



RCN Policy and International Department
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Moving care to the community: an international perspective

RCN Policy and International Department
020 7647 3723
Email: policycontacts@rcn.org.uk
www.rcn.org.uk/policy

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Forewords

Moving patient care out of acute hospitals and into the community has been a UK-wide priority for over a decade; however despite national commitments made to encourage this shift, there is limited evidence to show a tangible investment in the community. Moreover, our *Frontline first* campaign has highlighted concerning examples of service and staff cuts and the impact of these short-term savings on patient safety and overall quality of care. The RCN is very supportive of moving care closer to patients' homes, where it is clinically appropriate to do so; however we believe that more community investment is needed to facilitate this shift.

Advancements in medical and health technology have enabled the population to live longer, however more people are living with co-morbidities and needing complex care interventions. In the UK, there is a push to deliver value for the taxpayers' money and build a sustainable health and social care service for future generations. We know that investing in community services and the community workforce will help to deliver positive health outcomes and free hospitals to provide more acute and specialised care. Community and specialist nurses, and advanced nurse practitioners, continue to play a key role in taking this reform forward. These professionals often work at the interface of health and social care and are instrumental in co-ordinating patient care pathways following discharge from hospital.

The UK does not have all the answers when it comes to nursing best practice and policy and there is much we can learn from our international colleagues. *Moving care to the community: an international perspective* sets out the international thinking behind the acute to community shift, the types of policies and programmes implemented in various countries and offers learning opportunities for the UK. The report also highlights international trends and makes recommendations for commissioners, providers, governments, policy experts and clinicians on a way forward.

Peter Carter
Chief Executive & General Secretary

The Queen's Nursing Institute (QNI) welcomes this report and believes that there is much to be learned from sharing experiences with our nursing colleagues in other countries. The comparative European data presented shows the UK to have the longest length of hospital stay. This is an unsustainable position economically and we know that patients prefer to be cared for, where appropriate, in their own homes.

This report brings together innovative ways in which the need for more nursing care in the home has been met in other countries. The message is clear: if the UK is to succeed in moving care out of hospitals and into the community we need a whole system and mind set change at the policy, practice and education levels. Integrated working by acute, community, primary care and social care services - and the community nursing workforce - is critical to such a change.

This report is published in the context of a serious decline in the UK in the numbers of qualified district nurses. There are fewer district nurses now than there were five years ago, just at a time when more patients need more complex care to be delivered outside of hospital. This report provides further evidence in support of the QNI's longstanding campaign for the right nurses with the right skills in the community.

The RCN's recommendations are fully supported by QNI and we will continue to work at every level to make the rhetoric of increasing care in the community a reality.

Crystal Oldman
Chief Executive, The Queen's Nursing Institute



Acknowledgements

The RCN's Policy and International Department in keeping with the organisation's strategic vision focuses on three main areas: influencing and shaping nursing and health care issues at European Union and international level, promoting global health and achievement of millennium development goals; and learning from nursing best practice overseas to inform key national priorities and organisational positions. The RCN works closely with our EU and international partners, sister nursing organisations and key health stakeholders to identify good practice and innovation that can be shared more widely, and uses this knowledge to inform nursing policy and practice in the UK.

The RCN has interviewed a number of nursing policy and practice experts working in national nursing associations (NNAs) in Canada, Australia, Sweden, Denmark and Norway to understand the reality behind the rhetoric on the shift from acute hospitals to community care and to understand the impact of this shift on the nursing workforce. These discussions have helped to shape the country-specific intelligence and analysis in the report.

Julianne Bryce, Senior Professional Officer, Australian Nursing Federation, Australia

Crystal Oldman, Chief Executive, The Queens' Nursing Institute, London, England

Ulla Falk, Förbundsombudsman/Adviser, VÅRDFÖRBUNDET (Swedish Association of Health Professionals), Sweden

Elizabeth R Foley FACN, Federal Professional Officer, Australian Nursing Federation, Melbourne, Australia

Trude Hagen, Senior Adviser, Norsk Sykepleierforbund (Norwegian Nurses' Organisation), Norway

Janne Due Sommerset, Consultant, Dansk Sygeplegerad (Danish Nurses' Organisation), Denmark

Executive summary

The Royal College of Nursing (RCN) is the UK's largest professional association for nurses, midwives, health visitors and health care assistants with more than 420,000 members.

The movement of care from acute hospitals to the community is an international priority. Many countries acknowledge the need to improve productivity whilst reducing or stabilising health care costs. Furthermore, global drivers for change such as rising patient need; an ageing population and workforce; demand for care to be delivered closer to the patient's home; and reducing unscheduled health care use, are putting more pressure on health systems to deliver safe, timely and quality care.

The RCN has worked closely with other national nursing associations (NNAs) to understand how similar moves have been implemented in their own countries and identify learning opportunities for the UK. The RCN's analysis of the shift has shown that each country is starting out at a different point in the reform process with diverging national priorities, and as such, the success of this shift is difficult to evaluate.

Key messages

- To effectively shift care out of hospitals and re-provide these services in the community, a whole-system approach is needed. Hospital restructuring cannot happen in isolation but must go hand-in-hand with reinvestment strategies. Otherwise, there is a possibility of creating a transition gap in service provision.
- Internationally, there is much focus on integration and co-ordinated care as a means to improve continuity, reduce fragmentation within the health and social care systems and deliver good patient outcomes. Nurses play a pivotal role in supporting and promoting better coordinated care. Where integrated care models have been successful, there is evidence to show that close collaboration between local authorities, commissioners, service providers and frontline staff have been instrumental in that success.
- Investments must be made to strengthen the community nursing workforce if the rising challenges and demands of an ageing population with more complex and multiple health and social care needs are to be met. The community nursing workforce is already under tremendous pressure due to workplace shortages, downbanding of nursing roles and an ageing community nursing workforce set to retire over the next decade. Priority must be placed on enabling and supporting nurses through education, training, and developing leadership skills to ensure the right nurses with the right skills are leading the way.

Introduction

Medical treatments that were once provided in hospital are being increasingly administered in the community. Within health systems, there is a renewed focus on delivering general health care in the community, freeing hospitals to provide more complex, specialised and emergency care. As the drive to shift specialised and non-specialised care out of hospital gathers momentum, there is a greater demand for a skilled and competent community nursing workforce to facilitate this shift at a local level. Nurses are essential in the delivery of continuous care as they often serve as an interface between acute and community care, focusing on prevention, self-management and providing support to transition patients smoothly across the health and social care services.

Moving care to the community has been a UK-wide health and social care policy priority for more than a decade. However, progress has been slow and in some cases fragmented. In order to address the issue, it is important to first review where this shift has been implemented and which lessons can be learned from international experiences. The RCN is committed to working closely with its equivalent nursing organisations overseas to learn from international best practices and incorporate some of this learning to shape health and social care policy in the UK, and more specifically promote good nursing practice.

This report will focus on system-wide or sector specific reforms in Australia, Canada, Sweden, Norway and Denmark as these countries have at one point or another addressed the need to deliver care outside of hospitals, either in patients' homes, GP clinics, community-based centres or care home settings.

It will:

- investigate and analyse the movement of clinically appropriate services out of hospitals – the processes and structures that have been implemented internationally to facilitate this shift (ie workforce development, reconfiguration of services and modernising nursing roles)
- highlight emerging international health system trends
- identify the impact these reforms have had on the nursing workforce, nursing practice and training.

UK policy context: the acute to community shift

The launch of the White Paper '*Our health, our care, our say*' in England (Department of Health, 2006) and the *Transforming Community Services Programme* delivered a clear mandate to strengthen and improve community care. The paper identified six specialties (general surgery, orthopaedics, urology, gynaecology, dermatology and ear, nose and throat) that were most appropriate to be delivered in primary care settings (Snow, 2007; Department of Health, 2006). Further policy developments since 2006 have led to an increase in community-based services and treatments for older people, people with long-term conditions and people suffering from mental health conditions.

Despite a strong political push, uptake of this initiative has been slow, fragmented and lacks co-ordination and strategic planning. Similar concerns are voiced in Scotland, Northern Ireland and Wales where in reality little is being done to facilitate and manage this movement of care to the community.

In 2012, the Health Select Committee (HSC) published a report for Westminster on public expenditure in England and cautioned against short-termed 'salami slicing' of existing health services in order to deliver £20 billion in efficiency savings by 2014/15. In addition, a 2014 follow-up report added that an additional £4 billion of annual cost pressure on the NHS was expected by 2016 and indicated that NHS England would "need to work with partners to shift spend to support more primary and community based care and prevention."¹

The RCN strongly supports care being delivered closer to home where it is clinically appropriate and safe to do so. However, a recurring theme highlighted through the RCN's *Frontline First* campaign reveals that services are being cut in the acute sectors with little evidence to demonstrate an increase in community provision or a boost in the community nursing workforce. In fact, district nursing numbers in England over the last decade have steadily declined. There is a lack of investment in community nursing despite increased evidence of patients requiring complex care and more complicated nursing interventions and services in the community (RCN 2012a; RCN 2012b; RCN 2013).

Nurses play a pivotal role in the delivery of safe and effective primary, long-term care and home care services. Despite numerous examples of nurses delivering cost-effective care in the community, the health and social care sectors in the four UK countries are not investing in the community nursing workforce. Concerns voiced by the RCN also resonate at a national level. These include:

- a lack of strategic workforce planning and limited resources earmarked for community nursing
- inadequate education preparation and training for community nurses, both at pre-registration and post-registration level
- insufficient training being made available for nurses who are transferred from hospital setting to the community
- few community placement opportunities for pre-registration nursing students
- cuts to district nursing community specialist practitioner posts, leading to an increase in workload pressures and rising wait times to access community services
- short-sighted community service cuts, which do not save money in the medium to long term.

¹ Health Select Committee, 'Second Report – Managing the Care of People with Long-Term Conditions', <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/401/40102.htm> (June 2014)

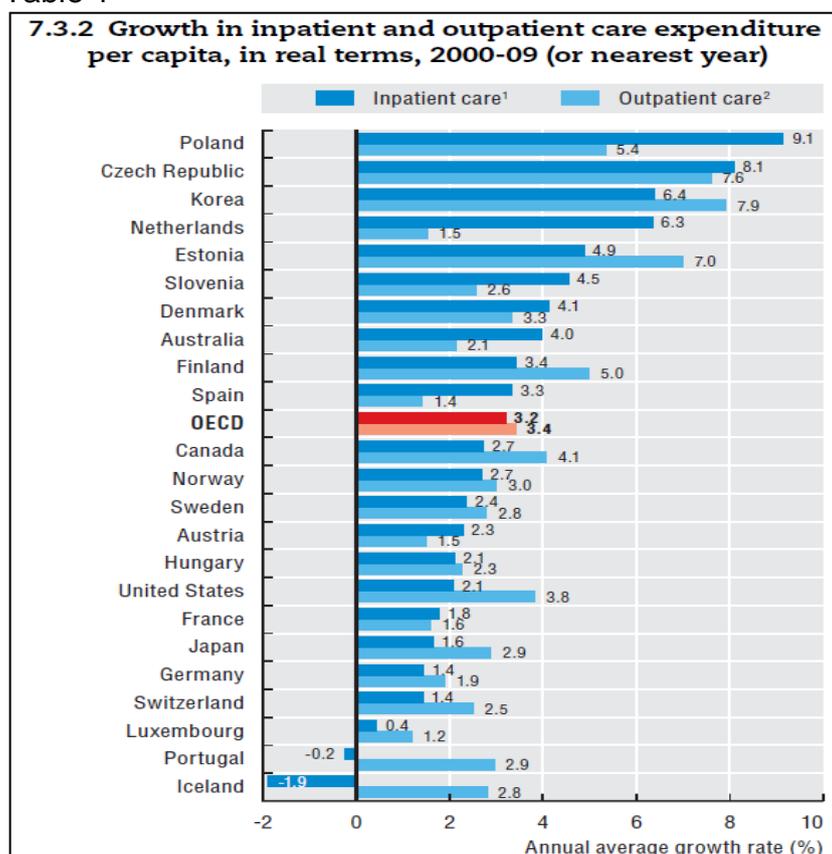
The RCN's *Pillars of the Community* (RCN, 2010) publication outlines its UK-wide position and the pressing need to build, develop and strengthen the community nursing workforce as this is where health care is going to be predominantly provided in the future.

International perspective on the movement of care

Internationally, despite variations in policy reforms and health incentives, the rationale for moving selected hospital services to the community has been fairly consistent across countries. This includes: delivering care closer to home; reducing hospital readmissions and average length of stay (LOS); increasing patient choice and satisfaction; addressing the health needs of an ageing population; and investing in health promotion, early intervention and disease prevention strategies. There is also more emphasis placed on the patient's flow of care to ensure that appropriate care pathways are created and managed to deliver prompt and effective care.

In terms of per capita spend, statistics produced by the Organisation for Economic Co-operation and Development (OECD) show a shift in the delivery of health care services with an increased emphasis on outpatient care (including home-care and ancillary services) compared to inpatient care (including day care). Table 1 highlights country variations in inpatient and outpatient care expenditure from 2000 to 2009, revealing increased investment in outpatient, community care services and primary care. Countries that have spent the most on outpatient care are Korea, Estonia, Finland, Canada, United States, Norway and Sweden. The UK is not represented in this table.

Table 1



Source: OECD Health at a Glance 2011

However, the trends evidenced in the table above have yet to make a discernible impression on rates of cumulative health spend. Between 2009 and 2011, the ratio between inpatient spend to

outpatient spend across the entire OECD remained consistent at 29 per cent, to 33 per cent. A probable contributing factor to this is that health budgets across developed economies have been under sustained pressure throughout this period. Notably, however, in the USA where the Patient Protection and Affordable Care Act of 2010 has provisioned hundreds of billions of dollars in increased health investment – the percentage spend on outpatient care has remained static at 51 per cent.²

The distribution of nurses working in acute, community and other settings (ie private, teaching, public administration, etc.) is fairly similar across England, Canada and Australia where a large proportion of nurses continue to work in acute (hospital) settings. However, Norway has a larger cohort of nurses working in the community and long-term care settings compared to England, Australia and Canada.

Table 2: Distribution of registered nursing workforce in community and acute settings

	Community and LTC sectors (%)	Acute (hospital) sector (%)	Other settings (%)	Source
England	21%	54.7%	24.3% (estimated)	NHS Information Centre, 2012. [2010 data] Please note this data does not include the private sector workforce statistics
Australia	21%	71%	7.9%	AIHW Nursing and Midwifery Labour Force Survey, 2009. [2009 data] (see appendix 1)
Canada	29%	56%	13%	Canadian Institute for Health Information, 2012. [2010 data] (see appendix 2)
Norway	32.3%	40.6%	27.4%	Data from Norwegian Nurses Organisation

International reforms: shifting care to the community

The movement of care from hospital into the community is a global trend. A few health care systems have nationally embraced reforms to support this shift to the community while others have strengthened their community sectors at a regional/provincial/state level.

This section will focus on reforms in Norway, Sweden, Denmark, Canada and Australia. It is important to note that most health care systems differ in the way they fund, procure and deliver health and social care services. Therefore, in addition to evaluating the cost-effectiveness of a particular model or initiative, it is also important to assess for transferability and adaptability into a specific health care system.

² Organisation for Economic Co-operation and Development (2013), http://www.oecd-ilibrary.org/sites/health_glance-2013-en/07/03/g7-03-01.html?contentType=%2fns%2fChapter%2c%2fns%2fStatisticalPublication&itemId=%2fcontent%2fchapter%2fhealth_glance-2013-66-en&mimeType=text%2fhtml&containerItemId=%2fcontent%2fserial%2f19991312&accessItemIds=&_csp_=62b0a47fe3d565f241a79f8ea78653b

The RCN has interviewed a number of nursing policy and practice advisers working in national nurses' associations (NNAs) in the above-mentioned countries to understand the reality behind the rhetoric on the movement of care to the community (ie whether reforms have been successful, where has it fallen short and what are the reasons for the shortfall); identify key drivers for this reform; and understand the impact on the nursing workforce. These discussions have helped to shape the below country-specific intelligence and analysis.

Norway

All Norwegian residents can access health care through the National Insurance Scheme (NIS), which is a tax-funded, universal, single-payer and centrally run health care system. The health care system is financed through general taxation (national and local), government block grants and out-of-pocket payments for private care. Health care is split into two main sectors: 1) the hospital and specialised health care services, 2) primary health and long-term care. Services relating to primary health care, health promotion, care of the elderly and care for long-term conditions are provided by the 430 municipalities that are responsible for GPs, public health nurses, home care and nursing homes within their jurisdiction (Romoren *et al.*, 2011).

The Co-ordination reform

To address issues of fragmentation, lack of co-ordination and inadequate integration between hospitals and primary health care sectors, the Norwegian Ministry of Health and Care Services in 2010 put forward a Green Paper on *The Co-ordination Reform - proper treatment at the right place and the right time*. This policy set out to address key challenges (ie lack of patient-centred co-ordinated services; little focus on early intervention and prevention of long-term conditions; and increasing care demand in light of changing demographics) and created a system of clear agreements between national, municipal and local service providers and stakeholders (Norwegian Ministry of Health and Care Services, 2010).

The reforms aim to see fewer people being treated in specialised health services (hospitals) for general health concerns. The goal is to strengthen primary health care to increasingly diagnose and treat people with general ailments and long-term conditions in the community. This could even help develop specialist care services for patients with long-term conditions and provide comprehensive care plans that encourage self-managed care (Norwegian Directorate of Health, 2012).

Currently, there is an intense debate in Norway on the number and size of local hospitals. A big push as part of the co-ordination reform is to *make the specialised health care more specialised* which means moving non-specialised care into community and primary health care sectors while offering specialised health care services in hospitals and specialist centres. Despite this initiative, the Norwegian Government has made a commitment not to close any local hospitals. Future health care services are expected to be delivered by locally based services.

Key proposals of the co-ordination reform include:

- a clearer role for patient pathways and the role of local authorities
- increasing the local government role to emphasise prevention, early intervention and long-term disease management; building agreements between local authorities and health authorities
- tackling funding barriers and using incentives
- assisting special health care services to focus on increasing competence.

Implementation of this reform began in January 2012. The reform is nationally driven but implementation and ensuring quality, safety and sustainability are addressed at a municipal level.

To support the reform, specific structures and processes have been put in place:

- a legally binding system of agreements has been initiated between municipalities and specialised health services (health authorities) to distribute tasks and increase co-ordination between sectors. Agreements should elaborate on how specialist health care services will decentralise outpatient clinics, use GP services, and assist with transfer of knowledge and internship opportunities (Romoren et al., 2011)
- a financial model was developed based on a similar model in Denmark. It includes the use of a municipal co-financing incentive and enforcing fines against municipal-initiated delayed discharges. As of January 2012, municipalities will be fined NOK 4000 per day per patient if they delay in accepting patients discharged from hospital. The financial tool is meant to encourage municipalities to keep patients out of hospital and discourage bed blocking. It is also meant to establish services to prevent and shorten the length of hospital admissions
- establishing a Civil Procedure Commission; a national dispute resolution board of arbitration with an advisory function only. The commission assists with any disputes and disagreements between municipalities and health authorities by acting as a mediator, however both parties need to reach a consensus to make any agreements legally binding (Norwegian Association of Local and Regional Authorities, 2012).

Impact and implications for nursing in Norway

The Co-ordination reform will bring new opportunities and extend the responsibilities of nurses. For example, one municipality has established a discharge nursing service where a discharge nurse visits hospitals to assess a patient's health care needs and level of support required post discharge. In another example, an Oslo municipality has set up a 24/7 hospital nursing team that co-ordinates patient transfers from hospital to the community and keeps the municipalities updated on discharge plans and the level of follow-up required. The municipalities are encouraged to develop new opportunities for nurses to help facilitate and coordinate care in the community.

The Norwegian national nurses' association states that there is a lack of support and training for nurses working within local services. This is further compounded by the fact that the acuity of community care needs are escalating and advanced medical equipments such as respirators and home dialysis machines are more commonly used in home care settings. Moreover, to meet

process driven hospital targets, hospitals are discharging a sicker cohort of patients after short stay periods and transferring their care to community staff. This has placed huge pressure on the local council and the existing community workforce to address rising demand in the community.

A survey undertaken by the Norwegian nurses' association showed that 35 per cent of municipalities did not feel like they had the necessary professional skills to take the co-ordination reforms forward. Approximately 44 per cent reported that lack of nurses in this sector was a major obstacle (NorgesBarometeret AS, 2012). However, there is widespread recognition amongst municipalities that nurses have the necessary professional skills needed to successfully implement these reforms. Municipalities are beginning to employ more specialist nurses in the community, but it is still too early to gauge the extent to which this is happening.

At a national level, there has been no clear steer on what the right workforce for the 'right place and right time' should resemble. This responsibility has been delegated to municipalities and specialised health services to shape and develop. The Norwegian Government released a Green Paper in 2012 outlining the need to change the education system for health care professionals in support of this reform. It is hoped that this will address some of emerging issues on education and training.

What is the success of these initiatives?

It is still too early to tell if the Norwegian reform will succeed in improving co-ordination between municipalities and health authorities, boosting primary health care and effectively moving care out of hospitals. However the financial tool has already delivered some positive results as delayed discharges from hospitals have reduced by nearly 50 per cent in 2012 (Norwegian Nurses Organisation data).

Denmark

Health care in Denmark is funded through a tax-based system, where acute and community care is free at the point of delivery. The cost of dental care, outpatient prescription drugs and optometry services are shared between the service user and government and this cost is often covered through complementary private insurance. General practitioners (GPs) act as gatekeepers to secondary and specialist care services. In 2007, health reforms focused on reducing unnecessary structural layers and bureaucracy by reducing the number of regions (from 14 to five) and municipalities (from 275 to 98). The five regions are responsible for providing hospital and primary health care whilst long-term care and social care are provided in collaboration with the municipalities – a lower tier of local government similar to district or city councils (Commonwealth Fund, 2010).

Home and community care reforms

Denmark is often cited as a model system for delivering integrated home and community care services for frail older people. The *Commission on Elderly* launched in the 1980s aimed to deliver care services for older people 'in their homes as long as possible' and reduce unnecessary hospital admissions (Colmorton *et al.*, 2003). The Skævinge project, piloted in 1984, was an

innovative, forward-thinking, integrated care model that ran for 20-25 years and formed the foundations for long-term care in Denmark. The project focused on preventative and self-care techniques. It addressed gaps between nursing homes and home care services by integrating services, changing the law so that nursing homes would be called housing for older people, and established the first Danish 24-hour home care service (Wagner *et al.*, 2008). One of the key project platforms for this model was to embrace the concept of self-care, where older people were encouraged to live as independently as possible and use their own resources, while nursing staff were responsible for treatment, care and supervision. This initiative was successful in decreasing service expenditure despite an increase in the elderly population.

Municipal reforms in 2007

National and regional initiatives since 2007 have focused on improving efficiency in hospitals by reducing average LOS and shifting care from inpatient to outpatient settings. These initiatives (Magnussen *et al.*, 2009) include:

- establishing regional consultative committees to bring together the regions, the municipalities and private practice to discuss discharge plans for weak and elderly patients, social services for people with mental health problems and prevention and rehabilitation care programmes in the community
- setting up health centres with municipal oversight to support prevention and rehabilitation. However, time constraints on the availability of government funding and GPs reluctance to practice in health centres that have chipped away at their professional autonomy and increased bureaucracy are a few of the factors that have limited the success of this initiative.

The delivery of health care in Denmark has changed since the 2007 reforms. Increasingly, home care services are treating more complex and multiple-care needs due to the changing population demographics (the population is getting older and many have long-term conditions) but also because hospitals are becoming more specialised centres, focusing on short hospital stays. This has meant that patients are being discharged from hospital much sooner and many have long-term conditions to manage at home. Management of patients with long-term conditions is currently picked up by the home care sector along with other services that have shifted from hospitals to the municipalities, for example physical therapy, rehabilitation and health promotion.

In Denmark, many small hospitals have closed and their functions have either transferred to larger specialised hospitals or health centres that provide more general services like rehabilitation, prevention and health promotion.

A national health agency was established to ensure that the necessary checks and balances were put in place to promote safe, quality care while services were being transitioned from hospitals to municipalities. As this vetting agency was set up after the reforms were introduced, many of the policies like national recommendations for municipal rehabilitation, recommendations for patient care and so on have not been sufficiently taken forward or implemented at local level.

Furthermore, health care agreements between regions and municipalities (that set out individual responsibility and accountability for services provided) have not been implemented.

Impact and implications for nurses in Denmark

Home care nurses are an important part of the home nursing workforce, caring for patients with more complex and long-term care needs. A few new nursing responsibilities have developed as part of the home care reforms— for example home care nurses now provide services like IV medication, telemedicine wound care, tube feeding, respiratory therapy, chemotherapy, patient education and home dialysis treatments. Nurses are also taking on new co-ordination and case management roles for palliative and end of life care.

In Denmark there are approximately 10,000 home care nurses practicing within the 98 municipalities. However, this number is decreasing as municipalities are increasingly shifting registered nurse tasks to unregulated support staff.

The Danish Nurses' Organisation has identified a few key challenges facing the home care sector, specifically:

- some nurses do not have the necessary training and competence to provide complex nursing care
- lack of effective communication between sectors
- home visits do not always allow time to carry out a comprehensive patient health; assessment, affecting the nurse's ability to properly care for the patient
- limited development at a national level to encourage advanced nurse practitioner roles.

Despite these barriers, home care nurses have developed a few innovative initiatives at municipal level to address quality and safety issues. These include:

- using telemedicine in wound care and COPD
- introducing course co-ordinators to promote good transitions and co-ordination of care from hospitals to the municipalities
- running nurse-led clinics
- developing national clinical guidelines in the community to ensure high quality care.

Sweden

The Swedish health care system is publically funded and largely decentralised with shared responsibility for health care divided between central government, county councils and municipalities (ie district or city councils). Health care services are funded through local taxes, national government subsidies and user charges. User charges for health care visits and per bed-days are determined by county councils and municipalities. Health care management is delegated to councils and municipalities, allowing greater freedom to prioritise local health needs (Commonwealth Fund, 2010; Anell *et al.* 2012).

Movement of care to the community

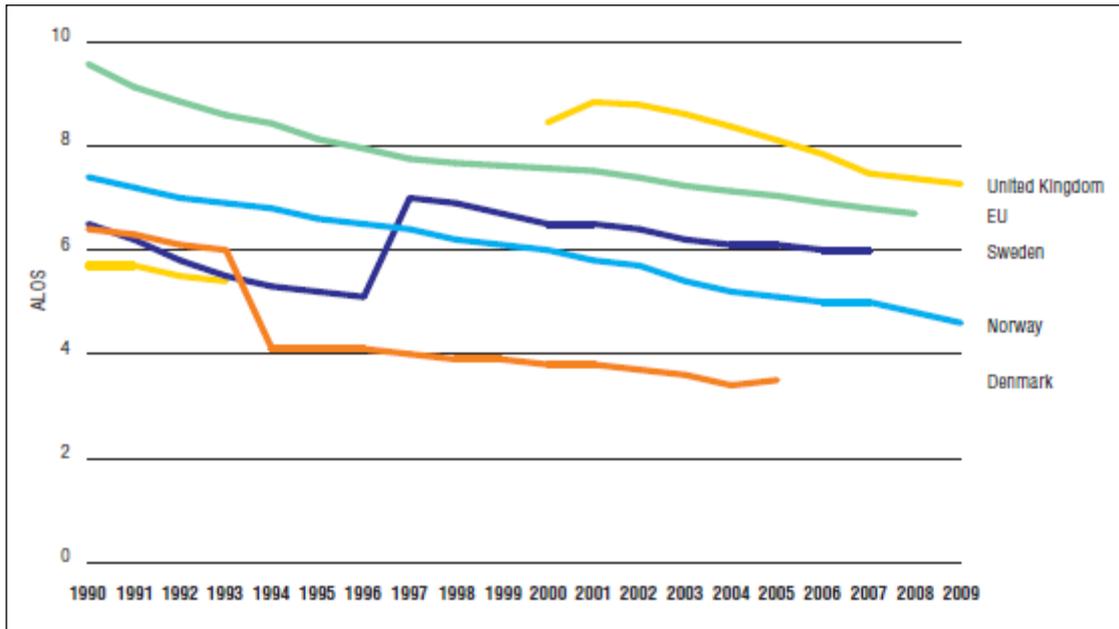
Sweden was one of the first countries to recognise the limitations of hospital delivered care and the importance of primary care and prevention care strategies, especially for older people. The economic recession in the 1990s helped the country to recognise the need for health sector reforms. In the mid-1990s, care for older people shifted from county councils to municipalities who assumed the responsibility for provision of social care services and recruiting the staff to deliver this care.

Hospital reforms in the 1990s focused on two main areas: increased specialisation and concentration of services. 24/7 emergency care services were concentrated in larger hospitals, while smaller hospitals provided more specialised services like outpatient treatment and community care services. As the focus shifted away from acute, episodic care to primary and preventative care, the average length of stay (LOS) for surgical procedures in hospitals decreased following an initial blip between 1995-97 (figure 1). However, the average LOS in Sweden is still lower compared to other European countries.

This movement of care has been a gradual process. Strategies designed to take this policy forward are:

- increasing the number of doctors in the population – currently 3.7 doctors per 1,000 population (OECD, 2011)
- a strong push from the municipalities to reduce LOS. Average LOS has reduced from 7.9 days in 1992 to 5.7 days in 2009 and the money saved has encouraged investments in community services (Anell *et al.* 2012)
- a free choice given to patients by all county councils in 2010 to access primary care services (if they preferred) in a private or public health centre. Municipalities were not afraid to use the private sector to provide community care and currently it is estimated that a tenth of health care services are provided by private organisations, most of whom are primary care providers (Swedish Institute, 2012)
- the freedom for patients, from 2003, to be able to choose where they would like to receive treatment, not restricted to their home county.

Figure 1: Average length of stay in acute hospitals between 1990-2009



Source: Anell *et al.* 2012, WHO Regional Office for Europe, 2011

A few innovative initiatives designed to boost primary care and improve co-ordination of services between health and social care sectors have been led by Norrtälje municipality and Jönköping County Council.

Jönköping County Council's Esther project: In an attempt to improve patient flow and co-ordination of hospital and social care services for seniors, a group of clinicians and leaders came together to learn from the case study of Esther, an 88 year old Swedish woman living in the community who had a long-term condition but occasionally required acute care services. By mapping Esther's care pathways across the system, these professionals were able to identify gaps and develop plans to improve patient flow, strengthen co-ordination and communication between providers and across systems (Baker *et al.* 2008; Baker and Denis, 2011).

The Esther project helped Jönköping County Council to improve its system by:

- redesigning intake and transfer processes across the continuum of care
- integrating documentation and communication across providers and commissioners
- introducing team-based phone consultations
- introducing open access scheduling (ie same day access to an appointment)
- educating patients on self-management tools and skills.

In 2006, Norrtälje municipality established an integrated health and social care model of delivering care which focused on planning, financing and organising care based on three specific groups: birth to 18 years, 19-64 years and 65 years and older. The key driver for this reform was the proposed closure of Norrtälje hospital. Following a consultation process with local stakeholders, trade unions, municipalities and Stockholm County Council, it was decided that a new organisation, TiaHundra, would be set up to deliver health and social care services and commission services for the local population jointly with the political governance board (Øvretveit

et al., 2010; Robertson, 2011). Since TiaHundra was jointly funded by Norrtälje municipality and Stockholm County Council, most of the employees, IT e-health records and co-ordinated patient pathways for stroke, home care and older people's care services were transferred to the new organisation and integrated.

During the initial set-up of the Norrtälje model, clinical staff had very little input but they were later consulted more thoroughly to determine care pathways, identify ways to improve co-ordination and focus on preventative care.

Impact and implications for nurses in Sweden

In the early 1990s, municipalities began to employ more community specialist and district nurses to support the movement of services to the community, however since 2000, community nursing numbers have fallen. By 2020, approximately two out of every three district nurses will retire (Vårdförbundet, 2012), flagging a potential mismatch between supply and demand in the community and the need for prompt action.

Nurse shortages continue to be a pressing issue, especially shortage of community specialist and district nurses. According to the National Board of Health and Welfare, nursing shortages are becoming more prevalent, especially in older people's settings (Vårdförbundet, 2012). As a consequence of staffing cuts, fewer Swedish nurses are undertaking specialist training and education as they are not confident they will have the opportunity to utilise their specialist qualification to secure an appropriate job. It is estimated that approximately 1.6 per cent of nurses working in health and social care setting for older people have completed specialist qualification training. A forecast from Statistics Sweden show a shortfall of nearly 170,000 trained professionals; a significant proportion of this shortage is seen in older people's settings (Vårdförbundet, 2012).

In 2011, the Swedish Ministry of Education and Research consulted on expanding specialist education training programmes for nurses in light of increasing patient acuity and prevalence of long-term conditions. Currently, there are eight ministry-regulated programmes. The Swedish Association of Health Professionals supports the expansion of specialist nurse training, however it is opposed to unregulated programmes set up by individual education institutions which create inconsistencies in setting a national framework (Vardforbundet, 2013).

It is unclear what role nurses have played in the reforms in Jönköping and Norrtälje as there is very limited English literature in the public domain that discusses the influence and impact of the reforms on nurses and nursing.

What is the success of these initiatives?

Evidence from Jönköping County Council initiative revealed a 20 per cent reduction in hospital admissions and a redeployment of resources to the community, reduced length of stay for patients with heart failure and reduced wait times to see specialists (Baker *et al.*, 2008). Evaluations on the

Norrtälje model, despite only two years of running, reveal an improvement in efficiency, reduction in hospital admissions and stabilised/reduced costs (Robertson, 2011; Øvretveit *et al.*, 2010).

Australia

Australia's universal health care system, known as 'Medicare', is a tax-funded public insurance system that provides free or subsidised health care services such as: general practice and hospital services, and prescription drugs covered by the Pharmaceutical Benefits Scheme. The federal government funds most health services, while the Australian states and territories have responsibility for the delivery and management of acute, community and public health services. Care for older people and care for people with disabilities are jointly funded by the federal government, states and the territories. Most GPs act as gatekeepers to specialised care; they work in private practice and are paid on a fee-for-service basis (Commonwealth Fund, 2011; Australian Government, 2012a).

National primary health care reforms

There is no formal national move to shift hospital services to the community, however, there is an incremental shift driven by national health priorities to improve general practice, primary health care, community care and home care services in Australia. At a state/territory level, there are a few locally driven initiatives to move care to the community, such as increasing the number of GP super clinics and community-based services. Utilising community resources for Australia's growing elderly population has also been an important driver. A 2014 study found that 25 per cent of government-subsidised aged care places in June 2013 were for community-based care, up from 20 per cent five years ago.³

In 2000/01, the Australian government was determined to improve general practice and so a financial incentives programme was set up to support improvements in continuity of care, health outcomes and quality of care. Administered by Medicare, *Practice Incentive Programs* (PIP) offered additional payment incentives for general practices if they registered for any of the 13 PIP incentives for which they were eligible (programmes included diabetes incentive, cervical screening incentive, asthma incentive, after hours incentive, teaching incentive and so on). One of the incentives was to increase the number of practice nurses employed in GP clinics. This initiative has increased the number of practice nurses from 5,000 to nearly 9,000 over a ten-year period (Australian Institute of Health and Welfare Nursing and Midwifery Labour Force, 2011).

In January 2012, the *Practice Nurse Incentive Program* (PNIP) was established which formalised the PIP practice nurse incentive and consolidated funding into a block funding model for general practices to support an enhanced role for practice nurses (Australian Government, 2012a).

Primary health care has a central focus in the health and hospital reforms being led by the Federal Government in Australia. In February 2011, the Government published its primary health care

³ Australian Institute for Health & Welfare, 'Shift from Residential Aged Care to Community Care is Continuing', available at: <http://www.hospitalhealth.com.au/news/aged-care/shift-residential-aged-care-community-care-continuing/> (September 2014)

strategy *Improving Primary Healthcare for All Australians* (Australian Government, 2008; Australian Commonwealth Government 2011) which outlined key improvements including:

- establishing an independent primary health care organisation called Medicare Locals with a responsibility for identifying local population health needs, improving access to services, driving information technology advancements and co-ordinating integration between general practice and primary health care
- investing \$436 million to co-ordinate care for patients living with diabetes to manage their care and treatment
- investing \$650 million to build 64 GP super clinics across the country. As of February 2011 there were already 29 GP super clinics delivering comprehensive services through inter-professional team models under one 'community' roof
- increasing access to out-of-hours services and availability of afterhours GP help lines, co-ordinated by Medicare Locals
- funding approximately 425 primary care infrastructure upgrades to general practices, primary health care and community health services, and Aboriginal Medical Services, to improve access to integrated GP and primary health care
- investing \$339 million to increase the number of GP training places.

Recognising the importance of workforce planning to meet future health needs of the community, the Australian Health Minister commissioned Health Workforce Australia to produce the *Health Workforce 2025* report in April 2012. This report highlights medium and long-term national workforce projections for doctors, nurses and midwives based on modelling estimates of the number of students entering the profession and postgraduate and specialist training required, between 2012 and 2025. Projections reveal a significant shortage of nurses by 2025 compared to doctors and midwives. To manage this shortfall, nursing stakeholders and health ministers are determined to take steps to improve retention, manage demand and boost productivity. The report stresses the importance of nurse retention strategies to reduce the gap between demand and supply projected by 2025; therefore, investments must be made to retain the existing nursing workforce (Health Workforce Australia, 2012).

Primary health care model in State of Victoria

In 2006, the Victorian state government launched a framework *Care in your Community*, which outlined a shift away from hospital-delivered care and a commitment to improve integrated community-based services. The purpose of this 10 year vision plan was to create an integrated and person/family centred health system in Victoria (second most populated state in Australia). It incorporates four 'area-based planning elements': 1) population based planning, 2) integration planning, 3) community-based service reconfiguration planning and 4) regional and state-wide planning.

Care in your Community trials were based on action plans that included the following concepts:

- six guiding principles: best place to treat, together we do better, technology to benefit people, better health care experience and better place to work

- focus on patients with long-term conditions and complex needs, episodic and urgent care, and health promotion and illness prevention
- help to sustain projects and community teams like long-term conditions management, community based treatment teams and mental health teams
- learn from existing community examples and build on this knowledge. Modernising existing facilities and building new ones based on priorities like integrated business systems, multidisciplinary team environments and flexible use of staffing resources.

In order to implement integrated area-based planning the Victorian state government sought to integrate care by addressing 'integrated care enablers' such as funding models, workforce, integrated models, information and communication technology developments, and partnerships. Each enabler was required to address population need at a local level.

Reducing hospital re-admissions

At a national and state/territory level, there are health and community care services dedicated to reduce hospital re-admissions, improve community-based care and health outcomes.

For example, the *Hospital Admission Risk Program* (HARP) was set up to reduce the number of patients being readmitted to hospital by offering more support and follow-up for these patients in the community. This is a service provided by community nurses. In another example, the Department of Veterans' Affairs set up a community veterans' care programme that enrolled nearly 17,000 veterans with the primary aim to keep this group out of hospital and offer the necessary support structures in the community. Acute hospitals also provide 'hospital in the home' (HITH) services where acute sector nurses visit patients' homes to administer intravenous (IV) medicines and other treatments. Acute sector nurses link with community or district nursing services if patients require ongoing nursing intervention at a later stage.

Another programme, *Patients First Model of Care* for older people with complex care needs was developed and has been quite successful. An evaluation of the initiative over a 20-month period has revealed a significant reduction in hospital emergency room (ED) presentation rates (20.8 per cent), acute admissions (27.9 per cent) and inpatient bed days (19.2 per cent). The project was estimated to have saved approximately \$1 million, which represented a sustainable annual saving (Canadian Health Services Research Foundation, 2011; Bird *et al.*, 2007).

In 2010, the Australian Government announced the establishment of the *National Health and Hospital Network*, one of the largest reforms in Australia since Medicare was introduced in the 1970s (Australian Government, 2011). The government has made commitments to invest in four key areas: hospitals, general practice and primary health care, older people's care, and more generally the health workforce.

Impact and implication for nurses in Australia

Historically there has been an underinvestment in the nursing workforce. This has led to poor retention and nursing shortages that are projected to worsen by 2025. As one measure to address this, the government plans to invest \$390 million to support general practice to employ registered and enrolled nurses (Australian Commonwealth Government, 2011). No clear timelines have been identified.

Standards for university-based accredited education programmes leading to registration as a nurse now have a requirement for the inclusion of curriculum content on the national health priorities, which include primary health care. This aims to give nurses the necessary broad range of knowledge, skills and competence to meet the future needs of the community. Correspondingly, universities are increasingly offering primary health care/community nursing programmes at postgraduate level to better prepare nurses in general practice or a range of non-hospital settings, to meet population health and older people's care needs. The national government has earmarked some scholarship funding for postgraduate education programmes in primary health care, in keeping with promoting the national health priorities. Furthermore, a shift in the educational preparation of Australian enrolled nurses, from an older people's care focus to a more comprehensive focus on acute, community and preventative care, has been acknowledged.

Canada

The Canadian health care system, known as 'Medicare' is a single-payer, publicly-funded, not-for-profit system where health care is financed through general taxation and health care services (hospital care and physician services). The system is universally accessible and free at the point of use. Hospitals are largely private not-for-profit organisations and receive an annual operating budget from the provinces or territories; however, this hospital funding system is currently transitioning away from global hospital funding and moving towards a 'patient-based funding' model. Most family physicians work on salary for hospitals and/or community services, or a combination of fee-for-service and salary remuneration scheme. Primary health care services are more commonly provided by inter-professional teams consisting of family physicians, nurse practitioners, registered nurses (RNs), registered nurse practitioners (RNPs) and allied health professionals, acting as gatekeepers to secondary and specialist services (Commonwealth Fund, 2012; Health Canada, 2012).

Strengthening home and community care sector

Shifting health care services to the community has been a long-standing political priority in Canada, going as far back as the 1980s. The aim was to strengthen the home and community care sector so that more general health concerns could be effectively addressed in the community, leaving hospitals to provide specialised care. Investments in the community involve an increase in the number of community clinics, community nurses, midwives and nurse practitioner roles (Canadian Nurses Association, National Expert Commission, 2012).

There is no single strategy in place to facilitate the movement of services to the community; however, there are several initiatives both at national and provincial levels that have been implemented. Key drivers include increasing public demand for home and community care

services; a lack of alignment between services delivered in the physician's office and services delivered in home and community sectors; insufficient provincial investment in the home care sector; and addressing social determinants of health in local public health units (Ontario Public Health Association, 2010).

National initiatives set up in 2007 to strengthen primary care and home and community care services have included:

- *Primary Healthcare Transition Fund (PHCTF)*: This \$800 million, five-year fund was established in 2000 to encourage collaborative care between primary care and home and community care sectors under the new umbrella of '*primary health care*'. The emphasis was on prevention, health promotion, increased co-ordination, resource building between sectors and strengthening community health. Initiatives included expanding 24-hours-a-day, 7-days-a-week access to essential services; creating primary health care teams; managing patients with long-term conditions; and improving co-ordination between primary health care providers and acute sector staff. Three national strategies under the PHCTF were set up: the National Strategy on Collaborative Care, the National PHC Awareness Strategy and the National Evaluation Strategy (Health Canada, 2007).
- Funding for home care services is not covered under the *Canada Health Act* in the same way as medical care (hospital and physician services) and this is a cause for concern as demand to provide care closer to home increases. Under the 2004 *Health Accord*, federal and provincial governments agreed publically to fund particular home care services:
 - two weeks of short-term acute home care provision for case management, intravenous medications related to discharge diagnosis, nursing and personal care
 - two weeks of short-term acute community mental health home care (case management and crisis response services)
 - end of life care (nursing care, palliative-specific medications and personal care).
- According to the Canadian 2004 Accord (Health Canada, 2006), primary health care reforms also included provisions to:
 - increase the number of community primary health care centres that provide 24/7 access by 2011
 - establish best practice networks to share information and reduce barriers
 - accelerate the implementation of electronic health records including e-prescribing
 - set up a 24-hour tele-health service to support people in the community
 - improve access for remote and rural communities.

Alongside national initiatives, the provinces/territories also set up locally driven initiatives to take this policy forward, namely:

- British Columbia (BC): Primary health care strategies have been two-fold; firstly creating an incentive payment structure for family doctors to focus on preventative and health promotion related programmes; and secondly setting up Integrated Health Networks (IHNs) to better

integrate physician practices, community services and health authority services (Cohen *et al.*, 2009).

- Ontario: In 1996, the Ontario Government developed Community Care Access Centres (CCACs) with the purpose to 'bridge between hospital and home' and offer extra support for Ontarians to receive more comprehensive care in the community (Community Care Access Centre, 2012). Today, there are 14 CCACs in Ontario employing approximately 3,500 case managers and care co-ordinators; RNs fill most of these roles. CCACs are funded by the Ministry of Health and Long-term Care (MHLTC) and the Local Health Integrated Networks. They provide discharge planning; long-term care placements and administering programmes; are responsible for client assessments; and provide community resource information and referrals. More recently, CCACs have also added programmes such as the mental health and addictions nurses in district health boards, rapid response nurse programmes and the Nurse Practitioner Integrated Palliative Care Programme to their provision of services (Registered Nurses' Association of Ontario, 2012).
- The Ontario MHLTC published its *Action Plan for Health Care* in 2012, which supports the shift of care delivery to home and community settings. Currently, community services account for only six per cent of Ontario's health budget, whilst 34.7 per cent is dedicated to hospitals and 7.7 per cent to long-term care homes (Registered Nurses' Association of Ontario, 2012).

The Registered Nurses' Association of Ontario (RNAO) developed the Enhancing Community Care for Ontarians (ECCO) model, which is a three-year plan to improve community and primary health care services in Ontario with a key emphasis to reduce duplication and fragmentation within the system. The RNAO have raised concerns about the effectiveness of CCAC structures as they absorb nearly \$2 billion of public resources each year, however the cost savings are not easily recognised due to role conflict between CCACs, primary care, home care providers, acute hospitals and long-term care providers. The RNAO's ECCO model proposes that interprofessional primary health care organisations such as Community Health Centres, Nurse Practitioner-led clinics, Aboriginal Health Care Access Centres and Family Health Teams should expand their roles and remit (over the next three years) to gradually absorb the CCAC function within their services (and reduce duplication of services where present), doing away with CCACs entirely (Registered Nurses' Association of Ontario, 2012).

Impact and implications for nurses in Canada

Despite national and provincial initiatives to enhance primary health care and home care programmes, there has been very little dialogue on how the community nursing workforce will be strengthened to address the changing population need, social determinants of health and movement of services out of hospitals.

A few provinces like Alberta, British Columbia and others have made commitments to increase the number of nurse practitioners (NPs) in the community. The Canadian Nurses Association (CNA) launched a campaign to educate the general public on the effectiveness of NPs in improving access and delivering patient-centred care under the slogan “*Nurse Practitioners: It’s About Time!*”

In 2011, the CNA also established the *National Expert Commission*, which consulted with health stakeholders and the general public to report on the future of health and nursing care in Canada. Their final report, ***A Nursing Call to Action: The health of our nation, the future of our health system*** identified the need for ‘better health, better care and better value’ to address the current challenges facing the Canadian health care system. The Commission has outlined a 9-point-action-plan where nurses will be instrumental in leading ‘transformative care and real innovation’ in order to improve health care over the next decade. Some of the recommendations (Canadian Nurses’ Association, National Expert Commission, 2012) pertinent to community and primary health care include:

- **putting individuals, families and communities first** - nurses are able to effectively identify and address individual and community needs. As navigators, care coordinators and specialists working across health and social care settings, nurses are instrumental in delivering patient-centred and continuous care
- **implementing primary health care for all** - bringing together clinicians, policy makers and providers to transform primary health care services by 2017
- **invest strategically to improve the factors that determine health** - a special emphasis has been placed on the impact of the determinants of health on the lives of Canadians. Investing in strategies at local and national level to improve access and provide safe, effective and efficient care is key
- **prepare the providers** - updating nursing curriculum and programmes to instil advocacy and leadership skills at each level. The CNA will play a key role in developing nurse leadership programmes that are fit for purpose.

Nurses are delivering integrated care, especially in speciality areas like palliative care, end of life care and through nurse-led clinics. Some Canadian provinces have established a geriatric emergency management nurse initiative, where geriatric nurses are placed in emergency departments to navigate and coordinate care pathways during hospital stay and then linking these patients with appropriate community and home care support services.

Furthermore, there are a number of programmes at post-university/college level to train nurses to work in primary health care settings, creating an increased interest in primary health care nursing.

What are the successes of these initiatives?

Overall, there are a few successful, locally driven initiatives to move services to the community and invest in primary health care, home and community services; however, there are very few published evaluative studies measuring the cost-effectiveness and overall success of these initiatives.

Analysis and implications of this shift

Shifting care out of hospitals and into the community has increasingly become an international priority, driven at national or regional levels with the aim to reduce average hospital LOS, increase patient choice and satisfaction, improve health outcomes, reduce unscheduled health care use, embrace prevention and health promotion models, deliver care closer to people's homes and save money. Each country is starting out at a different point in the reform process with diverging national priorities, and as such, the success of this shift is difficult to evaluate.

Some countries are further along in the process than others - for example Australia, Norway and Sweden. In a few countries, plans to shift care out of hospitals can be part of a wider health reform agenda – for example to restructure hospitals, enhance primary and community health care, reduce hospital readmission rates and reduce financial deficits.

Most proposals to transfer care out of hospitals have looked to re-provide these services in:

- primary health care
- home and community care
- long-term care facilities.

Countries like Australia, Canada, Sweden, Denmark and Norway have undertaken significant reforms and restructuring to strengthen their primary and community health care sectors.

I. How have countries shifted care to the community?

Of the countries discussed in this report, most have proposed and/or implemented a number of strategies to help move services to the community, illustrating that there isn't a 'one-size fits all' solution to facilitate this move and recognising that there are no quick fixes. The policy underpinning this shift will undoubtedly have an impact more widely across the health and social care sectors and more specifically within various settings like home care, long-term care, community care and primary health care. Moreover, a whole systems approach is needed to address key issues like restructuring and reinvesting in the health care system and the nursing workforce.

A few parallels can be found in the way countries have chosen to invest in the community and reduced their reliance on hospital services. These include:

- **integrating care and encouraging more joined-up collaboration between sectors and systems:** many countries are focusing on some form of integration – health and social care and/or acute and community care – as an approach to deliver care closer to home, improve patient outcomes, improve dialogue between sectors and key players (commissioners, providers, the government and frontline health professionals) and encourage better co-ordination of patient care pathways. For example, the co-ordination reforms in Norway have encouraged more joined-up collaboration between health authorities and municipalities to facilitate smooth transfer of patients from acute hospitals to the community or long-term care

facilities. Steps were also taken to increase the role of local authority, placing more emphasis on them to develop preventative, early intervention and long-term conditions management services; encouraging proactive rather than reactive care. Success of this reform is too early to evaluate. Local government in Sweden (*Norrtälje* and Jönköping County Councils) and Denmark (*Skævinge*) have also led on innovative reforms to integrate care sectors and reduce health disparities

- **investing in initiatives to reduce hospital readmissions:** there is a big push at national and local level to reduce hospital readmission rates and average hospital LOS. Investing in inter-professional teams, intermediary health services, nurse-led clinics and primary health care services have made it possible to redirect care away from hospitals and provide alternative access points to care services in community settings. There are a few initiatives like the hospital admission risk programme (HARP) in Australia; placing geriatric nurses in emergency departments and ‘hospital at home’ models to reduce patient reliance on hospitals as their first point of access and avoid unnecessary admissions. Incentives are being woven into payment models to encourage primary care practitioners to take an active role in health promotion and disease prevention – for example the *Medicare Practice Incentive Program* in Australia and the *Primary Healthcare Transition Fund* in Canada. Financial incentives and hospital performance targets are also designed to reduce LOS. However, a negative consequence of financial incentives and process-driven targets is the unacceptable rise in the number of patients being discharged early from hospital who are recovering but require very intensive and often specialised community nursing care. This has placed added pressure on community services and particularly nurses who are required to care for patients with more complex and long-term care needs in home, long-term care facilities and community settings.
- **strengthening the workforce:** transferring care out of hospitals can place a lot of strain on the health system, especially during the transition phase when services deleted from one sector have not been re-provided elsewhere. A strong, knowledgeable, compassionate and skilled workforce is needed to take health reforms forward and deliver safe, quality care. There is a lot of rhetoric at national level to invest in the nursing workforce; however, the reality on the ground is very different in most countries. There is an underinvestment in nursing, especially specialist community practitioner (district nurse), nurse practitioner (working especially in GP practices and nurse-led clinics) and specialist nursing roles (focusing on disease specific areas). Under investments in district nursing has led to a shortfall in leadership roles within community nursing teams; this needs to be addressed urgently. Very few countries have earmarked resources for training and development. NNAs report that task shifting nursing roles to unqualified workers has become increasingly common. Furthermore, most countries have not undertaken any strategic workforce planning to determine if they have the right staffing numbers and right skill mix to address local health and social care need in the community. In England, the Centre for Workforce Intelligence (CfWI) is undertaking some work on workforce planning for community nursing teams

- **supporting local initiatives and innovation:** it is important not to reinvent the wheel but to learn from existing community examples and build on this knowledge. There are many nurse-led and community-based services that already exist and are reported to be cost-effective. Community services are not necessarily cheaper than hospital care in the short-term as it costs money to properly staff health services with a strong nursing skill mix ratio and up to date diagnostic equipment and information technology. However, the medium to long-term health benefits and monetary savings of community-based services are well acknowledged. Modernising ways of working to reduce waste and building modern facilities on models like integrated business systems, multidisciplinary team environments and flexible use of staffing resources are increasingly seen as a way forward
- **reducing unnecessary bureaucracy:** reducing unnecessary structural layers and bureaucracy has helped local providers to bring together hospital, primary care and social care sectors to encourage joined-up thinking. Where local providers and stakeholders have been empowered to take ownership and responsibility for implementing reforms, there is greater success of integration between sectors – for example *Norrtälje* and Jönköping county councils in Sweden. It is also important to engage clinicians in improvement work. Where there is a lack of transparency, poor governance and poor accountability structures, it has been difficult for local stakeholders to reach a consensus and implement reforms.

II. What has been the impact on nursing and nurses?

Lack of investment in the community nursing workforce has been a key concern emerging from the RCN's county-specific discussions and analysis. Among the countries discussed in this report, few have made investments in primary health care and community nursing and nurse practitioner roles, but more generally nurses are not receiving the investment they need to properly address rising patient acuity and care quality concerns in the community. Few countries have invested in nursing education and training programmes for post-registration specialist practice education, however this is not adequate for long-term sustainability of the community workforce.

Specialist versus 'generalist' nursing

As patient acuity and long-term and complex-care needs continue to rise, there is a significant debate in the UK to determine if a generalist nurse training model should be embraced in the community instead of a specialist nursing model. To address this question, there is first a need to clarify what we mean by the terms 'generalist' and 'specialist' nursing practice. Generalist nurses are registered nurses who have completed a pre-registration nursing qualification programme and practice in a wide range of health care settings. Generalist practice encompasses a comprehensive spectrum of activities, reflecting a broad range of knowledge and skills directed towards a diverse population with varying health needs (RCN, 2003). There are two types of specialist nurses: 1) specialist by environment of care (ie district nurses with the specialist practice qualification); 2) specialist by disease/condition (ie specialist diabetes nurses, etc.) who may work in the community or between hospital and community settings.

Nursing advisers in Canada and Australia feel that all nurses are already trained at a general level and by definition are 'generalist' nurses before they undertake further training and qualifications to practice as a specialist nurse or nurse practitioner in a particular speciality or environment of care. Pre-registration nursing education and training differs internationally. For example, in Canada, nursing students on a degree-level education programme pathway will undertake clinical placements across a variety of settings and sectors over the course of a four year programme. Upon completion, Canadian nursing students will graduate with a general nursing qualification and subsequently take the Canadian Registered Nurse Examination to practice as a general registered nurse in any of the Canadian provinces or territories, following registration with the appropriate nursing regulator in that province/territory (Canadian Nurses Association, 2012a).

In both countries there are no firm plans to increase the number of generalist nurses in the community as a substitute for specialist nurses. General and specialist nurses are equally vital components of the community workforce and have individual, specific roles to fulfil. It is more important to ensure that specialist and general nurses perform to the full scope of their practice and qualification as often this is a most widely reported barrier in the workplace (Canadian Nurses Association, National Expert Commission, 2012; Australian Nursing Federation, 2009).

Nurse-led services

Internationally, NNAs are continually lobbying and influencing governments to invest in nurse-led services, primary health care nurses, nurse practitioners, specialist nurses and nurse prescribers. Nurses play a pivotal role in integrated care as they often work at the interface, bridging the gaps between health and social care systems, and hospital, long-term care and community services. A few government organisations are beginning to acknowledge the cost-savings and continuity of care that nurse-led services can deliver, however the extent of investment in the nursing profession and nurse leadership roles is yet unknown. This is partly due to the lack of robust evidence to demonstrate the monetary value of nurse-led services.

III. Which countries have successfully shifted care out of hospitals?

It is difficult to pinpoint a particular country that has successfully moved services out of hospitals and into the community. Most countries have used a number of strategies to facilitate this shift, for instance:

- investing in primary care services
- providing incentive packages for clinicians to focus on prevention and promotion
- setting up hospital admission risk programmes and hospital at home initiatives to reduce readmission rates
- linking hospital providers with local authorities using national reforms
- focusing on integrated care
- setting up nurse-led clinics
- increasing nurse practitioner roles
- investing in inter-professional community teams
- enhancing services for older people and patients with long-term conditions.

Some countries have a few strategies running simultaneously to re-provide appropriate and selective hospital care in the community.

A few countries are addressing the need to move care closer to home. Significant resources must be invested to determine what this shift would mean for:

- hospital delivered care (ie more specialised hospitals, hospital at home services or HARP programmes);
- primary care (ie enhancing general practice, strengthening the primary health care workforce, creating incentive structures for general practice and encouraging more dialogue between sectors)
- home and community care (establishing a fair funding system for home care services, investing in the workforce)
- long-term care and social care (increasing collaboration between local authorities and the health sector, tackling funding issues and efficiently regulating systems and professionals).

A few successful integrated care models have demonstrated money savings and improvement in health and social care outcomes, namely the *Norrtälje* and Jönköping examples in Sweden and the Skævinge example in Denmark. Canada and Australia have also established several initiatives with some successful outcomes, however it is unclear if these initiatives have on their own or in partnership with others enabled countries to facilitate this movement of care to the community.

Recommendations

The RCN organised a breakfast seminar and roundtable discussion in November 2012 to present the findings of this report to a diverse group of health and nursing policy experts under the Chatham House Rules. The themes that emerged from the roundtable discussion were used to inform our recommendations.

A whole-system approach

- To effectively shift care out of hospitals and re-provide these services in the community, a whole-system approach is needed.
- Hospital restructuring cannot happen in isolation but must go hand-in-hand with reinvestment strategies otherwise there is a possibility of creating a transition gap in service provision. In the UK, we are already seeing a gap in service provision as patients discharged from hospitals continue to require intense care and support in the community, yet there is little evidence to show an investment in community services or workforce.
- It is also important to note that not all services can be moved to the community. An open dialogue between government officials, commissioners, service providers and frontline staff is needed to ensure that services re-provided in primary care and in the community are executed efficiently and do not jeopardise patient care.
- Historically, commissioners and providers have ignored the financial and system-wide implications the cuts in the acute sector have had on community-based services. However, the

current NHS reforms offer an opportunity to influence and lobby for more joined-up care and to develop firm strategies that clearly outline a community re-provision strategy.

Towards service integration

- There is much international debate and a focus on integration as a means to promote continuity and seamless patient care, reduce fragmentation and improve outcomes. Until recently, the focus has been on vertical integration of care, linking primary, secondary and tertiary care. However, increasingly health systems are placing more emphasis on prioritising horizontal integration. This involves linking multi-disciplinary teams through incentives and moving away from a model where GPs act as sole gatekeepers to a model where inter-professional teams act as gatekeepers to specialist services and integration between sectors (health and social care).
- Evidence of integration between health and social care services are prevalent in the UK on an ad hoc basis and are mostly locally led or on a national scale (for example, Northern Ireland has an integrated health and social care system). At a more local level, Torbay Care Trust in England is recognised as an integration pioneer. Positive examples that illustrate where community service providers are working jointly with local hospitals to improve the quality of care and overall service delivery should be shared more widely.
- Nurses play an important role in supporting and promoting better integration. Where integrated care models have been successful, there is evidence to show that close collaboration between local authorities, commissioners, service providers and frontline staff have been instrumental in that success.
- Recognising and addressing integrated care barriers and enablers are an important step towards reaching a consensus and nurses are ideally placed to recognise these barriers and enablers from a practice perspective.

Prioritise the nursing workforce

- Investments must be made to strengthen the community nursing workforce if we are to meet the rising challenges and demand of an ageing population with more complex and multiple health and social care needs. The community nursing workforce is already under tremendous pressure due to workplace shortages, down banding of nursing roles and an ageing community nursing workforce set to retire over the next decade. This is worrying as there is strong evidence in acute settings demonstrating the link between low levels of suitably qualified staff, deterioration in patient health outcomes and low staff satisfaction. Furthermore, there are not enough newly-qualified community nurses to replace the experienced nurses we are losing through retirement.
- Significant investment in resources is needed both at a national and local level to ensure the community nursing workforce is supported to deliver nursing care of the highest quality and standard and is sustainable. Furthermore, priority should also be given to assess financial incentives in the community that focus on prevention and rewarding integrated/multi-disciplinary team working rather than acute care only.
- Health care support workers (HCSWs) and nursing assistant roles are present in many countries and similar to the UK, there are concerns that unregulated nursing staff are more

commonly replacing qualified nurses in health and social care sectors, despite reduced training qualifications. In the UK, HCSWs are carrying out complex nursing tasks in the community that were previously only undertaken by a qualified nurse. This is concerning as HCSWs are not regulated. The RCN has been calling for a mandatory, statutory system of regulation for HCSWs to ensure accountability and provide assurance to nurses and patients that any HCSW has a core level of knowledge and skills, underpinned by a clear and consistent regulatory structure.

- Priority must be placed on enabling and supporting nurses through education, training and developing leadership skills to ensure the right nurses with the right skills are leading the way.

Balancing national uniformity with regional plurality

- There is a fine line between excessive regulation and bureaucracy that can stifle innovation and too little regulation that can lead to fragmentation. A balance must be struck allowing local providers to engage in national improvement strategies from the onset but also encourage locally driven and population specific solutions. International case studies have shown that where this balance has been achieved, health outcomes have improved.

The RCN's view

The RCN supports care being delivered closer to home where it is clinically appropriate and safe to do so. To effectively shift care into the community, hospital restructuring reforms should be implemented in parallel with community reinvestment programmes, and both sectors should collaborate with each other to address gaps in service provision as they emerge.

The RCN strongly believes that providers and commissioners of health care services must undertake robust workforce planning to reduce the likelihood of a diluted nursing workforce and inappropriate skill mix. The RCN has continually called for mandatory nurse to patient ratios and regulation of HCSWs, as there are sufficient reports into care failings that highlight the risks associated with poor workforce planning. The RCN views optimal staffing ratios and regulation of HCSWs as a prerequisite to safeguard the quality of patient care (RCN, 2012b c).

Nurses play a pivotal role in the delivery of clinically appropriate and safe care across the health and social care continuum. To build a sustainable community workforce, investments must be made to support, train and develop nurses to work in community, primary care and long-term care settings. The essential career pathway of community specialist practice (district nursing) must be reinstated and promoted to encourage knowledgeable and qualified specialist nurses to develop in leadership roles. New entrants into the nursing profession should also be exposed to community and primary care nursing as a career option equal to acute nursing practice.

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Appendix 1

Nursing and Midwifery labour force 2009

Work setting of main job	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Australia
Hospital	41,356	38,560	27,961	13,917	15,186	3,798	2,126	2,309	145,213
Psychiatric hospital/mental health facility	2,814	2,287	1,654	719	869	249	93	128	8,812
Outpatient clinic	917	510	577	241	371	n.p.	46	n.p.	2,853
Day procedure centre	773	830	718	214	279	76	13	58	2,961
Residential aged care centre	5,931	4,244	3,193	1,909	1,076	642	61	129	17,186
Hospice	119	162	65	71	116	n.p.	n.p.	n.p.	580
Other residential care facility	1,014	626	246	220	170	51	23	44	2,394
Community health centre	4,257	3,071	2,590	1,427	1,242	521	565	298	13,971
Defence force facility	180	89	114	19	7	n.p.	78	n.p.	540
Government Department	326	573	181	254	202	n.p.	109	n.p.	1,860
Doctors rooms/Medical practice	2,205	2,121	2,242	869	923	268	85	174	8,889
School	349	424	353	46	228	7	31	16	1,454
Commercial/industry/business	380	473	484	160	251	77	n.p.	n.p.	1,896
Tertiary institution	655	829	598	360	352	90	n.p.	n.p.	3,022
Other	244	2,264	1,637	878	207	213	293	144	5,879
Not stated	4,591	879	724	238	927	40	54	78	7,530
Total	66,110	57,940	43,337	21,540	22,407	6,233	3,707	3,766	225,040

(a) State and territory estimates for 2009 should be treated with caution due to low response rates in some jurisdictions. See *Explanatory notes* for further information.

Legend	
Blue	nurses working in acute, day surgery and tertiary institution settings
Green	nurses working in community, aged care centres, hospice, schools, general practice settings
Purple	nurses working in other settings (i.e. Defence force facility, government, commercial business and other)
Orange	nurses working in aged care settings

Source: Australian Institute for Health and Welfare, 2011

Appendix 2

Regulated Nurses: Canadian Trends, 2006 to 2010

	Hospital	Community	Long-term care facilities	Other
Registered nurses (RN)	61%	13%	9%	16%
Licence practice nurses (LPN)	43%	9%	36%	12%
Registered psychiatric nurses (RPN)	45%	25%	18%	13%
Total nursing workforce by sectors	56%	13%	16%	13%

Source: Canadian Institute for Health Information, 2012