Healthcare and Elderly Care in Europe

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Institutions, Challenges, and Solutions for Better Coordination

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Thomas Bahle, Mareike Ariaans, Katharina Koch, and Claus Wendt
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1. Healthcare and elderly care in Europe: an introduction

This book provides a cross-national analysis of coordination problems in healthcare and elderly care systems. We focus on four European welfare states with well-developed but differently institutionalized healthcare (HC) and long-term care (LTC) systems: Germany, the Netherlands, Sweden, and Switzerland. The empirical data are drawn from official records and from interviews with major stakeholder organizations in the four countries.

When reaching old age, many people become dependent on social support. Their opportunities and resources are limited in many cases. Potential support networks tend to decline. At the individual level, this lack of resources and capabilities in old age has always existed and was often more severe in the past. At the societal level, the high dependency of large groups of older people is a more recent phenomenon, which has been predicted in many ways, but arrangements to cope with the consequences of these challenges have not been made to a sufficient extent.

Coordination between healthcare and long-term care systems is a major challenge in all mature welfare states, exacerbated by demographic aging. The number of people over the age of 80 has strongly increased and will continue to grow.[1] Modern societies had already realized the need for social care systems in the early 1990s. The German social care system, for example, was institutionalized in 1995, more than a hundred years after the introduction of social health insurance. Of course, elderly care homes, home care, and other arrangements had been set up long before, and the poor houses dating back to the 18th century provided shelter for many old and poor people (Alber, 1982; Bahle, 2007).

Over a long time, the pressure to take political action grew. The burden on traditional forms of support, in particular the family, increased. At the same time, families' capacities to care for older family members decreased. Women, who as partners, daughters, and daughters-in-law had shouldered much of the social care for family members for decades, increasingly entered the labor market. Their time resources therefore declined. Besides the family, the second institution responsible for fragile older people was the healthcare system. Older people sometimes spent longer time in hospital than medically necessary if they were not able to care for themselves but social or family care after the

hospital stay could not be arranged. We do not address in this book, however, the great importance of religious associations, which for centuries have provided various services to older people. Today, many of these institutions, such as elderly care homes, are part of the long-term care system, and we include these associations and organizations in our analysis but without discussing their important historical role (see, for instance, Alber, 1982; Bahle, 2007).

After the set-up of LTC systems, transitions of clients between different healthcare and social care organizations have remained critical junctures in the process of care. Examining these processes and the relationships between the organizations involved is at the core of this comparative book. These critical pathways can be analyzed from various angles, with the field of health service research being the most established one. The question of how this process is coordinated and which actors are mainly responsible for ensuring that individuals receive the right treatment at the right time has been less studied. And there are even fewer comparative studies that focus on studying the view of organizations with respect to this book's guiding question of who is and should be responsible for coordinating the process of care for older people.

Coordination is a structural challenge that requires an institutional answer. In general, and independent of the particular context of action, institutionalization processes are the result of problems that are not solved by existing institutions and are therefore externalized (Lepsius, 2017; Wendt, 2017). Externalization of care for older people to another context of social action always takes place when the care requirements cannot be met within the institution of the family. Processes of institutionalization and de-institutionalization always follow the change in values in the society. Values such as women's rights, which include financial independence and labor market participation, reduce women's time resources for the care of close family members. These changes are partly in conflict with values and beliefs that support the acceptance of traditional care within the family. Furthermore, it is uncertain whether these developments correspond to the wishes and needs of older people in need of care.

A second phase of extensive institutional change started when services that did not involve medical care were increasingly externalized from the hospital. Long hospital stays were partly the consequence of a lack of care outside the hospital, so patients not in need of medical treatment often received social care in the hospital. The process of reducing the length of hospital stays had already started in the mid-1970s, and this externalization process accelerated with the introduction of diagnosis-related group (DRG) systems, which began in most European countries in the 1990s (Schmid et al., 2010; Wendt, 2013). The pressure to develop new institutional solutions outside the healthcare system therefore increased.

Social care systems, in contrast to healthcare systems, are not designed to cure and restore health. Values important to social care systems range

from providing the basic needs of daily living to enabling older people to lead independent and self-determined lives. The value conflicts in the newly institutionalized social care systems have not yet been solved, and it is not predictable which values will finally prevail. A value of great importance for the institutionalization of social care systems is aging in place: the deep wish of most elderly people to live in their homes until they die. Earlier discharge from hospital is therefore consistent not only with the economic forces that have increased with the introduction of DRG systems but also with the values and perceptions of the group of older people as well as of society at large. Furthermore, older people have a strong desire not to become a burden on close family members. The institutionalization and professionalization of elderly care, therefore, seems to correspond to the changing values in modern societies.

Besides discharge processes from hospital, we focus on home care. Both contexts of social action, the transition from hospital care to home care and the integrated care of older people at home, require intensive, comprehensive, and flexible coordination. The needs and wishes of the people in care are highly diverse because they depend on patients' social and health conditions as well as on their resources and potential support networks. Coordination is not only a question of better aligning the HC and the LTC systems. The service package for elderly persons is complex even if provided within one single system. It usually combines social and health-related care as well as supplementary services such as housekeeping or meals-on-wheels, often provided by different actors operating in different regulatory contexts and at different times. The inherent complexity of these services is the key to understanding why coordination is a problem in all countries. For this reason, it is insufficient to analyze coordination by exclusively looking at formal institutional arrangements or policies at the macro level. Coordination is in fact a set of practices that come into play during the process of active service provision. Analyzing the role of actors and how they respond to changing institutional structures is important in order to better understand how the coordination of HC and LTC services actually takes place in different countries.

High coordination requirements can also be the consequence of institutional barriers established by previous institutions. For the long-term care system, these powerful institutions are the family and the healthcare system. In an institutional context in which support from family members is reduced, additional care outside the family is required at an early stage but without necessarily going beyond the quality of care provided within the family. Therefore, care workers with comparably low qualifications can potentially be employed, as is also the case with personal carers. Such developments increase the coordination requirements because these services need to be adjusted toward being services provided by more professionalized healthcare personnel. At the same

time, semi-skilled social care workers will not be able to fulfill coordination tasks for which high qualifications are required.

The HC system is a highly developed institution with established professions and hierarchies. For LTC systems, the institutional precedence of healthcare systems has assets and drawbacks. It is a possible advantage that the processes of care and their requirements, as well as the existing gaps and therefore the responsibilities of the LTC system, are largely predefined by the healthcare system. In principle, a precise identification of the tasks and responsibilities of the LTC system helps to assess the number and qualifications of the required LTC workforce. This assessment, however, is undertaken from the perspective of the HC system, which, with its focus on curing, follows different guiding principles than the LTC system, with its focus on caring. Other possible disadvantages of the institutional precedence of HC systems are often related to strict hierarchies in the field of healthcare, with the medical profession at the top. Institutional borders between HC and LTC due to the different values and interests of the actors involved are further reinforced by different modes of financing. At the same time, the earlier developed HC system often seeks to expand hierarchies established in its own context of action toward the LTC system.

An institutional core of many HC systems with relevance for LTC systems is the establishment of general practitioners (GPs) as gatekeepers with comprehensive coordination responsibilities. If gatekeepers are institutionalized, they are—except in cases of emergency—the first point of contact and therefore the primary care doctors coordinate other healthcare services for their patients and, if necessary, transfer patients to specialist care inside or outside the hospital. Primary care doctors or primary care centers collect and coordinate much information with relevance to their patients' health. In such an institutional context, which some of the countries studied here have set up, the GP is a potential candidate for coordinating care processes between HC and LTC systems. At the same time, healthcare systems in which the GP has a strong position often have lean hierarchies, and other professions such as nurse practitioners have been established. Higher levels of qualification among nurses have the effect that other professionals besides medical doctors can take over coordination tasks in HC and LTC. Interestingly, digitalization in healthcare and social care is often more developed in healthcare systems with strong primary care institutions and gatekeeping than in healthcare systems with a free choice of doctors and direct access to different general practitioners and specialists (Thiel et al., 2018). Establishing an actor or organization with comprehensive coordination responsibilities, in this case the primary care doctor or center, seems to foster processes in which further coordination tools and responsibilities are defined. In our four-country comparison, we analyze whether this pattern can also be identified in infrastructures outside the healthcare system.

Coordination of healthcare and social care services is not an end in itself. The primary goal is to harmonize processes of care in a way that they meet the wishes and needs of older people. Whether coordination is successful could be analyzed by studying older people's satisfaction with existing services in HC and LTC. However, it is important to keep in mind that the target group and its particular needs, for instance in the case of dementia, are not easy to assess. Second, satisfaction studies have to consider historically developed expectations (Wendt, Mischke, & Pfeifer, 2011), and therefore even highly effective systems sometimes generate lower levels of satisfaction than systems of a lower quality that have improved in recent years. This is one reason why we decided to assess the responsibilities for coordination in the care process of older people through interviews with the organizations in charge of care. These expert interviews constitute the empirical basis of our comparative volume. This perspective also requires an understanding of the respective context, and higher-quality service provision could also raise the expectations of providers, with the result of negative assessments by organizations if progress is lacking.

To be able to include and analyze different institutional contexts at the system level, we selected HC and LTC systems with common features but also specific institutional differences. In Germany, a health insurance system was established in which the medical profession has already had a dominant position from the early 20th century. The healthcare system is characterized by a strict hierarchy, and other occupational groups are subordinated to medical doctors. The principle of primary care doctors with strong gatekeeping is not fully established, and the number of general practitioners is small compared to specialists. There is a strict separation, also in financial terms, between inpatient and outpatient healthcare, which already negatively affects the continuity of patient care within the healthcare system. The LTC system had been institutionalized in 1995 according to the model of the health insurance system, with the German LTC system being characterized by a large number of service providers that are small in size and compete with each other on the care market. At the same time, the care of older people is influenced by conservative elements of the German welfare state. The family receives a high level of support, and in line with the principle of subsidiarity, mutual help within the family is fostered and demanded. The number of people working in the LTC system is comparatively small. On average, they are well qualified but without strong academization and without the possibility of reaching a professional level similar to medical doctors in the healthcare system.

In the Netherlands, the healthcare system developed in parallel with the German one for many years. The primary care doctor model and gatekeeping, however, were institutionalized quite early. The primary care physician collects and forwards necessary information in the healthcare system and decides about necessary further treatments inside or outside the hospital. General

practitioners not only have comprehensive responsibilities but are also large in number. The number of specialists is comparatively small, and they mainly work in hospitals, with only a few working in an outpatient practice. In hospitals, inpatient and outpatient specialist treatment takes place, and if general medicine is involved, hospitals cooperate with primary care doctors or centers. The processes of patient transfer within the healthcare system are therefore less complex than in Germany. The LTC system in the Netherlands is financed from social insurance contributions for HC and LTC as well as other public and private resources, depending on the care provided. While residential care is mainly organized within the LTC system, home care is mainly financed by health insurance funds and organized by district nurses, and home help services are financed and organized by municipalities. LTC personnel are on average well qualified. While in Germany none of the involved professions seems to be the obvious coordinator of HC and LTC services, in the Netherlands there are two: general practitioners in the HC system and district nurses in the LTC system.

In Switzerland, private insurance was predominant in healthcare for many years. Since 1996, insurance has been mandatory but is still mainly provided through private insurance companies and financed through per capita premiums with public subsidies in case of financial need. Health insurance today is strongly publicly regulated and since 2011 includes nursing care, but with capped benefits only. Since health insurance is mandatory and publicly regulated, the OECD counts most expenditure in this sector as public, and since nursing care benefits are capped, the share of private out-of-pocket payments in LTC is among the highest in the OECD. Nonetheless, the LTC sector is highly developed in terms of personnel and is also among the most professionalized systems in the OECD. Like in Germany, healthcare is dominated by specialists who, in outpatient care, primarily work in smaller units. Gatekeeping is supported by financial incentives, which is why the primary care doctor principle is more established than in Germany. However, depending on the particular insurance contract, patients may have direct access to specialists and a free choice of doctors. Within the healthcare system, coordination through primary care doctors, therefore, is restricted or rather depends on the insurance.

In Sweden, the healthcare system is based on public organization and tax financing to a much larger extent. Gatekeeping and primary care doctors are firmly established, and these doctors have coordination responsibilities for processes of healthcare outside the hospital. Municipalities are not only responsible for primary care but also for organizing the LTC system. They manage the system at the local level and operate as the first points of contact for persons in need. Services can be provided either directly as part of local social services or by private companies working on behalf of municipalities (contracting-out services). Personal carers with comparatively low qualifica-

tions represent the vast majority of LTC personnel. Primary care doctors and nurse practitioners in the HC system as well as higher-qualified nurses in the LTC system could take over coordination tasks.

The book proceeds as follows. Chapter 2 presents the theoretical and conceptual perspectives on which we base our main expectations with respect to the challenges of coordination of medical and social care for older people. We outline the cross-national institutional framework of the study and identify the levels that are relevant for coordination at the two critical interfaces: transition from hospital care to home care and integrated home care arrangements. In this chapter, we also explain the selection of countries and typologize the HC and LTC systems. Germany, the Netherlands, Sweden, and Switzerland represent specific models of coordination that may be similarly institutionalized in other HC and LTC systems. We identify other countries that are similar to the four countries under study. Chapter 3 describes the methods of our study. It provides details on the organizations we interviewed and how we conducted and interpreted the interviews. Together with secondary data, these interviews are the empirical basis of our study. We also lay out which organizations have been selected to identify the assessment of coordination problems as well as possible solutions on the basis of the interviews. Examples of organizations included in our interviews are GP organizations, LTC ambulatory service providers, hospital associations, and health insurance companies. Chapters 4 to 7 form the empirical core of our volume. Each chapter looks at the situation in one country. The purpose of the country chapters is to understand the coordination problems in their specific institutional contexts. First, we outline the main characteristics of the HC and LTC systems. With reference to the institutional context, we then analyze and interpret the interviews with organizations that are strongly involved in the process of care. We assess, for instance, the main problems in the coordination of care related to the respective institutional structures as well as possible means to address these deficits. The results are used in Chapters 8 and 9 to compare the coordination problems in the four countries and to suggest possible reforms on the basis of best practices. Chapter 8 looks at coordination from the perspective of professional challenges and solutions. We discuss coordination with respect to the involved occupations and professions. Our main question in this chapter is which occupations and professions would be accepted as care coordinators and have the necessary time resources and qualifications. Chapter 9 analyzes these challenges and solutions from the perspective of institutional regulations. The main question in this chapter is whether we can identify common institutional problems and solutions in the countries under study and which country-specific challenges exist. In the concluding chapter, we summarize our findings and make suggestions for future developments to better connect healthcare and long-term care in periods of deep demographic change and scarce resources.

NOTE

1. Between 2010 and 2050, the proportion of people over the age of 80 among the total population will grow from around 5 percent to 15 percent in Germany, from 4 percent to 11 percent in the Netherlands, from 5 percent to 10 percent in Sweden, and from 5 percent to 12 percent in Switzerland (OECD, 2021).

2. Theory: institutions and actors

2.1 INTRODUCTION

This study focuses on organizations' perceptions of coordination problems in healthcare and elderly care within different institutional contexts. In this chapter, we sketch out the theoretical and conceptual framework of the study. It combines a cross-national institutional perspective with an actor-centered approach. The focus is on coordination problems between healthcare (HC) and long-term care (LTC) as perceived by major stakeholder organizations. In line with institutional theory, we assume that different institutional settings have an impact on actors' perceptions of coordination problems as well as on their opportunities and constraints for imagining, developing, and implementing solutions.

The chapter proceeds as follows. Section 2.2 discusses the general theoretical approach based on sociological and historical institutionalism. Section 2.3 identifies the main coordination challenges between and within HC and LTC systems. The main focus is on the links between hospital treatment and ambulatory LTC and between medical and social care at home. Section 2.4 discusses systemic, organizational, and professional levels of coordination.

2.2 SOCIOLOGICAL AND HISTORICAL INSTITUTIONALISM

Institutional theory provides us with a number of concepts that guide the analysis. Hall and Taylor (1996) distinguish between three streams of institutional thinking: sociological, historical, and rational-choice institutionalism. A general assumption shared by all streams of institutional theory is that institutions pre-structure actions. The first two theoretical approaches are most relevant here because they conceptualize the impact of institutions on social actions (Hall & Taylor, 1996; Lepsius, 2017; Wendt, 2017).

Sociological institutionalism goes back to the work of Max Weber and his theory of social action. In our study, we particularly refer to an eminent contributor to this tradition in German sociology, Rainer Lepsius. In Lepsius' thinking, institutions build the bridge between general ideas and social actions. It is through institutions that ideas become "real" in actions and thus have

consequences for social life. Moreover, institutions are not a given product or a predefined set of rules. Instead, they should be conceptualized as processes, that is constantly changing processes of institutionalization or de-institutionalization. In the institutionalization process of a general idea, Lepsius (2017) identifies five main dimensions: (1) defining the key rationality criteria of the guiding idea; (2) establishing relevant social contexts for actions; (3) setting up rules and sanctions for these actions; (4) externalizing contingencies; and (5) solving potential conflicts plus establishing mechanisms for coordination with other institutions. Any successful institutionalization of a general idea for human action needs to develop on all these dimensions. The question of where the ideas come from is not a sociological issue in itself, but points to religious and cultural domains.

Regarding the institutionalization of HC and LTC, the two systems markedly differ in their basic features. The guiding idea in terms of Lepsius' theory of institutions, or in the words of Thornton, Ocasio, and Lounsbury (2012) the institutional logics, in HC is curing while in LTC it is caring. The rationality criteria therefore differ. For HC, it is medical treatment based on general scientific evidence whereas in LTC the main rationale is assistance in everyday living based on individual personal circumstances. In this vein, the main goals also differ. In the medical realm, success means preventing death and improving health whereas in the realm of LTC success means coping with everyday life and preventing social exclusion. Based on these rationality criteria and basic aims, the process of institutionalization establishes the social contexts that are relevant for social actions oriented toward these objectives. The most relevant social contexts are organizations such as hospitals, old-age homes, and ambulatory settings for curative and caring actions.

Let us first look at hospitals and old-age homes. Both are types of organizations. Lepsius (2017) reminds us that institutions should not be confounded with organizations. Indeed, within the same organization usually several guiding ideas and social contexts are active, sometimes conflicting, sometimes interacting with each other. He exemplifies this thought by the example of the university which is an organization that combines the guiding images and social contexts of science (knowledge production) and teaching (knowledge transmission), but also operates as an economic entity (for employees) and as a social space (for students and staff). While most observers would agree that the first two rationales are the paramount functions of a university while the latter two are secondary, the balance between the institutions of science and teaching is always ambiguous and shifting.

This example alerts us to being careful in our institutional analysis. In particular, we should not assume that the organization of a hospital or an old-age home would be fully compatible with the social action rationales aiming at either curing or caring. The hospital is not only a social context for

curative actions, but also for caring. Moreover, hospitals have increasingly become economical-oriented organizations seeking profit or asserting against competing hospitals or both. Management tasks that for many decades were in the responsibility of chief physicians have been increasingly transferred to hospital managers without a medical background (Kirkpatrick et al., 2016). These rationales and actors following them in fact often conflict with each other. Several policy reforms and changes at the organizational level of hospitals have weakened the medical for the benefit of the economic rationale (Rothgang et al., 2010). The same can be said with respect to old-age homes where privatization and marketization have also strengthened the economic rationale and therefore the institution of the market (Anttonen & Karsio, 2017; Ranci & Pavolini, 2013). Moreover, the growing importance of economic rationales in both sectors has increased the inherent contingencies in each of them and led to a further externalization of costs. In hospitals, the medical and economic rationales often go better together than the economic and caring rationales, or to put it differently: in the last decades the medical rationale has been more open to the economic than to the caring rationale. Thus, the caring "costs" have been increasingly externalized. Externalization of costs requires, however, the establishment of coping and conflict-solving mechanisms between different institutions. Uwe Reinhardt (1996) has shown how in highly competitive HC and social care systems, such as in the United States (US), externalization processes may result in cost increases in both systems. In a way, these developments may be regarded as typical processes of institutional differentiation and functional specialization, whereby caring is increasingly shifted outside hospitals and toward specialized caring organizations. However, even in European welfare states with a lower degree of competition than in the US, this shift does not go without transaction costs and therefore requires more coordination between specialized providers and further actors.

In the ambulatory social setting, circumstances are different. Economic rationales have also gained ground vis-à-vis both curing and caring, but the relationship between the latter two ideas is different compared to transition processes in the context of hospital stays. The question is less about the externalization of costs but rather about the internalization of benefits. Both curing and caring institutions need to cooperate in a shared social context so that both can be successful in realizing their objectives. Curing cannot effectively work without caring and vice versa. They depend on each other. Despite differentiation and externalization processes, the main issue therefore is not conflict but inadequate integration. The two institutional logics have historically evolved quite separately and largely independently from each other. The medical realm has been mostly evolved in private GP (general practitioner) practice while long-term care has been mainly established within families. These two institutional mindsets now need to develop mechanisms of exchange and cooperation

in a social context in which families are increasingly replaced by formal care workers. This requires a new momentum in the institutionalization process and presumably also a change in the guiding ideas and underlying values (Lepsius, 2017, in particular chapters 6 & 7).

If we seek to understand cross-national differences in the coordination between HC and LTC, we additionally need a second stream of institutional theory: historical institutionalism. Like sociological institutionalism, historical institutionalism has both internal and external dimensions (Hall & Taylor, 1996; Béland, 2005; Wendt, 2017). In Lepsius' (2017) concept, rationality criteria, social contexts for action, and sanctions are internal, whereas externalization of contingencies and conflict solutions are external dimensions (Lepsius, 2017, chapter 3). In historical institutionalism, drift and layering are internal processes, whereas timing and sequence are external dimensions (Mahoney & Thelen, 2009). According to historical institutionalism, institutions develop over time, which means that different institutions develop at different times and late-coming institutions adapt to the already existing ones.

Historical institutionalism has developed the concept of path dependence that is crucial for analyzing both internal and external dimensions of institution-building (Ebbinghaus, 2009). The main idea of path dependence is that once a specific institution is in place, it becomes difficult and costly to change it fundamentally or replace it. The main reason is that actions within the institution, but also external exchanges with other institutions in society, are all oriented toward existing institutional regulations. Historical institutionalism originally focused on the specific historical conditions under which institutions had once developed and on their continuing impact on social action even under changed circumstances. Yet, this idea of a long-lasting shadow of history has been increasingly replaced by concepts that are open to institutional change. Institutional drift or layering have added substantially to historical institutionalism (Mahoney & Thelen, 2009). Drift occurs if the original guiding ideas for social action are changed by practices from below and step-by-step. It is a gradual and bottom-up process of institutional change closely linked to actions. Layering instead occurs if new institutional elements are added top-down to existing institutions. Both drift and layering have the potential to changing institutions over time without questioning their original general ideas in a manifest conflict.

In this vein, the interface between HC and LTC can be regarded as the result of a historical process of multiple institutional layering. Everywhere, HC was the preceding system rather than LTC. The main reasons for this typical sequence were, first, that the family has remained the main care agency until today, while medical treatment became professionalized at least from the late 19th century onwards; and second, that medicine developed on a much larger scale, comprising the whole population, whereas LTC remained limited to

a specific, economically unproductive population group. As a result, LTC in all countries was the late-coming and therefore potentially adaptive system relative to HC.

Institutionalists like Lepsius (2017), Hall and Taylor (1996), Béland (2009; 2017), or Thornton, Ocasio, and Lounsbury (2012) generally refer to Weber's triad of interests, ideas, and institutions. Interests, respectively actors, are key for constituting institutions and defending its, in Lepsius' (2017, chapter 3) words, "validity context". They establish veto positions so that once they are established institutions often continue to guide social action even when the belief in their guiding ideas is waning. This is why early established veto positions of actors like the medical profession often maintain their power within institutions of HC provision even when other actors enter the field, and why preceding institutions like HC structure the "validity context" of later institutions like LTC. However, in her study of Swiss, Swedish, and French health policy, Immergut (1992) emphasizes that intense conflicts over more constrained resources reduce the veto power of medical provider groups (Marmor & Wendt, 2011; Immergut et al., 2021). Therefore, actors and institutions in HC and LTC as well as the interfaces between them are more open to change as the financial situation in both systems remains difficult.

Moreover, within both systems a second historical layering took place. In HC, the hospital sector was earlier and more strongly institutionalized than the ambulatory sector. Medical treatment by professionals was most strongly established in hospitals. In LTC, a similar development can be observed. Care by non-family members was earlier and more strongly established in old-age homes and homes for the poor than in private households. The ambulatory sector developed much later and has remained less professionalized until today. As a result of this double layering, there is a typical historical and professional rank order: HC came first and prevails over LTC and the hospital and old-age home sectors came before the ambulatory sector. This is a consequence of the different timing and sequence in their historical developments and of different degrees of professionalization.

In contrast to layering, institutional drift is a slower, at the beginning often undetected, process of change taking place inside institutions and driven from below. It is actors and actions that drive this change. Therefore, the question of how actors perceive the situation is most relevant, for two reasons. First, sociological institutionalism points to the fact that institutions live by and through social actions. Following Max Weber, the focus of sociological analysis is on social action. Institutions structure social action and thereby realize general guiding ideas (Lepsius, 2017, chapters 2 and 3). This process is always at risk of failure. Institutions can only operate successfully if the relevant actors believe in their basic ideas and follow the main frames of action within their social settings.

In this respect, the concept of trust plays a crucial role. According to Lepsius (2017), trust in institutions develops over time and is constantly at stake when there is disorder or change. Trust can have three main forms: trust in the guiding ideas themselves; trust in the results of actions; and generalized trust in the institutionalized order of the entire society of which the institution at stake is part. We leave the latter form aside, since this is most relevant only for basic social institutions such as democracy, the rule of law, or the welfare state. For medium institutions such as HC or LTC it is through ideas or results that trust can grow or equally decline. How actors assess the situation is crucial for both the institutionalization process itself as well as the evaluation of its results, since each actor contributes to the success or failure of the institution. In this vein, trust is a paramount generalized resource for institutionalization. Lack of trust may lead to a growing disorientation toward the guiding idea and eventually to significant institutional drift.

Studies on trust usually look at the wider population and how they perceive institutions. Studies have shown that trust in doctors, satisfaction with the results, and agreement with the underlying values such as solidarity and equity are important for building up trust in HC systems (Wendt et al., 2010; Wendt, Mischke, & Pfeifer, 2011; Immergut & Schneider, 2020) and that cost barriers not only reduce access to HC but also trust in the respective institution (Wendt et al., 2012). Going beyond these studies, we can take account of the institutionalization process itself by looking at actors in the field. We expect to identify signs of malfunction and mistrust leading perhaps to institutional drift at the point of emergence. In our study, trust has a second component which is inter-organizational trust. On the basis of interviews, we not only study how the institution as a whole is working from the point of view of an individual actor but also how this actor perceives the co-production of the institutional good together with other actors in the field. Actors may therefore identify major problems of malfunctioning either at the overall (system) level, at the inter-organizational, or at the inter-professional level in relation to other actors in the field. This distinction is highly important for thinking about success or failure in the institutionalization of caring and curing (see Section 2.4).

2.3 COORDINATION CHALLENGES

The analytical focus of our study is on the medical–social border where we expect the strongest and most severe coordination problems in elderly care. We study this border at two typical interfaces between the medical and the social care system: (1) transition from acute medical care in a hospital to home-based LTC; and (2) integrated medical and social care at home. The transition from hospital to home-based care must bridge the deepest institutional, organizational, and professional gaps between HC and LTC. The

home-based environment is the most demanding one for service coordination. Hence, both interfaces represent two highly critical challenges for coordination (see Table 2.1).

Table 2.1 Coordination challenges

Interface	Challenge	Institutional problems
Hospital → Home care	Bridging the gap between two different social settings	• Avoiding/managing externalization of costs • Establishing inter-sectoral communication/ cooperation
Integrated home care	Integrating different services and actors within one social setting	• Managing internalization of common purpose/ good • Establishing inter-professional communication/ cooperation

Source: Own compilation.

Coordination challenge 1: Transition from hospital to home-based care. The transition from acute hospital care to home-based care is a process which demands strong coordination and in which different actors from the HC and LTC systems are involved. In this process, the two very different reasonings of HC and LTC clash. HC in hospital is case-oriented, medical-dominated, and limited in time. Services are provided in a strict hierarchical institution dominated by the medical profession. In addition, economic rationales have increasingly gained a key role. The introduction of diagnosis-related groups (DRGs) in hospital financing regulations has altered both the content and time frame of service provision (Scheller-Kreinsen, Quentin, & Busse, 2011). People are dismissed from hospital not when they are able to perform the daily activities of life without assistance from others, but as soon as the acute medical treatment for which the hospital is necessary has ended, which means that earlier and with more limitations than before the introduction of DRGs, people are supposed to leave the hospital. For elderly persons in particular, this new regime is a major challenge and requires coordination mechanisms to provide for a relatively smooth transition without provoking the danger of early hospital re-admission. In all countries, the actors assess this transition as a major problem, but they perceive coordination practices and results quite differently. In most cases, the process is medical-driven, but the extent to which information is shared and collaboration across sectoral borders is practiced vary (see Chapters 8 and 9).

Coordination challenge 2: Integrated home-based care. Integrated home-based care is a constant challenge rather than a process. Integrated care usually includes medical, social, and supplementary service components. Often, these components are provided by different organizations and profes-

sions, and it is a major challenge to coordinate their services. Better coordination can either be achieved by domination by one profession, or by domination of one organization, or through collaboration and joint management. Although service provision is often formally medical-dominated, in practice social aspects and partly also supplementary aspects play a greater role. In fact, in this area formal competencies and real practices perhaps differ most, which means that the involved actors must use the space for maneuvering at their disposal and achieve pragmatic solutions. Our study seeks to find out if and to what extent actors use this space or whether constraints such as financial regulations at the system level or inter-professional conflicts hinder them from doing so.

2.4 LEVELS OF COORDINATION

In line with Valentijn and co-authors, we distinguish three coordination levels: system, organizational, and professional (Valentijn et al., 2013; Valentijn, 2016). These analytically separated levels are in practice strongly linked to each other. Coordination at one level may cumulatively impact on other levels or compensate for missing coordination at the latter. Coordination is a process that takes place in service provision, and we therefore analyze the perceptions of actors in this area. The distinction between the three levels of coordination is the conceptual framework with which we analyze and interpret these perceptions (see Table 2.2).

Table 2.2 Focus of analysis

Levels of coordination	**Key elements**
System level	• Scope of formal care services • Institutional regulations • Financing rules
Organizational level	• Local organization • Delivery structures • Market conditions
Professional level	• Division of labor • Hierarchy • Communication
Tools	• Electronic communication • Case management

Source: Own compilation based on Valentijn et al., 2013; Valentijn, 2016.

Coordination level 1: System. The system level defines the scope and boundaries of formal services, sets the rules, and regulates financing and access to services. The first distinction is which services are formalized and which are

not. Formalized service is at least to some extent regulated with respect to access and financing. The second distinction concerns the scope. Elderly care services have at least three components: a medical, a social, and a supplementary one. The medical component includes basic physical care and treatment. The social component covers most activities of daily living. The supplementary component includes home assistance, mobility, and other supplementary services not directly related to physical care of the client. Countries differ greatly in the kinds of services that are formalized. In some countries, the formal benefit package includes all three kinds of services, in other countries only one or two. This pattern is closely linked to the way in which services are provided and therefore to the professional level. The third distinction refers to the institutional boundaries with respect to the three service components. The three service components may all be integrated under a single system or they can be separated, each following different rules of access and financing. This is where countries differ most in the relationship between HC and LTC systems. Access rules have a strong impact on the extent of formal services and their actual usage. Public financing sets the frame for both service supply and demand on HC and LTC markets. Public financing is therefore closely linked to the organizational level.

The main cross-national differences at the system level concern three characteristics: to what degree elderly care services are formalized, which service components are covered, and how different components are allocated to HC respectively to LTC systems. Some of the countries have separate institutionalized LTC systems while others provide most services under the umbrella of the HC system. These institutional differences open up different risks and opportunities for the coordination of services by actors.

Coordination level 2: Organizational. The organizational level pre-structures service delivery, either in a hierarchical way or on service markets. This level is closely linked to the system level through access rules and financing regulations. However, it is not pre-determined by the institutional set-up. Rather, it constitutes an empirically independent dimension. Personal social services are defined as services on persons, which require a direct interaction between provider and client, and which are simultaneously produced and consumed. These basic features require both a specific time and space of service delivery. Personal services need local producers with direct access to clients. Apart from these basic conditions, service delivery may be organized to be monopolistic, oligopolistic, or in a competitive market environment. At one local place, one organization may be responsible for all services (e.g., local communities), a few organizations may split up the market (e.g., welfare organizations), or many smaller organizations may compete for clients. In practice, there is often a mix of the three market types, depending on the kind of service offered and local circumstances. A second major dimension concerns the "third" party

which is always present in *social* services (Rothgang et al., 2010). The market for social services does not only consist of suppliers and consumers of services, but also includes the third (public) party which rules access and regulates financing conditions. The third party may actually decide who has access to which services and may directly finance the organization responsible for delivering services either within a public organization or through contracting-out services to private providers. In this case, "quasi-markets" are established where clients have no direct individual choice, but in which purchasers of services may bargain on their behalf. The other extreme is a market in which the third party (the public domain) directly finances the client and leaves it up to him or her to seek and choose a suitable provider. We expect that these different purchaser–provider models have different effects on the coordination of services.

The main cross-national differences at this level concern two characteristics: to what degree are service delivery markets monopolized; and to what degree do different markets for different service components exist? In some countries, most services are provided under one umbrella and are almost monopolized, whereas in others, various organizations provide different kinds of services. These different structures presumably have a strong impact on actors' perceptions of coordination problems and their ability to influence coordination.

Coordination level 3: Professional. The professional level sets the conditions for the actual contents of services in different contexts. It is the core of the definition of a personal service since it concerns the action itself rather than the organizational structure or the institutional framework for action. At the professional level, the decision is made about what is done and by whom. The division of labor in actual service provision can be organized in different ways. One can distinguish between a hierarchical and a horizontal division of labor. Along the hierarchical dimension, various professions and occupations co-produce services. However, some professions or occupations decide, others execute, and others assist. This reflects the classical division of labor in the medical sector with doctors having a paramount position in the hierarchy whereas nurses, care workers, and particularly care assistants have much fewer competencies. A crucial question is to what extent these "medical" structures also influence elderly care services or whether a different division has gained ground. In the horizontal dimension, the main question is how far the different components of the service package (medical, social, and supplementary) are integrated or separated, i.e., "produced" by the same person or at least by a co-working team or by different persons working in different organizations at different times. We expect that these two extremes have different impacts on how actors perceive and solve coor-

dination problems in service provision. The same holds for professional settings which are strongly hierarchical compared to those with less hierarchy.

At the professional level, partly contradictory developments have taken place. In fact, professionalization and de-professionalization may occur at the same time, even within a single country or within one system (Ariaans, 2021; Pavolini & Kuhlmann, 2016). The division of labor among different professional groups in elderly care has changed in recent decades. Some segments of services have become occupationally dominated by a highly educated and trained workforce whereas in others untrained helpers and assistants have gained ground. A stronger division of labor in a more segmented workforce may facilitate hierarchical forms of coordination, but it sets limits to grass-root and case-oriented forms of coordination. At the same time, the rise of a professionalized LTC workforce offers new opportunities for coordination, but it may also generate or aggravate existing conflicts with the established medical profession, which hinders coordination. Here, too, we are interested in how the actors perceive the situation in their country and field of activity.

The main cross-national differences at the professional level concern three aspects: which role does the medical profession play in the division of labor; what is the professional or occupational background of the main workers in service provision; and to what extent are medical, social, and supplementary service components produced independently from each other? In some countries, the medical profession has also upheld a dominant position in LTC whereas in others a higher-educated professional LTC workforce has achieved higher levels of competency and autonomy. In most countries, medical and social components usually go together while supplementary services are outside the standard scope, but the professional and occupational level at which the social component is provided varies a lot between countries.

Since coordination refers to the process of actual service provision in different institutional and practical settings, the view of actors is crucial for understanding the main differences and similarities between countries. Actors may employ various practical tools assisting them in solving coordination problems. However, some tools may be used independently from the specific national and institutional background. Indeed, some tools can be employed in quite diverse settings. One key instrument of this type is information sharing through digital tools such as electronic patient records. Another instrument is case management in which client-oriented teams from different organizational and professional backgrounds cooperate not only in information sharing but also in decision-making. Our empirical results demonstrate that these tools are indeed widely used, but their effectiveness for improving the coordination process is perceived quite differently

by different actors. Not all countries are at the same level in using these instruments, but also here, a clear extension can be observed. Some national systems, however, show higher barriers for an extension of these tools than others. We are interested in which contexts these tools are regarded as effective for improving coordination. Furthermore, we are interested in the main loci of coordination problems and possible solutions identified by the actors.

3. Data and methods: interviews with stakeholder organizations

3.1 INTRODUCTION

This chapter briefly describes the main data sources for the subsequent country chapters and the two comparative chapters. The main sources are face to face and online interviews with stakeholder organizations in the field of elderly care in each country. The chapter sketches out which types of organization we selected for the interviews (Section 3.2), how the interviews were structured and conducted (Section 3.3), and how they were analyzed (Section 3.4).

We decided to conduct interviews with experts from organizations for several reasons. First, organizations accumulate knowledge and interests from their members and thus provide a coherent view on coordination problems from a specific perspective. Second, we interviewed different types of organization in order to gain a comprehensive perspective on coordination problems. Each organization has a specific task and view as well as particular interests concerning coordination. Conducting interviews with several different stakeholders allows us to gain several subjective insights but in combination with an objective view on coordination problems. Third, organizations are involved in policymaking and could thus tell us about their own initiatives and the general debates in the area of care coordination.

3.2 SELECTION OF ORGANIZATIONS

The study focuses on the coordination of elderly care services in the formal care market. We therefore contacted in each country organizations which are responsible for financing, organizing, or delivering formal care services in the HC (healthcare) or LTC (long-term care) sectors. Purposeful sampling was used to generate "maximum variation" (Emmel, 2013; Patton, 2015) in terms of perspectives on care coordination in each country. The purpose was to achieve a comprehensive picture on the actual care coordination problems and a wide spectrum of possible solutions. Hence, a wide range of different organizations were interviewed, including local governments, health and long-term care insurance companies from the private and public sector, non-profit and

for-profit care service providers, hospitals, and professional groups such as general practitioners, hospital managers, social care professionals, and (transfer) nurses. Of course, not all of these organizations have been interviewed in all countries, as either some organizations do not exist or are irrelevant for the process of coordination in the respective country. Likewise, in every country organizations such as client and consumer organizations were included, if these have been identified as relevant stakeholders. We identified relevant organizations in each country by conducting a literature review. In addition, some interview partners were recruited by means of snowball sampling (Bogner, Littig, & Menz, 2014; Schreier, 2018; Wassermann, 2015), which means that each interviewee was asked which, in their opinion, additional organizations we should interview. These organizations have then been contacted, in case they did not belong to the list of initially contacted organizations.

Table 3.1 shows the overall number of interviews conducted in each country and the number of interviews for different categories of organization. It is important to note that some organizations in the sample belong to more than one category. For example, in Sweden, municipalities are responsible for the provision and financing of LTC as well as for needs assessment. In this case, we listed the organization of Swedish municipalities in the category "home care provider", because this was the focus attributed by the interview partner. All organizations are thus just listed in one category in the table, according to their main focus.

Table 3.1 Interviewed organizations in each country

	Germany	Netherlands	Sweden	Switzerland
GPs	2	3	-	1
(LTC) nurses	2	2	2	1
Transfer nurses	1	1	1	-
Geriatrician	1	2	-	-
Hospital	1	-	-	1
(Home) care provider	3	1	4	2
Funding agencies	1	2	-	1
Supervisory agencies	-	1	3	1
Care assessment	1	1	-	-
Other (e.g., clients)	5	2	-	1
Total	17	15	10	8

Source: Own compilation.

Table A.1 in Appendix 1 shows for each country the name of the organizations (abbreviation, full national name, English translation), their function within the system, as well as information if the interview was conducted before or after the start of the COVID-19 pandemic. In case the organization is very small, not the name but the kind of organization is given. Furthermore, the table includes information on the main operation field of the organization (HC or LTC) and a short description of its main purpose.

3.3 STRUCTURE OF INTERVIEWS

We conducted 50 interviews in total: 17 in Germany, 15 in the Netherlands, ten in Sweden, and eight in Switzerland. The interviews were held in 2019 and 2020. All interviews before the COVID-19 pandemic were held face to face, usually at the organization's headquarters. Interviews during the pandemic were conducted via the video-conferencing tool Zoom. We contacted the interviewed organizations via e-mail informing them about the project and the purpose of the interviews and asking them to take part. In case organizations decided to participate in the study, they (sometimes including consultations with us) chose the person among themselves who should do the interview. Some organizations sent more than one interview partner usually because they had different areas of expertise and could complement each other. In two interviews, a second person additionally served as a translator. Usually, interviews lasted for 40 to 60 minutes.

We conducted qualitative guideline-based interviews, which means that we went with the same interview guideline into every interview. However, we adapted the general interview guideline for each country to account for national specificities, recent reforms, and discussions. The interview guideline was pre-tested, which resulted in minor modifications. Following a problem-centered approach, the interview guideline contained open questions about five different but interrelated topics about the coordination of elderly care aiming at initiating an open conversation on the views and experiences of the interviewed organization. The guideline was used flexibly during the interviews allowing for changes in the order in which topics were introduced (Bogner, Littig, & Menz, 2014). The five general topics of the guideline aimed at assessing how the organizations view: (1) recent developments in HC and LTC; (2) the transition from hospital care to home care; (3) the provision of integrated HC and LTC services at home; (4) the relevance and role of rehabilitative and preventative services; and (5) the importance of electronic tools and patient records for the coordination of care. In addition, we asked about the perceived and preferred responsibility for care coordination in particular for the second and third topics. The interview guideline was sent to the participants in advance in order to give them the opportunity to prepare

for the interview and to build trust between the researchers and the interview partners (Bogner, Littig, & Menz, 2014).

The interviews in Germany and Switzerland were conducted in German, whereas the interviews in the Netherlands and in Sweden were conducted in English (for the English version of the interview guideline see Appendix 2). One interview in the Netherlands was conducted primarily in Dutch from the side of the two interviewees, but questions from the interviewer were mainly in English (the interviewer had a good passive command of Dutch). This interview was later translated into English by a dual-speaker with a professional command of English and Dutch. Swedish and Dutch interviewees had a high command of English, and the matter of the research is not highly language sensitive. However, language problems and problems to express some topics in a detailed and nuanced way were considered when analyzing the interviews. All interviews were audio-recorded with the respondents' consent and transcribed and pseudonymized afterwards. During the process of pseudonymization, sensitive data, in particular names and places, have been replaced by pseudonyms to protect the respondents' identity (Kuckartz, 2014).

3.4 ANALYTICAL METHODOLOGY

The interviews were analyzed using qualitative content analysis (Mayring, 2015; Schreier, 2014). We wrote summaries for every interview and coded each interview with a deductive coding scheme. The coding scheme and the summaries followed the same rules for every country to ensure the comparability of results.

The coding scheme includes mainly deductive elements, but is supplemented by inductive ones (Kuckartz, 2018; Schreier, 2014; 2019). The coding system was tested and modified several times before coding the entire volume of material (Schreier, 2019). To ensure reliability, at least one interview from each country was coded by two different researchers. The software MAXQDA 2020 was used for coding. The interpretation and comparison of the coded interviews was the responsibility of the researchers (Silver & Lewins, 2020). The coding unit for the analysis was determined as one section of the interview, which contained only one particular topic or idea. Hence, a coding unit comprised at least half a sentence up to one paragraph (Schreier, 2019). All rules for coding were written down in a codebook which included both general coding rules and the final coding scheme. All codes of the coding scheme are defined in the codebook including examples from the interviews. The coding system and the codebook are only available in English so that all transcripts—German and English—are coded via this English coding system.

The coding scheme aims at structuring the information in the interviews into specific themes and thus makes the information of the interviews comparable.

In general, the coding scheme differentiates between two dimensions: "interface" and "integration level", which are based on the theoretical considerations and serve as the main categories. The interface dimension shows where a coordination problem exists (hospital to home care transition, home care setting, rehabilitation, electronic tools, general). The integration level shows on which level coordination problems mainly occur (system, organizational, professional, normative level). Integration dimension and interface level are always coded together. For each integration dimension, subject areas were differentiated, were built inductively, and served as sub-categories. The system level focuses on the macro level and the structure of the HC and LTC systems. Thematically, coordination problems, which arise from problematic access to HC or LTC services, insufficient supply of services, system fragmentation and thus unclear responsibilities, or by competing or insufficient regulations, are included in this level. On the organizational level, problems relating to organizational entities and relations between them are coded, including dysfunctional cooperation and competing or overlapping tasks of organizations. On the professional level, problems relate to the roles, responsibilities, and cooperation of different HC and LTC professionals. Coordination problems at this level are differentiated into training and education, communication between professionals of both systems, diverging interests and expectations, collaboration in inter-professional teams, and case management tools, which are understood and used differently. As the interviews take a problem-centered focus, integration level and interface are the most important and most used categories in the coding scheme. However, we included a problem-solving category named "responsibility", which contained statements on the desired responsibility for a certain interface. The responsibility level included codes relating to the specific actor: patient/family, GP, primary care center, home care provider, home care nurse, hospital transfer nurse/transfer management, district/community nurse, government/state, municipality/local entity, needs assessor, shared responsibility, and healthcare or LTC fund/insurance companies.

An additional step of analysis was summaries that were drafted for each interview. These summaries gave a short overview on the main evaluations made in an interview. These summaries provided a systematic basis to compare the main evaluations of coordination problems across all interviewed organizations in one country and across countries. The summaries included the main aspects that may have also been subjects of the coding scheme (Kuckartz, 2014). Each summary contained the main coordination problem(s) and possible solutions, and in particular the transitions from hospital to home care and in the home care context.

We need to mention two aspects that could limit the comparability of interviews, in particular between countries. First, we want to address several aspects relating to language. Most interviews in the Netherlands and Sweden

were held in English, which was the non-native language for the researchers and all interviewees. Although most interviewees had a good command of English, the information and discussions might have been more extensive and precise if the interviews had been held in their mother tongues of Dutch or Swedish (Resch & Enzenhofer, 2018). The second aspect that might limit the comparability of our results is the fact that some interviews were gathered before the outbreak of the COVID-19 pandemic (mainly in the Netherlands and Switzerland), while some others (mainly in Germany and Sweden) were conducted after the first wave of the COVID-19 pandemic in Autumn 2020. In the interviews which were held after the outbreak of COVID-19, we included questions about new, aggravated, or even decreasing coordination problems. It turned out that some problems that may have already been present in the coordination of HC and LTC services for older patients before the pandemic had been intensified while others had decreased due to more pragmatic handling of rules. However, as a significant share of our data was gathered before the start of the pandemic, we were not able to compare countries on this topic systematically and decided to not go into detail on the effects of the pandemic on the coordination of elderly care services.

4. Germany: social insurance with a divide between healthcare and long-term care

4.1 INTRODUCTION

Germany is a federal country and a conservative welfare state. The key social support systems against existential risks in the life course are all based on social insurance (Wendt & Bahle, 2020). Healthcare (HC) and long-term care (LTC) are covered by separate social insurance systems. Germany's population is one of the oldest in the world and is also old compared to the other countries covered in this study. In 2020, 21.8 percent of the German population was 65 years and older and 6.8 percent 80 years and older (OECD, 2022).

This chapter first presents the institutional setting of the German HC and the LTC system (Section 4.2). This includes the split between mandatory public and mandatory private insurance systems, the major reforms, and the most important changes in care coordination for the elderly in recent years. This description of institutional characteristics is followed by our main hypotheses on coordination problems in this field. Based on interviews conducted with organizations operating in HC and LTC in Germany (see Chapter 3 and Appendix 1 for an overview of the organizations), the following sections discuss the main coordination problems from their perspective, covering the system level (4.3), the organization level (4.4), the profession level (4.5), and the preferred responsible actors for coordination (4.6). The concluding section 4.7 evaluates the results.

4.2 GERMAN HEALTHCARE AND LONG-TERM CARE SYSTEMS: SEPARATE FINANCING AND MISSING LINKS

In Germany, healthcare and long-term care are covered by mandatory public (statutory) or private insurance (Wendt, 2013). Most citizens are enrolled in public health insurance (social health insurance, SHI), while many self-employed and high-income earners as well as most civil servants

have private health insurance (Immergut & Wendt, 2021; Rothgang et al., 2010). Today, there are 97 SHI funds (GKV-Spitzenverband, 2022), from which individuals are free to choose. In 2019, the general contribution rate for SHI was fixed at 14.6 percent, equally shared by employers and employees, and total health expenditure (THE) is mainly financed from these sources (Blümel et al., 2020). Statutory insurance funds have to offer the same benefit package, which is determined by the Federal Joint Committee (*Gemeinsamer Bundesausschuss*, GB-A), a corporatist actor composed of the peak organizations of medical doctors, dentists, hospitals, and statutory insurance funds (Immergut & Wendt, 2021).

How service providers are paid influences the quantity and quality of care. Ambulatory healthcare services are provided mainly by self-employed GPs and specialists in solo practices, who are mainly paid on a fee-for-service basis. This increases the quantity of healthcare services provided but has no clear effect on quality. Patients are free to choose their GP and their specialist (Immergut & Wendt, 2021). Nevertheless, GPs are usually the first point of contact for a patient and refer patients to specialists, but patients also have access to specialist treatment without referral and at no additional cost (Reibling, Ariaans, & Wendt, 2019). In the inpatient sector, a diagnosis-related group (DRG) financing scheme was introduced in the early 2000s to increase competition among hospitals. As a result, the number of hospitals and hospital beds as well as the average length of stay were reduced (Gerlinger & Rosenbrock, 2020; Rothgang, 2010). The average length of stay decreased from 10.2 to 8.9 days between 2005 and 2018, and the number of acute hospital beds per 100,000 population declined from 8.5 to 7.9 between 2005 and 2019 (OECD, 2022). However, both indicators are still above the OECD average. At the same time, a privatization process took place (Gerlinger & Rosenbrock, 2020; Immergut & Wendt, 2021).

The German healthcare system is based on governance structures that mainly rely on corporatist actors. The national government provides the main regulatory framework for the healthcare system (e.g., contribution rates, financing mechanisms, and guidelines for covered services). Healthcare funds are self-administered bodies and negotiate with associations of panel doctors on the health benefit package and the global budget for outpatient healthcare. Inpatient service provision lies in the responsibility of the states (*Bundesländer*), which negotiate with the peak organization of the hospitals (*Deutsche Krankenhausgesellschaft*, DKG) on financing and provision issues (Immergut & Wendt, 2021).

The LTC system was introduced in 1995 (benefits for home care) and 1996 (benefits for residential care) as a social insurance system similar to the healthcare system. People covered by mandatory public or private health insurance are automatically enrolled in the LTC insurance fund of the respec-

tive health insurer. Despite the close connection between HC and LTC funds, financing and administrative structures are strictly separated. LTC benefits can be paid out in different forms: as a cash benefit, which care recipients can spend at their discretion and thus without any supervision of how the money is spent; as ambulatory services; or as residential services. LTC recipients are free to choose between the different forms of benefits and may also choose a combination of ambulatory services and cash benefit (Götting, Haug, & Hinrichs, 1994; Rothgang, 2010). Eligibility for LTC benefits is not dependent on an age limit, although about 80 percent of the beneficiaries are 65 years or older (Rothgang, 2010; Statistisches Bundesamt, 2018; own calculations). In general, all benefits are capped, which means that a significant share of LTC costs must be financed privately. If the beneficiary cannot afford the private share, the social welfare system—which is financed by municipalities—steps in (Rothgang, 2010). This feature of the German LTC system is also a reason why the families of care recipients are still a major resource in the organization and provision of social services for the elderly.

The benefit system distinguishes five care degrees (*Pflegegrade*), with care degree one involving the lowest level of need for care and the lowest level of benefits and care degree five involving the highest level of need for care and the highest level of benefits. The level of dependency and thus the care degree is determined by a standardized assessment procedure on the basis of a person's needs but not their means. The assessment is performed by the Medical Service (*Medizinischer Dienst*) for the publicly insured and by the private company Medicproof for the privately insured (Nadash, Doty, & von Schwanenflügel, 2018; Rothgang, 2010). In 2021, the Medical Service for the publicly insured, which is independent in its organization from statutory health insurance and statutory LTC insurance, replaced the former Medical Service of Health Insurances (*Medizinische Dienst der Krankenversicherung*, MDK) and the Medical Service of the National Association of Health Insurance Funds (*Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen*, MDS) (Stief, 2021). Assessments are conducted by specifically trained (LTC) nurses (MDS & GKV-Spitzenverband, 2021) and follow the same guidelines, which means that the assessment procedure and the allocation of benefits is the same for all people in Germany. Legally, there are no regional differences in access, assessment, or level of benefits. But in practice, access to medical care and the quality of care varies between urban and rural regions (Bauer et al., 2018; Gerlinger, 2018; MDS & GKV-Spitzenverband, 2021; Schneider & Holzwarth, 2021).

In the past two decades, reforms in LTC introduced market mechanisms, which led to an increase of private care providers, particularly in ambulatory care, where their market share increased from 57.6 to 67 percent between 2005 and 2019 (Statistisches Bundesamt, 2007; 2020). One major point of criticism

since the establishment of the LTC system has been the insufficient inclusion of patients with dementia and the focus on physical instead of mental impairments. These issues of eligibility and quality have gradually been addressed by several reforms since 2008 (Bäcker et al., 2022; Steffen, 2021). There have been no major reforms that focused solely on the coordination of LTC. However, the Care Worker Strengthening Act (*Pflegepersonal-Stärkungsges etz*), passed in 2018, introduced measures that aimed to ensure a better level of cooperation of GPs and dentists with residential care facilities (Bäcker et al., 2022; Steffen, 2021). Although the GP is consulted in the event of problems with social care, institutionally this role should be taken over by care support centers (*Pflegestützpunkte*), which have been established specifically to inform patients and their families about their rights and opportunities within the LTC system. Counseling can also be provided by care providers or the Medical Service and Medicproof, respectively. In general, these counseling services are delivered by specially trained (LTC) nurses (Reibnitz, 2020). Hence, from an institutional perspective, GPs have only a marginal role in the provision of information, consultation, assessment, and LTC.

Germany experiences a significant lack of GPs and nurses in both HC and LTC. This staff shortage in both areas has increased in the last decades. For example, 3,570 GPs were missing in 2019/2020 (Robert-Bosch-Stiftung, 2021), and 20,700 job vacancies in LTC could not be staffed in 2020 (Bundesagentur für Arbeit, 2021). Although the number of GPs has slightly increased, the shortage is expected to worsen because of the increasing number of frail elderly people and the high number of GPs who will retire in the next years (Bundesärztekammer, 2021).

In 2020, vocational training for nurses in HC and LTC was reformed by implementing so-called generalist nursing vocational training, which merged the traditionally separate education for healthcare and LTC nurses. The basic objective of this reform was to provide apprentices with the professional skills required for acute and permanent inpatient and outpatient care of people of all ages (Wecht, 2021).

Germany is a latecomer regarding digitalization in HC and LTC (Fischer, Müller, & Neumüller, 2021; Mohr, Riedlinger, & Reiber, 2020; Thiel et al., 2018). With the law on e-Health from 2015 (*E-health-Gesetz 2015*), a formal schedule for the digitalization of HC was introduced. But there is no separate budget for digitalization and no authority that exclusively drives digitalization in the HC and LTC sector (Thiel et al., 2018; Trill & Pohl, 2016). Since 2021, members of statutory health insurance are eligible to have an electronic patient record (*elektronische Patientenakte*, ePA), provided by their health insurance provider, which contains medical diagnoses and information from previous examinations and treatments. However, the ePA only serves as information for the patients themselves, but so far there is no effective nationwide infrastruc-

ture for the exchange of patient data between professionals (Bertram et al., 2019). Instead, separate documentation systems are used in healthcare, and as a result patient data is hardly ever digitally shared (Thiel et al., 2018).

We expect that the institutional set-up of and the developments in the HC and the LTC system affect the coordination of care for the elderly at different levels: at the system, organizational, and professional levels. The system level refers to the overall institutional framework, the organizational level to the rules and procedures established for the provision of services, and the professional level to the actual practice of service provision (see Chapter 2 for a detailed description of the levels). We expect that the coordination of services in HC and LTC is affected at the system level by marketization and privatization. The introduction of DRGs and the decrease of hospital beds and the privatization of LTC service provision are developments that might have put pressure on the coordination of services, especially in the transition from hospital to home care. We furthermore expect that the increasing lack of staff in both HC and LTC is a barrier to effective coordination at the professional level. Furthermore, GPs play a key role in the HC system but have no formal role in the LTC system. Hence, there is no profession that is fully integrated institutionally in both HC and LTC and thus acts as a link between the two systems. As a result, a coordinating role of GPs is presumably not assigned on a legal or habitual level but on a case-by-case basis. Concerning the responsibility for care coordination, we expect that patients and their family play a major role in the coordination of LTC processes because the German LTC system is still fostering the involvement of the family. Since most developments in the German HC and LTC system have focused on the system and professional levels, we do not formulate any hypotheses on coordination problems at the organizational level.

In the following sections, we analyze how the main stakeholder organizations assess the coordination problems between HC and LTC for the elderly in Germany. We conducted interviews with representatives of these organizations which focused on coordination problems between HC and LTC at two critical interfaces: the transition from acute medical care in hospitals to LTC at home; and the provision of integrated ambulatory health and long-term care (see Chapter 3 for more information on the organizations and interviews).

The German interviews coincided with the COVID pandemic, and most of them were conducted in Autumn 2020. Although we did not ask specific questions about their experiences during the pandemic, most interviewed organizations provided insights related to the pandemic. The interviews also coincided with the implementation of generalist nursing vocational training in Germany, which merged the formerly separate vocational education of medical nurses and LTC nurses. These changes were mentioned in most interviews because organizations expected that this would affect the staff shortage

in LTC and create new competition mechanisms between hospitals and LTC facilities over staff.

The interviewed organizations mention various changes in the HC and the LTC systems that have affected care coordination in recent years, both positively and negatively. The developments that, according to the organizations, have had a positive influence on care coordination are the implementation of care support centers and thus the expansion of counseling structures as well as a more holistic redefinition of care needs, which has strengthened LTC as an independent area of social policy and led to changes in the assessment of needs. In HC, the organizations see the expansion of hospital discharge management as a positive development. One development in healthcare that is perceived as having a negative impact on care coordination is the introduction of DRGs, which has led to shorter hospital stays and earlier discharges. In LTC, the lack of capacities, especially in post-discharge care, and staff shortages are regarded as obstacles to coordination.

4.3 SYSTEM-LEVEL PROBLEMS: BUREAUCRACY AND LACK OF CAPACITIES

In Germany, the provision of healthcare and long-term care is characterized by rigid structures in the HC and LTC system and highly bureaucratic processes, and in particular the highly standardized LTC insurance gives the individual actors in the system little room for maneuver. Against this background, the organizations identified four main systemic problems for care coordination: the DRG system, which leads to early hospital discharges; the lack of capacities for post-discharge care; high levels of bureaucracy; and lack of financing for care coordination.

The interviewed organizations consider the introduction of DRGs to be a major obstacle for care coordination because they lead to shorter hospital stays and higher post-discharge care needs. Shorter hospitals stays put pressure on discharge managers because less time is available to organize the transition. As a patient organization points out:

> Of course, the introduction of DRGs has had quite significant effects on discharge management and lengths of stay, which also considerably reduces the possibilities for effective discharge management. (DAlzG)

The strong financial incentives set by DRGs to discharge patients sooner rather than later cause gaps in discharge planning, which means that some patients are discharged without secured post-discharge care and aids. This practice is criticized for increasing the burden on patients and relatives to organize care

themselves. But deficits in discharge planning are also compensated for by home care providers and GPs:

> Today, the efforts for GPs to coordinate additional nursing services and keep everything ready in the home when the patient is discharged from hospital are completely different. Before the introduction of DRGs, they had more time to organize everything and the patient was also a bit fitter. (KBV)

From the organizations' perspective, problems resulting from early hospital discharge are aggravated by an overall lack of capacities in ambulatory LTC services and nursing homes. This lack of capacities complicates the coordination of hospital discharge because extensive efforts are required to find providers and places in LTC. One discharge manager at a hospital describes the problem as follows:

> My workload per patient has significantly increased. Because it's not enough to contact ten nursing homes, but 30, 40, 50, and you also need to expand the search radius. (Discharge management)

Moreover, the organizations perceive the lack of capacities as a threat to the continuity of care, as it is very likely that the discharge manager fails to organize a place in time. The organizations identify the shortage of LTC staff as the main reason for the lack of capacities in LTC, but also the lack of physiotherapists and GPs.

Furthermore, the organizations emphasize that the infrastructure for post-discharge care is not well developed. Earlier discharges need to be compensated for by more short-term care places; however, financing for this form is insufficient, so there are not enough places available. Furthermore, patients discharged earlier and particularly elderly people with comorbidities need subsequent rehabilitation (at best geriatric rehabilitation), but capacity has not been increased sufficiently in these facilities either. Organizations also criticize the lack of financial incentives for inpatient LTC facilities to create and maintain places for short-term care. This includes that efforts of short-term care aiming to enable a patient to live independently are not adequately remunerated:

> It is a major financing problem that short-term care is so inadequately funded. It is the infrastructure that is too poorly equipped by both LTC and health insurance, and that's why there are too few short-term care places. (BAGFW)

Another critical issue at the system level mentioned by the organizations is the high level of bureaucracy, which delays the coordination and provision of care. In the home care setting, providers complain about strict rules for care, which

are time-consuming and leave little space for care coordination. Furthermore, several organizations mention the application process for the assessment and assignment of a care degree to be lengthy, complicated, and cumbersome. This makes it difficult to plan the transition from hospital to home care due to uncertainties about follow-up financing of LTC. The lengthy procedures and uncertainties about who will cover what costs are perceived as highly problematic in the context of hospital discharge because the organization of formal post-discharge care depends on the cost being approved by HC or LTC insurance:

> The home care service is not allowed to start working until the cost issue has been clarified. And when I imagine that people are at home for two to three days, maybe even longer, and their care is not guaranteed. … That is simply unacceptable. When someone is discharged, home care has to be organized. … And that is not always the case. (Care support center)

According to some organizations, simplifying procedures would be a solution, but the German Hospital Federation (*Deutsche Krankenhausgesellschaft*, DKG) points out that health insurers are not willing to do so:

> Of course, that's a big hurdle. I know on Monday "You're going home on Thursday," but I'm not allowed to finish the prescriptions already on Tuesday or Wednesday. If that were possible it would be so much easier for doctors, nurses, and case management to organize, but the health insurers don't want that. (DKG)

Another system-level problem according to the organizations is the lack of financing for coordination. They criticize that care coordination so far has been an unpaid activity that is in addition to professionals' core tasks:

> Who should pay for professionals to communicate with each other? For example, the home care provider says "Well, I can't pay for this," and the physiotherapist can't pay for that either. The GP doesn't make house calls because he doesn't get additional remuneration and says "I could actually treat three patients in my practice taking care of one patient at home". (DV)

Organizations also observe that there is a lack of financing for coordination provided by home care services. In the past, home care providers visited patients while they were still in the hospital, but this is no longer done because it is not remunerated. Overall, the organizations attribute these gaps in financing for care coordination to the fact that coordination is not recognized as a discrete task. Hence, the organizations demand that coordination should be remunerated as a separate task, which would enhance the recognition of coordination and the commitment of the various professionals.

In Germany, HC and LTC are strictly separated institutionally and financially, which many organizations see as a problem for care coordination. Health gains (e.g., through rehabilitative measures) or the loss of mobility have financial repercussions on HC and LTC insurance. Yet, only LTC insurance finances measures to preserve health. In practice, this leads to situations in which a patient is shifted from one sector or care provider to another based on financial rather than quality considerations. Hence, the organizations call for joint budgets to allow for better financial coordination of those cases and ask for a permanent solution to this problem, as project-based solutions already exist but disappear when their financing runs out.

4.4 ORGANIZATIONAL-LEVEL PROBLEMS: OVERLAPPING STRUCTURES AND TOO MANY ACTORS

While the organizations are relatively clear about the system-level problems in the interviews, the problems at the organizational level are less straightforward, because the organizations discuss very different issues. Many organizations mention overlapping structures, the high number of organizations in ambulatory LTC, and the lack of priority for coordination within and between organizations to be major problems in elderly care coordination at the organizational level. They recognize the potential of the use of electronic tools, which, however, also brings its own problems.

For the organizations, one problem in coordinating care services in home care and in the transition from hospital to home care is that the counseling structures overlap. The LTC sector has established various parallel structures for care counseling, with numerous actors offering counseling (e.g., home care providers, (neutral) care support centers, health insurance providers). Organizations attribute the fragmentation of counseling to distrust between providers, which then tend to establish their own counseling services rather than relying on and recommending existing offers. In the context of hospital discharge, there is a considerable risk of parallel structures because both discharge managers in hospitals and home care providers offer counseling. As these actors are hardly connected, double work for the organizations and insufficiently informed patients are often the result. The organizations therefore emphasize that counseling in general needs to become more patient-oriented:

> Because otherwise it can happen that the social service in the hospital has already started planning, but the client doesn't know, how should he. And the senior citizens' counseling service then also starts planning. And then they both do something, and that's not the purpose. (Care support center)

The involvement of too many organizations is not limited to care counseling but seems to be a general problem in the delivery of integrated HC and LTC services. In particular, the specialization of care providers in the home care setting (e.g., general care, wound care, care for specific medical conditions) entails that many different professionals and organizations are involved:

> We often get the feedback from patients in specialized outpatient care that they have the feeling that it's open house day. It can happen that each task is handled by a specialized staff member. One home care nurse comes to do the basic care, then the next comes who is responsible for tube feeding, and then one who is responsible for catheters and another who does wound care. Then two different therapists come in and so on. (BV Geriatrie)

The organizations consider the high number of actors to be a burden for patients and their relatives, because they struggle to maintain an overview and to coordinate all the services being provided. Furthermore, this multitude of actors and professionals leads to a lack of interpersonal trust and bonding between professionals and patients, which is seen as an important aspect in the coordination of care. Overall, the high number of actors is considered to substantially increase the need for care coordination.

Organizations also claim that coordination is not a priority for any organization or profession and criticize the fact that (mainly other) organizations and professions set priorities that conflict with the goal to improve care coordination. For example, the German Association of Family Doctors (*Deutscher Hausärzteverband*) mentions that specialist doctors are not willing to collaborate with GPs due to missing incentives. Hospitals criticize the often slow and bureaucratic communication with insurance providers and their inability to appoint contact persons for coordination and discharge issues. Hence, organizations emphasize that there is a need for shared standards and responsibilities. The German Association for Social Work in Healthcare (*Deutsche Vereinigung für Soziale Arbeit im Gesundheitswesen e.V.*, DVSG) points out that in the past, home care providers have in many cases compensated for the lack of coordination by fulfilling tasks beyond their core responsibility:

> I'm pretty sure that a lot of things were simply done covertly, and the home care providers now say, "we're reaching our limits, we don't have staff capacity, and so on," and then they realize that it actually wasn't their original assignment, but that they did it extra. (DVSG)

The organizations also criticize that the recently introduced electronic patient record (ePA) system is inadequate to simplify care coordination because it is designed to mainly provide information to patients but not to actors in HC and LTC. Nevertheless, the organizations see great potential in using digital

tools to facilitate information sharing and inter-professional collaboration and thus to improve care coordination. This also includes the potential of digital tools to save time on documentation, which can be used to provide better care. Moreover, the organizations believe that medical and social care in rural regions might benefit most from the use of digital tools. Besides that, they consider digital tools to be effective in providing information about services to the public. Overall, the ways digital tools are designed and implemented determine if they improve care coordination. The organizations agree that digitalization cannot and should not replace direct human contact within HC and LTC and consider it merely an addition. While some organizations understand digitalization as a necessary process to tackle staff shortages, others highlight that digitalization is by far not sufficient to compensate for the lack of capacities and staff. Organizations also point to several major barriers that reduce the acceptance of digital tools such as lack of utility, lack of benefit in practice, lack of equipment due to high costs, resistance among older GPs, and LTC professionals' fear of losing their independency at work by being controlled by a digital system. Almost all organizations emphasize the importance of data protection. They also point to risks for patient safety posed by patients' right to decide which information is made available to HC and LTC staff. While the organizations assess digital tools to currently work better in local contexts and model projects, they criticize that a nationwide solution has not yet been successfully implemented. From the organizations' perspective, an overarching system is needed. In this context, they mention the problem that the current approach to implement a digital infrastructure does not obligatorily include LTC organizations and criticize that this creates new problems for communication by reproducing the separation of HC and LTC. They also address the lack of compatibility between the existing documentation systems. For example, approaches developed in model projects are not usually designed to connect with systems outside the project.

4.5 PROFESSIONAL-LEVEL PROBLEMS: STAFF SHORTAGE AND INTER-PROFESSIONAL CONFLICTS

At the professional level, the main problems identified by the organizations are staff shortages, lack of communication, and the resistance by the medical profession to transfer tasks to the nursing profession.

Staff shortages concern both HC and LTC and limit the resources for communication and coordination. Although the organizations perceive GPs as important actors in care coordination, they consider their involvement to be too low. They attribute this lack of involvement to a general shortage of GPs and their resulting high work density, which reduces the time GPs have for coordi-

nation tasks. GPs have limited capacities for home visits, and the organizations have experienced that patients confined to bed often have difficulty in finding a GP. Furthermore, in the transition from hospital to home care, GPs do not have the capacity to take on care coordination tasks at short notice, although this is often required:

> At hospital discharge, this coordination service has to be available really quickly, but again we have the problem of the shortage of GPs. That means it is difficult to get a GP, and the GPs are busy with their appointments from morning to night. In general, bureaucracy really eats up a lot of time and makes it even more difficult to provide coordination services at short notice. The burden further increases when a colleague retires and the GP has to take over these patients and has to do this coordination work additionally. (KBV)

However, not only GPs' work density is mentioned as an impeding factor for care coordination but also that their willingness to engage in coordination differs from case to case. Organizations report that GPs are more willing to coordinate care when they have had a long-standing relationship with the patient, which is usually more common in smaller GP practices:

> It is actually more the GP in the solo or group practice with whom you have direct contact, who is not part of a larger organizational unit. These GPs can manage these additional things because they know their patients very well. (KBV)

Although many organizations stress that GPs have a high workload and are thus unable to take on many coordination tasks, the German Association of Family Doctors emphasizes that GPs often compensate for the deficits in the discharge process caused by hospitals' insufficient care planning. Although the organizations agree that GPs are important for the coordination of elderly care services, some organizations, such as the National Association of Statutory Health Insurance Physicians (*Kassenärztliche Bundesvereinigung*, KBV), propose delegating GPs' care coordination tasks to other professionals:

> Once the diagnosis and treatment have been established, follow-up prescriptions can also be delegated to medical professionals who work under a GP's direction, for example, to physician assistants. So, delegating tasks wherever possible is one solution to relieve the GPs. (KBV)

Staff shortages and high workload not only affect GPs, but are a huge problem in LTC, too. Staff shortages in LTC contribute to an insufficient number of places in residential and ambulatory LTC facilities and thus to waiting times for patients. Furthermore, LTC staff experience a high workload, which leads to a lower quality of care and less time for coordination tasks. For example, hospital discharge managers report that they do not have enough staff to

assess the situation of each patient by themselves and instead must rely on the physicians' and nurses' assessment in the hospital. Organizations agree that staff shortage is not a new phenomenon and cannot be solved in a short period of time. However, the lack of well-educated staff is being aggravated due to unattractive working conditions (comparatively low pay, shift work, night work) and low societal recognition. Hence, many LTC workers leave this field. The organizations fear that the drain of workers in LTC will be exacerbated in the future due to the newly introduced generalist nursing vocational training, in which apprentices are no longer restricted to work in a specific field—but can freely choose in which kind of healthcare, long-term care, or social care facility they want to work. As hospitals usually offer more attractive working conditions (higher pay, easier choice of shifts), LTC facilities fear that attracting workers will be even more difficult. Hence, the organizations propose to solve the lack of LTC workers by recruiting migrant care workers, involving other professions, and delegating tasks to experienced relatives. Yet, the organizations admit that these are suboptimal solutions, because high-qualified staff are needed for high-quality care and in particular for coordination tasks. In this regard, organizations also criticize that care coordination has little relevance within curricula, as the German Nursing Council (*Deutscher Pflegerat e.V.*, DPR) reports:

> In principle, communication within nursing depends on good training, which of course also depends on good practical guidance. But if you look at the current structures or the curricula of generalist nursing vocational training, you can say that the focus is not so much on digital competence or interface competence and that there is of course room for improvement. (DPR)

The organizations have different views on the need for education in care tasks. Some organizations maintain that all professions involved in the care of a patient should be educated in care coordination, whereas other organizations argue that this is only necessary for the professionals who are involved in coordination. There is general consensus that coordination tasks in LTC are best performed by academically educated staff; however, some organizations object that academization does not solve the underlying problem of staffing shortages.

Lack of communication between the actors involved in HC and LTC for elderly people is perceived as a further deficit at the professional level. This lack of communication is also related to the insufficient language skills of staff with a migration background, which leads to imprecise patient documentation files and causes problems in information sharing. These improperly documented patient files create misunderstandings inside and between LTC facilities but also complicate the communication with GPs and hospital

doctors. Due to these language problems, the organizations therefore criticize the current strategy to recruit staff from abroad:

> But what does it help to bring in someone from abroad who doesn't even know German properly? How is he supposed to write the documentation? (Care support center)

Precise communication is thus important for the coordination of care. However, even in the absence of language deficits, communication between professionals is often lacking and thus hampering care coordination. Organizations criticize that professionals—in particular physicians—primarily focus on their own area of expertise and responsibility and show little understanding for the needs and information requirements of other professionals:

> People are still thinking in terms of areas. In other words, medicine is not yet thinking in terms of nursing care. (DVSG)

Inter-professional networks are one way to improve inter-professional communication and cooperation. In this respect, the organizations point to small but close networks, which in their opinion work best. A further way to strengthen communication and cooperation is the reallocation of tasks and responsibilities. A common problem the organizations report is that the medical profession is reluctant to shift tasks to the nursing profession. In Germany, most medical tasks are the responsibility of medical doctors while nurses and therapists are not allowed to fulfill such tasks independently. These tasks have to be assigned, delegated, or supervised by a medical doctor, even if nurses have the competencies to assess a medical problem and perform the necessary procedures independently. Hence, some organizations advocate delegating more medical tasks to nurses or therapists and thus decrease unnecessary inter-professional communication. Furthermore, delegating more tasks in general and coordination tasks in particular to nurses would relieve the burden on GPs. In addition, it creates more opportunities for career progression for nurses and thus might convince more LTC nurses to stay in LTC:

> Tasks in which nurses are clearly more competent than physicians should also be performed by nurses. The same applies to physiotherapists. So, whoever has the greater competence should actually do it. And in Germany, there is a very strong doctor's prerogative for all activities. (BAGFW)

4.6 RESPONSIBLE ACTORS: CASE MANAGERS AS A SOLUTION FOR OVERBURDENED PROFESSIONALS?

The organizations have similar views on who should be responsible for the transition from hospital to home care but have different opinions about who should be responsible for the integrated delivery of HC and LTC services at home. The organizations agree that hospitals should be primarily responsible for discharge management in the transition from hospital to home care. However, as the quality of discharge management varies—usually with better quality in larger hospitals—some organizations suggest involving home care providers and social workers more in this process. They also consider their involvement to be crucial because hospitals' responsibility for the transition to home care ends when the patient is discharged, but even after discharge, patients need professional support to organize subsequent and continuous HC and LTC services. Some organizations see a solution in the involvement of independent case managers, who would oversee the entire process and have an overview of patients' situations:

> I can only initiate discharge management if I know the patient, so I used to think that was a nursing task, because they know the patient. But of course, hospital nurses say "we can't handle that, we're relieved when the case manager comes in, or the social worker". (DKG)

The organizations consider GPs, home care providers, and social workers to be potential responsible actors for the coordination of home care. However, the organizations differ in their opinions about the role of GPs in coordinating care. Several organizations maintain that GPs should be the key coordinators (e.g., to recognize early symptoms for deterioration in the physical or mental condition of elderly patients and to organize subsequent specialist examinations and communicate with home care staff and relatives). This role as "a spider in its web" is consistent with GPs' self-concept as the professional group that has the best overall medical expertise and knowledge of a patient's situation and is therefore in the best position to coordinate care:

> Who if not us is going to do that? I don't see any other player who is so close to the people and has so many strings in his hand as a GP. And this coordinating function alone should be remunerated highly. (HÄV)

Although GPs see themselves in the coordinating role, other organizations, such as the National Association of Statutory Health Insurance Funds (GKV), see diagnosis and treatment as the core tasks of GPs and—especially consid-

ering the shortage of GPs—do not want to overburden them with additional coordination tasks:

> I think GPs would be overburdened if they were now given such an additional management task, which keeps them from performing their actual core competencies. And there is no need that these coordinating tasks are done by a physician. (GKV)

Likewise, some of the organizations demand that home care providers assume a greater role in coordination, but again, the staff shortages are a barrier to taking over these additional tasks.

Hence, some organizations suggest transferring the responsibility for care coordination from home care to case managers. Some organizations highlight the potential relief for the medical and LTC professions. In particular, the organizations with a focus on social care stress that case managers in care coordination—who are usually trained as social workers—have a holistic perspective and take the entire situation of the patient into account. Furthermore, they emphasize the importance of case managers for patients who do not receive formal care by a home care provider and therefore are responsible for coordination themselves or their family. Yet, the role of case manager is also seen critically. Case managers constitute additional actors, who further increase the level of professional communication at the various interfaces. Alternatively, some organizations suggest that efforts should focus on improving communication between the existing actors. HC organizations in particular oppose the involvement of case managers, criticizing their lack of medical knowledge and understanding due to their background as social workers:

> I think it would be rather an additional bureaucratic authority, which then develops its own life again and won't necessarily make anything better. I would rather focus on the structures that already exist, because a lot of things are already working there. (GKV)

All organizations highlight the importance of involving relatives, who often compensate for the lack of coordination both in the transition from hospital to home care and within home care. Voluntary work buffers current deficits in elderly care coordination, especially in the social domain. However, the organizations interviewed underline that this high involvement is an additional burden for relatives. In this context, they see the establishment of counseling structures and care support centers as important structures to help relatives navigate the complex systems of HC and LTC. However, all organizations demand further improvements in counseling services and in measures that relieve relatives of caregiving and coordination tasks.

The organizations regard the implementation of counseling services and care support centers as improvements for care coordination. Most organiza-

tions, e.g., the Medical Service (*Medizinischer Dienst*, MD), prefer that counseling should be provided by an independent actor to ensure patient choice:

> Ideally, this should not be delegated to a home care provider; independent nursing consultants could also perform this task. (MD)

In many countries, municipalities are important providers of HC and LTC services and actively engaged in coordination (see Chapters 5 and 6 on the Netherlands and Sweden). In Germany, municipalities have a weak role in HC and LTC provision and coordination. Many of the organizations interviewed demand the increased responsibility and participation of municipalities in care coordination, as these have extensive knowledge about their population and local problems, are able to connect local structures and providers, and can act as independent organizations that counteract the logics of marketization in HC and LTC. The organizations are therefore calling for more financial resources for municipalities, for example to employ district nurses, who could be an important piece of the puzzle in coordination, as other countries illustrate (see Chapters 5 and 6 on the Netherlands and Sweden).

4.7 CONCLUSION

Germany faces several challenges in the coordination of healthcare and long-term care services for the elderly. Our empirical findings provide new insights on the current state of coordination of elderly care services in HC and LTC. They also offer specific suggestions on how to cope with existing problems to offer better coordinated care in the future, when these problems are expected to grow due to an increasing number of frail elderly people. The organizations' assessments do not differ fundamentally, and although some of them set different priorities, they agree on what the main coordination problems are in the German HC and LTC system.

Coordination problems exist at different levels, are often interdependent, have cumulative negative effects, and complicate institutional change toward better coordination. The experiences of the interviewed organizations reveal that the existing institutional structures strongly determine how services, and social action in general, are provided. Consequently, if social care and its coordination are to be improved, change must occur at the institutional level. Any institutional change, however, may have unintended consequences. For example, the introduction of DRGs has decreased the length of hospital stays and thus increased pressure on the coordination of post-discharge LTC. Our analyses show that HC and LTC organizations are aware of the existing coordination problems but have limited influence in tackling systemic shortcomings.

The interviewed organizations locate the main problems of care coordination at the system level. Structural shortcomings such as financing logics and bureaucratic procedures set the framework for care coordination. Systemic weaknesses are intertwined with the highly problematic staff shortage, especially in LTC. The organizations also repeatedly mention the separation of the HC and LTC system as a problem. The HC and LTC system are assessed to follow different logics concerning their legal and financial basis, which makes coordination across systems difficult. The result is a highly fragmented provision of care in many respects at the interfaces of HC and LTC. Therefore, some organizations advocate a system change, e.g., by creating a comprehensive system of financing including HC and LTC, but the interviews also offer insights into how care coordination could function better without changing the systems. A possible starting point for improving care coordination could be to reduce the lack of staff and capacities, which would facilitate care planning. Higher motivation and willingness to collaborate as well as better mutual understanding between medical and nursing professions could also contribute to better care coordination. This would mean, however, that the traditional responsibilities and privileges of the medical profession are put to the test. Another improvement in care coordination could be to establish common standards for care coordination—a change, however, that needs to be implemented at the political and institutional level.

Clear and concise responsibilities are considered to be critical and a starting point for better care coordination. Most organizations want municipalities to be given greater responsibility in this area because they have profound knowledge of the local structures and needs of the respective population and are therefore in a position to develop tailored solutions. They agree that LTC nurses, and GPs in particular, are overburdened and therefore cannot take on more responsibility. Case managers with a focus on coordination tasks are seen as a possible solution, but some organizations argue that this would bring in an additional actor and make the care setting more complex. Case managers therefore require acceptance and the willingness to cooperate from the other actors in HC and LTC before they can fulfill their role in care coordination. They would also need expertise in medicine, LTC, and social work to understand the individual case in a holistic perspective as well as the requirements of the professions involved. High-quality training of case managers is therefore required. The organizations also suggest that care coordinators could work in GP practices, but even this additional support is often refused because professions, especially physicians, are reluctant to relinquish tasks and responsibilities. The organizations interviewed emphasize the important role of relatives, who often assume responsibility for coordinating care. Organizations agree that the coordination of care should not be the responsibility of relatives, as they are already overburdened and are often overwhelmed by rapidly increas-

ing care needs. Instead, the organizations argue that care coordination should be the responsibility of professionals.

A high potential to improve communication among actors in HC and LTC and care coordination is seen in digitalization processes, but the implementation of digital tools in HC and LTC is associated with manifold challenges. It requires acceptance among its users, which could be achieved through offering visible benefits, highlighting the importance of utility, and providing a pragmatic solution for data protection. The organizations considered it essential that HC and LTC use a common system, which is not taken sufficiently into account in the current approach to implement a digital infrastructure.

5. The Netherlands: institutional fragmentation in a patient-centered system

5.1 INTRODUCTION

The Netherlands faces the challenge of providing healthcare (HC) and long-term care (LTC) for an increasingly aging population. In 2019, 19.2 percent of the Dutch population were 65 years and older, and 4.5 percent 80 years and older (OECD, 2022). For a highly developed country and compared to the other countries discussed in this book, population aging is at a medium level. In the Netherlands, HC and LTC provision and administration are institutionally divided. In the early 2000s and 2010s, both fields of social policy experienced similar developments, including the integration of market mechanisms. In 2015, however, an encompassing reform of the LTC system reorganized and shifted LTC tasks and responsibilities toward new entities and organizations. As a result, the number of involved actors has increased and the provision of the various forms of LTC (home care, residential care, nursing care) has been devolved to different governance levels. This reorganization has increased the number of interfaces within LTC and thus also the risk of coordination problems. In this reform, like in earlier reforms, cost containment was a primary policy concern, especially in residential care. Cost containment can be considered a further source of coordination problems in HC and LTC.

In this chapter, we first describe the institutional setting of the HC and the LTC system in the Netherlands. We focus on the main reforms and most important changes that have taken place in the coordination of care for the elderly in recent years. On this basis, we develop our main hypotheses about what the main coordination problems are in the Dutch HC and LTC system. In the results section, we analyze these hypotheses based on interviews conducted with organizations that operate in healthcare and LTC in the Netherlands (see Chapter 3 for an overview of the organizations and Appendix 1 for a complete list) to identify the main coordination problems from their perspective. The coordination problems are evaluated at three different levels: (1) the system level; (2) the organizational level; and (3) the professional level. The system

level refers to the overall institutional framework for the provision of services, the organizational level to the rules and procedures established for the work of professionals, and the professional level to the actual service provision (see Chapter 2 for a description and theoretical elaboration of the levels). Furthermore, we examine who the organizations consider to be responsible for the coordination of care. The concluding section summarizes the results and evaluates them in the light of the theoretical considerations.

5.2 THE DUTCH HEALTHCARE AND LONG-TERM CARE SYSTEM: INSTITUTIONAL FRAGMENTATION

In the Netherlands, the HC system has been implemented as a Bismarckian model with social insurance contributions and public and private health insurers (Wammes, Stadhouders, & Westert, 2020). After a long time of political debate, a major HC reform was enacted in 2006, replacing the dual public and private health insurance system with a single scheme and introducing more consumer choice and new market mechanisms (Maarse & Meulen, 2006). This reform became possible because "there has always been a broad consensus on the merits of a single scheme because it makes health insurance less complex and strengthens solidarity" (Maarse & Meulen, 2006, p. 38). Accordingly, all Dutch residents have to purchase HC insurance with a statutory insurer (Wammes, Stadhouders, & Westert, 2020), and insurers are obliged to offer all residents the same basic insurance package (Kroneman et al., 2016). Patients pay monthly premiums as well as an annual deductible, which can be increased in exchange for lower monthly premiums (Kroneman et al., 2016). Patients can choose their health insurer freely and change it at the end of each year (Kroneman et al., 2016). Most Dutch residents purchase private insurance in addition to the basic package, e.g., to cover dental care or eyeglasses and contact lenses (Wammes, Stadhouders, & Westert, 2020). Preventive services are mainly financed and organized by municipalities and are generally not part of the health insurance scheme (Wammes, Stadhouders, & Westert, 2020).

With 1.62 general practitioners (GPs) per 1,000 population in 2017, the Netherlands has one of the highest densities of GPs among OECD countries; higher than, e.g., Sweden (0.64), Germany (0.98), and Switzerland (1.14) (OECD, 2022). Most GPs are self-employed and work in outpatient group practices and clinics; only 18 percent work in solo practices (Wammes, Stadhouders, & Westert, 2020). They have a key role in the HC system and act, for instance, as gatekeepers to specialist care (Kroneman et al., 2016). Since 2005, hospitals are financed on the basis of diagnosis treatment combinations (*diagnose-behandelcombinatie*, DBCs), the Dutch version of diagnosis-related groups (DRGs) (Kroneman et al., 2016). DBC financing in hospitals accounted

for about 85 percent of all costs in 2011 (Cots et al., 2011). In the Netherlands (as in Finland, Iceland, and Norway), the use of telemedicine is regulated and implemented at the national level (OECD, 2020a). Most other OECD countries either have no rules or legislations on telemedicine, devolve this issue to the regional or local level, or include it into healthcare laws.

The LTC system was established in 1968 and was financed for many years under the exceptional medical expenses act (*Algemene Wet Bijzondere Ziekenkosten*, AWBZ). The financing scheme covered non-acute chronic care and therefore also nursing care and social care for the elderly (Da Roit, 2013; Mot, 2010). This comprehensive LTC system underwent a major reform in 2006, was dissolved in 2015, and now consists of different parts.

The AWBZ, the comprehensive scheme for all LTC benefits, was a public insurance system covering all residents in the Netherlands without age-based eligibility thresholds (Mot, 2010). The scheme financed residential care and home care. Home care benefits were provided in cash or in kind (or as a mix), while institutional care was provided only in kind. In 1995, the cash benefit "personal budget" (*persoonsgebonden budget*, pgb) was introduced as a bound benefit, which was 25 percent lower than the in-kind benefit (Mot, 2010). The introduction of the AWBZ was partly driven by the housing shortage after World War II and contributed to alleviating it by the construction of care and nursing homes (Da Roit, 2013). This initial focus on residential care solutions in the Dutch LTC system has remained a central institutional characteristic over the following decades (Alders et al., 2015).

Since the 2000s, reform activities in LTC have increased due to concerns about the future financial stability of the system. Small-scale reforms in 2003, 2004, 2005, and 2009 focused on introducing provider competition and ensuring financial stability by allowing for-profit providers to offer home care nursing and care under the AWBZ, increasing individual co-payments, changing institutional structures and responsibilities, and reducing financing for specific small-scale measures in LTC (Da Roit, 2013; Mot, 2010). In 2007, a larger institutional reform was implemented. Social services and home help services such as meals-on-wheels, home adjustments, and transport were shifted from the AWBZ scheme to a new scheme, the Social Support Act (*Wet maatschappelijk ondersteuning*, Wmo). Still, the AWBZ covered 95 percent of the LTC costs and the new Wmo 5 percent (Maarse & Jeurissen, 2016). In contrast to the AWBZ, the Wmo was tax-financed and run by municipalities. This reorganization of LTC went hand-in-hand with budget cuts for home help services. In most cases, home help recipients did not receive much less help after the reform, but co-payments increased and providers were paid lower tariffs (Da Roit, 2013; Maarse & Jeurissen, 2016). Furthermore, geriatric rehabilitation was transferred from the AWBZ to the HC system in 2013 (Kroneman et al., 2016).

In 2015, a major reform reorganized the whole LTC system. The main financial and organizational responsibilities of the AWBZ were replaced by the Long-term Care Act (*Wet langdurige zorg*, Wlz). This scheme was set up as a public social insurance but included residential care only. Home care was transferred from the AWBZ to the Health Insurance Act (*Zorgversekeringswet*, Zvw) making health insurance companies responsible for this type of care. Social care under the revised 2015 Social Support Act (*Wmo 2015*) is now the responsibility of municipalities. With the reform, responsibility for community nursing and body-related personal care has passed to the health insurers and all further non-residential care services to the municipalities (Maarse & Jeurissen, 2016). The reform aimed to decrease the high institutionalization rate in LTC and increase other forms of community and family care. Hence, access to nursing homes has been restricted: LTC beneficiaries with lower LTC needs are not eligible for publicly funded institutional LTC anymore (Maarse & Jeurissen, 2016). Furthermore, the pgb is no longer paid out as a cash benefit and is administered by the municipalities according to the budget holders' will (Maarse & Jeurissen, 2016).

Co-payments in the Dutch LTC system depend on income, household members, and the age of the recipient, starting at less than 20€ per month for single low-income households in home care. Co-payments in residential care are higher, starting at about 150€, and are subject to income testing. After co-payment, each institutional care recipient has to be left with 280€ for clothing and pocket money (Mot, 2010). Since 2005, the Needs Assessment Center (*Centrum Indicatiestelling Zorg*, CIZ) has been responsible for assessing the level of need. The CIZ is an autonomous nationwide organization with local branches to perform assessments in the form of classifications (Da Roit, 2013; Mot, 2010). The classification is based on a model that determines the required volume of care, the period until the next assessment, and delivery conditions according to the (physical, mental, and instrumental) situation of the applicant and other public and family support schemes (Mot, 2010). Since the 2015 reform, the CIZ has been responsible only for assessing residential care recipients, while responsibility for assessing home nursing tasks has been transferred to district nurses and for assessing home assistance to the municipalities (Kroneman et al., 2016). Care offices (*Zorgkantoren*), subdivided into 31 regions, are responsible for organizing care for people who qualify for residential care after assessment by the CIZ (ZN, 2022). Non-24-hour care at home is organized by municipalities (Kroneman et al., 2016).

To sum up, the features of and developments in the HC system and the LTC system in the Netherlands have in part been similar. HC and LTC are highly developed and institutionalized areas of the welfare state, with a high level of financial resources. In the last two decades, considerations about the future financial stability of both systems and the efficient provision of services have

dominated policymaking and reforms. In both HC and LTC, reform measures have focused on cost-cutting and the introduction of market mechanisms. The most important reform measure has been the reduction of residential care in favor of home care arrangements. This reform measure is highly important for two reasons. First, it influences the institutional structures in LTC. The shift from residential to home care arrangements has led to the need for expanding the latter structures. Second, the shift influences people's long-lasting expectations on the provision of care services in later life. People have expected to move to an old-age home or a residential care facility when their need for help and assistance in old age increased. Reforms in recent years have increased the options available to HC and LTC beneficiaries (e.g., more choice of benefits and providers) and thus also the actors and administrative levels involved in the provision of benefits and services. In a nutshell, the introduction of market mechanisms and the aim of future financial stability in HC and LTC has led to changes that may have a strong impact on the coordination of care.

We now outline our expectations regarding the consequences of institutional conditions and reforms in the HC and LTC system for elderly care coordination. We expect that the increase in the number of schemes, benefits, and providers, and the introduction of cost-cutting measures and market mechanisms have caused major problems at all three levels of coordination. At the system level, we assume that the main problem in the coordination of care is the high institutional fragmentation of responsibilities and schemes for care services. At the organizational level, we hypothesize that the main reasons for coordination problems are the increase in LTC providers due to the market entry of private for-profit providers in recent years (Bos, Kruse, & Jeurissen, 2020) as well as the fragmentation of home care and home help services, which should have resulted in a higher need for communication and cooperation between the HC system actors. At the professional level, we assume that coordination is hampered mostly by the shortage of nursing staff. Following the 2015 LTC reform and the shift from residential to home care, nursing and care homes closed and care staff lost their jobs. Attracting this staff to home care has proven difficult because the sector's image is rather poor (OECD, 2020b). Concerning possible solutions to these coordination problems, we hypothesize that the implementation of telemedicine at the national level (OECD, 2020a) could facilitate the implementation, acceptance, and use of electronic patient records and further technical solutions to coordinate care.

In the following, we examine these expectations by presenting the results from the analysis of the interviews we held in late 2019 and early 2020 with representatives of organizations (or in some cases of professional groups) that operate in HC and LTC (see Appendix 1 for a full list of the interviewed organizations). The interviews have been analyzed by a qualitative deductive coding scheme (see Chapter 3 for the methodological approach) and parts of

the interviews are used to illustrate our interpretations, evaluations, and important aspects of the coordination problems that emerged from the interviews.

In general, the organizations we interviewed referred to the same main problems in the coordination of HC and LTC services for the older population. According to the interviews, effective coordination of services is hampered at the system level by too many different benefit schemes and at the organizational level by too many providers. At the professional level, they consider the shortage of nurses and physicians as the main problem. However, the organizations have different views on who should be responsible for coordinating care in the future.

5.3 SYSTEM-LEVEL PROBLEMS: TOO MANY DIFFERENT SCHEMES

The system level refers to the institutional framework for the provision of services, including financing and administration. In the Netherlands, HC and LTC are provided by many different schemes, involving many administrative actors and financing structures. Organizations agreed that the unintended negative result of the 2015 LTC reform was that coordination problems in HC and LTC have significantly increased. However, the interviewed organizations report that coordination was also a major problem before 2015.[1] While the organizations consider the higher quality of care in each LTC scheme to be a positive outcome of the reform, they find that the division of responsibilities and functions has fueled coordination problems.[2]

> The problem of the care for the elderly in Holland is that it is divided in several systems and that's the problem. (CIZ) What I see right now is that the problems we have in the coordination are often the result of these three systems not being sufficiently integrated. (ZN)

In particular, immediately after the 2015 LTC reform had been implemented, patients had difficulty in finding and contacting the actor responsible for their requests, needs, and benefits. Once the new structures were institutionalized and matured, such access problems diminished.[3]

> And the point of contact for clients is crucial. … And that was an issue in early 2015. Yes, they did not know whether they had to go to the Wmo domain or to the insurance company or a Zorgkantoor. That was quite a thing, but that has become quite structured by now. (NZa)

Even the actors responsible for financing and providing HC and LTC did not in all cases know which actor was responsible for financing and coordinating care services. In the interviews, several organizations discuss the financing

structures. Each form of care is financed according to a separate scheme. Overlaps and transitions between the different schemes, however, are not adequately financed.[4] How these gaps in financing overlap and how transitions between the different schemes influence the provision of care is illustrated by the interview with ZN:

> If people have to eat their meals, they sometimes need some guidance … or people should look after that they're really eat their meal. Well, there was a discussion about whether this is a medical thing? In this case, the health insurance companies should pay, or is it a more general "household help" thing, in this case the municipality should pay. Often there was discussion about the municipalities who didn't want to pay. Health insurance companies said, "well, we are not going to pay everything". So, we had this talk with these organizations. … The final solution was that the health insurance companies said "well, we just pay for those two days where there is a discussion about the responsibility for financing, we just pay no matter if it's okay or not, and after these two days the municipalities should have made up their mind and make other arrangements if necessary". It's an example of what we try to do from our role as Zorgverzekeraars Nederland. (ZN)

This statement is underlined by a representative of a care office (*Zorgkantoor*), who criticizes the fact that the coordination of care is often violated by the financing structures and that this problem has not been resolved although the Ministry of Health is aware of it:

> But they [the ministry] don't want to make a new law. Because that's a big thing. Sometimes they stimulate to just arrange it [joint financing] a little bit creative. But it's hard because it requires a change of the law. (VGZ)

From the perspective of organizations, financing structures contribute to shifting costs and responsibilities from one scheme to the next scheme in line.[5] Effective coordination is further complicated because HC, residential LTC, home care, and home help are organized by different institutions, each covering different areas (national, regional, municipal).[6]

> It's very hard to coordinate care, nobody really knows who is in charge. (Verenso)

The organizations share the opinion that e-Health measures and devices can facilitate the coordination of care between schemes and professionals. Today, all schemes and organizations operate with electronic systems. In most cases, these electronic systems are not compatible, which hampers coordination, and sometimes either information is not shared between the professionals or the patient is responsible for information sharing.[7]

> Now we are busy all day with mailing, telephoning, logging into systems, that somebody uses another system, that we cannot exchange safe e-mails. So then, you

> have a password for this, password for that. It would be fantastic if you can log-in and see the whole package. (Transfer nurse)

The first projects have been implemented to solve some of the compatibility issues that have been mentioned above.[8] Most organizations see electronic patient records and other electronic means (video calls, dispensing pharmaceuticals by electronic devices) as (partial) solutions to solving or alleviating coordination problems and supporting coordination between professionals.[9]

> Ideally, you would have just one electronic patient file per patient, accessible for all healthcare providers, hospitals, nursing homes, GPs. (Geriatrician)

Organizations think that it is important to consider and address privacy issues with electronic patient records but that these privacy issues should not delay or prevent the implementation of general electronic patient records.[10] Furthermore, the implementation of general electronic patient records should be initiated and managed at the national or at least the regional level.[11] One interviewed representative of a care office also sees a better digital infrastructure as a solution to reduce the problem of staffing shortages:

> We definitely don't have enough staff. But I think it can be a chance for the entire society so that we can have more e-health, more digitalization. (VGZ)

The 2015 reform restricted access to residential care and made home care the new norm for old-age care. Although the organizations are generally in favor of this change, they think that further measures, such as investments in adequate and safe housing for older people, are required.[12] Furthermore, the interviewed organizations demand forms of community living with higher care capacities.[13] According to them, home care capacities need to be increased because the demand for home care cannot be satisfied due to staff shortages.[14] Shortages of both staff and home care spots result in longer hospital stays.[15] When there is no medical need that requires inpatient care, however, hospital stays can be considered an additional burden for patients that may even compromise the process of recovery.[16]

There are also examples at the other extreme. Partly because hospitals are mainly funded by DRGs, they discharge patients quite early even when no coordination of care or further care services at home have been arranged.[17]

> First of all, there are older people admitted to hospital who shouldn't be there. Because there is no other place for them to go. (V&VN) I always want to stress that for these older patients being longer in hospital than they need is unhealthy. Because in our academic hospital and in any hospital for that matter, we are not trained to

> deliver geriatric care to frail older people. (Geriatrician) And in the hospital, everyone should go back home as quickly as possible. (Huisarts)

The transition from a system in which residential care has always been the main option to one that concentrates on ambulatory care is difficult to explain to older people, particularly in these times of the increasing need for HC and social care services. Older people have been socialized and have developed trust in the traditional residential care structure, and they have therefore planned their later life with the old system in mind.[18] Some organizations question whether the strict change from residential to ambulatory care has been the right decision because some people might be better off in a nursing home although they do not qualify for it.[19]

5.4 ORGANIZATIONAL-LEVEL PROBLEMS: TOO MANY DIFFERENT PROVIDERS

The organizational level provides the structures for the work of professionals. At the organizational level, the interviewed organizations perceive the large number of different providers, especially in home care, as the main problem in coordinating HC and LTC services.[20] They consider the number of (small) organizations that provide home care services as being too high in many cities and municipalities.[21] Often, patients have no information about which provider to contact when they need home care services.[22] In addition to this lack of transparency, another reason why coordination of care is restricted by the high number of home care providers is the competition between them. Competition between home care providers reduces information sharing and makes it more difficult to identify adequate care solutions.

> It is simply difficult to have 30 companies in one city that provide home care. They should have some kind of togetherness, some kind of cooperation, some kind of phone number or a website, well that comes together. … That should be made simpler and now it is all competition, marketization. In some regions this works perfectly, they work together, and they make an appointment with the hospital together. … But in others they say "No! I am not going to talk to my competitor". (Actiz)

When hospitals are operated by the same owner as home care facilities, coordination becomes easier.[23] Furthermore, care service providers and GPs are often not in contact with each other, and there is hardly any exchange of information about the needs of their clients.[24] In cases in which GPs and care

organizations cooperate and share information, older people in need of care benefit significantly.

> For instance, in the city where I'm living, our organization is the biggest and we talk to all GPs every month, in the entire city. We are in the lucky position that there are no other care organizations. So, we have a good relation with the GPs, they with us, we trust each other and we can easily pick up the phone and call, because they know us. But in areas with for example ten organizations, GPs don't know the home care nurses and then it is more difficult to just pick up the phone and call. (Home care nurse)

Most providers have a lack of staff and therefore a capacity shortage. New clients may have to contact several providers before they find a care provider, and sometimes waiting times apply.[25] Staff shortages and the resulting shortage of capacity is therefore another reason why patients occupy hospital beds for longer than is necessary.[26] Larger home care organizations also suffer from staff shortages and therefore have limited capacity. In contrast to smaller agencies, however, they are able to inform potential new clients more quickly if they have capacity: most larger home care organizations have information systems in which the different care teams report to the organizations' back offices on their capacity (number of patients and level of care) and, consequently, on their capacity to provide care to a new patient. When potential new clients approach such an organization for home care services, the back office can make arrangements directly and without delay, without having to contact the nurses during their work. Such a coordination service, however, is not implemented nationwide and facilitates the coordination only in larger home care provider organizations.[27]

5.5 PROFESSIONAL-LEVEL PROBLEMS: LACK OF STAFF AND OF COMMUNICATION

The professional level refers to the actual service provision, i.e., the interaction between the patient and the service provider (e.g., GP, nurse). The following statement by a transfer nurse illustrates one major problem at the professional level of HC and LTC provision in the Netherlands which is the lack of inter-professional cooperation:

> So everybody is working on their own piece and there's nobody who makes the puzzle. (Transfer nurse)

The other major problem at the professional level is one that has already been identified at the system level and at the organizational level: staff shortages. These shortages affect almost all HC and LTC sectors but are most severe in

home nursing care.[28] The number of geriatricians, especially those taking over home care services, is also considered to be too low by many organizations.[29] Rural areas face a shortage of GPs in particular.[30] Staff shortage is a problem in itself, as it impedes the delivery of high-quality care but also increases the problems in the transition of patients between sectors and the exchange of information between professionals.

As for specific transitions, communication and cooperation between professionals are rated as positive by the organizations, and in many cases home care nurses and GPs as well as other providers have established relationships with high levels of trust.[31]

> If you know people it will save time, if you know the colleagues in the hospital or the caregivers. (NHG)

Still, communication and cooperation between professionals can be further improved. For instance, GPs and home care nurses are not always informed when their patients are admitted to or discharged from hospital, especially in cases of shorter hospital stays.[32] Furthermore, several organizations criticize how information is shared. In general, organizations consider transfer nurses as being able to take on a central role in coordinating the transition from hospital care to other forms of care. This role, however, can only be fulfilled if transfer nurses have access to all necessary patient information. The interviewed home care nurse criticizes the fact that transfer nurses do not always have all the relevant patient information, which makes communication between the transfer and home care nurses difficult. Hence, the home care nurse suggests that communication with transfer nurses should be replaced by direct consultations between the ward nurses of the hospital and the home care nurses. From her perspective, this direct communication would be more effective in coordinating the appropriate steps in the transition from hospital to home care.[33] In contrast to this interviewed home care nurse, the interviewed transfer nurse sees great potential for improving the role of transfer nurses as the coordinator and communicator, especially if, as is the case today, their place is not…

> … at the end of the cycle in hospital. We as *transferverpleegkundige* [transfer nurses] want to sit in the driving seat. (Transfer nurse)

5.6 RESPONSIBLE ACTORS: PATIENT-CENTEREDNESS AND SHARED RESPONSIBILITY

The previous section has already addressed the issue of who should be responsible for coordinating care in a specific setting. Responsible actors for coordination can be identified at all three levels. However, the answers in our interviews mostly focus on the professional level. While the organizations interviewed are virtually unanimous on the problems in HC and in LTC, they are much more divided on the question of which institutions, organizations, or professionals should be responsible for the coordination of care.

The interviewed GP sees an increasing need for coordination due to the specialization of professions in HC and LTC. According to the GP, the need for coordination would be reduced if generalists had a more important role in the care for older patients and specialists were less involved.[34] Furthermore, many organizations argue that patients and their families should have a central role in the coordination of care and should be the actors who make the final decision as long they are capable of decision-making.[35]

> That's a risk, of course, if you arrange too much coordination and "Well I'm going to do everything for you" and then you are going to do nothing yourself. (Actiz)

The organizations also demand that coordination tasks are facilitated by an adequate infrastructure at the local level[36] as well as compatible electronic patient records.[37] Often, the GP coordinates various interfaces and transitions between HC and LTC schemes for older patients, but not all organizations consider this as a responsibility of the GP.[38]

> It's too much. And also the question is whether "it is the task of the GP to arrange the care," because the GP is the doctor. So, if these are medical questions, okay. But if it is a care problem, so that patients cannot wash themselves or they have problems with the toilet etcetera, or sleeping problems, or they have a risk of falling, well we can think of that. But we cannot just make phone calls and arrange that. (NHG)

With regard to the specific transition from hospital to home care, the interviewed organizations name various professional groups that they believe should take over the main coordinating task either alone or in cooperation with others: the home care nurse,[39] the transfer nurse as the central actor supported by the home care nurse, the GP, and the geriatrician.[40] Some organizations demand shared responsibility: by the GP, the transfer nurse, the geriatrician, and the community nurse,[41] and by the home care nurse and the transfer nurse.[42] The organizations in our interviews do not see the GP as the central actor responsible for coordinating the transition from hospital to home care.[43]

Organizations demand joint responsibility even more in the home care setting than in the transition from hospital to home care. Most organizations consider the GP to be responsible for coordination, either alone,[44] supported by a community nurse,[45] in a team including the home care nurse,[46] or in a team including the home care nurse and a social worker.[47] Some organizations also see home care nurses in the main coordinating position,[48] or as the main coordinator together with the GP.[49] At the system and organizational level, the Needs Assessment Center (*Centrum Indicatiestelling Zorg*, CIZ) demands that the municipality or local level should assume a greater role in coordinating home care.[50]

5.7 CONCLUSION

In the Netherlands, both HC and LTC are highly developed and highly institutionalized welfare state systems that consume a large amount of monetary resources and provide comprehensive services (Ariaans, Linden, & Wendt, 2021; Reibling, Ariaans, & Wendt, 2019). In the early 2000s and 2010s, both systems underwent major reforms, which aimed at decreasing costs by implementing pro-market mechanisms, provider competition, and costumer choice. In LTC, the 2015 reform restricted the eligibility for residential care and introduced a higher number of parallel schemes and thus a multitude of administrative actors. We expected that the increased number of schemes and the shift toward market mechanisms would make the coordination of HC and LTC services for older patients more difficult.

Our results support our expectations and show that the shortage of staff, in particular of home care nurses, geriatricians, and GPs in rural areas, has intensified coordination problems. It is striking that all interviewed organizations, although having different structures, interests, and aims, identify and assess the coordination problems in HC and LTC for older patients rather similarly. This coherent assessment indicates, first, that the identified coordination problems are "real" problems for the different actors and organizations and, second, that these organizations may support reforms that reduce coordination problems.

One major problem is the high number of different schemes that provide HC and social care services for older patients. The 2015 reform has increased the number of schemes and therefore the number of administrative bodies and access points. All interviewed organizations consider this number to be too high. In the initial period following the implementation of the 2015 reform, patients had difficulty in identifying and contacting the administrative body responsible for their specific care situation. Although this problem seems to have partly been solved through adaption processes, the existing differences in regional settings and the non-harmonized financing systems are seen as a major deficit of the whole HC and LTC system. According to the interviewed

organizations, the coordination of elderly care services requires a certain level of "creativity".

The implementation of market mechanism and cost containment measures in HC and LTC have had two opposing consequences. Cost containment in hospitals and in particular the DRG financing scheme has led to shorter hospital stays. Short-term discharges, with GPs and other service providers being insufficiently informed about the patient's situation, have resulted in a lack of coordination and continuity in home care. At the same time, restricted eligibility for residential care has greatly increased the demand for home care, while home care capacities have been unable to meet the demand due to a lack of financial and human resources. Hence, patients sometimes stay in the hospital for longer than is necessary until home care or other facilities are available.

Pro-market reforms have led to a proliferation of often very small home care providers, making the transition from hospital to home care a time-consuming endeavor, as transfer nurses (or in some cases patients and their families themselves) have to contact several providers before finding a place for the patient. Competition and fragmentation make the coordination of home care services even more difficult because providers are often not in direct contact with each other. High-quality care, however, is based on direct interaction and mutual trust between the involved actors, in particular between home care nurses and GPs. When many actors are involved in home care, this relationship of trust is more difficult to achieve.

The shortage of staff constitutes one of the major challenges for the coordination of care and for the provision of HC and LTC services. In particular, the interviewed organizations see the lack of nurses in the home care sector as highly problematic in itself, because home care services cannot be provided and the coordination of care in the home care setting is not a priority for nurses. Moreover, the interviewed organizations also consider the number of geriatricians and GPs to be too low. All organizations perceive e-Health measures to be beneficial for coordinating care services, and one organization even sees staff shortages as a chance for a more dynamic development in the field of digital HC and LTC. Overall, staff shortages seem to be the determining factor for whether and how care coordination for older patients can be achieved in the future.

Even if reforms in the future tackle the problems at the system and organizational level (e.g., reducing the number of schemes, closing the gaps in financing care coordination), the provision and coordination of care will remain highly dependent on the work in the field and thus on the workforce in HC and LTC. This reliance on different professional groups will remain, although past reforms and many organizations stressed that patients and their families should take over more responsibility in the care coordination process.

All organizations agree that the marketization reforms in HC and LTC have had adverse effects on the coordination of care. Some organizations believe that coordination problems have always existed and that only the way in which specific coordination problems unfold has changed. However, most organizations perceive the marketization reforms and especially the latest LTC policy reform, which increased the number of schemes and responsible administrative actors, as a policy change that has exacerbated coordination problems in the provision of HC and LTC services. This does not mean that these policies have not achieved their goals (e.g., decreasing the share of old-age people in residential care). Rather, they did not intend to improve care coordination in the first place. According to the interviewed care office and the Dutch Healthcare Authority (*Nederlandse Zorgautoriteit*, NZa), not only the involved organizations and professions are aware of this lack of coordination, but also the Ministry of Health. The problem, however, is the lack of political will to explicitly address this issue.

NOTES

1. CIZ; Home care nurse; VGZ.
2. Actiz.
3. NZa; Patientenfederatie.
4. CIZ; Ineen; NZa; Patientenfederatie; Verenso; ZN; Geriatrician; VGZ.
5. Verenso; NHG.
6. ZN; NHG.
7. Home care nurse; Geriatrician; NHG; Geriatrician.
8. NHG.
9. ZN; VGZ; Ineen.
10. ZN; Geriatrician.
11. ZN; Ineen.
12. CIZ; Huisarts; Patientenfederatie.
13. V&VN; Verenso.
14. Huisarts.
15. Home care nurse; V&VN; Transfer nurse; Geriatrician.
16. Geriatrician.
17. CIZ; Huisarts; Verenso.
18. CIZ; Transfer nurse.
19. ZN; VGZ.
20. Ineen; V&VN; ZN; Actiz.
21. ZN; V&VN.
22. V&VN.
23. NHG.
24. Home care nurse.
25. Home care nurse.
26. Geriatrician; Transfer nurse.
27. Home care nurse.
28. Home care nurse; Patientenfederatie; Transfer nurse.

29. Ineen; NZa; Verenso.
30. Ineen; NZa; NHG.
31. NHG; Home care nurse.
32. Huisarts; NHG.
33. Home care nurse.
34. Huisarts.
35. Patientenfederatie; Ucentraal; V&VN; Verenso; Actiz; NHG.
36. NZa.
37. Ineen; Patientenfederatie; ZN; Transfer nurse.
38. ZN; NHG.
39. Patientenfederatie.
40. Transfer nurse.
41. Actiz.
42. VGZ.
43. Verenso.
44. Verenso.
45. NZa; V&VN.
46. Huisarts; Actiz; VGZ.
47. Ineen.
48. Home care nurse.
49. Patientenfederatie.
50. CIZ.

6. Sweden: regional and local autonomy

6.1 INTRODUCTION

Sweden has a comprehensive welfare state system that covers all Swedish residents. The Swedish healthcare system and the social care system are among those with the highest funding and the highest quality in the OECD. However, the provision of services for patients who require services from both systems is not always adequately coordinated. This lack of coordination might cause increasing problems in the future due to ongoing demographic aging. Today, 20 percent of the Swedish population are 65 years of age and older (OECD, 2022), which is at a medium level compared to the other countries discussed in this book, and this share is expected to increase further in the following decades (Sveriges Kommuner och Regioner, 2021a).

The universal Swedish welfare state is characterized by generous financing out of general taxation, equal access and rights to services for all citizens as well as residents, an absence of means-testing, and a high quality of services (Meagher & Szebehely, 2019). The service-centered character of the Swedish healthcare and social care systems is reflected by the wide range of public care services offered. Healthcare (HC) and long-term care (LTC) are strictly separated institutionally, and administrative responsibilities are located at different political and administrative levels. Since the 1990s, reforms in both the healthcare and the social care systems have focused on limiting public spending by implementing privatization and marketization measures (Peterson, 2017; Szebehely & Meagher, 2018). There has been a significant shift from inpatient to outpatient care in both HC and LTC (OECD & European Observatory on Health Systems and Policies, 2019). For instance, the number of beds in LTC facilities for the elderly aged over 65 has decreased from 88.4 in 2005 to 68.1 per 1,000 population in 2019 (OECD, 2022). Against this background, both the HC and the LTC systems face major coordination challenges. Combined with a growing need for coordination due to demographic aging, care coordination at the intersection of HC and LTC is expected to gain further importance in the coming years.

This chapter is structured as follows. Section 6.2 provides contextual knowledge about care coordination in Swedish elderly care, discussing the institutional setting of the Swedish HC and LTC system by focusing on the

main reforms and most important changes regarding care coordination in recent years. Against this background, we develop our basic assumptions about how the institutional setting affects care coordination. Based on interviews conducted with organizations operating in HC and LTC (see Chapter 3 and Appendix 1 for an overview of the organizations), the following sections present the results from our study of the Swedish case and describe the main coordination problems, which can be divided into four areas: coordination problems at the system level (6.3); coordination problems at the organization level (6.4); coordination problems at the professional level (6.5); and the preferred responsible actors for coordination (6.6). Our descriptive analysis of the perspective of actors and organizations also reveals good practices and possible solutions for coordination problems. The concluding section (6.7) summarizes the results and discusses them in the light of our theoretical considerations.

6.2 THE SWEDISH HEALTHCARE AND LONG-TERM CARE SYSTEM: REGIONAL AND LOCAL COMPETENCIES

The healthcare system and the long-term care system in Sweden are institutionally separated and decentralized, with the national government providing the general legislative framework and being responsible for supervision (Peterson, 2017). While the responsibility for the provision of healthcare services lies with the regional councils, municipalities are responsible for the provision of social care services including both home care services and nursing homes for the elderly (Glenngård, 2020; Peterson, 2017). Both systems are characterized by a high level of regional and local autonomy. As regional and municipal governing bodies are free to set local priorities, this leads to variations in how HC and LTC are provided within the country (Glenngård, 2020; Paju, 2019).

The Swedish HC system relies predominantly on public funding through taxes raised at the regional and municipal level. Political and financial power is located at the regional level (Ahgren & Axelsson, 2011), with county councils or regional bodies being responsible for providing healthcare (Øvretveit, Hansson, & Brommels, 2010). In 2016, regions bore 57 percent of the overall health expenditures and municipalities up to 25 percent. Additionally, the national government grants subsidies to buffer regional inequalities or support specific initiatives that are of national priority (Glenngård, 2020). Healthcare financing is publicly regulated, and a variety of measures aim at keeping rising healthcare costs under control, e.g., tendering processes, global budgets, volume caps, and capitation formulas assigning financial responsibility to the providers of healthcare (Glenngård, 2020). As is characteristic of a universal welfare state and high-performing public HC system (Reibling, Ariaans, &

Wendt, 2019), the share of private out-of-pocket expenditure is below the EU average (at 13.7 percent of total health expenditure; OECD, 2022). Private health insurance is of marginal importance, accounting for less than 1 percent of health expenditure, and is used as supplementary coverage to provide quicker access to specialist doctors and elective treatment (Glenngård, 2020).

Like the other healthcare services, hospital care is financed and provided by the regions. Accordingly, all but six hospitals are run publicly by the regions (Glenngård, 2020). Hospital care is primarily financed through global budgets. DRGs (diagnosis-related groups), which constitute less than half of total payments, are partly used as a payment mechanism, but also for managerial purposes, transparency, and health statistics (Sérden & Heurgren, 2011). However, DRG financing is used to varying degrees in the different counties. Overall, performance-based payments constitute less than five percent of total payments in the Swedish HC system (Glenngård, 2020).

Since the 1990s, Swedish healthcare reforms have largely aimed at cost containment. To stabilize costs in the cost-intensive inpatient sector and provide patient-oriented care outside the hospital, the number of hospital beds has been almost halved since the 1990s (Ahgren & Axelsson, 2011; OECD, 2022). Sweden has one of the lowest numbers of hospital beds within the EU with 2.07 hospital beds per 1,000 total population in 2020 (the EU average is 5 hospital beds per 1,000 population) (OECD & European Commission, 2020). A similar trend is observed for the average length of stay in hospitals for all causes of hospitalization. In 2020, the average length of acute hospital care in Sweden was 5.6 days (OECD, 2022), which constitutes one of the shortest in the EU (EU average: 7.5) (OECD & European Commission, 2020, p. 224). Rationalization processes in the hospital sector and hospital payment methods set incentives for hospital discharges as early as possible. As a result and intended consequence, the provision of post-discharge home care has increased, because the need to deal with more severe health and LTC needs often requires immediate care and more time and personnel resources (Nordmark, Zingmark, & Lindberg, 2015). Starting with the *Ädelreformen* in 1992, municipalities received financial incentives to organize home care after hospital discharge in time, as they were made liable to pay hospital costs for those who do not need further medical treatment but cannot be discharged due to a lack of alternative outpatient care (Edelbalk, 2010). Swedish municipalities and regions consider delayed hospital discharges to be a sign of coordination problems at the regional or municipal level (Sveriges Kommuner och Regioner, 2021b).

At the same time, primary care has been given priority and is predominantly organized in primary care centers, in which several GPs, nurses, therapists, midwives, and psychologists work together in a team (Glenngård, 2020; Hasvold, 2015). Overall, 60 percent of all primary care centers are owned by

the counties and 40 percent privately. In both public and private primary care centers, physicians are predominantly salaried employees (Glenngård, 2020). The density of GPs varies between regions and is, with 0.6 GPs per 1,000 population, about one-third below the EU average, which is at 1 per 1,000 population (OECD & European Observatory on Health Systems and Policies, 2019). There is a general shortage of GPs across the country, and this shortage is expected to increase, making the provision of primary care, continuity of care, and collaboration with municipal healthcare even more difficult (Hasvold, 2015; Ljungbeck & Sjögren Forss, 2017; Reibling, Ariaans, & Wendt, 2019).

Overall, GPs and district nurses serve as common first points of contact for patients (Glenngård, 2020; Hasvold, 2015). GPs generally do not have a formal gatekeeping function in the Swedish healthcare system, because the population has direct access to most specialists (Glenngård, 2020; Hasvold, 2015). However, in some regions patients require a referral from their GP to receive specialist care (Blomqvist & Winblad, 2021; Larsen, Klausen, & Højgaard, 2020). As a GP referral generally reduces waiting times for secondary care (Blomqvist & Winblad, 2021), it is likely that in practice GPs act as important gatekeepers to specialist care. The role of primary care has been subject to recent changes (Myndigheten för vård- och omsorgsanalys, 2020). Since 2018, efforts have been made to strengthen the role of primary care as the first access point to healthcare, aiming to improve the accessibility, patient participation, patient-centeredness, and continuity of healthcare. However, GPs are heavily burdened and therefore have little resources to look after the elderly in home care settings (Lagerin et al., 2021; Modin, 2010; Sveriges Kommuner och Regioner, 2020).

District nurses coordinate care for patients with chronic illnesses or complex needs and constitute a link between primary care and home care (Glenngård, 2020). They are employed either by the county or the municipality (Modin et al., 2010). Depending on the district nurses' assignment to either a county council (as part of HC) or a municipality (as part of social care), the degree of collaboration between district nurses and other actors in primary care and home care varies. Collaboration between district nurses and GPs is more intense when district nurses are employed by the county (Lagerin et al., 2021; Modin et al., 2010). In contrast, district nurses employed by the municipality collaborate better with home care providers and therapists, but they face various difficulties in teaming up with actors from the HC sector. These difficulties include lack of contact to and support from GPs and a lack of access to patient information (Josefsson & Peltonen, 2015).

Since the 1990s, Sweden has pursued the policy of aging in place, which aims to enable older persons to live in their home as long as possible instead of in nursing homes (Brändström et al., 2022). Accordingly, the Swedish LTC system has a particular strong focus on home care (Glenngård, 2020),

resulting in a constant decrease of the number of beds and elderly living in LTC facilities (Fukushima, Adami, & Palme, 2010; Johansson, Sundström, & Malmberg, 2018; Peterson, 2017; Ulmanen & Szebehely, 2015). While there were 88.4 beds per 1,000 population aged 65 and older in LTC facilities in 2005, there were only 68.1 in 2019 (OECD, 2022). However, Sweden has a comparatively high share of elderly living in LTC facilities (4.2 percent in 2019), and the number of LTC beds in institutions per 1,000 population aged 65 and older is the fourth highest among the OECD countries (OECD, 2022). Because the responsibility for elderly care lies with the municipalities, the extent and details of service provision vary among them. In the 1990s, the care sector was opened to for-profit providers, and in the 2000s, customer choice models and a tax deduction on household services and personal care purchased on the care market were implemented. Today, municipalities can either provide elderly care services themselves or commission them to or purchase them from external private and non-profit providers (Szebehely & Trydegård, 2012). For-profit providers operate in parallel with public providers and non-profit providers, respectively. In accordance with the principle of local self-government, municipalities are largely free to decide whether they want to open up to private providers (Szebehely & Trydegård, 2012). Overall, an increasing share of municipal elderly care activities has been transferred to external providers since the early 2000s (Peterson, 2017). In 2018, 15 percent of elderly care was provided by external providers compared to 9 percent in 2008. Initially, competition between providers was based on price, but today it is mainly based on quality as municipalities remunerate public and private elderly care equally (Peterson, 2017; Szebehely & Trydegård, 2012).

Municipal taxes finance 85 percent of eldercare, while the remainder is covered by national taxes (10 percent) and user fees (5 percent) (Peterson, 2017). User fees are paid to the municipality and are determined by income and the amount of care. They are the same for home care and residential care, irrespective of whether services are public or private (Peterson, 2017). User fees are capped by national legislation; the current maximum charge is around 200€ (2,139 SEK) per month (Socialstyrelsen, 2020). Eligibility for care services is determined by needs assessment conducted by municipal care managers (Peterson, 2017). As the assessment follows local guidelines, access to home care and residential care varies between municipalities (Fukushima, Adami, & Palme, 2010; Peterson, 2017). Recently, an increasing number of municipalities have simplified the needs assessment procedures (Socialstyrelsen, 2021). Care services are provided in kind without means-testing (Glenngård, 2020; Paju, 2019).

Since the 1990s, social care policies have focused on retrenching benefits and eligibility. Hence, access to elderly care services has increasingly been limited to those with the most care needs, whereas a few elderly people

with fewer care needs were no longer eligible (Edelbalk, 2010; Meagher & Szebehely, 2013; Peterson, 2017). For the latter group, a dualization of care can be observed insofar as they either resort to informal care provided by family members or purchase services on the care market (Edelbalk, 2010; Meagher & Szebehely, 2013).

The principle of customer choice has become central in both HC and LTC service provision in the past two decades. The basic idea of customer choice in Swedish social policy is that patients can choose their primary care center (Glenngård, 2020) and that they can choose between public and private LTC providers listed by the municipalities (Paju, 2019). Customer choice was introduced with the expectation that the right to choose and change a provider would increase the quality of care (Peterson, 2017). To this end, the national government has set financial incentives for municipalities to implement customer choice in social care. In 2016, customer choice was implemented in approximately 60 percent of Swedish municipalities (Vårdföregatarna, 2022). However, several municipalities have turned away from customer choice because the costs for coordinating these services have increased (Jordahl & Persson, 2021). In primary care, customer choice policies have mostly replaced the traditional model, in which the responsibilities of primary care centers for residents were determined by geographical location (Hasvold, 2015). Instead, patients are now free to choose their primary care center. As patients usually choose a primary care center but not a particular GP (Glenngård, 2020), they do not necessarily have regular contact with a particular primary care doctor (Sveriges Kommuner och Regioner, 2020).

In recent years, politicians' awareness of coordination problems in the HC and LTC system has increased, and care coordination has become a national policy goal (Glenngård, 2020; Sveriges Kommuner och Regioner, 2021a). Various initiatives were launched to strengthen collaboration within and between HC and LTC. The main innovations from these initiatives are the introduction of individual care plans (*samordnad individuell plan*, SIP), the involvement of care coordinators serving as permanent contacts for the patients, and mobile doctors supporting LTC nurses on the spot. Additionally, there are various model projects at the local and regional level working in innovative ways to organize HC and LTC in a more integrated way. Sweden is a pioneer in the digitalization of healthcare and social care (Busse, 2011; Thiel et al., 2018) and has implemented a national e-Health policy with a focus on the integration of systems and interoperability (Ministry of Health and Social Affairs & Swedish Association of Local Authorities and Regions, 2016; OECD & European Observatory on Health Systems and Policies, 2019; Thiel et al., 2018). There is a long tradition of using electronic patient records in the HC sector, dating back to the 1980s (Kajbjer, Nordberg, & Klein, 2011). However, documentation systems in home care are separated from the medical

electronic patient record (Törnqvist, Törnvall, & Jansson, 2016). Electronic patient records have initially been implemented only at the municipal and regional level. However, in 2009, national electronic health records have been introduced (OECD & European Observatory on Health Systems and Policies, 2019), complementing but not replacing the established systems at the municipal and regional level. Between 2012 and 2018, nationwide patient accessible electronic health records (PAEHRs) have successively been introduced (Cijvat, Cornet, & Hägglund, 2021; Moll et al., 2018), and the use of telemedicine has rapidly increased in recent years (OECD & European Observatory on Health Systems and Policies, 2019). Reflecting the increasing importance of digitalization, the Swedish e-Health agency (*eHälsomyndigheten*) was established in 2014 with the goal of implementing e-Health at a national level (Thiel et al., 2018).

When analyzing these institutional settings, we identified six features of the HC and the LTC system in Sweden that could pose challenges to care coordination. First, due to the high degree of institutional decentralization of HC and LTC, the responsibilities for the administration and provision of care lie with different agencies that use different financing modes and communication systems. This may lead to coordination problems at the interfaces between HC organized at the county level and LTC organized at the municipal level. Therefore, one could expect communication problems between actors in HC and LTC. This affects all settings in which actors from HC and LTC need to collaborate, such as in the context of hospital discharge or between primary care centers or GPs and home care providers. Moreover, as district nurses are employed by either county councils or municipalities, the quality of collaboration between district nurses and GPs or between district nurses and home care nurses will depend on the care setting. Collaboration can be expected to work better between actors that are employed by the same entity (county or municipality). Furthermore, financing coordination could be a problem because healthcare or social care rely on separate budgets on the regional or municipal level. Therefore, financing coordination across the interfaces of HC and LTC can be expected to be difficult because counties and municipalities need to agree on a mode of financing coordination. Second, the high degree of autonomy at both the regional and the municipal level allows for regional and local variations in providing care. Therefore, coordination problems and best practices can be expected to differ locally depending on the entities' priorities. Third, the privatization of LTC services might have increased coordination problems due to the resulting higher number of actors in the systems. Especially, in combination with customer choice, one could expect that a higher number of different actors at the regional and the municipal level need to interact with each other to coordinate care. As a result, the workload of professionals and coordination costs might increase. Fourth, GPs traditionally

have been involved in care coordination in ambulatory care, and thus in elderly care, to a very limited extent. This indicates that there is a gap between medical care and home care that could constitute a problem for care coordination. District nurses constitute a link between HC and LTC, and we expect that they might compensate for the lack of GP involvement to a certain extent. Although GPs have become increasingly involved in care coordination in recent years, they probably have not yet fully adapted to their new roles. We also expect that the shortage of GPs limits their capacity for coordinating care. Fifth, shorter lengths of hospital stay might contribute to coordination problems at the interfaces between hospital and home care because the burden for home care providers increases, who are responsible for more intense care needs that require higher care coordination. As financial incentives for municipalities to organize post-discharge care have been implemented, we expect that municipalities will comply with the existing rules and try to provide post-discharge care in time as far as possible. Sixth, there have been increasing efforts to improve care coordination in recent years, which might mitigate coordination problems particularly in the context of hospital discharge. Therefore, we expect that there are fewer coordination problems when care plans are regularly in use. Even though e-Health is comparatively well developed and electronic patient records have been in use for decades, separated communication systems, which are partly a result of institutional decentralization, might increase coordination problems.

In the following sections, we present our analyses of how Swedish key stakeholder organizations in the areas of healthcare and long-term care financing, regulation, and delivery structures perceive the coordination problems in HC healthcare and LTC in their country. Our findings are based on interviews conducted with representatives of these organizations. It is important to note that three of the interviewed organizations are involved in model projects that aim to improve care coordination. Some of the interviews were conducted in January/February 2020 but most were conducted in Autumn 2020, after the first COVID-19 wave. Therefore, the impact of the COVID-19 pandemic on care coordination has been implicitly or explicitly discussed in the latter interviews. Chapter 3 and Appendix 1 provide further information about the interviewed organizations and how the interviews were conducted.

Following our theoretical approach (Chapter 2), we categorize the problems identified by the organizations into three dimensions: systemic; organizational; and professional. The systemic level refers to the institutional structure of the HC and the LTC system, the organizational level to specific organizational mechanisms and instruments, and the professional level to the division of labor between different occupations and how they communicate and cooperate with each other.

The organizations interviewed report that there have been various changes in the HC and the LTC system in recent years that have negatively affected care coordination. Major changes from their perspectives were a reduction in the length of hospital stays, a tendency of hospitals to send elderly people directly home instead of placing them in short-term care, and a bigger role of primary care. At the same time, the organizations acknowledge that the implementation of tools such as care plans, digital communication systems, legal innovations such as the entitlement to a care coordinator, and new procedures between regional HC and municipal LTC have improved care coordination. Examples are mandatory meetings organizing the transition from hospital to home care. Despite such positive developments, the organizations identify various problems in HC and LTC services for older people in Sweden that hamper care coordination: at the system level, the fragmentation of communication systems caused by the autonomy of local entities and laws hindering information sharing; at the organizational level, the low priority of care coordination within organizations and the high number of potential provider combinations caused by customer choice policies; and at the professional level, the shortage of qualified staff and the lack of involvement of primary care providers in home care. Regarding the question of who should be responsible for coordinating care, the organizations differ slightly in their opinions, but all agree that it depends on the individual needs of the patient, not on the profession and thus the status of the actor.

6.3 SYSTEM-LEVEL PROBLEMS: FRAGMENTATION OF COMMUNICATION SYSTEMS

From the organizations' perspective, the major problems at the system level are the fragmentation of communication systems, legal barriers to information sharing, and a lack of clarity about how coordination is financed. The organizations attribute the fragmentation of communication systems to the separation of the HC and the LTC system and the extensive autonomy of local entities, which hinders the development and implementation of more encompassing communication systems. Regions and municipalities can choose freely between various electronic information sharing systems, which leads to the use of different systems and parallel information sharing structures, which often are not compatible with each other. Moreover, there are separate digital systems for HC and LTC, which the organizations consider to be a serious problem for communication between HC and LTC, particularly for LTC staff, who do not have access to the medical databases. Furthermore, the organizations see incompatible information systems as a heavy burden for professionals in both HC and LTC because they need to invest time in gath-

ering all the relevant information on a patient, which reduces the time that is available for actual service provision. Moreover, the organizations criticize the fact that the current information sharing systems run the risk of losing information, which could compromise patient safety. For example, no nationwide medical database exists that provides an overview of a patient's medication that is accessible to both medical and LTC providers. Also, at the national level a number of digital systems coexist that are not interconnected, such as electronic medical records and electronic prescription records. All organizations agree that the solution for those communication problems is to implement digital systems that are interconnected and accessible to professionals from both HC and LTC. Moreover, they consider it important that all information in these systems, being highly sensitive, is stored and shared in compliance with high safety regulations. Despite the fragmentation of communication systems, all organizations believe that the implementation of digital tools improves care coordination, information sharing, and direct interaction and care planning between professions, as the following quote illustrates:

> The dream should be that for example the nurse coming home to the patient to take the laptop and have a direct discussion with the patient's doctor or with a social worker and solve the problem right away. (Regional council)

Furthermore, some organizations report that digitalization and the acceptance of digital tools has accelerated during the pandemic. All organizations see digital tools as promising for improving inter-professional communication across the HC and LTC sector, however, they mention that legal barriers hinder information sharing between organizations and sectors and consider the current laws to be inadequate. Some organizations see the high standards of data protection as a barrier for information sharing because the patients' privacy rights are prioritized over patients' safety. Although the organizations regard the patients' privacy rights as essential, they question whether the power of patients to determine which parts of their health and care information they share helps in coordinating and providing adequate care. Therefore, some organizations, such as a provider of integrated care, call for legislative changes to enable data sharing:

> I think there are too many legal barriers hindering you, stopping you from getting the complete picture of the patient's needs. It is all fragmented in little boxes, and you have access to this box and someone else has access to another box. (Tiohundra)

A further problem at the system level is the lack of coherence and the lack of clarity about how coordination is financed. The organizations see different priorities for the financing of social care services by municipalities as a hindrance for care coordination. Municipalities differ in their overall financial situation

and therefore also in the level of funding for elderly care and care coordination. Furthermore, funding for elderly care competes with funding for other social services, as the National Board of Health and Welfare (*Socialstyrelsen*) points out:

> It is the staff working around the elderly that needs to be coordinated. And that's something that depends very much on the financial situation of the municipality or company. How much they can spend, how much money they have. (Socialstyrelsen)

Additionally, the Health and Social Care Inspectorate (IVO) reports that the financial burden of the municipalities has increased because patients are discharged from hospitals earlier and this increases the need for all-encompassing and thus more expensive post-discharge healthcare, long-term care, and rehabilitation services. A municipal public care provider with a focus on hospital discharge management has also reflected that the separate budgets for HC and LTC lead to conflicts between regions and municipalities over the responsibility for financing certain services. In sum, financing care that crosses the boundaries of regional and municipal responsibility is complicated and needs to be negotiated between individual regions and municipalities as no predefined national guidelines exist. However, some organizations believe that the financial incentives in the context of hospital discharge, which obligate municipalities to pay for prolonged hospital stays when they fail to organize post-discharge care within the legally prescribed period, are helpful for increasing the municipalities' willingness to coordinate the transition to home care and thus comply with the existing laws. They find that these incentives work well and make the coordination of hospital discharge smoother:

> Probably it's the economic incentives. Because the municipalities have been forced, if they cannot take the patient home, they have been forced to pay the inpatient stay. So, they tried to create places to take them home. Because otherwise they have to pay for it. (SBU)

At the same time, the Swedish Society of Nursing (SSF) criticizes the lack of financial incentives for hospitals to engage more fully in care coordination and to comply with the guidelines for care coordination. Therefore, municipalities and region-steered hospitals receive unequal incentives to engage in the transition from hospital to home care. Moreover, the organizations consider the financing of innovations as a problem because local authorities have limited financial resources and are not always open toward such innovations. Organizations believe that digital tools have the potential to mitigate coordination problems. However, it is still unclear how digital tools in elderly care are reimbursed and whether alternative digital services are equally paid in case they replace standard services in the home. Some organizations emphasize

that improving care coordination requires new ways of financing and mention model projects and partnerships with companies as suitable ways to fund innovations.

Care coordination in the context of hospital discharge is also complicated by the needs assessment process, which according to most organizations is too time-consuming. Other organizations consider it to be inaccurate because care needs usually decrease quickly in the first days after hospital discharge. Therefore, several organizations recommend that the regular needs assessment should not be performed directly after hospital discharge to allow time for the patient to adapt to the new home care situation and thus ensure that the needs assessment reflects the care situation more adequately. For the first days after discharge, a preliminary decision should be made based on the hospital's recommendation, which could speed up the discharge process. However, this would require new responsibilities, as the hospital would be responsible for the initial assessment and municipalities would have to accept and trust the preliminary evaluations of hospitals and rely on these assessments for the funding allocated during the first days.

6.4 ORGANIZATIONAL-LEVEL PROBLEMS: LOW PRIORITY FOR CARE COORDINATION WITHIN ORGANIZATIONS

At the organizational level, the organizations identify two major coordination problems: the low priority given to care coordination within organizations and the high number of provider combinations resulting from customer choice policies. There are several innovations to support care coordination, such as care plans and care coordinators, which are supported by the national government. Although the use of these tools and measures has increased in recent years, the organizations see several obstacles when using them. According to the interviews, how these tools and measures are used in practice depend highly on the local context and the involved actors and organizations. They also mention that professionals lack knowledge and confidence in relation to the way in which individual care plans should be implemented. As a result, individual care plans are not used as much as they should be, although they are needed. Furthermore, the organizations report a lack of public knowledge about the existing right to an individual care plan.

The organizations also report that there are often communication problems at the time of hospital discharge that are related to insufficient communication structures between the involved organizations. Communication between hospital and home care organizations is problematic not only during hospital discharge, but also during hospital admission of elderly people who are in home care, as the Swedish Society of Nursing emphasizes. Often, the hospital

does not receive information about the patient from the home care provider. Furthermore, home care nurses and district nurses are often not informed about their patient's hospitalization. Consequently, they have to do their own research about what has happened to the patient, which takes up vital resources. The Swedish Society of Nursing suggests digital tools that share information with hospitals if a patient has already been a home care recipient could be a possible solution.

Generally, the organizations consider that care coordination in smaller settings (e.g., smaller municipalities but also smaller hospitals) is easier to manage than in bigger care settings, because organizations in smaller entities work together more closely and know each other. A problem in this context is that the hospitals in some cases do not fulfill their expected role in the coordination process. The organizations point out that acute care hospitals have traditionally not prioritized care coordination. Since the elderly are more often discharged directly to the home care setting, the role of the hospital in care coordination has become more important in recent years. However, organizations complain that some hospitals do not sufficiently fulfill their role in coordinating post-discharge care. Such a lack of involvement by hospitals in care coordination is often compensated for by municipal home care services.

According to the interviews, recent policy changes regarding the responsibility for coordination have created a new context for care provision. Now, the challenge is that organizations adapt to these new guidelines and rules and their willingness to do so is considered as crucial for the success of changing the responsibility patterns of the organizations. Organizations that have already implemented model projects[1] report that continuous communication within organizations is essential to improve care coordination and raise awareness of care planning. There is a risk that coordinating tasks are implemented at the expense of direct care provision. From the organizations' perspective, a balance between the two areas of activity is needed.

Some organizations attribute coordination problems to the changing landscape of LTC providers. The privatization of LTC organization has increased the number of actors in the LTC system and hence also the number of home care providers that need to be included in care coordination. All organizations agree that this increase in the number of potential actors in an individual care setting complicates inter-organizational and inter-professional communication and cooperation. The increased freedom of patients to choose their HC and LTC provider leads to case-specific constellations of providers, causing problems for care coordination:

> It would be better for the patient to choose something that is connected, instead of choosing because just you want to choose. So, we have a problem with the politicians, they think the more choices you have, the better it gets. We say, you don't

> want more choices, you want to have something that is connected, that works. Our problem right now is that it is not synchronized. (Tiohundra)

A higher number of actors in the system also means that organizations and professionals do not know each other well and thus no formal or informal structures of cooperation exist. According to a provider of integrated care, a promising solution would be a connected or integrated option in which specific GPs and home care providers cooperate. Instead of choosing from all the available GPs and home care providers within a municipality, patients would choose a specific combination of HC and LTC provision in which collaboration between HC and LTC is a major goal. Although such formal cooperations exist, it is still illegal to convince clients to choose the integrated solution. The severity of the problem might vary throughout the country depending on the level of privatization in the LTC sector.

6.5 PROFESSIONAL-LEVEL PROBLEMS: SHORTAGE OF QUALIFIED STAFF AND LACK OF GP INVOLVEMENT

At the professional level, the organizations rate the shortage of educated staff and the lack of involvement of GPs in the home care setting as major problems for care coordination. Staff shortages concern home care nurses, physiotherapists, and GPs, but more so in the rural regions of North Sweden than in the urban centers. According to the organizations, the recruitment of staff is particularly difficult in the home care sector because work in this sector is unattractive due to low salaries. As one municipal public care provider points out, staff shortages will become even more severe in the coming years when the number of frail elderly patients with increased care needs continues to rise:

> To recruit and retain staff is also a challenge. Because we're going toward a population that we don't have enough hands in care or people in care and more and more elderly. (Äldreomsorg)

According to the organizations, one factor that increases the need of well-trained home care staff is shorter hospital stays. Patients discharged from hospital have more extensive care needs and require home care staff that are qualified to respond to their needs and to coordinate care. Moreover, the organizations see staff shortages as a reason for the limited exchange of information between physiotherapists and home care staff. As physiotherapists are seen as being overworked by the organizations, and thus as not having the time to communicate with home care staff and instruct them, continuous rehabilitative services are hindered.

All organizations agree that well-trained staff are essential in care coordination. A major problem in this context is the lack of education among auxiliary nurses in home care. These nurses often have a migrant background and a low level of education. Their lack of proficiency in Swedish is seen as a problem for care planning because they have difficulty in reading and writing care plans. Moreover, some organizations report that auxiliary nurses have problems understanding the basic principles of the HC and LTC system and the normative and legal background of their work, as exemplified by a nurse involved in municipal hospital discharge management:

> Right now, we're not able to go there because of too low levels of education. Language is an issue and also an understanding of the complex organizations, their rules, the perspective of the elderly person in focus, rehabilitation perspective, and such things. It's quite far away because to understand those things we need to have common ground, quite well-educated personnel that understands different rules, different organizations, and it's quite abstract. (Tryggt mottagande)

Hence, organizations call for better education of auxiliary nurses. Due to the difficulties in finding staff, the municipalities are willing to educate auxiliary nurses in language and technical skills, but there are not enough nurses to take on the role of educators because they would then be missing from LTC service provision:

> As the situation is tough to find staff with education, you have to put a lot of effort into educational programs. And I think that is what's lacking today. They don't have the time, they don't have staff to cover up to, during the time somebody is being educated or taking part. So it's kind of a negative spiral in that way. (IVO)

In model projects, several of the interviewed organizations[2] have put into practice a better educational standard of home care nurses, which these organizations regard as a desirable future standard for regular home care training. Connected to the problem of staff shortages is the problem of staff turnover, which the organizations consider hampers the continuity of care. The problem concerns the major professions involved in elderly care: GPs, hospital doctors, and home care nurses. The organizations associate staff turnover with frequent changes in contact persons, making it difficult for professionals to maintain accurate knowledge exchange about a patient. The following quote describes the experiences of a district nurse when trying to obtain information about a patient from hospital:

> So I will speak to the doctor. But the doctor is not there and the doctors is not the same as yesterday and it's not the same who saw the patient two months ago. (SSF)

A further problem in the context of care coordination mentioned by organizations is the insufficient knowledge of professionals about each other's skills, tasks, and processes. For example, regional healthcare providers criticize that there is little knowledge within hospitals about care provision at home. A regional healthcare provider with a model project on multiprofessional teams in elderly care reports similar observations with regard to multiprofessional collaboration in the home care setting:

> We had nurses from the hospital and we have home care nurses in the same room. And it was so obvious that they didn't know what the others do. "Oh can you do that in home care? I didn't know that at all." They don't have really an idea about what home care can do. (Qultrum)

All organizations emphasize the need for professionals to learn from each other. For example, healthcare workers and home care staff have different areas of knowledge about, and unique perspectives on, a patient, and therefore could complement and educate each other. This integration of perspectives also includes physiotherapists, who are considered to be an important and integral profession in the home care setting. The interviewed organizations consider multiprofessional education to be an important tool to increase mutual understanding and trust between professions. Best practices mentioned in this context are care simulations that provide a space for supervision and help to increase the professionals' awareness of each other. However, a district nurse[3] considers it to be a problem that not all professions make such educational offers a priority and particularly that medical students are often difficult to reach and involve.

Another major problem addressed by the organizations is the lack of involvement of primary care actors—in particular GPs—in home care. All organizations consider that GPs are crucial actors in care coordination and at the same time they rate their involvement as too low. Hence, organizations demand a stronger involvement of primary care actors in home care, which is illustrated by the quote from a district nurse:

> At least in this city we need higher support from the doctor profession in basic home care. They're all so booked up with their patients at the healthcare center. So, we [district nurses] don't have much assistance. There is not much of a team. (SSF)

The main reasons for the lack of involvement of GPs in the coordination of home care are their high workload and, furthermore, they are not used to taking over the coordination of such tasks. This lack of involvement of GPs in the coordination of home care is expected to increase in the coming years because they will have to provide even more services to the rising number of frail elderly patients. Hence, organizations call for new solutions on how to provide

primary care for the elderly. One solution is to establish more home care physicians who focus exclusively on the elderly home care recipients. Another solution mentioned by the district nurse above is to intensify involvement and inter-professional exchange within the existing structures, which means that the GP needs to officially take over these tasks. Irrespective of possible future initiatives and solutions, the organizations demand that GPs generally need to develop a greater awareness of their role in the coordination process and increase their engagement for home care recipients.

Overall, the organizations rate the existing laws and procedures for care coordination as sufficient. The crucial, but currently incomplete, task is to follow existing rules and use the tools available in practice. The legal right for a care plan (SIP) is a strong instrument with the potential to facilitate the transition from hospital to home care. Organizations have previously experienced that professionals within the hospital in primary care are sometimes not able or not willing to implement care plans. According to the organizations, routines for care coordination are not always followed, either at the time of hospital discharge or within the home care setting, as a district nurse emphasizes:

> But when they come directly from the acute hospital, generally we have many misunderstandings and problems, and they [the hospital] don't follow the routines. Even the routines that are established, so they should … actually do it, but they don't do it many times. So that's a problem for us. (SSF)

Some organizations point out that the existing procedures and tools should be put entirely into practice before more rules or guidelines are implemented. At present, the organizations see no need for more regulations, except for more information sharing between organizations as discussed above.

6.6 RESPONSIBLE ACTORS: PATIENT-CENTEREDNESS AND SHARED RESPONSIBILITY

Regarding the question of which actors should be responsible for care coordination, the preferences of the organizations differ slightly. Overall, they do not think that responsibility for coordination is tied to a specific profession but rather to the specific case. All actors emphasize that a patient-centered approach is the starting point for care coordination. Consequently, the procedures need to be adapted to a patient's needs and resources. Organizations support an active role of the patient in the coordination process, which should be achieved by appointing one contact person for the patient. Overall, there is a common understanding among organizations that care coordination should not rely solely on the client or the family.

Regarding who should take the overall responsibility for the coordination of the transition from hospital to home care, the organizations' opinions are mixed. In general, they emphasize that the transition to home care constitutes a process in which several actors are responsible at different stages. Hence, even though one primarily responsible actor for coordination should be appointed, which could be GPs, district nurses, and professional care coordinators, other organizations and professions should be integrated into this process. For example, care coordination at the time of hospital discharge requires that the hospital and the LTC facility share the responsibility for coordination depending on the stage of the process.

Furthermore, organizations consider the profession of the coordinating actor to be secondary in home care and believe that the task can be fulfilled by several professions including district nurses, physiotherapists, occupational therapists, primary care nurses, district nurses, and professional care coordinators. They consider it to be particularly important that the most suitable actor take on the task of coordination, as the Health and Social Care Inspectorate (IVO) points out:

> But still, someone has to have an extra assignment to do that. And I think whether this is a social care service staff, a nurse, a physiotherapist, or an occupational therapist. But someone who is really involved in this patient. And it can change over time as well who has that role. (IVO)

The organizations regard the involvement of GPs as crucial in home care and emphasize that the role of occupational therapists and physiotherapists is more important here than in the transition from hospital to home care. Furthermore, there are differences between larger and smaller municipalities. According to the organizations, care coordinators are given a more important role in larger municipalities. Overall, the organizations consider the quality of care coordination to be highly dependent on the competency and abilities of the coordinating actor. Moreover, they emphasize the importance of appointing a clearly responsible actor, who is also the permanent contact person for the patient and relatives.

6.7 CONCLUSION

The Swedish HC system and the LTC system are both highly developed and institutionalized, with high levels of monetary resources to provide comprehensive services. The HC system is characterized by a high level of regional autonomy and the LTC system by local autonomy, resulting in a high level of variation in HC and LTC provision across the country. Since the 1990s, marketization policies have led to a diversification of the provider structures,

which has affected both the HC system and the LTC system and has increased the number of providers involved in care. Reforms in both systems have aimed to contain costs by implementing more market mechanisms such as customer choice. Moreover, aging-in-place policies combined with a reduction in the length of hospital stays have marked a shift from institutional care to home care, leading to multiple burdens for the municipalities both in terms of financing and with regard to the workforce in LTC. Against this background, we expected that differing local priorities and the shift in focus toward marketization and ambulatory care had posed challenges to the coordination of HC and LTC services for the elderly. The results confirm these assumptions and reveal additional problems in care coordination.

The institutional decentralization and thus the separation of HC and LTC as well as the autonomy of county councils and municipalities lay the foundation for problems such as the fragmentation of communication systems and a lack of clarity about who is responsible for financing care coordination at the interfaces between HC and LTC. Although Sweden is a pioneer in e-Health, the fragmentation of communication systems turned out to be a major problem at the system level. Therefore, it became obvious that the great advance in digitalization does not necessarily improve the levels of communication. Instead, barriers at the system level are reproduced in the context of digitalization. The fragmentation of communication systems poses a serious barrier to information sharing between organizations and professions. Because regions and municipalities are free to choose their own system, various databases and digital information systems exist in parallel, with access to the single systems being restricted to specific professional groups. Although the organizations see high potential for digital tools that aim to improve care coordination and a lot of digital tools and services are already in place, care coordination by these tools is still difficult. Therefore, the organizations call for more integrated and centralized systems as well as for laws that enable the exchange of information while respecting data protection.

Surprisingly, the issue of marketization has rarely been addressed by the organizations. Consistent with our assumptions, the organizations consider the major problem in the context of marketization to be the high number of actors that are not well connected but need to be able to collaborate in various combinations of care, not least because of customer choice. This indicates that current customer choice policies need to be carefully reviewed in terms of whether they are able to increase the quality of care in practice. However, the divide between public and private providers is not regarded as a major problem for care coordination.

The results confirm that the involvement of GPs is a crucial aspect in care coordination. To date, most GPs do not seem to fulfill their expected role adequately. Overload and a traditionally low focus on the elderly in a home

care setting are considered to be major barriers for GPs to engage in elderly care. The lack of involvement of GPs in elderly care causes a gap in the provision of healthcare in the home care setting. Recent reforms have attempted to strengthen the role of GPs in care coordination, but the results have been small because GPs have not adapted to their new responsibilities yet.

The organizations consider the time of hospital discharge to be a crucial interface and several procedures and tools are in place to organize this transition to be as seamless as possible. Due to these mechanisms, the collaboration between hospitals and ambulatory home care has improved in recent years. According to the organizations, shorter hospital stays can be successfully compensated by more extensive home care, provided that post-discharge care is delivered seamlessly and in a professional way. Also, the organizations consider that financial incentives for municipalities to comply with the existing rules by coordinating the transition from hospital to home care within the specified period could be helpful for care planning at the time of hospital discharge.

At the professional level, the shortage of educated staff, particularly in rural areas and in home care, is seen as one of the most important problems for care coordination. Staff shortages lead to high workloads for the present staff, which limits their resources and time for care coordination and follow-up services. In this context, the lack of involvement of GPs requires the development of new structures of service provision and making more resources available with a specific focus on home care recipients. Furthermore, staff turnover increases coordination problems because the continuity of care is hampered and actors do not obtain the information they need. Auxiliary nurses in home care are often low educated and have a migrant background, which is why they are often unable to read and write care plans. Care providers are willing to educate them, but this is hardly possible due to staff turnover and limited resources. Multiprofessional education needs to have a higher priority which can then help to increase the mutual understanding between professions by raising the awareness levels of the competencies and processes in other organizations and professions. However, medical professionals are less interested in care coordination and inter-professional collaboration and tend to focus more on their area of expertise. Consequently, the awareness of the need for coordination needs to be increased among professionals. Academically trained home care nurses take over a number of medical tasks. Our analyses do not reveal any conflict concerning responsibilities between the medical professions and home care nurses. The lack of conflict is related to the long tradition of academic nursing education in Sweden. Also, GPs' overload might prevent such conflicts about responsibilities as they do not have the resources for stronger involvement in elderly care.

All the organizations we interviewed show an awareness of coordination problems and believe that care coordination has improved in recent years

through the introduction of new policies, tools, and measures such as care plans and care coordinators. This especially applies to the organizations that have implemented model projects that aim to facilitate care coordination, who emphasize their experiences with useful tools and the reporting of best practices. However, there are still problems at the organizational and professional level when care coordination is put into practice. Therefore, the willingness of organizations and professionals to be involved in care coordination is crucial. Interestingly, the interviewed organizations also emphasize coordination problems around the admission to hospital, caused by a lack of information sharing and communication between LTC and hospital staff. Unlike in the context of hospital discharge, up to now no measures have been implemented to mitigate those coordination problems.

Our analysis has shown that the organizations included in the sample, which differ in their structures, interests, and priorities, identify similar problems in the coordination of HC and LTC services for older patients. Furthermore, all organizations show an understanding of the problems and actions of the other organizations. We can therefore say that their assessment of the coordination problems is rather objective. Overall, the organizations offer little criticism of the institutional structures of the HC and LTC system. Instead, they seem to accept them and try to make the best of the given conditions.

In conclusion, the roots of coordination problems lie in the institutional structures of the Swedish HC and LTC system, but also the priorities of organizations involved in elderly care contribute to them. At the professional level, resources for care coordination are tight because the shortage of educated staff and staff turnover hamper the continuity of care. Overall, the analyses have revealed no fundamental differences between the organizations' assessments. Although the organizations partly set out different priorities, there is a general consensus on what the major coordination problems are:

- at the system level, fragmentation of communication systems caused by the autonomy of local entities and laws hindering information sharing at the system level;
- at the organizational level, low priority of care coordination within organizations and the high number of potential provider combinations caused by customer choice policies at the organizational level; and
- at the professional level, the shortage of qualified staff and the lack of involvement of primary care providers in home care at the professional level. The organizations interviewed also agree that the responsibility for coordinating care depends on the individual needs of the patient, and thus the profession of this actor is subordinate.

Overall, the analyses indicate that organizations at all levels (national, regional, and municipal) are aware of coordination problems and that there are already mechanisms in place that aim to facilitate care coordination.

NOTES

1. Tiohundra; Tryggt mottagande; Qultrum.
2. Tiohundra; Tryggt mottagande; Qultrum.
3. SSF.

7. Switzerland: merits and downsides of medical dominance

7.1 INTRODUCTION

Switzerland is a federal country and a liberal welfare state (Obinger, 1998; Obinger et al., 2010). The 26 cantons and the municipalities have extensive authority in social and health policy (Trein, 2019). In addition, there are strong private individual responsibilities for dealing with social risks. Nonetheless, Switzerland has one of the most developed healthcare (HC) and long-term care (LTC) systems in terms of resources and services among OECD countries (OECD, 2021a; Höpflinger, Bayer-Oglesby, & Zumbrunn, 2011). In addition, the Swiss population is highly satisfied with the performance of the HC system in general: 91 percent of the people are actually satisfied with the availability of quality healthcare (OECD, 2021b). The high share of private out-of-pocket funding (OECD, 2021b; Strohmeier Navarro Smith, 2012) and a limited central state intervention require elaborate forms of cooperation and coordination.

In Switzerland, the HC system plays the dominant role in both medical treatment and LTC. This role is, however, confined to curing and basic medical care (*Grundpflege*), whereas the social aspects of care are not included and need to be covered outside this system. The gap between health-related and social aspects of care is wide: the first is covered by health insurance (HI) and regulated by federal law, and the second is largely privately financed and the responsibility of cantons and partly of municipalities (Knöpfel, Pardini, & Heinzmann, 2018). The strong medical orientation of the system gives GPs a central role.

7.2 INSTITUTIONAL SETTING: THE HEALTH INSURANCE UMBRELLA

Since 1996, Switzerland has had a compulsory universal health insurance (HI) system based on financing through per capita premiums and a supplementary social component supporting premium payments for low-income groups (Rüefli, 2021). The services and treatments covered by HI are

regulated by federal law and include the basic medical aspects of LTC. In 2011, a new framework law for LTC financing came into force (Knöpfel, Pardini, & Heinzmann, 2018). Since then, HI has covered long-term medical care in residential facilities and at home, excluding the social dimensions of care (Schweizerische Eidgenossenschaft/Bundesrat, 2016; Spitex-Verband Baselland, 2012). Yet, the financing modes differ: acute medical treatment in hospitals is mainly financed based on diagnosis-related groups (DRGs), whereas flat-rate benefits are provided for long-term medical care up to a maximum. Transitional care (*Übergangspflege*) as a new instrument in the transition from acute hospital care to LTC is financed from separate budgets. Like hospital care, it covers all costs including accommodation, which are not part of the LTC benefit package. Additional LTC needs surpassing the limit of the flat-rate benefits provided by HI have to be financed privately. The same holds for all social components of care and supplementary services such as housekeeping or mobility, which are not part of the medical service package (Knöpfel, Pardini, & Heinzmann, 2018). However, for needy population groups with low incomes, these expenses are partly socially financed via pension insurance benefits or by cantonal social welfare. For these reasons, private financing makes up a huge share in the Swiss LTC system. Moreover, since long-term care benefits in HI are legally capped, rising costs completely fall on the private and social welfare spheres.

Due to these basic institutional features, coordination between the two areas of medical and social care is difficult to manage, at both the federal and the cantonal level. Federal HI has no special earmarked budget and no institutional mechanisms for coordination. Moreover, per capita financing in HI is a high barrier to any extension of services. On the other hand, the fact that the medical aspects of LTC are part of HI also stabilizes this part of the service package. This is perhaps one reason for the highly developed care system in Switzerland in terms of professional services. Medical and basic LTC service provision in Switzerland is high in both the ambulatory and the residential setting, but the mix of the two sectors strongly varies regionally (Dutoit, Pellegrini, & Füglister-Dousse, 2016). The interviews in our project were conducted in the German-speaking part of Switzerland and thus refer only to the situation in these cantons. The federal regulations obviously also apply to the French- and Italian-speaking cantons, in particular the rules concerning HI, whereas the structure of LTC services differs between the language regions. In the German-speaking areas, for example, the share of LTC recipients in old-age homes is higher whereas in the *Romandie*, the vast majority of clients are cared for at home. In addition, the share of public providers in home care is significantly higher in the *Romandie* than in the German-speaking cantons (Dutoit, Pellegrini, & Füglister-Dousse, 2016).

In ambulatory settings, basic LTC is usually provided by Spitex, the nursing organization at the local level, which historically developed as part of municipal public HC and welfare. In recent years, private Spitex organizations have developed alongside the established public organizations, but their market share remains smaller (TRISAN, 2018). Clients can choose between these alternatives. The basic service package that is financed by HI is the same for both organization types, but additional services as well as their prices vary. Spitex services, whether public or private, are part of HI and therefore highly professionalized.

Both residential and home care services need to be prescribed by GPs who in Switzerland mainly work in private practice and act as gatekeepers to the basic care system (Trein, 2018). In contrast, the social aspects of care fall outside this realm and are therefore much less professionalized. In fact, social and additional services are mainly provided by private associations which often work with volunteers. This basic structure of service delivery in ambulatory settings raises two coordination challenges: first, between GPs and Spitex (public or private); and second between Spitex and social and additional services provided by other organizations. HI is the legal frame for the first problem, whereas the second challenge concerns the link between HI and private or local financing.

Managing the transition from acute medical care in a hospital to ambulatory LTC poses a huge challenge in Switzerland (Füglister-Dousse & Pellegrini, 2019). The Swiss hospital sector is among the best in the OECD world in terms of quality of treatment. At the same time, Switzerland has the second most costly HC system in the world behind the United States. Switzerland has introduced DRGs relatively late. They have now been the standard form of payment in the hospital sector for more than a decade (Blenk, Knötig, & Wüstrich, 2016). In doing so, Switzerland has largely followed the German DRG system which itself has followed the lead of other OECD countries. Beside general hospitals, there is also a growing sector of geriatric hospitals in Switzerland. DRGs potentially increase the risk that clients are dismissed from hospitals before they are able to manage their daily activities without assistance. This risk is even higher for elderly persons (Tuch et al., 2018). In response to that problem, a new type of transitional care (*Übergangspflege*) was established in 2011.

Most clinics have specialized personnel managing the transition from hospital to residential or to home care (Camenzind & Bonassi, 2015). They have expertise in the non-medical aspects of care, too. Nonetheless, the organizational gaps in these transitions are wide: first, between hospital services and private GPs; and second, between hospitals and Spitex. In fact, all three parties are stakeholders in these transitions. There is neither any formal responsibility for coordinating this process nor does earmarked financing exist. Like

in other countries, digital communication tools are an instrument for better coordination between HC and LTC. However, Switzerland is a latecomer in digital healthcare. In 2020, the electronic patient record (*Elektronisches Patientendossier*) was introduced, starting with the hospital and inpatient sectors. For organizations operating in these sectors, the implementation of these electronic tools is mandatory. For GPs and Spitex, providing medical care in ambulatory settings or at home, electronic patient records are voluntary. In addition, they are also voluntary for each client (Schweizerische Eidgenossenschaft/Bundesrat, 2021).

Due to these basic institutional characteristics, we expect that coordination problems in the transition from hospital to home care should be less severe than within the home-based setting. At both interfaces, private GPs have a pivotal position. Therefore, the organizations' assessment of how GPs fulfill their role is crucial. Due to the strong divide between health-related care and the social aspects of care including supplementary services, we expect that there are major coordination problems in the home care setting. Moreover, we expect that the "double voluntariness" of the electronic patient record causes coordination problems and hinders its effective implementation outside the hospital sector and even within hospitals.

In the following sections, we analyze how key stakeholder organizations in the areas of service financing, regulation, and delivery in health and LTC in Switzerland perceive the coordination problems between HC and LTC in their country. For this purpose, we conducted interviews with representatives of these organizations. Chapter 3 and Appendix 1 provide further information about which organizations we interviewed and how the interviews were conducted. The interviews focused on two critical interfaces: the transition from acute medical care in hospitals to LTC at home; and the provision of integrated HC and LTC in ambulatory settings.

We classify the problems identified by the organizations into three dimensions: systemic; organizational; and professional. Systemic problems refer to the institutional set-up of the HC and the LTC system, the organizational level to specific organizational mechanisms and tools, and the professional level to the division of labor between different occupations and how they communicate and cooperate with each other. The theoretical background and conceptual rationale for our classification is explained in Chapter 2.

In Switzerland, the interviews coincided with the preparations for a people's initiative for a better recognition of professional LTC work, spearheaded by occupational care organizations. The people's initiative is a major instrument in the Swiss federal constitution, which allows for a public referendum by people's vote outside Parliament. The care initiative demanded higher qualifications, better working conditions, and more authority for LTC professionals and workers. The repercussions of this debate are strongly reflected in the

interviews. We locate this discussion at the professional level because it mainly concerns the division of labor between GPs and occupational carers. The Swiss people approved the LTC initiative in November 2021, after the time of the interviews (Schweizerische Eidgenossenschaft/Bundesamt für Gesundheit, 2022).

7.3 SYSTEM-LEVEL PROBLEMS: THE PREDOMINANCE OF HEALTH INSURANCE

The organizations report three main systemic problems in the interviews: the financing of LTC through HI; the lack of financing for coordination tasks; and the lack of financing for social aspects of care. One critical issue is the system of financing of basic care through HI, which in Switzerland is based on per capita premiums plus financial support for persons with low incomes (social redistribution). Due to per capita premiums, the barriers to the expansion of services are high. As the Federal Office of Public Health (FOPH) says:

> [The] per capita premium is a hard instrument for the people, we actually don't want social or societal issues herein … but this must be financed by tax funds of municipalities and cantons. And I think that this basic decision is comprehensible in itself and I would not consider it as false, but it leads to great consequential problems. Within this kind of thinking, the cantons and municipalities opt for different solutions, they try to avoid this pressure, partially by an increased participation of the affected persons. (BAG)

This statement suggests that a shift of costs to the "weaker" parts of the system is the main problem related to the mode of financing. There is, however, a follow-up problem: the avoidance of payments for "public goods" costs such as coordination. Coordination tasks are not directly financed within the system; there is no earmarked budget for this purpose. In practice, coordination tasks are therefore often avoided and shifted to other organizations or "hidden" in other budget positions. This point is made clear by the Association of Swiss GPs and Pediatricians (Mfe):

> From our perspective, that is the GPs' perspective, we naturally deliver coordination tasks, that is part of our mission which has never been rewarded and won't be rewarded now. … Till now, it has not been possible to attribute a pay scale item to the GPs by which they could charge coordinating services. (Mfe)

Another consequence of this basic form of institutionalization is a strong medical bias in elderly care, which tends to shift social aspects and supplementary services to the side. The lack of financing shows up in a lack of integrated services, with the social aspects of care tending to be neglected. The system

has a strong institutional and medical bias, with social needs not being well represented. This perspective is widely shared among the interviewees, as a statement by the Swiss Association of Occupational Carers (SBK) illustrates:

> And that is an enormous shortcoming, this has been … integrated before, nursing care and social care were the same, and with the new regulation, this has been split up so that all day support and care will not be paid for anymore … At the moment, with the way it goes in the Swiss healthcare system, the human being is not at its core. (SBK)

A further aspect is the rising costs in LTC, which are not equally distributed among the financing institutions. Since HI benefits are legally capped, rising costs mostly fall on cantonal budgets or even personal out-of-pocket payments. This problem is clearly seen by the Association of Swiss Health Insurance Organizations (*Santésuisse*):

> We know exactly how much energy is put in the financial questions around nursing and social care, … with the demographic questions, well, we will have a doubling or tripling in a relatively short time. … The health insurance pays for nursing care, but not for social care, … principally, this is capped …, and the rest of the funding of the LTC, that is the part that is dynamic and will grow, has to be borne by the municipalities. This is the solution of today. … The actual health insurance is not really financed socially, … not by percentual contributions of wages, but by per capita premiums, so that it probably cannot manage it. And this is the big problem. (Santésuisse)

Most other interviewees also agree that per capita financing of HI is a big systemic barrier to social care financing and to integrating medical and social care, including the payment of coordination costs.

7.4 ORGANIZATIONAL-LEVEL PROBLEMS: LACK OF NETWORKS AND COMMUNICATION TOOLS

At the organizational level, the organizations pointed to three main problems: the lack of effective case management; an unbalanced mix of private and public organizations; and ineffective communication tools, in particular electronic patient records. Case management is relevant at two interfaces: integrated medical and social care at home; and the transition from hospital to ambulatory care. As for the first interface, there are no institutionalized forms of coordination on a broader base in Switzerland. All organizations believe that such case-oriented coordination might be useful, but it is not explicitly financed and in practice mainly depends on informal contacts between the involved organizations. In addition, there is no clear role definition as to who is mainly responsible for coordination. Therefore, whether and how things

work in practice mostly depends on local and even individual circumstances. The role of GPs in that respect is highly controversial among the organizations (see Section 7.5).

By contrast, the second interface, i.e., the transition from hospital to ambulatory care, is more institutionalized. Most clinics have established hospital discharge services, which have become more important after the introduction of the DRG system in hospital financing. Though institutionalization exists at that interface, the organizations disagree about its effectiveness. The Association of Swiss GPs and Pediatricians blames a lack of contacts between these services and the GPs, who have to open the door for follow-up home care:

> Today, acute clinics with these shortest durations of stay are no longer able to design the planning of dismissal in a way to guarantee carefully the long-term care in terms of social needs and aspects of physiotherapy and occupational therapy, there is simply no time for this. The geriatric clinics do this in high quality … In Switzerland, we have a strong dichotomy between hospital and practitioners, which means that GPs rarely go in the hospital, and the hospital rarely comes to the GP. (Mfe)

In general, however, the transition from hospital to ambulatory care is not seen as highly problematic, even after the introduction of the DRG system. For example, the Swiss Association of Occupational Carers has a relatively positive view of hospital case management in that respect:

> Already at the admission to hospital, the planning of the dismissal is initiated, and I think this can easily be done with regular admissions and with younger persons, but if the admission is a case of emergency and with elderly people, this is a little bit more difficult. And I think that there is a sensitization for it, the realization depends on the hospital and on how high this is ranked. … When the hospitals are specialized in acute geriatrics, they are well prepared because … they have the eye, the ear, and the sensorium for it and for elderly people. (SBK)

Not surprisingly perhaps, the assessment of the Swiss Hospital Organization (H+) is even more positive:

> The introduction … of the DRG system … has led to a country-wide professionalization of the discharge management in the hospitals, which means that already at the admission, I think about how the transition will work even with shorter durations of stay. … We have made the experience that all these worries, well, bloody dismissals, revolving door effect which was feared by the state, we can now scientifically prove that this has not happened. (H+)

In this statement, the introduction of the DRG system is even seen as a trigger for more professional hospital discharge management. Indeed, other organizations agree that the transition from hospital to home care has become more

professional and that most clinics have introduced special services for management in which social aspects play a crucial role. This is seen in contrast to the ambulatory setting in which social aspects are not taken systematically into account by the other organizations.

A second problem concerns the role of public and private ambulatory services. The integration of private service providers poses a problem for the Swiss system for two main reasons. First, since coordination is not institutionalized, a lot depends on informal contacts and arrangements, which seems to favor established organizations in the field. Second, the mode of financing seems to be a high barrier to new market entrants. Yet, the different organizations obviously assess the role of private organizations quite differently.

The Association of Swiss GPs and Pediatricians reports that the contact and exchange between GPs and private care organizations is even less developed than the already loose contacts to public care organizations. The Association of Private Basic Care Organizations (private LTC providers, ASPS) also states that they are not well integrated into existing coordination mechanisms. Moreover, the organization is critical that the financing rules benefit the public providers because they have a duty to serve, which is financed by the local communities quite comfortably. This gives them an advantage over private providers which have to calculate their costs more tightly. On the other hand, the public service providers argue that they have a duty to serve and partly blame private providers for "cream skimming" (i.e., selecting only the best, most profitable cases).

This discussion shows that private and public organizations are not integrated into the system on the same basis, which obviously poses problems for effective coordination. This circumstance is also put forward by the Swiss Organization of Elderly Persons (SSR), a client organization:

> The non-profit basic care organization (Spitex) gets its service mandate by a community and has to deliver all tasks in social and nursing care, for example to give an insulin syringe somewhere in a valley or to prepare pharmaceuticals, the charging is regulated in the health insurance law. The private Spitex has no obligation, it can choose individual persons like the cherries of the cake because it has to be financed somehow. (SSR)

Obviously, public and private service providers are in part financed differently, because they have different tasks in the system. As a consequence, the market is not really competitive but fragmented and segmented along social, regional, and needs-related dimensions. The private providers operate more in the high-income strata and city areas.

The third organizational problem relates to communication tools and was a highly debated issue in Switzerland at the time of the interviews. In 2020, hospitals had to introduce an electronic patient record, but the introduction

was voluntary for ambulatory services—in particular GPs and Spitex. The same holds for each individual patient. Electronic patient records thus work differently in residential and ambulatory settings. The interviewed persons have similar but also differing views on these regulations. The Association of Private Basic Care Organizations is very skeptical about these regulations:

> [The] electronic patient record is important, and good that it has been started now, but it will surely last another 20 years until we can say yes, principally, the collecting of important patient data has really been working continuously, … but until this will work, the hospitals have to introduce it only in April. What will they do? They will store some pdfs somewhere where nobody has a look into, simply to fulfill the legal obligation. (ASPS)

The Swiss Hospital Organization strongly criticizes the "double voluntariness" of the electronic patient record:

> The electronic patient record [EPR] could be an ideal instrument in the integrated treatment networks or on the chain when always being kept up to date with this EPR; the problem is that we had to make many compromises in our dovish federal democracy and have a double voluntariness in this law. (H+)

The Swiss Hospital Organization also reports that GPs in the ambulatory sector are especially unwilling to invest in new electronic communication tools due to high costs and their limited time perspective because many of them are relatively old and will soon leave medical practice. The expectation therefore is that change needs time. Another problem is that the software is not always compatible among all organizations. Some of the interviewed persons therefore mention "PDF cemeteries", in which PDF documents are uploaded but never used and never integrated into practical work and communication.

Concerning the chances for the electronic patient record, some organizations are skeptical about current rules and miss a tighter level of regulation, while others are more optimistic that the system can also work with current regulations over time because all organizations will ultimately adapt to the new requirements and needs. The Association of Swiss Health Insurance Organizations has a pessimistic view on this issue:

> This mixture of obligations and voluntariness depending on the care providers, this is purely impossible, there, a political concession was made to the practitioners, the freely practicing medical profession, which is actually impossible. … Here, there is a lack of clear leadership and order, … this is my major concern, that if it does not succeed to generate benefit, it will never pay for itself. (Santésuisse)

By contrast, the FOPH sees positive medium- and long-term effects of the electronic patient record, despite this "double voluntariness", and has confidence in it:

> With the registered doctors/practitioners … there is a lot of reservation, well there is no enthusiasm at all, but I think that even if it is said "well, they have fundamental objections that such a thing is not necessary at all", this is not true, but it is all about the way how we implement it, how we make it work, … I think that the basic assumption that this is a necessary instrument and that actually the coordination can be improved, … there is no doubt about it. If we have created all the institutions, the stationary ones, I am actually convinced that the pressure from the patients will continuously grow, and on the ambulant service providers to participate. (BAG)

In sum, at the organizational level, each sector of the system seems to work well from the organizations' point of view, but inter-sectoral coordination is still weak and often depends on informal arrangements. Case management works more or less well in the hospital sector and on discharge from hospital but is almost non-existent in the ambulatory sector. The electronic patient record has made a first step, but it will likely take quite a while until most ambulatory service providers will voluntarily integrate into the system.

7.5 PROFESSIONAL-LEVEL PROBLEMS: GPS' AND CARE PROFESSIONALS' WORK OVERLOAD

At the time of the interviews (Spring 2020), the status of LTC in society was a hotly debated issue in Switzerland. The professional care organizations initiated a public referendum on strengthening the role of professional care and carers in society. The initiative also demanded more authority for occupational carers. During the period in which the interviews were conducted, the initiative was under way but not yet decided upon. The initiative was approved, however, in November 2021, i.e., after the interviews were completed.

At the professional level, the main problems identified by the organizations are a general lack of staff in most sectors, a mismatch between occupational education and practical work, and a lack of inter-professional cooperation. All organizations agree on the first problem, but they have different opinions about the other two aspects.

The lack of staff concerns both LTC workers and GPs. Switzerland has a high share of foreign LTC workers, which is a partial solution to rising demand but poses follow-up problems. According to the Swiss Association of

Occupational Carers, language problems aggravate communication barriers, and the quality of services is partly at stake:

> We just want that care has a future, … that we just have people who … are qualified and sufficiently trained. There are too few people being trained, … we will let many people immigrate from abroad, which causes problems in ethical questions. … We also want to foster the patients' security in order to ensure that people speak the same language and have all the right qualification. (SBK)

The same organization considers that the lack of staff is related to difficult working conditions in this field and also concerns GPs:

> I think that there are too few general practitioners, it is not attractive as mentioned before. We also have no or too few doctors specialized in geriatrics, and the general practitioners are a little bit antiquated so that they do not know the state of the art in geriatrics. … And when we as caregivers point to this, they feel somewhat afflicted or stepped on their feet, and this is relatively difficult because I think that we continue to undergo training and visit courses. (SBK)

In this statement, the staff shortage is also explicitly related to a mismatch in inter-professional communication between GPs and professional carers. Not only the shortage of GPs is a problem, but also missing knowledge or sensitivity for care issues. The various aspects of the problem push each other. The problem of staff shortage is even more pressing in the social domains of care and in supplementary services. In this field, volunteers play a significant role, which makes coordination with the other service providers in the field difficult. According to the Association of Social Services Organizations for the Elderly (ProSenectute):

> The whole social care, … there is a strong tendency to give it back in the hands of volunteers or the family. And these volunteers, … they must be coordinated, motivated and supported by us, and to find volunteers who really make these things continuously over a long period of time is challenging, too. (ProSenectute)

While the lack of staff is a general topic in all interviews, the educational and professional profile of people working in LTC is more controversial. A main aspect is the question of academic versus occupational education for LTC professional workers, or rather the mix between the two pillars. Most organizations think that the educational profile in Switzerland is good, but that the division of tasks between the different educational pillars is the real issue. The client organization also thinks that the occupational training system is actually quite good and provides a stable basis for LTC work.

Some organizations have an ambivalent opinion on this issue. From GPs' point of view, there is a lack of academically trained staff in LTC, but at the same time:

> in my opinion, this university academization is not on an ideal path because the best trained people are withdrawn and switch to some management posts. (Mfe)

This skeptical view on further academization of care professionals is supported by the Association of Swiss Health Insurance Organizations:

> I think that we do our work well in Switzerland, we have currently high but reasonable costs, a high, but good standard. … The challenge lies within the future, even in our country, we will face a lack of skilled labor, I think that the key is actually the right skills mixture. But not every action must be executed by these academicized, and this is a question of faith in today's discussion, the trade unions want that everything works academically, and often the health insurer say "no, of course not, for this tasks we have physicians", and I think that the truth lies in the middle. We need all, all three, four levels [of qualifications], and they must be well mixed up. (Santésuisse)

The Swiss Association of Occupational Carers favors more academic training, because this would enable better communication with GPs on the basis of mutual understanding and equal exchange of views:

> That we as caregivers simply show up and say "we know this from studies", therefore, there is a need for more care specialists, we have to argue on an academic level with the physicians, then we have a chance, … it has to be based on evidences. (SBK)

In this statement, the issue of training and education is closely linked to the issue of inter-professional communication and coordination. Communication among equals is expected to have clear benefits. This issue is part of the wider problem of communication and coordination between the different occupational groups, in particular between GPs and LTC workers. Many of the interviewees regard this interface as a major challenge, but the views of organizations relating to this point differ. The Association of Swiss GPs and Pediatricians reports that missing contacts and lack of information sharing between GPs and care workers are a big problem for the everyday routines of care:

> The contact points between these organizations, above all between the private Spitex organizations and the GPs, are traditionally very few. … They don't know each other, they don't see each other, they are involved ad hoc together somewhere. … Otherwise, the exchange is comparatively low and depends a little bit on how committed the individual nurse or the individual GP is. (Mfe)

The Association of Private Basic Care Organizations points out the structural problems in the role of GPs in this context. Their role expectations do not fit with their organizational resources in solo practices with a variety of patients. Moreover, the clients of GPs and of Spitex organizations do not neatly overlap because there are more GPs in an area than Spitex organizations. In addition, there is the dualism between public and private Spitex. Hence, a clear-cut and organized communication network is difficult to imagine. Therefore, there is a big gap between theory and practice with respect to the role of GPs:

> Well, the GPs can't do this, this doesn't work, we also have far too many, who should coordinate this and how? That a GP has his personal Spitex organizations with which he collaborates, and could then undertake perhaps some tasks, … but this is difficult, no, no, this doesn't work. (ASPS)

The FOPH points to the same problem:

> Today, the practitioner must order the care. Afterwards, a nurse comes on site, determines what the need really is, goes back, reports to the GP who says "it is ok, that is the care they need." And then, you can start and execute the care. … With the functioning of the charging system, there is no other way but the practitioner actually undertaking the coordination. Of course, we know from the practice that many practitioners do not mind, but only if a nurse says that Ms. Müller needs care, then an order is issued and afterwards, it is just ticked off … by the practitioner. (BAG)

One could argue that the role of GPs in that respect is characterized by overload. The rules give them a key position, but in practice things have to be arranged differently due to this overload. According to the Swiss Organization of Elderly Persons:

> Actually, it is a little bit a strange situation, as Spitex, I only can deliver health insurance services if I have a signature from the GP. … These so-called prescription sheets are signed in blank by the practitioner so that he has not so much work with it. (SSR)

It shows up that inter-professional communication and coordination is lacking at several interfaces within the system. On the other hand, the Association of Swiss Health Insurance Organizations defends the pivotal role of GPs in the current system:

> What still remains, the GP is the entrance gate for financing by the health insurance, this has stayed the same, the caregivers are rebelling against it, they would like to decide it themselves. Well, from our perspective, this works, this actually works well, and we tend to change nothing on it. We do not think that the practitioners fulfill this mission excellently, … not at all, … there is a lot of selfishness and ego-

> istic perspective, but overall it works, and we simply say that we need a gatekeeper at the entrance door. (Santésuisse)

Quite clearly, the interest to avoid strong increases in costs goes together with the key role of GPs as gatekeepers to the LTC system. In practice, however, this mechanism does not really work smoothly and has come under pressure from various sides. The issue of how to solve the problem is discussed in the next section. The views of the various organizations differ a lot in that respect, too.

7.6 POSSIBLE SOLUTIONS: INTEGRATED FLEXIBLE LOCAL NETWORKS

All organizations agree that coordination problems exist, and that current institutional regulations and practices do not solve them. Although the organizations are critical of the basic features of the Swiss system, for example the integration of LTC in HI and the federal structure of service delivery and supplementary financing, no organization asks for a complete overhaul of the system. In most interviews, federalism is mentioned as a potential hindrance to better coordination. However, most of the interviewees also clearly defend the system because it is a central part of Swiss identity and the political system. Moreover, some organizations explicitly regard federalism not as a problem, but as part of the solution.

The possible solutions mentioned in the interviews therefore more or less build on the existing institutional framework. One reason for this is that most organizations also agree that the system works quite well in general, even if some problems such as coordination do exist. Other reasons for this generally positive assessment could be that the interviewed organizations of course argue from the perspective of existing institutional circumstances or that all of them also have vested interests in the existing system. All interviewed organizations also have a quite pragmatic view and mainly think about solutions within the existing setting.

The current system of financing is strongly criticized, as we have seen above. An obvious solution would be to establish special funding for coordination tasks. According to the Association of Swiss GPs and Pediatricians:

> The coordination of healthcare services should be better defined, and if they have been defined, they should be rewarded adequately, well, I think that structures should be established where one could say, well "we want to deliver GP's coordination in the long-term care, this should be done so and so, and if the quality criteria were fulfilled, it should be rewarded so and so." (Mfe)

Most organizations demand more funding, especially for the social aspects of care, but do not fundamentally question the current system. Interestingly, however, it is the interviewee from the Association of Swiss Health Insurance Organizations who states:

> The really big problems are not solved, but still be procrastinated and left in a patchwork solution. I think this is more or less the perspective of the social care financing. Personally, I basically would like it better to create a new social insurance, … integrating nursing and social care, then there would be a neat and socially financed solution. (Santésuisse)

In addition, though some organizations complain about the complexities of the federal system, none asks for stronger centralization. By contrast, the solution preferred by most organizations is integrated networks of service delivery at the regional and local level. As the FOPH puts it:

> The tradition with these managed-care organizations in Switzerland is something that we actually want to intensify, … so that we established so-called coordinated care networks where the Spitex is actually embedded. Because in this way, everything actually comes from one hand, … we need a certain flexibility in the coordination. (BAG)

Most other organizations also prefer flexible and managed networks. The Swiss Hospital Organization believes that service providers would clearly prefer such a system. The Swiss Organization of Elderly Persons also considers flexible and managed networks to be desirable in general:

> [I see the care system as] a composite system, divided in care regions, we actually have still too many hospitals, in care regions, which means that a care region encompasses the acute medicine, the elderly people's and nursing homes and the ambulatory sectors, and this care region works together. I could imagine that everything is under one umbrella, so that a board from a Spitex organization or a nursing home is no longer needed, but that everything is consolidated in a common firm placed in inverted commas. Well, the idea of total networking. But also, the possible exchange of staff between ambulatory and stationary can offer chances. (SSR)

According to most organizations, these integrated networks should be established at the local and regional level. As the Association of Social Services Organizations for the Elderly puts it:

> Our 24 cantonal, regional organizations are all autonomous and self-reliant foundations or associations to which we cannot say "you have to". With Spitex, this is far worse, they have bodies going down to the communal level. … And with the Swiss Red Cross it is the same, and with the Alzheimer's organization it is the same, that is that there are federalist structures, so that the process has to go from the very bottom to the top. (ProSenectute)

The idea is that all organizations should cooperate in a flexible network at the local level to assure better coordination of all services, including medical and social aspects as well as professional and voluntary work. The lead lies not necessarily always with the same professional group or organization but depends on local and individual circumstances. Of course, such a flexible framework also requires flexible financing instruments.

7.7 CONCLUSION

The Swiss system shows the merits but also the problems of a medical-dominated LTC system combined with strong federalism. The merits are clearly a high level of professionalism and well-developed sectoral services. This feature has positive repercussions, in particular, on the coordination of the transition from hospital to home-based care. In hospitals, discharge management has been professionalized in recent years, and the first point of contact for clients at home is Spitex, which is also a highly professionalized service. Furthermore, both of these organizations operate under the roof of health insurance regulations. The new electronic patient record is potentially an effective instrument for further improving this process. It remains to be seen, however, if and how it can be successfully implemented. The transition from hospital to home care, therefore, can be handled quite well within the existing professional framework.

The main problems are the integration of social aspects of care and the coordination of services at the local level. In this respect, the crucial question is, how organizations outside Spitex, which offer supplementary services, can be better integrated into overall service provision. These organizations are mostly privately paid and often work with volunteers. A better coordination among these various services and Spitex can best be achieved by flexible local networks with more case management elements. Here, purely professional solutions inside the healthcare area are not sufficient. Rather, more open and flexible networks including volunteers at the local level are required.

Overall, the interviewed organizations envisage possible solutions to coordination problems mainly within the existing institutional framework, because they find that the parameters of the system work quite well. More flexible and explicit financing for coordination tasks and the integration of all service components within local networks are the preferred solutions. This may involve that the roles of the various professional groups shift or are seen as being a bit different by different organizations, but none question the role of the others in general. The most obvious case in that respect is the role of GPs, which is naturally relatively strong in a medically framed system. The GPs are the gatekeepers to the system, but their role is limited in practical coordination tasks due to various reasons including work overload and lack of financing. Yet, the highly professionalized system as such is not questioned, on the contrary. As

the successful people's initiative spearheaded by the professional care organizations shows, the Swiss people demand even more professionalism, better education, higher payment, and more authority for professional carers. Surely, this will shift the balance between GPs and professional carers, but it will not break up the basic institutional parameters of the system. Rather, institutional continuity prevails.

8. Professional-level problems: staff shortage, divided responsibilities, or missing communication?

8.1 INTRODUCTION

Institutional regulations and organizational conditions set the framework for social action, but ultimately it depends on the people who are working in the field of HC and LTC as to how services are provided and coordinated. The workforce implements the rules of the systems, largely influences the quality of services, and determines how coordination unfolds in everyday practice (Castle, 2008; Schwinger et al., 2018).

This chapter focuses on the different professions and occupations that provide healthcare (HC) and long-term care (LTC) services. Coordination, cooperation, and communication across different occupations can be facilitated or hampered by institutional and organizational conditions. Yet, informal arrangements between different occupations may also compensate for institutional shortcomings. The chapter takes a comparative view and analyzes HC and LTC workforces in Germany, the Netherlands, Switzerland, and Sweden. We investigate common problems concerning the coordination of elderly care services in relation to staff. We focus on three aspects identified in the country chapters: (1) shortage of staff; (2) unclear or divided responsibilities; and (3) hampered communication. We analyze the shortage of staff by focusing on different occupational groups and on working conditions. Responsibilities relate to the competencies and tasks of different occupational groups during coordination processes. In addition, we look at the various formal and informal modes of inter-professional communication and cooperation.

The chapter proceeds as follows. The next section (8.2) discusses the role of staff in HC and LTC and provides general assumptions about the problems that staff face regarding the coordination of elderly care services. The following section (8.3) describes empirically the main structural features and the overall size of staff in HC and LTC. It focuses on the most important staff groups that are relevant for the coordination of elderly care, GPs, LTC nurses, and LTC personal carers, and provides comparative workforce data. Based on these

data, the general assumptions made in the prior section are extended to specific assumptions for the four countries. The subsequent three sections focus on the three most pressing problem areas for coordination of elderly care services related to staff. These sections draw on the interviews and evaluate the main statements of staff in light of the national institutional setting and in comparison to the other countries. The first one (8.4) concentrates on the shortage of staff and on working conditions. The second one (8.5) analyzes the responsibilities of different occupational groups in coordination processes. The third of these sections (8.6) focuses on inter-professional communication including tools such as electronic patient records, which should facilitate cooperation. The final section (8.7) summarizes and generalizes the coordination problems related to staff and discusses how European welfare states can respond to these challenges.

8.2 THE ROLE OF STAFF IN HEALTHCARE AND LONG-TERM CARE

HC and LTC staff are essential for the coordination of elderly care services (Laugaland, Aase, & Barach, 2012; Nosbusch, Weiss, & Bobay, 2011). The workforce needs to take an active role in the coordination process. Their responsibilities and engagement in the coordination process determine whether transitions between HC and LTC and joint provision of services run smoothly (Laugaland, Aase, & Barach, 2012; Storm et al., 2014). For the workforce in general (e.g., employees, workers, occupations, professionals) and staff in HC and LTC (e.g., physicians, GPs, (LTC) nurses, personal carers, auxiliary nurses), various terms are used. We use different general terms interchangeably except for the term profession. Here, we rely on the definition by Abbott (1988, p. 8) who describes professions as "exclusive occupational groups applying somewhat abstract knowledge to particular cases." Hence, we only use the term profession for physicians and (LTC) nurses. Physicians are usually depicted as professions due to their academic education, occupational power, autonomy, and their role for clients and the society in general (Pfadenhauer & Sander, 2010). We also use the term profession for (LTC) nurses since, in most countries, they represent highly skilled occupations (sometimes with academic education) with great autonomy and the highest responsibility for care work. The terms personal carers and auxiliary nurses are used interchangeably. These workers are not defined as being in professions because they only have a short and mainly practical education in health and social care and usually take over routine care tasks (OECD, 2021).

Several factors influence how different employees in HC and LTC define their role and fulfill coordination tasks. The most important factors we identified in the country chapters are (1) a lack of staff, (2) various responsibilities

of staff, and (3) communication between staff. All three factors depend on country-specific institutional settings. There are, however, common traits and developments that lead to general assumptions about coordination in relation to the three aspects.

The lack of staff in HC and LTC is a concern for many OECD countries today and it will continue to grow as a problem (Colombo et al., 2011). Many OECD countries have implemented measures to increase the number of physicians and nurses such as intensifying the inflow into educational programs and facilitating the migration of healthcare workers (Colombo et al., 2011). However, gaps in the service delivery of HC and LTC services are still a problem due to several reasons. First, demographic aging continues, resulting in more elderly people with complex care needs (Colombo et al., 2011). Furthermore, service delivery in rural and remote areas is a continuous problem as the number of GPs and LTC nurses in these areas is much lower than in urban centers (OECD, 2016). Furthermore, the number of employees in LTC is a concern in many OECD countries, which is related to unfavorable working conditions such as low pay, frequent shift work, and insufficient opportunities for job progression (Buchan & Black, 2011). Employment density may impact the coordination of care as a low number of workers in either HC or LTC may compromise the continuity of care and communication between service providers at crucial transition points between the systems. A low density of employees in LTC may lead to a shortage of available places in residential and ambulatory LTC. Furthermore, low numbers of employees in both fields may lead to a high workload, and therefore an exacerbation of unfavorable working conditions in which coordination is considered to be subordinate when compared to other tasks.

Working conditions (e.g., pay, working times) in LTC are usually lower than in healthcare (Eurofound, 2020). Hence, we focus on working conditions in LTC, which seems to be the potential breaking point regarding the continuity and coordination of care. Furthermore, working conditions in HC and LTC influence the number of workers (Buchan & Black, 2011) and impact on whether and how staff and nurses in particular are able to take over coordination tasks. First, educational degrees determine whether nurses can work in HC *and* in LTC or if they can only be employed in one of the two sectors. In Germany, until 2020, education for HC and LTC nurses was divided, and it was almost impossible for LTC nurses to work in healthcare. A lot of HC nurses, however, worked in LTC (Ariaans, 2021). In Germany, the educational difference of HC nurses and LTC nurses manifested itself in the institutional divide of ambulatory HC and ambulatory LTC services at the professional level. In many countries, a consequence of this institutional divide is differences in working conditions, e.g., regarding wages, working hours, and career opportunities. Usually, working conditions for nurses and personal carers are

at a lower level in LTC than in HC. This is not only the case in Germany but in most developed welfare states (Eurofound, 2020). Furthermore, working conditions (pay, part-time work) in ambulatory settings are usually at a lower level than in institutional settings (Eurofound, 2020). Due to poor working conditions, particularly in the ambulatory LTC sector, LTC experiences a high fluctuation of LTC nurses as well as a high share of low-qualified staff, many of them with a migration background, who in many cases have insufficient language skills and experience with social contacts and communication in this field of work (Eurofound, 2020). For nurses, it is therefore more attractive to work in HC than in LTC and more attractive to work in residential than in ambulatory facilities. Due to better and more secure working conditions in healthcare, HC nurses possibly take over coordination tasks between HC and LTC more often than LTC nurses.

Besides the number of staff and the working conditions in HC and LTC, the formal responsibilities of occupational groups are important for coordination processes in elderly care. These formal responsibilities are bound to the education of staff and the hierarchies within each system. In healthcare, physicians are academically educated and have secured their status as a leading profession for decades. Physicians are in charge of making decisions for, and sometimes in cooperation with, the patient. They delegate and control the work of subordinated nurses and other healthcare providers (van der Biezen et al., 2017). Nurses have a shorter and more practically oriented education than physicians. But in the last two decades, the education of nurses has become increasingly more academic. This academization is in general related to the organizational and administrative functions of nursing and higher responsibilities in these areas. But also nurses in direct care are increasingly being academically trained, and new positions such as physician assistants and nurse practitioners have been introduced in many countries (Kuhlmann et al., 2018; Pulcini et al., 2010). Since not all countries followed this path, the level of academic education of nurses varies greatly between countries (Dury et al., 2014). Additionally, the tasks and responsibilities of physicians and nurses might differ, and in particular in countries with a high level of academically trained nurses, it is the nurses who may take over coordination tasks (van der Biezen et al., 2017). Within LTC, hierarchies have not been developed to a similar extent as those established in HC. LTC nurses and personal carers (in some contexts labeled as auxiliary LTC nurses) perform the majority of LTC services for the elderly. Usually, LTC nurses have a longer and more theoretical education than personal carers. Furthermore, LTC nurses perform more complex tasks whereas personal carers are responsible for more routine care tasks (OECD, 2021). Although LTC nurses are higher up in the hierarchy than personal carers, in the LTC field they may still not hold the highest position in the professional hierarchy. LTC nurses with additional training could be

responsible for decision-making and organizational tasks, but if there is a lack of academically trained staff, it is often physicians who are responsible for decision-making in LTC (Lovink et al., 2018).

The third aspect—communication—is closely related to the prior aspect of responsibilities. The institutional context is important for the development of inter-professional communication. Although LTC systems have developed and become more professionalized in many OECD countries in the past two decades, informal care work taken over by family members is still a large part of the total care provided to elderly patients. This is the case in particular in informal or semi-formal family care regimes such as Germany and Switzerland (Pfau-Effinger, 2014). Communication between occupational HC and LTC workers, the patient, and the family carer can thus lead to many interfaces making communication necessary. We expect that systems in which HC and LTC are considered to be equally important and are provided within the same institutional and financial framework suffer less from inter-professional communication problems, as different occupations already work closely together. Furthermore, we expect that a stronger implementation of digital tools for cooperation (e.g., electronic patient records) in HC and LTC results in more inter-professional communication and cooperation.

8.3 SIZE AND STRUCTURE OF THE WORKFORCE

The four countries are characterized by different levels of GP and specialist density per 1,000 population (see Figure 8.1). Germany has the highest density of specialists, both in 2010 and 2018 (2.81 and 3.33). The Netherlands, in contrast, has in both years the lowest number of specialists (1.71 and 2) but the highest GP density of all four countries (1.25 and 1.67). Switzerland and Sweden have levels of GP and specialist density between these extremes. In all four countries, both for GPs and specialists the density of physicians has increased at different speeds. In Switzerland and in the Netherlands, the increase is more pronounced for GPs, and in Germany and in Sweden more for specialists. Overall, Germany's healthcare system has the strongest focus on specialist treatment, whereas the Dutch healthcare system concentrates on GP treatment.

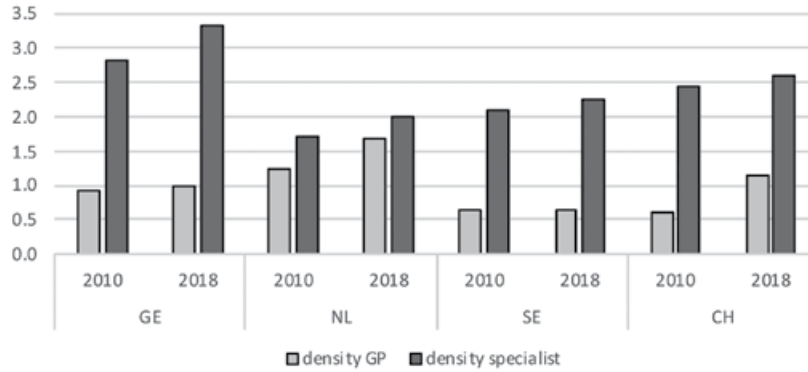
LTC employment reveals further differences between the four countries. The levels and development of LTC staff density vary highly between the four countries (see Figure 8.2). Furthermore, there is a substantial difference in the distribution of staff between LTC nurses and personal carers and therefore the education of staff (see Figure 8.3). The density of overall LTC employment in 2018 is highest in Sweden (12.1 per 100 population aged 65 or older), followed by Switzerland (8.2), the Netherlands (7.9), and Germany (5.4).[1] From 2010 to 2018, LTC employment has been reduced in Sweden and the Netherlands

and increased in Germany and Switzerland. Furthermore, the shares of nurses and personal carers in LTC differ fundamentally. In Germany and Switzerland, the majority of employees in LTC are nurses, whereas in Sweden and the Netherlands the majority of employees are by far personal carers. The decrease of workers in Sweden and the Netherlands has been mainly achieved through a reduction of personal carers. Sweden is an interesting case in this regard. LTC staff in Sweden, which is at a very high level per 1,000 population, almost entirely consists of personal care workers. The Netherlands has experienced a gradual shift in LTC employment from (high) quantity to (higher) quality. In Germany and Switzerland, the LTC workforce is lower in numbers, but most of the care work is provided by higher-qualified LTC nurses. The data show the picture of formal LTC employment only. Still, informal LTC employment, in particular, in the form of help and care provided by family members, is an issue and a substitute especially for low-qualified formal LTC work. Official numbers on informal LTC work are lacking, but international surveys show that help and care from family members is highest in Germany, followed by Switzerland, the Netherlands, and Sweden. Here, coordination is restrained by the strong impact of informal arrangements instead of professional rules. Organizations may regard this situation as problematic for their coordination efforts. They may, however, also consider it to be a relief since the responsibility for coordination can be externalized to the family. We expect that organizations see more of the negative than the positive effect since they are confronted with coordination problems related to informal arrangements in their daily practice.

In the four countries, part-time work in LTC is more prevalent than in the EU in general (on average, 42 percent for EU27 in 2019) with a part-time share of 47 percent in Germany, 48 percent in Sweden, and 87 percent in the Netherlands (Eurofound, 2020). For Switzerland, there are no comparable data available. Part-time work in LTC is more prevalent than in the national labor markets in general where the average part-time share of work in 2019 is 13.4 percent in Germany, 13.7 percent in Sweden, 37.0 percent in the Netherlands, and 26.9 percent in Switzerland (OECD, 2022). Atypical working times (work at weekends, shift work, and night work) are more prevalent in LTC but also in HC, than in the total workforce (Eurofound, 2020). Furthermore, wages in LTC are below the average for national earnings. According to calculations from 2014, in Germany, earnings in social services are at 81 percent of average earnings while in healthcare, earnings are above average (107 percent). In Sweden, earnings in healthcare are similar to Germany, and earnings in social care are slightly higher (85 percent). In the Netherlands, levels are higher with earnings in social services being at 94 percent and in healthcare at 117 percent of average earnings (Eurofound, 2020). For Switzerland, we do not have comparable data.

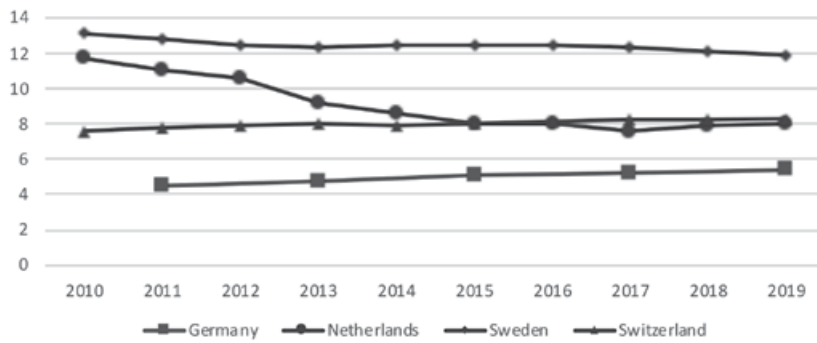
Concerning the use of digital tools in different HC and LTC facilities and their interconnectedness, international comparative data in particular for LTC is scarce. According to data from the Commonwealth Fund (2022), 70 percent of primary care physicians report using electronic patient medical records in their practice in Switzerland in 2019. This is the lowest share for the four countries under study, with Germany reporting 88 percent, Sweden 98 percent, and the Netherlands 99 percent. The Bertelsmann Foundation developed a Digital Health Index from institutional and expert survey data for 17 EU and OECD countries, with a range from 0 to 100. In this index, using data from 2016, Sweden and the Netherlands rank in the upper middle (rank 7 with an index value of 68.3 for Sweden, rank 9 and a value of 66.1 for the Netherlands) whereas Switzerland and Germany rank at the bottom (rank 14 with a value of 40.6 for Switzerland, rank 16 with a value of 30 for Germany) (Thiel et al., 2018).

On the basis of these workforce data and the earlier theoretical considerations, we develop the following country-specific hypotheses regarding the coordination of care at the workforce level. First, concerning staff shortages, LTC staff density is lowest in Germany in 2018. We expect that staff shortages are the most severe in Germany with negative consequences for coordination and cooperation between professions. Furthermore, for all countries, the low quality of working conditions in LTC might pose a common problem, which aggravates existing coordination problems and might restrict opportunities to transfer responsibilities for coordination to LTC staff. Second, concerning responsibilities in the care coordination process, GP density is particularly high in the Netherlands and at a high level in Switzerland as well. We expect that both countries rely in particular on GPs for the coordination of care services. Additionally, countries with a high level of LTC employment might transfer coordination tasks to LTC employees. We expect that Sweden depends the most on LTC staff for coordination tasks. On the other hand, Sweden relies heavily on personal carers, who might not be qualified for coordination tasks. Third, concerning the communication and cooperation of different staff groups, we expect that Sweden has larger coordination problems than Germany and Switzerland, because Sweden employs a high number of personal carers who might not be equipped with the knowledge to communicate on an equal footing with higher-qualified nurses and physicians. Furthermore, we expect that Sweden and the Netherlands show more communication and cooperation via digital tools than Germany and Switzerland, due to their more developed digital health infrastructure.



Source: OECD (2022).

Figure 8.1 GPs and specialists density per 1,000 population

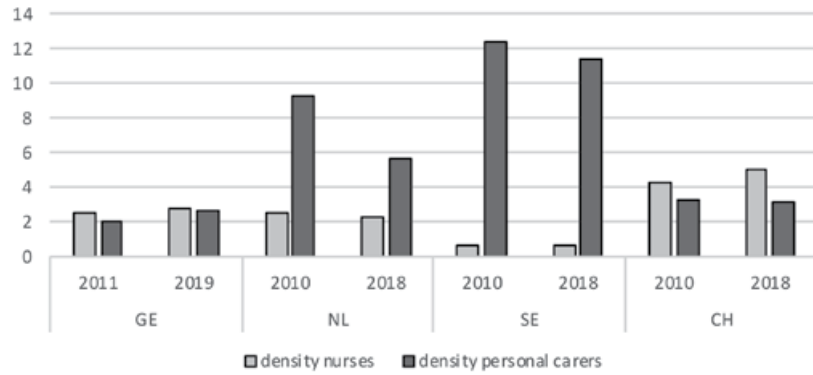


Source: OECD (2022).

Figure 8.2 LTC workers per 100 aged 65+

8.4 STAFF SHORTAGES

From our interviews, it becomes evident that staff shortages are a problem in all countries, which confirms earlier findings and projections in this field (OECD, 2016). The "staff shortage" hypothesis argues first of all that it is not the institutional setting, qualification, or hierarchies that determine the responsibilities for care coordination, but that the occupational groups that are least affected by the shortage of skilled workers primarily take over coordination



Source: OECD (2022).

Figure 8.3 Density LTC nurses and personal carers per 1,000 population

tasks. The reason is that other occupational groups simply do not have the time for these tasks due to a high workload. As the workforce data revealed, the staff shortage should be most severe in Germany. Thus, we expected that coordination problems related to staff are also the most severe in this country.

Irrespective of the size and development of the workforce in healthcare and LTC, interviewees in all countries assess the amount of staff in both fields as being too low. This staff shortage extends to GPs as well as LTC nurses. The shortage of GPs is discussed as a huge problem in particular for rural areas in all countries. In the Netherlands and Sweden, the shortage of home care nurses is emphasized as the most pressing problem. In all countries, staff shortages are related to the topic of high workloads for all professional groups. In Sweden, high staff turnover rates of all professional groups involved in HC and LTC are discussed as negatively affecting the continuity of care. Furthermore, the shortage of LTC nurses is related to a shortage of places and long waiting times in home care and residential care in Sweden, Germany, and the Netherlands. In Switzerland, staff shortages and the stressful working conditions in LTC are linked to high turnover and drop-out rates.

It is striking that, in all countries, the amount of staff in healthcare and LTC is assessed as being too low, although the amount and development of staff is fairly different. For example, the density of LTC workers in 2018 was more than twice as high in Sweden compared to Germany (see Figure 8.2). Yet,

organizations in both countries evaluate the number of LTC staff as being too low:

> The shortage of skilled workers is acute. That is what our facilities experience every day. They are flooded with inquiries and we already have the situation in many federal states that they have to reject requests. Both in outpatient care and in inpatient care, they have to say that they cannot accept new patients. (Bpa, Germany)
> To recruit and retain staff is also a challenge. Because we are going toward a [situation] that we don't have enough hands in care or people in care and more elderly. (Äldreomsorg, Sweden)

Similarly, the number of GPs is twice as high in Switzerland than in Sweden, but again organizations in both countries criticize the current number of GPs as being too low or complain about the high workload of GPs who, in addition to their curing role, (should) take over a coordinating role. In addition, in Switzerland the relatively advanced age of GPs is mentioned as a problem, in particular with respect to higher workload and the introduction of new coordination instruments such as digital tools and case management.

Working conditions are another potential threat for the coordination of care and are in many cases determined by a staff shortage. In our interviews, a high share of part-time work and the low incomes of LTC employees are problems that are rarely discussed in relation to the coordination of care. Still, in Sweden and Switzerland, working conditions are characterized by problems such as high turnover rates of staff and the high level of migrant care workers who on average have a lower level of education, communication skills, and training for the care requirements of their clients. In Germany, the Netherlands, and Sweden the high number of small LTC companies is discussed as a restriction for care coordination, not mainly due to the often-lower rates of pay or higher workloads in small LTC companies, but due to the higher number of actors and thus the need for communication and cooperation. It is hard to speculate why working conditions are not viewed as a major concern when discussed in relation to staff shortages and coordination problems. This can possibly be explained by the fact that organizations do not evaluate most working conditions (e.g., pay and working hours) as impinging on the coordination of care directly and thus do not mention it.

In summary, according to the interviewed organizations, the number of staff strongly influences the coordination of care, whereas working conditions are subordinate to the challenge of care coordination. First, although staff levels differ in the four countries, even in countries with higher LTC employment, the numbers are considered as being too low to meet the growing demand for HC and LTC services. Poor working conditions in LTC intensify staff shortages as employees are hard to find and to keep in LTC. Second, there is a potential lack of employees in particular in LTC, who are able to take over and execute

coordination tasks. Swedish data show a low level of LTC nurses with training to provide more complex nursing tasks including coordination responsibilities. In Sweden, the interviews do not reveal a general lack of higher-educated LTC staff but more specifically a lack of staff able to fulfill coordination responsibilities. Third, the historical and institutional context is important when assessing staff levels and the quality of service provision. In a historical context of high LTC workforce density, this peak probably serves as a reference point and a decrease, as in the Netherlands and in Sweden, is perceived as a growing shortage. Fourth, the organizations' assessment in our interviews could also be the result of problems not related to available personnel resources. They may consider the quantity of staff as being too low and believe that coordination problems will decrease with more staff, but without taking other deficits into account that cannot be solved by higher numbers of employees. These deficits might be related to unclearly defined formal and informal responsibilities of the workforce as well as to problems in inter-professional communication and cooperation.

8.5 SHARE OF RESPONSIBILITIES

The responsibilities of nurses in connection to their roles and qualifications are discussed intensely in all countries. In Germany, the discussion about responsibilities in care coordination processes is connected with the discourse on the academic education of nurses. This topic has been highly controversial. The academic education of nurses is considered as necessary for taking over coordination tasks by some organizations while other organizations stress that the academic education of nurses is not a primary concern since all professional groups should be responsible for coordination. In Germany, the role of nurses therefore is seen as ambiguous. Direct communication between GPs and LTC nurses, for instance, is considered as highly important for care coordination. At the same time, direct communication is restricted due to the huge difference in the competencies of the two professions. There are only a few voices in favor of a greater harmonization of competencies, for instance through academization and professionalization. At the same time, the strong focus on locating responsibility within the physicians' domain is criticized as those professionals have the responsibility but not necessarily the most expertise for specific tasks:

> Tasks in which nurses are clearly more competent than physicians should be performed by nurses. The same applies to physiotherapists. So, whoever has the greater competence should actually do it. But in Germany, there is a very strong doctor's prerogative for all activities. (BAGFW, Germany)

In Germany, the attitudes and interests of organizations in this field are guided by the conflicting idea of "more but not too much professionalization" which in turn weakens the professionalization of LTC nurses (see also Ariaans, 2021 on organizations' view on professionalization in Germany).

In Sweden, the quantitative data show that the LTC services are predominantly provided by personal carers and therefore by employees with a lower level of education (OECD, 2019). Swedish organizations are critical that, due to their migrant background, many personal carers have insufficient language skills to provide and organize complex care tasks. The academic education of nurses is not discussed in the Swedish interviews, but organizations clearly distinguish between academically trained nurses and semi-skilled personal carers. Academically trained nurses are considered as being highly competent and fulfilling several medical tasks for which physicians are responsible in other countries (e.g., Germany). Organizations emphasize, however, that communication between nurses and physicians often lacks a mutual understanding of tasks and competencies, making a joint provision of services more difficult. This lack of mutual understanding is presumably a particularly serious issue in Sweden where most LTC personnel have lower levels of qualification:

> But right now, we're not able to go there because of too low levels of education. … We need to have common ground, well-educated personnel that understands different rules, different organization, and it's quite complex. And that takes a bit more of education than we have. We have people doing that work, coming from other countries with just two years of education right now. And it's really hard to learn this if you don't have your mother language and abstract thinking. (Tryggt mottagande, Sweden)

From the perspective of the Swedish organizations, HC and LTC personnel should collaborate closer and learn from each other in order to bridge the gap of mutual understanding and of knowledge about the capabilities of other professions in the field.

In the Netherlands, the academic education of nurses has been established since the late 1980s (Diepeveen-Speekenbrink, 1992; Spitzer & Perrenoud, 2006). Today, the academic education of nurses is taken for granted and presumably the reason why the higher education of nurses is an issue that is not mentioned by the organizations in our interviews. Instead, the main focus is on the responsibilities nurses (should) have in coordination processes. Overall, HC and LTC nurses take over roles in the coordination of elderly care services, and home care and discharge nurses are the main profession involved in the transition from hospital to home care. Still, organizations have differing views about best practice solutions for different categories of nurses. According to the organizations, home care nurses and transfer nurses favor different solutions to compensate for the lack of information in the discharge process from

hospitals. Home care nurses favor direct communication with the ward nurse before discharge who usually has more information about the patient than the transfer nurse. Transfer nurses, in contrast, demand more responsibility for the overall coordination process. They want to be the occupation which is responsible for collecting all patient information as soon as the care process starts in the hospital while currently they are mainly involved at the end of the whole process, namely the discharge.

In Switzerland, academic education is a big issue and closely related to demands for more competencies and responsibilities for LTC nurses raised by occupational organizations of nurses. The gap in hierarchy and competencies between the medical profession and LTC nurses is seen as a problem for coordination, not least because many actors agree that GPs are not able to fulfill their coordinative tasks due to work overload. The actual practice is that GPs operate as gatekeepers to LTC services as they prescribe services. However, these prescriptions and the amount and type of services are largely determined by LTC nurses and communicated to the GP for their prescription. Thus, the role of GPs in coordinating services is in practice a purely formal one. Due to this practice, organizations report that nurses—in particular those with higher and academic education—are dissatisfied with the current situation and demand more formal responsibilities. Furthermore, organizations evaluate that these demands for more competencies of LTC workers have become more widespread and louder. Here, we identify a "paradox of competencies": the smaller the gaps between professions, the higher the demand for equality or substitution. This issue is particularly relevant in Switzerland where the LTC system is clearly medically dominated (see Chapter 7). Moreover, in Switzerland, there is a big gap between the medical elements of LTC provided by LTC nurses and the social elements including supplementary services that are often provided by other workforces with lower qualifications or by volunteers. Concerning this medical–social interface, there is a debate about better coordination, but not about education, hierarchy, or competencies.

The differences in the discussion of responsibilities of (LTC) nurses in the coordination of care are often connected to discussions about their educational level and academic training. Academic training is not a matter of debate in Sweden and in the Netherlands. Both countries have a long tradition of academic training of nurses (Diepeveen-Speekenbrink, 1992; Råholm et al., 2010; Spitzer & Perrenoud, 2006). Due to the long experience with academic training, organizations in both countries do not question the academization of nurses and do not consider it as an important issue for coordination. Still, qualifications and hierarchies play a role for formal responsibilities for coordination in all countries. In the Netherlands, the divide between the competencies of GPs and specialists on the one hand and of HC and LTC nurses on the other hand, is not discussed as a major issue for the coordination of care. Rather

how nurses communicate with each other and which specific competencies they (should) hold in coordination processes is discussed as a topic. According to the interviews, the establishment of clearer and more specific competence profiles for nurses in specific functions would benefit coordination processes. In Sweden, differences in the mutual understanding between physicians and LTC employees are discussed as a reason for inadequate care coordination. This problem might be particularly related to the fact that most employees in LTC are low-qualified personal carers. However, physicians are also criticized for having a lack of knowledge about care coordination combined with being unwilling to collaborate closer with LTC staff. In Germany, nurse education and academization are topics which are discussed by multiple stakeholders in relation to staff shortages and coordination, specifically because a new law introduced in 2020 changed the education of nurses so that LTC and healthcare nurses are no longer separate educational degrees and only an education as a general nurse (generalist nursing vocational training with specialization in geriatrics or pediatrics) exists. While some organizations assess this change as a chance to enhance LTC nurses' competencies and responsibilities, other organizations predict a further increase in staff shortages in LTC, because the better working conditions in the HC sector will lead graduates to take on jobs in this sector rather than the LTC sector. In Switzerland, responsibilities and qualification are discussed together, but most actors agree that the academization of nurses is not a solution to all problems of coordination, in particular not for staff shortages. Moreover, the academic education for nurses needs to be complemented by a vast and perhaps dominant layer of medium occupational qualification for LTC staff. Most actors evaluate that this should form the basis of the system and that Switzerland already has a good system of occupational qualification for this layer.

8.6 COMMUNICATION AND COOPERATION

The formal responsibilities of nurses and, therefore, their educational level do not only influence coordination directly, but we also expect these factors to influence the communication processes between GPs and employees in LTC. We assume that the higher that nurses in HC and LTC are educated—particularly those nurses who take over coordination tasks—the easier the communication with GPs and medical specialists. Hence, we expect the most communication problems to be in Sweden due to the high level of employment of personal care workers. Nevertheless, we expect that in Sweden and the Netherlands, communication and cooperation are facilitated via the more widespread use of digital tools as compared to Germany and Switzerland.

In all countries, the discharge from hospital to home care is evaluated as a process that requires intense inter-professional communication. Home care

nurses and GPs depend upon information about the situation of the discharged patient, whether and which further medical treatment and supervision at home is needed, and which tasks (e.g., eating, washing, getting out of bed) the discharged patient is able to perform independently. In all countries, the interviewed organizations report that information on the discharge of a patient is often provided late. In many cases, the patient has already been discharged or the timing is insufficient to organize all the necessary services and aids that the patient needs at home. In all countries, this problem is connected to the introduction of DRGs (diagnosis-related groups) and the decreasing length of hospital stays as well as insufficient inter-professional communication. The decreasing length of hospital stays has led to an institutional setting in which inter-professional communication has come under increasing pressure. This is made explicit by an organization in Germany:

> Time pressure has become much greater, and hospital stays are shorter and shorter. And then something must happen quickly and ad hoc when it comes to discharge. (DPR, Germany)

In all countries, hospitals have set up discharge teams for managing the discharge process for the patient respectively in cooperation with them. In all countries, the decreasing length of hospital stays has put more time pressure on these teams to find a place in residential or ambulatory LTC or in rehabilitation. In many cases, no appropriate place can be identified since time in the discharge process and available places are scarce. The hospital discharge teams are mainly an intermediary or additional actor who is connecting different professions (GP, specialist in hospital, ward nurse, home care/residential care nurse). Such intermediary agents are principally important for collecting and consolidating information about patients. In Switzerland, these hospital discharge teams have been established in line with the introduction of DRGs. Although actors agree that these teams have made the discharge process more effective and qualitatively better, the quality of discharges still largely depends on how each hospital manages the transition process. Hospital discharge in Sweden is assessed as well structured as it involves all relevant actors from the hospitals and ambulatory setting tailored to the patient's individual needs and is considered to have clearly improved in recent years. In Germany and the Netherlands, there are voices demanding more direct communication between professionals who actually work with the patients. Furthermore, in all countries, professionals complain that even if information is shared in time, this information is often incomplete. Hence, insufficient or low-quality inter-professional communication and cooperation in the transition from

hospital to home care is assessed as a problem in every country. This fact is emphasized by a Swedish organization:

> The main national challenge we have, that's why we started this project, is that we had a lot of elderly people who were treated properly at the healthcare and were medically ready to go home. But they couldn't because the home care service was not able to manage the extensive preparations for home care in time. (Tryggt mottagande, Sweden)

In the home care setting, in the Netherlands and Sweden, the increase of (often small) private home care providers is discussed as making communication and cooperation more difficult. This development has increased the number of organizations involved in home care and thus more communication with different providers is needed. In this case, choice seems to contradict coordination, at least in part, as a Swedish organization puts it:

> The patient can choose between several companies for home care, and the patient can also choose between several companies for primary care, so the patient can make two choices. And one patient, for example, chooses company 1, us, as the primary care, but they choose another company for home care. And another patient chooses company 1 for home care but another GP. This makes it much more complex. It would be better for the patient to choose something that is connected, instead of choosing because just you want to choose. So, we have a problem with the politicians, they think the more choices you have, the better it gets. We say, you don't want more choices, you want to have something that is connected, that works. Our problem right now is that it's not synchronized. (Tiohundra, Sweden)

In Germany, too, the overall number of actors who are involved in care for one patient is criticized as being too high. In this country, the high and increasing number of small private home care providers is not mentioned as an important development with a negative effect for inter-professional communication. Rather, these providers are evaluated positively because they often communicate to a higher extent and more directly with other actors, which is attributed to a faster system of internal communication compared to larger care providers. Interestingly, the coordination of the transition from hospitals to home-based care on average seems to work better than the integration of services and cooperation among professionals in the home care setting in all countries. It is reported that GPs, LTC nurses, and workers in social care rarely meet and discuss problems together. Communication is always one way and mostly indirect. No real exchange or joint management is taking place. In all countries, organizations stress that inter-professional cooperation and communication are often based on the engagement of individual actors and become easier if all actors know each other. It seems that under the current institutional

regulations and structural conditions, the various professional groups are unable to fulfill the task of coordination effectively.

In all countries, interviewees discuss digital tools as possible solutions for faster and easier communication between different occupational groups and different organizations. As a German organization puts it:

> And my hope is that with a digital communication structure, we can get people around the table more quickly in order to work together on a case, communicate better with each other. (DV, Germany)

Organizations stress that data protection is important because digital tools such as electronic patient records include a lot of sensitive data and information on a person. However, in all countries, we found views which emphasize that data security should not go too far and that the benefits of electronic systems should outweigh their possible costs. Among the four countries, Sweden and the Netherlands have a better infrastructure and use of digital tools in HC and LTC (Thiel et al., 2018). Even these countries, however, have not yet implemented nationwide unified electronic systems which can be accessed by all relevant HC and LTC providers. In all countries, organizations complain that electronic communication and cooperation systems vary between different service providers and regions.

The degree of digitalization and, therefore, the context for complaining about insufficient electronic systems differ. Sweden and the Netherlands had already implemented electronic systems in healthcare and social care in the early 2000s, whereas Germany and Switzerland have made progress only in recent years. Their level of digitalization still clearly lags behind the other two countries (Thiel et al., 2018). Despite varying degrees of digitalization, in all our countries the digitalization in HC is more advanced than the digitalization in LTC. In HC, nationwide systems are more prevalent than in LTC. For example, in Sweden nationwide databases and electronic patient records exist for HC. Furthermore, telemedicine is comparatively advanced in Sweden as it is an important tool to provide medical care in the rural regions in the North. In LTC, data are rarely shared and usually remain with the organization by which they have been collected. Similar to Sweden, the Netherlands have introduced electronic patient records quite early, starting in the 1990s (van der Lei et al., 1993), but hospitals, GPs, specialists, and pharmacies all used different systems (Michel-Verkerke, Stegwee, & Spil, 2015). In our interviews, organizations complain about these different systems and the consequential

difficulties to share information. Even in Sweden, where digitalization is most advanced, problems of a lack of compatibility exist:

> We have an electronic medical record, an electronic care record and an electronic prescription record. But they are not integrated, so we should have some sort of digital integration also. (Tiohundra)

However, the Netherlands have started to implement a "personal health environment" (*persoonlijke gezondheidsomgeving*, PGO) in which medical, pharmaceutical, and social care information by all relevant providers should be integrated. The patient is encouraged to take an active role in the management of their personal health environment by adding data such as physical activity data, demanding to delete data, and allowing access to data to specific providers (Rijksoverheid, 2022).

In contrast to Sweden and the Netherlands, electronic patient records have only recently been introduced in Germany in 2020 and in Switzerland in 2021, and are still far from being fully implemented. In both countries, not all relevant actors are obliged to use those systems. In Germany, since 2021, hospitals and physicians are bound to implement electronic patient records, but LTC providers are not yet able to up- or download data into those files but should participate voluntarily in the future. German organizations consider this (at least temporary) exclusion of the LTC sector to be a serious problem for care coordination. In Switzerland, the use of electronic patient records is obligatory for hospitals and clinics since mid-2020, and voluntary for GPs and ambulatory services. Thus, Germany and Switzerland are still at the beginning of comprehensive systems to share health and care information between providers, whereas Sweden and the Netherlands are further ahead in this process. Furthermore, it will be interesting to see whether these comprehensive electronic patient records develop in the direction of mere patient information systems or if these systems are used in practice by professionals in the field to coordinate care.

8.7 CONCLUSION: STAFF SHORTAGES, RESPONSIBILITY, OR COMMUNICATION?

This chapter has focused on the workforce in HC and LTC and asks which common problems concerning staff hinder but also facilitate the coordination of elderly care. We have used the interviews with organizations and the analyses of these interviews which are provided in the country-specific chapters (4 to 7) of this book to answer this question. Furthermore, the specific national and international context is considered to classify the information from the interviews and thus compare the four countries.

We identify three dimensions related to staff that complicate the coordination of care: (1) staff shortages; (2) the lack of allocation of responsibilities; and (3) the lack of inter-professional communication. All three dimensions play a different role in each country, but have an effect on the occupational coordination of care in all countries. Despite their various institutional set-ups in HC and LTC and the different approaches to the coordination of elderly care services therein, we have arrived at some general lessons to be learned and provide general suggestions to decrease problems in the coordination of care.

The first common problem is staff shortages, in particular GPs and (LTC) nurses. Organizations in all countries report that staffing is deficient and estimate that this problem will intensify in the future. This common problem exists despite different levels of employment in HC and LTC across countries, regions, and sectors. A common concern is the low density of GPs and of LTC nurses in rural and remote areas. Hence, organizations in all countries demand more staff in order to decrease their workload and thus open up more space in the workforce to take over coordination tasks. The comparison shows that there are important reasons for each country to invest more resources into better working conditions and more competitive pay to gain and retain more staff, particularly in LTC. However, our research shows that more staff will not automatically solve all the underlying structural coordination problems in healthcare and LTC. If institutional conditions are too strong and inflexible and set strict limits to financing or to occupational competencies, a pure increase in the number of people working will not be sufficient. Although most interviewees are critical about staff shortages, the consequences of this shortage on coordination are perhaps overestimated and vary among countries. This overestimation may particularly be the case in strongly institutionalized systems. This conclusion does not deny that staff shortages constitute a serious problem in many countries and in particular in rural areas. Without a certain level of healthcare and LTC staff, other solutions including our own recommendations will certainly fail.

The second common problem is a lack of formal responsibilities of (LTC) nurses in the care process. In all countries, the education and qualifications of LTC nurses and their responsibilities differ widely. In the Netherlands and Sweden, the formal responsibilities of nurses in the coordination of transitions from hospital to home care and within the home care setting are much wider than in Germany and Switzerland where the academic education of nurses has developed later, is less widespread, and under more debate than in the former two countries. In Germany and Switzerland, hierarchies within HC and LTC are largely based on the delegation of tasks and the supervision of tasks by medical doctors. In Switzerland, GPs operate as gatekeepers to LTC benefits, but mostly act and prescribe LTC services based on the assessment and recommendation of the LTC nurse. In contrast, LTC nurses in the Netherlands

have both the competencies and responsibilities to assess and determine the amount of home care services. This practice is similar to Sweden where GPs have never taken over formal roles in LTC and thus, responsibilities for coordination primarily lie with LTC nurses. In Germany, LTC nurses have long lacked the education and thus competencies for many (medical) tasks and thus coordination has rested with either GPs and medical staff in hospitals or has been transferred to the family. The country cases show that higher-qualified LTC staff as such will not necessarily change or improve the coordination of care, but there is a need for institutional rules in which responsibilities for coordination are clearly defined and distributed in a way that all occupational groups are integrated in order to guarantee that no occupational group is overburdened with the task of coordination.

The third common problem is the lack of inter-professional and inter-organizational communication. In all countries, organizations report problems in this area. With regard to the transition process from hospital to home care, all countries have experienced a decreasing length of hospital stays due to the implementation of DRG financing, which has resulted in less time to manage the transition. Although specific discharge teams in hospitals organize the transition, GPs and home care nurses often do not have sufficient time or lack the necessary information to organize the appropriate care services for an elderly patient. In the home care setting, the communication between the different professions, and the various organizations in which these professions work, poses a problem. Organizations in all countries report that it is mostly the goodwill of particular persons who engage in bringing all care providers together to talk about a specific case. Electronic patient records could facilitate inter-professional communication. Although the Netherlands and Sweden complain about deficiencies in their systems—largely about parallel structures or deficits in the compatibility of data and systems—both countries use these tools more widely to communicate and share information than is the case in Germany and Switzerland. Our analyses thus show that communication should be based on enforceable institutional structures of inter-professional communication, which can be aided and facilitated by a more comprehensive development of digital health infrastructures.

Overall, the comparison shows that the coordination in elderly care services is largely influenced by the size, the responsibilities, and the communication of different occupations in healthcare and LTC. Although Germany, the Netherlands, Sweden, and Switzerland have very different institutional settings in HC and LTC and different sizes and qualification profiles of their workforces, the three dimensions highlighted in this chapter represent problems that are common in all countries. There are country-specific differences in the severity of problems in each dimension and these problems need to be considered within the institutional and historical background. Not only for the

countries analyzed and compared in this chapter, but for all countries which are interested in increasing the quality of transition processes from healthcare to LTC and in providing integrated elderly care service, a sufficient number of professionals in healthcare and LTC is necessary. What a "sufficient" number of professionals actually means, has to be determined in each country separately by considering the size, structure, and health level of the elderly population and the entire welfare system. Our analysis shows that all countries should pay particular attention to employment density and service provision in rural and remote areas. Adequate staffing levels are a necessary but not sufficient condition for a high-quality level of elderly care coordination. Countries should focus on appointing clear formal responsibilities to specific occupational groups in coordination processes. We argue that well-educated, in particular academically trained, (LTC) nurses could take over many coordination tasks and take a leading role in coordination processes, which would benefit both nurses and GPs. Nurses would be more highly valued and have better opportunities of career progression, and thus gaining and retaining nurses particularly in LTC would be easier. GPs would benefit as they could focus on their curing function and hand over some of their high workload to nurses. Enhancing inter-professional communication seems to be an issue in all countries and potentially countries can benefit from comprehensive digital tools to share information. Digital tools can facilitate communication and cooperation; however, our analyses have also shown that the time given to actually coordinate care and organize services and aids is a common problem, in particular with transitions from hospital to home care. We encourage policymakers to develop solutions to provide professionals with more time to organize and coordinate care.

NOTE

1. German data are from 2019.

9. System-level coordination problems: impact of the institutional structure

9.1 INTRODUCTION

This chapter analyzes the key coordination problems in healthcare (HC) and long-term care (LTC) at the system level (see Chapter 2 for a definition of the different levels of coordination problems), as assessed by the organizations. The system level refers to the basic institutional framework under which health and long-term care systems operate in the different countries. It can be divided into four main dimensions: functional; territorial; financial; and access (see Alber, 1995; Bahle, 2003; 2007; Kröger & Bagnato, 2017; Wendt, Frisina, & Rothgang, 2009 for a further discussion of these dimensions). The chapter has two objectives: first, to identify general coordination problems that can be located at the system level; and second, to highlight the most critical coordination problems in each country in the context of their specific institutional setting.

The first system-level dimension comprises the functional organization of services, i.e., the scope of professional care versus informal care and the division of tasks within professional care (Brandt, Haberkern, & Szydlik, 2009; Daly & Lewis, 2000; Pfau-Effinger, 2005). When analyzing the two systems of HC and LTC in combination, the crucial question is how the different components of care are integrated. HC and LTC systems follow similar but also different, sometimes opposing logics and goals. Both systems focus on individuals who are (temporarily or chronically) ill and incapacitated, and therefore unable to live independently and care for themselves. Both systems may deal with the same individual at the same time or sequentially (Bauch, 2016). The HC system is primarily designed to help those who are temporarily ill and to cure the underlying illness. By contrast, the LTC system aims to help individuals who are permanently, or at least for an indefinite time, ill and incapacitated (see Apesoa-Varano, Barker, & Hinton, 2011 for a discussion of the origins and strands of the cure–care divide). Additionally, LTC addresses not only the physical but also the mental and social incapabilities of living (i.e., activities of daily living and instrumental activities of daily living). For reasons of simplicity, in the following we distinguish between three care components:

medical treatment ("cure"), physical LTC ("nursing care"), and social LTC ("social care"). In addition, supplementary services such as mobility or housekeeping are important, but usually not part of care services. In each country, the service package for curing and caring is organized differently, and the scope also varies within countries. In the following, this dimension is labeled as the "functional integration" of services.

The second dimension, territorial, refers to the territorial regulation of services within welfare states (Alber, 1995; Rothgang et al., 2010). This relates to the question of centralization or decentralization in the welfare state and is crucial for all social services, in particular for HC and LTC. The territorial dimension can be subdivided into local, regional, and national levels. If key issues of service provision are decided at the local level, a system is defined as locally centered. If decisions are made at the regional or national level, a system is considered to be regionally centered and nationally centered, respectively. The responsibilities for allocating funds, granting access, and providing monetary and personal benefits are often located at different levels (OECD, 2017). For example, the service package for a LTC patient can be determined on the basis of national rules and implemented by regional and local entities. If the institution which is responsible for a specific task (e.g., allocating funds) is located at the same level in both the HC and the LTC system (or if the same institution performs the same function in both systems), coordination problems are likely to be minor and easily solved. Yet, if the institution responsible for a specific task is situated at different levels in the two systems, coordination problems are presumably larger and less easily solved. In the following, we summarize these aspects under "territorial integration".

The third system-level dimension comprises the financing structures (Field, 1973; Rothgang et al., 2010) and focuses on the input and distribution of financial resources. In mature welfare states, fundamental reforms have led to a privatization of costs and marketization in service delivery structures (Theobald, 2015). In turn, the resulting marketization has been a major trigger for reform and transformation of welfare services in all countries, albeit in different forms, at different paces, and with different effects (Brennan et al., 2012; Gingrich, 2011). With respect to financial regulation, two aspects are of particular importance: the main sources of financing and the mechanisms by which funds are allocated to services. Unclear financing structures can lead to lengthy decision-making processes in which patients wait for services because the institutional actors in both HC and LTC may try to shift the burden of financing to the other. Furthermore, the introduction and expansion of diagnosis-related groups (DRGs) and the growth of private for-profit hospital chains in the HC systems of many OECD countries indicate that the importance of economic rationalities has increased. Similarly, the increase of private for-profit service providers, particularly in residential care, shows that

economic rationalities have also gained importance in LTC (Ranci & Pavolini, 2015). In everyday practice, the economic rationale of profit-seeking may contradict the objectives of curing and caring in both systems. In many welfare states, processes of marketization and privatization of welfare services started in the late 1990s and early 2000s. With neoliberal policies, governments aimed to limit public welfare spending (Pavolini & Ranci, 2008). Despite a common neoliberal rationale, the actual policies of new public management, rationalization, and outsourcing varied considerably. We hypothesize that the higher the degree of privatization and marketization in HC or LTC, the greater the coordination problems.

Our fourth dimension is how access to systems is regulated. A good example of access regulation is gatekeeping (Wendt, Mischke, & Pfeifer, 2011; Reibling & Wendt, 2012). This dimension is linked to the issue of targeting and the opposing tendencies to open up systems to new and diverse needs. Access to services can be regulated quite differently (Reibling & Wendt, 2012). We focus on regulating care through a gatekeeper, such as a GP, as a means of guiding patients or older people to the services that they need. When focusing on a single area of service provision, gatekeeping may have positive effects on coordination because it reduces the number of tasks, structures the process of service provision, and can even increase the resources per (accepted) case. However, since HC and LTC are highly connected, gatekeeping in one system may have severe consequences for the other system. If gatekeeping policies for LTC services are strict, for instance, the refused services may fall back on the private (family) sphere, the healthcare system, or the social welfare system. If the extent of gatekeeping differs between HC and LTC, coordination problems may increase. Similar access rules, in contrast, may strengthen cooperation between the two sectors.

The chapter proceeds as follows. Section 9.2 provides a comparative overview of the basic institutional settings in the four countries and outlines our expectations about what the main coordination problems are at the system level. Section 9.3 focuses on the main problems identified by the organizations in the four system-level dimensions: functional integration; territorial integration; financing; and access regulation. In Section 9.4, the specific profiles of system-level coordination problems in each country, as they emerge from the interviews, are lined out. In the conclusion (Section 9.5), we present general and country-specific lessons learned from the analysis.

9.2 INSTITUTIONAL SETTINGS IN COMPARISON: CROSS-NATIONAL SIMILARITIES AND DIFFERENCES

The four countries represent four different combinations of HC and LTC systems. Therefore, our country sample allows for testing the question of whether and how institutional structures shape coordination. In the interviews of our study, the basic country-specific institutional features are often taken for granted, since they represent the framework for all actions. In addition to the qualitative interviews, we therefore provide information on the features of the institutional structures that the organizations identify as problematic for coordination.

In the countries studied here—Germany, the Netherlands, Sweden, and Switzerland—the types of HC and LTC systems, as well as the interplay between them, differ. Comparative research has developed several typologies of HC and LTC systems to better capture and compare their institutional characteristics. These include more theoretical ones, which focus on ideal types in a Weberian sense (e.g., Wendt, Frisina, & Rothgang, 2009 for HC; Pfau-Effinger, 2014 for LTC), and more empirically based ones (e.g., Wendt, 2009; 2014 for HC; Halásková, Bednář, & Halásková, 2017; Damiani et al., 2011 for LTC). Although the types identified in these studies depend on the period studied, the countries, dimensions, and indicators included in the analysis, and the method used (as a rule, different forms of cluster analysis), recent typologies help to clarify the main institutional differences in HC and LTC.

The HC and LTC typologies used for our purposes here have been developed in two comparative studies that performed several hierarchical and k-means cluster analyses and can be used flexibly. They share similar methodological approaches, time periods, data sources, and indicators. The healthcare typology by Reibling, Ariaans, and Wendt (2019) clusters 29 OECD healthcare systems according to OECD data for 2011 to 2014 and institutional indicators collected through expert surveys. The LTC typology by Ariaans, Linden, and Wendt (2021) clusters 25 OECD LTC systems using OECD data for 2014 to 2017 and institutional indicators collected through expert surveys as well. As for the indicators, both typologies cover the dimensions of supply, public–private mix, access regulation, and performance. The healthcare typology additionally includes primary care orientation. As a result of the similarity in methodology and data, the typologies and the country clusters can be better compared.

Table 9.1 lists the system types in the typologies as well as their labels and the countries belonging to them. Accordingly, Germany, the Netherlands, Sweden, and Switzerland belong to different HC system types but the Netherlands and Switzerland belong to the same LTC system type.

Table 9.1 HC and LTC system types as categorized by Reibling, Ariaans, and Wendt (2019) and Ariaans, Linden, and Wendt (2021)

HC system types	LTC system types
Low-supply and low-performance mixed system EE, HU, PL, SK	Residual public system CZ, LV, PL
Performance- and primary-care-oriented public system FI, JA, KO, NO, NZ, PT, **SE**	Public supply system DK, IE, NO, **SE**
Regulation-oriented public system CA, DK, ES, IT, **NL**, UK	Need-based supply system AU, BE, **CH**, LU, **NL**, SK, SI
Supply- and choice-oriented public system AU, AT, BE, CZ, **DE**, FR, IE, IS, LU, SI	Private supply system **DE**, FI
Supply- and performance-oriented private system **CH**, US	Evolving private need-based system EE, ES, FR, IL, NZ, UK, US
	Evolving public supply system JP, KR

Note: Countries analyzed in this book are marked in bold.

In these typologies, Germany's HC system is categorized as a supply- and choice-oriented public system, and its LTC system is classified as a private supply system. Both systems have medium to high levels of supply. Financing in the HC system is mainly public, whereas the LTC system has one of the lowest shares of public expenditures among the OECD countries. Access restrictions are low in HC as well as in LTC. Furthermore, the German HC system belongs to the cluster with the highest share of GPs compared to other healthcare system types, while the performance levels are medium to low. The Dutch HC system is classified as a regulation-oriented public system and its LTC system as a need-based supply system. Both systems are characterized by medium to high supply and average to high public funding. Furthermore, they both apply high access barriers, and performance is medium to high. Sweden's healthcare system represents a performance- and primary-care-oriented public system and its LTC system a public supply system. Both systems are marked by medium to high resources and above-average public spending levels. Access to the HC system is regulated by gatekeeping, whereas access barriers in the LTC system are low. Choice is more limited in both systems than in most other countries. Performance is high. The HC system shows a strong primary care orientation, with a high number of GPs. Switzerland's HC system is defined as a supply- and performance-oriented private system and its LTC system as a need-based supply system. Both systems are characterized by high supply. In the healthcare system, private financing and out-of-pocket expendi-

ture play a major role. Access restrictions apply to both HC and LTC benefits and services. Performance levels in HC and LTC are above average.

Two of the system-level dimensions that are central to our study are also used in the two typologies as criteria for classification: financing structures and access regulation. In order to understand coordination problems better, we need to look at the specific institutional features in our four country cases. In Switzerland, federal health insurance is the primary source of financing for both medical treatment and physical LTC (Trein, 2018). The benefit package in both cases is clearly defined and depends on need, not means (Rüefli, 2021). The same is true for Germany, except that the two service components are financed separately (Blümel et al., 2020; Gerlinger & Reiter, 2017; Gerlinger, 2018). In both countries, social care is not covered by the service package. Consequently, private financing plays a crucial role also in LTC, because the publicly financed package is strictly limited and does not cover all needs (Wendt & Bahle, 2020). In the Netherlands, financing for healthcare services is based on social insurance contributions to healthcare funds (Anderson & van Druenen, 2021). Residential LTC and 24-hour home care are financed through contributions to LTC social insurance, whereas non-24-hour home care is financed through HC funds and social LTC by municipalities (Kroneman et al., 2016). In Sweden, financing sources for healthcare services are mainly regional taxes and also national grants, although to a lesser extent (Blomqvist & Winblad, 2021). Home care and residential care are financed by municipalities and municipal taxes, respectively (Schön & Heap, 2018). Overall, the financing structures seem to conflict with the task of coordination, particularly in Germany and the Netherlands. Separate public funding for HC and LTC provides incentives for strategies to avoid and shift costs from healthcare to long-term care insurance. Externalizing costs rather than improving coordination can be considered as a well-suited strategy in these institutional settings. In Switzerland, financing does not facilitate overall coordination either, but at least supports a better integration of nursing care in health insurance. Although HC and LTC are funded separately in Sweden, care coordination has become a national priority, resulting in the provision of state grants for initiatives to improve coordination (Schön & Heap, 2018).

Gatekeeping structures differ as well between the four countries under study. In the context of our comparative analysis, two elements of gatekeeping are important. First, the question of responsibility and, second, the degree of gatekeeping. In Germany and Switzerland, gatekeeping in LTC is low because access to benefits is regulated by federal law. At the same time, however, the service package does not cover all needs but only a basic set of benefits. Therefore, in many cases access restrictions exist due to difficulties in covering the costs of private services or providing services within the family. Furthermore, gatekeeping in LTC exists with respect to the existing

basic benefit package. In Germany, the Medical Service, an independent body including medical and care professionals, decides through a standardized needs assessment about access to LTC (Blümel et al., 2020). In Switzerland, it is usually a GP who approves the need for basic care and therefore a person who is involved in actual service provision. This gives the GP a central position in Switzerland. In the Netherlands, gatekeeping policies for residential care are very strict, with the result that most LTC needs and services are transferred to the home care setting (Kroneman et al., 2016). In healthcare, GPs are the central contact point and responsible for gatekeeping to specialist care (Anderson & van Druenen, 2021). In Sweden, no general gatekeeping exists in the healthcare system, only in some regions is a GP referral required and this is generally associated with faster access to specialist care (Blomqvist & Winblad, 2021). In contrast, gatekeeping in the Swedish LTC system is based on a needs assessment carried out by the municipalities, each of which follow different guidelines (Schön & Heap, 2018). Therefore, the procedures and results of the needs assessment vary from municipality to municipality. Overall, we expect the negative effect of gatekeeping structures on coordination to be strongest in Switzerland, followed by Germany, and weakest in the Netherlands and Sweden.

Functional and territorial integration, which we use as system-level indicators in our analyses, are not explicit elements in the typologies by Reibling, Ariaans, and Wendt (2019) and Ariaans, Linden, and Wendt (2021). They represent additional dimensions that are particularly important for coordination and vary widely among the four countries. Concerning the functional dimension, the service package is distributed quite differently in the countries under study. In Switzerland, medical treatment and nursing care are included in health insurance, while social care is excluded from the service package (Rüefli, 2021). In Germany, the medical treatment and physical aspects of LTC are strongly separated. Medical treatment within LTC is part of the HC system, and nursing care is covered by LTC insurance (Blümel et al., 2020). Social LTC, in contrast, is generally excluded. In the Netherlands, medical treatment, nursing care, and social care are in most cases defined and provided separately (Mot, 2010; Kroneman et al., 2016). In Sweden, planning and providing HC and LTC is institutionally separated (Schön & Heap, 2018). Overall, however, the functional integration of the service package is higher in Sweden than in Switzerland, the Netherlands, and Germany. We therefore expect "functional" systemic coordination problems in particular in the latter three countries.

Concerning the territorial dimension of service organization and regulation, each country shows a distinct profile. In Switzerland, both medical treatment and nursing care are ruled by federal law, whereas social care is a cantonal and municipal obligation (Rüefli, 2021; Trein, 2018). In Germany, both HC and LTC are regulated by federal social insurance law (Immergut & Wendt, 2021).

In the Netherlands, healthcare is mainly determined by national rules. These rules are implemented via healthcare funds, which cover most healthcare costs (Kroneman et al., 2016). In LTC, the main rules are also set at the national level, but financing and provision are more fragmented. Residential LTC is organized regionally via care offices, while ambulatory LTC and home help services are organized by municipalities (Kroneman et al., 2016; ZN, 2022). The LTC system in the Netherlands is therefore highly fragmented spatially. In Sweden, national laws and guidelines provide the legislative framework for both HC and LTC. The organization and provision of healthcare and LTC is decentralized and strictly separated: counties are responsible for healthcare services and municipalities are responsible for social care services (Blomqvist & Winblad, 2021). Due to the traditionally strong autonomy of counties and municipalities, the organization of HC and LTC services varies widely (Glenngård, 2020). Therefore, spatial segregation is high within the Swedish HC and LTC system. Overall, territorial integration in service regulation is weaker in the Netherlands and Sweden than in Switzerland and Germany, where both HC and LTC are largely regulated by federal law. At the same time, however, federal law is at a distance from actual service provision and local conditions, which makes it a rather unpractical coordination tool. We therefore expect stronger coordination problems related to the territorial system-level dimension in Switzerland and Germany than in Sweden and the Netherlands.

9.3 IMPACT OF INSTITUTIONAL DIMENSIONS ON COORDINATION: IT'S NOT ALL ABOUT FINANCING

In this section, we look at system-level problems that are relevant in all the countries under study. The empirical base are interviews conducted with organizations operating in HC and LTC in Germany, the Netherlands, Sweden, and Switzerland. All organizations interviewed mention systemic coordination problems, but the significance and impact of those problems vary between the countries. Due to differences in the institutional settings, not all dimensions are equally important in the four countries.

In the interviews, the lack of functional integration of the different components of care is often reported as a substantial problem for service coordination. Most of the Swiss organizations interviewed by us complain that the institutions do not acknowledge the social aspects of care as being as important as the medical ones. As a result, the coordination between medical and social care is a major challenge, for which the current institutional system in Switzerland does not provide an easy solution. Most Swiss interviewees perceive the strong and integrating role of health insurance as positive for HC and LTC. Many accept, but also strongly criticize, the downside of this arrangement, the exclu-

sion of purely social aspects of care. In the Netherlands, medical and social aspects seem to be equally important in elderly care. This becomes evident at the professional level: the rights and obligations of professionals in HC and LTC differ. For instance, GPs and specialists assess and decide on (acute) medical needs, and district nurses assess and decide on (medical) long-term home care needs. Nevertheless, all organizations consider the parallel structure of different schemes to be a problem and criticize that too many actors and entities are involved. Furthermore, they see the large number of small home care organizations as a problem for care coordination because hospitals and GPs need to build and maintain contacts with many different actors and organizations. The Swedish organizations mention the same problem in the interviews. The German organizations interviewed criticize the legal divide and different logics of financing and service provision in HC and LTC. In their view, this divide complicates care coordination. Particularly, the highly standardized LTC insurance, institutionalized as social insurance, restricts freedom of action. There is no profession which is institutionally fully integrated in both the HC system and the LTC system. As in other countries, such an actor could potentially serve as a link between the two systems. Today, German GPs have a marginal role in the provision of information, consultation, and assessment in LTC, as their main task is the provision of medical care. In the interviews, the organizations report the positive effects of care support centers on care coordination. At the same time, they criticize the high number of actors from HC and LTC involved in the counseling sector, leading to a fragmentation of counseling and parallel structures. In Sweden, the functional dimension seems to be less relevant. The interviews provide evidence that, despite the institutional separation of HC and LTC, coordination and communication across the interfaces seem to work relatively well.

The territorial dimension is most often discussed by organizations from Switzerland and Germany, where the HC and LTC systems are federally organized, as well as from Sweden. In these systems, the different government levels often do not interact smoothly with each other. Some Swiss organizations are quite critical of federalism and its consequences, such as differences between the cantons in implementation processes and policies in HC and LTC. No organization, however, demands a complete restructuring of the system. Most evaluate national regulations in health insurance positively and consider them as the most important pillar of the system. Deficits are identified particularly at the local and regional level. Some interview partners complain about a lack of locally organized networks for better service coordination, while others emphasize a lack of financial resources for coordination standardized by national regulations. In most statements, however, the territorial divide is not identified as the main problem, nor as the most pressing problem to be solved. In the interviews with German organizations, the territorial dimen-

sion is not explicitly identified as a major problem for care coordination. Nevertheless, differences between federal states resulting from insufficient national regulation are mentioned, leaving the federal states with the freedom of whether to establish specific services or not. For example, care support centers do not exist in all federal states, and curriculums in nursing education vary. In the Netherlands, LTC is divided into several schemes, which are all based on different organizing entities, financing mechanisms, and service providers. Organizations point out that the number of schemes and potential contact organizations have resulted in confusion in the first years following the 2015 reform, when different schemes were introduced. According to the organizations, patients have now developed trust in the new schemes, and it has become less difficult to find the right contact person. In the interviews with the Swedish organizations, the spatial dimension is a highly important topic. The autonomy of regions and municipalities is assessed to have ambivalent effects. The reason is that the autonomy allows counties and municipalities to respond quickly and adequately to local challenges but also leads to the fragmentation of regional and local solutions. Particularly the fragmentation of communication systems is assessed as a major problem related to the high level of autonomy at the regional and municipal level. The organizations see one solution in digital information systems, but due to the existing regional and local autonomy, many different information systems have been introduced, which are often not compatible with each other. Therefore, Sweden's regional and local fragmentation undermines its pioneering role in e-Health.

Processes of marketization and financial rules are rather different in the four countries, and the organizations identify major coordination problems related to the respective arrangements. The Swiss organizations believe that the practice of financing LTC through health insurance both improves and prevents coordination. This ambivalent view is reflected in many statements made by the interviewed organizations. Standard and reliable financial resources are mentioned as the main merits of the system. The limitation to medical aspects of care and a strong fiscal barrier regarding the further development of services are mentioned as the main shortcomings. The latter point is related to the Swiss form of healthcare financing through per capita premiums. Several organizations assess capitation premiums as a problem related, for instance, to social inequality, but some consider it to be a necessary cost containment mechanism. Marketization is rarely mentioned as a problem for coordination. Although there is competition between public and private LTC providers, this is not seen as particularly relevant for service coordination. In the Netherlands, financing plays an important role in the coordination of elderly care services. Each form of care is financed through a separate scheme. As expected, the organizations report that the overlaps and transitions between the different schemes are not adequately financed and that the structures contribute to shifting costs from

one scheme to the other. Furthermore, according to the organizations, the introduction of a DRG system in hospital has resulted in earlier discharges and therefore a shorter period of time for organizing follow-up care services. In Germany, too, the separate financing of HC and LTC causes conflicts about who is responsible for financing coordination measures that help improve the integration of services across systems. Moreover, according to the organizations, in both systems coordination tasks often cannot be remunerated due to inflexible accounting models. The organizations criticize that DRGs in the German hospital sector only insufficiently cover coordination tasks. The introduction of DRGs is associated with earlier discharges, increasing the pressure to organize post-discharge LTC. In Sweden, shorter hospital stays create financial burdens for the municipalities, which face rising costs due to higher post-discharge care needs. However, the implementation of financial incentives seems to increase the municipalities' willingness to coordinate the transition to home care. Another issue related to financial regulations is that there are separate budgets for HC and LTC, which leads to conflicts between regions and municipalities over the responsibility for financing certain services. Additionally, depending on their financial situation and priorities, municipalities have different financial resources to provide LTC for the elderly, which results in regional inequalities in service provision. The Swedish organizations assess marketization policies as a minor obstacle because the same rules and payment conditions apply to public and private home care providers. Therefore, it is assumed that competition between public and private providers is not based on price, but on quality.

Gatekeeping is rarely mentioned in the interviews but plays an implicit role. Access rules vary strongly between the countries. In all cases except Sweden, the extent of gatekeeping is lowest in LTC. Limiting access through gatekeeping can be regarded as a relief mechanism for overburdened systems as well as a tool to improve coordination. In healthcare, a GP as a gatekeeper is responsible for guiding patients to the services and providers that they need most. Furthermore, however, restricting access and reducing the number of consultations has the effect that available resources can be distributed among fewer cases. In Sweden and partly in the Netherlands, service providers have an influence on access and, according to the interviews, consider it as an important steering mechanism. This is not the case in Germany and Switzerland, where access is regulated by federal law, independent bodies, or professional groups. In Switzerland, access to LTC is open to any person with health insurance in need of medical long-term care. Formally, access is regulated through medical prescription by GPs, who therefore act as gatekeepers to the system. In the interviews, access control as such is not blamed for generating coordination problems but rather its specific form of institutionalization. The German organizations criticize that bureaucratic and lengthy assessment

procedures delay access to LTC. The existing procedures also contribute to uncertainties about the financing of services, as the elderly and their relatives face the risk to bear the costs themselves. This is particularly the case in the transition from hospital to LTC. The Swedish organizations criticize the timing of LTC needs assessment by municipalities, which directly takes place after hospital discharge. As care needs usually decrease quickly in the first days after hospital discharge, organizations argue that the needs assessment should be carried out later to obtain more reliable results. The organizations suggest that a preliminary decision should be made based on the hospital's recommendation so that the discharge process is not delayed. However, this requires that municipalities trust hospitals' recommendations.

9.4 IMPACT OF INSTITUTIONAL SETTINGS IN INDIVIDUAL COUNTRIES: VARYING PROFILES

This section summarizes the various systemic problems of each country from the perspective of the organizations. Each country's institutional set-up shows its own problem profile. The German system is functionally divided. In the territorial dimension, both HC and LTC have similar priorities regarding the coordination of services. Marketization is strong in both systems and gatekeeping is weak. HC and LTC are both organized under compulsory social insurance, with access to services, financing modes, and service packages being regulated at the national level. In functional terms, however, the two systems are strictly separate from each other. Healthcare, even if provided within LTC settings, is always the responsibility of the HC system, while nursing care is part of LTC. The purely social aspects of care as well as supplementary services are usually not financed. Despite institutional isomorphism, there are strong boundary conflicts between the two systems. These conflicts are mainly the result of strong and dynamic marketization in both systems. In HC, cost pressure is high in both inpatient and outpatient care, leading to cost avoidance and a shift of the financial burden to the LTC system. In the hospital sector, DRGs are the predominant form of remuneration, which does not include LTC. In the outpatient setting, medical home care and home visits by GPs are not adequately funded. Service provision in LTC is highly competitive due to a high number of small private service providers. Furthermore, financial resources for services are limited and highly standardized for each case, leading to high cost pressures. At the same time, both systems are relatively "open" regarding access to services, because gatekeeping is weak. In HC, there is no gatekeeping at all, and in LTC, federal law defines standard service packages for standard cases of need. This open system with easy access and dynamic marketization results in strong competition and cost pressure for all service providers, which is highly problematic for coordination efforts. In addition, there is a social

divide in Germany in HC and LTC, i.e., between social and private insurance. Moreover, LTC insurance benefits are capped. The (sometimes very high) remaining costs have to be shouldered by the persons in need and their families or, in case of insufficient means, by social welfare. This feature of LTC is another barrier for coordination, since LTC service providers have no incentive to improve their services through coordination. While HC externalizes costs to LTC, LTC providers may shift financial burdens to families and individuals in need. This process of cost-shifting reduces the incentive to save costs through better coordination. As a result, coordination problems are high in Germany. The organizations interviewed mainly point out that financing regulations and functional aspects are the main problems, since the other systemic aspects are more "hidden" in their daily routines.

The Swiss system is strongly divided in functional terms, whereas the territorial dimension is more integrated than might be expected given the federal and decentralized political system. This is due to the high importance of federal health insurance for both HC and LTC. Federal law regulates both the access to and financing of HC and LTC. The downside of this predominance of health insurance is the equal predominance of health-related aspects in LTC services. Social aspects and especially supplementary services are not part of the package and have to be financed purely privately or, in case of insufficient means, through regional and local social welfare. The strong functional divide is a negative corollary of the high territorial and financial integration. At the same time, the high level of private funding and the wide exclusion of social care from the service package cause a strong social divide. Coordination problems are therefore most relevant in the cases of those with low means, whereas higher-income groups are usually able to find their own private solutions for better services. This aspect also constitutes a strong political barrier to the expansion of services or their better coordination. Moreover, since most finances and services flow through health insurance, there is strong competition for resources and responsibilities among the different professional groups within this system. This fact is most obvious in the latent conflict between GPs and professional LTC providers. In such a setting, there is a strong common interest to improve coordination, but practically no incentive for anyone to act accordingly. The interviewees in Switzerland have shown that they are highly sensitive to the coordination problems, but often indecisive about the necessary means to solve them.

In the Netherlands, we find a high degree of functional and territorial disintegration, while there are only minor problems at the level of social integration. The systems of HC and LTC are clearly divided. Acute healthcare services are provided by the HC system. All Dutch residents have to purchase HC insurance with a statutory insurer, and insurers are obliged to offer all residents the same basic insurance package. Since 2005, hospitals are financed on the basis of

diagnosis treatment combinations (*diagnose-behandelcombinatie*, DBCs), the Dutch version of DRGs. One would perhaps expect that this HC system (which includes strong market elements) would externalize costs to other welfare state systems—in particular the LTC system. However, this externalization does not seem to be the main problem for coordination, but rather the functional and territorial disintegration of the LTC system. The financial and organizational responsibilities in LTC nursing care are regulated by the Long-term Care Act (*Wet langdurige zorg*, Wlz). This scheme is a public social insurance system and includes residential care only. Nursing care at home is provided in accordance with the Health Insurance Act (*Zorgversekeringswet*, Zvw), with health insurance companies being responsible for financing and provision. Social care (*Wet maatschappelijke ondersteuning*, Wmo) is the responsibility of municipalities. This LTC structure is the result of the larger 2015 reform, which had the major aim to decrease the high rate of LTC cases in residential care and to increase community care. Co-payments in the Dutch LTC system depend on income, household members, and the age of the recipient. Many organizations and institutional levels are included in the provision, financing, and organization of LTC services, and when healthcare needs enter the equation—which is usually the case—even more actors are involved in the care for an elderly patient. Means-testing and private co-payments are not a large problem in LTC and do not impede care coordination.

The service-oriented Swedish HC and LTC systems offer a wide range of public care services. HC and LTC are institutionally strictly separated, and administrative responsibilities are located at different political and administrative levels. A major characteristic is strong regional autonomy in the HC system and local autonomy in the LTC system. Therefore, the degree of spatial disintegration is high and leads to variations across the country in how HC and LTC are provided. The institutional separation between HC and LTC and the autonomy of counties and municipalities provides the background for more concrete problems such as the fragmentation of communication systems and the lack of clarity about the financing of care coordination at the interfaces between HC and LTC. The separation of budgets for HC and LTC leads to conflicts over responsibility for the financing of certain services. Considering the strict separation of the HC and LTC system, care coordination has become a national policy goal, and a number of laws and procedures have been implemented that aim to strengthen collaboration within and between HC and LTC. Since the 1990s, marketization policies have resulted in a diversification of the provider structure, which has affected both the HC system and the LTC system and increased the number of actors involved in care constellations. However, the divide between public and private providers is assessed by the organizations to be subordinate and thus not a major problem for care coordination in Sweden.

9.5 CONCLUSION: LESSONS FOR POLICIES

Four general lessons for policies can be drawn from these findings. First, the functional disintegration of healthcare, nursing care, and social care services is a major problem for coordination in all institutional settings. Although the functional dividing lines vary from country to country, many organizations, particularly in Germany, the Netherlands, and Switzerland, complain that services are not well integrated institutionally and financially. The main lesson learned is thus to integrate all necessary services as far as possible within a single institutional framework and to ensure coherent financing. An alternative solution is the institutionalization of clear and reliable mechanisms that link the various aspects to each other.

Second, locally organized systems seem to offer advantages for coordination. Although federal laws, such as those in Germany or Switzerland, provide standard access rules and guarantee standard benefit packages in each case, they are not suitable to solve the coordination problems. Therefore, the lesson learned is to also strengthen the local pillar of service provision in more centralized systems. Such a shift in emphasis is a precondition for better coordination. The Swedish case shows the significance of the local level even within a functionally divided system. In other words, local coordination can be an effective tool to bridge gaps even between strongly functionally divided systems.

Third, many organizations in all countries deplore a lack of financing for coordination. Often, the lack of financing goes together with a lack of clearly defined formal responsibility for coordination. The main lesson learned from this finding is that earmarked financing and a clear definition of responsibilities for coordination are necessary in all institutional settings. The specific solutions, however, such as defining who actually is responsible for coordination, may vary, but a clear institutional set-up is necessary in any case. For years, the main policies in most countries to improve the efficiency and effectiveness of service systems have been marketization and competition. Our results clearly show that policies that focus on cooperation and coordination are needed now. Improving the conditions for cooperation is most likely the better choice to increase the effectiveness and quality of service provision, since competition and marketization can produce good results within a system but tend to externalize costs and fail to create stable conditions for the public good of exchange and coordination between the systems.

Fourth, although access is rarely mentioned explicitly by the organizations as a significant element of coordination, our cross-national comparison shows that gatekeeping itself is a means for better coordination. It offers organizations a strong tool to develop and organize a ready-made well-suited service

package for each individual case at the beginning of the service process. Therefore, the main lesson learned is that the systems that have so far operated mainly on the basis of individual rights to standard benefit packages (such as those in Germany or Switzerland) should consider introducing elements of gatekeeping. Of course, this should go hand-in-hand with a clear division of responsibilities. A possible institutional solution is to involve case managers or care coordinators who enter the care process at an early stage.

The analysis at the system level has shown that there is no perfect system. Each country's institutional setting has its advantages and disadvantages. However, some seem to be better prepared to solve the problem of coordination than others. In addition, it is obvious that each system has to find its own solutions, since a complete overhaul is unlikely and could result in creating other problems of adaptation. Nonetheless, our analysis shows the directions that policy changes at the system level should take to improve coordination: integrating all necessary services under one institutional roof as far as possible; strengthening the local pillar of service organization; providing extra resources for the public good of coordination while limiting the impact of marketization and competition; and introducing elements of gatekeeping in all systems. This conclusion is surely not a formula for every individual case, but it may serve as a guideline for further policy developments.

10. Conclusion: coordination requires financing reform, institutionalization, and academization

10.1 WHY COORDINATION IS CRUCIAL

The living conditions of older people depend heavily on how they are cared for in case of need and whether they are able to lead an enjoyable life even in times of frailty and health limitations. Healthcare and elderly care systems are crucial in this respect, but are rarely effectively coordinated. Both systems face the challenge of growing caseloads, limited funding, and a shortage of qualified staff. In combination, these risks can lead to an overload of the system and place a serious burden on older people. Under such constraints, the need for coordination increases.

Many processes in the context of hospital care and long-term care are unfamiliar to older people and can cause uncertainty and fear. Positive outcomes of service provision depend on older people's trust in the organizations and actors involved as well as on mutual trust between these. Since trust must be maintained even if a single actor drops out, elderly care requires not only interpersonal, but also institutional trust (Lepsius, 2017). To improve institutional trust, a transparent and effective coordination of the different steps in the care process is essential.

In this book, we have analyzed how the co-production of elderly care as a public good can be improved through coordination. We have asked who *is* responsible for coordinating care in Germany, the Netherlands, Sweden, and Switzerland and who the organizations from the four countries we interviewed think *should* be responsible. On this basis, we have identified malfunctions at the system level, the professional level, and the organizational level. Coordination is essential for a better integration of the two separate institutions of healthcare (HC) and long-term care (LTC), which involve different actors and hierarchies that focus on either curing or caring. The HC and LTC organizations from the four countries we interviewed agree that a better coordination of service provision across the two institutions is necessary, because effective curing requires high-quality caring and vice versa. The specific reasons given

for the increased need for coordination are rather similar and probably apply to other OECD countries as well.

Two major developments in European care systems that have increased the need for coordination are, first, shorter hospital stays and fewer hospital beds and, second, a change in focus on aging in place, with people being cared for at home rather than in institutions.

As for the first change, the much shorter length of stay of older people in hospital than in the early 1990s leaves less time to organize continuous care after discharge from hospital. Furthermore, hospital financing based on diagnosis-related groups (DRGs) provides a strong incentive for the early discharge of patients with greater care needs even if out-of-hospital care is not ensured. Interviewed organizations from all countries observe that information that a patient is being discharged is often provided late, and that patients are sometimes discharged before all post-hospital services are organized. All interviewed HC and LTC organizations that are involved in the care process in such a system with high time pressure perceive a lack of inter-professional communication. Most organizations are highly critical of the DRG financing system and consider it to be a barrier to coordination. It is evident from the interviews that to improve coordination, a financing system is required that is more responsive to the patients' needs while reducing the currently strong impact on the length of hospital stays. It is not just about the length of stay but rather about the "culture of care," since DRGs incentivize the involved actors to think about how to reduce time and costs rather than about how to improve care. This view is supported by the fact that the pressure on discharge management is perceived rather similarly, although the average length of hospital stays differs across the countries. The Netherlands is an example of flexible adjustment in times of reform. The Dutch hospital system has also seen shorter lengths of stay and short-term discharges, and the interviewed organizations criticize that GPs and other service providers are insufficiently informed about patients' situation upon discharge from hospital. When home care was prioritized over inpatient care and home care capacities did not meet the demand, patients sometimes stayed in hospital longer than medically necessary until facilities became available. Flexible decisions by individual actors, however, only work in a short transition process.

The second development is more complex and less fueled by economic rationalities. All four countries support a policy that responds to the desire of elderly people to live in familiar surroundings in old age. Aging in place can be considered a basic need that people have, and the countries under study have started—although to different degrees—to relocate long-term care from residential care homes for the elderly to ambulatory care at home. The former model corresponded with a situation in which older people were mainly supported by family members and moved to a nursing home when

family members could no longer cope with the growing care needs of their relatives. With an increasing number of people in need of care due to demographic changes, the demand for home care increased rapidly when the length of hospital stay was reduced and LTC systems, including home care facilities, were built up. In Sweden, the shift from residential care to home care is at the heart of the country's aging-in-place policy, placing a heavy financial and personnel burden on the municipalities and causing staff shortages in LTC. In the Netherlands, the 2015 reform severely restricted access to residential care, with home care becoming the new norm in elderly care. Although shortening hospital stays mainly follows economic rationalities, this process also corresponds with patients' desire to spend no more time in hospital than necessary and receive follow-up care at home. The criticism that such a policy does not necessarily reduce costs (Reinhardt, 1996) is legitimate but mainly applies to healthcare systems such as the US system, which is not well connected to long-term and social care. The four countries under study, in particular Sweden and the Netherlands, as well as other countries, such as Denmark (Paul, Schaeffer, & Coustasse, 2017), demonstrate that shorter hospital stays correspond with the wishes of patients when HC and LTC are well connected. Our interviews with Swedish organizations show that shorter hospital stays can be successfully compensated for without compromising the quality of care if home care is extended and post-discharge care is delivered professionally and without interruption between hospital care and home care. Our analyses demonstrate that, first, high-quality coordination is essential to improve the life situation of older people in need of healthcare and social care. Second, an effective implementation of coordination tasks to link different institutional contexts requires a clear definition of responsibilities. Our cross-country comparison shows that four institutional characteristics affect the coordination of HC and LTC services: the institutional divide of HC and LTC; the role of GPs; the state of LTC institutionalization; and institutional trust.

10.2 PROBLEMS AND SOLUTIONS FOR COORDINATION AT THE SYSTEM LEVEL

10.2.1 Institutional Divide of HC and LTC

The first challenge to providing continuous linked-up care for older people is the institutional separation of HC and LTC. The more HC and LTC systems are separated, the more we observe an externalization of costs. Separate funding systems almost always have the consequence that costs and responsibilities are shifted from one system or sector to another. Organizations from all four countries report transition problems due to the decreasing length of hospital stays as a result of DRG financing. Inside the hospital, special

discharge teams organize the transition process, but outside the hospital, GPs and home care nurses do not have enough time or information or have to wait for the confirmation of funding and are therefore often unable to organize immediate care services for older patients. Furthermore, in most countries, the home care setting is an emerging area with little institutionalization and no clear relationships and responsibilities between the different provider groups. Organizations from all countries report that a communication system between different professions and occupational groups has not yet been established and that it often depends on the goodwill of single persons to bring all provider groups together to exchange information about a particular case.

In Germany, the financing of HC and LTC is strictly separated, and within HC there is also a divide between inpatient and outpatient financing. Hospitals have established a discharge management system, but it does not play a role in the coordination of care outside the hospital due to the financial separation. The financial and organizational separation of HC and LTC is strongly criticized by the interviewed organizations. Both systems follow different institutional logics, which the organizations see as a barrier that makes coordination across systems difficult. As a result, the provision of care at the interfaces of HC and LTC is highly fragmented. The organizations locate the main weaknesses of care coordination at the system/institutional level. These problems are exacerbated by a significant shortage of staff, particularly in LTC.

In the Netherlands, home care has become the responsibility of health insurance, and a more integrated system that includes hospital care, outpatient healthcare, and home care has been established. Social care, in contrast, has become the responsibility of municipalities. At the same time, access to nursing homes has been restricted, and people with fewer needs are not eligible for residential long-term care. Aging in place has been strengthened by a clear allocation of responsibilities for medical care and nursing and body-related personal care on the one hand and social care on the other hand, and a better integration of care within the respective sector.

In Sweden, HC is the responsibility of the regions, while LTC, with a focus on home care, is the responsibility of the municipalities. Despite the institutional and financial separation, primary healthcare and hospital care on the one hand and long-term care on the other hand are well connected, and there are strong financial incentives that home care is provided in time.

In Switzerland, the first part of the transition process from hospital to long-term care has been established. According to the interviewed organizations, DRG financing has even strengthened the establishment of hospital discharge services. Organizations, however, disagree on how effective the discharge service at the interface of hospital care and long-term care is. Actors involved in the discharge from hospital have little control over the provision of care outside the hospital. Regarding the integration of medical and social

care at home, there are currently no responsibilities for coordination tasks. The interviewed organizations consider case-based coordination to be useful, but no financing scheme for such a practice has been established so far. Furthermore, it depends on informal contacts between the actors involved as well as on local circumstances whether coordination is practiced. GPs are considered as possible candidates to take on this coordinating role, but their role is assessed as highly controversial by the organizations.

These examples from the four countries indicate that a better coordination of HC and LTC requires a better integration of the financing systems and, as in Sweden, the abolishment of incentives to shift costs from one system or sector to another. Cost-shifting increases the strain on older people and their families and increases the overall financial costs of both HC and LTC. DRG financing systems are heavily criticized by all organizations from the four countries, and there is consensus that a better integration of the process of care in HC and LTC requires a financing mode with less emphasis on DRGs.

10.2.2 GPs are Key—Even When Not Involved

The second institutional aspect with enormous consequences for the coordination of care is the role of the family practitioner in the respective healthcare systems. Family doctors are the main actors in outpatient healthcare and are generally considered as the first point of contact for patients. In a system with highly institutionalized gatekeeping, patients are registered on the list of a general practitioner (GP) and have access to specialist healthcare only with a referral or in case of emergency. In such a system, specialist inpatient and outpatient healthcare are primarily provided in hospitals. There is a division of labor, with primary care being mainly provided and coordinated by GPs outside the hospital and specialist healthcare being provided and coordinated inside the hospital. In gatekeeping systems, GPs are responsible for coordinating the process of care as well as the transfer to and from hospital. Inside the hospital, the coordination of inpatient and outpatient specialist healthcare is facilitated by the fact that the process of care takes place within one organization and is often the responsibility of transfer nurses.

It emerges from our interviews that these institutional arrangements in the HC system (GPs as gatekeepers and coordinators of outpatient care; concentration of specialist outpatient and inpatient care in hospitals) have a significant impact on the coordination of healthcare and long-term care. In the Netherlands, the family doctor principle and gatekeeping are well established. In Sweden, gatekeeping is practiced as well, but without a strong regulatory framework, and in Switzerland, gatekeeping models are part of most private insurance contracts. Only Germany has no firmly established gatekeeping system. Furthermore, in- and outpatient specialist healthcare in

the Netherlands and Sweden mainly takes place in hospitals. In contrast, in Germany and Switzerland hospitals are mainly responsible for inpatient care, while specialist outpatient care takes place outside the hospital in practices with self-employed doctors.

In line with this institutional context, the Swedish and Dutch organizations we interviewed consider GPs to be highly important for coordination. In their view, GPs' role could go beyond the coordination of outpatient healthcare and the coordination of care at the interface of primary care and hospital care. It could include the processes between hospital care and elderly care and therefore tasks that go beyond the main scope of GP service provision. As GPs already have coordination responsibilities in primary care, they are also considered to be candidates for taking on the coordinating role in elderly care. Many German organizations we interviewed do not see GPs in such a role, and despite their legal responsibility for assessing elderly care in Switzerland, most Swiss organizations we interviewed do not see GPs as being the main coordinators. At the same time, it is emphasized that GPs are already overloaded with other tasks, and the Swedish and Dutch organizations in particular consider non-medical service provider groups to be potential candidates for coordinating healthcare and long-term care services alongside GPs.

10.2.3 State of LTC Institutionalization

A third institutional aspect with implications for the coordination of healthcare and long-term care is the institutionalization of LTC. It is related to the question to what extent models of care that used to be prevalent, in particular through family members, are still relevant and to what degree the state is responsible for elderly care. In Germany, the conservative element of the country's welfare state is evident. In financial and personnel terms, the family is much more involved in the care of older relatives than in the other three countries. A model that combines long-term care provided by public and private organizations with care provided by family members has particularly high requirements for coordination but with no additional actor taking over the coordination tasks.

Interviewed organizations from all countries consider it to be highly important that the wishes and interests of the persons in care and their families are taken into account. Patient-centeredness is particularly strong in Sweden, and the Swedish organizations we interviewed emphasize the goal of maintaining and strengthening older people's autonomy. They see elderly persons as important actors in old-age care, who should be enabled to make independent decisions. Professional carers provide and coordinate services that help older people to lead an independent life. In Sweden, patient-centered care is the baseline for care coordination, and it is emphasized by the organizations that services should be coordinated to match patients' needs and wishes, their

financial resources, and their capabilities. The organizations highlight the active role of older people in the care process can be achieved by appointing a specific contact person who takes care that the older person and the family are not overburdened by coordination and other tasks. The interviewed Dutch organizations emphasize that people who need care trust that they will receive the services they need and that service providers will develop, if necessary, "creative solutions" to respond to the demand. Like the Swedish organizations, they emphasize that the wishes and needs of older people and their families need to be taken into account. Family members are seen as an important part of the care process, which should be integrated in the overall care system but without overburdening the family with care and coordination responsibilities.

The analysis of the Swedish situation demonstrates that similar questions arise when care through family members is replaced by care through auxiliary nurses. Personal carers with a low level of qualification are of great importance in the Swedish LTC system. The interviewed organizations emphasize that the involvement of personal carers with low qualifications makes care coordination difficult due to cultural differences and low verbal skills, which requires comprehensive training by qualified nurses. However, these instructors are also needed for LTC provision and coordination, and even auxiliary nurses with additional training cannot fulfill the coordination tasks. The German stakeholders we interviewed consider the focus on the care needs of older persons to be an important starting point for a higher degree of patient-centeredness. Unlike in Sweden and the Netherlands, in Germany this concept is not combined with changes in the assessment of older persons' needs, the assignment of a specific contact person, or changes in coordination.

10.2.4 Trust and Transparency

A fourth aspect at the institutional level with importance for the coordination of HC and LTC concerns trust in institutions (Lepsius, 2017). The question of trust in the protection and responsible handling of patient data is particularly relevant. In the case of trust, care providers share information with other providers and organizations who are involved in the care process. In the case of mistrust or if there is high competition, information is often not shared. In our comparative study, it becomes evident that HC systems with established family doctor models and gatekeeping have more experiences with and mechanisms for information sharing, which forms the basis for successful coordination. Countries with family doctors as gatekeepers, furthermore, have also developed other instruments to improve information sharing and coordination, including health information technology. Sweden has the highest proportion of electronic patient records among the four countries. Although Sweden is a pioneer in e-Health, the fragmentation of communication systems has turned

out to be a major problem at the system level. Currently, electronic systems in HC and LTC are not fully compatible, but, according to the interviewed organizations, compatibility is necessary to improve cooperation and coordination at the interface of HC and LTC. The interviewed organizations emphasize that electronic patient records which can be accessed by LTC staff, who in turn can provide information for HC providers, would greatly improve the communication, cooperation, and coordination of care in both systems. The Swedish organizations we interviewed call for more integrated and centralized systems as well as for laws that allow information to be shared while respecting data protection. Stakeholders from all four countries agree that electronic patient records have the potential to facilitate inter-professional communication. The Swedish and Dutch organizations from our study complain about deficits in their communication systems, in particular because of parallel systems and the lack of compatibility with HC and LTC. In both countries, however, electronic tools are widely used, while in Germany and Switzerland electronic patient records and similar tools are still in a premature phase. Our analysis has shown that inter-professional communication and cooperation are essential for improving HC and LTC services for older people, and that they must be enforced by institutional structures and strengthened by digital health infrastructures that integrate both systems.

10.3 PROFESSIONAL-LEVEL COORDINATION CLOSES INSTITUTIONAL GAPS IN THE CARE PROCESS

When focusing on the various professions and occupations that provide HC and LTC services, it becomes evident that coordination and cooperation are influenced by the institutional and organizational context as well as by the number, qualification, and diversity of providers. In all four countries under study, the number of providers is considered to be too low. This assessment is significant because the problem of finding and employing a sufficient number of care providers will become even greater in the future due to demographic aging and the associated higher demand for healthcare and long-term care and reduced financial and personnel resources. The growing lack of qualified personnel will particularly affect the LTC sector, as wages are lower and working conditions less attractive than in the HC sector. This is not only a problem in the Netherlands and Switzerland, whose LTC systems are mainly based on higher-qualified providers, but also in Germany, where family members are still involved significantly in the care of the elderly, and in Sweden, which has a high proportion of low-qualified auxiliary nurses. Organizations from all countries report staff shortages and expect this problem to intensify in the future. A common concern is particularly the low density of GPs and LTC

nurses in rural areas, which undermines the aging-in-place policy. To cope with the growing burden of elderly care, the organizations demand more staff as well as more time and additional financial resources for coordination tasks.

At the same time, the organizations criticize that too many different actors are involved. In this respect, long-term care follows the healthcare path toward higher specialization, which has resulted in a growing number of different highly specialized providers. The organizations believe that such a process requires an actor who coordinates the different specialized services in both systems. In the HC sector in Sweden, the Netherlands, and in part in Switzerland, this actor is the GP. In Germany, the multitude of actors reduces trust between patients and service providers and among professional groups, and the high number of different actors increases the need for coordination. Interviewed GP organizations in Germany claim to be responsible for coordination not only in HC but also in LTC, but are considered by other stakeholders to be already overburdened.

In Sweden, the lack of qualified staff, especially in home care and in rural areas, is considered the most pressing problem for care coordination. The organizations interviewed precisely describe that staff shortages result in high workloads for the remaining staff, who in turn have less capacity for care coordination and communication with follow-up service providers. Because of the low involvement of GPs, who in Sweden are considered potential candidates for coordination tasks but have no time resources to shoulder this additional responsibility in LTC, organizations demand that new structures and a coordinator for home care services should be established. The high level of staff turnover, which is seen as the result of the low qualifications of part of the workforce, further increases the need for coordination, as information is lost when staff keep changing. However, even the appointment of a coordinator does not seem to be sufficient, as many auxiliary nurses in Sweden—according to the interviewed organizations—often have difficulty reading and writing care plans.

In Switzerland, GPs officially have a key role in LTC because they act as gatekeepers. According to the organizations interviewed, however, in practice GPs are hardly involved in the process of care, and GPs, LTC nurses, and social care workers rarely meet. Organizations from all countries report a lack of inter-professional cooperation and joint management, and that a better coordination of care often depends on the efforts of individual actors. The situation improves if actors know and trust each other. This, however, is difficult to achieve in larger organizations (which, however, have the capacity to coordinate care) or when smaller organizations compete with each other and do not share information. Organizations from all four countries agree that, under the current institutional regulations combined with staff shortages, the professional groups involved are unable to fulfill the task of coordination effectively.

The second common problem is that LTC nurses often lack formal responsibilities in the process of care. In part, this is related to the lack of qualifications, but in some countries, the nursing profession has already gone through a longer process of academization, without being assigned a role similar to that of gatekeeping GPs in primary healthcare. Again, institutional principles such as GPs acting as gatekeepers set the stage for developments in other sectors. In Sweden and the Netherlands, nurses have more formal responsibilities in the transition process from hospital to home care as well as within the home care setting. In Germany and Switzerland, the academic education of nurses has developed later or is still in an early phase, and hierarchies in HC and LTC are organized in a way that medical doctors are officially responsible and delegate service provision. In Switzerland, GPs are officially the gatekeepers to LTC benefits but prescribe LTC services based primarily on the assessment and recommendation of LTC nurses. In the Netherlands, in contrast, LTC nurses have both the competencies and the responsibility to assess and determine home care services. In Sweden, LTC nurses also have the main responsibility for assigning and coordinating LTC services, while GPs have never assumed a formal role in this field.

The organizations agree that a greater differentiation of the HC and LTC workforce and higher levels of qualification of the different occupational and professional groups have positive consequences for the delivery of high-quality care even if this may produce further communication and coordination problems. Countries with gatekeeping GPs are often characterized by flat hierarchies and a more dynamic process of academization of non-medical occupational groups. Our interviews have shown that professions with further qualifications, such as nurse practitioners, have the greatest potential to perform the task of coordinating HC and LTC for older people. This is because they have comprehensive competencies in medical, nursing, and social care, which are essential for coordinating service provision across HC and LTC. However, even without this additional responsibility, this occupational group has a high workload but is not as overburdened as GPs.

In Sweden, academically trained nurses in HC and LTC are considered to be highly competent by the interviewed organizations. They fulfill many medical tasks for which medical doctors are responsible in other countries. Home care and discharge nurses are involved in the transition from hospital to home care and both require higher responsibilities for coordinating the whole process. In Sweden, the problem is therefore not a lack of qualified nurses but a lack of assignment of a responsible coordinator as well as of financial resources for this task. In the Netherlands, too, HC and LTC nurses are highly qualified and able to coordinate medical and long-term care. The organizations consider medical and social aspects to be equally important in elderly care. While GPs and specialists assess and decide on medical needs, in the Netherlands this is

the responsibility of district nurses, who assess and decide on long-term home care needs including medical needs. The organizations interviewed demand that additional competences and functions should be established for nurses so that they can also fulfill coordination tasks. On this basis, most interviewed Dutch organizations agree that the coordination of the transition from hospital to residential care or home care should be undertaken by nursing professionals. In Switzerland, the academic education of nurses is highly supported as well, and LTC nurses demand more responsibilities in the organization and coordination of care. Most organizations agree that the role of GPs in LTC is a purely formal one and that GPs should not, and due to time restrictions cannot, become more involved in providing or coordinating services in long-term care. Unlike in Sweden and the Netherlands, however, there is no agreement among the organizations interviewed that hospital or home care nurses should take on these tasks. Moreover, most organizations do not consider the higher academization of nurses to be a solution to all the problems related to the lack of coordination. The organizations see the increasing level of staff shortages as the main problem in LTC and suggest that additional staff with qualifications below academically educated HC and LTC nurses should be employed. Furthermore, the coordinator of HC and LTC services should also take the social aspects of care into account, but the Swiss organizations interviewed do not agree whether the HC or LTC profession should take on this task.

In Germany, the education of HC and LTC nurses is no longer separated. Some organizations we interviewed consider this recent change as a possibility to increase the competencies and responsibilities of LTC nurses. Regarding the academization of nurses, however, Germany is a latecomer among the four countries. Therefore, despite the upgrade of LTC nurses, Germany seems to have the lowest potential for identifying a coordinator of HC and LTC services due to low academization, shortage of nurses, in particular in LTC, and the challenge to incorporate care through family members. Furthermore, GPs have a marginal role in the provision of information, consultation, and assessment in LTC, as their main task is the provision of medical care. There is no profession which is institutionally fully integrated in both the HC system and the LTC system.

10.4 SOLUTIONS TO COORDINATION PROBLEMS AT THE ORGANIZATIONAL LEVEL

Our findings at the system level and the professional level have consequences for our assessment of the organizational level. The high diversity in the LTC workforce creates difficulties for the coordination of these services, which is assessed as problematic by the organizations from all four countries. The multitude of actors can be attributed partly to the fact that various public, private

non-profit, and private for-profit providers compete on the LTC market. Often, different types of services, including publicly funded services from the standard benefit package and additional, privately financed services, need to be coordinated. Since competition may negatively affect information sharing, coordinating HC and LTC services is more difficult in a LTC market with a high number of providers.

This is the case in the Netherlands, where pro-market reforms have led to a high number of small home care providers. The transition from hospital is often time-consuming, since transfer nurses or family members have to contact several organizations before finding a home care provider. The Dutch organizations interviewed report that such structures reduce information sharing and trust between the different types of providers. The Swedish organizations we interviewed do not criticize marketization as such but complain about the resulting high number of actors, which are not well connected. Most organizations support customer choice policies, but mainly to respect the wishes of older people in care and to improve quality. Future studies should therefore analyze whether choice among different providers actually corresponds with people's wishes and increases quality. At the same time, however, all organizations emphasize that it is easier to build up relationships of trust in smaller entities. Larger organizations, on the other hand, have more capacity for management and information systems. Large home care organizations in the Netherlands, for example, have established information systems that are used by care teams to report to the organizations' back office about capacities to provide care for patients as well as about the level of care and whether care for a new patient is available. If patients or transfer nurses seek care, the back office can directly make arrangements. The organizations demand, however, that such a coordination service be implemented nationwide and include all available providers.

The current trend toward larger organizational units in most OECD healthcare systems could therefore also be a model for better integration and coordination of healthcare and long-term care services. Primary health centers and larger hospitals have capacity for coordination not only in healthcare but also in long-term care. Larger organizations in the field of long-term care or specific organizations such as care support centers in Germany are alternative models, with coordination responsibilities being established as part of the LTC rather than the HC system. Our interviews have shown that this would require an academic qualification for the actor in charge and that such units are able to provide and coordinate services for rural areas, where difficulties providing not only adequate home care but also healthcare services are particularly large today. Aging-in-place policies require that people in remote areas are reached. In Sweden, a solution for coordination problems could be integrated teams with established procedures for exchange, and in rural areas such teams should

also include providers from healthcare, long-term care, and social work to be able to provide healthcare, nursing, and social care services at home.

Another organizational unit that could assume a coordination function and is often responsible for long-term care services is the municipality. In Sweden, the municipality is responsible for residential care and home care services in financial and organizational terms. In the Netherlands, the CIZ (www.ciz.nl) is responsible for assessing residential care, district nurses for assessing home nursing, and municipalities for assessing home assistance. Care offices at the regional level organize residential care, while municipalities organize home care. In Sweden, where municipalities have for many years been responsible for long-term care, the assessment is mixed. The organizations rate it as very positive that municipalities can organize processes in a way that can meet older people's needs. The organizations also report positive experiences with model projects on the municipal or regional level in which the coordination of elderly care services has been implemented. In this respect, Sweden seems to be ahead of other countries and has determined the municipality as a possible coordinator. This pioneering role also means that Sweden can report the negative consequences of local-level coordination, e.g., regional inequalities. Accordingly, the interviewed organizations demand higher levels of standardization to reduce regional inequalities, but without the municipalities withdrawing from their responsibilities. The German organizations demand that municipalities play a greater role in coordination as well, since they know the local situation and resources as well as the needs of older people in the local environment. They point out that a greater involvement of municipalities could simplify coordination and speed up the process when care is needed. The Swedish example demonstrates that services are provided to a greater extent according to the needs and wishes of those in need of care if processes are transparent and people know who is responsible in the case of positive or negative outcomes.

Organizations from all countries see municipalities as important actors in care coordination due to their knowledge of local structures, resources, and needs. Since municipality staff generally lack the necessary expertise in medical, long-term, and social care, they have to employ or collaborate with experts from the provider side to fulfill this task. Case managers, who often have a background as social workers, are probably not ideally suited either, since they lack expertise in medicine and nursing as well. They could, however, be part of an interdisciplinary team with coordination responsibilities. According to most organizations we interviewed, academically trained nurses in collaboration with or employed by municipalities are the best candidates to fulfill coordination tasks in healthcare and home care.

10.5 POTENTIAL REFORMS FOR BETTER COORDINATION

Our comparative study shows that countries should invest more resources in better working conditions and more competitive pay to attract and retain qualified staff, particularly in LTC. More staff, however, will not automatically solve the underlying structural coordination problems in HC and LTC. It is important to explicitly entrust a specific professional group with the formal responsibility for coordination. It emerges from our interviews that academically trained nurses are particularly suited to assume coordination tasks. This would also increase the reputation and career opportunities of nurses, which in turn would have a positive effect on the number of available service providers in this field. The other professional group that qualifies for coordination tasks, namely GPs, would benefit from a reduced workload and a partner for collaboration, especially in home care. However, this would not be sufficient to cover remote areas and the growing needs of older people. Therefore, the implementation of larger organizational units with coordination capacities and the involvement of municipalities are essential. To assign the responsibility for coordination to a specific professional group or actor and ensure the improvement of services for the elderly, several steps are necessary. If no improvement has been achieved, health and social policy reform processes are required. We regard most steps as a sequential process, and the implementation of later reforms and finally the assignment of an explicit authority for coordination will be difficult without the preceding steps.

First, the institutional divide of HC and LTC needs to be reduced. The currently strict financial separation of HC and LTC in countries such as Germany as well as DRG financing must be changed in such a way that healthcare and care providers can concentrate on patients' needs and have no incentive to shift costs and responsibilities to other sectors or institutions. Currently, financing structures often conflict with coordination tasks. As the Swedish example demonstrates, coordination can also be improved with separate funding of HC and LTC if patient-centered care and patients' needs are prioritized, and incentives are set for collaboration and coordination to fulfill these tasks.

Second, assigning GPs the function of gatekeepers and coordinators of services within primary healthcare and in the transition from primary healthcare to hospital care is important for improving coordination in other areas. Positive experiences with the coordination of healthcare services by GPs, often in the context of a primary healthcare center, contribute to the development of trust in information sharing and services provided by other occupations in the process of care. Due to GPs' focus on curing, their already heavy workload, and their lack of experience in home care services, they should not take on additional

coordination tasks in the field of caring but collaborate with care coordinators. Without a strong position of GPs in primary healthcare, coordination of long-term care is difficult to achieve.

Third, transparency and information sharing are key to collaboration between the different service providers and the coordination of these services. Health information technology is a powerful tool to obtain important information regarding health, healthcare, nursing care, and other services for elderly persons as well as to provide access for different provider groups to this information. A uniform system that includes healthcare and long-term care is essential for providing and coordinating services that meet older people's needs.

Fourth, healthcare systems with flat hierarchies and a prominent role of GPs have often been pioneers in the academization of nursing. The organizations we interviewed believe that the profession of academically trained nurses is widely accepted by other actors and organizations in this field and well prepared to take on coordination tasks due to their expertise in medical and nursing tasks. A higher reputation and better career opportunities for the nursing profession through the institutionalization of this role, which is similar to GPs' role in healthcare, would also increase the attractiveness of LTC positions.

Fifth, coordination in this field cannot be the task of a single person. In general, only larger organizational units have the capacity to coordinate services provided by different professions and occupations. In HC, countries with longer experience in coordination have first assigned this task to GPs and later demanded that GPs within larger units, often primary care centers, become the facilitators of coordination. In the interviews, the organizations argue that elderly people need to know the persons in care, who also need to know each other, and therefore suggest smaller interdisciplinary care teams that are coordinated by qualified nurses within a larger organizational unit.

Sixth, municipalities are an important collaborator in the coordination of HC and LTC services due to their comprehensive knowledge of the local context and of the needs, wishes, and risks of older people who live there. In particular, covering remote areas is difficult without the involvement of municipalities. At the same time, nationwide standards and presumably also financial redistribution need to be implemented to reduce regional inequalities. The Swedish case demonstrates that local coordination can bridge gaps when HC and LTC are not fully integrated.

Seventh, in addition to clearly defined responsibilities for coordination and the power to link different provider groups and impose sanctions for a lack of collaboration and information sharing, earmarked funding for coordination is essential. Without funding for this time-consuming task, which nevertheless saves time and money and improves the quality of care, coordination cannot be implemented.

The experiences of the organizations interviewed reveal that the existing institutional structures strongly determine how services are provided. Consequently, if HC and LTC and its coordination are to be improved, change must start at the institutional level.

Appendix 1

Table A.1 List of organizations

Germany					
Abbreviation	**Full national name**	**English translation**	**Main task**	**Date**	**Type of survey**
BAGFW	Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege e.V.	Federal Association of Non-statutory Welfare	(Home) care provider	21.09.2020	Online
BAGSO	Bundesarbeitsgemeinschaft der Seniorenorganisationen	German National Association of Senior Citizens' Organizations	Other	09.10.2020	Online
Bpa	Bundesverband privater Anbieter sozialer Dienste e.V.	Federal Association of Private Providers of Social Services	Home care provider	14.02.2020	Face to face
BV Geriatrie	Bundesverband Geriatrie	German Federal Geriatrics Association	Geriatrician	26.11.2020	Online
Care support center	Pflegestützpunkt der Caritas	Care support center	Home care provider	10.09.2019	Face to face
DAlzG	Deutsche Alzheimer Gesellschaft e.V. Selbsthilfe Demenz	German Alzheimer Association	Other	11.09.2020	Online
Discharge management	Entlassmanagement einer deutschen Universitätsklinik	Discharge management of a university hospital	Transfer nurses	10.09.2019	Face to face
DKG	Deutsche Krankenhausgesellschaft	German Hospital Federation	Hospital	05.10.2020	Online
DPR	Deutscher Pflegerat e.V.	German Nursing Council	LTC nurses	19.02.2020	Face to face
DPR	Deutscher Pflegerat e.V.	German Nursing Council	LTC nurses	07.10.2020	Online
DV	Deutscher Verein für öffentliche und private Fürsorge e.V.	German Association for Public and Private Welfare	Other	21.09.2020	Online
DVSG	Deutsche Vereinigung für Soziale Arbeit im Gesundheitswesen e.V.	German Association for Social Work in Health Care	Other	20.10.2020	Online

GKV	GKV-Spitzenverband	National Association of Statutory Health Insurance Funds	Funding agency	23.10.2020	Online
HÄV	Deutscher Hausärzteverband	German Association of Family Doctors	GP	13.10.2020	Online
KBV	Kassenärztliche Bundesvereinigung	The National Association of Statutory Health Insurance Physicians	GP	30.11.2020	Online
KDA	Kuratorium Deutsche Altershilfe	Board of Trustees for German Old Age Assistance	Other	12.11.2020	Online
MD	Medizinischer Dienst	Medical Service	Care assessment	22.10.2020	Online

Netherlands

Abbreviation	Full national name	English translation	Main task	Date	Type of survey
Actiz	ActiZ	Organization of employers of care facilities	Home care provider	19.11.2019	Face to face
CIZ	Centrum Indicatiestelling Zorg	Needs assessment center	Care assessment	08.10.2019	Face to face
Geriatrician	[individual/non-organizaional actor]	Geriatrician working in a university hospital	Geriatrician	14.01.2020	Face to face
Home care nurse	[individual/non-organizational actor]	Home care nurse	LTC nurse	18.10.2019	Face to face
Huisarts	[individual/non-organizational actor]	GP	GP	29.10.2019	Face to face
Ineen	InEen	Association of primary care providers	GP	16.10.2019	Face to face
NHG	Nederlandse Huisartsen Genootschap	Dutch General Practitioners Association	GP	16.01.2020	Face to face
NZa	Nederlandse Zorgautoriteit	Dutch Healthcare Authority	Supervisory agency	22.10.2019	Face to face

Patientenfederatie	Patiëntenfederatie Nederland	Dutch Patient Organization	Other	24.10.2019	Face to face
Transfer nurse	[individual/non-organizational actor]	Transfer nurse	Transfer nurse	22.11.2019	Face to face
Ucentraal	Ucentraal	Welfare organization with a focus on organizing voluntary work	Other	07.11.2019	Face to face
V&VN	Beroepsvereniging Verzorgenden Verpleegkundigen	National Association of Nurses and Carers in the Netherlands	LTC nurse	11.11.2019	Face to face
Verenso	Vereniging van specialisten ouderengeneeskunde	Dutch Association of Elderly Care Physicians	Geriatrician	12.11.2019	Face to face
VGZ	VGZ Zorgkantoor	Care Office	Funding agency	03.12.2019	Face to face
ZN	Zorgverzekeraars Nederland	Umbrella organization of health insurers	Funding agency	14.11.2019	Face to face

Sweden

Abbreviation	Full national name	English translation	Main task	Date	Type of survey
Äldreomsorg	Äldreomsorg [pseudonymized as it is a small organization]	Municipal public care provider	Home care provider	13.02.2020	Face to face
Famna	Riksorganisationen för idéburen vård och social omsorg	Association of Non-profit Care Providers	(Home) care provider	04.09.2020	Online
IVO	Inspektionen för vård och omsorg	Health and Social Care Inspectorate	Supervisory agency	26.11.2020	Online
Qultrum	Qultrum	Center for Learning and Innovation in Healthcare	(LTC) nurse	17.09.2020	Online
Regional council	Region Stockholm	Regional council	Healthcare provider	06.02.2020	Face to face

SBU	Statens beredning för medicinisk och social utvärdering	Swedish Agency for Health Technology Assessment and Assessment of Social Services	Supervisory agency	03.02.2020	Face to face
Socialstyrelsen	Socialstyrelsen	National Board of Health and Welfare	Supervisory agency	31.01.2020	Face to face
SSF	Svensk sjuksköterskeförening	Swedish Society of Nursing	(LTC/District) Nurse	23.09.2020	Online
Tiohundra	Tiohundra AB	Provider of integrated care	Healthcare and home care provider	01.09.2020	Online
Tryggt mottagande	Tryggt mottagande [pseudonymized as it is a small organization]	Municipal hospital discharge management	Transfer nurses	18.09.2020	Online

Switzerland

Abbreviation	Full national name	English translation	Main task	Date	Type of survey
ASPS	Verband der privaten Spitex-Organisationen Association Spitex privée Suisse	Association of Private Basic Care Organizations	(Home) care provider	04.03.2020	Face to face
BAG	Bundesamt für Gesundheit Office fédéral de la santé publique	Federal Office of Public Health (FOPH)	Supervisory agency	05.03.2020	Face to face
H+	Die Spitäler der Schweiz Les Hôpitaux de Suisse	Swiss Hospital Organization	Hospital	06.03.2020	Face to face
Mfe	Haus- und Kinderärzte Schweiz Médecins de famille et de l'enfance Suisse	Association of Swiss GPs and Pediatricians	GP	14.02.2020	Face to face
ProSenectute	Soziale Dienste für ältere Menschen	Association of Social Services Organizations for the Elderly	(Home) care provider	12.03.2020	Face to face
Santésuisse	Branchenorganisation der Schweizer Krankenversicherer Santésuisse	Association of Swiss Health Insurance Organizations	Funding agency	12.03.2020	Face to face

SBK	Schweizer Berufsverband der Pflegefachfrauen und Pflegefachmänner Association suisse des infirmières et infirmiers	Swiss Association of Occupational Carers	LTC nurse	05.03.2022	Face to face
SSR	Schweizerischer Seniorenrat Conseil suisse des aînés	Swiss Organization of Elderly Persons	Other	11.03.2020	Face to face

Note: As some organizations fulfill several functions and cover multiple areas, this section names the main task of each organization referring to the focus of the interviews.

Appendix 2

Table A.2 Interview guideline

1. Key Question: assessment of recent developments	
Intention: evaluation of recent development for the coordination of health and long-term care; consequences for this organization	
1a) What do you think about the current practices of coordination of medical and long-term care for the elderly people in [country x]?	
Interest	Sub questions
Evaluation of the current situation	What do you think is the biggest problem of the current situation? What do you think is the biggest possibility of the current situation?
Changes/if	In which ways do you think have recent reforms in the sectors of health and care affected coordination? Did anything change in the coordination between health and long-term care? If yes, what? (e.g., legal reforms)
Changes/what	In your opinion, which changes have affected the coordination of health and long-term care in recent years?
1b) In which way do these changes affect your organization's work?	
Interest	Sub questions
Influence on this organization's practices	How do you cope with the new situation? (strategies and measures)

2. Key Question: transition from hospital care to ambulatory long-term care (interface 1)	
Intention: understanding coordination practices and problems, their causes, need of improvement; role of certain actors	
2a) How do the current coordination arrangements or practices between hospital and ambulatory care services currently work? Which problems do you see for coordination in this field?	
Interest	Sub questions
Challenges	What do you think are the biggest challenges in the coordination of the transition from hospital care to home care?

2. Key Question: transition from hospital care to ambulatory long-term care (interface 1)	
Rules & Practices	How do you assess existing rules and practices in planning the transition from hospital care to home care? (how do institutional rules and practices cause coordination problems?)
Financing aspects	How do you evaluate the current financing practices in regard to the transition from hospital to ambulatory care? (how do financing aspects cause coordination problems?)
Communication aspects	How do you evaluate the communication between the actors involved in the coordination process? (how do communication aspects cause coordination problems?)
2b) Having in mind the coordination problems mentioned before, what improvements are most needed?	
2c) What should be done to improve the transition from acute hospital care to home care?	
Interest	Sub questions
Leading role	Who should take the leading role in the coordination of the transition from hospital to home care and why? *(GP, discharge planning nurses, home care providers, the family and other informal caregivers)*
Institutional adjustments	Which institutional transformations are needed to make improvements?
Role of inter-professional teams	What do you think could be the role of inter-professional teams?
Role of this organization	How can your organization improve coordination at the transition from hospital care to home care (now and in the future)?

3. Key Question: integrated service provision at home (interface 2)	
Intention: understanding coordination problems, their causes, need of improvement; role of certain actors	
3a) How do you assess the current coordination of home care services? Which problems do you see for coordination in this field?	
Interest	Sub questions
Challenges	What do you think are the biggest challenges for the coordination of home care?
Rules & Practices	How do you assess existing rules and practices in planning home care as various providers and actors are involved? (how do institutional rules and practices cause coordination problems?)
Financing aspects	How do you evaluate the current financing practices in regard to home care services? (how do financing practices influence coordination problems between home care services?)
Communication aspects	How do you assess the current communicationbetween the actors involved in the coordination process? (how do communication aspects cause coordination problems?)

3. Key Question: integrated service provision at home (interface 2)	
3b) Having in mind the coordination problems mentioned before, what improvements are most needed?	
3c) What should be done to improve the coordination between healthcare and long-term care at home?	
Interest	Sub questions
Leading role in the coordination of home care	Who should take the leading role in the coordination of home care and why? (*GP, home care providers, home help services, physiotherapists, healthcare specialists, the family and other informal caregivers)*
Institutional adjustments	Which institutional transformations are needed to make improvements?
Role of inter-professional teams	What do you think could be the role of inter-professional teams or care networks?
Relevance of individual care plans	In which way could individual care plans contribute to the coordination of home care?
Role of this organization	How can your organization improve coordination in home care, now and in the future?

4. Key Question: relevance of rehabilitative care (interface 3)	
Intention: relevance of rehabilitative measures and their potential to tackle coordination problems	
4a) What importance do rehabilitative measures have in coordinated care for the elderly? (are they part of coordinated care?) In which ways does rehabilitation affect the coordination of care? Are there specific coordination problems?	
Interest	Sub questions
Limits of rehabilitative measures	Which problems do you see for rehabilitative measures in social care for elderly people? (e.g., adds another actor to the system)
Financing aspects (shifting responsibility/funds)	How do you evaluate the current financing practices of rehabilitative measures for elderly people? Are they sufficient? Which positive/negative incentives are set with this? What should be done to avoid conflicts concerning the financing of rehabilitative measures for elderly patients?
4b) What do you think should be the role of rehabilitative measures in the coordination of elderly care?	
Interest	Sub questions
Contribution to reduce coordination problems	In which way are rehabilitative measures able to reduce coordination problems? What needs to be done, so that rehabilitative measures can reduce coordination problems in practice?

5.1. Key Question: e-Health	
Intention: role of other digital tools for coordinating elderly care	
5.1a) In which ways do digital tools influence the coordination of elderly care services? (In which way can coordination of care be simplified by e-Health?)	
Interest	Sub questions
Institutional limitations	How do the existing communication structures determine the application/introduction of digital tools? How do you think e-Health could change the current structures and practices of communication in coordinating care?
Interaction between actors	How can digital communication support the communication between actors of health or care at the interfaces between hospital and home care/within home care? What should be done? For which actors is digital communication most important?
5.1b) What are the barriers to implement e-Health?	
Interest	Sub questions
Clients' limitations	In which ways is the use of digital communication tools limited? What needs to be done to change this?
Future development	How do you think e-Health will develop within the next 5 years?
Ideal future development	How should e-Health ideally develop, what do you wish should be achieved?

5.2. Key Question: electronic patient records	
Intention: role of electronic patient records for coordinating elderly care	
5.2a) In which way do electronic patient records influence the coordination of elderly care services?	
Interest	Sub questions
Benefit	In which way can coordination of care be simplified by using electronic patient records?
Disadvantage	Which problems do you see for the use of electronic patient records to coordinate care?
Type of data	Which data of the clients should be shared in order to coordinate care?
Data protection	Which data should be particularly protected?

6. Key Question: concluding reflections on coordination from the organization's point of view	
Intention: strategies/instruments of the organization in relation to coordination	
6a) We have discussed a couple of things now. All in all, which strategies/instruments do you [does your organization] use/prefer to solve coordination problems between acute healthcare and long-term care?	
Interest	Sub questions
Collaboration	In which way are you cooperating/or do you wish to cooperate with different organizations to solve coordination problems together?
Financing	How (if at all) should financing systems in healthcare and long-term care be improved to achieve better coordination?
Benefit	What do you think is the major benefit of coordination for your organization?
6b) If you could decide about policies and guidelines in healthcare and long-term care, what would be your priority?	
Interest	Sub questions
Future goals	Which aim does your organization follow concerning the coordination of elderly care?

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