The negative, and more probable, explanation is that hospital patients cleared for discharge to some extent supplant other seniors from health and care services.

Raised Thresholds and More Specialization

A clear tendency in our data is that the threshold for being granted a place in a nursing home, as well as home care services, has been raised. There is a lack of institutional rehabilitation capacity, short-term as well as long-term. Keeping short-term capacity free in order to receive patients cleared for discharge is challenging. The consequence is that some short-term patients are offered twin rooms, and that established relief services for elderly still living at home (in particular the demented) are down-prioritized.

The establishment of dedicated short-term wards has introduced a new health care service to most municipalities. Short-term stays become shorter and more concentrated, and are upgraded with respect to personnel and equipment. These can be interpreted as signs of a more specialized service where the municipalities, like the hospitals, become more diagnosis- rather than person-oriented. We find the same tendency, a shift away from general to more medical nursing and care, in the home service.

The purpose of The Coordination Reform is partly that municipalities shall take over the responsibility for some of the services previously administered by the specialist health care providers, and partly that the municipalities should be given incentives to do more preventive work. Paradoxically, the increasing specialization may supplant simpler nursing and care services, thus reducing the preventive effect these may have.

Who Lose?

In most of our case municipalities, informants have told us of patient groups being down-prioritized because patients ready for discharge are being prioritized. This is, however, a topic several informants have not wished to discuss. To the extent that specific patient groups are highlighted, they tend to include demented patients living at home, as well as patients with mental and/or drug problems. The informants are worried about patient groups lacking clear public voices, those without resourceful next of kin, and those without clear diagnoses but still in poor health.

The reduced number of inhabitants in institutions, and the reduced stability of the share of the oldest cohorts receiving home care services, may indicate that the build-up of short-term treatment- and follow-up services for patients ready to be discharged may have harmed long-term services for the elderly. The qualitative data material partly confirms this impression. A healthier population of seniors may also play a part. Short-term capacity being allocated to long-term patients, and vice versa, tell of a shortfall in capacity but also of flexible adaptation. Demand exceeds supply. This seems to result in stricter criteria for the granting of long-term services than previously. Although it is a stated goal that the elderly keep living at home as long as possible, it is hard to imagine that the demand for long-time capacity will fall given the expected rise in the senior population and of life expectancy.

The Need for More Primary Prevention

There are no direct economic incentives in The Cooperation Reform for conducting primary preventive care among the elderly, and in spite of extra resources being made available for this purpose in some municipalities, the general trend is that is not prioritized. As a consequence of the Cooperation Reform, municipalities increasingly concentrate their resources around caring for the very ill, and this is prioritized above primary preventive care. It is rational for the municipalities to set their priorities thus, as they face economic repercussions if they do not manage to provide for patients cleared for discharge. The scheme where municipalities immediately start covering the costs

of patients cleared for release has, in other words, contributed to a limited degree to freeing up resources for primary preventive care. These are the two incentive schemes introduced by The Cooperation Reform – and none has furthered primary preventive care.

The home care services are introducing or planning measures to improve rehabilitation efforts, in order to deal with increased demand, but these are early days. If improved home care rehabilitation is to be achieved, targeted economic incentives may be needed. Such measures will produce long-term gain if they postpone or avoid illness.

Bigger Challenges for Bigger Municipalities

The situation created by quicker transfer of patients declared ready for discharge is handled in different ways by different municipalities. Bigger municipalities face considerably bigger challenges than small, and they have primarily focused on structural changes to their capacities and organization. Smaller municipalities have instead preferred to make minor adjustments to their allocation of personnel and nursing home beds.

Both big and small municipalities have focused on not incurring extra costs by having patients cleared for discharge remain in hospital. The bigger municipalities' challenges with low institutional capacity have been underscored by their failing to accommodate the rising numbers of patients discharged from hospital, incurring higher costs now than when the reform was introduced. Our informants in smaller municipalities report few delays in transferring patients from hospitals, and these informants do not share the notion that patients discharged from hospitals are in worse condition than before. This is supported by evidence that smaller municipalities incurred higher medical costs than bigger in their nursing home services prior to the reform. It would seem that smaller municipalities experience The Coordination Reform as a formalization of an already established mode of operation, a notion particularly confirmed by informants from the Northern and Western municipalities far from hospitals.

Increased Demands for Competence

Our study cannot say conclusively that the municipalities' quality of care has been sufficiently raised to meet a wave of patients in worse health than before. Higher demands for formal competence in the health and care sector have been met by replacing auxiliary nurses with registered nurses, hiring more specialist nurses, increasing the presence of attending physicians in nursing homes, changing how resources are allocated in the course of the day, and focusing on learning and dissemination both inter- and intra-institutionally. Our informants say that The Coordination Reform has made their work more challenging and interesting, especially as it pertains to short-term patients. Several of the attending physicians interviewed confirm the professional challenges have increased following the Reform. Compared to the interviewed nurses, they are less assured of the nursing homes' capacity to adequately solve their new tasks.

Better Cooperation?

Our informants cannot answer conclusively as to whether the cooperation between municipalities and hospitals on individual patients has improved. They point out that the increased tempo in which patients are discharged, and the hospitals' prerogative to declare a patient for discharge, lead to poorer cooperation. The information following individual patients out of the hospital tends to be poor, which is not a new problem in the health and care sector, but in combination with earlier discharge makes the problem potentially more dangerous than in the past.

There are variations between municipalities as to how they handle deviations from the mandatory discharge agreement and the extent to which such deviations are reported. Some municipalities have routines in place, while others consider oral dialogue between the parties a better strategy. This, however, prerequisites a short geographical distance between hospital and municipality.