OECD "Silver Economy" – A Kotitori Case Study

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1 Introduction

The aim of this report is to describe the integrator model Kotitori established in Tampere, Finland. First, we describe the social care system in Finland and introduce the Kotitori model. Second, we shed light on different perspectives of Kotitori and how it differs from the traditional way to provide in-home care services in Finland. In the last section we discuss the strengths and weaknesses of the integrator model.

Finland is a country with 336 municipalities (in 2012), which are responsible for organizing – funding, providing and commissioning - health care and social services for their residents. The responsibility of the municipalities to organize social services for their residents is defined in the Social Welfare Act launched in 1982. According to the Act social services contain several activities such as social work, in-home care services, housing services, institutional care and family care. Focusing on the Kotitori the most relevant services mentioned are in-home care services. In-home services "are provided when clients experience difficulties to cope with routine tasks at home due to illness or reduced functional capacity" (Ministry of Social Affairs and Health 2012).

Social care for the elderly in Finland has gone through several reforms during the last few decades. One major change during the last ten years has been the so-called marketization of social care (Anttonen & Häikiö 2011). From the perspective of the service user, family or even a social worker, the system has become more complex than before. Also in the process of having social care services, the responsibility is quite strongly put on the user of the services or the family (Appendix figure 1). One of the challenges in Finland's current social care system is furnishing access for vulnerable client groups such as the elderly to services they need and prefer (See Topo 2011, 885).

Organizational structure of social care in Finland

The municipalities provide most of the social and health care services by their own provider units or by units owned jointly with other municipalities. However, there is a long tradition of deferring to private, largely not-for-profit providers especially in in-home care for the elderly (see Topo 2011, 882). There is also a long tradition of care of the elderly being taken on by their relatives.

During the past 20 years, the practice of contracting elderly care and primary health care services out to private providers has increased. Anttonen and Häikiö (2011, 6-8) have pointed out how "care is going private". Certain changes, such as legal changes in the 1980s and 1990s, have paved the way for the so-called marketization of social care. Since the administrative reform of the early 1980s, municipalities have been allowed to purchase social and health care services also from private for-profit providers. Subsequent to this development, municipalities have been developing their purchasing practices and also adopting ideas and working practices from the business sector. As a model to organize municipal services, the so-called purchaser-provider split emerged in the late 1990s, especially among the biggest municipalities. The municipalities may also offer their residents a voucher to by services from private providers. Vouchers are still fairly marginally used as an alternative but they are expected to become a more significant part of the public care service regime in the future.

The social care market has become more consolidated and, in contrast to traditional NGO-based non-profit providers, operates under a for-profit framework. All in all, the proportion of private for-profit enterprises has increased in social care. In recent years, private providers have produced about one-third of social care services. The most common field of private providers in social care in 2010 was housing services for the elderly. Within these services, the third sector is still an important resource for municipalities in the provision of care for the elderly (see THL 2011a; THL 2011b). Usually the providers in social care have been small and local instead of large, national or international. Social services purchased by private customers have traditionally been consumed by older people with an average or high level of income. The recent purchase of private services has been supported by making the services tax-deductible..

Financing and steering

The funding of social and health care services comes from municipal taxation, state subsidies and out-of-pocket payments. Local authorities have the right to levy taxes and thus they have a certain economic independence from the central authority (Kröger 2011, 149). The role of national government in financing and steering the social service system has varied in recent decades. Especially after the Social Welfare Act (1982) central agencies (the National Board of Social Welfare and provincial state offices) required action plans and reports from local social welfare authorities and inspected whether they were in accordance with the national policy

framework. This steering was significantly loosened in 1993 (Kröger 2011, 150-151). In the 21st century, there has been a slowly growing trend of increasing national regulation by way of, for instance, national quality guidelines and quality inspection.

The City of Tampere

Tampere is a large and growing city in Finland, currently home to over 213 000 inhabitants (Table 1). The greater Tampere municipal region also includes also includes its neighboring municipalities; the whole area has almost half a million inhabitants. Almost half of the inhabitants are of working age. Some 16.3 % of the inhabitants (about 34 000) are over 65 years old.

In the 2000s the city of Tampere underwent a series of administrative reforms, one of the most important being the reorganization of the city's administration by way of the implementation of the purchaser-provider split. Purchasing activities were organized into six core processes, one of those being *"Promoting the well-being of senior citizens".* It was also emphasized that the services would be organized by employing multiple providers, i.e. public, private and those of the third sector. Although the city of Tampere had previously employed public, private and third sector providers , the reforms potentially paved the way for varied and innovative ways to organize social and health care services in Tampere.

Table 1 Information about Tampere (Tampere Statistics 2011)

Tampere
▪ 213 217 inhabitants (in 2010)
▪ the third largest city in Finland
▪ land area 525.0 km²
▪ the largest inland centre in the Nordic countries
▪ 176 km to Helsinki, the capital of Finland
▪ 16.3% of inhabitants over 65 years old
▪ 43.0 % of inhabitants 31-64 years old
▪ model of mayorship[1]
▪ purchaser-provider split in the city administration

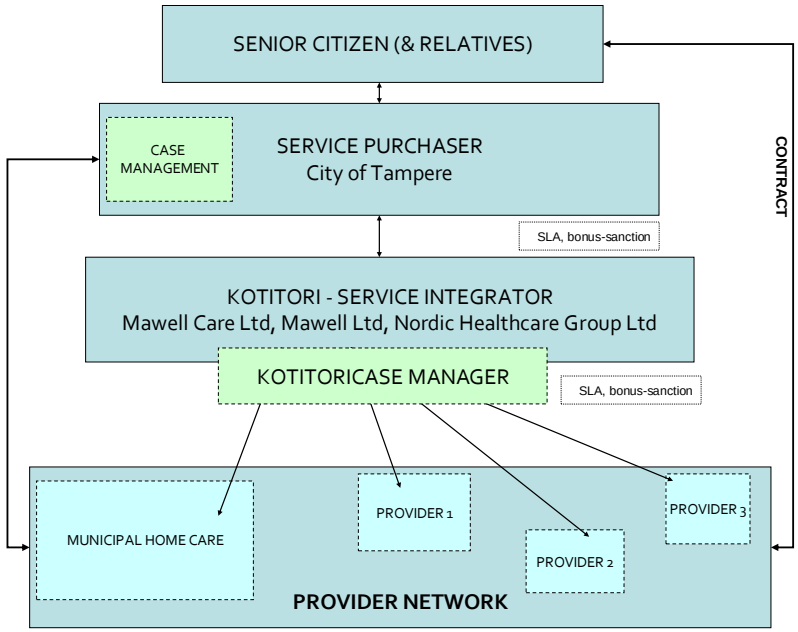
[1] The executive director of the City is a permanent professional position in other cities of Finland, in Tampere the executive director is a politician nominated for this position for a four-year term – four years also being the term of city council members, who win seats on the council via the general election.

2 Introducing Kotitori

In the Kotitori approach the focus is on a social innovation assisted by technological solutions. The main idea of Kotitori is to provide a "one-stop shop" of in-home help services with easy access for older people and their relatives. A basic customer process is modeled in figure 2 of the Appendix.

Kotitori is operated by Mawell Care Ltd, with which the municipality currently has a four-year contract (2009-2013) in which is included an optional two years. Mawell Care works in a partnership with the Nordic Health Care Group (NHG) and Mawell Ltd. NHG is responsible for quality control and setting quality standards for private providers as well as for coordinating the network of private providers. Mawell Ltd, in turn, has a responsibility for technological solutions.

Figure 1 Illustration of the Kotitori model (city of Tampere)



Kotitori integrates services carried out by public, private and third sector providers through case management. The case managers are employed by Kotitori and most of them have either a degree in nursing or in social services. The case managers collect and put together the service packages required by customers. The customer may purchase the services out-of-pocket or, if

certain eligibility criteria are met, have their in-home care services partially subsidised by the city of Tampere. Thus, in practice, Kotitori provides two kinds of services: *integrator services for all senior citizens in Tampere* and *municipal in-home care services for the central area of Tampere* (Table 2).

Integrator services include e.g. counseling and case management; needs assessment; service and care plans for citizens; directing of older citizens to private in-home help services carried out by private providers. These services are funded by the municipality. Eligible for the services are all the senior citizens living in Tampere or relatives who have an older relative living in Tampere. In addition, Mawell Care has an obligation to participate in the development of the processes and productivity of the city's own in-home care provision.

Municipal in-home care services refer to the need-tested services the municipality has to organise if a person meets a certain eligibility criterion. The services are financed partly by the city and partly by the customers via user fees. These services include nursing and in-home care support services such as security, transport, shopping, cleaning and catering services. Tampere has outsourced the provision of in-home care services of central Tampere (400 customers) to Kotitori. Kotitori purchases these services from its subcontractors. The services are financed by the municipality, but also include co-payments, the size of which depends on the income level and total assets of an elderly person. Mawell has subcontracted these services to private providers.

Table 2 The services organised via Kotitori, their target groups, financiers and providers

Integrator services	**For whom?**	**Financed by**	**Provided by**
Needs assessment and advice	All senior citizens living in Tampere	The city of Tampere	Kotitori case managers
Service planning for the senior citizens	All senior citizens living in Tampere	The city of Tampere	Kotitori case managers
In-home care services and support services, e.g., cleaning, shopping, security, social activities, catering, etc.	All senior citizens living in Tampere	The customers themselves	Private providers in the provider network of Kotitori
Municipal in-home care services	**For whom?**	**Financed by**	**Provided by**
In-home care belonging to the responsibility of the city and provided by the legislation	The senior citizens who live in the responsibility area[2] of Kotitori and are eligible for publicly subsidised in-home care	The city of Tampere and user fees	Kotitori contractors Mediverkko & Palvelutähti
Support services: Security services	The senior citizens in Tampere who are eligible for the services paid by	The city of Tampere and user fees	Kotitori contractors

[2] Publicly funded home care services are divided into x responsibility areas of the city of Tampere. One of these areas is outsourced to Kotitori.

Cleaning Temporary in-home care Shopping	the municipality		

Kotitori can be reached and contacted in three ways: by visiting their walk-in office in the city center, by ringing their call center or via Internet. Kotitori case managers also make home visits if an elderly person is unable to visit the office or call. An example of the customer flow during a given month is presented in Table 3.

Table 3 The customer flow in Kotitori in December 2011

Contacts	**Number of contacts**	**% of all contacts**
Via phone	629	68
At the office	232	25
Home visit	66	7
Total	927	100
Services provided via Kotitori	**Number of new customers**	**% of new customers**
Municipal in-home care services	16	27
Private in-home care	14	24
Private support services	29	49
Total	59	100

Private providers can apply for Kotitori provider status via the Kotitori website. A list of all the registered and approved providers, their contact details and descriptions of their service packages are available on the Kotitori website. In addition to this standard provider status, a provider can choose to become *a Kotitori partner provider*. Kotitori partnership means that the providers are obliged to comply with service standards and prices defined by Kotitori. Partnership status is subject to a charge paid on an annual basis. The charge is dependent on the annual revenue of the provider[3]. For the annual fee, the partners are eligible to use the Kotitori brand in their advertising. Moreover, the services of partnership providers are actively marketed to the customers by the Kotitori case managers. In August 2012 Kotitori had altogether 106 providers of which 31 were partner providers. Amongst the providers, 42% worked in nursing and in-home

[3] Annual revenue
- less than 150 000 € : charge 200 € / year + vat
-150 000 - 500 000 € : 350 € / year + vat
- 500 000 - 1 000 000 € : 500 € / year + vat
- over 1 000 000 € : 1 000 € / year + vat

care, 56% provided support services such as catering, security and cleaning and 29% provided complementing services such as physiotherapy, occupational therapy and chiropody.

3 A short history

Sowing the seeds

The seeds of Kotitori were sowed at a national level working-group that was established to consider new ways of organising services for the growing number of older people in the early 2000s. The working-group was established by the consulting company Eera. It received the assignment from the Ministry of the Treasury, which had an interest in economising health care service structures in Finland. In the process, the working group sought to establish new, innovative ways of organising health care services in the country.

The working-group involved representatives from the municipalities of Tampere, Espoo, Turku and Oulu, all among the ten largest cities in Finland. The member cities of the working group were provided with an opportunity to start developing the service delivery structures in the area they considered important in their own city. Tampere decided to embark on the development of new models of services in the area of in-*home care for the elderly*.

Creating and developing a service innovation

The development process was initiated in the spring of 2005 by a recruited task force. The process was led by the senior physician of elderly care services in Tampere. The process was conducted in co-operation with the Pirkanmaa hospital district, the consulting company Eera, the Technical Research Centre of Finland (VTT), the telecommunications firm TeliaSonera and the IT-consulting company WM-data (currently Logica). The process resulted in the idea of a service integrator that would combine counselling on and coordination of public services and private services purchased by the citizens themselves.

In order to pilot the new model of service delivery and to further develop it, the City of Tampere applied for funding from the Finnish Funding Agency for Technology and Innovation (Tekes). Tekes had launched a programme (FinnWell) that would award funding for *local level projects* aimed at developing innovative solutions for health care and social services. The application was successful; the funding was awarded for the pilot project which was called *"New models of cooperation – their evaluation and development in in-home care services for the older people"*. The

name of the project referred to the aim of the project, which was to develop a service delivery model with novel forms of cooperation between the public and private sectors.

This pilot project was initiated in 2006 in Tampere. Administratively the project was established under the office of the deputy mayor responsible for health care and social services in the city of Tampere and the director of the project was the current service-purchasing director of elder care services. The main aim of the pilot project was to develop the actual Kotitori concept. This was done by analysing the contemporary state of in-home care provision of the city, defining the targets for the development of service provision, modelling the principles and practices of the service purchasing, developing the actual integrator model, investigating juridical issues potentially related to the integrator model and exploring the alternatives for the integrator model. The development phase resulted in three optional ways the integrator model could have been implemented:

1) **City operating as an integrator**
   This model would not have altered the contemporary situation to any large extent. The City would still have an obligation to organise procurement in order to purchase services from the private sector[4].
2) **Joint-organisation involving the City and private partners**
   The City would have coordinated the operations of the joint-organisation via contracts. However, as the City would be involved in the joint organisation, it would have been defined as a public purchasing unit. Hence, it would have an obligation to organise procurement in order to purchase services from the private sector.
3) **A private consortium operating as a contractor of the City**
   This would have been a novel model of Public-Private Partnership, which was expected to create new models of service businesses and several related innovations. As the private consortium would be a contractor of the City it would not have an obligation to organise procurement in order to purchase services from the private sector.

Of these models the latter was chosen as the model the City started to develop further and implement, because it was considered to be the most appropriate solution to answer the need of

[4] The competition law requires municipalities to apply competitive tendering to all public purchases exceeding xx 000 Euros

the city. One of the main arguments was that as the integrator would be an actor operating outside the City organisation, it would have been able to operate in a more flexible way. By flexibility it especially referred to the demanding procurement processes that were obligatory for public units.

While the new model of service delivery was sketched, the pilot project was coming to its end. Consequently, continuation for funding was applied and awarded from Tekes's *FinnWell-project*. The development of Kotitori reached a new phase, the phase of implementation.

Implementation

The implementation project the Kotitori Project was initiated in the spring of 2007. It aimed to implement the integrator model and was based on the development work done during the pilot project described above. The main aim was to implement the integrator model in which a private provider would operate as the service integrator, which in turn, would be a contractor of the city.

During the project the City conducted a Request for Information –survey targeted to private service providers and to the third sector in order to explore the providers' willingness and ability to operate as the service integrator. Also the technological preconditions were investigated and the business plan for Kotitori was developed.

The introduction of a new model raised opposition among the politicians in the city council[5]. The representatives of the city of Tampere described that it was especially the conservative representatives in the city council that had reservations towards the Kotitori model. More liberal representatives were, in turn, rather supportive of the new model of service delivery. Due to the controversies in the city council, the city board[6] transferred control of the Kotitori project into the hands of the mayor's office. Thus, the implementation phase was conducted at the highest possible level in the city administration. All the political decisions were made by the city board.

[5] The supreme decision-making body in the city of Tampere, numbering 67 members. Council members and their deputies are elected in a municipal election held every four years.

[6] The city board has a chairman and 10 other members who each have a personal deputy. The city board administers the municipality and manages its finances, prepares and implements the decisions made by the city council and ensures that they comply with the current legislation.

The proposal for the integrator model was passed by the city board in 2008 and the preparations for the bidding process through which the integrator would be selected were started.

The bidding process was executed by way of a *consultation process*. At the first stage the city invited providers to informal meetings and workshops in which the city introduced the idea about the integrator model. After that the providers were invited to introduce their own ideas on the implementation of the model. Based on the workshops and the proposals of the providers the city prepared the tender and started with the bidding process in 2008. Within the bid, the services for which the integrator would be responsible were defined as follows:

1) Integrator services
    - Counselling on private service options available for the elderly
    - Case management (i.e., the integration of public and private services)
    - Needs assessment, service plans and care plans for the elderly
    - Developing the processes and productivity of the in-home care provision of the city
2) Municipal in-home care services
    - Provision of municipal in-home care in the central area of the city
    - Catering
    - Security
    - Temporary in-home care
    - Cleaning
    - Shopping

In the bid it was emphasised that the provider of the integrator services would not be allowed to provide the home help services described above. Instead, it was provided that the integrator has to contract those services out to its subcontractors. The contract was supposed to be valid for a term of four years. In addition, the option to renew the agreement under the same terms for the two subsequent years was included in the contract.

At the first phase bids were submitted by five prospective integrators. However, three of the five did not fulfil the qualifications set for the providers; two of the bidders were too small and one of

them did not fulfil the requirement that the integrator should not be the service provider it self. Thus, there were two provider consortiums[7] with which the city eventually started negotiations.

The negotiation process was described as being crucial for the development of the final Kotitori concept. It was described thusly by the service-purchasing director, who attended the negotiations: "*the model would not have been as it is if wasn't for the negotiation process. We would not been able to create anything like this by ourselves.* In addition she described that because the negotiation process was relatively long and demanding involving several intense negotiations, the relationship between the parties became tight and involved the establishment of mutual trust between the parties. The bidding process was closed in 2008 and the contract was awarded for the consortium led by *Mawell Care, the current provider of integrator services.*

[7] Mawell Care and Nordic Health Care Group

4 The important needs and the innovative solutions to answer them

4.1 Integrator services

Demographic changes and predicted increase in the demand for private services – a need for a service integrator

In the city's demographics there have been several developments because of which it was seen as necessary to also support the private consumption of home help services. Firstly, the city of Tampere was concerned by the ageing of the population, which would potentially result in a growing demand for such services. According to the prediction by Statistics Finland, the population aged 65 and over would increase in Tampere from 33 000 in 2008 to almost 60 000 by the year 2040 (Figure 2). Especially substantial was the growth predicted among those aged 85 and over. In that group the population was predicted to grow from 4000 in 2008 to 15 000 by the year 2040. In this group also the coverage of regular municipal in-home care has increased most rapidly since the early 2000s (Figure 3). It was perceived that the city will not be able to answer the growing need for services in the future. It was estimated that the eligibility criterion for in-home care funded by the municipality has to be tightened in the future, e.g., due to the growing demographic dependency rate (Figure 4) resulting in fewer taxpayers in relation to the elderly and children.

Figure 2 Predicted population growth in 65-74, 75-84 & 85-94 year olds in Tampere by 2040 (Statistics Finland)

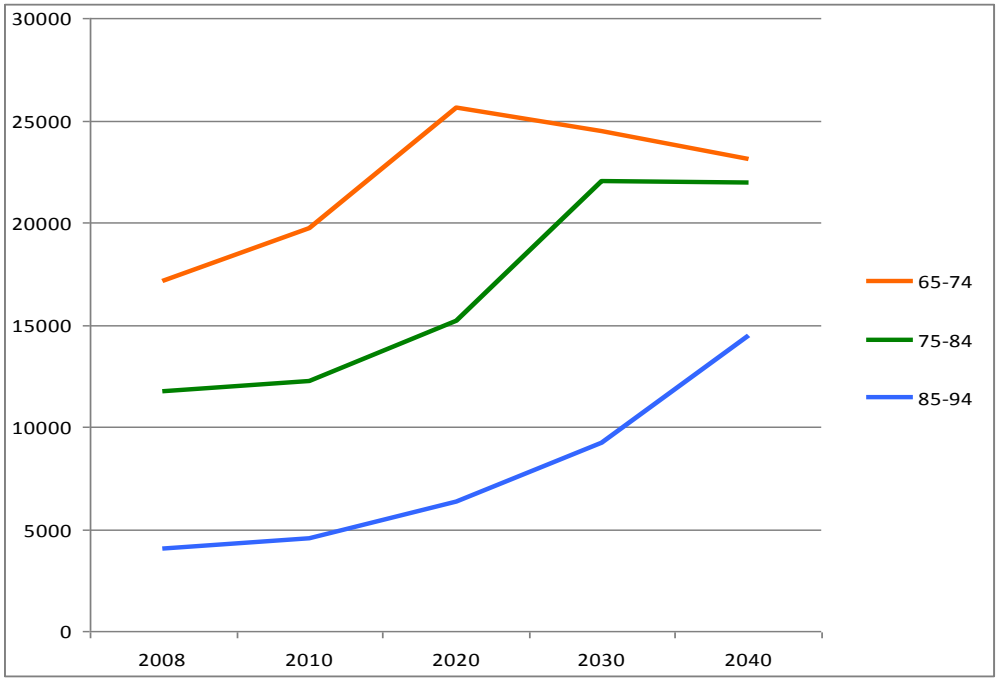


Figure 3 The proportions of regular home care clients as % population of the same age in Tampere in 2001-2010 (SOTKAnet)

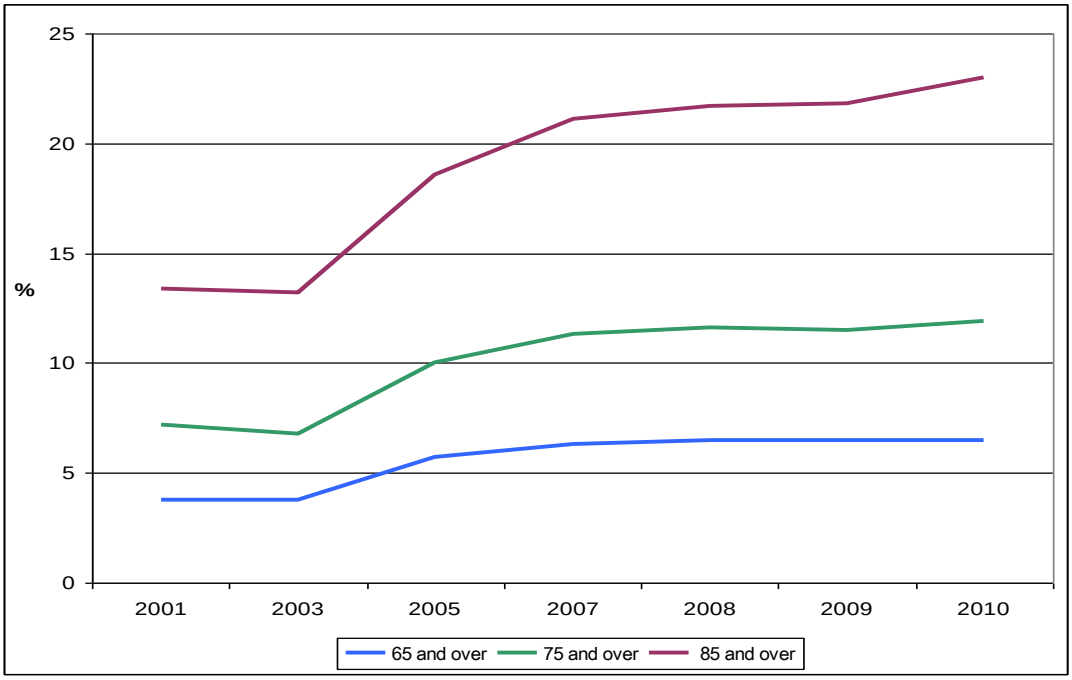
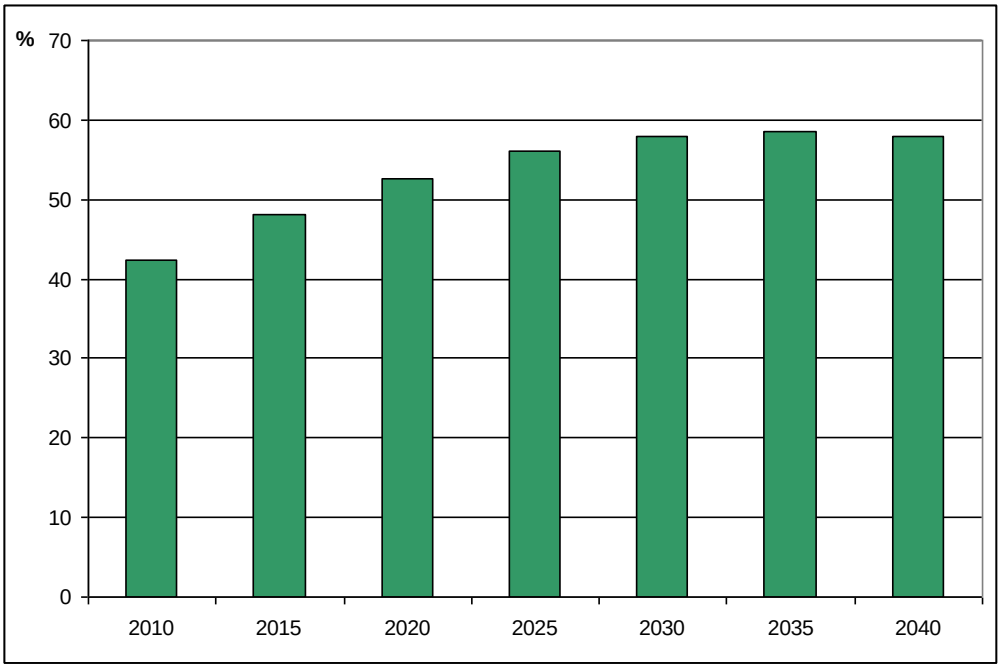
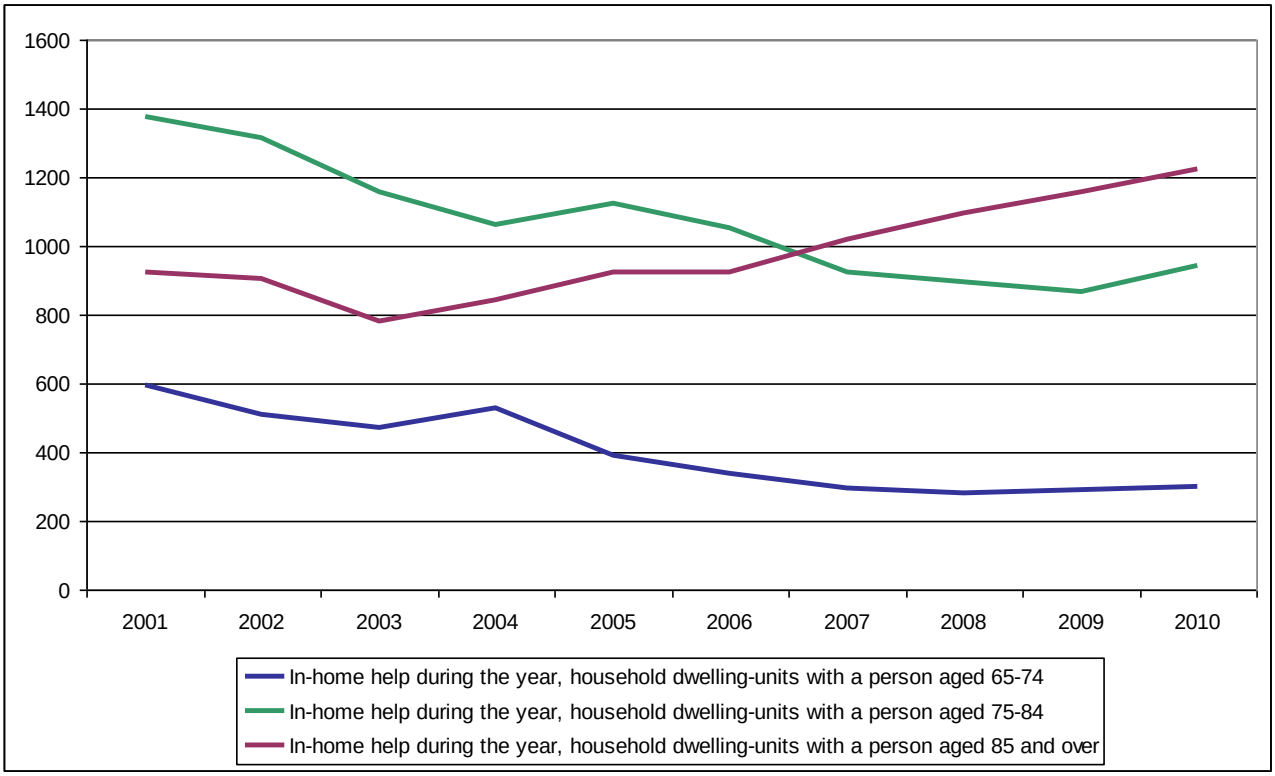


Figure 4 Demographic dependency ratio: the number of children (0-14) and older people (65+) in relation to 100 15-64 year olds (Statistics Finland)



Secondly, while the coverage of in-home care services, especially among those aged 65-84, has remained rather constant during the past decade (Figure 2), the absolute number of those not receiving municipal in-home care has increased and potentially will increase also in the future due to the tightening eligibility criteria for municipal in-home care. In addition, the number of households receiving in-home help services organised by the municipality has decreased especially among 75-84 year olds (Figure 5). By introducing the integrator model, city officials wanted to guarantee that the services are available for citizens even though they are not covered by the public sector.

Figure 5 Household dwelling-units that received in-home care support services organised by the municipality during the year, 2001-2010



Thirdly, approximately 50% of the citizens of Tampere aged 75+ live alone. While the majority of those receive help from their relatives, there are also a growing proportion of those older citizens who do not. For them private in-home help services were seen as complementary to the informal care provided by the relatives and thus, it was seen as important to make access to private services easier.

In addition to the predicted need for private in-home help services it was estimated that the elderly also have an increasing ability to pay for private service. For instance, the proportion of those receiving only the smallest possible pension (the full national pension[8]) has decreased steadily during the 2000s (Figure 4). Moreover, since 2001 households have been eligible for a tax deduction for household services such as home repair, care for the elderly and children, cleaning, catering and shopping. The use of tax reduction for household services has increased steadily among pensioners (i.e., those aged 65 and over) since 2001 (Figure 7), further indicating the growth of the consumption of private services. However, the range of income disparity among the elderly has increased and tax deductions benefit only older people in the highest income groups.

[8] Most of those receiving only the full national pension are also eligible for other benefits such as a housing subsidy.

Figure 6 Those aged 65 and over receiving only the full national pension in Tampere and in the whole country in 2000-2010, as % of the population of the same age (Statistics Finland)

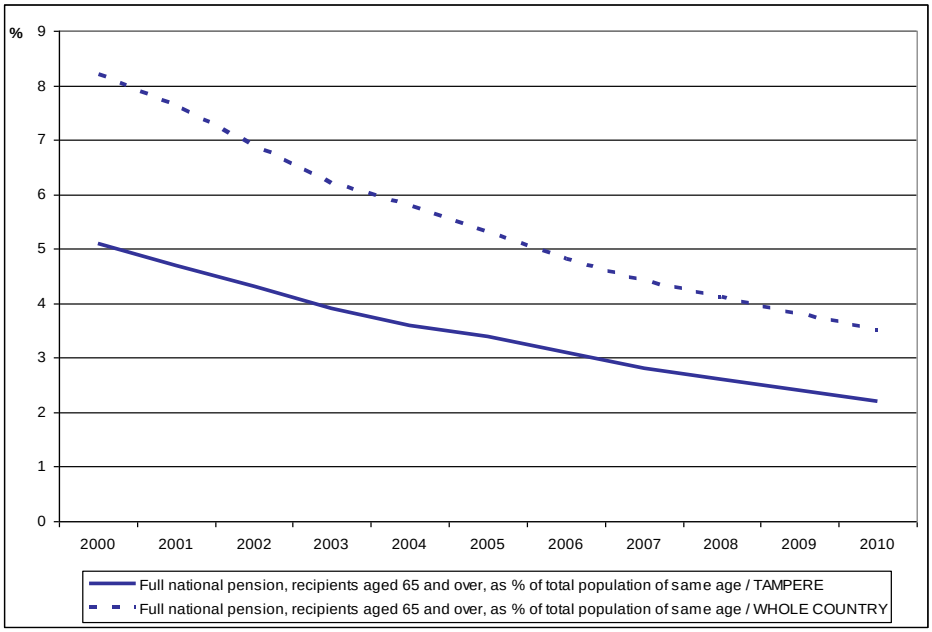
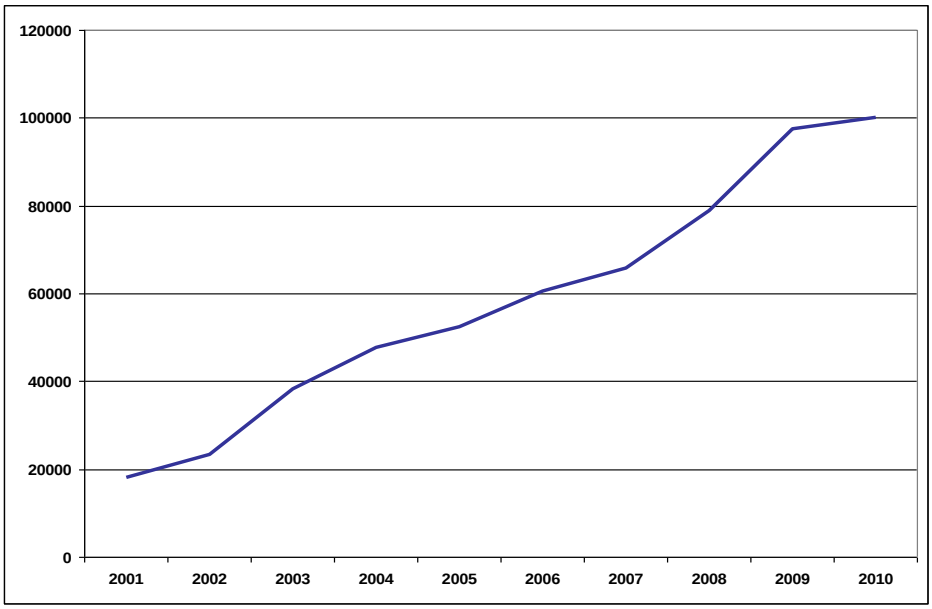


Figure 7 The number of pensioner households utilizing tax deduction for household services in Finland from 2001 to 2010 (Taxpayers' Association of Finland)



Clarifying the complicated provider market

In order to support the consumption of private in-home help services it was deemed necessary to clarify the provider market that had become diverse and complicated from the customers' point of view. By diverse and complicated this description referred to the lack of aggregated information of the service providers operating in the field of in-home help services. It was described by the city that while the elderly might be able to consume private services, they may not be aware of all of the services that would be available for them to purchase. In other words, the complicated and scattered private service market was perceived as impeding the consumption of private services in situations from which an elderly person would benefit.

One aimof the Kotitori model was to establish broker organisation, i.e. the integrator, to operate between the customers and the private providers and to collect a network of private providers that would have the potential to make use of private services easier for the citizens who can afford it. The integrator is responsible for running a provider network which consists of providers from different service fields. With this network Kotitori is able to provide a "One-stop shop" with easy access for the elderly and their relatives. Kotitori case managers work as key actors in integrating the services provided by different providers from different sectors. The customers can get information about the services provided via Kotitori and contact Kotitori case managers by visiting the Kotitori officein city hall or by calling the Kotitori call centre. An information package, including a list of providers, services, quality standards etc., is available in Kotitori's Internet portal.

From standard packages of care towards diverse service solutions

In addition to demographic changes, there was also a cultural change among elderly care professionals, among the older people themselves and in the society that pushed for the new models of service delivery. The Kotitori model was needed as it was finally acknowledged that the needs of the elderly population were diverse and that they had to be met with diverse means. It was seen that combining private, third sector and public services would potentially result in the more versatile selection of services for the elderly and their relatives.

Kotitori case managers use *solution-focused approach* to meet the needs of the older customers. This approach was initially adopted from child protection services, for which the service manager of Kotitori had previously worked in the city of Tampere. The main idea of the solution-focused

approach is that the services are tailored on the basis of the customers' needs, hopes and preferences. Thus, the customer is not provided with a standard package of services, but with tailored help that enables the customer to lead the life to which she/he is accustomed and which is in accordance with their wishes. This is done by selecting the appropriate mix of public, private, and third sector service providers. The help may also actualize in the form of social activities or hobbies.

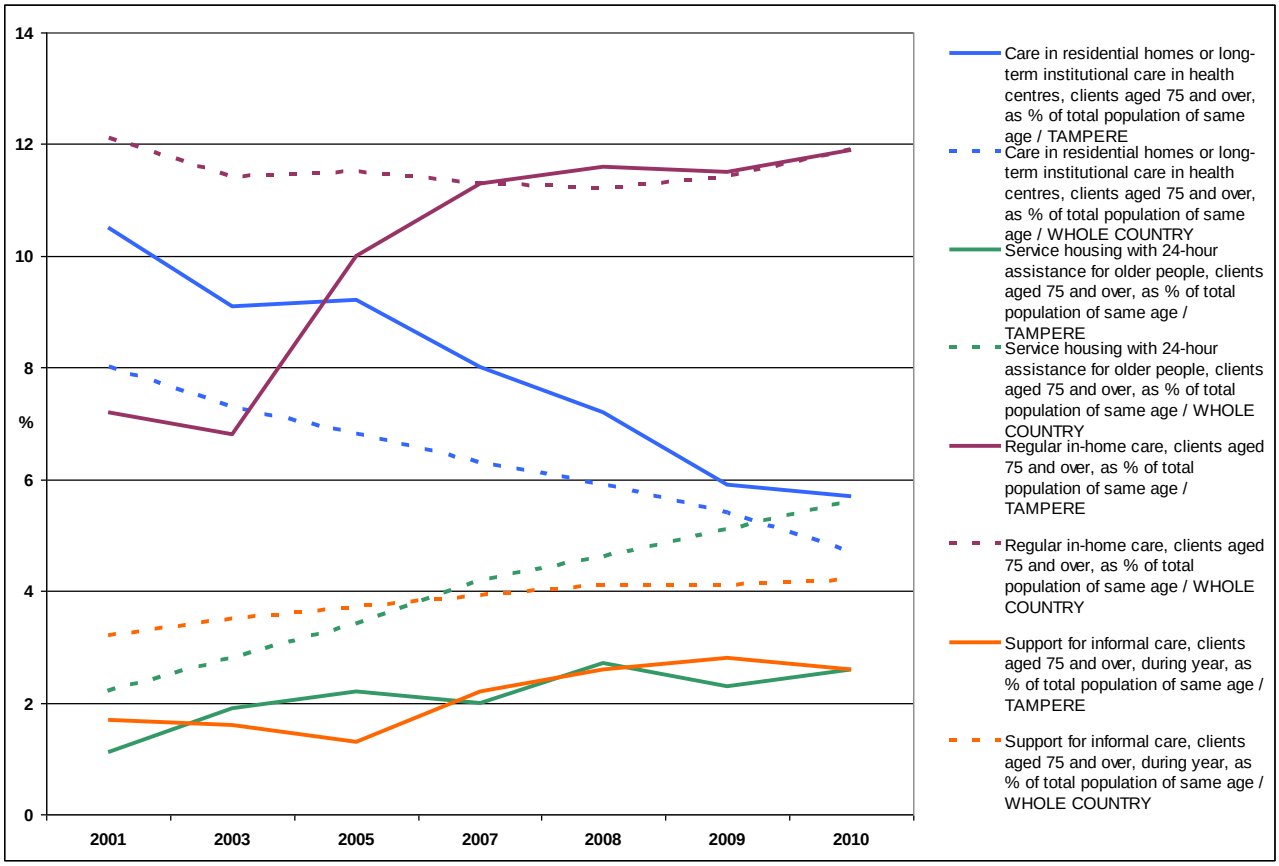
4.2. Municipal in-home care services

Policy shift – the need to develop the in-home care provision programme of the city

The phenomenon of a relatively large proportion of elderly people receiving institutional care has been unique to the service delivery structures in Tampere (Figure 6). However, during the last two decades, the emphasis of federal policies has shifted from institutional care towards in-home care and in-home help. This potentially also worked as an incentive for Tampere to embark on developing its in-home care services. Changing the service structure towards out-patient oriented service provision was also seen essential because if nothing was done, the increase in costs would be uncontrollable in the future, given that institutional care is substantially more expensive than outpatient care.

The city perceived that the service culture in its own in-home care unit was not customer-oriented, efficient or productive. It was acknowledged that the delivery patterns and working culture needed to be changed systematically. However, despite several attempts by several managers at different levels of the organisation, the development had not been successful. Consequently, the city decided to proceed with the work with the help of a contributor coming from outside the city's official ranks. Thus, in the Kotitori contract it was agreed that the service integrator contributes also to the development of the city's own in-home care provision. In addition the private providers who also deliver municipal in-home care have tried actively to communicate their ideas to the representatives of the city. The development work has especially focused on the information architecture of the city.

Figure 8 Service delivery structures in Tampere and in the whole country in 2001-2010, as % of the total population of same age



Streamlining the procurement process

The competition law (Laki julkisista hankinnoista 2007/348) allows municipalities to apply competitive tendering to all public purchases exceeding 100 000 Euros. If a public procurement is executed there are two alternative ways to proceed in a traditional model of organising services:

(1) Organise a procurement for the whole service package and deal with one provider

- Bidding for the services of a large area or for a big service package enables only a few large provider organisations to attend
- Small providers may be forced out of the market
- The costs of the process would be relative moderate

(2) Divide the area into several districts and assign each one out to small providers.

- The costs of setting up and finalizing contracts would substantially increase due to several negotiations with several small providers.
- Would also enable smaller providers to participate.

The city wanted to streamline these demanding procurement processes for the in-home care services for which it is responsible. At the same time it was also perceived important to support local providers and local employment. However, it was seen that this was not easy in the traditional service provision model applied in the public sector. Thus, as a part of the Kotitori model, the city of Tampere decided to only contract out the municipal in-home care services of one area of the city (i.e. the central area). The services were contracted out to the provider of the integrator services (i.e. Mawell Care), which was obliged to sub-contract the various services out individually.

This approach enables the municipality to harness the advantages of both alternatives. As to the municipal in-home care services of the central district of Tampere, the Kotitori model provides a single bidding process from the municipality (that is the procurement of Kotitori) but also enables the municipality to indirectly support small providers as the integrator is allowed to sub-contract with several small providers.

Table 4 A summary of the perceived needs, problems in a current situation and solutions provided by Kotitori

Integrator services			
Driver behind the needs	**Need for new policies**	**Problem in the current situation**	**Solution provided by Kotitori**
Population ageing	Growing demand for services	Inadequate resources of the municipality → tightened eligibility criteria for municipal in-home care services	- Support for private consumption of in-home care and in-home help services
Inadequate resources of the municipality	Support for private consumption of in-home care and in-home help services	Diffuse service network. People are not aware which services are available for them to consume privately.	"A one-stop shop" in which the information of the services provided by the public, private and the third sector are gathered in one place.
Cultural change	Diverse service needs of the elderly	Rigid/standard packages of care provided by the public sector	Tailoring services for citizens applying case management and combining the services provided by the public, private and third sectors.
Municipal in-home care services			
Driver behind the needs	**Need for new policies**	**Problem in the current situation**	**Solution provided by Kotitori**
Increasing contracting out of municipal services	Streamlining of the bidding process but also support small, local providers	The bidding process would be very demanding and costly if the city had to negotiate with all of the small providers separately	Contracting with an integrator that is allowed to make contracts with several small providers
Shift in policy: emphasis from institutional care to in-home care	Develop the in-home care provider framework of the city	Rigid and conservative working culture in which the implementation of changes have been perceived as difficult, if not impossible	Including consultation and development tasks in the contract with the integrator

5 What is the context in which innovation is taking place and the enabling conditions?

Demographic changes

Demographic changes were the main driver, as the very first discussions of the integrator model were started first at the national level and then locally in Tampere. It was forecasted that the demand for elderly care services would possibly increase while the resources designated to cover them would likely decrease or remain constant (see above).

Characteristics of the city and Reforms in the city organisation in the 2000s

In order to be appropriate, the Kotitori approach requires a sufficiently large population base. Tampere is a relatively large city with c. 200 000 inhabitants and thus provides a population base large enough for a service market in which multiple providers may operate and even compete. The context is also urban, which lets one to assume that there is slightly more purchasing power in the population compared to the more rural areas. Moreover, Tampere has a strong tradition of exploiting private, mostly not-for-profit organisations, in their service delivery, especially in field of elderly care.

In the 2000s the city of Tampere went through a series of administrative reforms. As to the establishment of Kotitori, the most important reform was the one of the city administration that was reorganised by introducing the purchaser-provider split. Purchasing activities were organised into six core processes, one of those being "Promoting the wellbeing of senior citizens". It was also emphasized that the services are organized by employing multiple providers, i.e., those of the public, private and third sectors. These reforms also potentially paved the way for Kotitori establishment by opening the window of opportunity for further reforms in the organization of the services.

Market conditions

The local providers market was going through two parallel reform processes during the late 1990s and early 2000s. On one hand there was an increase in the number of small private providers and it was felt in the city that the service network was becoming diffuse, which is why it was perceived

that it was rather difficult for the citizens to benefit. On the side of elderly care services contracted out to the private sector, the market seemed to be developing towards an oligopoly in elderly care services. Nationally there were a few big provider organisations[9] that, if nothing was done, were feared to take over the market as the small providers had rather poor chances to succeed in competition with the big firms. These two parallel developments pushed the city to search for alternatives that would support the establishment of a more coherent service network and that would improve the conditions of the small local providers to participate in service delivery.

Policy entrepreneurs, political mood and the drive for innovations

In order to arise, an innovation needs drivers to promote it. In the case of Kotitori one can identify several policy entrepreneurs that saw its potential and started to promote the idea. Firstly there was a person who took the idea from the national level working-group to the municipal level. Then there was the director of development of well-being services. Finally there was the mayor, who supported the idea even though it did not pass the city council in the first place.

In addition, to the active individuals in the city administration, a supportive political mood is crucial to the actualisation of the new innovations. In the 2000s and even before there has been a strong desire to search for new ways to find novel ways to organise municipal services. This strong drive for renewal of service delivery patterns and the administration of the city has most potentially contributed to the establishment of Kotitori, which really was (and still is) something quite unique in the Finnish context.

National level supporters for the local initiative

In addition its local supporters, Kotitori also had national level supporters that contributed to its establishment. These included the Finnish Funding Agency for Technology and Innovation (Tekes), which provided funding for the pilot project of Kotitori, the Ministry of Employment and the Economy and the Nordic Healthcare Group, which is a private think tank and a part of the Kotitori consortium.

[9] Mostly owned by multinational private equity companies. Several provide both health care and care for the elderly (especially sheltered housing)

Consultation procedure

The negotiation process was crucial for the development of Kotitori for at least two reasons. Firstly: "*The model would not have been as it is, there would not have been the negotiation process. We would not been able to create anything like this by ourselves,"* the purchasing director opined on the importance of the negotiation process through which the actual model was created in cooperation with the city and the private contractor. Secondly, it was described that as the negotiation process was rather long and demanding, the relationship between the parties became tight and involved mutual trust between the involved parties.

The integrator described the consultation process as being rather costly and demanding. One reason for that was that while it negotiated on a contract with the city it had to organise its own procurement of the in-home care services for which it would be responsible. It was also described that even though the procedure was called a negotiation/consultation procedure it lacked the dialogue between the bidders and the city. That is, the city must be neutral and give the same information to all of the bidders. From the provider's point of view it might have been better if the process had been based more on informal negotiations.

Adequate technological solutions

In order to work efficiently the Kotitori approach provides appropriate technology. Mawell Ltd has experience in similar technological solutions in a number of other service fields.

Legislation and federal policy

Legislation allows municipalities to apply competitive tendering to all public purchases exceeding xx ooo Euros. Contracting with several providers is rather costly, which may prompt municipalities to search for alternatives that would reduce the costs of public procurement. Moreover, during the last two decades the emphasis of federal policies has shifted from institutional care towards in-home care and in-home help. This potentially also worked as an incentive for Tampere to develop its in-home care services. Changing the service structure towards out-patient oriented service provision was also seen as essential because if no action was taken, the cost increase would be uncontrollable in the future.

6 The specific benefits – are they superior to traditional alternatives?

Kotitori has been operating for three years and thus, is in its early stages. While we are not able to provide any hard data on the implications of the Kotitori model, we can contemplate the model's potential pros and cons from the perspectives of different stakeholders.

6.1 The customer perspective

Integrator services

From the customer's point of view, the major difference between the Kotitori model and the traditional model of service delivery relates to the availability of private services. In the more traditional system there has not been any formal integration of public and private services, while one of the main tasks of Kotitori is to deliver private services for citizens. Thus, it seems that the Kotitori model especially benefits citizens who can afford to buy private services.

One aim of the Kotitori model was to clarify the service network for the older people and in that way support the use of private in-home care services. The Kotitori model has potentially made it easier for older people and their relatives to seek private services and purchase them. In this sense, citizens may exercise bigger choices compared to the more traditional system. In addition, the choice may also be more informed than in the situation in which elderly people purchase the services from the private sector without the support of case managers, who help the older customers to make their choices about private services. Thus, the integrator model may be especially beneficial for those citizens who can afford private services but do not have relatives who potentially would help in the decision making.

The contract between the city and the integrator is base on a Service Level Agreement (SLA) in which the minimum level of the quality of the services is defined. As to the integrator services the agreement is signed by the city and the integrator. However, the same service levels apply to all the private providers the integrator approves to its provider network. Because of this the representatives of the citizens found the integrator model to be a more secure way for elderly people to purchase services compared to a more traditional situation in which the citizens

consume private services without quality control of any third party. As the integrator is connected with the city, which ensures that the integrator complies with a certain level of service quality, the integrator is obliged to regularly monitor the providers in its network.

Kotitori is marketed as a "One-stop shop" of in-home care services, referring to a marketplace in which elderly people are provided with information on private services. For the older people who cannot afford private services, Kotitori does not, in its current form, provide added value compared to the traditional system. "One-stop shop" does not involve primary and secondary health care services or service from other sectors of the city. The model might benefit all citizens better if in addition to municipal in-home care services and private services, older people were also able to have access to health care services via Kotitori. Currently the cooperation with health care services was described as being difficult by the Kotitori case managers. It was especially emphasised that the health care professionals do not seem to be aware of Kotitori and the services it provides. From the customer's perspective, this is an important point that should be taken into account if a similar service concept is developed elsewhere.

Currently e-Kotitori seems to play only a minor role in the operations of Kotitori. Kotitori case managers describes that the users of e-Kotitori are primarily the relatives of an older person. This is rather expected as the number of the elderly actively using the Internet is rather low compared to other age groups. However, in the future the importance of e-Kotitori may increase as the coming generations will reach their later years already used to regular web usage as a part of their lifestyle. However, care for the elderly is a service that can never be taken wholly onto the Internet as the ability to use these services may be substantially lowered if a person's ability to survive without services is low. Thus, the role of the relatives in the use of this service will potentially remain large.

Finally, the Kotitori model acknowledges that senior citizens are not a homogenous group, but a group with diverse needs, abilities and desires. In the very core of the Kotitori model are the case managers, who use *a solution-focused approach* in their work. In other words, the point of the departure is not a standard service package, but customer needs and wishes to which the solutions are then adapted. In addition, it was emphasised by the case managers that in the

Kotitori approach it is possible to combine several kinds of services but also other activities, such as social activities and hobbies, for senior citizens.

The solution focused approach can be regarded quite differently from the traditional model of municipal in-home care services in which the customer's needs are adapted to a standard service packages and not vice versa. Naturally, the working culture could and should also be developed in this direction in the public sector. For Mawell it was, however, potentially easier because it started from zero without a burden of the history of the management traditions of the city. Thus, compared to employees in the public sector, Kotitori employees and management were more free to innovate and find the solutions for their own work. In addition, Mawell was also bound by the contract to find more flexible and innovative ways to organise the services. Finally, the organisation of Kotitori was described as being more flexible than the one of the city. The flexibility refers to the ability to change the processes and working patterns if a need for change was perceived. In the city organisation, in turn, the management culture was seen to support stable and unchangeable working patterns (or at least they do not encourage employees to develop them further). They also shared that in comparison to the city organisation, in Kotitori the managers fully trust their employees. This was seen as crucial to innovation and creativity among personnel.

The solution focused approach and the ability to work proactively as to the customers' needs indicate that the Kotitori model is, in this respect, potentially superior to the traditional model of service delivery. However, it must not be taken for granted that private providers are the only participants that are able to change and operate proactively. Thus, to be able to create a working culture similar to Kotitori does not necessarily need an integrator model to be successful. On the other hand the solutions tailored to the customer seem to be rather dependent on the supply side of the services. If an old lady needs a hair cut but there is no hair dresser in the network it may be that the lady is left without the service. In its current form Kotitori does not seem to be a user-led innovation to any large extent.

Municipal in-home care services

If we look at customer satisfaction with municipal in-home care services it seems that there are no substantial differences between the different areas of Tampere in 2010 and in 2011. In 2010

the respondents were asked to evaluate the quality of in-home care on a scale of 4to 10. The average in the Kotitori area was 8 while the city average was 8+ (Figure 9). In 2011 the customers where asked to rate the quality of municipal in-home care services, satisfaction with municipal in-home care services and satisfaction with municipal in-home care support services on a scale of 1 to 5. In general, customers were most satisfied with support services and least satisfied with the quality of in-home care (Figure 10). The average in all three categories was the lowest in the Kotitori area, but the differences were not substantially different between areas. In total, the performance of the private providers in the Kotitori area has not been superior to the performance of the public providers with regard to customer satisfaction. Thus, whether the services are provided via integrator by private service providers or through a system without a service integrator does not seem to have an influence on customers' perceptions of the services.

Figure 9 The quality of in-home care rated by the customers on a scale of 4 to 10.
Comparisons between Kotitori area and other areas operated by public providers in Tampere in 2010

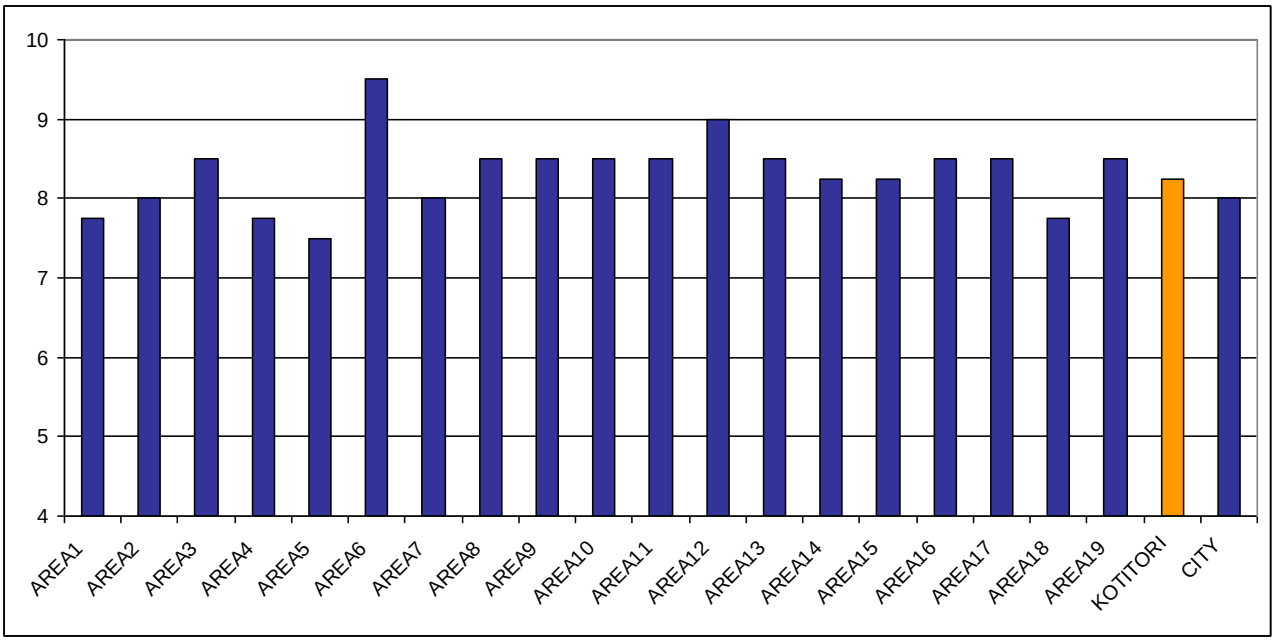
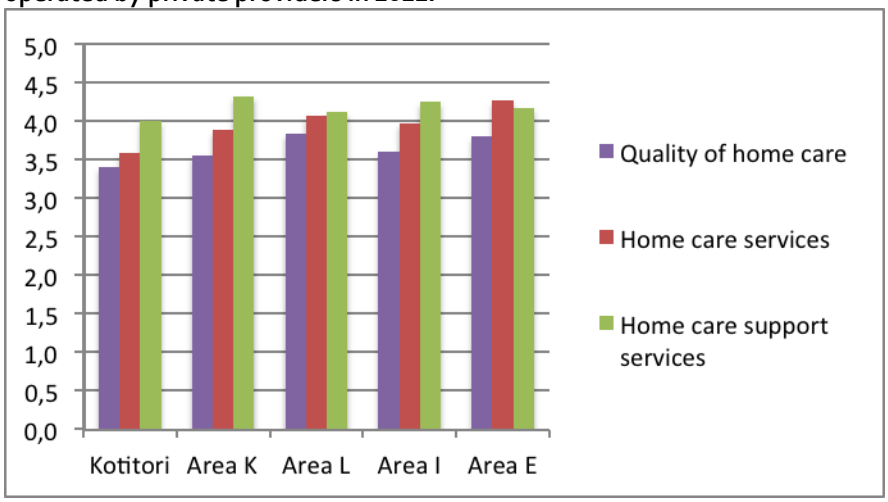


Figure 10 Customer satisfaction with in-home care services, in-home care support services, and with the quality of in-home care presented in service areas operated by public providers (Area K-Area E) and the Kotitori area operated by private providers in 2011.



6.2. The city of Tampere

Integrator services

The city of Tampere has potentially been one of the biggest beneficiaries of the Kotitori model. The model involves substantial agreement on consultation and development work of the in-home care provision of the city. The development work includes the development of the processes and working culture at the systemic level but also the development of the technological architecture of the city. One of the subcontractors of Kotitori has been especially active in communicating its technological solutions applied in its own in-home care towards the city. It has participated for instance in the development of the ERP system of the city. The Nordic Health Care Group, in turn, provides the city with data on the performance[10] of Kotitori providers but also on the performance of the providers hired directly by the city. Thus, the Kotitori model provides the city with a benchmarking opportunity and a tool to develop its operations with this knowledge.

The integrator model in which citizens are also provided the option to purchase private services creates an opportunity for the city to transfer a part of the costs of care to citizens. The model makes it increasingly possible for the city to tighten the criteria for the municipal in-home care services and support services as the citizens' access to private services is supported via the integrator model. The idea of the city to invest in Kotitori was that, if the services were utilized in

[10] E.g., the performance measures indicated in the contract between Mawell and the city

a timely manner (i.e., early enough), the use of costly A&E services, hospital wards and the rate of hospitalizations would potentially decrease. Thus, if the support for living at home is also increasingly purchased by the citizens themselves it may be that the model results in overhead cost savings.

Municipal in-home care services

The contract on municipal in-home care services is based on SLA (see above). In addition it includes a bonus-sanction model, which is not common either in the contracts on health care and social services or in the contracts between purchaser and provider in municipal organisations in Finland. Bonuses are rewarded if the integrator is able to meet the performance targets for in-home care specifiedin the contract. If the targets are not met the integrator has sanctions put upon it by the city. The indicators to measure the performance include, e.g. transfers to sheltered housing, use of hospital wards and utilisation of A&E services, i.e., the services that are more costly for the city compared to in-home care services. These incentives in the contract have potentially been included to prevent unnecessary use of hospital wards and A&E services as well as early transfers to sheltered housing or institutional care. However, they also leave us with a question, whether they can also work as barriers to receive, e.g., secondary care or sheltered housing services also in cases where the use of these services would be necessary.

The integrator monitors the performance of Kotitori in-home care providers based on the performance indicators set in the contract between the integrator and the city. According to the self-evaluations conducted by the integrator[11] in the Kotitori area, there was, e.g.:

- 29 % lower rate of transfers to sheltered housing compared to other areas
- 30 % lower secondary care hospital costs compared to the costs of elderly people in other areas
- 15 % of primary care hospital costs compared to other areas
- 14 % lower utilisation of A&E services compared to other areas

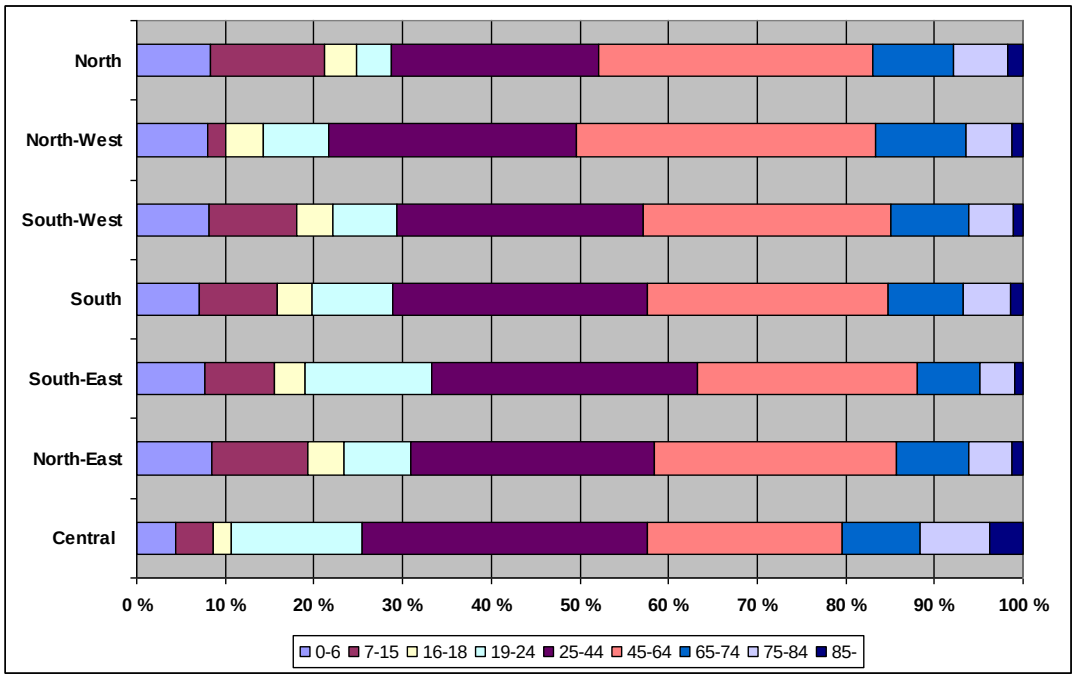
It was also estimated by the integrator that the unit cost per customer was lower compared to that of in-home care provided by the city. However, the reliability of these results cannot be evaluated by the researchers as we did not have knowledge on whether the comparisons were

[11] In particular, it is the Nordic Health Care Group that conducts the evaluations and collects data on the performance of the providers

made by controlling for, e.g., demographic structure and morbidity of the different areas of the city. Thus, we can only speculate if the contract has influenced the Kotitori providers' performance in a way the city would have expected. In addition, these numbers tell only what has happened to the use of the services. They do not say anything about the need for the services.

If we look at the age structure in different areas of the city (Figure 11), we can observe that in the city's central district, i.e., the area for which Kotitori is responsible area, there is a larger proportion of those citizens aged 65 and over as well as those aged 75-84 and 85 and over. The results presented by Kotitori may then indicate two things. It may be that Mawell has been able to cut the unnecessary use of the above mentioned services. In this case the performance of the Kotitori providers has been superior to those of public providers. However, the age structure of the area lets us also speculate with the option that the incentives have also worked as barriers to receive, e.g., secondary care or sheltered housing services in cases where the use of these services would be necessary. Potentially these cases are among the minority, but this possibility is good to have in mind as the contract and its impact are evaluated. If the contract has also worked in this direction, it is of benefit to neither the city nor the customers.

Figure 11 The age structure in the different areas of Tampere in 2011 (city of Tampere)



As to the differences between the in-home care provider of the city and Kotitori it was also mentioned that the role of the contract is different in the city organisation and in Kotitori. The case managers shared that the contract directs their operations and also the operations of the in-home care contractors of Kotitori. In turn, the employees in the in-home care provision of the city were seen as rarely aware of the content of the contract or as not "respect[ing] what has been agreed upon". Indeed, also the purchasing manager saw that in the Kotitori model the contract has an important role as a steering mechanism. Thus, for the city the integrator model potentially works as a tool for stronger steering power via the contract.

6.3. Private providers

Integrator services

As most of the in-home care and in-home help providers are small or medium-sized firms, their negotiation power in dealing with the city alone rather small. In the Kotitori model, the integrator is able to collect the wishes and needs of the smaller providers and bring them forth in the city administration. The integrator is potentially better heard by the city compared to small local private providers as it works in close partnership with the city. By strengthening their voice towards the city, the Kotitori model especially benefits smaller providers.

One of the aims behind the Kotitori concept was to establish a more coherent network of the providers delivering services for the elderly. For private providers, it was believed that a more coherent network would provide possibilities to change ideas and good practices and to search for synergy gains with other providers. Since 2009 the provider network has grown from zero to 110 private providers. The majority of the providers are sole traders (47%) or small or medium sized enterprises (39%). Of the network providers 8% are third sector organisations and 6% are large companies. Thus, Kotitori has proven especially capable of attracting the small local providers in the network.

There were no statistics available on the benefits of Kotitori in a form of new customers for private providers. However, it was estimated by Kotitori that on average 70 % of *new customers* purchase services from private providers, while 30 % are granted municipal in-home care services. In December 2011 Kotitori engaged with 59 new customers, of which 14 purchased private in-

home care and 29 chose private support services. This would mean that approximately every fourth provider in the network would have a new customer every month. This lets us assume that the effect on employment in the region is rather marginal. If that is the case, it may be asked if Kotitori is only regarded as one platform of advertising for the providers, rather than as a substantial source of new customers.

Municipal in-home care services

In recent times, federal for-profit providers have operated mainly in the fields of sheltered housing and health care services. They are also however increasingly interested in in-home care services because these services are also the emphasis of the current policies concerning elderly. One of the aims of the Kotitori model was to support the small, local providers' ability to compete with the large federal providers for the municipal contracts. The Kotitori model provides a single bidding process from the municipality (that is the procurement of the integrator), but enables the municipality to indirectly support small providers as the integrator is allowed to sub-contract with several small providers. In theory the idea seems to be feasible. In practice, it is unclear whether the integrator model is able to support the local provision of services.

Currently, Mawell has two sub-contractors that deliver in-home care services in Kotitori's responsibility area: Mediverkko and Nordic Senior Services. Neither of them is a local provider; Mediverkko is a federal operation, while Nordic Senior Services provides services in three municipalities in Finland. Both of them are providers that seek growth in the in-home care market. In the first bid on the municipal in-home care services organised by the integrator there were national level, regional level and local level providers. However, at least in this bid the local providers did not succeed. This is quite natural as the large providers are likely to have more potential to invest in the development work, which is provided in the contract. In addition, they may also have better competencies to comply with the requirements of efficiency and cost effectiveness of the in-home care provided by the city. Moreover, the costs of negotiating with several small providers are as costly for the integrator as it is for the city. As there seems not to be an incentive for the integrator to actually support the local provision, the integrator model may not support local providers in practice.

6.4. Municipalities elsewhere in Finland and in other countries

The Kotitori model has not yet been transferred to any other municipalities in Finland. However, it was expressed by Mawell Care that all of the large cities in Finland have been interested in this new model of service delivery. However, in order to be feasible, the Kotitori model requires a sufficiently large population base. Tampere is a relatively large city with some 200 000 inhabitants and thus provides a population base large enough for a service market in which multiple providers may operate and even compete. The context is also urban, which lets one assume that there is slightly more purchasing power in the population compared to the more rural areas. Thus, the transferability of Kotitori is restricted to the cities with sufficient demand and supply for private in-home care services.

The transferability of the Kotitori model is also fairly strong internationally. However, in addition to sufficient demand and supply also the market should consist of small providers with diverse service profiles. The model might be beneficial also for countries with interest in developing integrated care as the model also has the potential to integrate the services from both the health care and the social service sectors.

7 Conclusions

The main difficulty in evaluating the Kotitori model is a lack of reliable data. In order to say something about the cost-effectiveness of the Kotitori model compared to the traditional model, the demographic and socio-economic factors of the elderly population should be taken into account in the analysis. In addition, an attempt should be made to analyse what has happened to the need for the services among the older citizens living in the area for which Kotitori is responsible.

The integrator model in which the citizens are also provided the option of purchasing private services creates an opportunity for the city to transfer a part of the costs of care to the citizens. The model makes it increasingly possible for the city to tighten the criteria for the municipal in-home care services and support services as the citizens' access to private services is supported via the integrator model. Within this development it has to be ensured that the most vulnerable client groups are not excluded from the system. In its current form the Kotitori model does not yet answer the major challenge of the Finnish social care system: how to support the access of vulnerable client groups such as elderly people to the services they need and prefer.

Kotitori is marketed as a "One-stop shop" of in-home care services, referring to a marketplace in which older people are provided with information on private services. For the elderly people who cannot afford private services, Kotitori does not, in its current form, provide added value compared to the traditional system. "One-stop shop" does not involve primary and secondary health care services or the service from other sectors of the city. The model might benefit all citizens better if in addition to municipal in-home care services and private services, elderly people were also able to access to health care services via Kotitori.

The city of Tampere has potentially been one of the biggest beneficiaries of the Kotitori model. The model involves substantial agreement on consultation and development work of the in-home care provision of the city. The development work includes the development of the processes and working culture at the systemic level but also the development of the technological architecture

of the city. In addition, the Kotitori model provides the city with a benchmarking opportunity and tool to develop its operations with this knowledge.

The Kotitori model benefits especially the small providers by strengthening their voice and increasing their power in negotiations with the city. It has indeed been able to attract small providers to its network. A more coherent network provides a more apt framework for the exchange of ideas and good practices and to search for new sources of synergy with other providers. However, the effect on employment in the region is potentially fairly marginal. It may be asked if Kotitori is only regarded as one platform of advertising among providers, rather than as a substantial source of new customers.

Nationally and also internationally, the transferability of the Kotitori model is rather strong. However, in order to be beneficial, the market should consist of small providers with diverse service profiles. The model might be beneficial also for countries with an interest in developing integrated care as the model also has the potential to integrate services from several sectors of society.

8 Data

The primary data of this case study are X informant interviews conducted in January and February 2012 by the researchers. The informants represent key stakeholders regarding the establishment and operation of Kotitori. The informants represent following stakeholder groups:

- Customers, i.e. senior citizens and their relatives (indirectly)
- Kotitori case managers
- The integrator (Mawell Care and Nordic Health Care Group)
- Administrative level of the city of Tampere (service purchasing director and director of development of well-being services)
- Kotitori in-home care contractors

In addition, the researcher have employed their previous knowledge on Kotitori as well as interview data collected for the purposes of another research project to the extent it included information on Kotitori the researchers were provided with the key policy documents concerning the establishment of Kotitori by the city of Tampere. Finally, the researchers have employed the data provided by The Statistics Finland and SOTKAnet-data base.

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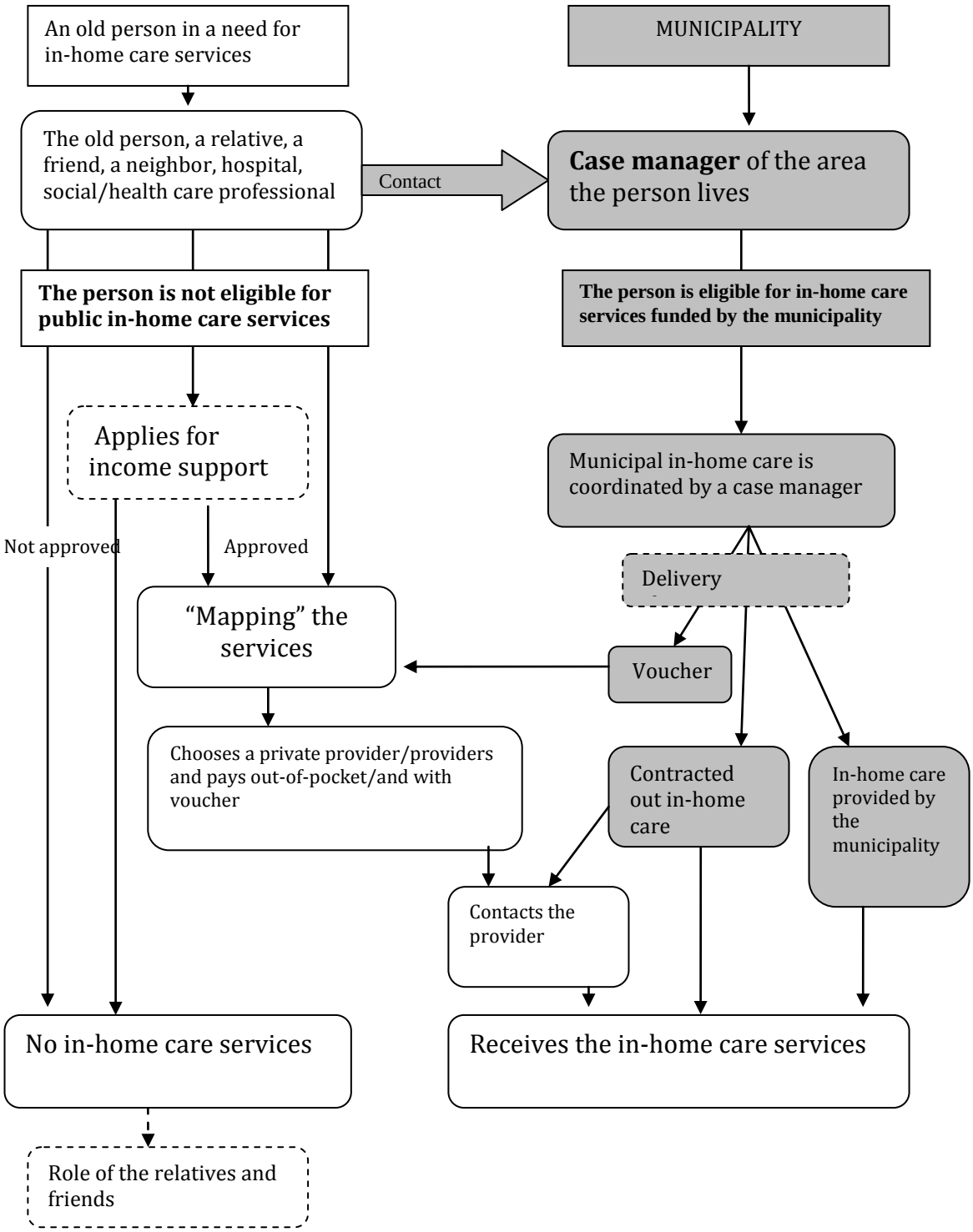
Appendix

Appedix figure 1 A basic process of getting in-home care for an elderly person in the traditional system
Boxes with grey backgrond: An active role of the city/the case manager
Boxes with white background: Responsibility of the elderly person



Appedix figure 2 A process of getting in-home care for an elderly person in the integrator model
Boxes with grey filling: An active role of the integrator
Boxes with white filling: Responsibility of the elderly person