LAUREA

Helena Erjanti & Koichi Ogasawara (Eds.)

REFURBISHING ELDERLY CARE
The New Streams and Organisational Transformation in Finland and Japan

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Content

To The Reader

Tohoku Fukushi University, Tohoku Fukushi Corporation, Helsinki School of Economics, Laurea University of Applied Sciences and the cities of Espoo and Vantaa have since 2006 implemented a research and development project that targets the development of services for the elderly on the basis of a mutual cooperation agreement. One of the project's work methods includes international seminars; the third seminar was held in November 2007 in Japan and the fourth in September 2008 in Finland. A number of other Finnish higher education institutions have joined the cooperation between Japan and Finland by means of individual cooperation agreements with Tohoku Fukushi University. The aim has been to foster new types of treatment to activate the elderly and to develop operating models for improving the quality of treatment and care through international cooperation.

Editors of the joint publication for the seminars include Professor Koichi Ogasawara Tohoku from Fukushi University and Regional Principal, Doctor of Health Sciences Helena Erjanti from Laurea University of Applied Sciences. On behalf of coordinator of the project, Laurea University of Applied Sciences, I would like to extend my sincere gratitude to the editors and writers for transforming the seminar results into the form of a publication.

Pentti Rauhala
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Forewords

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The articles for this book are based on papers presented at the third Sendai-Finland Seminar (in November 2007 in Sendai, Japan) and the fourth Finland-Sendai Seminar (in September 2008 in Vantaa and Helsinki, Finland). The seminars are the annual events for the Active Project entitled "Refurbishing Elderly Care", which is the joint R&D project agreed by Laurea University of Applied Sciences, Helsinki School of Economics, the City of Vantaa and the City of Espoo in Finland and Tohoku Fukushi University and Tohoku Fukushi Corperation from Sendai, Japan.

The targets of the project are, first of all, to share an understanding, which is elaborated from fact based research, of the tasks our public policy and social strategy choices must face in the area of elderly care if they are to decrease social costs and improve efficiency in the provision of health care services. Secondly, we aim to create innovations in health and social services that are motivated by a desire to provide a greater quality of life by integrating expertise from a variety of professions and fields. Thirdly, we seek to improve the model of service provision system and have used the value creating nets theory to do so.

The first Sendai-Finland Seminar was held in Japan in March 2006. The second seminar was held in Finland in September of the same year. In the seminars, experts from the Tohoku Fukushi University, the Helsinki School of Economics, Laurea University of Applied Sciences, and professionals from the health and social care sector in Japan and Finland introduced potential new solutions for

fulfilling the health care service needs for a rapidly ageing population in both countries.

The outcome of the first Seminar has already been published, in a special version of the annual report of Kansei Fukushi Research Center at Tohoku Fukushi University, in August 2006, under the title; Refurbishing Elderly Care - Evidence and Theoretical Targets. Papers for the second Seminar have also been edited into Refurbishing Elderly Care – The Strategy of Cost Efficiency in Theory and Practice, Helena Erjanti ed, Laurea Publications, 2007. The third Sendai-Finland Seminar (SFSIII) was held in November 2007 at Tohoku Fukushi University, Sendai, under the title "Refurbishing Elderly Care - New Health and Social Services Networks". Twenty three papers were presented in two days of sessions. The fourth Finland-Sendai Seminar (FSSIV), entitled "Bed Is Nobody's Home – Services for the Elderly in the Change, was held in September 2008 as a Sendai Knowledge Cluster Initiative – A Global Linkage Program affiliated event, with 22 presentations.

Most of the services for the elderly in Finland are produced as service production by the public sector. The purchasing of care, nursing, rehabilitation, and corresponding services from outside the public sector is currently significant in Finland, and it will most likely continue to increase in the future. If the operations models made by the public and private sectors for maintaining health and preventing health problems continue to be developed, a better quality of life can be produced for the elderly at a lower cost. The central means for developing the operations models have, with the joint research and development programme, been proven to be network competence and the utilising of welfare technology. The need to develop operations models in order to maintain health and prevent health problems in the elderly can be considered to be equal and parallel in Finland and Japan.

On the other hand, the Japanese long-term care system is now just in the middle of a period of self adjustment to a more community comprehensive care system rather than the quasi-market model it used to be. Together with community critical path system, introduced by medical legislative reform in 2006, the long-term care system is now being integrated with other related services in order to target a more comprehensive and continuous approach to individuals who are in need. Networking as a tool to the solution of creating values and merits is a currently a hot topic for social innovation in this field, and the Finnish model of value creating nets will hopefully provide their Japanese counterparts a useful point of reference.

This publication contains 22 articles based on the presentations given at SFSIII and FSSIV. The themes have been discussed from the point of view of both Japan and Finland. Comparative knowledge has contributed to the development of services in both countries and to guaranteeing a good quality of life for the elderly. The publication consists of presentations that explain the service structure for the elderly, the improvement of quality in the lives of the elderly, redefining the concepts of elderly care, innovations in service and organisation, and their analysis and research. Also, the first results of the ACTIVE research and development programme, aiming at the development of the services for the elderly, based on the above mentioned cooperation agreement are discussed in this publication. This publication is part of the publication series of the Laurea University of Applied Sciences.

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Part 1

Quality of Life and New Interpretation of Rehabilitation

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In the next few decades the number of elderly people will rapidly increase. We will have over one million elderly people in Finland in 2020 according to recent statistics (Kettunen 2003). This means that the need for elderly services will increase and because the number of care givers appears to be on the decrease, real challenges lie ahead. It also means an increase in costs in the health and social sector. The innovative application of technology is needed in order to be able to provide elderly people with high quality services in the future.

CaringTV - service design with and for elderly people

CaringTV is one of the promising innovations discovered and developed as a service design with and for elderly people by Laurea University of Applied Sciences, TDC Song and Videra Oy and Espoo City. CaringTV is a concept where Laurea operates as the researcher, developer and content provider. The concept includes two research and development projects, Coping at Home and HOME, funded by TEKES/ Finn Well programme and EU/ InnoElli Senior pro-

gramme which aim to find new solutions for elderly people living at home and for municipalities dealing with current problems in health and social services.

In the Coping at Home project our pilot group consists of 25 family care givers living in Espoo, whereas in the HOME project there are 60 high risk clients from Vantaa City and 40 elderly people using services delivered by special service houses in Espoo, Turku and Lappeenranta. The interest is in discovering new, technology based solutions which support elderly people in staying at home and improving their quality of life by allowing them to have more control of their own lives.

CaringTV is a two channel interactive TV system through which guidance and support services are given as various participative programmes to improve and promote the capacities of elderly people living at home. The content of guidance and support services and participative programmes are planned together with clients according to their own expectations and with the supervision of experts. In planning these services an elderly person is considered both as an active partner and as a holistic being (e.g. Rauhala 1995) with his or her own knowledge base, skills and abilities, values and experiences (e.g. Raij 2003). We call this a client - driven model. In the first phase, a municipality buys the TV channel for selected elderly people. In the second phase, it will be offered to the private sector. This will mean that everyone living at home can buy a product which includes both the technology and the content production (see Piirainen and Raij 2006). Laurea is responsible for the research and development of CaringTV concept and participative content production, while TDC Song and Videra LtD, two of the private companies involved, provide the technology and the participating municipalities (e.g. Espoo and Vantaa) provide the guidance and support services. There are also other private companies: Medixine LtD is the developer of the tools for advanced e-services, and PhysioSporttis LtD and Lääkärikeskusyhtymä LtD are the developers of physiotherapeutic and medical services. The third sector, in turn, provides experts when needed. The development of CaringTV opens new doors and gives us valuable knowledge on how to proceed towards the development of a virtual clinic. CaringTV also offers a learning environment for students where they can achieve new competences by working together with educators, working life experts and clients, according to the Learning by Developing action model developed at Laurea (e.g. Raij 2007).

The CaringTV concept consists of improving security, safety and action competences increasing possibilities for participation in social interaction, and promoting the well-being of care receivers and family care givers. Elderly people seem to be very interested in knowing more about their illnesses and they favor pro-

grammes where they can consultant physicians and other experts. They like to participate in morning gyms, they wish to have cooking advice designed especially for them, and they like to look back on their lives and share their experiences. The concept seems to be successful in improving the well-being of elderly people living independently at home.

CaringTV has also given us valuable knowledge of how to introduce new technological innovation to an end user by proceeding from a user centric to a user-driven action model. In this process, defining the concept of the environment as a physical, symbolic and social environment (Kim 1983) has helped. The development of CaringTV seems to open new doors by inviting new groups of people to participate and it also opens doors for new business. It means integrating welfare expertise, technology, business and research and development expertise.

Action research leading to the client driven methods of the service design

Action research is based on interventions. It can be seen as a practical, participative, reflective and social process. It is meant to study social reality in order to change it and to change reality to be studied again. In action research, as a process, there are different cycles following each other and in each of them four phases can be identified as observing, reflecting, planning and implementing. The whole study usually consists of three implementing cycles. (e.g. Heikkinen, Kontinen and Häkkinen 2006.)

In action research, the interest of knowledge will be defined by the target of the research. By applying Habermas (1973), Heikkinen et al. (2006) present that efficiency and effectiveness is guided by a technical interest of knowledge. Whereas the interpretation of social action is related to practice, a hermeneutic interest in knowledge and influencing a world is linked to an emancipatory interest in knowledge. According to them, action research can serve all of the three interests of knowledge. In the development of the CaringTV concept, all of them can be seen to be included. It serves the technical interest of knowledge in the development of technology needed in delivering new, virtual services, which aim to add efficiency and new kinds of technically effective solutions. Practical, hermeneutic and emancipatory interests of knowledge are present in the content development of virtual CaringTV services. Interpretation of the social actions of participative clients is essential when developing new services together with cli-

ents and influencing the development of new action models is one purpose of the studies of Coping at Home and Home.

In the CaringTV research projects the purpose is to enhance the quality of life of elderly people living at home. They also aim to find new solutions for municipalities who have to face the future challenges in health care and social services. In his book about the quality of life, Rapley (2003, 212-224) concludes that the concept of quality of life as a formally operationalized and measurable construct is very problematic and, rather, offers a sensitizing concept of thinking through the delivery of services or ways of enhancing the livability of human communities. As a sensitizing concept, subjective well-being and life satisfaction, which are subjective and objective descriptors identified in many studies (see e.g. Rapley 2003, 215) could have a special meaning if they are defined by clients who need human services and experts responsible for the delivery of services. All this led, in our projects, to the design and development of new services for elderly people, a process which included them, and home care professionals as a focus group. The development process is based on clients' expectations; their view on how services should be improved and what kind of services should be developed and how clients could be involved. Elderly people, as clients, with their own home environments, are seen to form a living lab where service design and development can take place in a client - driven way. Because of this, action research was chosen as a research method. It means that elderly people and focus groups, which consist of experts, have been interviewed three times from autumn 2005 to autumn 2007, in the beginning, in the middle of the process and at the end. All the three cycles have consisted of the phases of observing, reflecting, planning and implementing as mentioned above.

Quality of life in elderly based on earlier research

Defining the concept of quality of life seems to be difficult and offers many critical challenges for researchers (e.g. Rapley 2003, Walker 2005). It has been defined by many researchers and groups of experts. In the definition given by the WHO Quality of Life Group (1998) quality of life is defined "as individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns". It is emphasized that "quality of life cannot simply be equated with the terms health status, life satisfaction, mental state or well-being". Close to the WHO definition is the description presented by Felce and Perry (1993) where

quality of life is defined " as an overall general well-being which comprises ob-
jective descriptors and the subjective evaluations of physical, material, social
and emotional well-being together with the extent of personal development and
purposeful activity all weighted by a personal set of values". In these definitions,
there is a multidimensional concept related to an individual's perceived quality of
life, which includes their own evaluations, but as Rapley (2003, 50) points out, it
is unclear how an individual's perception of their position in life or a subjective
evaluation is understood in relation to an individuals' mental state.

As Walker (2005, 7) points out, there is a tradition of gerontological research
looking at successful ageing (e.g. Baltes 1993, Hooyman and Kiyak 1999, Jylhä
2000 and Marin 2000), positive ageing (e.g. Johnson 1995) and healthy ageing
(e.g. Rowe and Kahn 1997) with regard to quality of life. According to these de-
scriptions, quality of life consists of indicators like functional capacity, health
status, psychological wellbeing, social support, morale, dependence, coping and
adjustment (Walker 2005). Hooyman et al. (1999, 172) describe a model of suc-
cessful ageing as active participation in society, which also includes avoiding ill-
ness and weakening action competences as well as maintaining cognitional and
physical capabilities. In the Ageing Well project (see Walker 2005, 8) the effects
of the five key components of quality of life have been estimated to the outcome
variable ageing well. Physical health and functioning, mental efficacy, life activ-
ity, material security and social support as separate domains are validated;
however, this was derived from previous scientific researches without taking
subjective opinions into account. Walker's criticism, in general, concerns the use
of experts when describing ageing without referring to the ways in which elderly
people define their own quality of life or the value they place on the indicators
given by experts.

In four of the five European countries, in which we have compared our concepts
of the quality of life, the substantial experiences in measuring quality of life in old
age are included. The main results show that there is a similar agreement in all
the countries that health is the major determinant of quality of life. Good health
seems to be one of the most important life goals according to the elderly people
informants in the studies. This is in line with the value of quality of health and
social services as a part of quality of life. Key themes seem to be accessibility
and suitability of care services. Housing is also an important aspect, and across
the EU there is a clear trend towards living alone in old age. The major area of
dissatisfaction concerns personal safety and being alone on a street at night.
According to ETAN (1998), information and communication technology seems to
have the potential to improve the quality of life of older people but it also seems

that elderly people form a disadvantaged group in the information society, and that they are not involved in product design. Also among the elderly, income is an essential contributor to well-being and quality of life. Wilkinson (1999) has shown the negative impact of low incomes on mortality, morbidity and social participation.

In all countries, elderly people see personal relationships as important for well-being and intergenerational family solidarity is a critical determinant of quality of life. It seems, however, that in northern countries the family is still central in the lives of elderly people but friends play a more and more important role in providing assistance and support. Activity is highly correlated with health and is essential for quality of life. Participation seems to decline with age, although there are also, statistically, high levels of participation in a small minority group of active elderly people. According to extensive research in the Netherlands, loneliness means an absence in a person's social relations, a feeling of being alone and it is experienced as unpleasant and depressing. Referring to the findings presented by Fernandez-Ballesteros, Zamarron and Ruiz (2001) life satisfaction has been described as the subjective expression of quality of life. In their analysis, educational level and monthly income are the antecedents of all factors and they have a direct effect on life satisfaction and indirect effects on psychosocial factors like activity, physical illness and perceived health. In this group, activity had the strongest impact on life satisfaction. Different points of view were expressed when we compared the concepts of life satisfaction and well-being in the five European countries (Walker 2005, 10-25.)

According to the definitions and findings mentioned above, the determinants of quality of life are related to: 1) good health, 2 activity, 3) social support and 4) housing. Physical and mental health includes mental efficacy, accessibility and the suitability of care services and the quality of health. Activity, in turn, includes functioning and social support, includes the quality of social services, participation and personal relationships. Housing covers safety, material security, ICT-technology for the elderly and income.

According to Rapley (2003, 215), the problem of defining the quality of life is dependent on the problem of method. This difficulty, in turn, is related to the way of theorizing a person. Rapley indicates that the theories of the person are almost always implicit and the endeavor to measure the amount of quality of life does not necessarily equate to the stated theory of the person. That is why, in the Caring TV- concept, the theory of the person, based on the research findings by Rauhala (1995) and Raij (2003), has been selected as basis for research and development work. This is considered the most humanistic approach. In this pro-

ject, it has been considered essential that the client is equal and participative in the project. It means that his or her own knowledge, skills and abilities, values and experiences have been taken into account when developing virtual services. After having analyzed the material collected in our interviews, we have constructed the description of quality of life based on the elderly people's (25 family care givers and 60 home care clients and 40 service house clients) own conceptions, expectations and competences. The found indicators of quality of life will be presented in the conclusion.

New interpretation of rehabilitation

The concept of rehabilitation includes divergent meanings. The main purpose is to promote well being by action competence. We talk about failing, impressiveness or system. Rehabilitation happens to an individual, a community or at a society level. (Valkonen 2002) At the individual level, rehabilitation means that something is missing from the original whole we had. This limits the functional capacity, so that we no longer function as the whole used to allow. The World Health Organization's International Classification of Functioning Disability and Health (ICF) is one most accepted biopsychological model of rehabilitation theory (WHO 2001). In this disable discussion we look at the past and at the same time lost the individuals future. Also we lost his living environment. (Cottone 1987, Worrall 2005.)

Another way to think about rehabilitation is to consider the possibilities of participating and the empowerment of the person (Cardoli et al. 2002). Then rehabilitation is an active and dynamic process, where the actor is in the main role of rehabilitation and makes her/his own decisions. The actor is learning to live in new situation, where the habit does not work. They have to learn something new. (Jarvis 2004, 69-82.) The solutions rest in equal opportunity for people in old age. This means that she/he is also responsible from her/his choices together with her rehabilitation staff. In Finland, the new way of institutional rehabilitation has come to a crossroads. It is time to look rehabilitation in a new way. (Suikkanen and Lindh 2007). In the future, rehabilitation should be at an area or at a society level. In the area level, the rehabilitation networks teams include different rehabilitees', workgroups, researchers and educators, who share their knowhow and create proactive solutions to changing situations. As such, we need a new concept to talk about, like habilitation. The habilitation creates new innovations together with rehabilitees' and workers from both private and public sectors. In that way, it can also answer the challenges of an aging population.

The purpose of this part of the article is to describe habilitating by answering the research questions;

How do aging private family caregivers experience their life situation?

How are aging private family caregivers made aware of new technology they could use in their life?

How do we create a new client respected service model which uses new technology?

Successful private family care giving in old age

The new interpretation of rehabilitation includes a new attitude to the ageing persons' values and attitudes. Then we accept that inhabitants are going to get old and the old people still have power and innovations to develop our society. The new sociocultural attitude (see Koskinen 2006) highlights old person's historic, social and cultural aspects. Then it is possible to accept that older people are different persons who made their own life decisions in the context of their own culture and society.

The concept of successful aging has been described by Rowe and Cahn (1997). Successful ageing is described as being constructed from active life attitudes, avoiding low functional capacity and illnesses and having a good cognitive and functional capacity. An active life attitude includes active participation so that the person has the possibility to effect her own life. Avoiding illnesses and low functional capacity includes the possibility to create effect by active movements and other actions. You can affect the incidence of illnesses by adopting healthy habits, including maintaining a healthy diet. Also the physical environment, economy, work environment, services, social relationships, social capital, friends and values in society play an important role. Active social participation provides support living at home (Pynnönen et al. 2007).

A new interpretation of rehabilitation is as a concept which describes how to succeed in your life. Then we can speak about successful aging as a part of habilitation. Habilitation is seen as action which looks to the future and thinks about those possibilities, and when and where these are possible. Habilitation coincides with a person, who is building her own life in new situation and the focus is in her own actions (Piirainen 2006). This action, from her point of view, is differ-

ent from action from the staff, relatives, community or society (Jyrkämä 2007, 209-212). The question is how you use your action competency.

The average age of the population in Finland is going up. To solve the inevitable challenges accompanying this basic fact our government has provided a solution in providing support to relatives or other nearest persons to take care of their significant others in the form of a small salary when they do this work. The workers are private family care givers. In Finland, there are about 150 000 over 60-year-old private family care givers (Voutilainen et al. 2007). There are twice as many (300 000) private family care givers who don't get any salary from society. The municipality only pays them a salary when they take care of their relatives at home. In our research-project, Coping at Home, we concentrate on this group of persons and try to make their life more satisfying by using new welfare technology to support them living at home. The main points of the project are to enable the well being of aging. Since the purpose of the project is to promote the new technology from a private family care givers perspective, we took the participants with us to find out and develop new technology in a matter which suits them and which at the same time has the capacity to change the way the welfare workers carry out of their functions. (Piirainen and Raij 2006)

In the beginning (2005) of our Coping at Home research, we find that successful family care giving is a new interpretation of rehabilitation. The above mentioned 25 family caregivers who take part in our projects are from the Espoo area in Finland and are over 70-years old and their giver receivers are older than them. According to our interpretations of the interviews of 25 private family care givers and their care receivers, the lack of safety, action competency, participation and the work of private family care givers are the reasons for unsuccessful family care giving. (See table 1)

Table 1. The concepts of private family care givers

Unsafe
Fear of not getting help
Need for specialist advice and instructions from experts
Worry about a relative when that person is absent.
Need for CaringTV as cure
Action competency
The weakness of functional capacity
Change in marital relationships
Limited social partnership
Participation
The private family care giver is forgotten at home
Common work gives power
Self reflective peer groups help maintain motivation
The work of private family care givers
Family care giving is a new job
Family care givers indisposition
Easy program pleases relatives and gives time for caregivers.

To receive successful family care giving, an aging person needs to feel safe and secure, as well as action competency and the possibility to participate and promote in the competences of the family care givers (see Figure 1). How should the services be organized so that also those family care givers can get them at home? The CaringTV project is an answer to those willing. (Piirainen and Sarekoski 2008)

Figure 1. Successful family care giving Family care giver perceptions of their own life situations according to the content analysis of thematic interviews conducted in the pre-liminary Coping at Home survey

The concept of CaringTV for private family care givers

The starting point is that there are different kind of clients who can use well be-ing technology. The new CaringTV started its programs in April 2006. We made the focus group interviews with the users of CaringTV after two months (18.5.–8.6.2006, N=32, 17 private family care givers and 15 care receivers, 82 pages) and after 1,5 years (8.−19.10.2007, N=17, 11 private family care givers and 6 care receivers, 169 pages). According to the findings of the focus group inter-views, the users of CaringTV could be divided in four groups according to their interpretation of the services. There were four kinds of clients: active, silent, and occasional and transferor users. Active users: take part, develop and see the TV as their own. Silent users: use mostly personal services and sometimes take part in programs. Occasional users: Active family care givers, who sometimes

take part in TV programs. They concentrate on the work of family care giving. Transferor: They give up because of technological reasons or because of bereavement after the death of a relative. This change in life situation meant a change in the way they use the CaringTV. (Piirainen and Sarekoski 2008.)

Caring TV has a different meaning for different user groups. To active users, Caring TV is an important part of their everyday life. They also want to be part of its creation and work together with municipal workers and other servers. To silent users, Caring TV provides security and so adds to their quality of life. To occasional users, Caring TV is one of a number of ways to participate and get the information they need. Transferors also consider Caring TV as one possibility, which helps them when their condition is not so good, or it gives them a place where share the sorrow − after the loss of their significant others. (See Figure 2.) Also, other Finnish researchers have findings concerning old homecare clients. According to those findings, clients can be divided into four groups: self responsible, directed from outside, self-willed and transferor (Backman 2001). The private family care Caring TV users are all self responsible, self-willed and transferor clients, but in our research, there were no clients directed from the outside, since being a private family care giver demands self directing competencies and that is why these clients differs from old homecare clients.

Answering the willing of private family care givers challenged us to develop new services for different clients groups. The concept of Caring TV needs at least two kinds of services. One is CaringTV programs, which were planned according to the family care givers successful aging concepts of coping at home with their significant others. The TV programs designed to support the needs of the elderly covered the following: safety, promoting action competence and participation, and supporting private family care givers knowledge and abilities. The services provided by Caring TV include: a) Interactive instruction and advice, b) personal instruction and c) support services like advice and support the users by using the technology, d) program evaluation, and e) networking with other services. During the research project we find that the technology was also constantly in the process of developing together with clients, Espoo City workers and other private technology producers.(Piirainen and Sarekoski 2008.)

The purpose was to produce a model where we respect the aging and enable her/him to drive the development and use technology as a part of their everyday life. The model includes four different considerations, the most important two of which are the persons who are going to use this four different reasons, namely the elderly themselves and the municipal or private workers who have to modify

the work they do in many ways. Another aspect is technology, which has to modify to the different environmental and economical constraints. The other consideration is program producers who have to plan, make participating programs and make arrangements with the private family care givers who take part in these programs.

Services:
Interactive instruction and advice Personal instruction
Experts services: homedoctor, homephysio-

Silent Occasional
Caring TV users

Active Transferor

Participating Caring TV-
programmes:
Themes: **Promote safety,
Action competence and
participating Increase
competency of family care**
giving

Technological services:
**follow coping at home,
VAS-painline, func-
tional assessment,
sleep-awakening-
rythm, blood pressure,
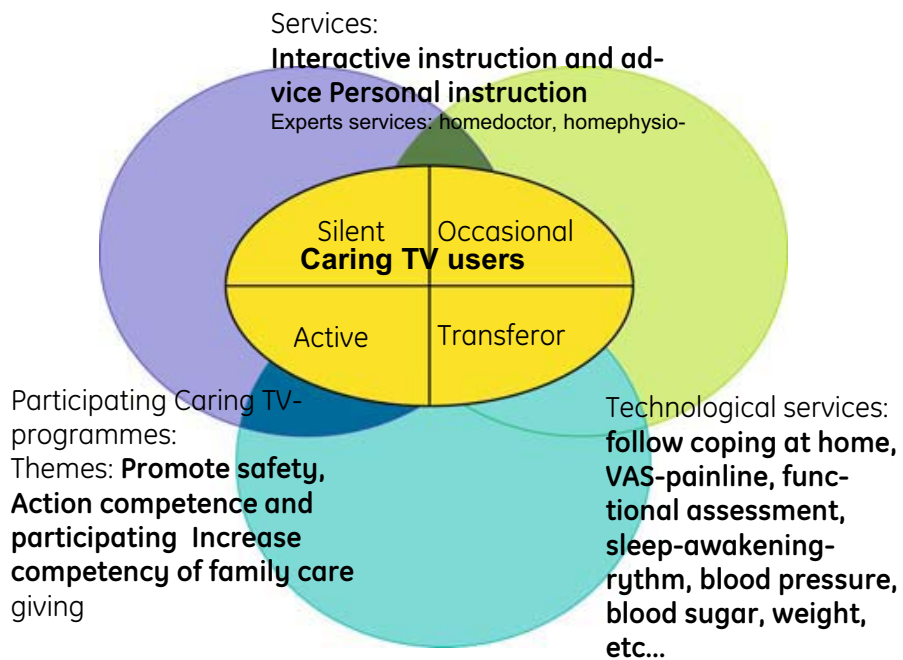blood sugar, weight,
etc...**

Figure 2. Concept of Caring TV according to the habilitation

The new empowering and participating habilitation model consists of new kind creativity, where cooperation and the sharing of all aspects of participations are important. The active, and in some cases quite driven, participation of the clients (the users) was of great importance when constructing this model. Obviously, the participation of those who work with clients and technological production processes is essential. When developing and using new service technology it was important to have workers the clients trust. In this respect, the new rehabilitation respects the aging persons' lifestyle, which had an impact on both history and culture. It has enabled them to create their own habilitation services so that a successful aging process is possible together with social and healthcare workers by using new technological innovations and services like CaringTV.

Supportive methods through Caring TV − safe discharge from hospital to home

The purpose of this part of article is to describe and consider safe discharge from the hospital from the point of view of elderly home care clients. Safe discharge is considered through the ongoing Going home- research project. The purpose of the research is to produce a new model using interactive CaringTV. Participants in the research are homecare clients over 65 years old a high risk of hospitalization. The expectations of the clients and professionals have been collected through interviews. The clients, the home care professionals and students have collaborated to plan programs based on the information gathered. The challenge is to respond to issues like loneliness and unsafe, self-care and monitoring, the activities of daily living and rehabilitation at home after discharge from hospital. The client driven approach in CaringTV means that, based on the findings, the contents of the programs and new virtual services are planned together with clients and their significant others and also with home care professionals. The voice of the client is seen as the most important source of information when planning and broadcasting programs through CaringTV. The action research and Learning by Developing –model are the basis of the methodological approach.

Discharge from hospital as a phenomenon

Health and functional capability are related. Functional capability refers to the physical ability to cope with the activities of daily living, self care and self manag-

ing one's affairs. Psychosocial and emotional functions and capabilities include cognitive ability, self concept and the empowering of wellbeing. Social functioning refers to relationships with significant others, friends and other important people. (Rissanen 1999) Often long-term illness or difficulties in managing ordinary life can reduce the ability of elderly people to function.

Hospitalization can be considered through the concept of transition (Meleis 2002). Transition can be analyzed as a change in the health-illness dimension, related to human being's developmental phases or life situation or from the perspective organizational changes. When the focus is on elderly and hospital admission or discharge, it is a question of change in the health-illness dimension, and also a change in life situation. Admission to hospital or discharge from it can be very stressful for the elderly and also for their significant others and it can influence their life situation significantly (Åstedt-Kurki et al. 1999, Backman 2001, Mäkinen 2002)

Being in hospital, from the perspective of the elderly, is a very sensitive phenomenon. Based on earlier studies (Mäkinen 2002), the elderly feel insecure in new environments, and the hospital environment is no exception. Dealing with strangers, the changed in daily activities, as well as the change in habits and manners can cause distress. The elderly may feel restless. Also, they may worry about their significant others and their ability to cope at home (Pitkälä et al. 2000.) Discharge from hospital is often eagerly anticipated and being able to go home is strongly desired. However, there are many thoughts, feelings and even fears related to this prospect. The fear of coping and managing at home is the most significant concern. They can be afraid of how to manage with new treatments or medication at home. Because a large number of elderly are not in any type of supportive program which provides them assistance with managing at home, many are re-admitted to hospital. Hospitalization for the elderly can be risky and can cause longer stays in hospital and a reduction in their capacity and ability to function. (Cicatiello 2000)

The most important priority is to plan the discharge from hospital carefully with the elderly clients and their significant others. Client participation in planning discharge procedures is essential in order to succeed in the going home process. (Bull et al. 2000, Bull and Roberts 2001)

Many studies (Männistö 1998, Driscoll 2000) have shown that when an elderly person must be admitted back into hospital it is due to a lack of knowledge and lack of continuity of care. When it is obvious that an elderly person has many problems and difficulties, it should be included in the geriatric assessment before

discharge. (Onen et al. 2001) Planned individual solutions and tailor-made services at home can support the elderly to cope at home and admissions back to hospital can be avoided. (Kinnunen 2002, Vaarama et al. 2002) Continuity of care, the sharing information and the ability to seek and receive good advice supports the elderly in coping safely at home after discharge (Karppinen 1997). Social support plays an important role in family care, and insufficient social support is related to higher levels of distress. Also, a health education programs should be designed to improve the primary care giver's knowledge of how to provide care, to improve their social support, and to thus reduce the overall burden of care. It is important to understand all the contributing factors in order to support the family in the care giving process. (Pi-Chu and Chang-Ming 2007) In a study about rehabilitation at home after an acute stroke (Wohlin Wottrich et al. 2007) supporting continuity included, for example, a rehabilitation program in the home environment. Patients greatly appreciated this program. A multiprofessional rehabilitation program was introduced before discharge and was implemented at home. One of the goals in this program was to strengthen and confirm patients´ positive feelings and to support their former social roles.

The methods used in discharging elderly patients from hospital are yet to incorporate the benefits of modern technology. It is very possible for the elderly to learn new ways to make contact with and communicate with various professionals through different types of tele-communication or telemedicine if these solutions and equipment are considered and made available. The health care system and its providers need to be more user-friendly, allowing clients to access and receive care and feel good about themselves. Information and patient education need to be more flexible and multiple new options need to be sought. (Cicatello 2000, Travis 2000)

GOING HOME -research and development project

Going home after being discharged from hospital is considered through the research and development project "Going Home" which is part of the European Union's InnoElli Senior Program 2006−2007. The main focus of the InnoElli Senior Program is to develop innovative methods for elderly people managing at home. The Going Home R&D-project is funded by the European Union Regional Program.

The ongoing study is being carried out at Laurea University of Applied Sciences Well Life Center with the co operation of The City of Espoo and City of Vantaa. The purpose of the study is to investigate, develop, produce and evaluate supportive services at home for elderly people and their significant others in order to manage/cope at home after discharge form hospital. The questions this research is addressing are as follows:

What kind of service concept will be formulated for support of elderly and their significant other?

What are clients´ and home care professionals´ expectations of coping at home after discharge from the hospital?

What are the contents of the program planned through Caring TV?

What kind of methods is applied in program broadcasting?

What are the experiences and the feedback from the elderly and their significant others and professionals about the program at Caring TV?

Participants in the study are clients of home care over 65 years old with a high risk of being taken into a hospital settings (N=32), the clients´ significant others (N=12), and clients from service houses (N=40). Also, professionals from the home care (N=8) and service houses (N=22) were interviewed. The data was collected in three phases. During the first phase, the data methods were interviews and a focus group-method. The purpose of the data collection was to study expectations of the clients and professionals in order to get a basis for setting up programs through CaringTV. The data was analyzed by qualitative content analysis (Dey 1993, Gray 2004, Silverman 1994, 2001). The findings which emerged from the data were based on an inductive approach (Dey 1999). The findings of the first phase are described through the following categories: stimulation (refreshing) of the mind, safety of the environment, safety at home, activation of participation, belonging and togetherness, daily living activities, rehabilitation and physics and caring and monitoring. The basis of the themes was analyzed by using The Six C´s (Glaser 1978) and are conceptualized as follows: updated issues, timing, repetition, participation, and continuity. Based on the findings, the content of the program and the broadcast was planned and then sent through interactive Caring TV. During the spring and summer over 250 interactive programs were produced.

The purpose of the second phase of the data collection was to focus on the experiences and evaluations of the study participants. Data was collected from clients (N=32) using individual interviews and also through group interviews.

Professionals (N=30) gave their feedback in written form. Based on the findings of the second data analysis, four main elements emerged: technology, contents, methods and services. These are the structural elements of developing and producing the model of client driven services at CaringTV. (Figure 3)

services   methods

Clientdriven
holistic
services
through
CaringTV

technology   contents
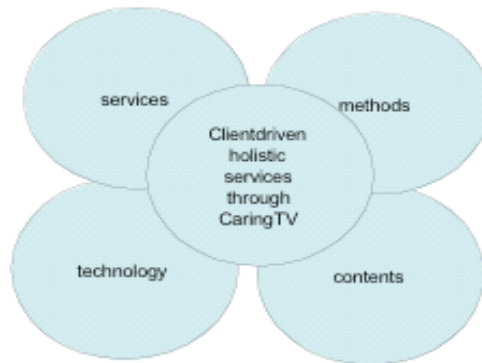
The elements of client-driven services through CaringTV

Figure 3. The elements of client driven services through CaringTV

The client driven method means that the client is seen as an active participant and co-partner in planning, implementing and evaluating the broadcasting process of CaringTV. Based on the feedback of clients and professionals, the programs and supportive services through CaringTV were reconsidered and renewed during the process. In order to help with managing at home after discharge, more tailor-made supportive and safe services are required.

The broadcasted programs can be categorized as follows:

The informative programs: These are, for example, professional sessions about the services available, information about the benefits and the challenges of new technology, and information about coming events on CaringTV.

The content based programs: These are evidence based programs designed to inform clients about of different care situations, illnesses, and medication, for example. Content based programs require participants to ask questions and discuss issues together with professionals or students. Often this kind of program included a demonstration or a model. Some programs, for example, those featuring physical exercise, are broadcasted systematically every morning and afternoon. The topics for discussion are quite often open and flexible in order to respond to participants' current interests and situations.

The participative programs: These are all interactive. The main idea of these programs is to become activated and to challenge the participants to talk about the topic with others. The topics include, for example, remembering the past events, music, poems or art, and they can be very effective at inspiring enthusiastic communication between participants.

The interactive participation of elderly clients increases when the focus of the program shifts from being information based to content based. Based on the feedback from our ongoing research on programming and broadcasting, a model of holistic client driven services can be illustrated, indicating the supportive methods. (Figure 4)
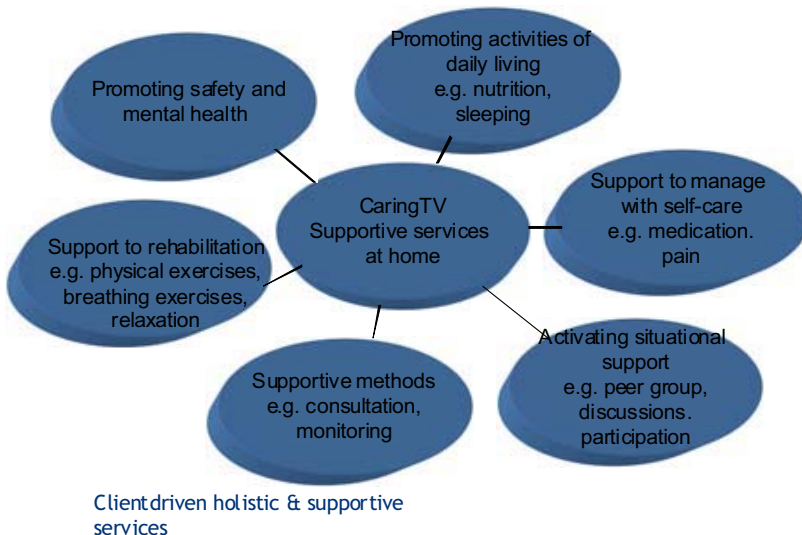
Figure 4. The model of supportive methods using CaringTV (Lehto 2008, 64)

Client driven holistic services using CaringTV for use after being discharged from hospital are still at the process stage. They are based on the active research being carried out in the Going Home -R&D project. Supportive services at home after discharge will be designed and produced in a CaringTV context. The main focus is on developing integrated services in order to cope safely at home after being discharged from hospital.

The challenge is to have more research based data in order to develop supportive and safe CaringTV programs and services as holistic solutions for the elderly and their significant others at home. Also, the contents, methods and services best suited to consultation and for self monitoring via CaringTV are still at the research stage. The value of CaringTV and its´ potential usefulness to the elderly and their significant others requires ongoing research in the future.

Conclusions

In this article, the CaringTV concept has been described briefly, along with the results of the two ongoing research projects which are focused on it. The aim of both is to improve the quality of life of elderly people. The decision to use action research as research method was made because elderly people as our clients were considered active developers in the projects. The concept of quality of life and the conception of a human being as a holistic one with regard to the concept of CaringTV was outlined with reference to earlier research findings and then based on the research findings of Dr Katariina Raij. Finally, she presents the indicators of quality of life based on the conceptions of elderly people.

In the first CaringTV research project, Coping at Home, a new interpretation of rehabilitation was developed by Dr Arja Piirainen. She concludes by introducing the concept of habilitation, which has been constructed together with elderly people with and for family caregivers. The new interpretation of rehabilitation as habilitation allows the development of client-driven services.

The third part of the article deals with supporting methods through Caring TV developed with and for high risk patients, with the help of home care professionals. New methods have emerged during the process and were identified by Dr Paula Lehto. The supported methods are congruent with the content themes of the programmes sent through Caring TV.

In conclusion, in the indicators referring to our findings, which have been validated by our clients, the quality of life consists of indicators described in the circle shown in Figure 5. In this process, the conception of a human being as a holistic being (e.g. Rauhala 1986) with his or her own knowledge base, skills and abilities, values and experiences (e.g. Raij 2003) has been used as the theory of a person.

```
                          Mental health
                        Sense of Belonging
                         Absence of fear
                        Mental stimulation
                        Memory activation

       Health                                              Nutrition
Knowledge of illnesses                                   Cooking skills
     Good sleep                                          Healthy food
  Right medication
  Assessment and            Indicators of
      control              Quality of Life
      Hygiene                   And
                            Habilitation
                                                           Activity
     Habitat                                            Physical balance
     Security                                           Physical workload
      Safety                                           Physical activation
   Obstacle free                                          Right tools
                                                         Empowerment
                         Social Support
                      Availability of services
                        Religious services
                        Significant others
                          Peer support
                          Participation
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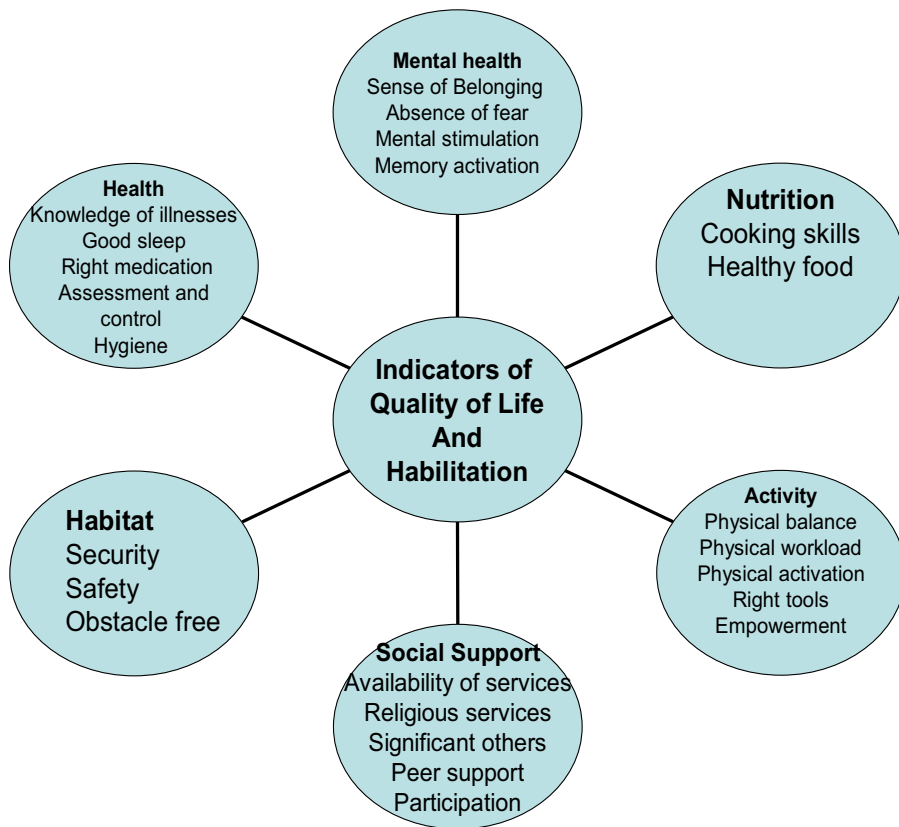
Figure 5. Indicators for quality of life

The indicators of quality of life described above show us how an elderly person looks at his or her own life situation. They are very much in line with the determinants of quality of life found by Wilkinson (2005) in the European definitions. There are, however, some differences. In our projects, elderly people recognized

nutrition as one of the indicators. According to them, being elderly has presented them with new challenges in buying food and preparing meals, with their health status and maybe also their incomes being considerations. Our clients also described more details related to activity. They emphasize the importance of having a physical workload and physical balance in their daily activities.

In our earlier writing (Piirainen and Raij 2006), quality of life was described in relation to the theory of each person existing as a holistic being. According to Rauhala (1989) a human being exists as an organic, conscious, situational and spiritual being. Also Raij's (2000) view of seeing a person as a holistic being with his or her own knowledge base, skills and abilities, values and experiences, were added when developing our action research set. If we compare the determinants of quality of life presented by Wilkinson (2005), the indicators of quality of life we have identified and the conception of a human being, some links are to be seen. Existing as an organic and conscious being is related to physical and mental health, and activity. Existing as a situational being, in turn, is related to social relationships, income, housing, technology applications and participation, and also, in our findings, to habitat, nutrition and activity. In the definitions there are, however, no determinants linked to a human being as a spiritual being, which we found to be one of the factors in elderly people's wellbeing.

The indicators presented here could be useful in designing services with and for elderly people. In our case they are used as guides in the development of virtual services through CaringTV. They also offer tools for municipalities to decide what kinds of services could be delivered by CaringTV.

References

Aromaa, A. and Koskinen, S. (Eds) 2002. Terveys ja toimintakyky Suomessa. Terveys 2000 -tutkimuksen perustulokset, Kansanterveyslaitoksen julkaisuja B3, Helsinki.

Aromaa, A., Heliövaara, M., Impivaara, O., Knekt, P., Maatela, J., Joukamaa, M., Klaukka, T., Lehtinen, V., Melkas, T., Mälkiä, E., Nyman, K., Paunio, I., Reunanen, A., Sievers, K., Kalimo, E. and Kallio, V. 1989. Terveys, toimintakyky ja

hoidon tarve Suomessa. Mini-Suomi terveystutkimuksen perustulokset, Kansan-eläkelaitosten julkaisuja, Sarja tutkimukset 13, Helsinki.

Backman, K. 2001. Kotona asuvien ikääntyvien itsestä huolenpito. Acta Universitatis Ouluensis Series D Medica 624, Oulu.

Baltes, P.B. 1993. Successful Ageing: Perspectives from the Behavioral Sciences. University Press, Cambridge.

Bull, M. J. and Roberts, J. 2001. Components of a proper hospital discharge for elders, Journal of Advanced Nursing, 35(4), 571-581.

Bull, M. J., Hansen, H. and Cross, C. R. 2000. Predictors of elder and family caregiver satisfaction with discharge planning, Journal of Cardiovascular Nursing, 14(3), 76-87.

Cardoli, M., De Jong, B.A. and Wardi, C.D. 2002. On autonomy and participation in rehabilitation, Disability and Rehabilitation, 24(18), 970-974.

Cicatello, J. 2000. A perspective of health care in the past-insights and challenges for a health care system in the new millennium, Nursing Administration, 25(1), 18-29.

Cottone, R. 1987. A systematic theory of vocational rehabilitation, Rehabilitation Counseling Bulletin, 30, 167-175.

Dey, I. 1993. Qualitative data analysis: a user-friendly guide for social scientists. Routledge, London.

Dey, I. 1999. Grounding grounded theory. Guidelines for qualitative inquiry. Academic Press, USA.

Driscoll, A. 2000. Managing post-discharge care at home. An analysis of patients´ and careers` perception of information received during their hospital stay, Journal of Advanced Nursing, 31(5), 1165-1173.

ETAN. 1998. Ageing population and Technology. European Commission, Brussels.

Fernandez-Ballesteros, R. Zamarron, M. and Ruiz, M. (2001) The contribution of socio- demographic and psychosocial factors to life satisfaction, Ageing and Society, 21(1), 25-44.

Felce, D. and Perry, J. 1993. Quality of Life: A Contribution to its Definition and Measurement. Mental Handicap in Wales. Applied Research Unit, University of Wales, College of Medicine.

Glaser, B. 1978. Theoretical sensitivity advances in the methodology of grounded theory analysis, Mill Valley, The Sociology Press.

Gray, D. E. 2004. Doing research in the real world. Sage Publications LtD, London.

Habermas. J. 1973. Knowledge and Human Interests. Beacon, Boston.

Heikkinen. H.. Kontinen, T. and Häkkinen, P. 2006. Toiminnan tutkimuksen suuntaukset. In Heikkinen, H.. Rovio, E. and Syrjälä, L. (ed.) Toiminnasta tietoon, Dark Oy, Vantaa.

Hooyman, N. R. and Kiyak, H. A. 1999. Social Gerontology. A Multidisciplinary Perspective. Fifth Edition. Allyn and Bacon. Boston.

Jarvis, P. 2004. Adult education & Life long learning. Theory and Practice. Routledge, London.

Johnson, T. 1995. Ageing well in contemporary society: introduction, American Behavioral Scientist, 39(2), 120–30.

Jylhä, M. 2000. Onnistunut vanheneminen ja vanhuuden muuttuvat mielikuvat. Gerontologia.

Jyrkämä, J. 2007. Toimijuus ja toimijatilanteet - aineksia ikääntymisen arjen tutkimiseen. In M. Seppänen, A. Karisto, T. Kröger (eds) Vanhuus ja sosiaalityö: Sosiaalityö avuttomuuden ja toimijuuden välissä, PS-kustannus, Jyväskylä, 195-217.

Karppinen, P. 1997. Yli 65-vuotiaiden kotiutus akuuttisairaalasta heidän itsensä ja heidän omaistensa arvioimana, Pro gradu -tutkielma, Kuopion yliopisto, Hoitotieteen laitos, Kuopio.

Kettunen, T. 2001. Neuvontakeskustelu: tutkimus potilaan osallistumisesta ja sen tukemisesta sairaalan terveysneuvonnassa, Acta Universitatis Jyväskylä Sport and Health Sciences, Jyväskylä.

Kinnunen, K. 2002. Postponing of institutional long-term care in the patients at high risk of institutionalization, University of Helsinki, Helsinki.

Koskinen, S. 2006. Toinen kansallinen ikääntymisen foorumi 2005. Sosiaali- ja terveysalan tutkimus- ja kehittämiskeskus, Helsinki.

Lahtela, K., Grönlund, R., Röberg, M. and Virta, L. 2002. Arvioita suomalaisesta kuntoutusjärjestelmästä, Kuntoutusbarometrihankkeen ensimmäisen vaiheen havaintoja, Kansaneläkelaitos, Helsinki.

Lehto, P. 2008. KOTIIN-hankkeen tutkimus- ja kehittämistoiminta. In Lehto, P. (ed.) KOTIIN-hanke. Asiakasvetoiset interaktiiviset ratkaisut ikääntyvän kotona selviytymisen tukena. Laurea-ammattikorkeakoulun julkaisusarja A 63. Redfina Oy, Espoo, 17-128.

Marin, M. 2000. Onnistunut vanheneminen. Gerontologia 14(1), 34-36.

Meleis, A. I. 2002. Theoretical nursing: development and progress. J.B. Lippincott Company, Philadelphia.

Mäkinen, B. 2002. Iäkkään potilaan omaisena erikoissairaanhoidossa. Omaisen, lääkärin ja sairaanhoitajan näkökulma, Turun yliopiston julkaisuja, Sarja C, osa 183, Turun yliopisto, Turku.

Männistö, T. 1998. Iäkkään potilaan turvallinen kotiutuminen sairaalasta. Turun yliopisto, Hoitotieteen laitos, Turku.

Onen. F., Abidi, H., Savouy, L., Elchardus, J.M., Legrain, S. and Coupron, P. H. 2001. Emergency hospitalization elderly in a French university hospital: medical and social conditions and crisis factors presipating admissions and outcome at discharge, Aging 13(6), 412-413.

Pi-Chu, L. and Chang-Ming, L. 2007. Psychosocial factors affecting hip fracture elder´s burden of care in Taiwan, Orthopaedic Nursing, 26(3), 155-161.

Piirainen, A. 2006. Asiakkaan ja asiantuntijan pedagoginen suhde. Acta Universitatis Helsinki 270, Helsinki.

Piirainen, A. and Raij, K. 2006. Coping at Home, In Annuals of the Kansei Fuku-shi Research Centre, Special Issue, Refurbishing the Elderly Care-evidence and Theoretical Targets, 13-21.

Piirainen, A. and Sarekoski, I. 2008. Client-driven CaringTV concept for elderly family care givers living at home. Final report of the Coping at Home research. Laurea-publications A62. Edita Priima Oy, Valvanne.

Pitkälä, K., Valvanne, J., Kulp, S., Strandberg, T. and Tilvis, R. 2000. Paraneeko vanhusväestön terveys? Helsinkiläisvanhusten toimintakyky ja avuntarve 1989 ja 1999, Suomen Lääkärilehti, 35, 27-29.

Pynnönen, K., Sakari-Rantala, R. and Lyyra, T-M. 2007. Sosiaalinen inaktiivi-suus ennustaa iäkkäiden ihmisten laitoshoitoon sijoittumista. Gerontologia, 21(1), 27-36.

Raij, K. 2003. Osaamisen tuottaminen ammattikorkeakoulun päämääränä. In Kotila, H. (ed.) Ammattikorkeakoulupedagogiikka, Edita, Helsinki.

Raij, K. 2007. Learning by Developing, Laurea Publication A58. Edita, Helsinki.

Rapley, M. 2003. Quality of Life Research, Sage Publications, London.

Rauhala, L. 1989. Ihmisen ykseys ja moninaisuus. SHKS, Helsinki.

Rauhala, L. 1995. Tajunnan itsepuolustus. Yliopistopaino, Helsinki.

Rissanen, L. 1999. Vanhenevien ihmisten kotona selviytyminen. Yli 65-vuotiaiden terveys, toimintakyky ja sosiaali- ja terveyspalvelujen koettu tarve. Acta Universitatis Ouluensis, D Medica 560, Oulun yliopisto, Oulu.

Rowe, W. and Kahn, R.L. 1997. Successful aging, The Gerontologist 37, 433-440.

Silverman, D. 1994. Interpreting qualitative data. Methods for analysis talk. Text and interaction, Sage, London.

Silverman, D. 2001. Doing qualitative research, a practical handbook, Sage Publications LtD, London.

Suikkanen, A. and Lindh, J. 2007. Rehabsaurus – lajinsa viimeinen? Keskustelun avauksia kuntoutuksen tulevaisuuden haasteisiin. Kuntoutus 35(2), 4-8.

Travis, I. 2000. Remote symptom monitoring: home management of heart failure patients using transtelephonic stethoscope – pilot study, Nursing Administration 25(1), 148-153.

Vaarama, M., Voutilainen, P. and Kauppinen, S. 2005. Ikääntyneiden hoivapalvelut. In M. Heikkilä and M. Roos (eds) Sosiaali- ja terveydenhuollon palvelukatsaus 2005, Stakes, Saarijärvi, 36-59.

Vaarama, M., Voutilainen, P. and Kauppinen, S. 2002. Ikääntyneiden palvelut. In Heikkilä, M. and Parpo A. (eds), Sosiaali- ja terveydenhuollon palvelukatsaus, Sosiaali- ja terveysalan tutkimus- ja kehittämiskeskus, raportteja 268/2002, Gummerus Oy, Saarijärvi. 76-105.

Valkonen, J. 2002. Mistä puhutaan kun puhutaan kuntoutuksesta? Kuntoutus 30(1), 3-20.

Walker, A. 2005. Quality of Life in old age in Europe, In Walker, A. (ed.) Growing Older in Europe. Open University Press, McGraw-Hill House.

Wilkinson, R. 1999. Unhealthy Societies, Routledge, London.

World Health Organization. 2001. International Classification of Functioning, Disability and Health, World Health Organization, Geneva.

Worrall, L. 2005. Unifying rehabilitation through theory development, Disability and Rehabilitation. 27(24), 1515-1516.

Wohlin Wotrich, A., von Kuch, L. and Tham, K. 2007. The meaning of rehabilitation in the home environment after acute stroke from perspective of a multiprofessional team, Physical Therapy, 87(5), 778-788.

Voutilainen P, Vaarama M., Kattainen E. and Heinola R. 2007. Omaishoidon tuki sosiaalipalveluna. Selvitys omaishoidon tuesta ja sen vaihtelusta 1994–2006. Sosiaali- ja terveysministeriön selvityksiä, 28. Sosiaali- ja terveysministeriö, Helsinki.

The WHOQOL Group 1998. Development of the World Health Organization WHOQOL-BREF Quality of Life Assessment. Psychological Medicin 551-558.

Åstedt-Kurki, P., Lehti, K., Paavilainen, E. and Paunonen, M. 1999. Family member as a patient in a hospital – sentiments and functioning in a family, International Journal of Nursing Practice 5(3), 155-163.

Elderly People's Grief and Quality of Life

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This article describes the relationship between grief and the quality of life in old age. In the following article, the experience of grief caused by the death of a loved one and its consequences among aged people in Finland will be discussed. The focus of this investigation was a new theory of an individual's bereavement experience. The core process of grief is revealed to be a process of giving in. The article is based on the empirical data of 112 bereaved persons who had lost a loved one. The research method in this article is based on the qualitative grounded theory method.

The purpose of this paper is to examine the way elderly people experience grief and what kind of effects grief has on the quality of their lives. The focus is on what elderly people know and how they understand their life after someone close to them has died. Furthermore, the focus is on describing the core process of grief for the elderly, on identifying the consequences grief has for them and on the strategies they use when living with grief. In this paper, we start the discussion about elderly people's experience of grief and describe a new grief theory, which is based directly on empirical data (Erjanti 1999, 2004).

Research data and methods

Grief theory is based on research data, which consists of 112 Finnish people who have lost their spouses. The average time from the death of the spouse

was approximately 2 years and 8 months at the time of the research. The death of the spouse had, in the vast majority of cases, taken place in hospital and was caused by natural illness. The average age of the sample group was 53.7 years; the oldest person interviewed was 75 years old. The death came without warning to 44 % of the sample group. Only 36 % of the sample group knew that the death of their spouse was close, that time frame being approximately a couple of months to half a year or so before the death. A total of 22 % of the sample group took part in grief groups. The research involved interviewing those who had experienced grief, and the data was analysed with a qualitative grounded theory method (Glaser and Strauss 1967, Glaser 1978, Corbin and Strauss 1990).

Elderly people's process of giving in

As a result of the study a new substantive grief theory was created according to which the core process of grieving is one of giving in. Giving in, as experienced by grieving elderly Finns, had thirteen dimensions, which were identified in the research: emotional turmoil, physical protest, making the loss real, self-examination, breakthrough in thinking, a transformed awareness of one's own reality, grief modifiers, groping for meaning, breaking grief's dominance, the self-regulation of grief, recovery, interaction and personal growth. The giving in process developed from the external to the internal and to a meta level. Giving in was a developing, dynamic and nonlinear process, which was comprised of the suffering of the grieving person, and can be said to include struggling and metamorphosis. Grief did not have clear phases. The laws of reciprocal motion, recurrence, whether it was the first time or not, and adaptation to change defined the process of giving in. Giving in included the creation of a new way of life in stages and was realised at the stages of giving in. Grieving elderly people had four different strategies to break the dominance of grief: in going, out going, unsociable and encasing. Grief was understood as a process that would last for the rest of their life, which required energy, and included a sensitivity period favourable for promoting health. In addition, permanent change took place in the grieving person as grief had an interactive nature, **and its positive result was the growth of personality.**
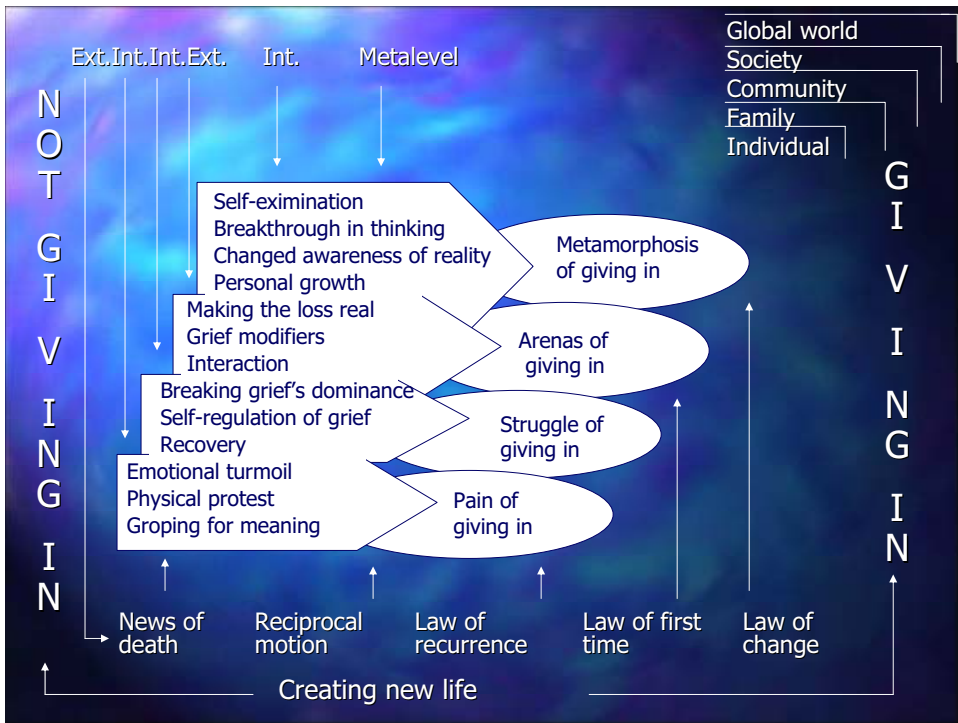
Figure 1. Theory describing the experience of bereavement: the process of giving in

Special characteristics of elderly people's experience of bereavement in the process of giving in

The disbandment of social relationships, a decline in health and physical capability, and a decline in one's financial position are often connected to an elderly person's loss of their spouse. In the Western world, the core process of an elderly people's grief is giving in, and there are typical characteristics of this process of giving in that can be identified.

1) Anxiety caused by giving in

It is commonly claimed that, in Western countries, the grief and process of giving in experienced by elderly people is not as oppressive as that of younger people's experiences. According to Salben (1991), elderly women who have been widows for 1 to 3 years do not cope with the loss of a spouse or adjust to it any better than younger women. On the contrary, older widowed women can show greater grief, be more distressed and depressed than younger women. It can be assumed that older people do not accept such a loss easily, and, in fact, they grieve longer and in a more permanent way than has been previously assumed. A comparison of widows and widowers over 60 showed no significant differences in coping methods or grief experiences (Salbe 1991). Elderly people's will to commit themselves to their spouses is often seen as a lifelong process, and their adult relationships stay in their minds in the form of indelible and loving memories. Attachment theory (Bowlby 1982) is seen as a way of understanding elderly people's grief and anxiety.

2) An increasing number of elderly people have experienced grief and are living alone

The growth in the number of elderly people compared to younger generations has long been noted. In the future, the number of elderly women who have already lived alone for years, and especially those who have experienced loss, will grow. This is because women tend to outlive men and marry men older than them. However, if more attention is paid to elderly grieving widows, the negative consequences caused by the loss and the grief of elderly people can be reduced. Despite the rapid growth in the number of elderly widows, and the fact that the previously unrecognised problems caused by the loss of a spouse have now been identified, there have not been many studies that focus on how the elderly experience loss. Most of the previous grief studies and theories have usually concentrated on younger widows. It can be stated that the relationship of age and grief caused by loss has not been fully studied yet.

3) Differences in elderly and young people's adjustment to loss

Assumptions of adjustment have been contradictory when young and elderly people have been compared in Western countries. Women under 65-years-old use more medication and see doctors more often due to emotional problems than elderly widows (e.g. Parkes 1970). Men and women over 57 years old adjust better than younger people (e.g. Garey 1977). Elderly people deny the feelings of deep despair, shock, fear of mental breakdown and weakening more often than younger people. The reason for denying such feelings is often thought to be the fact that elderly people feel that shock and grief are acceptable and

part of life. Despair, fear and breakdown have a different kind of meaning and threat for young and elderly widows and are consequently different in their content (e.g. Sanders 1981).

Preparing for the loss of a spouse is seen to be related to how well elderly people handle the process of adjustment. It is believed that elderly people adjust well because the loss takes place during a time in their lives when it can be expected. It is also thought that they have some kind of flexibility, which enables them to adjust to the loss over the long term. On the other hand, the loss takes place during the final stage of life when an attachment in a relationship tends to grow stronger rather than weaken.

The connection between prolonged grief and attachment relationships has been identified. Those elderly people who felt closest to their spouses were classified as the ones who grieved the most. Elderly adults grieved the loss of their loved ones for much longer than was thought, sometimes even forever. Grief became a part of them but was changed and expressed as a more gentle grief in the process of giving in. Grief was not connected to the practical problems caused by loss or to the fact that it was not problematic. Age itself was found not to explain individuals' ways of coping with loss (e.g. Bowlby 1982). Elderly women, who have lost their spouses, seemed to be sadder during their first three years than younger women. Their grief lessened with the passing of time but it did not lessen significantly (see Salbe 1991). According to Bowling and Cartwright's (1982) comparison, 50 % of those over 65 year olds studied, who had experienced the loss of a spouse, were as depressed, apathetic and socially isolated during the first half year after their loss as younger people. It is possible that elderly people's many physical symptoms may cover the real extent of the grief they feel, as those physical symptoms are too readily connected to problems related to ageing.

4) Less opportunity to replace a lost relationship

Elderly people's adjustment is made more difficult by the fact that elderly women and men do not have much opportunity to replace the missing relationship with another comparable intimate relationship. Losing a long-term relationship and an aged spouse who has been part of an elderly person's life for years, can be an excruciating experience. This experience is connected to time, as is the stress of ageing. On the other hand, if a new relationship is started the adjustment to loss is better compensated for. Loss confuses an elderly widow's experience of the meaning of life because it is bound up with her own special attachment feelings (see Marris 1974). The fact that elderly people look at their lives retrospectively

and focus on the past is seen as especially dangerous for the elderly. The loss of a spouse can affect the amount and nature of the years an elderly people has left since it makes them think about their lives as if they were already over and lived. This type of thinking, which is connected to adjustment, can stop elderly people from seeing the meaning of loss in their lives or prevent them from achieving a feeling of importance and starting any new relationships in their lives.

5) Social needs and problems

Western widows, who have lost their spouses, can have problems when they lack an alternative role for their life and have medical problems and experience increasing isolation as their ability to move reduces with age. On the other hand, emotional stability, a good financial income and social networks can promote adjustment and help with the process of giving in. Elderly people want social contacts the same as younger people do, and elderly widows feel that social relationships help with handling fears, anxiety, the feeling of loneliness and allow them to share feelings and experiences. Often elderly people's social needs are not recognised due to their physical problems, loss and the prejudices connected to the ageing process in Western culture.

6) Preparing beforehand for the forthcoming death of a spouse

It has been assumed that the preparing beforehand for the death of a spouse eases the grief and the process of giving in. According to this theory, during the illness, spouses discuss the changes that will take place and their financial situation. However, the results of research about being aware of the imminent death of a spouse vary. Some researchers have noted that adjustment after a spouse's short illness is worse than after a protracted illness. Other researchers have reached the opposite conclusion, and argued that adjustment after a chronic illness has been worse. There are also researchers who have not found any connection between knowing about a spouse's forthcoming death and the grief process in relation to the length of the illness. The research conducted by Glick et al. (1974) showed that knowing about a spouse's imminent death beforehand had a positive impact with regard to the adjustment time and the acceptance of becoming a widow. Results that demonstrate the opposite, i.e. that knowing about a spouse's imminent death would worsen their adjustment to life without the spouse, have not been found. Hill et al. state (1988) that elderly widows' expectation of death is not connected to the adjustment to loss. In the research those who had anticipated and prepared for the role of a widow did not adjust any better than those who had not done so.

Long-term illness affects an elderly person's adjustment to the loss of a spouse more than age. Death after a long illness is often experienced as a relief since the spouse's suffering is then over. Those who have experienced relief adjust to loss more quickly than others. The stress caused by knowing about a forthcoming death can be especially hard for elderly people, and having to provide care can worsen the health problems of the elderly spouse providing the care (Averill and Wisocki 1981). Current research has shown that caring for a loved one is painful and physically tiring for elderly people.

However, knowledge of the spouse's coming death offers the couple time to prepare for the death in many practical ways. The death of a spouse can result in substantial changes in the financial circumstances of an elderly person as well as the need to move apartments, restrictions in their mobility and difficulties in taking care of insurance and pensions. In situations in which both spouses are aware of the facts, it can be assumed that it is sensible to discuss the future circumstances of the spouse who would be alone after the death. This assumption is supported by O'Bryant's (1991) research, which states that those over 60-year-olds who knew about the coming death of their spouse and who discussed that together had a more positive attitude than those who did not know about the death beforehand or did not discuss it. However, discussions about future everyday life and matters connected to income at the time the spouse's death was getting closer were seen as difficult, although important. In this research the difficulty of talking was connected to the marriage model of mutual speechlessness, which had developed over many years. Knowing beforehand was connected to the highest level of a widow having a positive attitude but it was not connected to any negative effects. Talking about financial matters was significant from the viewpoint of a positive adjustment.

Thus knowing beforehand about an imminent death can make the adjustment to being a widow easier. Knowing beforehand also enables the processing of grief to begin in some respects before the spouse's death, and it also tends to prompt spouses to have discussions about matters which have an affect on the remaining spouse's future circumstances.

7) The threat of being given the status of a dying person

A bereaved person's orientation to the knowledge of life's limitations, to the fact that there is a limited time left and that the time of one's death is unknown, and that death cannot be avoided are connected to being an elderly widow and to their grief. Being an elderly widow can be compared to being given the status of a dying person. In the case of Western widows over 70 years old, it can be as-

sumed that they will most likely stay widows. Losing a spouse has a profound effect on their attitude towards death, with them becoming aware of their own death. This can be seen as reflecting the conceptual move to the status of a dying person.

When a spouse dies, women are often classified as widows and they "step" into the role of a widow, into a subculture which focuses on experiencing loss, which brings permanent change to their identity and social status, and gives birth to a state of grief, constant stress, weaker finances and social isolation (see Howie 1993). In this way, elderly widows move to the status of a dying person. Elderly widowhood is a prolonged process, the end of which is not another marriage but death, and its timing is impossible to define. When elderly people recognise the closeness of death, an attitude of acceptance towards death arises, and a reorientation to life takes place. The knowledge of their own mortality and knowledge of death operates in a paradoxical way. In fact, it offers an opportunity to stress the need for an active commitment to the years they have left and to filling those years with autonomy and meaning. Understanding and accepting all the factors connected to an elderly widow's grief as part of being a widow develops their own collective control of the years they have left. It leads them towards taking meaningful action and developing greater mental strength.

8) Coping with grief

In research mapping over 60 year old Finnish widows' and widowers' grief experiences and the ways they cope with grief, the elderly people saw their children, grandchildren, friends, relatives and neighbours as the most important factors for helping cope with grief. Also different kinds of activities, such as household work, hobbies and doing something that was important to themselves helped them to cope with their grief (Kaunonen et al. 1996). Thus, social support is a very important factor. It has been noted that people aged between 50 and 93 have quite extensive social networks of relatives and friends in which it is also possible to express feelings of grief (Dimond 1981). The members of these networks often are in contact and share their feelings in confidence. They often have contacts and share their experiences and offer advice on coping. The feeling of closeness with other members in a network results in less depression, a greater sense of happiness with life and a sense of being in better health. The qualitative features of social networks, such as the quality of interaction, directly impact upon depression by reducing it and create a sense of happiness with life. Women estimated their networks to be stronger than men's. Thus, the structural features of networks differ from the qualitative features. However, the dimensions of a social network after spouse's death are not strong predictors for cop-

ing with depression, for promoting good health or being happy with life after the first year after a loss (Dimond 1981). Nevertheless, social support is meaningful for elderly people who are trying to cope in the first two years after their loss. The effect of the closeness and the extent of a network in coping with grief has been researched and it has been found be that a network can be too extensive or too close or so strong that it rather serves to restrict its members' common qualitative interaction rather than make it easy, thus preventing them from finding relief from grief. It seems that elderly grieving people sometimes have an extensive network of friends but still no true close friends they can confide in (Hogan et al. 1996).

Highlighting the help elderly people need is crucial for a society in which the elderly are prone to feeling as if they are being pushed away from the mainstream. It seems that in society young widows get more attention, sympathy and support although they are a much smaller group than the constantly growing group of elderly widows. Young widows are uncommon among their peers and there are many who are willing to rally to their support. They also tend to have actively founded good support groups and networks. In contrast, elderly people's grief takes form in the process of giving in. Elderly people, as well as other grieving people, become caught up in the suffering involved in giving in, which ends when they finally give in. Highlighting elderly people's grief in society requires a change in people's attitudes.

Conclusions

Grief was originally a term used in nursing science, which opened up a new area termed nursing: bereavement care. Research created a new theory from the viewpoint of nursing science. It is possible to create new scientific knowledge on grief and discover qualitative connections between people suffering from grief. With the help of grief theory, elderly people's special needs can be fulfilled, risk situations can be recognised, help can be focused in a more useful and more individual way, the health of grieving elderly people can be better looked after, and social problems can be prevented through social care and health care.

References

Averill, J.R. and Wisocki, P.A. 1981. Some Observations on Behavioral Approaches to the Treatment of Grief among the Elderly. In Sobel H.J. (ed.) Behavioral Therapy in Terminal Care, Ballinger Publishing, Cambridge.

Bowlby, J. 1982. Attachment and loss: Retrospect and prospect. American Journal of Psychiatry 52(4), 664-679.

Bowling, A. and Cartwright, A. 1982. Life After Death, Tavistock Publications, New York.

Boyle, F.M., Vance J.C., Najam, J.M. and Thearle, M.J. 1996. The mental health impact of stillbirth. Neonatal death or sids: prevalence and patterns of distress among mothers. Social Science of medicine 43, 1273-1282.

Carey R.G. 1977. The Widowed: A Year Later. Journal of Counselling Psychology, 24(2), 125-131.

Corbin, J. and Strauss, A.L, 1990. Grounded Theory Research: Procedures, Canons and Evaluative Criteria. Qualitative Sociology, 13(1).

Dimond, M. 1981. Bereavement and the Elderly: A Critical Review with Implications for Nursing Practice and Research. Journal of Advanced Nursing 6, 461-470.

Erjanti, H. 1999. From Emotional Turmoil to Tranquility. Grief as a Process of Giving in. A Study on Spousal Bereavement. Acta Universitatis Tamperensis 715. Vammalan kirjapaino, Tampere.

Erjanti, H. and Paunonen-Ilmonen, M. 2004. Suru ja surevat. Werner Söderström Oy, Porvoo.

Glaser, B.G. and Strauss, A.L. 1967. The Discovery of Grounded Theory: Strategies for Qualitative Research. Aldine De Gruyter, New York.

Glaser, B.G. 1978. Theoretical Sensitivity. Advances in Methodology of Grounded Theory. University of California.

Glick I.O., Weiss, R.S., and Parkes, C.M. 1974. The First Year of Bereavement. John Wiley and Sons, New York.

Hill, C.D., Thompson L.W., and Gallagher D. 1988. The Role of Anticipatory Bereavement in Older Women's Adjustment to Widowhood. The Gerontologist, 6(28), 792-796.

Hogan, N.S., Morse, J.M., and Tason, M.C. 1996. Toward an experimental theory of bereavement. Omega. Journal of Death and Dying, 33, 43-65.

Howie, L. 1993. Old Women and Widowhood: A Dying Status Passage. Omega 26(3), 223-233.

Irving S. 1973. Basic Psychiatric Nursing. W.B. Saunders Company. Philadelphia.

Kaunonen M., Paunonen M., and Laakso, H. 1996. Yli 60-vuotiaiden suomalaisten kokemuksia surusta ja surusta selviytymisestä puolison kuoleman jälkeen. Gerontologia 2(10), 82-88.

Marris, P. 1974. Loss and Change. Random House, New York.

O'Bryant, S.L. 1991. Forewarning of a husband's death. Does it make a Difference for older Widows? Omega, 22(3), 227-239

Parkes, C.M. 1970. The first year of bereavement. Psychiatry, 33, 444-467.

Sable, P. 1991. Attachment, loss of spouse and grief in elderly adults. Omega, 23(2), 129-142.

Sanders, C.M. 1981. Comparison of Younger and Older Spouses in Bereavement Outcome. Omega 11(3), 217-232.

Multi-expertise Team Care for the Dementia

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Population projection

Japan is currently facing a number of social problems, one of which is the expected continued increase in the proportion of the burden borne by the working-age population for the support of society. This can be seen in the 2006 figures from the National Institute of Population and Social Security Research's "Population Projection for Japan," which provided data regarding the median statistics for Japan's current birth and death rates (http;//www.ipss.go.jp). Based on these, Japan's population is expected to decrease from a figure of 120 million in 2025 and fall below a total of 100 million by 2046 (fig.1). This is also expected to coincide with Japan's elderly population passing the 30 million mark by 2012—when Japan's baby-boom generation will reach 65—and will go on to reach 35 million by 2018. Japan's elderly population will continue to grow after this, and is only expected to decline when it reaches a peak of 38.63 million in 2042.
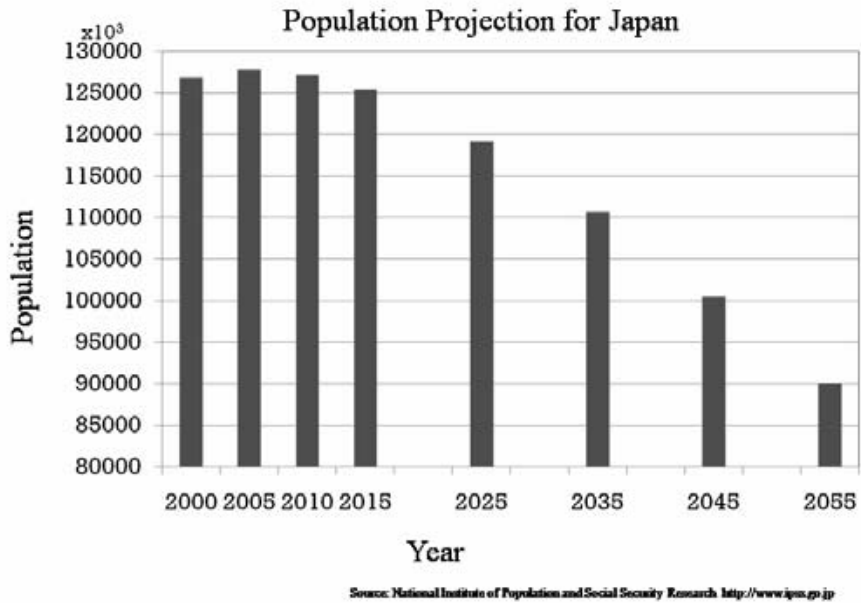
Figure 1. Population projection for Japan

This data indicates that as Japan's total population continues to decline, the proportion of elderly citizens making up this number is expected to increase. As of 2006, the percentage of over-65s making up Japan's population stood at 20.8%. This, however, is expected to rise to 25.2% by 2013, and further increase to 33.7% by 2035. It is ultimately expected to reach a high of 40.5% by 2055 (fig.2).
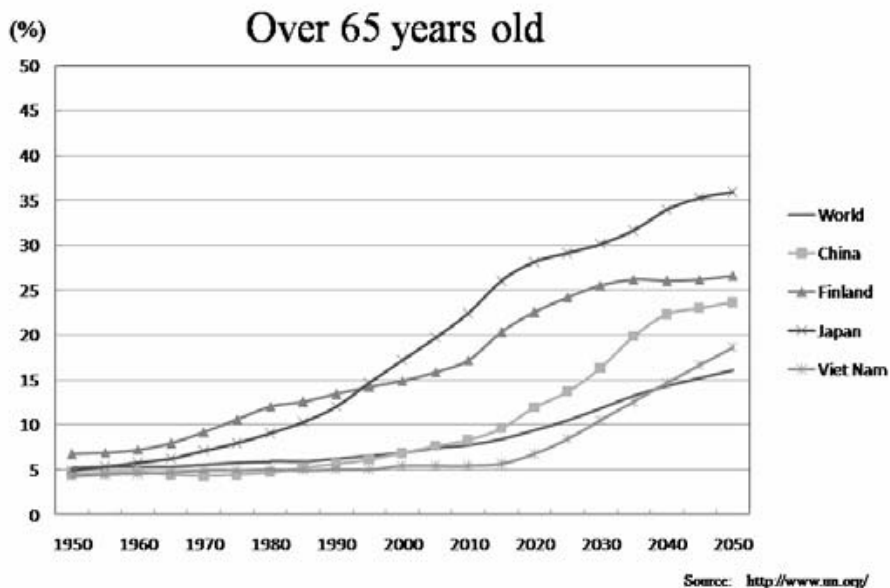
Over 65 years old

Figure 2. Over 65 years old

Within this rise, the proportion of "old-old" citizens, classified as over 75, will ultimately rise above the proportion of "young-old" (those aged 65 to 74) by 2017, and this is expected to further increase from this date.

Revision of nursing care insurance system

A number of measures are being implemented in order to avoid the collapse of this unprecedented super-aging society and to maintain a functioning state that can support this kind of population. This involves countermeasures against the falling birth rate, a novel employment strategy, increasing the healthy life expectancy, and alleviating the burden of nursing care costs on the working-age population.

Set against this backdrop, Japan's nursing care insurance program, which was initiated in 2000, has been subject to a number of significant revisions over the

five years it has been in existence. The biggest issue regarding these revisions has been looking to avoid a financial crisis in the nursing care insurance program brought about by the sudden increase in Japan's elderly population. The total number of persons recognized as either requiring nursing care or support under the nursing care insurance program as of 2005 came to 4,175,000 (amounting to 16.6% of Japan's over-65 population); this was an increase of 1,704,000 from 2000. The total expenditure on nursing insurance also increased from 3.6 trillion yen in 2000 to 5.1 trillion yen by 2005 (an increase of 41%). If expenditure is to continue at current rates, then the total figure is expected to reach 20 trillion yen by 2013. The most recent changes to the system mean that in the event of no further adjustments to the benefits payment over the next seven years, this total can be reduced by 1.8 trillion yen and be capped at 8.7 trillion yen. This will also enable the average monthly insurance premium to be reduced by 1100 yen from the current 6000 yen to 4900 yen.

The content of the current reform can be seen as a transformation to a nursing care prevention system. In looking to avoid any deterioration in service, as well as looking to limit any further increase in the burden of cost to the insured, it is necessary to ensure that while nursing care insurance covers all eligible persons, it also does not extend to anyone not requiring such care. Promoting the underlying philosophy of Japan's nursing care insurance system—of "respecting individuals' lifestyles and existence and supporting the right to live as independently as possible" or, in other words, "self-reliance"—this means having to prevent any deterioration in the care condition of persons requiring minor nursing care. Such persons make up over half of the persons receiving treatment under the nursing care insurance program classified as "requiring support" or "requiring nursing care level 1" (approximately 2 million people). This also requires focusing on ensuring that healthy elderly subjects, who do not require any such care, do not subsequently come under this program's coverage. This involves the active promotion of activities such as health prevention seminars and training aimed specifically at elderly people.

Approach for the dementia

Dementia is one of the leading illnesses affecting the elderly, and as the number of elderly persons suffering from dementia in Japan continues to undergo a significant rise, a number of preventative measures are beginning to be implemented that cater to affected persons.

The number of elderly Japanese suffering from dementia stood at 1.49 million as of 2002. This represents approximately half the number of people recognized as requiring support or nursing care. Of this number of dementia sufferers, approximately half (730,000) continued to maintain an independent home-based lifestyle, while approximately 80% of residents of nursing care facilities were comprised of dementia sufferers. The total number of elderly dementia sufferers rose to 1.69 million in 2005 and is expected to increase to 2.5 million in 2015, 3.23 million in 2025, and 4.0 million by 2040 (Akasaka. 2006) (fig.3).

Dementia Population (over 65)

Figure 3. Dementia population (over 65)
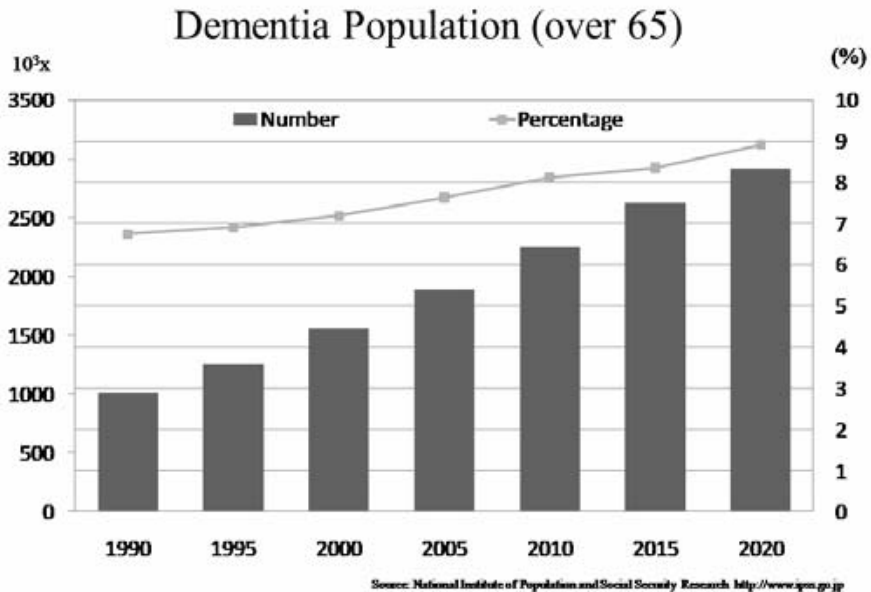
Although a certain level of success has been attained in treating dementia with drug therapy and rehabilitation, a truly effective treatment for this illness has yet to be developed. Approaches and underlying philosophies towards dementia treatment and care vary from country to country. This has resulted in a wide range of techniques and approaches to treatment that cover everything from

medical, psychological, nursing, welfare, and construction, including reminiscence therapy and music therapy aimed at stimulating cognitive and storage function; activity care that makes use of artwork and drama; and group home nursing that looks to provide small scale care that can be adapted to each subject's living conditions. The results of studies into nursing care techniques towards dementia care, however, mostly remain at the research stage, with any attempts at systemization and theory having only just gotten underway.

Set against this background, Dementia Care Research and Training Centers were established in Tokyo, Obu, and Sendai in 2000 as a national grant-aided project. These centers were charged with carrying out research into dementia nursing care, as well as developing a training system for practitioners of nursing care for dementia. These centers train specialist professionals to work in the field of dementia nursing care and aim to disseminate the results of these activities to old-age facilities and home care services throughout Japan. In 2005 the Japanese Society for Dementia Care also established an accreditation system, "Dementia Carer Qualified," as they sought to promote the fostering of specialist professionals in the field of dementia nursing care. This accreditation system would equip holders with a high degree of training, education, technical skill, and standards of ethics towards nursing care treatment. This has involved getting rid of the experiences of conventional dementia care and aiming to develop standardization of care and creation of a dementia care model. This subsequently developed into aiming to develop a team care approach that emphasises a multidisciplinary role, and incorporates different healthcare professionals.

Team care

The history of the development of nursing team care within Japan can be traced back to the World Health Organization's (WHO) efforts at developing comprehensive medical health care programs and comprehensive medicine in 1963 (Kawakubo and Yamada 2000, 14). Following this, since the second half of the 1990s, while related occupations continue to assume their independence and individuality, the idea of a "team care" approach that focuses on interaction between different healthcare professionals has come to be increasingly adopted in the field of general nursing care (Terui and Nomura 2006).

When, however, what is outlined above is viewed from the prospect of approximately half of Japan's elderly population requiring nursing care, and up to 80% of residents of care facilities suffering from dementia, healthcare professionals

engaged in nursing care have to understand the concept of dementia and be able to provide the necessary treatment. More recently there has been an increasing demand for elderly subjects suffering from dementia to be treated in such a way that there is interaction between different healthcare professionals. This usually involves family or home-helpers, care workers, and nurses providing direct physical care or household assistance for subjects, although occupations related to medicine or welfare and the provision of direct or indirect care to affected persons are also indispensable to ensure such persons can maintain their lifestyles. This has led to the development of various professional interrelationships, suggesting that, putting aside the argument that this framework may well have been based on awareness of such knowledge, this idea of team care has come about organically.

When developing a team care structure that allows for members drawn from related professions to carry out their duties to the best of their ability, there needs to be a leader at the core who can balance the duties of each occupation to carry out problem solving, and is capable of developing a system for sharing information. This leader should take the form of a care manager, primary care worker, or a physician. Especially in recent years, the concept of a multidisciplinary approach to interaction between healthcare professions (such as collating information from different specialist professionals and sharing information as a team), have continued to take hold throughout the nursing care profession. These include an interdisciplinary approach, where planning and evaluation for treatment are carried out, and care plans are made based on cooperation at a specialized and dedicated level, and a transdisciplinary approach, in which the aim is to expand the common areas between each specialist profession and respond flexibly to meet the needs of subjects as the situation demands.

The team care approach to nursing care involves cutting across the different roles of healthcare professionals to share duties and information. As this approach is increasingly implemented, there is an increased tendency for the content of the work carried out by each profession to complement and closely resemble work done by others. This approach also involves the need for frequent conferences and other meetings in order to establish understanding based on diverse occupations, and to promote the integration of information. The treatment policy and decision making of such teams has conventionally been based on the leadership decisions of the team physician in cases requiring a high degree of urgency and restrictions to the treatment of problems. In looking to provide rehabilitation treatment and lifestyle support for chronic illness and recovery from disability, however, this involves the setting of relatively long term targets

and the establishment of an assistance policy, meaning that there is a tendency for the team's decision making process to be carried out based on parallel interaction between all of the parties involved.

In the event of the degree of contribution to the team being unequal, differences arise between professionals in terms of the level of sharing of information. A variety of different factors impact the incompatibilities between members of a particular team, between relationships involving family members of the affected subjects, and changes in the subject's physical condition or living conditions. Continuing to allow the different specialist areas from each healthcare professional to be used for each different set of circumstances, however, allows for the affected person to request the appropriate degree of nursing care to suit his or her situation, meaning that the respective specialities of each team member have to be respected while ensuring that all members share the same goals and guiding philosophy.

By looking at the eating habits of elderly sufferers from dementia, this section will examine the different contributions that healthcare professionals can make to elderly nursing care facilities while operating as multidisciplinary teams. This will be based on evidence from a case study analyzing the role of dental hygienists at such a facility in examining a team care approach to supporting residents' dietary habits.

Team caring for nutritional support − multi-occupational team and dental hygienist

Recently, there has been increasing awareness in Japan of the importance of adequate nutritional uptake in the management of illness and disability. This is reflected in the creation of independent nutrition support teams (NST) in hospitals' inpatient wards, with an increasing number of facilities looking to provide appropriate nutritional management. Such teams are typically composed of physicians, nurses, nutritionists, pharmacists, and clinical technologists, who assess patients' nutritional status at an early stage following admittance to provide appropriate management of subjects' nutritional status. This allows patients identified as suffering from poor nutrition to undergo an appropriate examination and treatment (such as oral, enteric, and intravenous alimentation), and be provided with nutritional support to improve their nutritional status. Nursing care facilities that provide rehabilitation for patients affected by problems with swallowing and achieving adequate nutrition have also been increasing in number. This team

care approach to providing support for dietary function requires the incorporation of a wide range of different healthcare professionals, with teams consisting of nurses and caregivers, as well as speech therapists, physical therapists, occupational therapists, dentists, and dental hygienists (fig.4).

Support for Eating

- Nutritional needs
- Life support - medical aspects
- Cognition of food-catching
- Placing food in the mouth
- Chewing, Masticating
- Swallowing
- Digestion
- Social eating, Manners
- Enjoyment
- Longevity and Health
- Quality of Life

Care Stuff

Registered Nurse

Medical Doctor

Occupational Therapist

Speech Therapist

Registered Dietitian
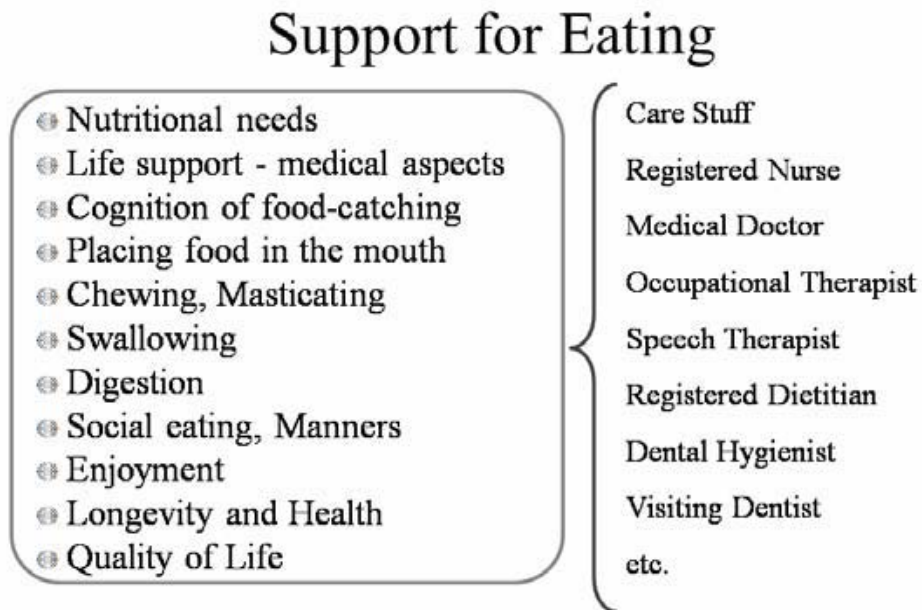
Dental Hygienist

Visiting Dentist

etc.

Figure 4. Support for eating

From its very inception, the nursing care facility Sendan-no-Oka (fig.5) has employed a dedicated dental hygienist responsible for performing oral care for residents, although the content of these duties has gradually changed since the initial appointment.

Facility User's condition of Sendan-no-Oka
94 person（Apr. 2007）

○ Average age   83.8 years old
○ Average duration in the facility   17.9 months
○ Average index of the need for care   3.6

Established: Apr. 2000

Capacity: 100 people

Needs of support for eating

Tube feeding 16

Independent 42

Full support 6

30 Partial support

Provided foods texture

Softened food 12

Tube feeding 16

Processed food 22

44 Normal food
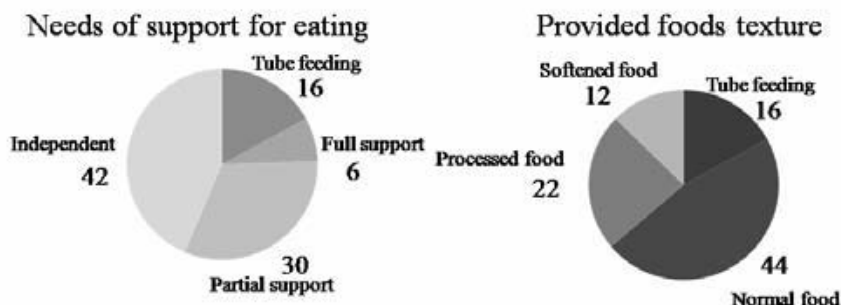
Figure 5. Facility user's condition of Sendai-no-Oka

At first, the dental hygienist's main duties were in improving residents' oral hygiene, but together with the addition of an additional dental hygienist, nutritionist, and speech therapist, this team formed the facility's "Oral Nutrition Section." This is at the center of the facility's efforts to bring each healthcare professional's specialist skills to bear on the issue of dietary support. Long-term residents of the facility were provided with support for oral hygiene care, enabling improvements in oral hygiene conditions as this took on the nature of an everyday habit. This in turn allowed the dental hygienist to focus more on assessing the oral hygiene conditions of new residents and providing support for dental treatment (Watanabe, Wakoh and Abe 2006). This increase in dental hygienists enabled the implementation of specialist care for oral hygiene for regular users of the facility, and through nursing prevention seminars and training, enabled the active dissemination of oral hygiene care and preventative measures. The facility was also able to monitor residents at mealtimes, allowing for the development of a system that could examine approaches to helping residents with eating from the

perspective of nutrition, eating and swallowing function, and oral hygiene. (See fig. 6.)

Transition of Oral Health Care Services in Sendan-no-Oka (2000-2007)

- a full-time dental hygienist had been employed
- Oral health Seminar for all staff
- Establishing an oral care method for clients (10 min/person, 20 people/day)
- Started dental treatment by visiting dentists
- Easy access to dental treatment
- Problem sharing with care staff
- Revise the contents and frequency of oral care practice for individual needs
- Providing an atmosphere where brushing teeth is natural after every meal
- Oral care as living support
- One more full-time dental hygienist had been employed
- Team approach with Speech Therapist and Dietitian
- Oral health care service for day-care users
- Promotion of oral health care as the care-prevention program

Figure 6. Transition of oral health care services in Sendan-no-Oka (2000−2007)

These developments have resulted in an easier exchange of information between the dental hygienist, speech therapist, and nutritionist. Having the care unit meeting with other contact persons, including the providers of the facility's meal service, to discuss management of the meal service, allows for the resolution of any problems concerning the dietary habits of the facility's residents. This can be seen as giving expression to the development of an interdisciplinary team in which the members continue to reinforce each other through sharing information among themselves and with outside professionals with the overall aim of supporting residents' dietary habits while continuing to maintain the dental hygienists' specialist skills. In terms of opportunities for sharing information, in addition to holding regular meetings about the provision of institutional food, there are also regular case conferences where the goals and policies for each individual resident are determined. Each care unit is also equipped with a notebook for

recording data, and detailed instructions for carrying out oral hygiene care are located near the wash areas of each resident room or unit so that information can be shared between team members. Conscious efforts are also made to hold regular study sessions and provide direct advice for new employees.

In playing a crucial role in such a team and putting such measures into action, the dental hygienists, in addition to answering questions regarding correct post-meal brushing habits, have also seen an increase in the number of times in which they respond to questions regarding approaches to dietary support, the best way to thicken food to make it easier to swallow, and other related techniques. As there are limitations to the number of residents to whom the dental hygienists can provide direct care among the 100 residents of the nursing home, one unit (20 persons) is seen each day, with each of the five units being seen on a different day of the week. The development of this system, in which residents know the dental hygienist will be present on a certain day, is also very clear for other healthcare professionals, and is thought to contribute to easier cooperation and improved efficiency in the facility.

The role of other professionals during the facility's mealtimes, such as the monitoring of meals by care workers, allows the staff to determine whether residents are actually eating their meals with enthusiasm. The occupational therapist determines whether residents are eating their meals properly and also looks at the necessity of self-help devices for residents. The national registered nutritionist's role focuses on the current nutritional status of residents, while nurses carry out detailed nutritional management and physical care management. The speech therapist evaluates the residents' swallowing function, and provides subjects who need help with swallowing training to ensure that they can safely ingest their meals. The resident physician is primarily responsible for the overall health management of the facility's residents, with appropriate drug administration management at mealtimes being an especially important part of this role. The dental hygienist performs oral hygiene management, in addition to oral function management. These are all part of the effort to ensure residents maintain a standard of oral hygiene that enables them to eat their meals properly. When seen from the perspective of the necessity of medical care, residents who do not use their oral cavity for a certain period of time can be subject to lowered production of saliva, increased dryness, and a deterioration of oral hygiene. When viewed as an entry point for nutritional uptake, then the oral cavity needs to be maintained and provided with support to allow it to be able to take in food. At this facility, dental treatment was provided by outpatient dental visits after obtaining

consent from the subject or his or her family, and post-operative care was subsequently carried out.

Besides providing preventative oral care treatment as a measure to prevent the need for nursing care, the dental hygienists also provide oral care treatment as an element of dietary support, and this is an essential function of the facility. In the future, the placement of such dental hygienists in nursing care facilities and institutes is something that should be considered necessary (Watanabe 2006).

The following is a case study of the role of the dental hygienist at Facility Sendan-no-Oka, examining the role of the dental hygienist in performing oral care for elderly sufferers of severe dementia who require nursing care.

A case study - oral health care for the dementia person

At nursing care facility Sendan-no-Oka, 85.7% (72 in 84 people, Feb. 2007) of the residents score below 20 on the revised Hasegawa Dementia Scale (HDS-R), and the majority of patients suffer from dementia. Subjects suffering from severe dementia often forget to maintain basic oral hygiene, forgetting to brush their teeth or swallowing water used for rinsing, meaning that it is common for residents to face difficulties in properly maintaining their dentures. Such subjects often prevent healthcare workers from examining sensitive areas of their oral cavity and may harm any such person attempting to do so.

Due to the presence of a dedicated dental hygienist engaged in providing long-term oral care in this facility, however, a process has been established to facilitate good oral care to be carried out. In examining the subjects on an individual basis, the facility has successfully implemented an advanced method for carrying out such treatment.

Case study

Subject A (73 years old) / Female

Previous medical history

      July 2003: Cerebral infarction

          February 2004: Diagnosed with Alzheimer's dementia

June 2005: Admitted to this facility

Oral hygiene condition (at time of entry)

Functioning teeth: 22 (Treated teeth: 14 / Untreated teeth: 6)

Gingival redness (+) / Swelling of the gums (+) / Halitosis (+) / Bleeding gums (+) / Plaque adhesion (+)

Post-admittance progress

No significant change in physical function was detected in Subject A from date of initial admittance to present, although the subject was incapable of concentrating at mealtimes due to decreased cognition, and showed an increasing frequency to wander around the facility holding dishes and chopsticks. Following Subject A changing living quarters from January 2007, the subject began to spend a significant amount of time in the adjoining toilet. Subject was able to go to the toilet after meals following instructions from staff, but was unable to follow verbal instructions and often went past the toilet. A case conference on Subject A was held every 3 months, with the following oral care-related problems brought up by nursing staff and the dental hygienist.

- Lack of recognition of verbal instructions and failure to respond was common.
- Unable to remain in one fixed spot, such as waiting before the washbasin.
- Strongly resistant to physical contact, especially of the oral cavity.
- Due to difficulty in self-brushing, concern over onset of decay and periodontal disease.
- Often unable to fully expel all water within oral cavity in one motion when rinsing mouth.
- Strong halitosis having an effect on interaction with other people.
- Level of assistance, such as verbal instruction, increasing at meal times.

In response to these problems, staff established three goals.

1. Prevent infection from the oral cavity and enable Subject A to lead a healthy and comfortable lifestyle.
2. By reducing extent of halitosis, aim to provide for smooth communication and interaction with other residents and staff.
3. Maintain and protect functional teeth and prevent any further deterioration in mastication capability, allowing for further sustained enjoyment at mealtimes.

The following approaches to oral care outlined below were subsequently implemented in an attempt to achieve these goals, with nursing staff sharing problems and ensuring adequate communication between team members.

- Implement these when Subject A feels good, irrespective of the time.
- Carry out care in location Subject A is comfortable in. Avoid any potential confusion.
- Turn off television to ensure no external distractions.
- Remove any excess objects and carry out adjustment of the surrounding environment.
- Include activities with meaning (such as songs etc.) to connect the act of brushing with enjoyable activities.
- Allow one-on-one situations where instructions are given in a clear and easy to understand manner, allow for maximization of subject's survival capability.
- More important than implementing these goals perfectly was to perform them on a daily basis to establish a stable lifestyle rhythm.

These activities resulted in Subject A becoming less confused and being able to relax at treatment times, allowing oral care to be performed, with team members seeing an improvement in oral hygiene. Halitosis was also seen as decreasing with the number of visible smiles increasing during one-on-one interaction. An increase in the time in which Subject A concentrated on eating and nutritional uptake was also observed when examining changes to the dietary situation and mealtime environment. Due to changes in subject's dementia condition, however, there were still occasions in which Subject A continued to refuse treatment due to changes in mood or physical condition. This resulted in restrictions on the time available for performing oral care, with it remaining difficult to achieve results from a single, short time period for care provision.

Through the work of the resident dental hygienist since Facility Sendan-no-Oka's establishment, it has become natural for residents to perform oral hygiene care following every meal. This has also resulted in all staff members taking an interest in ensuring residents perform adequate oral care, and making sure that any problems that do arise are reported to the dental hygienist. The dental hygienists provide specialist oral care once a week (sometimes two to three times depending on the individual case), and regularly provide a review of residents' oral hygiene and oral function. In addition, by communicating the necessity of oral care, oral hygiene status, care approaches, and selection of care products for each subject to other staff members, efficient and effective oral care can be imple-

mented at different stages within the dental hygienists' normal working hours at the facility.

This study revealed that for nursing care for elderly dementia sufferers, providing support that took into account each subject's lifestyle and pattern of daily activities was extremely important, as was examining each subject's current physical and mental state. This, therefore, meant providing care for subjects when they were most at ease and accessible, which involved being able to respond flexibly in terms of time and location, and meant it was better for nursing care staff to adopt a cooperative approach to care giving. The facility's resident dental hygienists were able to provide oral care through adopting a team framework approach that placed priority on keeping tune with the rhythm of subjects' daily lifestyles. Through this the facility was able to implement an effective oral care program.

Although clear changes were observed as part of the three goals that were implemented for change at Facility Sendan-no-Oka, the efforts initiated in these changes can be thought of as not limited solely to oral care but as part of a team-based approach to improving the living environment and subject's lifestyle. This type of case study is one of relatively few examples that have looked at lifestyle-based nursing for dementia sufferers from the viewpoint of oral care. The involvement of a dental hygienist in the nursing care sector can also be viewed as having a significant effect on treatment in this field.

The importance of oral care is widely recognized by healthcare workers. A variety of methods stressing the importance of team care and interdisciplinary approach to care among care workers and nurses have been introduced and are currently being implemented in actual situations. These case studies are expected to expose any problems or failings for each approach to team care, as well as contributing to carrying out any revisions and improvements.

References

Akasaka, H. 2006. Promotion of Alzheimer's disease programs. Journal of Japanese Society for Dementia Care, 5(1), 68-74.

Kawakubo, M. and Yamada, T. 2000. 80 points of successful team care for the elderly. Japan Medical Planning. Tokyo.

Terui, M. and Toyoko, N. 2006. Team care self-evaluation model in dementia care. Journal of Japanese Society for Dementia Care, 5(3), 416-425.

Watanabe, Y. 2006. Oral Health Care for the Elderly. Annuals of Kansei Fukushi Research Centre, Special Issue, Refurbishing the Elderly Care – Evidences and Theoretical Targets-, Chapter 9, 75-81.

Watanabe, Y., Wakoh, R., and Abe, K. 2006. Role of Full-time Dental Hygienist in the Health Services Facility for the Elderly as to Keep the Relationship with Dental Services: Oral Health Care including Dental Treatment Support to the Residents. Japanese Journal of Gerodontology, 20(4).

Active Art in Dementia Care

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Introduction

Active Art is a Finnish adaptation of the Japanese Clinical Art method, which contributes to the Finnish art therapy field a comprehensive, tested method focused on the joy of doing, on experience and on multisensory perception. Researchers from Tohoku Fukushi University (TFU) and Kansei Fukushi Research Center have found in studies on dementia and brain activity that Clinical Art therapy is effective both on aging patients with existing dementia and as a preventive measure. (Oshiro et al. 2006).

A presentation by Clinical Artist Taizo Oshiro at the First Sendai-Finland seminar in March 2006 awakened huge interest in the Finnish delegation, particularly in the Vantaa-based Anna-Liisa Korhonen, the director of elderly and disabled care, and Hannele Niiniö, a senior lecturer at Laurea. The seminar took place at an interesting point in time, as a cooperative effort in the city of Vantaa between the Social and Health departments' services for the elderly and disabled and Cultural Services had been in the works for some time. Plans for developing and reorganising daytime activities for the elderly were also under way. This formed a fertile ground for receiving new methodological ideas.

The underlying philosophy of Clinical Art is to see the Alzheimer's Disease (AD) patient first as an individual, rich in life experience. In Clinical Art heart-to-heart communication with patients is essential. Clinical Art aims at helping the patients to find joy in the process of creation and restore self-confidence. Clinical Art method has been developing since 1996 and used mostly with elderly persons but also with cerebrally, intellectually and developmentally challenged children. (Oshiro et al. 2006).

This text describes the contextual environment within which Active Art research and development takes place in Finland. We examine everyday activities among elderly groups, as well as the basic research framework within which the effects of Active Art will be evaluated. Two of the main pillars of the activities and research are resource-orientation and a socio-cultural concept of old age. These factors cannot be said to be a reality or a description of predominant conditions in Finland. They are more of a philosophy-like backdrop that guides the Active Art venture in Vantaa in the form of a strategic intent and vision.

We begin by briefly describing the historical framework and move on to the current state of elderly care services. We summarize the first year of the Active Art pilot project. At the end, we discuss challenges and research questions that we feel are relevant in Finland now and in the future.

Connections between art and well-being

Until the late nineteenth century, in Western philosophy, health was seen as a cultural and social phenomenon and a resource to be safeguarded. Developments in Western medicine and the strong advent of scientific background theories for medical research and activities at the turn of the twentieth century changed the prevalent concept of health. For nearly one hundred years, health was seen as the opposite or flipside of sickness. A holistic socio-cultural vision of health was not valued again until the late twentieth century (Hyyppä and Liikanen 2005, 20-34).

Visual expression was used diversely in rehabilitation and health care throughout the twentieth century in both Europe and the United States. In the UK, visual expression was used for example to support the psychological healing of war invalids. The Freudian school sees pictures as material for analysis, which provide information on the patient's subconscious processes. Art contributes to therapy a third element – the painting process and the finished piece – that can be used

in working with individuals and groups, in structured ways or freely (Liebmann 1992, 5-6).

The concept of art therapy is difficult to define. In his doctoral thesis, Antti Alanko (1984, 16-17) describes Boenheim's classification, according to which there are two forms of art therapy: art psychotherapy and art as therapy. In the early twentieth century, art was used in Finland particularly in psychiatric hospitals; there are records for instance of images created by patients at Nikkilä Hospital from 1919. Proper, regular art therapy activities as a part of care and rehabilitation began in Finland in the late 1960s, and the first full-time art therapist was hired at Hesperia Hospital in 1967. Art formed a part of nursing and rehabilitation at psychiatric hospitals, where the activities could be divided into three categories: 1) daytime activities, 2) creative methods to support rehabilitation and 3) art therapy using analytical methods (Hyyppä and Liikanen 2005, 120-122). We consider Active Art to fall into the second category. Art psychotherapy and the Freudian school of thought, according to which images represent subconscious processes, are far removed from the Active Art method.

Since 1973, art therapy has been included in the operations of all of Finland's central psychiatric hospitals. In that year, the Finnish Association for Mental Health organised the first national art therapy seminar, after which a memo was produced for the Ministry of Education on organizing art therapist training. The Finnish Association for Mental Health has been a pioneer in training art therapists in Finland (Alanko 1984, 16-20).

Theories that link culture and health are based on both humanistic theories (essence of culture and art) and scientific theories (relationship between art and health). John Dewey's pragmatism formed the basis for Richard Shusterman's thoughts (Shusterman 1997, 17-18). Shusterman describes Dewey's philosophy as a down-to-earth, joyful and democratic aesthetic that contrasts with the strict and elitist branches of aesthetics (ibid.,18-19). According to Shusterman, art is a two-way communication process, which is encountered as an experience. A cultural and artistic experience can be described as a sensation-like, bodily, dynamic, rhythmic and balance-seeking experience that generates well-being. According to Shusterman's pragmatist philosophy of art, interaction between the work of art and the person that experiences it is essential. In that context, art is seen as not just a piece of work but as a communication process that facilitates human activity. In Finland, for example Hanna-Liisa Liikanen's doctoral thesis is based on a pragmatic philosophy of art (Hyyppä and Liikanen 2005, 36-48).

Aesthetic experiences affect not only our emotions but also our psychobiology. Culture is the missing link that defines the quality, impact and processing methods of an artistic experience and our behaviour after the experience. Through emotions, artistic experiences affect the psycho physiological balance of the brain and therefore our health (Hyyppä and Liikanen 2005, 50-54).

In her thesis, Finnish art education researcher Tarja Pääjoki states that "*art can lead to a holistic sensory experience that gives room for encounters*" (Pääjoki 2004, 102). However, Pääjoki's theoretical links do not lean on the pragmatic philosophy of art or theories of art as communication, as Liikanen's texts do. Pääjoki's thoughts are induced from such Western contemporary philosophers as Hans Georg Gadamer, Mihail Bahtin and Michel Foucault. At the heart of the theory are deconstruction, contextuality, corporality, questions of power and opportunities that transcend and dissolve the boundaries of art (Pääjoki 2004, 17-18). Pääjoki's encounter-facilitating perspective toward art is a model that strongly supports diversity. The difference between it and the approach that emphasises communication may seem rather insignificant, but on closer observation, it becomes evident that in Pääjoki's theory, art is not so much a tool as a *place*. This is interesting from the point of view of Active Art. Art does not have to be instrumentalised even when it is included in a rehabilitating context. Instead, art can be seen more broadly as an opportunity to think differently and to tear down some of the power structures of individuals, communities and the society.

Finland has produced few critiques of the psychoanalytical concept of art therapy. In the UK, by contrast, Frances Kaplan has illustrated the interrelationships between art, research and art therapy in diverse ways. She asks whether it isn't time to put aside outdated psychotherapeutic models and let art therapy stand on its own feet. Making use of other researchers' findings, she sums up art as a form of cognition, a part of normal development and a way to structure experiences, saying that it offers an alternative communication method, can promote internal connections among those in a group, provides experiences of success to the severely handicapped and forms a special rehabilitating environment. These considerations lead Kaplan to describe art as able to promote or maintain activity, particularly among those who suffer from impaired brain activity, speech impairments, mental health problems or social issues (Kaplan 2000, 93-100).

From a new concept of old age to resource-orientation

Simo Koskinen polarises two main models that have usually been used to define old age and aging. In the juxtaposition, a biological and biomedical approach is contrasted with a socio-cultural approach. Koskinen implies that the biological-biomedical model medicalises aging. By principle, it focuses on deficiencies. Old age is defined through problems and defects. Koskinen stresses that this approach makes it difficult to build resource-focused debates and practices related to old age and aging. This problem-based model has been effective for half a century, but Koskinen identifies signals that indicate it may be moving aside, or at least being joined by a socio-cultural concept of old age. According to Koskinen, new voices are being heard from the fields of political economics, social constructionism, and humanistic and cultural gerontology. Within the context of the socio cultural concept of aging, old age can imply growth and development as well as decay and renunciation.

Gergen and Gergen (2003) have defined aging as a discourse whose appearance and nature can be deduced from human interaction in specific historical and cultural contexts. In this view, old age and aging are not an absolute concepts but are constantly changing, generated through interaction. Gergen and Gergen help to explain why old age is seen so differently in different cultures. There is no single homogeneous national gerontology discourse, because even national cultures consist of several subcultures. Different significances are also imparted to old age by the young and the elderly themselves. Regional phenomena have their own effects on the definition of old age: the long life expectancy of some areas, such as the autonomous Åland Islands in Finland or Okinawa Island in Japan (cf. Hyyppä), probably produces a different discourse from that which predominates in the capital cities in the same countries. In his thesis, Jyrki Jyrkämä (1995) looks at social aging and discusses the diversity of definitions of aging in different regions (1995, 135-150).

Koskinen emphasizes the fact that a cumulative vision of life makes it possible to identify resources and the factors that affect them. In this theory, an individual life history can be seen in parallel with social tendencies, identifying the dependencies that are built between the individual and the society. In addition to looking at the effects of insufficiencies and defects, one can examine the resources that individuals have gathered throughout their lives. Old age and aging can be seen very differently in the light of these resources. This model also has room for the

concept of resource-building – i.e. that people can be supported in a process by which they strongly take control of their own lives instead of having them defined externally. Koskinen derives his views from the model of good life described already in the 1980s by Powell Lawton, consisting of four aspects: psychological well-being, competent behaviour, a self-perceived quality of life and an objective environment (cf. e.g. Lawton 1983, 355). The concepts of "successful aging" and "courageous aging" also provide an interesting viewpoint into old age and into the production of new service methods and forms for geriatric care. Koskinen specifies: "The evaluations of the elderly regarding the outcomes of successful aging are important when mapping resources." Koskinen classifies resources according to the following main categories: 1) group-level or collective resources, 2) socio-cultural resources, 3) social resources, and 4) personal or spiritual resources.

Simo Koskinen criticises most studies that measure functional ability as focusing mainly on physical capability and ignoring other abilities. He also considers it problematic that most studies focus on individuals' qualities. Interaction theories have recently contributed a new research approach, in which functional ability should always be defined in terms of the relationship between the individual's characteristics and the environment's properties. Instead of functional ability, Koskinen proposes the concepts of well-being and quality of life, because they take into account the life of the elderly holistically (Koskinen 2006). Jyrki Jyrkämä goes along the same lines when he recommends that research should focus on understanding the social situations in which the elderly take part rather than on measuring the capabilities of individuals (Jyrkämä 2007). This would be an interesting challenge for Active Art: *to examine the social environment built by Active Art and its effect on the well-being or self-perceived quality of life of the elderly.*

Koskinen's texts contain a strong message related to research ethics, and a specific concept of humanity and reality can be discerned between the lines. We should involve the elderly more in debates related to themselves and leave room in evaluation methods for their own definitions. The lived and experienced life must not be obscured under a weighty research setting. People are not separate beings; we are linked to our environments on many levels (Koskinen 2004, 36-42).

The *Aging as a Resource* report commissioned by the Prime Minister's Office in Finland (Appendix 5 to the Report on the Future) probes the future scenarios of our aging society in an opportunity-oriented way. The report consists of eight articles whose authors are Finnish aging-policy experts from various fields. Mikko

Kautto's article "Ikääntyneet resursseina, ikääntyminen mahdollisuutena" ("The Elderly as a Resource, Aging as Opportunity") opens the report. Kautto summarizes some of the tendencies of the discourse on aging that has been ongoing in the last decades. He mentions that since the 1960s we have talked about successful aging, whereas productive aging came into the picture in the 1980s. Active aging came about from the thought processes of the 1990s, closely linked to the "society for all ages" idea of the UN and WHO, which sees aging as a process that brings generations together and affects everyone. A resource-oriented approach is related to the idea of healthy aging. In this context, preventive policies and measures that promote active and healthy aging take priority. The results of preventive work are only seen as unfulfilled expenses, which Kautto considers to be one reason for decision-makers still lacking belief in its importance (Kautto 2004).

Antti Karisto defines the "third age" as the period between working life and frail old age. According to population forecasts, by 2030 1.6 million people out of Finland's 5 million population will be aged 65 and over. Thus, in 2030, there will be more representatives of the third age than now. The identification of opportunities and resources is linked particularly to the potential of this age group. The close ties between biological age and self-perceived age have loosened, which means that the third age can be prolonged by supporting the elements of the self-perceived life (Karisto 2004).

Socio-cultural stimulation leads to increased social capital

According to Marja Vaarama, functional ability and vitality can be boosted with the help of exercise, culture and service centres. An active life produces happiness, health and functional ability. The conclusions of Vaarama's study to map the functional ability of and care services received by the elderly clearly indicate that in addition to physical capability, psychological and social capabilities are very important for the elderly to cope independently. According to Vaarama 2004, 186:

1)   The basis of elderly care services should be developed to be more socio-cultural, and the needs of the elderly should not be reduced to treating illnesses.

2)   Support for and maintenance of quality of life should become con-

scious targets for elderly care services, and training of management and practical workers should be developed correspondingly.

3) The physical, psychological and social abilities of the elderly should be promoted by providing programmes that maintain and improve these abilities.

In our experience, operations in Vantaa are in accordance with Vaarama's outlines. Anna-Liisa Korhonen, Director of Elderly Homes and Day Care Operations in Vantaa, speaks and works to promote this approach. The Active Art pilot cooperation between Laurea and Vantaa-based elderly care units is based on Vaarama's theses. Vantaa is an interesting environment in terms of aging, which takes markedly diverse forms in the area. Residents' life histories have been built in different environments and cultures. Today's elderly in Vantaa come from very assorted environments. Some have a background in the countryside with its agrarian lifestyles, while others have lived in urban service centres. The growing proportion of immigrants among the customers of elderly care services is another important phenomenon. As a strong net immigration region, Vantaa can be said to be a stage for the cultural diversity of aging.

Hanna-Liisa Liikanen's approach emphasises resource-orientation, interaction and enjoyment. Behind it lies Richard Shusterman's pragmatic philosophy of art, as well as the socio-pedagogical ideology of socio-cultural stimulation. Liikanen summarizes the importance of cultural activity in rehabilitating care by indicating that it strengthens networks, supports communities and prevents social marginalisation (Liikanen 2004, 73). The levels of significance thus range from individuals to networks. Similarly to Liikanen, Taina Semi builds her approach on the theory of stimulation. Behind the application of socio-cultural stimulation lies the social pedagogy developed after World War II and adapted to Finnish conditions by Leena Kurki (2000). In the last decade, Semi has developed an expressive rehabilitation method for dementia care, in her capacity as a practical nurse and care entrepreneur. The aim of the method is to facilitate and make evident the "significant and human day-to-day life of the culture of dementia patients". Semi's method leaves room for both individuality and communality (cf. Semi 2004a & 2004b). Semi ties everyday life to concrete values and management processes. The method focuses on the remaining resources of a dementia patient, and supports social interaction and a safe environment (Semi 2004a, 15; 2004b, 109).

Finnish researchers such as Petri Ruuskanen (e.g. 2001) and Markku T. Hyyppä have discussed the concept of social capital in their texts and research.

Ruuskanen investigates how the concept of social capital has been applied in empirical research (2001, 37-44). Although the emphasis has until now been on examining participation in society and in clubs and associations, this concept could offer an interesting perspective into evaluating the effectiveness of Active Art operations. Hyyppä describes social participation as essential in generating social capital (Hyyppä 2002, 178). Behind Hyyppä's theories are Pierre Bourdieu. The concept of social capital concerns the elements of interpersonal trust, communality and the resulting perceived quality of life. The concept lies somewhere between economics and social science, which is optimal in terms of our multidisciplinary network (Helsinki School of Economics, Laurea, Tohoku Fukushi University). A hypothesis that could be tested on the basis of this concept is that *Active Art produces trust between participants, care personnel, family and friends, and this strengthens the elderly patient's own perceptions of successful aging.*

Active Art pilot as collaboration between the City of Vantaa and Laurea

We consider it essential that Active Art is a target-oriented group-based method, in which a social peer group supports well-being through experience, stimulation and participation. By experience we mean that Active Art should be a multisensory art-like activity, in which the aging person is strongly positioned as the subject. Work that awakens the senses and shared, appreciative discussion of the products of the process help to connect participants to the present. Artistic activities offer opportunities for bringing out themes that are interesting to the elderly themselves. Involvement is the best way to define one's own life. In addition to stimulation, Active Art includes opportunities for hearing and being heard in the alternative language of art in relation to issues that the participants wish to communicate. The activity and participation facilitated by art are values in their own right. They also generate social capital and thereby support well-being. Art allows for a positive cycle.

Planning for the Active Art pilot project began in the autumn of 2006 at Laurea Tikkurila, in cooperation with the cultural affairs department and the elderly care services of the City of Vantaa. The autumn was spent gathering information on the Clinical Art method, negotiating expert exchanges with Tohoku Fukushi University, planning training and evaluation, and recruiting employees and students. The preparatory work was coordinated and networked by Project Coordinator

Hannele Niiniö, while Principal Lecturer Armi Jyrkkiö was in charge of planning evaluation. Training began in February 2007 under the direction of Laurea Senior Lecturer Tiina Pusa. A highlight of the spring's training period was the arrival of Clinical Art trainer Taizo Oshiro of TFU at Laurea to train the project team consisting of elderly care employees and lecturers and students from Laurea's creative method department.

Five Active Art groups began operating in late March 2007. The groups worked at the Suopursu elderly care home and day activity centre, at the Veturipolku elderly care home, and at the privately owned Atzalea care home. Six employees, six students and 30 old-age pensioners participated in the process. Most of the patients suffered from mild to intermediate dementia. The exception was the Suopursu day activity group, whose customers suffered from aphasia, i.e. difficulties in producing and comprehending language. The most severe dementia cases were at Atzalea, where the employee was supported by two students from Laurea. Each group got together in art sessions 8-9 times at weekly intervals, for an average of two hours at a time. An essential part of the process consisted of the project teams' supervision during the spring, where the employee/student pairs received the necessary support for their work. Supervision was provided by senior lecturers Tiina Pusa and Hannele Niiniö.

On the basis of the employee/student teams' experiences, the evaluation reports, the supervision and the seminar, we can say that the pilot was important in terms of initiating the process and creating a research base. The successful experiences provide good foundations for continued development of the Finnish version of the method, i.e. Active Art. Some of the strengths identified in the pilot project in Vantaa were the good groundwork done to promote socio-cultural elderly care work, the success of the two-person teams, and the positive feedback received from the elderly customers. The latest feedback was received this autumn from a patient suffering from intermediate dementia, who asked when we would start "doing art again". No one would have expected her to remember the art group after three summer months.

Active Art in future elderly care

Finnish debates on aging have shown signs of shifting from expense-focused discussions to a more resource-oriented discourse. The deficiency-focused, medicalised perspective is being replaced by the idea of approaching aging as a social and cultural phenomenon. Well-being is a concept defined by individuals

themselves, based on several aspects of their lives. In line with these trends, we want *to examine the social environment built by Active Art and its effect on the well-being or self-perceived quality of life of the elderly*. Our main background hypothesis for the approach is: *Active Art produces trust between participants, care personnel, family and friends, and this strengthens the elderly patient's own perceptions of successful aging.*

In "pilot no. 2" we will focus on developing evaluation methods. The project will involve the Vantaa care homes and day activity centres that were not involved in the first round. We will develop evaluation methods that bring to light the individuals' self-perceived quality of life. One possibility is to use a model developed by Jyrkämä, in which the perspective goes from functional ability to participation and its modalities (Jyrkämä 2007). Our main aim in the second round is to encourage the customers' family members to participate in Active Art activities and to allow participants to strengthen their close networks in a way proposed by Kenji Kaneko. According to Kaneko, the Clinical Art method strengthens family ties and increases mutual understanding between family members (Kaneko 2004). By the third round, the most appropriate evaluation methods for the circumstances will have been identified.

Elderly care work in Finland has had and will have room for artistic activities in which the recipients are elderly patients. Rehabilitating craft activities, implementing the repetitions required by the models, are probably also in place. However, we believe that these activities do not allow for sufficient use or support of the elderly patients' participation and involvement in determining their own lives. Aging contains opportunities when it is approached in a resource-oriented way. According to Kaplan, art can promote and maintain activity. As Pääjoki indicates, art can be a place for encounters that allow diversity. Meanings are changing constructs generated by the interaction between individual and community.

We want to increase cooperation between Laurea and Tohoku Fukushi University. We have found the support and collaboration until now to be most valuable. We believe that it would be fruitful to jointly agree on the research perspectives from which each party should approach the development of the method. Up until now, we have been on the receiving end. Our ideas are supported by Professor Masatake Uno's views on the fact that the Clinical Art method not only focuses on supporting brain activity in dementia care, but also offers opportunities for supporting the personalities, uniqueness and social capabilities of the individual (Uno 2004). We hope soon to be able to offer interesting perspectives and research outcomes in relation to the method's social dimensions in dementia care.

REFERENCES

Alanko, A. 1984. Taideterapia psykiatrisessa sairaalassa. Thesis no. 11/1984, University of Helsinki.

Gergen, M. and Gergen, K.J. 2003. Positive Aging. In Gubrium, J. F. and Holstein, J. A. (Eds.): Ways of Aging. Oxford, UK, 203-224.

Jyrkämä, J. 1995. Rauhaisesti alas illan lepoon?. Tutkimus vanhenemisen sosiaalisuudesta neljässä paikallisyhteisössä. University of Tampere, Acta Universitatis Tamperensis ser. A, vol. 449.

Hyyppä, M. T. 2002. Elinvoimaa yhteisöstä: sosiaalinen pääoma ja terveys. PS-kustannus, Jyväskylä.

Hyyppä, M. and Liikanen, H-L. 2005. Kulttuuri ja terveys. Edita Prima Oy, Helsinki.

Kaneko, K. 2004. Working in Art Therapy. In A Joyous Expression of Life. Art Therapy and the Alzheimer's Patient. Harukashobo, Japan.

Kaplan, F. 2000. Art, Science and Art Therapy. Repainting the Picture. Jessica Kingsley Publishers, London, UK.

Karisto, A. 2004. Kolmas ikä – uusi näkökulma väestön vanhenemiseen. In Aging as a Resource. Appendix 5 to the Report on the Future. Publications of the Prime Minister's Office 33/2004.

Kautto, M. 2004. Ikääntyneet resurssina, ikääntyminen mahdollisuutena. In Aging as a Resource. Appendix 5 to the Report on the Future. Publications of the Prime Minister's Office 33/2004.

Koskinen, S. 2004. Ikääntyneitten voimavarat. In Aging as a Resource. Appendix 5 to the Report on the Future. Publications of the Prime Minister's Office 33/2004.

Kurki, L. 2000. Sosiokulttuurinen innostaminen: muutoksen pedagogiikka. Vastapaino, Tampere.

Lawton, M. P. 1983. Time, Space and Activity. In Rowles, Graham D. and Ohta (Eds) Environmental Perspectives on Growing Old. Academic Press. New York, 41–61.

Liebmann, M. 1992**.** Mielen kuvia. Taideterapia käytännön hoitotyössä. Kustannusosakeyhtiö Puijo, Kuopio.

Liikanen, H-L. 2004. Taide kuntoutumista edistävän hoitotyön ulottuvuutena. In Heimonen, S. and Voutilainen, P (Eds.). Dementoituvan ihmisen kuntoutuksen lupaus. Tammi, Helsinki.

Pääjoki, T. 2004. Taide kulttuurisena kohtaamispaikkana taidekasvatuksessa*.* University of Jyväskylä, Jyväskylä Studies in Humanities 28.

Ruuskanen, P. 2001. Sosiaalinen pääoma: käsitteet, suuntaukset ja mekanismit. Valtion taloudellinen tutkimuskeskus, Helsinki.

Semi, T. 2004a. Ihmetekoja kaapista löytyvillä aineksilla. Opri and Oleksi, Espoo.

Semi, T 2004b. Kokonaisvaltainen kuntoutus – ennen kaikkea innostusta! In Heimonen, S. and Voutilainen, P (Eds.) Dementoituvan ihmisen kuntoutuksen lupaus. Tammi, Helsinki.

Shusterman, R. 1997. Pragmatist Aesthetics: Living Beauty, Rethinking. Finnish translation by Vesa Moisio. Gaudeamus, Tammer-paino Oy, Tampere.

Uno, M. 2004. Alzheimer's Patients' Messages from the Heart. In A Joyous Expression of Life. Art Therapy and the Alzheimer's Patient. Harukashobo, Japan.

Vaarama, M. 2004 Ikääntyneiden toimintakyky ja hoivapalvelut – nykytila ja vuosi 2015. In the report Aging as a Resource. Appendix 5 to the Report on the Future. Publications of the Prime Minister's Office 33/2004.

Non-print sources:

Jyrkämä, J. 2007. Toimijuus, arkielämä ja vanhustenhoito. Lecture on 19 September 2007 at the Tu-Ike seminar in Kerava.

Koskinen, S. 2006. Ikäihmisten voimavarojen ja toimintakyvyn tukeminen. Lecture on 1 September 2007 at a Geriatric Care Training Development seminar (VakkaVerkosto) in Tampere.

Oshiro, T., Aoki, K., Hosaka, Y., Kaneko, K., Nishida, K., Kimura, S., Sekine, K., Musha, T., Uno, M., Kuwabara, S., Maeda, Y & Kawai, N. 2006. Clinical Art for the Elderly. First Sendai-Finland Seminar, March 2006.

Developing a Conceptual Framework for the Human Side of Innovation with Particular Reference to Senior Citizens in Innovation Ecosystems

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Introduction

This paper briefly introduces concepts such as creative individuals, creative thinking, innovations, innovative processes and innovation ecosystems, in an attempt to apply and test human related concepts of the innovation process to elderly care. It also introduces the idea of the open innovation ecosystem where creative senior citizens take the role of creative users and developers of products and services, and collaborate with creative professionals. The purpose of this conceptual paper is to study what kind of challenges this type of approach might offer for the leadership and management of an open innovation ecosystem at various levels, in particular, the micro (individual), meso (organisation) and macro (national innovation system).

Many researchers take the view that creativity must be used every day if we are to fulfil our potential at all ages. While there is plainly a need for creativity in all aspects of our lives and in society as a whole, creativity is a powerful tool that will hopefully be used to tackle the current problems related to aging societies.

Inspired by Runco (2007), one can only hope that particular attention will be paid to the potential for the kind of creativity which has been intentionally fostered in order to help us to construct a better world for elderly and young alike.

The key players here are the senior citizens themselves as the end users of the service, but also the managers of professional and public service systems, such as elderly care, who are increasingly involved with organizational and societal environments associated with high creativity and productivity. They assume a particularly crucial role in implementing innovations and the ways they might be generated, especially in terms of how they relate to the creative professionals and innovators of the fuzzy front end of the innovation process. As such, this relationship can be seen as the ultimate litmus test for the leaders and managers of such systems and the unprejudiced product development of goods and services for (and in conjunction with) senior citizens.

The discussion of ideas and thoughts about the concept and nature of creativity and innovation may additionally throw light on the solution to the conundrum of how to bridge the gulf between mainstream aims, regulations and principles of management of productivity on one hand, and the creative development of new breakthrough goods, services and processes on the other.

There are, nonetheless, so many paradoxes and dilemmas relating to this subject that it is necessary to realise that creativity is not the same thing as intelligence, originality, innovation, nor invention (Runco 2007, Stefik and Stefik 2004). Moreover, it is necessary to try to conceptualise and identify what lies behind the innovation: the creative process, the creative individuals themselves, the ideas behind the innovation, and the environment in which these parts interact. Finally, it is necessary to be able to have a clear overall view of what is important to develop products so that everything will fall into its proper place.

Since the title of this paper is the human side of innovation, the logical place to start is the creative individual behind the innovation.

Creativity and individuals

The creative process starts with the individual, but creativity is not only a matter of importance for individuals, but it exists and is nowadays urgently cultivated, in its various forms, in different organisational and national strategies. When hiring people, employers are looking for persons with innovative potential, and it is only by actively fostering an environment in which creative thinking thrives that their

innovative potential can then be fully realised. This point is reiterated a little later in this paper by Sotarauta (2004).

But this can only occur if we are specific about what is involved. In everyday language, creativity has so many different meanings and connotations that the true meaning is elusive, and, like a piece of soap, when you try to grab it, it slips away.

As has already been suggested above, (Runco 2007) creativity is not the same as intelligence, originality, innovation, or invention. Also, adaptability and discovery can be distinguished from creativity. In an attempt to pin down its meaning, a creative idea has been defined as something that is novel or original as well as useful or influential (Flaherty 2005).

An additional component of creativity was added by Andreasen (2005), namely that it has to lead to a product of some kind. "Even though creativity begins as an inner process − a feeling or an idea − it must also produce an observable result" (Bean 1992).

The major thoroughfares to creativity are through the person (or personality), process, product, or place, persuasion and potential (Rhodes 1962, Richards 1999, Runco 2004, Simonton 1990).

From the point of view of a leader, however, the creativity – environmental interaction is a two-way process. It is not only leadership and environment affecting creative people but, as Simonton's (1990) notion of persuasion shows, creative people change the way other people think.

In the modern era, with growing emphasis on utility, the distinction between creativity and innovation is relevant to the current climate.

One way to distinguish creativity and innovation was suggested by Bandura (1997, 239): "Creativity constitutes one of highest forms of human expression. Innovativeness largely involves restructuring and synthesizing knowledge into new ways of thinking and of doing things. It requires a good deal of cognitive facility to override established ways of thinking that impede exploration of novel ideas and search for new knowledge. But above all, innovativeness requires an unshakeable sense of efficiency to persist in creative endeavours."

Runco (2007) attempted to encompass both originality and effectiveness in his work on innovation and creativity. He proposed a continuum in terms of the balance between originality and effectiveness in creative efforts. "Truly creative products and behaviours reflect balance, meaning that they are somewhat in the middle of the continuum. They therefore have some originality but also some ef-

fectiveness… often the effectiveness of an innovation is obvious to some public or business or audience. The effectiveness of creative things, on the other hand, may be personal and a matter of self-expression" (Runco 2007, 386). Runco refers to March (1978) when arguing that this view is consistent with theories of organisational creativity that contrast creative organisations with efficient organisations.

Originality   Effectiveness

Psychosis   Creativity   Innovation   Routine problem solving

Figure 1. Proposed Continuum Allowing a Balance of Originality and Effectiveness in Creative Efforts

Creative individuals, innovators and visionaries have affected human history, and thus have often been considered heroes. However, they are not infallible, nor is creative thinking something on which they have a monopoly. Indeed the level of creativity varies between individuals, as well as within the same individual in interaction with different situations and environments.

Most researchers state that human behaviour is a function of both stable traits and environmental and situational variables. While it can be argued that not everyone is   equally creative, Runco and Roger were clearly of the opinion that everybody is creative. Roger writes, "Self-actualisation or health must ultimately be defined as the coming to pass of the fullest humanness, or as the "Being" of the person, it is as if self-actualisation were almost synonymous with, or a defining characteristic of, essential humanness" (Runco 2007, 407).

However, only a tiny proportion of the population is involved in the creation of the vast majority of creative works and ideas (Simonton 1984, Runco 2007). Florida (2004) writes about creative and educated individuals as belonging to the creative class of the knowledge society; they are the drivers of the most successful and competitive regions; and it is them who attract the investors and companies to those regions where they live and work.

Creative individuals, as such, have some universal indicative characteristics, and some of these characteristics are typical for a certain domain and field. For example, Roe (1983) found that creative individuals working in physical sciences were observant, open to experience, curious, capable of accepting opposites and ambiguities, independent, self-reliant, perseverant, and appreciative of

complexity. Observations taken from literature also imply, among other things, that a highly creative individual has characteristics like, for instance, the capability for long term development of the skills and knowledge needed for the creative problem solving, or a preference for the challenge of disorder to the barrenness of simplicity. Technical entrepreneurs typically start their own companies and businesses because they really believe in a given product or service, and the organisation in which they have been working would not allow them to move forward with their ideas. Entrepreneurial anchored people are often obsessed with the need to create and can easily become bored or restless with the demands and routine of running businesses. Roberts has drawn a sharp distinction between those professionals who may be good at generating new ideas and those professionals who have the strong desire and capability to grab or exploit good ideas and persevere with them until they have been commercialised in the marketplace. (Katz 2004)

In spite of the above generally positive attributes, an uneasy equilibrium can be perceived in creativity and creative individuals, for creativity is associated with both favourable and unfavourable traits. Some of the traits, like autonomy, are a sine qua non condition. (Runco 2007) Nevertheless, the same trait can be socially undesirable and cause problems for the creative individual. MacKinnon (1965) found that the most creative architects were well-acquainted with the social challenges which were embedded in their creativity, and that they would have liked to improve their interpersonal reactions and social relationships. Other researchers (Crutchfield 1962, Griffin and McDermott 1988) connected characteristics like autonomy, nonconformity and rebelliousness to creativity. All these characteristics may constitute sources of inconvenience and discomfort in organisations and communities and can even lead, sometimes, to hostility towards creative individuals or creative ideas.

Creativity is a vital form of human capital (we want to speak about the idea of human capital as opposed to human resources because the individual is the focal point here and not a mere object), but one of the most fundamental hurdles which creative thinkers must overcome is turning the idea into an innovation. In other words "you can be creative without being innovative, but you cannot be innovative without being creative".

When it comes to organisational innovation, the innovation is the result of collective activities and the final realisation of this creative thinking. These collective

activities are nowadays facilitated at a global level by the existence of the inter-net or Noosphere[1].

Creative senior citizens and user oriented and open innovation

At the age of ninety-one "Linus Pauling[2] claimed that he has published twice as many papers between the ages of seventy and ninety than in any preceding twenty-year period," Chiksezentmihalyi (1977, 211) also writes "recent studies suggest that not only quantity, but quality is retained with age, and some of the most memorable work in a person's career is done in the late years".

Runco (2007) refers first to Lindauer et al. and writes about the old aging style that often characterizes the work of artists and creative persons on late life. Art-ists in their 60s, 70s, and 80s felt that their work had improved during adulthood. Then, Runco refers to Langer's work and writes "She ties creativity and aging both to mindfulness and demonstrated how very simple manipulations encour-age older adults to remain active and mindful, and how these may translate di-rectly into improved quality of life and longevity."

Runco continues "old age style and increased creative performance is probably very much a matter of choice". By that he implies that, when battling the changes related to aging, one can choose to change one's style by remaining flexible and increasing originality, or one can avoid stress by seeking a stress free environment in order to provide the needed energy to do the creative work.

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[1] "In geography, the Earth has been described as a combination of layers or spheres since the 1870's. Among the various spheres there are, for example the solid Lithosphere, the watery Hydrosphere and the gaseous Atmosphere, forming together the Geosphere. In addition to this nonliving system, there is the Biosphere and the human Anthroposphere as a part of it. In 1925, a French Jesuit priest and palaeontologist, Pierre Teilhard de Chardin (1959/2002), described the Noosphere as a sphere of thought, the soul of the Earth. The correspondence of the Noosphere and the Internet is clear and has been ob-served in many papers (e.g. Samson and Pitt 1999, 144). Being the collection of scat-tered human knowledge, the Internet is the manifestation of the Noosphere". (Kankaan-rinta)

[2] Linus Carl Pauling (February 28, 1901 – August 19, 1994) was an American scientist, peace activist, author and educator. He is considered the most influential chemist of the 20th century and ranks among the most important scientists in history. Pauling was one of the first scientists to work in the fields of quantum chemistry, molecular biology and orthomolecular medicine (optimum nutrition).

Runco once more argues for the choice to invest in our creative potentials throughout our entire lives. That optimistic view of aging and creativity is certainly needed when as individuals we face the threat of[3] losing so many other abilities and skills.

But are our societies ready to accept that positive attitude towards elderly people and their purported capacity for creativity? Is the above view an overly optimistic one? Is it too creative, or even too radical to regard the silver generation as a potential capital or resource for building a more creative and versatile model of innovation ecosystems? To actively encourage and support the elderly themselves to relay and exercise their own creative potential, and then to take that creativity potential seriously in a professional, non-professional and everyday context?

Open innovation is a good starting point for examining the validity of these questions

In 1988, Von Hippel described how close relationships with the users are important sources of innovations in product development. In user centred development of products, user explicit and tacit knowledge are merged with the knowledge of product development professionals. Open innovations quickly become commonplace alongside the in-house organisational innovations.

Since most ideas turn out not to be suitable, or the timing is poor, the wastage of ideas is high and a great number of ideas are needed for the innovation funnel. One way to increase the number of ideas is to utilize the innovation capacity that exists outside one's own organisation. Chesborough introduced this idea of open innovation in the year 2003.

During the modern era of open innovation, individuals in different roles, for example as visionaries, innovators, leaders, employees, clients and even the ordinary citizen have all been considered, as mentioned, as creative and having the potential to develop innovative ideas. The development of the knowledge society, the development of education standards, the increasingly open access to in-

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[3] Moreover the very latest biological research serves to underline the need for an active physical life. A recent King's College London study in Archives of Internal Medicine found that the most active people had telomeres of a length comparable to those found in inactive people who were up to 10 years' younger, on average. Telomeres are the repeat sequences of DNA that sit on the ends of chromosomes, protecting them from damage.

formation have changed the environment in favour of more creative and, simultaneously, more demanding clients and consumers. Senior citizens are a growing market and it is very probable those who are bold enough to access this body of tacit knowledge in the various ways of using goods and services will be the winners. It is evident that their productivity and quality of products will be superior.

Another aspect arising from the idea of open innovation that is worthwhile considering is related to the senior citizens' knowledge, creativity and experience, and how to integrate them into the professional development of products and the modern society.

Neglecting to involve this growing group of people in the innovative process may do serious harm the organisation concerned in an increasing competitive and market oriented environment.

Nature of innovation and innovation processes

Sometimes invention and innovation are closely linked, to the extent that it is hard to distinguish one from another. Invention is the first occurrence of an idea of a new product or process, while innovation is the attempt to put it into practice with the objective of increased efficiency, competitiveness, and returns. To be able to turn the invention into an innovation, however, a firm needs to combine several different types of knowledge, capabilities, skills, and resources. The role of the innovator, responsible for combining the various above factors may be quite different from that of the inventor[4] (Stefik and Stefik 2004, Fagerberg 2004).

Another set of complicating factors is that invention and innovation are continuous processes, and innovations do not take place in a vacuum. This paper stresses the systemic nature of innovation, since it characterises the collective achievement from the invention to the innovation. Systems are a set of activities or group of actors that are interlinked. (Fagerberg 2004)

In the knowledge society, organisational success or competitiveness is more often based on innovativeness and capability to learn than on other aspects. Inno-

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[4] Da Vinci had advanced ideas for flying machine, but these were impossible to carry out in practice due to lack of adequate materials, production skills and power sources.

vating is an interactive process between different actors and is based on diverse sources of information and flows of knowledge between individuals and organisations.

Incremental and radical innovation

Innovations can be divided into radical and incremental innovations. The benefit from incremental improvement is instant, while radical changes are rare and more difficult to achieve. In fact, the more radical an innovation is, the more it affects the system. To succeed, a radical innovation often requires infrastructural, organisational and social changes. However, the influence of existing organisational and institutional patterns creates inertia and makes changes difficult. (Stefik and Stefik 2004, Fagerberg 2004)

Saarikoski (2006) argues that breakthrough, disruptive or radical innovation means launching an entirely novel product or service rather than providing improved products and services along the same lines as those currently supported. The uncertainty of breakthrough innovations means that companies seldom achieve their development goals this way, but that, when the breakthrough innovation comes, the rewards can be tremendous. Disruptive or radical innovations involve larger leaps of understanding, perhaps demanding a new way of seeing the whole problem, probably taking a much larger risk than many people involved would wish to take. There is often considerable uncertainty about future outcomes, possibly leading to significant opposition to the proposal and questions about the ethics, practicality or cost. People may question whether this is in fact an advancement of a technology or process. That is the reason why radical innovations, which involve considerable change in basic technologies and methods, are normally created by those working outside mainstream industry and existing paradigms. (Stefik and Stefik 2004, Davila, Epstein and Shelton 2006)

Since this paper is more about the fuzzy front end of innovation and the radical thinking behind emerging radical innovations, as well as the interaction with the components of the innovation ecosystems, the concept of radical innovation is handled in considerable depth. Also breakthrough and disruptive innovation have been used as synonyms for those radical changes that affect, or will most probably affect, the existing paradigm in the field of those interviewed.

In this paper, radical innovation refers to all type of innovations resulting in radically improved performance or growth (technological innovations, process innovation including business models, social innovation, etc). It is accepted that all

organisations can innovate, including, for example, hospitals, educational institutions, and local government institutions. In this definition radical innovation emerges as a non-linear process.

Similar broad definitions can be found from the literature. In "How Breakthroughs Happen", Hargadon (2003) points out that radical innovation can be created by combining existing observations and by bridging the gap between industries. Rogers' definition for radical innovation, "a new paradigm for carrying out some tasks", allows for a broad set of different contexts (e.g. technological, company-wise, institutional, societal and one which challenges existing institutions) argues Saarikoski (2006). Hargadon (2003) has defined a radical innovation through its impact on industry.

However, in the literature, the notion of radical innovation often refers to scientific and technological innovation. Radical innovations have frequently and considerably reduced the costs of key economic inputs and have, therefore, been widely adopted and become the catalysts for major structural changes in the economy. Steam power, electricity, motorization, synthetic materials, radio communication and ICT are examples of innovations that have caused huge leaps in performance in specific fields. (Pavitt 2005) One of the most cited authors is Christensen; he defines disruptive technologies as technologies that disrupt an established trajectory of performance improvement (1997).

Nevertheless, a radical innovation is, according to Davila, Epstein and Shelton (2006) a significant change that simultaneously affects both the business model and technology of a company. Radical innovations usually bring fundamental changes to the competitive environment in an industry. Often, radical innovations have not only changed industry, but have led to a series of cascading semi-radical and incremental innovations. But first a risky, time consuming, and sometimes very hard journey has been undergone.

Radical innovations are often connected to simultaneous changes of business models. The interplay between technology and business model innovation has been expressed in a matrix (figure 2) in which three different types of innovations have been distinguished: radical, semi-radical and incremental. Radical innovations are comprehensive and they are not limited to individual organisations. They can also change the paradigm of the entire field or they can be related to industrial revolutions. A change in one part of the innovation ecosystem may modify the interaction between all the subsystems and, in that way, may force all those involved to react, causing a series of incremental innovations.

Innovation matrix

New	**Semi-Radical**	**Radical**
Near to Existing	**Incremental**	**Semi-Radical**
	Near to Existing	**New**

Technology

Business Model
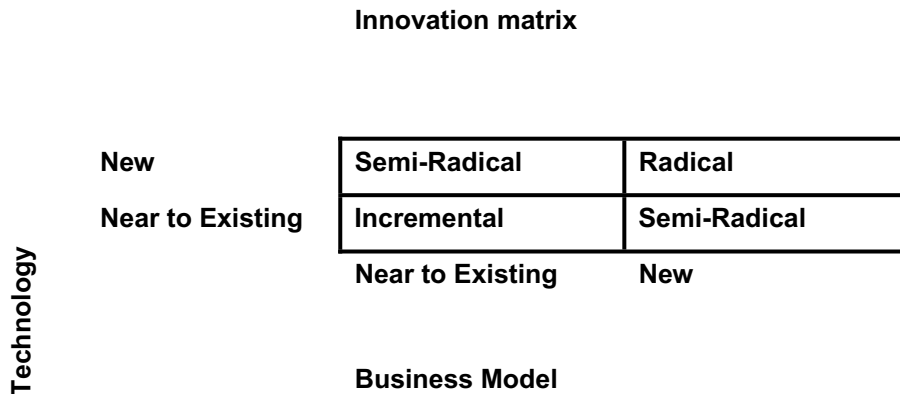
Figure 2. The Innovation Matrix (Davila, Epstein, and Shelton 2006, 14)

Organisation management literature introduces innovation portfolio tools to manage the innovation system at company level. For example, Davila, Epstein and Shelton (2006) underline the importance of creating a balanced portfolio of incremental, semi-radical, and radical innovation as well as appropriate business models and technological options to sustain innovation and growth.

Nature of innovation ecosystems

The new paradigm of systems thinking (Dynamic systems; e.g. Lorez, Prigogine, Maturana, Varela) has been used to analyse radical renewals, and on the basis of this analysis it could be argued that a well functioning innovation ecosystem is self-renewing and self-organising, and that it will find and lose the balance between radical and incremental innovations out of chaos over and over again (Ståhle 2004, Maula 2004).

System thinking has been applied to understand innovations during the last fifty years. Innovation systems, systems of innovation, national innovation systems and regional/local innovation systems are the notions often used. Innovations emerge in systems of innovation. Organisations and institutions are components of the systems. In fact the general definition of national systems of innovation includes "all important economic, social, political, organisational, institutional and

other factors that influence the development, diffusion and use of innovations" (Edquist 2005, Ståhle 2004, Miettinen 2002).

As Stefik and Stefik (2004, 7) imply "the future is not invented so much by a heroic loner or by a single company with a great product as by capacity to combine science, imagination, and business. Innovation ecology includes education, research organisations, governmental funding agencies, technology companies, investors, and consumers. A society's capacity for innovation depends on its innovation ecology."

Based on Dynamic Systems and System Intelligence, the innovation ecosystem is defined in this paper as an interactive community of individuals, organisations and their operative environment aiming at co-evolution and functioning as an "ecological" entity in the pursuit of innovation. The innovation ecosystem can be perceived throughout the interaction of its subsystems.

The notion of innovation ecosystem is a powerful metaphor adopted from biology and ecology; it helps to perceive and understand the interaction of different types of innovations and subsystems, and to study individuals and their thinking, organisations and networks, regional and national innovation systems as well as the supra system referring to globalisation.

As in nature, a minor change in one of the subsystems of the innovation ecosystem can affect everybody's life in what is defined as the "butterfly effect". As global warming changes the composition of the fauna, so any radical innovation, for example, the mobile phone or the SMS, will affect not only the life of the consumers, but also the structure of entire industries. Sometimes, crises or fear of crises may be a reason for prolific changes in the innovation ecosystem. That was the case when the economic depression in Finland restructured its society. The world's rapid population growth and changes in the global ecosystem, namely global warming, have catalysed an entire industrial revolution (Mäkelä 2006). The market for innovations leading to savings in raw materials and energy are growing and the development of those markets has been supported by public incentives and regulations.

Fear of crises, prolific changes in the innovation ecosystem and windows for market opportunities are all powerful drivers for radical innovations. For those who are behind the radical ideas, the drivers for innovating are often related to their values, like the wish to do something good for mankind or simply to achieve personal growth as a human being.

The development of a flourishing national or regional innovation system is based on a deep understanding of past, present and future as well as the nature of

human action when creating the future. It is all about understanding and managing complex processes. It is about, for example, feeling the pulse of the region and its institutions (Mintzberg 1989 in Sotarauta 2004)

Uncertainty is a crucial part of development; it is the source of energy for the development of the region. Dynamic and flexible reactions to the changes in the global environment are replacing mechanistic ways in which regions have previously been developed. Interaction between the different subsystems (e.g. regional innovation systems and the agglomeration of elderly care services, or networking between innovators and elderly care professionals), or between subsystems and the national innovation systems are highlighting the course and form of the change. The notion "emerging" has been used to describe the way in which new, earlier and unknown trajectories of change emerge, and how the elements of the system spontaneously become reorganised, constituting new coherent models, structures and ways of acting (Johanson, 2002).

The above type of innovation system could also be called an innovation ecosystem in order to distinguish its dynamic development style, and also to underline the importance of the innovative milieu to stimulate a creative tension between the various dimensions and layers of the environment where creative work and innovations take place (Sotarauta 2004).

Elderly care and the silver generation as a subsystem in the innovation environment

This paper proposes the idea that the silver generation and elderly care services are, in fact, a very important emerging subsystem that should be included and analysed as an element of the overall national and regional innovation ecosystem. Money has already found the silver generation, and senior citizens are already seen as a growing market for various products. However, the silver generation could be seen in a deeper and wider sense, as human capital - in other words as active members of society who by their choices and knowledge transform raw ideas into innovations. Networking between different types of institutions, like elderly care units and companies or schools, could create intersections to provide enriched environments for creative thinking, product development and learning. Interaction and social contacts between individuals of varying ages and backgrounds create not only learning networks and trust capital, which are a mandatory requirement for innovation, but also respect, which is a prerequisite for individual well-being and social cohesion in a globalised world. Johans-

son (2004) used the concept intersection of ideas, concepts and cultures to describe how the richness of the environment, inherited, for example, from the interaction of art and economy, creates wealth and wellbeing.

According to Sotarauta (2004), it is more probable that local networks and new ways of operating will emerge in institutionally rich and advanced centres with diverse structures than in centres which, in contrast, are homogenous in nature and institutionally thin. In institutionally rich centres, many of the institutions claim they are didcated to generating and applying knowledge, but in spite of that, they have very little real contact with the huge repository of knowledge and experience represented by the silver generation. The challenge is to create an intersection where all generations can communicate and interact.

Florida (2004) states that cities are competing for talented and creative professionals. However, in attracting members of the creative class to live and work in the cities and regions, a creative environment and opportunities for collaboration with peers in groups is crucial. This is not easy to achieve in areas of low population density, and it is challenging even in areas of high population density.

One of the approaches that could be explored in this respect is, for example, using retired professionals as mentors at universities and in companies.

The decent and respectful treatment of aging people, whether they are professionals or the grandmother next door, is one way of enhancing the image and attractiveness of the region in question, especially given the present trend in population demographics. Too many municipalities and regional authorities are pursuing the same strategy, and it would pay to look for diverse strategies when in order to promote their image. This could be one of those strategies.

Nahapiet and Ghoshal (1998) talk about social embeddedness and capital, the added value that organisations and individuals receive when they have a dense network of relationships, both formal and informal. Having a strategy which encourages all age groups to participate in these networks can help to realise the benefits of social capital for all parties in the network.

Nonaka and Takeuchi (1995) referred to the concepts of tacit and explicit knowledge. In the nature of things, it is easier and cheaper to deliver explicit knowledge than tacit knowledge (Teece 1998).

What is the practical application of the above ideas considering the position of elderly people in the community and in working life? It is often the case, for instance, that companies and organisations do not consult retired employees enough in dealing with situations with which they have personal experience or

know-how. This kind of knowledge is not explicitly available in many cases but only in the form of tacit knowledge. Its exploitation by new employees requires observation, collaboration and communication with their predecessors.

Research has indicated that many creative solutions are apparent, but we simply overlook them. In the same way, the silver generation is often a neglected source of useful knowledge and experience.

The higher education institutions are anchors of knowledge and dynamos of innovations in their regions, but they can do a better job. In Sendai, Japan, the Tohoku Fukushi University is not only training professionals for the social and health care sector and doing research into the various dimensions of the silver society, but is also providing common space and activities for senior citizens and younger professionals and students and, by these means, putting them all in touch with new social networks, or different streams of knowledge.

By enabling senior citizens to be at the core of the innovation system, Tohoku Fukushi University's programs mentioned above represent a significant step forward in developing the notion of the learning region (Florida 1995, Fagerberg 2003).

Management and leadership of innovations and innovation ecosystems

In organisational language, an interesting change is taking place. More and more often the concept "human resources" has been replaced with "human capital". There are many societal reasons for this change, but, from the point of view of innovations, the most crucial reason is a change in thinking. The rules of the game are modified when moving from an industrial to an immaterial and creative economy. Individuals are no longer factors in production or resources like they used to be, but are considered as fundamental assets, and their tacit knowledge and capability for "radical thinking" are assumed to be difficult to replace.

The human centred approach to innovations and innovation ecosystems can be found in the notion of super productivity (Bergqvist 2005, Handolin 2005) - the leap in productivity not only based on economical, technological and strategic productivity, but also on taking better advantage of human potential.

Individuals are different, their experiences and preferences vary, and this represents a source of innovation capacity for organisations. Organisations need dif-

ferent types of individuals, including creative individuals, as well as good organisers, to make the systems work and develop. Teruyasu Murakami and Takashi Nishiwaki (1991) found that, in large organisations, those who created ideas represented only 5 % of the personnel. From psychological research and studies about creativity, we learn that people are undoubtedly often more active and creative if they can develop and use their skills in accordance with their preferences and capabilities.

The challenge is then how to build the teams in which everybody can play the role that best suits him and the organisation, and how everybody can complement the skills and preferences of the other team members (Briggs and Myers, 1980).

If the changes in the innovation ecosystem force organisations to work hard to react to radical innovation, there are ways and means of helping even those who prefer to be involved in the implementation process to also participate in the innovation process. Indeed the existing literature supports the fact that creative problem solving methods and radical thinking can be understood and learned too.

However, the development of real radical innovation, an organisation or innovation ecosystem, may need a more radical management method. The role of top management is vital. (Davila, Epstein and Shelton 2006). Unfortunately, steering groups in effective organisations may sometimes present challenges due to groupthink (Janis 1971). Groupthink leads to careful, conscious, personal avoidance of deviation from what appears to be group consensus.

Isolation of the development of the innovation, e.g. venture unit or joint venture, may be necessary when creating the required environment, and the values and methods which support product development for the development of radical innovation, as well as for the maintenance of productivity of the mainstream of the organisation.

Radical innovation often relies on dynamic methods like management by vision. A heavy reliance on experimentation, and a focus on ambition and low process formalisation are typical for management for radical innovations (Davila, Epstein and Shelton 2006). A metaphor like guerrillas reconnoitre has been used to describe the unsure nature of the pioneers work in development of radical innovation (Linturi 2008). The leader's ability to convince the group of the logic and usefulness of gyration nature of the uncertain reconnoitre phase is crucial. Davila, Epstein and Shelton (2006) remind us that continuos support is more important than working for a reward in radical innovation.

Conclusion

This paper suggests that when exploring new solutions or innovations in the knowledge society we should also look at the silver generations for inspiration for new ideas to promote innovations. Creativity and innovativeness do not alter the fact that many of our vital capabilities are lost during the ageing process, and more help, especially expensive medical care, is needed. But this paper reminds us of the potential for creativity also in old age, and about the fact that many radical ideas and innovations are based on unprejudiced ways of breaking down the old existing categories and reconnecting things in a new way. This means that in striving for innovations in various fields and domains, intersections and sources of new ideas can be available in a form of the tacit knowledge of elderly people, if only we are prepared to look for it.

The most difficult, but also most desired innovations of all, radical break-throughs, are the sum total of many different factors. In the fuzzy front end of open and collaborative innovations, new ideas are born from the collision of is-sues to form a new synthesis. In networks, active seniors can be a source of valuable professional or non-professional immaterial capital i.e., "An innovative product is about the co-development of practices and meaningful products". Meanings are valuable pointers for the companies when anticipating the possi-ble collective needs and motives of the clients. Stories and all-around education are often accessible to those meanings. (Tuomi 2002) This paper suggests that active seniors can be the missing link in finding the wisdom to interpret the meaning of the stories.[5]

Table I sums up the interaction of the concepts used and ideas developed with reference to the silver generation. The type of innovation ecosystem refers to the level and form of potential innovation ecosystem. Other suggested factors are the key drivers for innovation and creativity, the key players and their roles in the innovation ecosystem, and the potential results and impact of the level and form of innovation ecosystem.

By environment for everyday creativity, this paper means the network of home, elderly care unit, living lab, hospital, recreation locations, higher education insti-tution, etc., where the daily activities of senior citizens take place and the pro-fessionals provide services for them. This environment can be considered as the micro level. The key driver of innovation and creativity in this form of ecosys-tem is the senior citizen's or the professional's need to fulfil their own creativity

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[5] Some of the factors leading to innovation can both inhibit and promote innovations.

potential. As subjects of their own life, the senior citizens and the professionals themselves are the key players, but it is up to the managers and the opinion leaders to encourage individuals to participate in creative everyday activities. The potential outcome of this ecosystem is the sensation of flow, joy of life and better overall quality of life.

The second type of innovation ecosystem is represented by the meso level and has been named the "Intersection for in-house knowledge and product development". The need for creativity and innovations in the company and organisation are the key drivers for this ecosystem. At this intersection, retired professionals and professionals in active working life are working side by side to create new innovations. The delivery of tacit knowledge and other benefits of intersection, such as different backgrounds, improve the productivity of the innovation process and can increase the likelihood of radical ideas and innovations.

Open and collaborative innovation is the third type of innovation ecosystem and its driver is the company's or organisation's need for creativity and innovations. Open and collaborative innovation is often a meso level ecosystem, but, by using the internet, it can integrate the macro level networks too, including the international networks (supra level). In this ecosystem, the senior citizens are in the role of users developing the products. This type of nonlinear innovation decreases the time needed to produce the type of innovation which fits in with the needs of the markets. This type of innovation can be an effective way to develop incremental enhancement.

The silver society oriented national or regional innovation ecosystem (NIS/RIS) is the fourth type of ecosystem and it represents the macro level. Regions and nations have a need to profile themselves in global competition, and that is the driver for this ecosystem. Politicians and professional managers are the key players with the resources of an entire community or nation placed at their disposal in order to create the needed knowledge network. If a change of attitudes and respect for the silver generation takes place as a consequence, the final impact can be an overall improvement in the development and social cohesion of society. This can in turn lead to a better image for the society in question, a prerequisite for global competitiveness.

Table 1. A summary of the interaction of concepts used and ideas developed with reference to the silver generation

Type of innovation ecosystem	Key driver of innovation and creativity	Key players and their roles	Result and impact
Everyday creativity environment (home/work/elderly care unit)	Need to fulfil one's own potential	Leaders and public opinion: encouragement of silver generation and/or professionals to take part in creative everyday activities	Quality of life plus & Sensation of flow Job satisfaction and motivation for work
Intersection – In-house knowledge and product development in organisations	Need for creativity and innovations	Retired professionals and professionals involved again in active working life	Delivery of tacit knowledge and the benefits of intersection
Open innovation ecosystem e.g. silver society oriented Living Lab	Need for creativity and innovations	Silver generation as users developing the products	Benefit of nonlinear innovations: right type of products for the market
Silver society oriented NIS/RIS	Need for profiling in a situation of global competition. Need to restrict the increase of public expenses.	Politicians and managers responsible for the strategy of the NIS/RIS	Societal development and social cohesion; creative tension and ethical development of the community as the source of the competitive advantage of the region

The idea of the potential for creativity in old age was certainly encouraged and used when elderly people lived alongside the younger generations. Now we have to find a new way to reinvent ways to boost that potential for future innovations.

There are many prerequisites for radical innovations, and radical thinking is one of the most crucial in order to break the "locks", the fixed ideas and categories

that imprison us and our way of thinking. As has been reiterated throughout this article, lots of ideas are needed for the innovations funnel before the ideas are selected and carefully tested and verified (Davila, Epstein and Shelton (2006). In the final analysis, the benefits of open and collaborative innovation with senior professionals can be verified only by digging deeper into the literature and by interdisciplinary empirical research.

References

Andreasen, N.C. 2005. The Creating Brain. Dana Press, New York.

Bandura, A. 1997. Self-efficacy: The Exercise of Control. Freeman, New York.

Bean, R. 1992. How to Develop your Children's Creativity. Price Stern Sloan Adult. Los Angeles CA.

Bergqvist, J.T. 2005. Teollinen tulevaisuutemme – systeemien hahmotus. In Hämäläinen, R. P. and Saarinen, E. (Eds). Systeemiäly. Helsinki University of Technology, Systems Analysis Laboratory.

Briggs, M. I. and Myers, P. G. 1980. Gifts Differing. Consulting Psychologists Press, Palo Alto, CA.

Chesbrough, H. 2003. Open Innovation: The New Imperative for Creating and Profiting from Technology. Harvard Business School Press; Boston, MA.

Christensen, C. M. 1997. The Innovator's Dilemma. Harvard Business School Press, Boston, MA.

Crutchfield, R.S. 1962. Conformity and Creative Thinking. In H.E Gruber, G. Terrell and M. Wertheimer (Eds). Contemporary approaches to creative thinking: A symposium held at the University of Colorado. Atherton, New York.

Csikszentmihalyi, M. 1997. Creativity: Flow and the Psychology of Discovery and Invention. HarperPrennial, New York.

Davila, T. Epstein, M. J. and Shelton, R. 2006. Making Innovation Work. Wharton School Publishing Upper Saddle River, New Jersey.

Edquist, C. 2005. Systems of Innovation, Perspectives and Challenges. In Fagerberg, J., Mowery, D.C., and Nelson, R. R. (Eds). The Oxford Handbook of Innovation. Oxford University Press, Oxford. 182-208.

Fagerberg, J. 2003. Innovation: A Guide to the Literature. In Fagerberg, J., Mowery, D.C. and Nelson, R.R. (Eds). The Oxford Handbook of Innovation. Oxford University Press, Oxford. 1-26.

Flaherty, A.W. 2005. Frototemporal and Dopaminergic Control of Idea Generation and Creative Drive. Journal of Comparative Neurology 493, 147-153.

Florida, R. 2004. The Flight of the Creative Class. HarperCollins Publishers, New York.

Griffin, M. and McDermott, M.R. 1998. Exploring a tripartite relationship between rebelliousness, openness to experience and creativity. Social Behaviour and Personality 26, 347-356.

Handolin, V-V. 2005. Työyhteisöjen systeemiäly ja supertuottavuus. In Hämäläinen, R.P. and Saarinen, E. (Eds). Systeemiäly. Helsinki University of Technology Systems Analysis Laboratory Research Reports B25.

Hargadon, A. 2003. How Breakthroughs Happen - The Surprising Truth About How Companies Innovate. Harvard Business School Press, Boston Massachusetts.

Janis, I.L. 1971. Groupthink. Psychology Today. 5, November, 43-46 and 74-76.

Johansson, F. 2004. The Media Effect: Breakthrough Insight at the Intersection of Ideas, Concepts and Cultures. Harvard Business School Press, Boston MA.

Katz, R. 2004. The Human Side of Managing Technological Innovation. Oxford University Press, New York.

Linturi, H. 2008. Radikaalit innovaatiot. TKK Dipoli. http://www.dipoli.tkk.fi/dipoli_info/index.html.

Mackinnon, D. 1965. Personality and the Realization of Creative Potential. American psychologists 20, 273-281.

Maula, M. 2004. Elävä organisaatio ja liiketoimintaekosysteemi: kompleksisten systeemien kaksi tulkintaa In Sotarauta, M. and Kosonen. K-J. (Eds). Yksilö, kulttuuri, innovaatioympäristö. Tampere University Press, Tampere.

Miettinen, R. 2002. National Innovation System. Scientific Concept or Political Rhetoric. Edita; Helsinki.

Mintzberg, H. 1989. Mintzberg on Management: Inside our Strange World of Organizations. The Free Press.

Mäkelä, T. 2006. New Generation. Parliament Magazine, 20[th] of February 2006. http://ec.europa.eu/environment/etap/pdfs/newgeneration.pdf.

Nahapiet, J. and Goshal, S. 1998. Social Capital, Intellectual Capital, and the Organizational Advantage. The Academy of Management Review, 23(2), 242-246.

Nivaro, H. 2007. Tehokkuus tappaa luovuuden. Fakta, October, 32-34.

Nonaka, I. and Takeuchi, H. 1995. The knowledge Creating Company. Oxford University Press, New York.

Pavitt, K. 2005. Innovation Processes. In Fagerberg, J., Mowery, D. C. and Nelson, R. (Eds). The Oxford Handbook of Innovation. Oxford University Press, Oxford. 86-114.

Rhodes, M. 1962. An Analysis of Creativity. Phi Delta Kappan 42, 305-310.

Richards, R. 1999. The Subtle Attraction: Beauty as a Force in Awareness, Creativity, and Survival. In S.W. Russ (Ed). Affect, Creative Experience, and Psychological Adjustments. Brunner/Mazel, Philadelphia. 195-219

Roe, A. 1983. Family Background of Eminent Scientists. In R.S. Albert (Ed). Genius and Eminence: The social psychology of creativity and exceptional achievement. Pergamon, Oxford. 170-181.

Runco, M.A. 2004. Personnel Creativity and Culture. In S. Lau, A.N.N. Hui, and G.Y.C Ng (Eds). Creativity when East meets west. World Scientific, New Jersey. 9-22.

Runco. M. A. 2007. Creativity, Theories and Themes: Research, Development and Practice. Elsevier Academic Press, USA.

Saarikoski, V. 2006. The Odyssey of the Mobile Internet. The Emergence of a Networking Attribute in a Multidisciplinary Study. TIEKE Tietoyhteiskunnan kehittämiskeskus ry. http://www.tieke.fi/mp/db/file_library/x/IMG/20156/file/Saarikoskivaitoskirja.pdf.

Simonton, D.K. 1990. In M.A Runco and R.S Alberts (Eds). Theories of Creativity. Sage, Newbury Park, CA.

Sotarauta, M. and Kosonen, K-J. 2004. Yksilö, kulttuuri, innovaatioympäristö. Tampere University Press, Tampere.

Stefik, M. and Stefik, B. 2004. Breakthrough. Stories and Strategies of Radical Innovation. The MIT Press, Cambridge, MA, USA.

Ståhle, P. 2004. Itseuudistumisen dynamiikka: systeemiajattelu kehitysprosessien ymmärtämisen perustana. In Sotarauta, M. and Kosonen. K-J. (Eds). Yksilö, kulttuuri, innovaatioympäristö. Tampere University Press, Tampere.

Teece, D.J. 1998. Capturing Value from Knowledge Assets: The New Economy Markets for Know-how, and Intangible Assets. California Management Review, 40(3), 55-59.

Teruyasu, M. and Takashi, N. 1991. Strategy for Creation. Woodhead Publishing Limited, Cambridge, England.

Tuomi, I. 2002. Networks of Innovation. Change of Meaning in the Age of the Internet. Oxford University Press, Oxford.

Von Hippel. 1988. The Source of Innovation. Oxford University Press, Oxford.

Conceptualizing Networked Value-creation and its Management in Health and Social Care Services in Finland

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Introduction

The focus of network research has increasingly been shifting from trying to understand networks to trying to understand their management (Ritter et al. 2004). Network management has been studied in several, often overlapping fields, including industrial and business networks (Ford et al. 2003, Ford and Håkansson 2006, Möller and Halinen 1999), strategic networks (Jarillo 1988, Möller et al. 2005, Möller and Rajala 2007, Möller and Svahn 2003, Gulati et al. 2000), innovation and development networks (Dhanaraj and Parkhe 2006, Heikkinen et al. 2007), health care networks (Provan and Milward 1995, Provan et al. 2004), and public policy networks (Kenis and Provan 2006, Klijn et al. 1995, Kickert and Koppenjan 1997, Agranoff and McGuire 2003, McGuire 2006). These studies, among other, have contributed different ideas and viewpoints to network management.

In its most abstract definition, a network is a "structure where a number of nodes are related to each other by specific threads" (Håkansson and Ford 2002, 133). The above all-encompassing definition remains rather general. Network man-
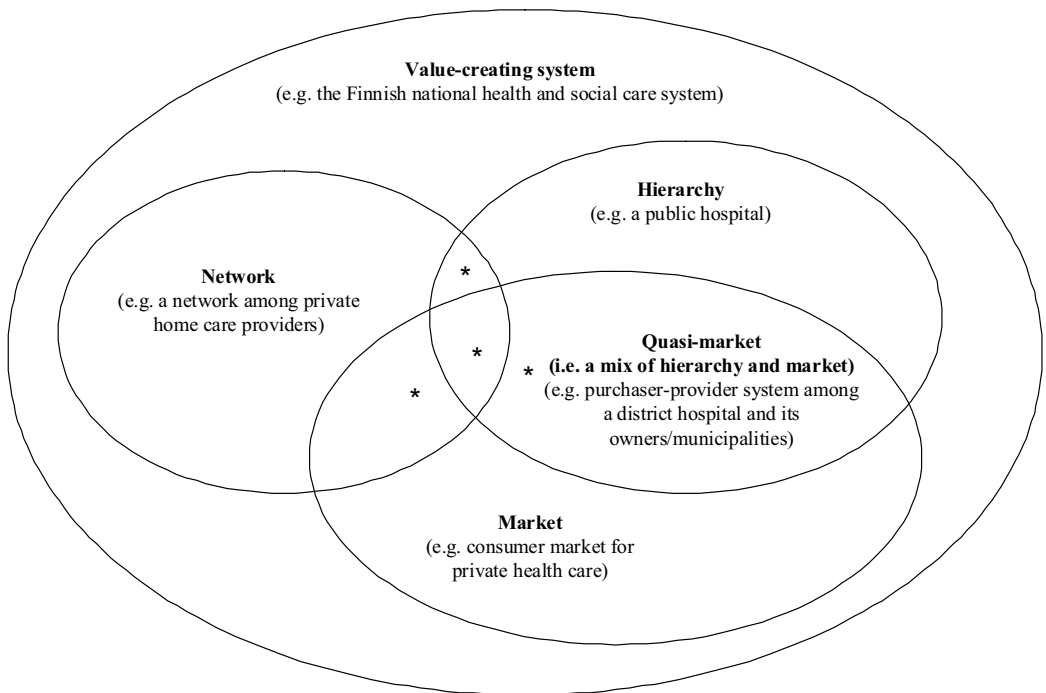
agement, within the above definition, would include the management of all kinds of networks: social and inter-personal networks, intra-organizational networks, inter-group networks, inter-organizational networks, global networks, etc. This would include also the management of hierarchies and market-based organizing, since also in hierarchies and competitive markets there are "nodes" which are "related to each other by specific threads"; the "threads" can thus be authority-based (in hierarchies), price- or competition-based (in pure markets), or trust-based (in certain types of networks).

If we, however, claim that network management is something else apart from hierarchical or market-based management (Powell 1990), then obviously we need to define a "network" apart from hierarchies and market-based organizing. Indeed, as a *governance* mode, a network can be defined as an intermediary, or alternative, form of governance, which is a distinct form of organizing. As a governance mode, a network is defined by enduring exchange relations among autonomous actors (Thorelli 1986, Jones et al. 1997, Park 1996, Powell 1990). A network can thus be defined as a group of autonomous actors (i.e. firms, hierarchical organizations, even people) that have repeated, enduring relations with one another in order to achieve some stated or un-stated objective(s), while lacking a legitimate authority that arbitrates and resolves disputes that may arise among the actors (Podolny and Page 1998). Key qualifiers in the definition are *autonomous actors* and *enduring relations*. These set networks apart from hierarchies and markets; hierarchies involve *authorial* relations between non-autonomous actors (e.g. between superiors and subordinates within a firm), and markets involve non-enduring (i.e. transactional) relations between autonomous actors (e.g. between buyers and sellers in a competitive, price-based context). In this paper, we use the term "network" to refer to this type of governance mode. Naturally, the idea of these three governance modes is based on the argument that they are *ideal* modes of governance; in reality, however, there may not be pure forms of these governance, but we can witness mixed modes of governance, with different degrees of hierarchy-, market- and network-like organizing.

In some market settings we can also identify another specific type of governance, a "quasi-market". This governance mode is in fact a mixed governance mode, or a combination of markets and hierarchies. A quasi-market is a public sector organizing structure based on a purchaser-provider logic (Bartlett and Le Grand 1993), often associated with the New Labour government in the United Kingdom. Quasi-markets in these terms are designed to produce efficiency gains through a market-like setting among publicly owned organizations without losing the equity benefits of systems of public administration and financing.

Thus, in quasi-markets, both the purchaser and provider are ultimately under the same hierarchy (under the state government or municipality), but the purchasing decisions are based on a market-like tendering and bidding process. Quasi-markets are, therefore, not pure markets, as the tendering/bidding process is closed to private companies (i.e. they are not completely free markets), but they are not pure hierarchies either, since there is a market-like element within the organizing. As a governance mode, a quasi-market is thus closer to hierarchical and market-based governance and quite unlike a network (trust-based) mode of organizing.

Sometimes the term "quasi-market" can be used also in another sense: it may be used to describe a whole system of organizing (e.g. a national health and so-cial care system) that includes all kinds of sub-types of organizing (hierarchies, markets, and networks). However, since the term "quasi-market" is often re-served for the specific type of governance as described above, we refer to the whole system simply as the "system" or "value-creating system", which may then include various modes of governance, including markets, networks, hierarchies, and quasi-markets (see Figure 1 with examples from the national health and so-cial care sector).

Figure 1. Relations between the concepts "value-creating system", "network", "hierarchy", "market", "quasi-market", and "mixed modes of governance"

In this paper, our purpose is to look at network management in a specific setting: health and social care value-creating systems. In the next section, we start by looking at what value-creating systems are, and how they can be managed. In this discussion, we will discuss how value-creation systems may constitute all three kinds of governance (i.e. markets, networks and hierarchies), and how these value-creating systems may be managed. Then we look at health and social value-creating systems and identify their basic dimensions. Through this discussion we will provide new perspectives on how to approach the management of health and social care systems. Next we will make use of the discussions in the previous sections to scrutinize the Finnish health and social value-creation system and its management. Finally, we provide our conclusions.

Managing value-creating systems: hierarchies, markets, and networks

Watson (2006, 167) defines the management concept broadly as the "overall shaping of relationships, understandings and processes within a work organisation to bring about the completion of the tasks undertaken in the organisation's name in such a way that the organisation continues into the future". Managerial work is the "activity of bringing about this shaping", and managers are the people given the official responsibility for carrying out this work (Watson 2006, 167-168). The function of management can, however, be carried out also by people not appointed officially as "managers" (Watson 2006, 167-171).

A well-known set of five functions of management was introduced by Fayol in 1949 (ref. Watson 2006, 172-173). According to Fayol, management consists of *planning* (devising a plan of action for utilizing the organization's resources to achieve the organization's objective), *organizing* (making sure that resources are available when needed), *commanding* (directing people so that they carry out required activities), *coordinating* (ensuring that all the activities support each other and combine to contribute to the overall fulfillment of the organizational objective), and *controlling* (checking that activities follow their planned course and correcting and deviations that are found). Since Fayol, this list has remained fairly unchanged; it seems that virtually all relevant, contemporary textbooks of management can be summarized in terms of four functions: *planning*, *organizing*, *leading*, and *controlling* (Tsoukas 1994).

Our original argument is that the management of networks is different from managing in markets and hierarchies. However, studies on network management, intra-organizational (hierarchical) management, and managing in competitive markets are fundamentally based on the same idea of value creation. We thus argue that each of the value-creating systems (including hierarchies, markets and networks) can always be defined as a set of actors, resources and activities (the ARA model, see Håkansson and Johansson 1992, Håkansson and Snehota 1995). Within this definition, actors are those who perform activities and control resources, and activities are the usage of resources to change other resources. Value is thus created through the interplay of the activities, actors and resources, and it is possible to observe this at any level of analysis, including intra- and inter-organizational settings.

We further argue that in all value-creation systems there are certain requirements for managing the value-creation system so that the system will create

value effectively and efficiently. In particular, we argue that there are four re-quirements for managing any value-creation system:

1. Managers need to set goals for the value-creation and make plans on how to achieve these goals.

2. Managers need to organize the patterns of actors, resources and activities that are needed to actualize the plans.

3. Managers need to make actors committed to carry out the required value-creating activities.

4. Managers need to follow-up that the value is indeed created as planned and if needed carry out corrective measures.

The four required management functions described above correspond respec-tively to planning, organizing, leading, and controlling in hierarchies, which we already previously described. In networks, management cannot be based on hi-erarchical planning, organizing, leading, and controlling, since network relation-ships are based on relationships among *autonomous* units and the relationships between these units are based on trust, not on authority (see e.g. Håkansson and Ford 2002, Ford and Håkansson 2006). The fundamental point here is that no organization can fully control, or manage, its networked resources in isola-tion, since many of the resources available to a firm are under the direct control of other actors in the network and can only be controlled or managed through the medium of interactive relationships between the actors (Ford and Håkansson 2006).

Therefore, we suggest that management functions in markets, networks and hi-erarchies are different. These differences are explained in Table 1.

Table 1. Managing value-creation in different governance modes: management functions

Type of value-creation system	Market	Network	Hierarchy
Governance based on	Price-based competition, control and cooperation through contracting	Trust-based collaboration, control and cooperation negotiated	Authority-based control between superior and subordinate, and cooperation induced through rewards
How does the system decide on the target of value-creation?	Decided by the buyer through **designing** the basis of tendering	Negotiated constantly through the process of **framing** among all actors	**Planned** by the superior (with the help of subordinates)
How does the system organize the patterns of actors, resources, and activities of the system?	The buyer opens a **tender** and suppliers make **offers** according to the tender; A contract is made; The supplier decides on the most effective forms of organizing actors, resources and activities	Negotiated constantly through the process of **activating** among all actors	**Organized** by the superior (with the help of subordinates)
How does the system make sure that actors are committed to do what they are supposed to do?	The buyers and suppliers make a **contract** based on the tender. The contract specifies the **sanctions** and **rewards** that induce commitment from the suppliers	Negotiated constantly through the process of **mobilizing** among all actors; **sanctions** and **rewards** are negotiated constantly	The superior **leads** the subordinates by using **rewards** and **sanctions** that are based on the superior-subordinate relationship between the actors
How does the system control and improve its output and process efficiency?	The buyers **follow-up** on the contract, and use sanctions and rewards to make sure that agreed efficiency-levels are realized	Negotiated constantly through the process of **synthesizing** among all actors; obstacles to interaction are removed as necessary	The superior **controls** the output and process efficiency through follow-up and sanctions/rewards

The general focus in this paper is on network management. Different perspectives and ideas on managing different kinds of networks naturally exist. Broadly conceived, network management can be defined as improving the ability of the network to operate towards accomplishing its varying objectives, or as the means by which network members influence each other and/or the network as a whole in order to improve network cooperation (see e.g. Järvensivu 2007, 21-24). At one level, network management involves restructuring the existing network, and, at another level, it involves improving the conditions of cooperation within the existing structure (Kickert and Koppenjan 1997, 46-53, Klijn et al. 1995). The former mode – restructuring – involves activities such as adding or removing actors, resources or value activities from the network as well as changing the ways in which the network relates to its environment. The latter mode – improving conditions of cooperation – involves various activities taken to

facilitate cooperation between network actors so that the network would accomplish its goals.

Network management as framing, activating, mobilizing and synthesizing

Based on our literature review, we propose that in networks the basic management functions could be labeled as *framing*, *activating*, *mobilizing*, and *synthesizing.* These concepts and their labels are not new; they were first coined by Agranoff and McGuire (2001) and further developed by McGuire (2002, 2006). They define framing as involving "establishing and influencing the operating rules of the network", "influencing its [the network's] prevailing values and norms", and "altering the perceptions of the network participants". Activating, in turn, "includes the process of identifying participants for the network… and stakeholders in the network… as well as tapping the skills, knowledge, and resources of these persons." Mobilizing involves inducing "individuals to make a commitment to the joint undertaking - and to keep that commitment", or briefly "motivating, inspiring, inducing commitment". Finally, synthesizing involves "creating the environment and enhancing the conditions for favorable, productive interaction among network participants" and "preventing, minimizing, or removing blockages to cooperation". (Agranoff and McGuire 2001, 298-300)

Figure 2 presents how the four network management functions fundamentally contribute to the value-creation in networked organizing. The argument is that the removal of any of the functions will impede the successfulness of network cooperation; thus together they comprise the *required* components of relationship management.

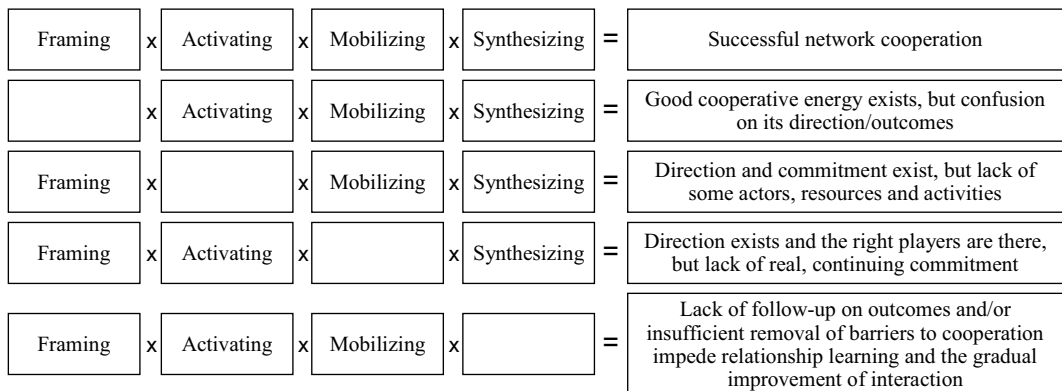| Framing	x	Activating	x	Mobilizing	x	Synthesizing	=	Successful network cooperation
	x	Activating	x	Mobilizing	x	Synthesizing	=	Good cooperative energy exists, but confusion on its direction/outcomes
Framing	x		x	Mobilizing	x	Synthesizing	=	Direction and commitment exist, but lack of some actors, resources and activities
Framing	x	Activating	x		x	Synthesizing	=	Direction exists and the right players are there, but lack of real, continuing commitment
Framing	x	Activating	x	Mobilizing	x		=	Lack of follow-up on outcomes and/or insufficient removal of barriers to cooperation impede relationship learning and the gradual improvement of interaction

Figure 2. Network management functions and their effects on the successfulness of cooperation

The four network management functions can be carried out using a wide range of network management mechanisms or tools. These tools have been identified and categorized by Grandori and Soda (1995) as (1) communication, decision, and negotiation mechanisms, (2) social coordination and control, (3) integration and linking roles and units, (4) common staff, (5) hierarchy and authority relations, (6) planning and control systems, (7) incentive systems, (8) selection systems, (9) information systems, and (10) public support and infrastructure. Inter-organisational researchers often include trust and commitment to the list of interorganisational coordination mechanisms (e.g. Morgan and Hunt 1994), but Grandori and Soda (1995) see trust or commitment as outcomes of coordination or characteristics of a relationship rather than coordination mechanisms *per se*, and so exclude them from their list.

Figure 3 provides a clarification of the relationships between the ten management mechanisms/tools and the four network management functions (framing, activating, mobilizing, and synthesizing). Our argument here is, on the one hand, that the network management functions can be carried out using one or a combination of several management mechanisms and, on the other hand, each of these management mechanisms may have one or several functional roles. For instance, framing can be achieved through the simultaneous utilization of communication and negotiation, social coordination and control and incentive systems. On the other hand, incentive systems may help simultaneously in, for example, framing, mobilizing and synthesizing.

	Network management functions			
Network management mechanisms/tools	Framing	Activating	Mobilizing	Synthesizing
1. Communication, decision and negotiation mechanisms	X	X		
2. Social coordination and control	X	X	X	
3. Integration and linking roles and units				X
4. Common staff			X	
5. Hierarchy and authority relations		X	X	
6. Planning and control systems		X		X
7. Incentive systems	X		X	X
8. Selection systems	X	X		
9. Information systems	X			X
10. Public support and infrastucture	X			

Note: X's are used here only as examples; in reality each management situation is different with regard to the X's. The purpose of this figure is to show that the management functions can be carried out through one or several several management mechanisms/tools, and that each mechanism/tool can perform one or several functional roles.

Figure 3. Relations between network management functions and mechanisms/tools

Finally, we argue that in each different type of network we will need different patterns of network management functions and mechanisms. In some networks, for instance, there will be more need to frame and activate, whereas in other networks there may be more need to mobilize actors and synthesize cooperation. In some networks, common staff and planning systems may be key coordinating mechanisms of the network, whereas in others the key mechanism may be incentive and information systems. The patterns of network management functions and mechanisms are ultimately determined by the characteristics of the network (its size, uncertainty of future, etc).

In the next section we will look more closely at social and health care systems and their different value-creation dimensions. This discussion is fundamental for the understanding and "framing" future discussions of networked value-creation in this sector.

Health and social care value-creation system and its dimensions

The ageing population presents one of the most important challenges to the Finnish health and social care system. At least two primary strategies have emerged to tackle this challenge. The first strategy is to postpone, or reduce, the need for in-patient elderly care by increasing resources in out-patient care. It is believed that by treating people as out-patients, e.g. at home, and thus postponing institutionalization, we can (1) decrease overall care costs, as out-patient care is suggested to be more cost-efficient than in-patient care, and (2) increase service quality, as the elderly themselves prefer to live at home rather than in an institution (Stakes 2006, 8-9, Vaarama et al. 2001, 7-8, Kinnunen 2002, 6, MSAH 2001).

The second strategy is to enhance care integration (Stakes 2006, 8-9, Mur-Veeman et al. 2003, Vaarama et al. 2001, 11-14, MSAH 2001). Integrated care can be defined as the processes of coordination to achieve seamless and continuous care, tailored to patients' needs with a holistic view of the patient (Mur-Veeman et al. 2003). Care integration may be vertical and horizontal. Vertical integration involves the coordination of care paths as the clients pass through different treatments within and between different care units and organizations (e.g. Katsaliaki et al. 2005). Vertical integration aims both at cost-saving (e.g. lower transaction costs) and increasing care quality (e.g. shorter waiting times for the patient). Horizontal integration, in turn, involves the coordination along the care scope (e.g. Kinnunen 2002, 23-24), namely the different types of care activities such as those of health care providers and social care providers. It is believed that a better coordination of the care scope will both (1) increase service quality as the patients will receive an optimal palette of services tailored to their individual needs and (2) decrease service costs through a better coordination of the care scope, thus eliminating resource misuse.

These two strategies – postponement of institutionalization and care integration – are not mutually exclusive. For instance, the careful coordination of care paths from out-patient care to in-patients care, and back, may help to postpone patient institutionalization, as, for instance, home care patients may sometimes need a brief period of rehabilitative in-patient care in order to stay at home longer.

There is evidence that the care postponement and integration strategies can benefit from the idea of networking, or looking at the care system through networked value-creation (e.g. Lega 2005, Page 2003, Kassler and Goldsberry

2005, Provan et al. 2005). Networking in health and social care seems to provide benefits similar to networking in other fields, including operative efficiency, economies of scale, service quality, access to resources and markets, learning and innovation, financial stability, power of influence, and legitimization (Lega 2005, Ortiz et al. 2005). We will next use the concept of the value-creation system presented in the first section of this paper to look at the health and social care sector.

As argued earlier, any value-creating network can be defined as a set of activities, actors and resources: actors are those who perform activities and control resources, and activities are the usage of resources to change other resources. Following this basic framework, we have outlined a general model of value creation within the field of health and social care (see Fig. 4).
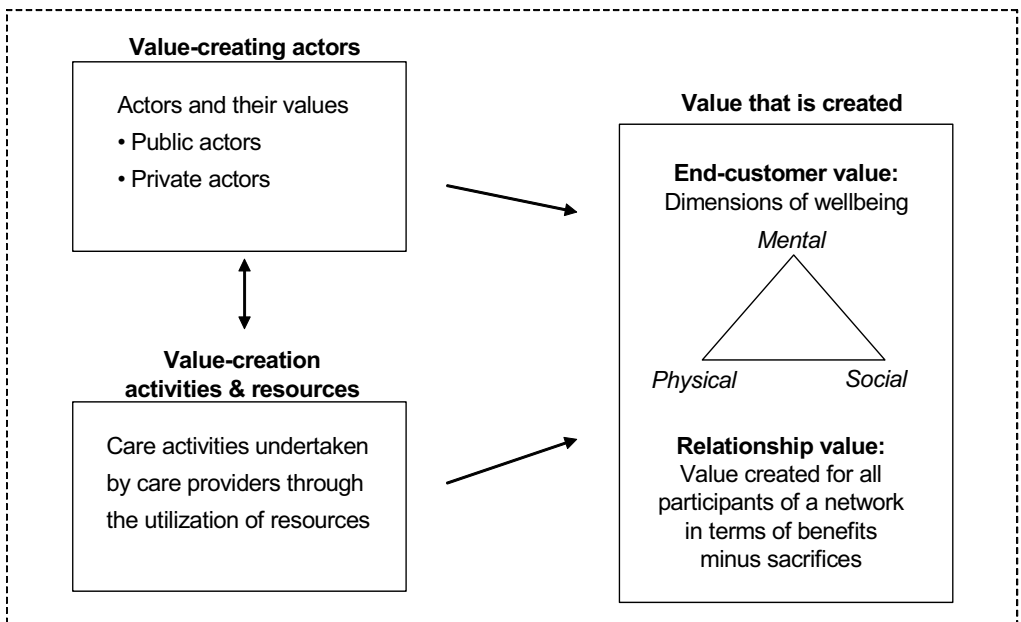

Figure 4. Value-creation in the field of health and social care

The model includes three key elements: (1) value that is created, (2) actors that perform value-creating activities and control resources, and (3) activities and resources that create value. Next, we will briefly discuss the model and its key elements.

Firstly, there are, in general, two basic, not completely unrelated, meanings to the term "value" in the networking context. On the one hand, value relates to the cultural values held by actors and, on the other hand, value may be perceived through the benefits and sacrifices of a relationship. (Flint et al. 1997, Eggert et al. 2006, Ulaga 2003, Möller 2006). The former meaning of value, cultural values, can be simply defined as beliefs held by actors about desirable ends and means, which serve as the basis for making choices (Connor and Becker 1994, Meglino and Ravlin 1998). The latter meaning of value, in turn, can be determined as the (desired or actual) benefits received by an actor minus sacrifices that went into producing and/or receiving the benefits (Eggert et al. 2006, Flint et al. 1997). In the latter meaning of value, effectiveness improves along with the increase of benefits, all other things being equal, and efficiency improves along with the reduction of sacrifices, all other things being equal.

The benefits–sacrifices definition of value can be interpreted at least from two perspectives: from the end-customer's perspective or more broadly from the relationship perspective. The end-customer perspective looks only at the benefits and sacrifices concerned with the end-customer. In the field of health and social care, for instance, the benefits for the end-customer can be seen as gains along the different dimensions of wellbeing (physical, mental, and social) and sacrifices are the resources that the end-customer uses to gain the benefits. The relationship perspective to value incorporates the benefits and sacrifices to all the participants of the relationship.

What is often not recognized is that the cultural approach and the benefits–sacrifices approach to value are closely related to each other, as the beliefs an actor has about desirable ends and means (i.e. cultural values) determine, in the end, how actors weight different benefits and sacrifices. In other words, the value that an actor gives to a certain benefit or sacrifice is a function of the actor's cultural values. This gets us to our second element in Fig. 4, namely that of actors and their values. The key point here is that different actors have different values, and these values determine what activities the actors undertake and what aspects of end-customer or relationship value they regard as important. In the field of health and social care, a basic division can be made between public and private actors.

Finally, we get to the final element of the model, namely that of the activities and resources used in value creation. As already established, value is created through the activities of the actors when utilizing and transforming resources. In the field of health and social care, activities are the care activities undertaken by care providers and other actors of the care network.

By looking at the actors and the different aspects of value-creation in the health and social care sector, we argue that there are 11 key dimensions through which we can "frame" or understand value-creation in this field:

1. Value creation varies along the *care process*, including different stages of care.

2. Value creation varies in terms of the *scope of services* the customer needs (Vaarama et al. 2001, 13-14, Kinnunen 2002, 38-39). A basic division can be made between social and health care services (Mur-Veeman et al. 2003).

3. Care can be offered as *formal or informal* care. Formal care is provided by public or private organizations or institutions that have a formally established role of providing care in a national care system. Informal care, in turn, means all the care activities that are undertaken by persons or organizations that are not officially appointed as care providers.

4. Value creation varies in terms of the *reactivity of care*: care provisioning can be proactive (health promoting) or reactive (care of ill) (Normann 2006).

5. Value creation varies in terms of the *intensity of care*: care can be intensive or non-intensive.

6. Value creation varies in terms of the *duration of care*: care services can be offered as short-term or long-term care (e.g. Mur-Veeman et al. 2003).

7. Value-creating activities/resources can also be divided based on their *centrality to value creation*. Some care activities may be classified as "core activities" and "non-core activities".

8. Value-creation activities can take place at three interrelated levels of analysis: *macro, meso and micro levels*. The macro level looks at value-creation from the perspective of whole networks. The meso level looks at organizing issues that fall in-between the macro and meso levels. The micro level looks at care activities taking place as part of the every-day provider-receiver relationships between service providers and their customers.

9. The scope, amount, and quality of health and social care provided in any community are directly influenced by *the values of the actors* in

that community. There are many different types of actors operating or influencing operations in the field of health and social care, each having their own values and interests related to services production and development (see Table 2). These cultural values determine how value is ultimately "framed" in each value-creating system.

Table 2. Actors with differing values and interests

Actor	Values and interests
Public elected officials	Serving the public good; Making political decisions; Winning elections
Public authorities	Serving the public good; Following and executing political decision-making
Public service producers	Serving the public good; Ensuring public health based on individual needs
Private companies	Increasing shareholder profit; Taking care of stakeholders
Research institutions	Research and innovation based on different expertise and value foundations
Third sector organizations	Serving public good and/or private interests based on different expertise and value foundations
Private citizens	Living a healthy and happy life

10. A key dimension of care effectiveness is the *extent to which the end-customer is empowered as a co-creator of value* in a specific care context/process.

11. Finally, networked value-creation and its management is contingent on the *value-creation continuum* (see Fig. 5) suggested by Möller and his colleagues (Möller et al. 2005, Möller and Svahn 2003, Möller and Svahn 2006).
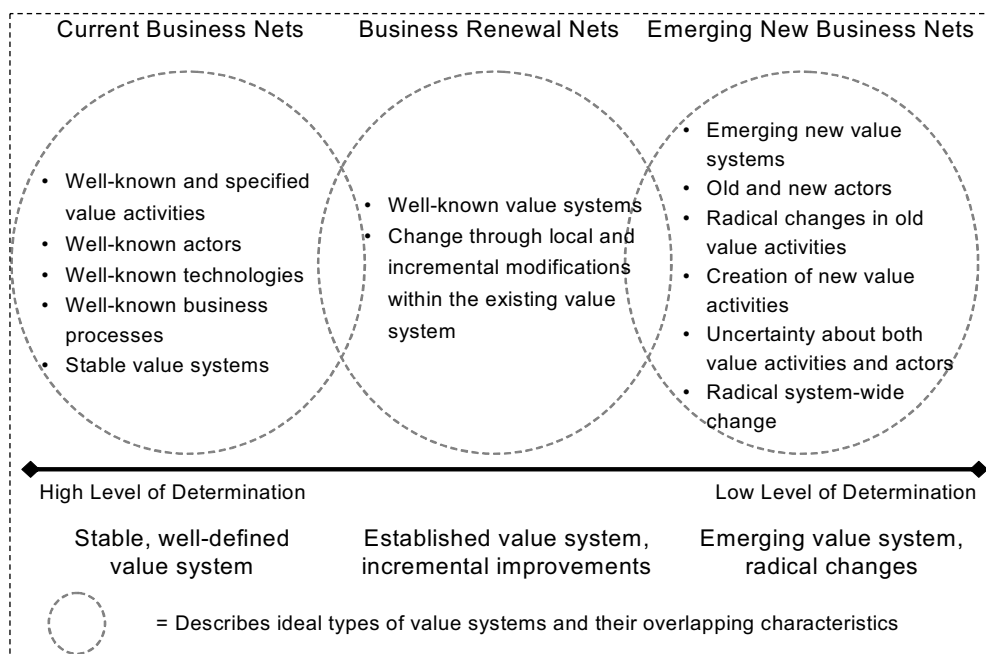
Current Business Nets Business Renewal Nets Emerging New Business Nets

- Well-known and specified value activities
- Well-known actors
- Well-known technologies
- Well-known business processes
- Stable value systems

- Well-known value systems
- Change through local and incremental modifications within the existing value system

- Emerging new value systems
- Old and new actors
- Radical changes in old value activities
- Creation of new value activities
- Uncertainty about both value activities and actors
- Radical system-wide change

High Level of Determination   Low Level of Determination

Stable, well-defined value system | Established value system, incremental improvements | Emerging value system, radical changes

= Describes ideal types of value systems and their overlapping characteristics

Figure 5. Value-system continuum (Möller and Svahn 2006, 989)

The above discussion of the dimensions of health and social care value-creating systems is important to our understanding of the management of health and social care networks since they help us to frame the discussion. In fact, the dimensions are needed when we engage in the management function that has been termed in this paper "framing"; in other words, we need the dimensions when we try to understand the whole value-creating systems as well as its parts.

In the next section we illustrate the usage of the value-creation dimensions by looking at the Finnish health and social care system through them.

The Finnish health and social care system: Framing the networks

The Finnish care system can be illustrated through several dimensions: for instance the scope of care (including health, social, and other wellbeing services); the reactivity, intensity, and duration of care, which together give us the dimension from acute emergency care to non-acute preventive care; informal/formal care; and inpatient/outpatient care. These dimensions are illustrated in Figure 6.
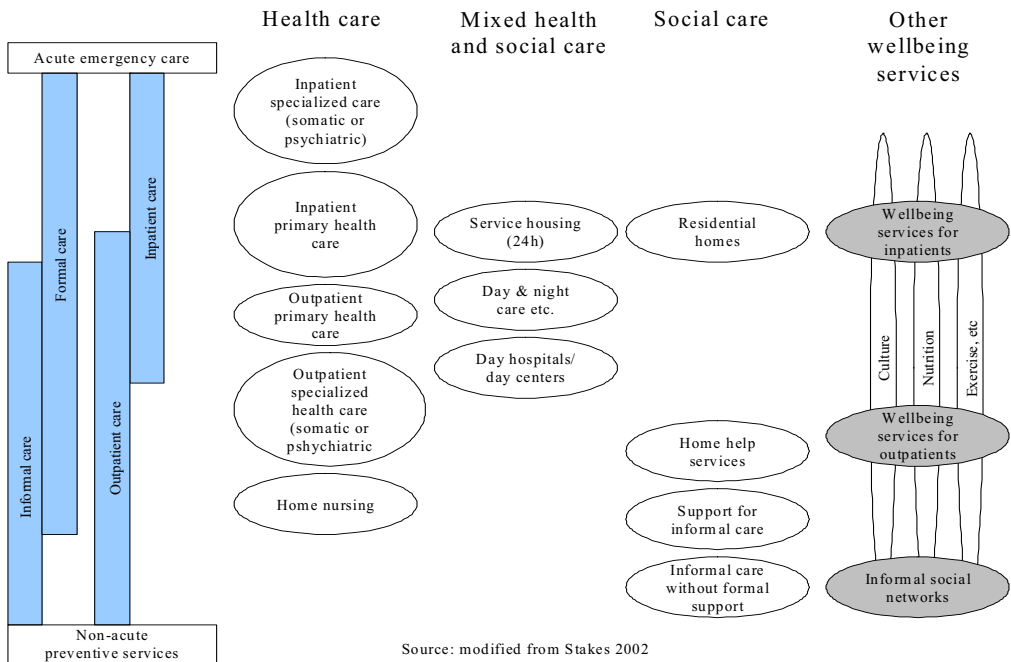

Figure 6. Services in the Finnish wellbeing system

This kind of figure helps us to frame the discussion on health and social care network management – what are the actual dimensions that we want to manage or focus on? Another way would be to look at the actors that are involved in

value-creation. In the Finnish system, municipalities can, for instance, organize long-term care through their own care providing units or through privately-owned care providers. The former would be based on hierarchical governance whereas the latter would be based on market-based governance. In Figure 7, we have looked at both the macro-meso-micro dimension and the actor-dimension, and described the possible governance relations between the different actors/levels. From this figure, we can see that the Finnish care system is, in fact, quite complex in terms of the possible governance modes.

Value-creating system of health and social care

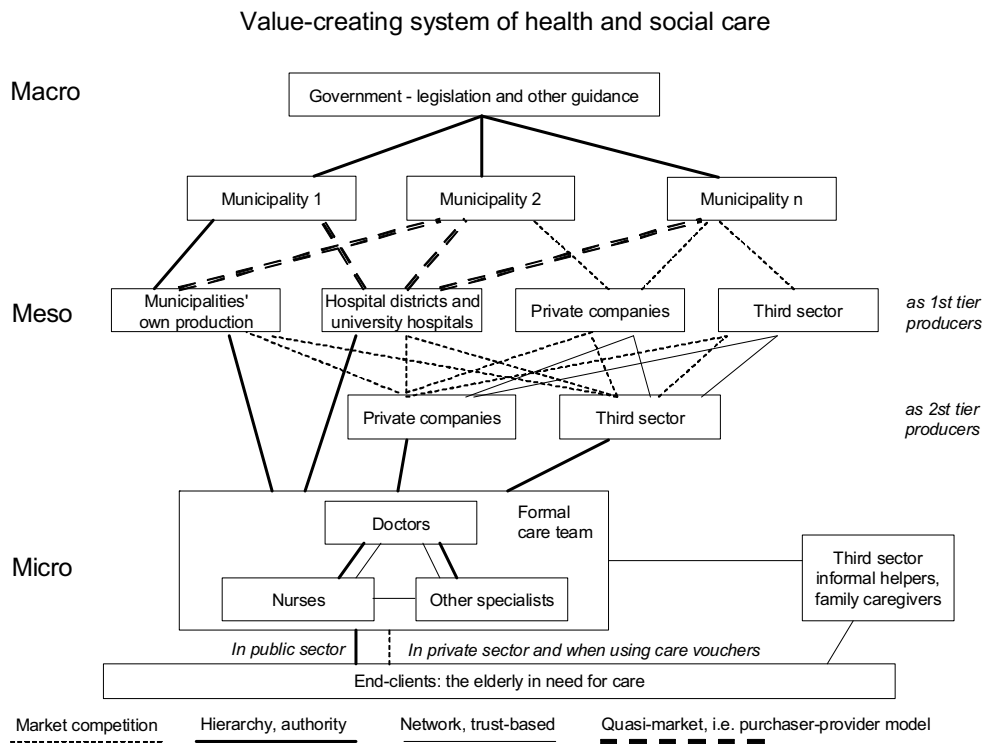Figure 7. The Finnish health and social care system: macro-meso-micro and actor dimensions

The Finnish government, from the macro level, has decided to leave it to the municipalities to decide how they want to organize their health and social services. The government stipulates, in a hierarchical manner through legislation, what *types* and *quality* of services the municipalities are obligated to provide, but

it has indeed chosen to let the municipalities decide how they organize the services.

At the meso level, the municipalities are quite free to choose whether they want to provide the services through their own production (hierarchical or quasi-market governance; the producing unit can be owned by one or several municipalities), through hospital districts and university hospitals (quasi-market governance), or through buying the services from the private or third sector providers (competitive market governance). The municipalities thus have basically two options: either to do everything by themselves, which means hierarchical or quasi-market governance, or to buy from the private markets, which by law means competitive markets based on tendering and bidding.

At the micro level, the care team (doctors, nurses, other specialists) is hierarchically governed by the organization that the team belongs to. The team itself can be organized as a hierarchical team or a network-based team. If one or several specialists of a care team belong to different "parent organizations" (e.g. a doctor is from a private company and a physiotherapist is from a public organization), then there might be network-like governance within the team, as no-one has hierarchical authority over the other. Third sector *informal* helpers or caregivers may take part in taking care of the end-customer; this would most likely mean network governance between the formal care team and the informal caretaker, at least if the informal caregiver has no market- or hierarchy-relationship towards the formal care team.

Finally, the end-customers may have a hierarchical-type relationship to the care team if the care is provided by a public organization (the relationship could be network-like if this is what the doctor/care team allows, but the relationship often is hierarchical, since the doctor is in a superior position towards the end-customer; the end-customer does not have choice as she/he would have in competitive markets). If the end-customer, however, buys the services from the competitive market (either by using own money or care vouchers provided by the municipality), the relationship between the care team and the end-customer is more likely to be based on a market-type relationship. Here it is good to remember that both hierarchical and market-type relationships may in time evolve into more trust-based relationships, as the care team and the end-customer learn to know each other better

Finally, we argue that a key dimension in networked value-creation is the value-system continuum. In other words, value-creation is not merely providing current

services as efficiently as possible, but also renewing current systems and even providing more radical innovations. In Figure 8, we provide a tentative framing of value-creation that connects the current Finnish health and social service system to the Finnish innovation system. This whole system seeks not only to produce wellbeing services but also *to renew and innovate around them*.
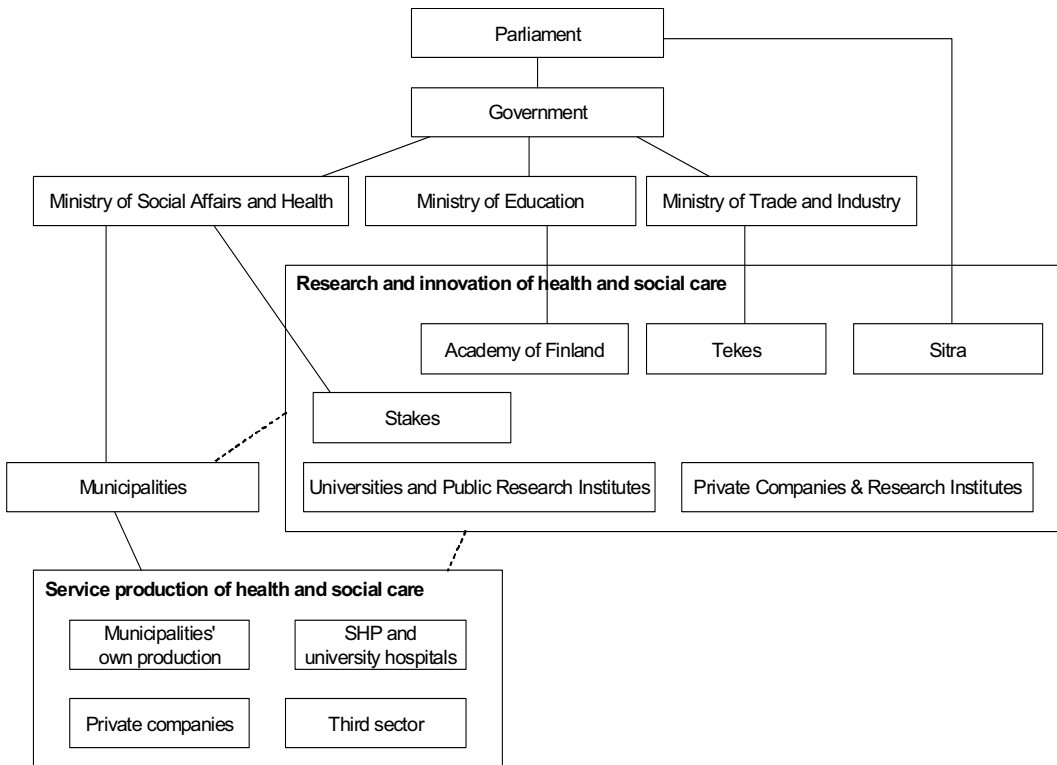

Figure 8. Renewal and innovation in the Finnish health and social care system

What is notable here is that the municipalities have an obligation, by law, to *provide* certain types and quality-level of services for the end-customers. This means that much of their resources are naturally bound to providing these services, and the linkages to the innovation system remain rather weak. This means that municipalities will concentrate on producing services efficiently through their current actor-activity-resource system. However, when considering the long-term effectiveness of the whole systems, it clearly depends on the *renewal and innovation* of the actor-activity-resource system. Especially now that the ageing of the population presents a great challenge in the coming decades, there will be a need for further renewal and innovation. This continuum and the interconnections between care production and innovation are not currently efficiently managed in Finland.

Conclusion

In this paper, we have focused on conceptualizing networked value-creation and its management in the field of health and social care services in Finland. We started the discussion with a brief introduction to the concepts of networks, markets, and hierarchies. Then we looked at how each of these modes of governance can be managed, and conceptualized network management through the functions of framing, activating, mobilizing, and synthesizing. We then introduced the concept of "dimensions" of health and social care, by which we can frame networked value-creation in this field. Finally, we looked at the framing of the Finnish health and social care system using several of these dimensions.

This discussion is a step towards managing networked value-creation in the field of health and social care. The dimensions we have described help us to engage in the managerial process of "framing" the networks of providing, renewing and innovating the care system. This paper, however, remains rather conceptual and our next task is to look empirically at different wellbeing network cases, scrutinize their management, and learn more about the dynamics and mechanisms of framing, activating, mobilizing, and synthesizing in these networks. This is the ongoing task of our ActiveNet project (more information: www.hse.fi/activenet).

References

Agranoff, R. and McGuire, M. 2001. Big questions in public network management research, Journal of Public Administration Research and Theory, 3, 295-326.

Agranoff, R. and McGuire, M. 2003. Collaborative Public Management: New Strategies for Local Governments. Georgetown University Press, Washington, D.C.

Bartlett, W. and Le Grand, J. 1993. Quasi-markets and Social Policy. Palgrave Macmillan.

Connor, P.E. and Becker, B.W. 1994. Personal Values and Management: What Do We Know and Why Don't We Know More? Journal of Management Inquiry, 3(1), 67-73.

Dhanaraj, C. and Parkhe, A. 2006. Orchestrating Innovation Networks. Academy of Management Review, 31(3), 659-669.

Eggert, A., Ulaga, W., and Schultz, F. 2006. Value Creation in the Relationship Life Cycle: A Quasi-Longitudinal Analysis. Industrial Marketing Management, 35(1), 20-27.

Flint, D.J., Woodruff, R.B., and Gardial, S.F. 1997. Customer Value Change in Industrial Marketing Relationships. Industrial Marketing Management, 26(2), 163-175.

Ford, D., Gadde, L.-E., Håkansson, H. and Snehota, I. 2003. Managing business relationships. John Wiley & Sons, Chistester.

Ford, D. and Håkansson, H. 2006. IMP – Some things achieved: Much more to do. European Journal of Marketing, 40(3/4), 248-258.

Grandori, A. and Soda, G. 1995. Inter-firm Networks: Antecedents, Mechanisms and Forms. Organization Studies, 16(2), 183-214.

Gulati, R., Nohria, N., and Zaheer, A. 2000. Strategic Networks. Strategic Management Journal, 21(3), 203-215.

Håkansson, H. and Johanson, J. 1992. A Model of Industrial Networks. In B. Axelsson and G. Easton (Eds). Industrial Networks: A New View of Reality. Routledge, London, 28-34.

Håkansson, H. and Ford, D. 2002. How Should Companies Interact in Business Environments. Journal of Business Research, 55(2), 133-139.

Håkansson, H. and Snehota, I. (Eds). 1995. Developing Relationships in Business Networks. Routledge, London.

Heikkinen, M., Mainela, T., Still, J., and Tähtinen, J. 2007. Roles for managing in mobile service development nets. Industrial Marketing Management, 36(7), 909-925.

Jarillo, J. C. 1988. On Strategic Networks. Strategic Management Journal, 9(1), 31-41.

Järvensivu, T. 2007. Values-driven Management in Strategic Networks: A Case Study of the Influence of Organizational Values on Cooperation. Academic Dissertation, Helsinki School of Economics, A-287, HSE Print, Helsinki.

Jones, C., Hesterly, W.S., and Borgatti, S.P. 1997. A General Theory of Network Governance: Exchange Conditions and Social Mechanism. Academy of Management Review, 22(4), 911-945.

Kassler, W.J. and Goldsberry, Y.P. 2005. The New Hampshire Public Health Network: Creating Local Public Health Infrastructure through Community-Driven Partnerships. Journal of Public Health Management Practice, 11(2), 150-157.

Katsaliaki, K., Brailsford, S., Browning, D., and Knight, D. 2005.Reports from Services: Mapping Care Pathways for the Elderly. Journal of Health Organization and Management, 19(1), 57-72.

Kenis, P. and Provan, K.G. 2006. The control of public networks. International Public Management Journal, 9(3), 227-247.

Kickert, W.J.M. and Koppenjan, J.F.M. 1997. Public Management and Network Management: An Overview. In Kickert, W.J.M., Klijn, E., and Koppenjan, J.F.M. (Eds). Managing Complex Networks: Strategies for the Public Sector. Sage Publications, London. 33-61.

Kinnunen, K. 2002. Postponing of Institutional Long-Term Care in the Patients at High Risk of Institutionalisation. Yliopistopaino, Helsinki.

Klijn, E., Koppenjan, J., and Termeer, K. 1995, Managing Networks in the Public Sector: A Theoretical Study of Management Strategies in Policy Networks. Public Administration, 73(3), 427-454.

Lega, F. 2005. Strategies for Multi-Hospital Networks: A Framework. Health Services Management Research, 18(2), 86-99.

McGuire, M. 2002. Managing networks: Propositions on what managers do and why they do it. Public Administration Review, 62(5), 599-609.

McGuire, M. 2006. Collaborative Public Management: Assessing What We Know and How We Know It. Public Administration Review, 66 (Special Issue), 33-43.

Meglino, B.M. and Ravlin, E.C. 1998. Individual Values in Organizations: Concepts, Controversies, and Research. Journal of Management, 24(3), 351-389.

Möller, K. 2006. Role of Competences in Creating Customer Value: A Value-Creation Logic Approach. Industrial Marketing Management, 35(8), 913-924.

Möller, K. and Rajala, A. 2007. Rise of strategic nets – New modes of value creation. Industrial Marketing Management, 36(7), 895-908.

Möller, K. and Halinen, A. 1999. Business Relationships and Networks: Managerial Challenge of Network Era. Industrial Marketing Management, 28(5), 413-427.

Möller, K. and Svahn, S. 2003. Managing Strategic Nets: A Capability Perspective. Marketing Theory, 3(2), 209-234.

Möller, K., Rajala, A., and Svahn, S. 2005. Strategic Business Nets − Their Type and Management. Journal of Business Research, 58(9), 1274-1284.

Morgan, R.M. and Hunt, S.D. 1994. The Commitment-Trust Theory of Relationship Marketing. Journal of Marketing, 58(3), 20-38.

MSAH. 2001. Strategies for Social Protection 2010 - Towards a Socially and Economically Sustainable Society. Ministry of Social Affairs and Health, Helsinki, Finland.

Mur-Veeman, I., Hardy, B., Steenbergen, M., and Wistow, G. 2003. Development of Integrated Care in England and the Netherlands: Managing across Public-Private Boundaries. Health Policy, 65(3), 227-241.

Normann, R. 2006. Challenges for Health Care in Western Societies. In R. Normann and N. Arvidsson. (Eds). People as Care Catalysts: From Being Patient to Becoming Healthy. John Wiley & Sons, Chichester, 1-7.

Ortiz, J., Fottler, M.D., and Hofler, R. 2005. Performance of Health Centers in Networks. Health Care Management Review, 30(2), 126-138.

Page, S. 2003. "Virtual" Health Care Organizations and the Challenges of Improving Quality. Health Care Management Review, 28(1), 79-92.

Park, S.H. 1996. Managing an Interorganizational Network: A Framework of the Institutional Mechanism for Network Control. Organization Studies, 17(5), 795-824.

Podolny, J.M. and Page, K.L. 1998. Network Forms of Organization. Annual Review of Sociology, 24(1) 57-76.

Powell, W.W. 1990. Neither market nor hierarchy: Network forms of organization. Research in organizational behavior, 12, 295-336.

Provan, K.G. and Milward, H.B. 1995. A preliminary theory of interorganizational network effectiveness: A comparative study of four community mental health systems. Administrative Science Quarterly, 40(1), 1-33.

Provan, K.G., Isett, K.R., and Milward, H.B. 2004. Cooperation and compromise: A network response to conflicting institutional pressures in community mental health. Nonprofit and Voluntary Sector Quarterly, 33, 489-514.

Provan, K.G., Harvey, J. and de Zapien, Jill Guernsey 2005. Network Structure and Attitudes toward Collaboration in a Community Partnership for Diabetes Control on the US-Mexican Border. Journal of Health Organization and Management, 19(6), 504-518.

Ritter, T., Wilkinson, I.F., and Johnston, W.J. 2004. Managing in Complex Business Networks. Industrial Marketing Management, 33(3), 175-183.

Stakes. 2003. Care and services for older people 2002, Official statistics of Finland. Gummerus, Saarijärvi.

Stakes. 2006. Stakesin asiantuntijoiden vastauksia kysymyksiin vanhustenhuollosta ja hoitotakuusta. Stakes. Stakesin työpapereita 23/2006, Helsinki.

Thorelli, H.B. 1986. Networks: Between Markets and Hierarchies. Strategic Management Journal, 7(1), 37-51.

Tsoukas, H. 1994. What is management? An outline of a metatheory, British Journal of Management, 5, 289-301.

Ulaga, W. 2003. Capturing Value Creation in Business Relationships: A Customer Perspective. Industrial Marketing Management, 32(8), 677-693.

Vaarama, M., Luomahaara, J., Peiponen, A., and Voutilainen, P. 2001. Koko kunta ikääntyneiden asialle: Näkökulmia ikääntyneiden itsenäisen selviytymisen sekä hoidon ja palvelujen kehittämiseen (in Finnish). STAKES, Sosiaali- ja terveysalan tutkimus- ja kehittämiskeskus, Saarijärvi.

Watson, T.J. 2006. Organising and Managing Work: Organisational, managerial and strategic behaviour in theory and practice. 2nd edition, Pearson, New York.

"Japanese Model" care service network — some advanced Japanese cases

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"Dependence" and "Independence"

"*The Anatomy of Dependence*" (Doi 1973) advocated the concept of "dependence" as the base of Japanese culture. For example, the nuance of the word "naive" in Japanese is positive rather than negative, whereas it's negative in European languages. In Japanese culture, the concept of "dependence" is less negative, contrary to Finnish culture, which puts more importance on "independence". Japanese culture is like a network of dependencies. Being dependent isn't so shameful in the Japanese cultural context. Such culture is at the root of the Japanese social and welfare system. We have to keep this basic feature of Japanese mentality in mind to understand the Japanese system properly.

The features of Japanese social systems

In the index of Japanese average life expectancy and average healthy life expectancy, Japan is at the top. Also in terms of education, Japan is among the top performers in the world according to statistics of OECD. But in terms of government expenditure for social security and education, Japan spends less than most other advanced countries. While some may think that this is proof of

an extremely efficient Japanese social system that would be a very superficial understanding.

If you were to take a close look at Japanese systems, you would find that the Japanese central government has succeeded to make political excuses for avoiding its principal public responsibilities. The Japanese central government has channeled the public funds saved into promoting industry in such a way that has boosted the Japanese economy. There is a historic basis for this. During the Japanese civil war in the nineteenth century the newly installed Japanese government intentionally retained some aspects of the feudal system, and this has continued to the present day. (Jinno 1987) It was considered both effective and efficient to keep the traditional systems active under the control of the central government that was installed even after WWII (Y. Noguchi 1995) and this way of thinking has continued until the present day. For example, the Japanese central government was able to significantly cut its defense budget thanks to its dependence on the US-Japan Security Treaty. In labor and economical policy, the central government has been able to keep its costs down by depending on private corporations through Japanese labor customs, like the intake of new graduates, the stable career educative OJT and lifetime employment. In the educational and welfare fields, the central government has been able to curb its expenses by its dependence on the housewife, who has been intentionally nourished since 1960. Actually even though the governmental expenditure for public education is small, family expenditure for private education like private supplementary schools known as "cram schools", is very high in Japan.

This public administration system is referred to as a "maximum mobilization system" (Muramatsu 1994). In this system, the central government can avoid its responsibility and decrease its fiscal burden since the central government can make laws, regulations and national announcements to mobilize local government, as well as the private and public sectors and put its policies into place. This public administration system makes it possible for the Japanese government to realize its aim with the maximum mobilization of the government-private partnership. While the government-private partnership has been strong since before WW Ⅱ, there is also a strong consensus that the public sector should be monopolized by the government (Yorimoto 2001). Considering this background, this government-private relationship is one in which the government has used the private sector as a tool to achieve its aims. The private sector has always played sub contractive or supplementary role.

Another feature of the Japanese public administration system is its strong sectionalism. The strongly centralized government, using a pre-modern feudal so-

cial system, paved the way for the excessive centralization of authority in the bureaucracy even after the systematic fatigue of this old fashioned bureaucracy.

The deficiencies of systematic sectionalism have prevented the maximum efficiency in each node and by extension the whole system. In a bureaucratic culture where the various bureaus take precedence over the ministries they represent, we can see many flaws in the sectionalist approach, including the failure of its professional qualification system, its job control area, and the organization of local governments. The sectional approach means that each node is segmented and isolated in the whole system, and, as a result, the system becomes inefficient and ineffective.

The former Japanese welfare system

The central Japanese government used to advocate that welfare is the responsibility of the private sector. The aim was clearly to avoid its public responsibility. Those who need special support should be looked after by their parents, siblings, relatives, or the local community. We can find this character in the first Japanese welfare system, "Jukkyu-kisoku". To avoid social security expenditure, the central government intentionally stamped a stigma on welfare clients. The targets of public care were limited to only the socially weak, who had no other alternatives than social welfare to live. In cases where the need for care arose, that care was to be provided by the elements of the private sector which the needy could get access to. Many Japanese were made to think it is shameful to be supported by social welfare and tried to avoid it. (The Japanese aren't so very keen to be independent. In many cases, they did not want to be dependent on social welfare, but were happy to be dependent on their relatives.) During this period the first priority was quantity fulfillment for such special socially weak, not for general citizens, so the quality of care wasn't a big issue. As Japan was not economically advanced at that time, there was no margin to improve care quality. In this system, women were core players as care givers. Especially the housewives, who were nourished politically, supported this trend even after WW II. In essence this system depended on unpaid female domestic labor.

It was also a supplier oriented system with the goal of quantitative achievement from the supplier's perspective. Catching up with the welfare level in advanced western countries in terms of quantity was the first priority. There were many failures caused by bureaucratic sectionalism in this period, but as the number of intended targets was small and an abundant budget guaranteed by rapid eco-

nomical growth covered the costs, this problem wasn't so serious. This system radically changed after 1990 tin response to various environmental changes.

Long Term Care Insurance

Because of the end of the high economic development that came soon after the oil shock in the mid 1970's, it was no longer possible for Japanese government to provide stable and universal economical benefits to all of Japan. In the 1980s, the Japanese central government made neo-liberalism systematic reforms in many fields. Welfare was just the target. Having established what it called a "Japanese welfare society model", all the central government did was to reduce its subsidy ratio for the local governments and advocate enlarging the self help to reduce central government expenditure. However, it never tried to reform the government weighted supplementary and sub contractive relationship model.

In the 1990s, the Japanese economy fell into a long and serious recession. It was at this time that aging advanced rapidly. Rapid aging invited a rapid increase in the elderly who needed special care. It was no longer impossible to reduce the care demand by restricting the targets to the rare socially weak. The extension of the potential recipients was accompanied with a change in the care needs. The targets were no longer the rare socially weak, but general citizens keen on maintaining their rights, dignity, privacy and personality. As a result, the quality and quantity problem merged at the same time.

In additional to the aging problem, changes in national life style resulted in various social conditional changes. The advancement of women socialization has decreased the ability of the government to rely on housewives to provide domestic care and made it impossible to restrict care problems in private field. As a result, the elderly welfare care problem also changed drastically in terms of quantity and quality. The care problem had to be socialized.

The central government tried to solve such problems by establishing Long Term Care Insurance, a kind of social insurance. It advocated a solution by suggesting the partnership of three actors, which meant a mixed welfare system including private help, mutual (public) help and government help. The central government explained that the reason why it used the social insurance system rather than taxation for the LTCI was to emphasize that receiving benefits from the LTCI wasn't shameful but a natural right for the insured. This concept of "from measurement to purchase" was so effective that after the introduction of the LTCI the mental obstacles of Japanese to get the LTCI benefit were largely erased.

Independence in the LTCI

There are numerous elements to consider in human welfare, but it's impossible to provide all kinds of care to support all of those elements with limited resources. The elements of care which should be covered with social insurance need to be decided in the LTCI system. Care function has been restricted to supporting the independence (not the whole life) of clients. The Japanese government designed the LTCI as a system to support only one aspect of personal life, independence. Functions to support whole life of the elderly (loneliness, etc) are excluded from the LTCI because these functions are expected to be provided by the private or public fields.

In establishing the LTCI system, it was essential to maintain the quantity of service provision all over Japan to avoid a situation where there is no available care service in some areas even though premiums are collected. As a result of this situation and the other restrictions of social insurance, the Japanese central government has been able to limit the scope of care, the need for which is clear, urgent, universal and persuasive.

By limiting the range of care, we have induced care into highly technical elements. Of course this is essential for the insurer to decide the unit of allowance for the care service provider for each care service. By inducing care into mainly physical elements, care isn't highly skilled work but a bundle of simple tasks which everybody can perform, so it's possible to introduce the market system to secure and improve care quantity and quality.

There is, however, a gap in this system with regard to Japanese culture. Not all Japanese elderly consider it important to be independent. Most tend to depend on the LTCI for whole life care because Japanese elderly tend to lack other effective tools. Various types of care are necessary to achieve the broad concept of health which is developing worldwide. But in Japan it's evident that more people will depend on the government sector for their rest of their lives. In social care frontlines there are conflicts between social care as a system and an ideal.

This gap between the LTCI system and Japanese culture makes it difficult to achieve a deep concept of care quality. As there is a cultural tendency to depend on the sensitivity of others to achieve understanding rather than make clear assertions, there will be more clients who cannot (or won't) express their needs and complaints effectively. It's impossible to be very sensitive to each and every client's individual needs and preferences and to provide tailor-made diverse personal services accordingly within existing welfare resources.

Very difficult but cost effective care, which has the flexibility to be molded to each client's personality and needs, and at the same time meet their requirements to maintain their dignity is urgently needed. Meeting this challenge in terms of both quality and quantity of care within the restricted budget available will require some great innovations.

The LTCI established a quasi-market solution as the engine for the required innovations. In 2006, the concept of community based comprehensive care was added to the LTCI. This was also systemized within the quasi-market system.

Quasi-market in the LTCI

In 2000, when the LTCI was launched, Japan was focusing on the concepts of market principle and competitive principles like privatization and deregulation. As a result, there is an expectation that the innovations necessary to develop management systems which are adequate in terms of both quantity and quality will be realized through market and competitive principles. The LTCI established a new quasi-market in the care field, which previously was catered to social welfare corporations or governmental sector, and allowed private enterprises to participate in this market, to address the inefficiencies in the old system. The LTCI tried to manage the maximization of quantity and quality in care provision, not by employing a tendering system, but by the direct selection of clients themselves from this quasi-market. Unlike the free market, the quasi-market can be strongly controlled by the government. This character is believed to improve not only the quality of care service, but also effectiveness and efficiency competition.

At the designing stage of the LTCI, the central government expected new actors who would pursue non-monetary reward in this quasi-market with a low allowance level. In the free market system, a high demand for a complicated service can result in a huge supply at high prices, meaning that those who make the effort to be innovative get the profit from their efforts. Innovative, well-designed services can develop a good reputation, which increases demand. In such cases, the companies involved can increase the cost to the consumer, and make a good profit. The profit has a direct relationship to its investment in making such innovations. In the quasi-market, however, the costs or subsidies are all but fixed, and enlarging the scale of services is also difficult, so the profit incentive doesn't exist. Since the effort made to be innovative in the quasi-market is on a volunteer-like basis, keeping the quality and quantity in care service is difficult. The concerns and interests of the new participants, especially private en-

terprises, have proven to be different from what the government expected. Profit is the sole motivator of the new comers to the care market. It has become obvious that some enterprises made cream skimming and some have behaved unlawfully. At the same time, there has also been trouble with the other new participants in the system: NPOs. Their lack of good management has made the sustainability of care service uncertain and many complaints about care, including abuse, have come about because of the unprofessionalism of NPO care workers.

At the end of the 1980s, quasi-markets in the UK's reformed NHS system were criticized (MacMaster 2002, Lapley 1993, Bartlett 1991). Since Japan has a culture of covering up trouble at all levels of society, the transactional cost in this market will be much higher. As a result, it will be difficult to achieve the expected improvements in the system through the quasi-market.

Of course, the clients don't care if the provider is the government sector, the public sector or the private sector as long as adequate service is provided (Koyama 1999). It's not the form of provider but the management provided by the government that maintains client choice and quality and quantity of care service. Partly because of these reasons the Japanese quasi-market in the LTCI has been unable to guarantee care service levels either in quantity or quality, despite initial expectations.

LTCI failure

In the LTCI reforms in 2006 home care has been supported in various ways, especially with regard to the insurance budget. Clearly more domestic care resources for home care are required but there is a paradox in this. Measures should have been included to complement the decreased domestic care ability with the women socialization. But in practice the LTCI system is still dependent on domestic care.

The reforms have maintained the principles of the quasi-market. Nevertheless, it doesn't in itself secure client choice, care quality and quantity, or even the adequate management of the insurer. The LTCI, which is consistent in thinking with the neo-liberal reforms of the 1980s, as well as the Koizumi reforms at the end of twentieth century, hasn't been able to respond adequately to the 21st century care problems. The quasi-market system has simply proved inadequate to meet the challenge of assuring optimum quantity and quality care.

The backwardness of care network

In previous system, service provision was monopolized by the government sector or the semi-public sector, the Social Welfare Corporation. In Japan, governmental control was so strong that it deprived the social welfare care actors of their ability to be either creative or flexible. Each ministry strongly maintains its right to exercise control over its section, but sectionalism tends to come with privileges for the participants. In addition, bureaucrats have strong control over each occupational system, meaning that sectionalism in the ministry spreads to sectionalism in the occupations in the front line levels of care.

In Japan each health, public health and social care system has significant strengths. There are many eager and talented medical doctors, dentists, nurses, social workers and care workers with lots of knowledge, know-how and experience as well as a strong spirit of professionalism and ethics. They take care of so many clients with minimum personnel (the ratio is one staff to 3.3 clients; the ratio is 1: 15-20 at night), and provide the best care practice possible within their limited resources. As individuals, these professionals tend to be very effective and efficient, but as a result of sectionalism, each service, each occupation and each institution tends to be segmented and isolated. This causes so many systemic pitfalls from when the client first enters the system through to all aspects of the client's life. In Japan, there are still many elderly people prematurely and unnecessarily bed-ridden by these pitfalls. If a seamless care provision system had been institutionalized, they wouldn't be bed-ridden. The pitfalls prevent the Japanese elderly social security system from being able to provide a high quality, cost effective service.

Unfortunately the quasi-market system, which is the engine of the LTCI with regard to innovation and regulating care quality and quantity cannot deal with these pitfalls by itself. Even though the LTCI is centered on the quasi-market, clearly it needs to be complemented if it's to effectively deal with these problems.

The need for a network solution

Considering the background, restrictions and conditions described above, there are clearly difficult challenges in quality and quantity to overcome, which are going to require some real innovations. It should be noted that being innovative doesn't require new products or systems to be invented: a new combination of

old elements also can create innovation. In fact, such innovation has the ability to change the whole value creation system. One possibility is to create a network among the existing actors and organizations in the system. Effective networking may overcome the problems introduced by sectionalism.

There are two reasons to establish networks. Firstly, they allow for a pitfall free system, which is therefore more effective and cost effective. These networks need to be established from the very first step in Japan. There is much to be learned from Finland, where seamless integrated care is provided through well-established networks. The second benefit of networks is their potential for innovation given that the collaboration among all the actors leads to an increased knowledge base and better quality care. This will be the seed of further innovations, not only in terms of care quality but also with regard to efficiency and effectiveness. To provide difficult new Japanese clients (highly claimable but highly dependent) with tailor-made care service within limited care resources, networks may be the key to providing the necessary innovations. The knowledge creating function of networks will contribute to making such innovations possible.

"Japanese Model" of health and social care network: community-based comprehensive care

Improving the residents' welfare is possible only if the players work in an integrated form, but sectionalism leads to systematic pitfall. In Mitsugi (Hiroshima), a community based comprehensive care system was established which provides health, public health and social care in an integrated form. This system was realized through firstly establishing resources within the local government and then through networking many organizations, professions and many actors. We can also find similar advanced cases in Japan (Hagino 2007). The features of these Japanese models of community based comprehensive model can be classified as below (Ogasawara and Shimazu 2007).

1. Systematic pitfall free continuance of care service longitudinally.

2. Comprehensiveness of integrated care provision between health, public health and social care from the clients' perspective.

3. Comprehensiveness in terms of providing treatment through the life stages of clients, from preventive to terminal care (from home care to institutional care).

The Japanese Model is a system for providing integrated care services with all the three elements through independent networks. Such cases have had success in overcoming pitfalls using both formal and informal networks, between various organizations, and in some cases, beyond the limits of organizations.

In these networks, professionals clearly play a big and essential role. The core actors are professionals with skills, experience, knowledge, morals, ethics, and responsibility. It goes without say that it is important to involve the clients, their family, NPOs, volunteers, and citizens in these networks. In some cases, however, clients and family can be too nearsighted to escape from imminent troubles. To support them all through their life stages, it is essential to use the various professionals and institutions in the networks which can manage clients and their environments objectively and with vision.

A core element in making such Japanese model network is the honesty and spontaneity of experts in the network (Ogasawara and Shimazu 2007). In each of these cases, medical doctors have realized their own powerlessness to support the elderly through all their life stages only with medical treatment. They have confessed their lack of ability to their colleagues and begged collaboration from other professionals. By opening up about their weakness, on the contrary, the tie between these players has become stronger (Boku 2003). Through this process, their network was established and expanded. At first, isolated clinics or hospitals could function as just points and could relieve only the small number of the elderly which was within their ability. By working together with medical actors in a hospital-clinic collaboration, however, they began to be able to play a one dimensional function and could help more people. Gradually, by achieving a collaboration between medical and non-medical actors, the network has become more complex, and has been able to contribute to the well-being of many citizens. IT was also well-utilized to overcome the pitfalls and address the problem of people becoming prematurely bed-ridden. They have been able to create new knowledge, and by involving citizens, such network has developed in many dimensions, enabling effective and efficient support with a comprehensive care system from the healthy stage to the terminal stage through all their life stages.

These Japanese networks aren't limited to the concept of a supply network designed to overcome systematic pitfalls, but they also provide methods for the fair distribution of various kinds of knowledge, which are valuable care resources.

These networks are useful as a system to share and create new knowledge through the integration of each of the nodes which make up the network, and the consequent exchanges of knowledge between the various actors, and the innovations made possible by the mutual stimulation of the network facilitates. With regard to care quantity, besides the improvements in efficiency the knowledge itself brings about, the process of sharing knowledge builds trust among the layers of the network. This trust has led to a decrease in the transactional costs among them. As a result, more cost effective care has been realized. In some cases, they started new trials to support clients' whole life beyond the limits of the LTCI.

It needs to be pointed out that such networks started well before the implementation of the LTCI. Mitsugi started this system about 20 years before the LTCI. Although they didn't introduce a market system, Mitsugi has developed a highly cost effective solution through innovations that were not fruits of market principles. In fact, the solutions were very different to anything that may have come about through the free market. The institutionalized LTCI care service tend to be restricted only to services with an affinity to the market system. There are many care services which aren't institutionalized in the LTCI but effective to support the elderly. In this regard, in some advanced cases, the establishment of the LTCI has disturbed the ability to provide comprehensive care in some fields.

These networks have been successful in making innovations. I propose such model as the Japanese Model.

This Japanese Model of Health & Social Care Network was institutionalized into the LTCI in the 2006 LTCI reforms. Nevertheless, the LTCI retains a quasi-market system as the engine for innovations. It includes an inherent contradiction in that the idea is to utilize a community based comprehensive care model, which depends on network model, and to improve the LTCI system, which is still based on the quasi-market. This system won't have an affinity with the market system. It's a little tragic.

Conclusion: networks (community), the market and hierarchy

The Japanese Model with its non-market solution has been contradictorily institutionalized in the quasi-market based LTCI. Are such network solutions or community solutions effective ways to complement market solutions? Can net-

work theory, which is effective for products or service development in the market mechanism, be used in the health & social care field based on the quasi-market? Some network theories, like resource based theory, won't fit.

Like the premise of the contingency theory, the best combination of variables may well differ ad hoc accordingly to the specific needs. What the best principles of care are will differ depending on the clients' life stage, the nature of desired care, and the number and variation of actors involved. In "lower level care" (in terms of the "needs of hierarchy" outlined by A. Maslow), care service should be provided to clients universally, without question and with urgency. Of course the degree to which these principles will change depends on the era, the country the client lives in, and their cultural norms and expectations. In some cases, however, sometimes the issues are black and white and efficiency should be ignored if it will come at the cost of not being able to provide adequate care. In some cases, hierarchical supplier-lead systematic innovation, may be more effective and efficient than other systems with regard to the savings on transactional costs. On the contrary, in providing care for an "upper level of needs", client driven innovations involving the clients themselves and their families, may increase the ability to provide care and also improve the subjective satisfaction of the clients. To optimize care which isn't urgent but diverse, innovations which involve autonomous clients may be more appropriate. In such cases a line up of various alternatives and an optimizer of efficiency capabilities are important in a market solution. In the intermediate field we can find successful cases achieved through both network solutions and community solutions (Kaneko 2002) based on various actors or communities. It's networks that provide the best solution to link these kinds of cases, since they can integrate others in the team.

The best course to pursue is the one that will result in the most adequate care principles accordingly to the nature and character of the care required. In some cases, the best care system may be driven by hierarchy, but in the other cases, the best may be to allow it to be driven by market for a wider range of alternatives, or perhaps community driven care is the best particularly in cases where innovation is desired to be based on the migration of knowledge. This flexibility will improve cost effectiveness and yield high results from the performance in each node most effectively and efficiently. Finally, network solutions which prove able to comprehensively integrate all such differences and principles tend to drive each of the nodes in the network in a new way.

In conclusion, the Japanese social care system is a mix based on the public-private partnership where each node plays an intrinsic role. Also, each node is driven by a different principle, and they perform efficiently and effectively at the

node level. Still, there is a lack of principles for the integration of these nodes. The quasi-market model in the LTCI won't be adequate in this regard. We need to continue to seek the most effective and efficient principle for each node in various case studies, and at the same time, need to seek principles for the best way to integrate these nodes for maximum effectiveness and efficiency of the whole body. The Japanese Model may be one such example. Through further research based on the character, the advantages, and the disadvantages of each principle of hierarchy, market and network/community should be cleared.

References

Bartlett, W. 1991. Quasi-markets and Contracts. A Markets and Hierarchies Perspective on NHS Reform. Public Money & Management. Autumn.

Boku,Y. 2003. The theory of networking organizations. Minerva. (In Japanese)

Doi, T. 1973. The Anatomy of Dependence. Kodansha, America.

Hagino, H., Youngsoo, Y., Doi, K., Endo, T. 2007. Medical & Health & Welfare Care network as the "BA" (Place) to Create Knowledge". Case in Japan. In Erjanti, H. (Ed.) Refurbishing Elderly Care. Strategy of Cost Efficiency in Theory and Practice. Laurea Publications, A 60. Laurea University of Applied Science, Vantaa.

Jinno, N. 1987. The establishment process of present Japanese tax system. 1,2. Keizaigaku-zassi 88(2.3), 88(5.6). (In Japanese)

Kaneko,I. 2002. Community Solution − toward voluntary solution. Iwanami. (In Japanese)

Koyama, T. 1999. Customer Choice in Public Service − analytical framework of quasi-market. Bulletin of Nagoya University Faculty of Law 177, 1189-222. (In Japanese)

Lapsley, I. 1993. Markets, Hierarchies and the Regulation of the National Health Service. Accounting and Business Research, 23(91A), 384-394.

McMaster, R. 2002. The analysis of Welfare State Reform: Why the 'Quasi-markets' Narrative Is Descriptively Inadequate and Misleading. Journal of Economic Issues, 6(3) September.

Ministry of Health & Labor. 2003. Research on terminal care. http://www.mhlw.go.jp/shingi/2004/07/s0723-8.html.

Muramatsu, T. 1994. The Japanese Public Administration – Transition of Active Bureaucracy System. Chuko sinsyo. (In Japanese)

Nonaka, I. 2003. Toward the Theory of Knowledge-based Country. Toyokeizaisinpo. (In Japanese)

Noguchi, Y. 1995. The 1940 Regime. Toyokeizaisinpo. (In Japanese)

Ogasawara, K and Shimazu, N. 2007. The Idea of Community Based Health and Welfare Care Network. Chikura Syobou. (In Japanese)

Yorimoto, K. 2001. The Private to Bear the Public – citizen-lead local autonomy. Commons. (In Japanese)

A Study on the Creation and Structure of a Health and Social Care Service Network

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Purpose

In this paper, a network generation and structure are verified with regard to the following four points.

1. Value creation in a health and social service network

2. Network generation theory and structure theory

3. Clusters and a small world network

4. The relationship between network structure, confidence, and knowledge.

The hypotheses which were taken into consideration when designing the research task investigating the health and social service network are specified in the following section.

Value creation in a health and social service network

The value creation network in a health and social service is compared with the value creation network in the manufacturing industry.

Value of manufacturing

The value network in manufacturing adds value at each process. It consists of the supply of raw materials, manufacturing, distribution, and marketing. That is, in the value network in the manufacturing industry, value is added step by step in each process. It can be said that the end products in the manufacture industry are a bundle of consumer needs.

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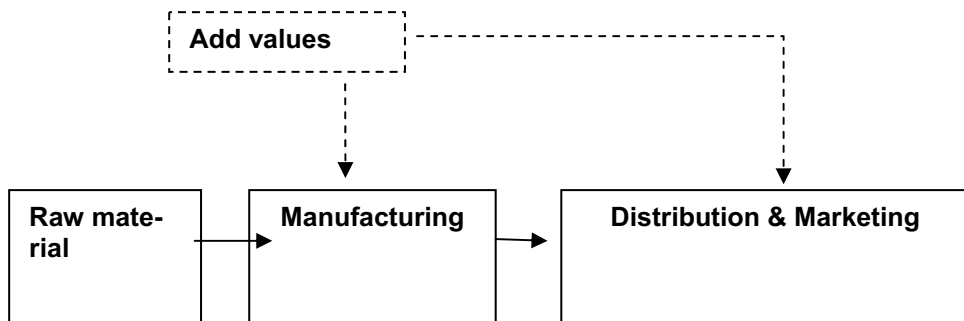
Figure 1. The value network of the manufacturing industry
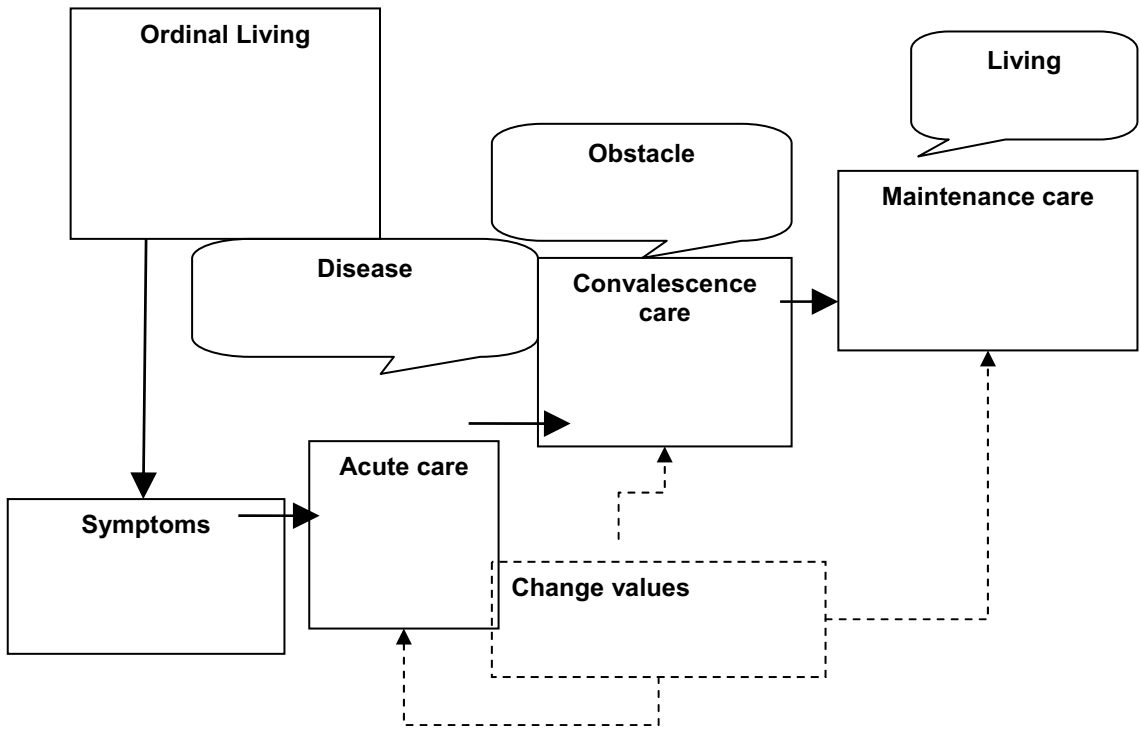
Value of medical care

Figure 2. The value network of the health and social service

In the case of health and social service, the value network begins from the pa-tient suffering from the disease. First, intensive medical treatment is given in cases where the medical problem is acute. In the case of stroke, the necessity for convalescence rehabilitation in order to overcome lingering problems arises after a period of time when the treatment was for an acute problem. After conva-lescence rehabilitation, the rehabilitation is required for an extended term to pro-vide maintenance care so that the patient can return as much as possible to the functions he had before the stroke. The health and social service value network responds to changing medical needs rather than adding value one step after an-

other like in the manufacturing industry. One of the strong points of the health and social service care network is to offer different value as the needs of the patient change.

The network generation theory and structure theory

In this section, the theories about network generation and structure in the network of health and social service are examined.

The fundamental differences between the two theories

The two theories differ in terms of how they recognize the relationship between the person in the network and the structure of the network.

One theory, the networking theory, analyzes the network creation process. This theory indicates clearly who makes the network and from what motivation. In this theory, the kind of functional requirements required for a network to be formed and to grow are taken into consideration. Thus, the networking theory focuses on the persons who design the network and constitute the network. (Lipnack and Stamps 1982)

Another theory, the social network analysis theory, analyzes the network structure. In this theory, the way the network structure affects the behaviour of members of the network is in the focus, and it does not pay attention to the attributes of the members themselves. (Yasuda 1997,41-42)
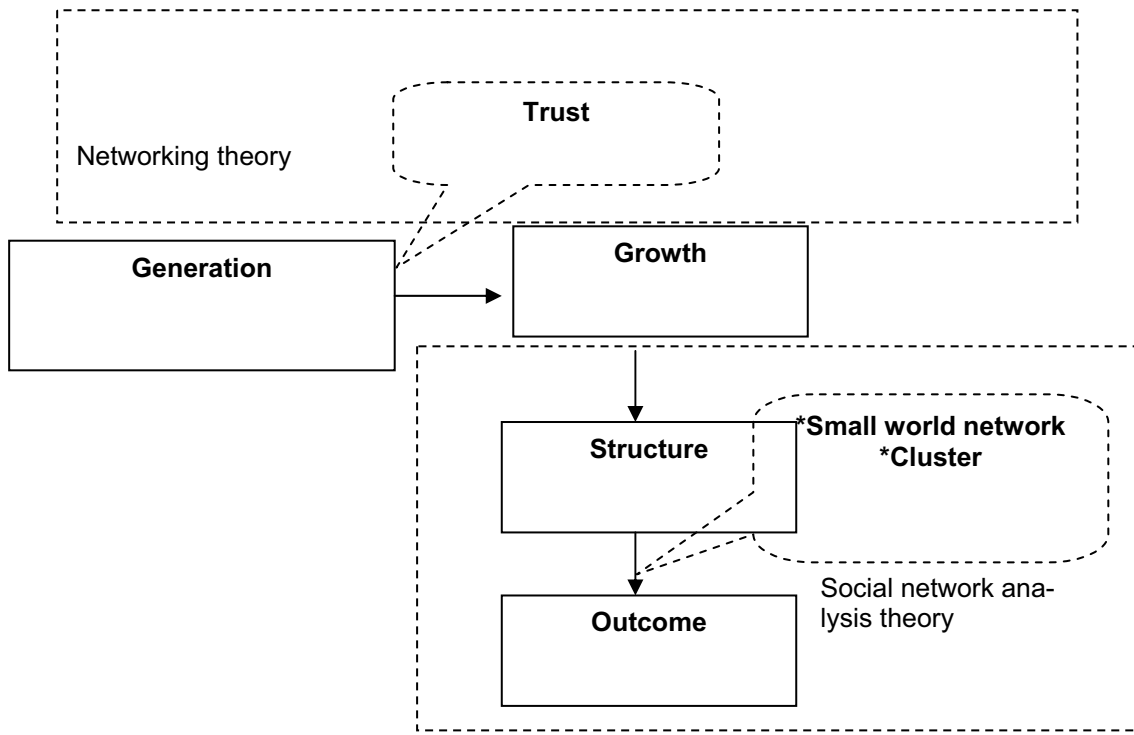
Figure 3. Networking theory and social network analysis theory

The cluster and small world network

Cluster

A cluster is formed by three or more persons and refers to situations in which the connections between each member of the network are close. The close relationships made possible by a cluster foster group consciousness (Coleman 1988). Clusters are connected with strong ties (Granovetter 1973). However, when a cluster becomes large, there is typically more distance between partners. For example, as the diagram shows, in order for A to arrive at Z, at least 6 steps are required.
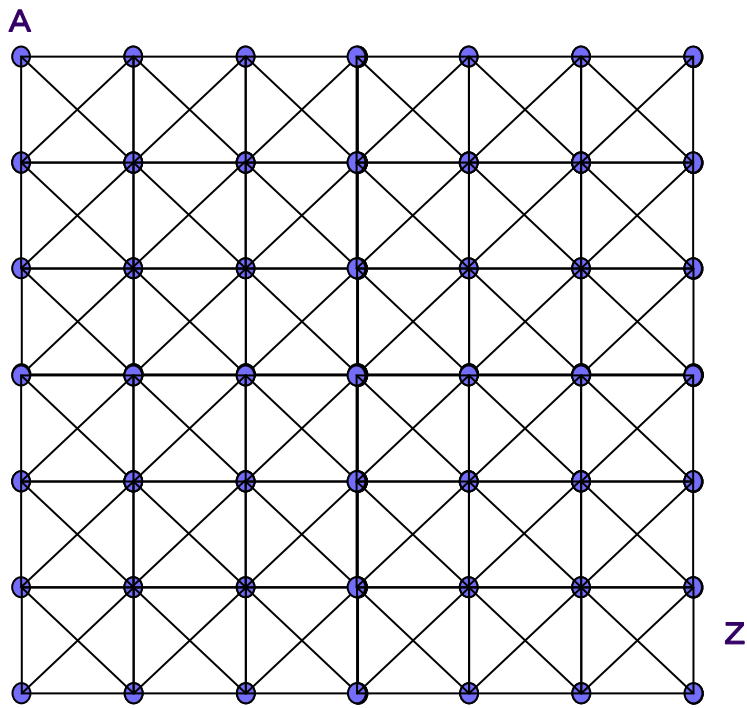
Figure 4. A large cluster network

Small world

Another type of network is known as a "small world". A small world can be defined as a network easily joined with another network by a shortcut (Milgram 1967). The members of the small world are connected to each other by weak ties (Granovetter 1973). If a small world is made, a person a long distance away can be contacted easily through a connection. For example, as shown in figure 5, A can arrive at Z in only three steps, if a shortcut is used. People a long distance away can gain new information from someone close by, and, as such, the small world created can bring about a new way of thinking.

Figure 5. Small world network

Cluster and small world

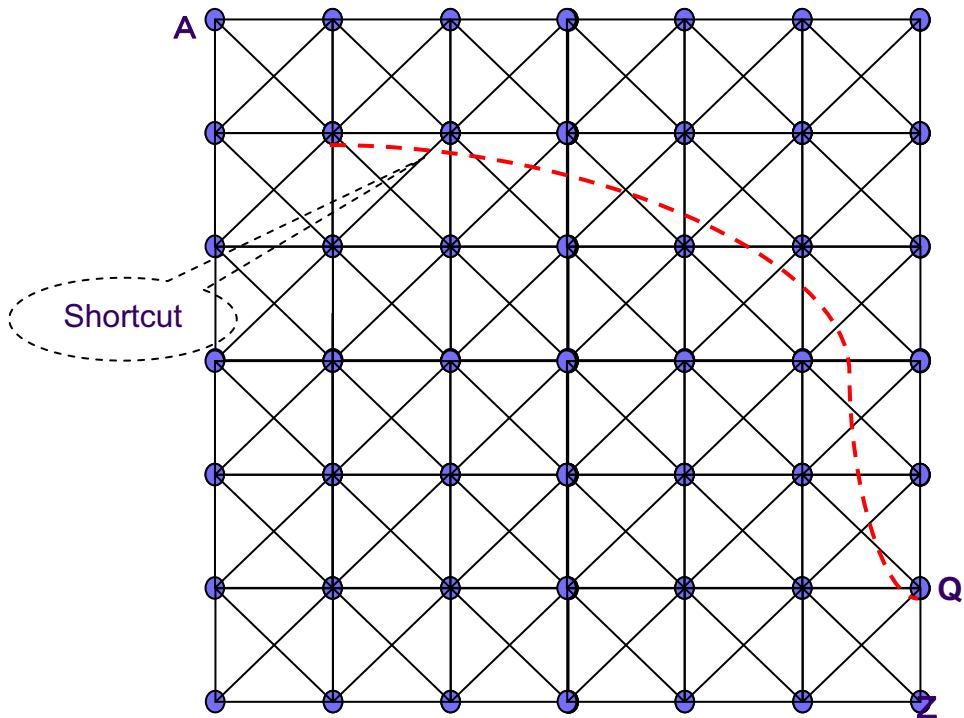It is said that the ideal network has the characteristics of both a cluster and a small world. That is, in order for a network to work effectively, both strong relationships and loose relationships are required (Watts. 1999).
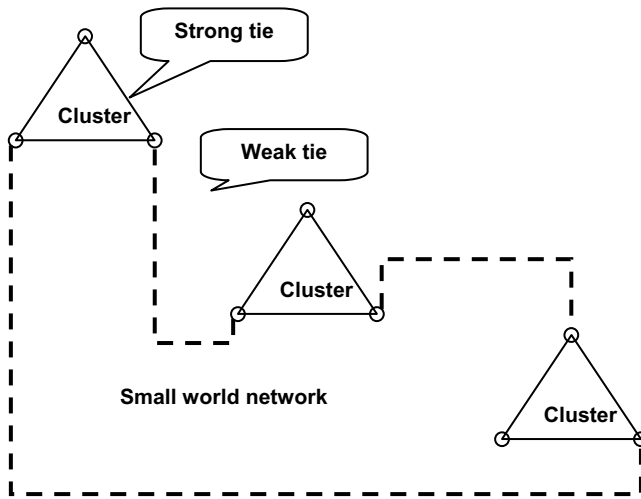
Figure 6. A network which has both cluster and small world characteristics
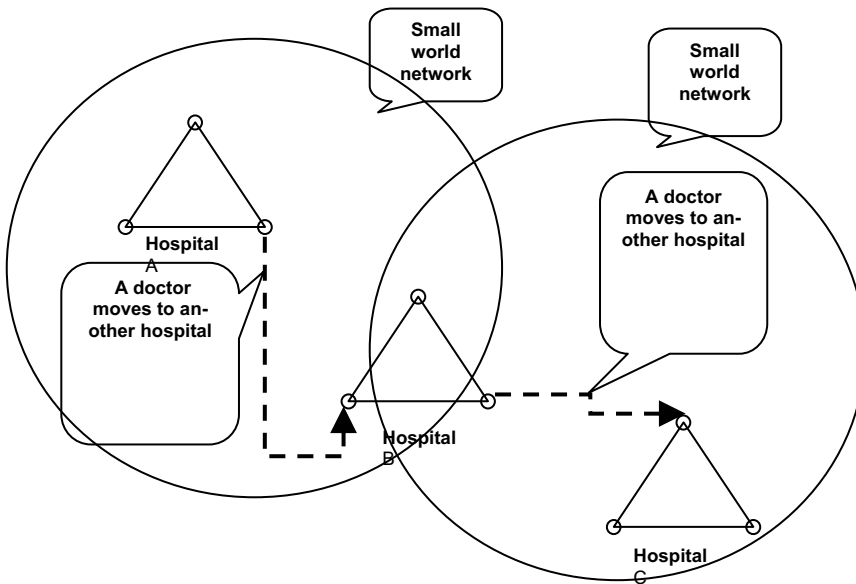
Figure 7. An example of small world networks in health care

The relationship between network structure, confidence, and knowledge

In this section we will discuss the relationship between network structure, trust, and knowledge. Closely structured networks are characterized by the formation of personal confidence and an environment where tacit knowledge is easy to share. On the other hand, if a network has a loose structure, there tends to be confidence in the abilities of the other members, and the movement of explicit knowledge tends to be easier. (Wakabayashi 2006, 124-127)

Openness (Small world network)		Closeness (Cluster)
↓		↓
Contractual trust **Competence trust**		**Goodwill trust**
↓		↓
Explicit Knowledge		**Tacit knowledge**

Figure 8. The relationship between network structure, confidence, and knowledge

The successful health and social care service networks in Japan tend to have been more like kinds of study groups and informal friendship societies before the networks were formed. It is in these various kinds of study groups and informal friendship societies that the trust based on goodwill is formed (Sako 1992, 37-

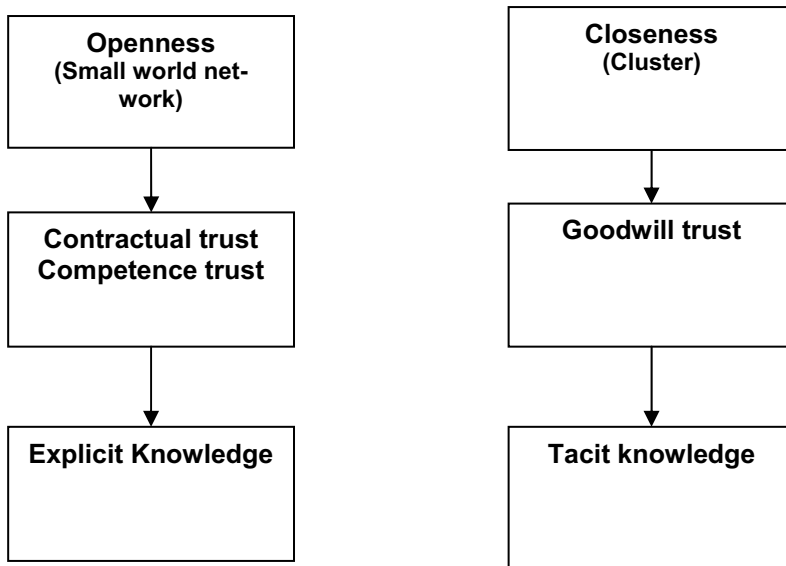48). In order to make a network, it is believed that such conditions are required. When there are such relationships, tacit knowledge moves easily between network members.

However, once a network is formed, it is necessary for each of the network members to understand what is required of them to carry out their role in the network if the network is to function well.

For that purpose, it is important that members of the network evaluate the competency of other members, and observe how the contract is carried out. Such trust is called competency trust and contractual trust (Sako 1992,37-48). The transfer of explicit knowledge is easy when a network is open, objective ability ratings are performed, and contract observance is also easy. Since it is clear that there is a relationship between the structure of a network and the amount of trust and the information flow inside it, it is clear that a good balance of openness and a closed nature is the best.

Hypothesis

In this last section, we introduce some hypothesis for future analysis.

Hypothesis 1: In order to form a small world network, to achieve network openness, the role which is played by the movement of professionals, such as health and social care services and social workers, in the workplace, is large.

Hypothesis 2: One of the conditions of a cluster is a study group and friendship society made up by professionals at various standpoints.

Hypothesis 3: Since the trust in care competency is related to evaluations and the transfer of explicit knowledge, it tends to be more a feature of open networks.

Hypothesis 4: Since contractual trust is a non-emotional relationship in nature, it is more easily fostered in an open network.

References

Coleman, J. 1998. Social Capital in Creation of Human Capital. American Journal of Sociology, 94, 95-120,

Granovetter, M. 1973. The Strength of Weak Ties. American Journal of Sociology, 78, 1360-1380.

Milgram, S. 1967. The Small World Problem. Psychology Today, 2, 60-67.

Sako, M. 1992. Price, Quality and Trust: Interfirm Relations in Britain and Japan. Cambridge University Press.

Watts, D. 1999. The Dynamics of Network between Order and Randomness. Princeton University Press.

Wakabayashi, N. 2006. Network and Confidence of Japanese Company. Yuhikaku.

Yasuda, Y. 1997. The Network Analysis. Shinnyousha.

Reforming Health and Social Care Services in the City of Vantaa

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Introduction

Social and health care systems in all developed countries are facing new challenges. While resources devoted to social and health care are limited, new developments in medical technology, an ageing population, and patients' higher expectations require new ways of providing quality services with available resources. Hence, there is a need for structural changes in social and health care systems to respond effectively to these challenges. This paper illustrates how care of the elderly is being reformed and developed in the Finnish city of Vantaa.

Vantaa is the fifth largest city in Finland and is located in the Helsinki metropolitan area. The population of the city is growing substantially and although today it is demographically rather young the proportion of older people is rising. The ageing of the population during the coming years will increase the challenges faced by the municipality in providing services with limited resources. While today the city has to invest in schools and children's day care centres, it also has to start to increase its service production for the growing elderly population.

There is a strong tradition of collaboration between social and health services in Finland. The new system for the delivery of health and social services in the City of Vantaa allows for such collaboration and promotes the development of services according to an integrated care approach.

In this paper, I will present my vision of the key challenges that lie ahead for a city like Vantaa and the central objectives that have to be reached in order to successfully tackle these challenges. I will start by briefly reviewing the Finnish health and social care system and then will turn to a discussion of services for the elderly in the City of Vantaa and will outline three central objectives that will allow the municipality to tackle the challenge of an ageing population.

The Finnish health and social care system[6]

Finnish public services are highly decentralised and municipalities have the main responsibility for arranging health care services as well as other basic services such as education and social services[7]. In terms of health care services, however, the municipalities only provide primary care. Hospital districts, which are federations of municipalities, have the task of providing secondary care, and every municipality has to be a member of one of Finland's 20 hospital districts.

Municipal autonomy is a highly respected value in Finland. However, in the provision of health services the decentralized system also creates problems with the assurance of sufficient skills for providing services and can create an economic risk to small municipalities. In addition, there is variation in service provision and per capita expenditure on health care services between municipalities.

Health and social care services are mainly financed by local taxes. There is a state subsidy from the central government. The subsidy is allocated to the municipalities according to a predefined need-based capitation formula. As local taxes and state subsidies are used for the provision of primary and secondary care to the population there is also a second financing system, the National Health Insurance (NHI), for certain health care expenditures, such as sickness and maternity allowances, medical services for students, pharmaceuticals, occupational health care services and the reimbursement of users of private health care. The rest of the health care funding comes mainly from user fees. During the last few decades, there has been a significant decline in the central govern-

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1 This chapter draws heavily on the following reviews: Järvelin J. The Health Care Systems in Transition (HiT), Finland: European Observatory on Health Systems and Policies, 2002. http://www.euro.who.int/document/e74071.pdf and Häkkinen U. The Impact of Changes in Finland's Health Care System. Health Econ 2005; 14, 101-118.

[7] There are over 400 municipalities, whose population varies from less than 1000 to 550000, averaging about 12000.

ment's share of costs. Simultaneously the role of local governments, NHI and households has increased. (See Table 1.)

Table 1. Financing of the Finnish health care system, % (Source: OSF 2007)

	1990	1995	2000	2005
Central government	35.6	28.4	18.4	20.8
Municipalities	34.7	33.8	41.3	40.4
National Health Insurance (NHI)	10.6	13.4	15.4	16.6
User fees and co-payments	15.6	20.5	20.4	17.8
Others	3.6	3.9	4.5	4.5

At the beginning of the 1990s, there was a major reform in the financing of health care. Before the reform state subsidies were allocated to municipalities according to actual costs. Since the reform, the subsidies have been allocated according to demographic and other need criteria, which also depend on the financial capacity of the municipality. There is a strong tradition of government regulation in the Finnish social and health care system. Simultaneously, with this financing reform, regulation by the state gradually decreased. A number of legal and administrative norms were overruled and the regulatory bodies were abolished. As regulation by norms decreased softer steering through information became more important. At the same time, the possibilities for municipalities to choose how to organize social services and health care were further reinforced. The reform also made it possible for a municipality to purchase services from other public or independent providers, or to contract out its service production.

Municipal health and social service provision in Finland is mainly public. There are, however, some areas that have departed from the traditional method of providing public services. Residential care services for the elderly are a good example of this development. Municipalities fund these services but they are produced by the independent sector. There are also municipalities that purchase primary care from private or third sector providers or have contracted out parts of their service production. Purchaser-provider models have also been introduced.

As a consequence of the reforms of the 1990s, several municipalities have chosen to merge social and health care into a single organisation to provide all municipal social and health care services. This reform was aimed at making co-operation between social and health care workers easier and to improve the quality and productivity of care, especially in the field of care for the elderly and disabled, mental care and in services for substance abusers. The restructuring took place in the city of Vantaa first in 1991 and later in 1997. In Vantaa, as in many other bigger cities in Finland, the reform was carried out so that the city was divided into five geographically defined areas and service provision was delegated to the social and health centres of the geographically defined areas, which were responsible for providing services to that area's residents. The population of that area varied from 25,000 to 50,000. These regional social and health centres were quite independent in decision-making. It was thought that this model would make it easier to produce client-oriented services and promote co-operation between social and health care. In a way, the organisation resembled the decentralized Finnish health care system, so it is not surprising that similar problems also arose. There were variations in service production and in expenditures, which could not be explained by need factors. The co-operation between regional social and health centres was not good enough, which led to inefficiencies. The last re-organisation took place in 2007 when the regional system was abolished. Then the Social and health services department was divided into four sectors according to the life-cycle model: Services for Families, Children's Day Care Services, Health Services and Services for the Elderly and Disabled.

Social and health care services for the elderly in the city of Vantaa

Demographically, the City of Vantaa is quite young. The population includes a large number of families with preschool and school-aged children and, until now, the proportion represented by the elderly population was small. Over 75-year-olds constitute 3.7 per cent of the city's population. However, the population is ageing quickly: the number of old people (over 75 years) will grow in the coming years by 5 per cent annually, and in less than 10 years' time the growth will be almost 10 per cent annually.

The strategic goal of the City of Vantaa is to ensure its elderly citizens a good and safe old age by respecting their independence and supporting their functional capacity and full participation in society.

Since the beginning of 2007, social and health care in Vantaa has been organised so that all the social and health services for the elderly are grouped in one department. These include home care, social work, service housing, day centres, health centre, hospital, and residential care and nursing homes. This integrated care approach makes it easier to meet the service needs of a growing population by reforming processes and practices. Three strategic goals shape the development of services: (1) a shared responsibility for a good old age, (2) the ability to live at home safely as long as possible, and (3) the development of geriatric assessment, care and rehabilitation. The opportunities and challenges involved in reaching these three goals are reviewed below.

A shared responsibility for a good old age

As resources do not increase at the same pace with the service needs of the elderly population, social and health care should concentrate on its core responsibility, i.e. the production of social and health care services. On the other hand, although the population is aging, elderly people are healthier and wealthier than ever before. It seems that illnesses and the greatest need for support and services is concentrated in the very last years of a person's life. In fact, only 25 per cent of those over 75 require special social and health care services, such as a nursing home, home care, or service housing. Consequently, elderly people are not a homogenous population. A majority of old people require similar services to the rest of the population. To reflect this phenomenon, gerontological literature has adopted the concept of a 'third age', which refers to the independent early years of retirement before actual old age when dependence on others increases (Karisto 2002).

Social services have traditionally been an important actor in providing services for the elderly. As the number of healthy older people increases it is important that all sectors take this group's needs into account when planning their services. Housing, transport, local services, sports and culture are key services, the quality of which has a crucial impact on the everyday life and wellbeing of older people. Lifts in apartment buildings and a general absence of obstacles in the local environment will allow older people to retain their independence and autonomy for longer. A shared responsibility for a good old age means that all

sectors understand and take into account the growing service requirements of old people in their policy and planning.

Local government does not have to produce all services needed by the elderly. The role of the third sector, such as charities or associations, is important, particularly for the provision of services for healthy older people. This can be encouraged through grants, the right to use public facilities or land allocation policies. Some of the services are normally offered by the private sector.

The strategic objective of shared responsibility is an excellent goal. It is mentioned in the most important planning document of the City of Vantaa, which highlights the commitment of the city's management to the objective (Vantaa 2007).

Living safely in one's home for as long as possible

Living safely in one's own home for as long as possible in spite of declining functional capacity is often included as a goal in health and social policies for the elderly. This might seem self-evident, as, it is said, everyone wants to live in his or her own home and not in an institution. Resources used in community care services are often used as an indicator to measure how well elderly care is organised. However, it may be wiser to use an effectiveness indicator, e.g. the share of the elderly living at home, as a measure of the success of the system. If we compare cities in Finland, the proportion of older people who are in hospital for long term care or live in a nursing or a residential care home or in service housing varies considerably. According to the latest benchmarking report of services for the elderly, in the six largest cities in Finland, the proportion of people over 65 using the above services in Vantaa is over one percentage point greater than in other cities on average (Kumpulainen 2007). This means about 200 beds and €10m of additional resources spent per year.

The reasons behind this difference are not completely clear. The need factors do not explain the difference. It seems that patients in Vantaa are discharged from hospital after acute illnesses slower and more often to a residential care or a nursing home than in other comparable cities (see below). In addition, it is possible that high supply increases demand. There are also people who live in service housing who do not require the services offered, which results in an inefficient allocation of resources.

To reach the objective of living safely at home for as long as possible, the successful operation of a number of actors and good collaboration between sectors is required. This is not only a key goal of community care. Rehabilitation has to take place successfully in hospital after an acute illness so that patients can be discharged to their own homes instead of a nursing home. In addition, home care should support safety at home 24 hours a day. Service housing has to be allocated so that it is targeted at those who need it most. Some service housing also offers special short term housing for those who leave hospital after an acute illness but are unable to return directly to their home during the recovery phase. These types of services should be taken advantage of whenever possible to increase the opportunity for patients to eventually return to their own home. We also have to succeed in supporting informal carers so that they have the energy and resources to continue with their valuable work. Finally, the development of preventative services is central to achieving this objective.

Services should be developed in such a way that limited resources are targeted at efforts that have been proven to be effective. Living at home is a good indicator of effectiveness. In Vantaa, our goal for the coming years is that 92% of residents over 75 will live in their own home or in service housing. At the end of last year, the proportion was 90.5%.

The current Finnish system of services for the elderly is built in such a manner that a person's home can change several times during the last years of their life. A person's own home may first have to be changed for a service house, then a residential care home or a nursing home, and even a hospital during the last weeks or months of their life. In addition to highlighting the importance of living in one's own home, we should also aim to build a system in which resources move their location, not the old person. In Vantaa, we want to tackle this problem by planning and building 'centres for the elderly', in which the traditional services of service housing and a nursing or residential care home are combined. In addition, there are facilities for day centres for the aging population of the area. The first centre is targeted for opening in 2010.

Development of geriatric acute care and rehabilitation

The majority of placements into nursing homes and residential care homes take place after a period of hospital care. As mentioned earlier, the care and rehabilitation that takes place in hospital has an important effect on whether a patient

returns to their own home. According to a study conducted in the Helsinki met-ropolitan area, elderly patients returned less often to their own homes after an acute episode in hospital in Vantaa than in other metropolitan cities (Mäkelä et al. 2007). In the Finnish two-tiered health care system, inpatient care is provided in secondary care as well as in the wards of health centres. As secondary care aims to raise the efficiency of its work, it attempts to reduce the patients' length of stay in hospital. The fact that the recovery of old patients takes longer than that of younger ones is in contradiction with the goals of reduced length of stay. In practice, the ageing of the population means that the patient is more often transferred from a secondary care hospital to health centre wards for rehabilita-tion. The above-mentioned study found that the absolute number of finished epi-sodes and days spent in secondary care beds reduced from 1998 to 2003 re-gardless of the simultaneous substantial increase in the number of older people. In turn, the number of patients transferred to health centre wards increased sub-stantially. The transfers are expedited by financial penalties that the municipality has to pay if it is unable to organise a bed for a patient on the day after the refer-ral letter from the hospital is received.

As a response to these increasing pressures, Vantaa is planning the opening of a geriatric assessment and care unit in Vantaa in 2008. The work of the unit will be based on quick assessments and effective care and rehabilitation from the very beginning. To complement the work of that ward, a 'hospital at home' will be set up to support a quick return to home for patients after an episode of care in hospital. In some cases, hospital care can be taken, by the 'hospital at home', from the very beginning, directly in the patient's home or e.g. at a nursing home.

The central aims of the new unit are the quicker rehabilitation and return to home of patients and a reduction in the number of needless hospital transfers and less long-term care in an institution. The municipality can also avoid finan-cial penalties, as secondary care is not needed.

In conclusion

In this paper, I have attempted to review the opportunities and challenges in-volved in providing health and social services for the elderly in the context of a decentralised and an integrated approach to service delivery in Finland, and, more specifically, in the City of Vantaa. In the context of an aging demographic, developing a system of service delivery that uses limited resources in the most effective way to improve the well being of older people is a challenge that each

municipality has to tackle. I have outlined the central methods with which the City of Vantaa is preparing itself for this challenge. I would argue that if we succeed in meeting these objectives, both the clients and the taxpayers will be satisfied.

The first key reform is the broadening of the responsibility for improving the well being of older people beyond health care and social services. A truly integrated approach involves coordinated action by a broad range of actors and sectors, and also allows health and social services to concentrate on their central mandate: the production of health care and social services. Second, the ability to live at home as long as possible is an important indicator of the effectiveness of the services for the elderly and should be used more widely in the monitoring and evaluation of such services and their development. Third, although a broad cross-sectoral approach is needed for providing services for the elderly, health care services retain an important position in the delivery of services for the elderly. Successful acute health care and rehabilitation are the key determinants of the ability of older people to continue living at home. Thus, it is important that hospitals are also aware and committed to the objectives we have set. Finally, the achievement of the main objectives will require broad based behavioural change as well as determined leadership. Consequently, continued monitoring, evaluation and learning during the implementation of the reforms will be of equal importance.

References

Järvelin, J. 2002. The Health Care Systems in Transition (HiT). Finland: European Observatory on Health Systems and Policies. http://www.euro.who.int/document/e74071.pdf.

Häkkinen U. 2005. The Impact of Changes in Finland's Health Care System. Health Economics, 14, 101-118.

Karisto, A. 2002. Mitä on kolmas ikä? Käsitteestä ja sen käytöstä. Gerontologia, 16(3), 138-142. (In Finnish)

Kumpulainen, A. 2007. Kuuden suurimman kaupungin vanhusten sosiaali- ja terveyspalvelujen ja kustannusten vertailu. Kuusikko-työryhmän vanhuspalvelujen asiantuntijaryhmä. Kuusikko-työryhmän julkaisusarja 5/2007. (In Finnish)

OSF Statistical Summary. 2007. Health Care Expenditure and Financing in 2005. Statistical Summary 2/2007. http://www.stakes.fi/tilastot/tilastotiedotteet/2007/Tt02_07.pdf

Mäkelä, M., Häkkinen, U., Juslin, B., Koivuranta-Vaara, P., Liski, A., Lyytikäinen, M., and Laine, J. 2007. Sairaalasta kotiin asti. Erikoissairaanhoidosta alkaneet hoitoketjut pääkaupunkiseudun kunnissa. Stakesin työpapereita 3/2007. Sosiaali- ja terveysalan tutkimus- ja kehittämiskeskus, Helsinki. http://www.stakes.fi/verkkojulkaisut/tyopaperit/T3-2007-VERKKO.pdf. (In Finnish)

Vantaa 2007. Vantaa's Balanced Strategy 2007−2009. City Council. http://www.vantaa.fi/en/i_perusdokumentti.asp?path=110;2508;2510;8062;4128 5;54616.

Reforming Elderly Care in the City of Espoo

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Introduction

With its 235 000 residents Espoo is the second largest city in Finland. Its number of elderly citizens (75+) is 9500 and this will increase by 400 to 500 per year during the next 10 years and will continue to rise after that.

The number of employees employed by the City numbers 13,500, of whom 1,100 work within the care for the elderly. Social services and health care services were combined in the 1990's. However, in 2004 a decision was taken to end the regional organisation of social and health care. In its place four departments, organised according to the life cycle of a human being were established (Figure 1).

Services for the Elderly consist of three units: Home Care, Geriatric Centre (hospital and out-patient services) and Long-term care.
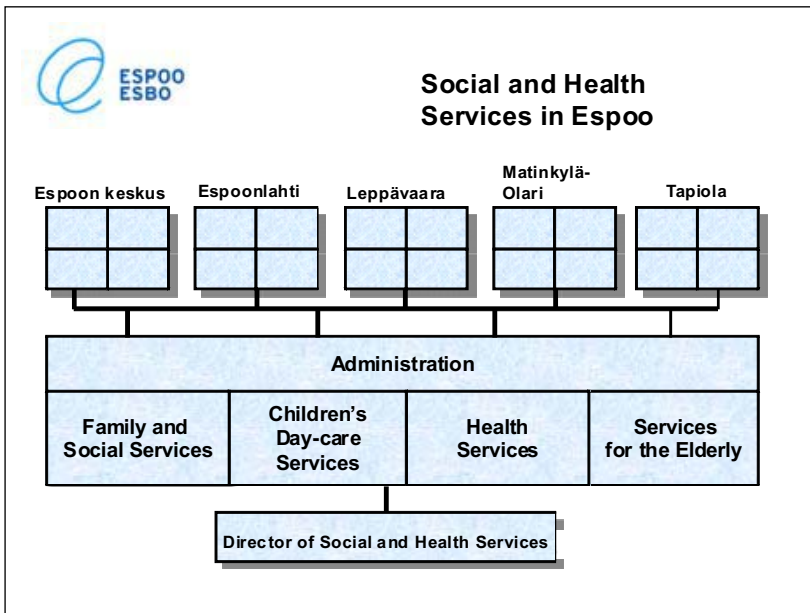
Figure 1. The organisation of Social and Health Services in the City of Espoo

The values set by the City of Espoo for everyone, old and young alike, are: resident and customer orientation, tolerance and equality, creativity and innovation, partnerships and communal operations, profitability and excellence, and sustainable development.

The most important social and health services which are commonly used by old people are shown in figure 2.
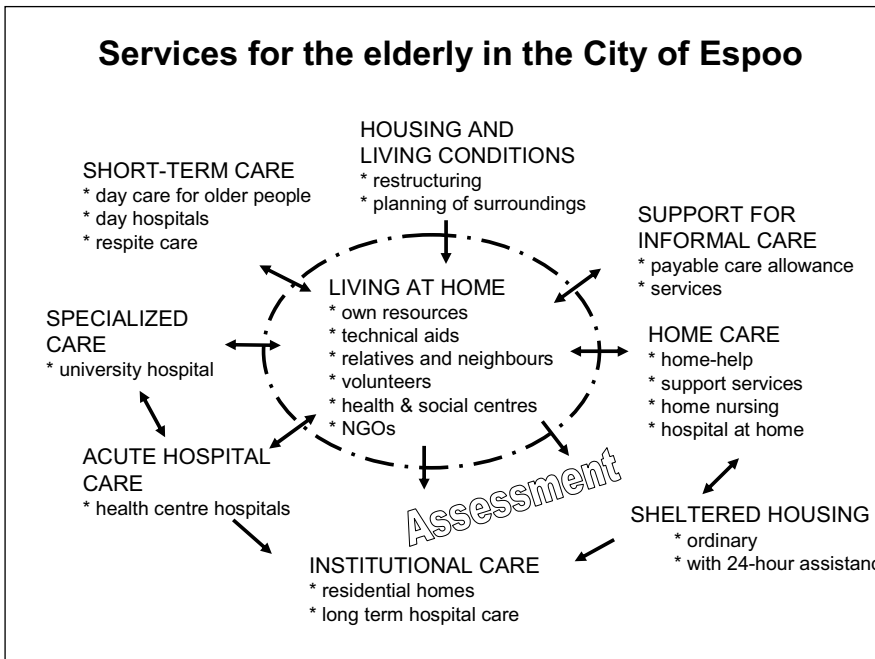
Services for the elderly in the City of Espoo

HOUSING AND LIVING CONDITIONS
* restructuring
* planning of surroundings

SHORT-TERM CARE
* day care for older people
* day hospitals
* respite care

SUPPORT FOR INFORMAL CARE
* payable care allowance
* services

SPECIALIZED CARE
* university hospital

LIVING AT HOME
* own resources
* technical aids
* relatives and neighbours
* volunteers
* health & social centres
* NGOs

HOME CARE
* home-help
* support services
* home nursing
* hospital at home

ACUTE HOSPITAL CARE
* health centre hospitals

Assessment

SHELTERED HOUSING
* ordinary
* with 24-hour assistance

INSTITUTIONAL CARE
* residential homes
* long term hospital care

Figure 2. Social and health services for the elderly in the City of Espoo

The first Elderly Policy Programme was approved by the City Council in 2002, and its leading principles were:

− Living in one's own home is our priority regardless of a decline in a person's daily activities.
− Our service provision is based on a framework that promotes preventive care and rehabilitation.
− 24/7 care is to be delivered in surroundings that resemble home as much as is possible.
− Hospital care is to be focused on acute care and rehabilitation for the elderly.

Since 2002 new basic principles, in developing services for the elderly, have been recognised and added to the programme e.g.:

− Self-determination ("the individual has the right to decide").
− One's own social networks are to be respected.
− Customer-oriented services.
− The implementation of the effective means for preventive care and other new forms of care.
− The development of the whole service system.
− Long-term care in home like surroundings.
− Co-operation between different actors.

- The application of new technology.
- Continuous quality improvement.
- The involvement of the community's members.

In spite of the common policy programme, there has been a fairly narrow and case-by-case approach to supporting old people who want to continue living at home. This is because the housing solutions and services, which will eventually be required, cannot be created without close co-operation between several actors and co-operative working models. The main developments in supporting elderly people living at home will be connected to the renovation and modification of existing residences and the finding of new housing solutions. The desired result is to provide functionality and accessibility for those residences through the application of welfare technology and the arrangement of services (figure 3).
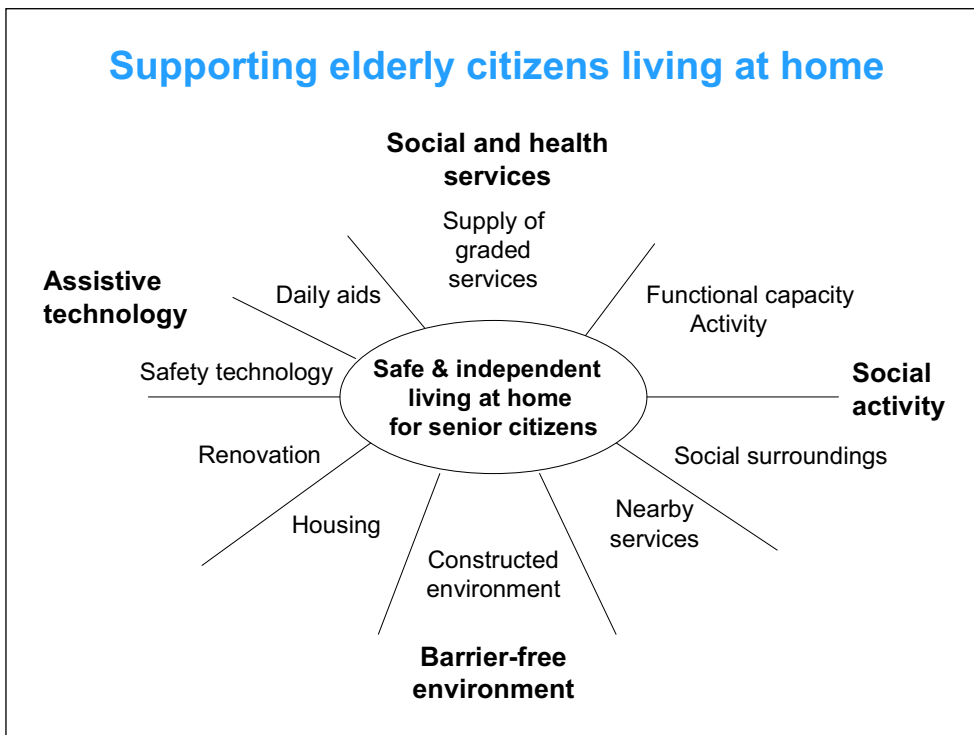

Figure 3. Methods that describe how municipalities can help support the elderly in their aim to live in their own home (Välikangas 2006)

Updating the Elderly Policy Programme

The process of updating the Elderly Policy Programme started at the beginning of 2007. The aim has been to involve elderly citizens and all essential partners in the process. Several workshops that have provoked much useful discussion have already been held. The active participation of the elderly in these discussions has been greatly beneficial to the programme (figure 4).

Figure 4. Interactive workshop in one of the service centres for the elderly

New concept

As a result of the workshops, a picture of the basic principles and the most important elements of the new policy have emerged (figure 5) and created the aim of providing optimal preconditions for independent living.
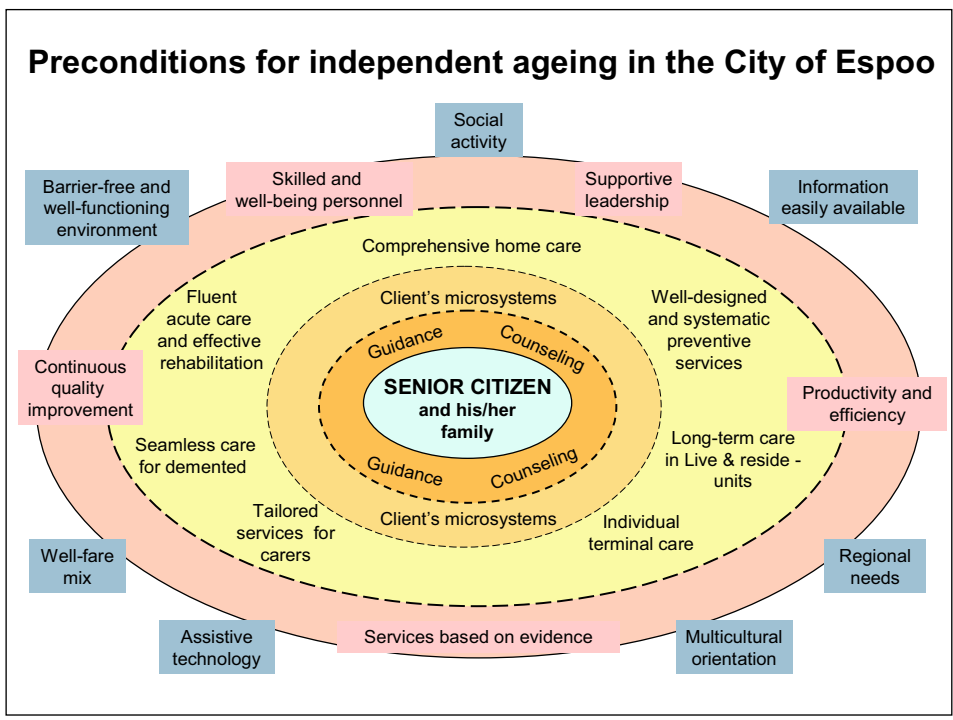
Preconditions for independent ageing in the City of Espoo

Social activity

Skilled and well-being personnel

Supportive leadership

Barrier-free and well-functioning environment

Information easily available

Comprehensive home care

Fluent acute care and effective rehabilitation

Client's microsystems

Well-designed and systematic preventive services

Continuous quality improvement

Guidance

Counseling

SENIOR CITIZEN and his/her family

Productivity and efficiency

Seamless care for demented

Guidance

Counseling

Long-term care in Live & reside - units

Tailored services for carers

Client's microsystems

Individual terminal care

Well-fare mix

Regional needs

Assistive technology

Services based on evidence

Multicultural orientation

Figure 5. The basic elements of the new Elderly Policy Programme of the City of Espoo

Senior citizens and their families are the focus of the programme and thus, up-dated information about services for the elderly is easily available. Individual guidance and counselling are also provided when needed. The elderly are also encouraged and supported in order to maintain their health and functional ability.

When the elderly require services they are seen as owners of their service proc-esses. In addition, the clients and their carers are involved in improving the ser-vice they receive together with their care-teams, which is a clinical micro-systems approach (Nelson et al. 2007).

The essential parts of integrated care are: systematic preventive services, com-prehensive home care, effective acute care and rehabilitation, seamless ser-vices for people suffering from dementia, individual terminal care and long term care in Live and Reside Units. In order to provide high quality, high productivity and efficiency, and both good leadership and skilled personnel are required. Therefore, services should be based on reports and documented successful care and continuous quality improvement should be used to improve the system.

Espoo believes that an environment should be barrier-free for frail and disabled elderly people. Thus, new technological solutions that help in coping with daily

tasks should be made readily available. Accordingly, special attention will be paid to the development of new technical solutions that increase the productivity and efficiency of the service system.

The services will also be a mix of municipal and private services (well-fare mix). Additionally the varying needs of different areas within Espoo are to be considered when planning the services and a multicultural orientation is needed due to the cosmopolitan nature of Espoo's population.

Integrated acute care

Improving acute care for the elderly is a challenge for the whole capital region. However, in the City of Espoo the improvement of the whole service chain is in its infancy and will be an ongoing process. Some of the main principles are shown in figure 6.
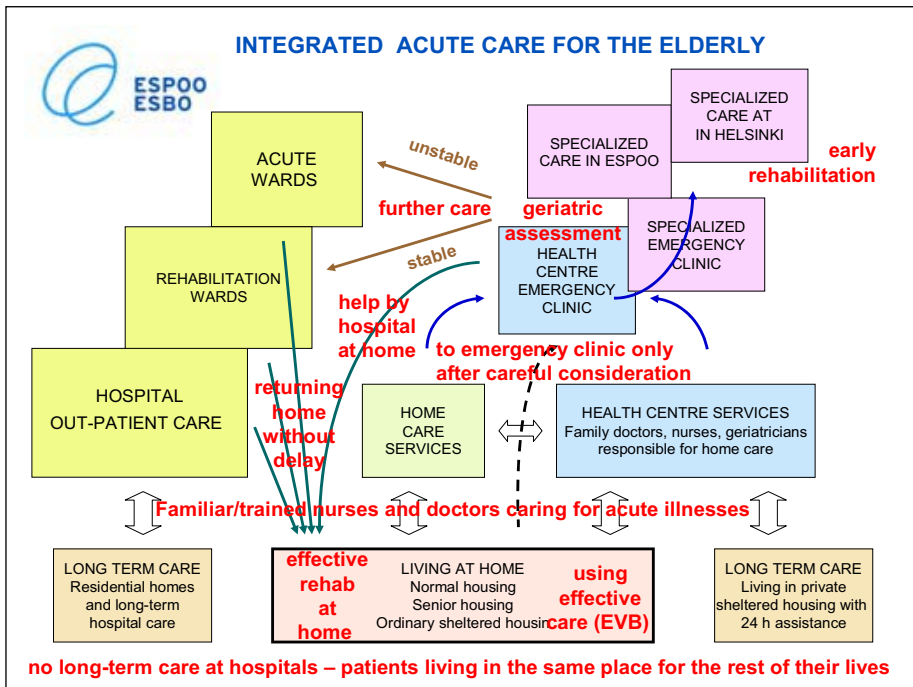

Figure 6. Espoo's service system for the acutely ill elderly and the main principles for improving it

A new model for long-term care - Life and Living

In Finland long-term care is graded according to a person's functional capacity. Ordinary sheltered housing is meant for the independent elderly. Sheltered housing with 24-hour assistance is for partly-disabled citizens. The next step is a residential home and if the help of two people is required for an elderly person they will have to move to long term hospital care. Thus, in our present system some clients have to move many times.

In the future all long-term units in Espoo will be of a new type (figure 7). These units will be called Life and Living Units and they will be functionally versatile. Thus, if the grading of a person's functional capacity reports that they have deteriorated a grade they will no longer have to move their place of residence. A service centre for the elderly will be included in every unit. This will allow increased possibilities for residents to participate in everyday life despite reduced mobility.
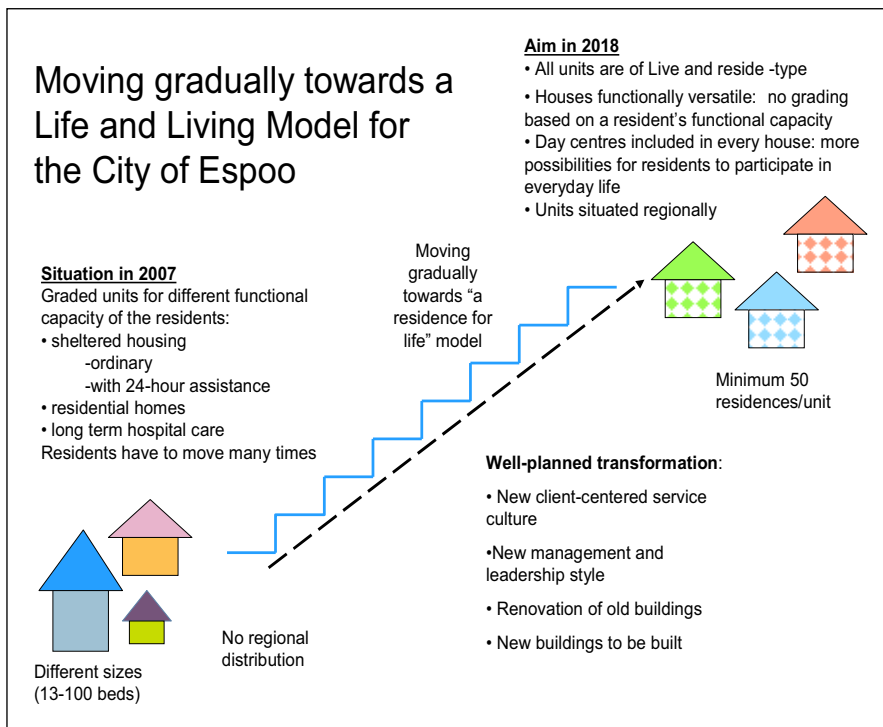
Moving gradually towards a Life and Living Model for the City of Espoo

Aim in 2018
• All units are of Live and reside -type
• Houses functionally versatile: no grading based on a resident's functional capacity
• Day centres included in every house: more possibilities for residents to participate in everyday life
• Units situated regionally

Moving gradually towards "a residence for life" model

Situation in 2007
Graded units for different functional capacity of the residents:
• sheltered housing
   -ordinary
   -with 24-hour assistance
• residential homes
• long term hospital care
Residents have to move many times

Minimum 50 residences/unit

Well-planned transformation:

• New client-centered service culture

•New management and leadership style

• Renovation of old buildings

• New buildings to be built

Different sizes (13-100 beds)

No regional distribution

Figure 7. Transformation from traditional long-term care to a new "Life and Living" model

The transformation process must be well-planned. Consequently, a client centred and rehabilitative service culture will be needed and must be ensured by the necessary preconditions of good leadership and strong management.

References

Välikangas K. 2006. Local authorities work to improve elderly people's possibilities of living at home and accessing services. Ministry of the Environment, Housing and Building Department. The Finnish Environment 21.

Nelson, E., Batalden, P., and Godfrey, M. (Eds.). 2007. Quality by Design: A Clinical Microsystems Approach. Center for the Evaluative Clinical Sciences at Dartmouth.

PART 2

Securing Liveliness of the Elderly

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Elderlization: emergence of a new society

The elderlization of society is not just a phenomenon of increasing ratio of the population at the age 65 and above. Even rapid increase of the population at the age 65 and above is not just the pressure on public policy for the allocation of medical/social service related resources and for the labour market and human resources development in the policy field. Although the elderlization of society is the common demographic trend in post industrial nations, phases for the society of getting elderlized is almost socio-cultural and historical in substance. This suggests an importance of psycho-social and anthropological examination on elderlization which emphasizes environmental determinants and differentials to optimal aging (Aldwin and Gilmer 2004, 2-3).

Elderlization is certainly a problematic social transition from the past angles of observation. It increases public costs more rapidly than the various optimistic estimations. It affects weakened value added performance of the economy and industries. It decreases total scale of consumptions. Therefore, it seems that the crises is about the post war system of redistribution of welfare resources. Those are certainly 'problems' from the view of the past thinking on social stability. However, at the same time, the reality asks for a new social principle which may symbolize social innovation from the past system. If elderlization is a socio-cultural phenomenon which reflects not only cognitive, emotional, and social but also psychosocial and behavioral factors, it must inevitably connote dynamism of socio-cultural gradation within a society which sharply reflects on the differentiation or even diversion in living circumstances. In another sense, the new emerg-

ing society by the elderlization is such that environmental risk in the life cycle, birth, education, work carrier, family, friends, neighborhood, luck and grieve etc. affects more straightly and individually to subjective comfort of one's life. New emerging society loses social sense of normality we used to have under the regime of a postwar welfare state which coincided with an average expectable environment where we possibly understood, predicted, and controlled our behavior and expectation (Austrian 2002, Introduction).

Therefore, social transformation though elderlization is not just something to do with the elderly, but underlines the necessity for new innovative social norms and rules. Social norms and rules of this mean should fit not just for wellbeing of the elderly, but also be reasonably universalized to the kinds of social issues conceptualized by socially handicapped, disadvantaged, deprived, or socially excluded. Elderlization is a phenomenon coherent with post-industrialization and globalization of the society, so the effect of the elderlization should not be narrowly assessed as only a question of the elderly.

Being aged and to be elderly

Being aged is not just something to do with getting older in the biomedical sense or simply elevating life-stages up. It is rather a process of unavoidable choices for the unforeseen future. Unavoidable choices are made in relation to one's own interests in a rather short run perspective. This is what Ulrich Beck terms "patchwork biography" (Beck 1986).

Choices are inevitably in one's cognitive context. In the cognitive approach, "negative thoughts, images, feelings, and beliefs produce undesired or maladaptive behaviors", therefore behavior change is enhanced within the context of cultural conditions (M. Sundel and S. Sundel 2005, 2, 4-5). Life is a process of human development which is influenced by one's given endowment and talents, but more over than those given, environmental posture at each stage of life cognitive range and behavioral culture. Being aged is in a sense a patch work process of accumulation of one's experiences. Even obstacle and physio-mental balance issues, e.g., risks in various means, regrets on the incidents ever had, grief and losing of valuables, are just in the content of one's life process, and those feelings of regrets, losing, grief as well as happiness and success are certainly reflections of one's own cultural posture. If it is reasonable to put the word "liveliness" on such a human competency that can cope autonomously with given environmental conditions and manage life events positively, "liveliness" is one's cultural driving force to change behavior and enhance positive way of cop-

ing at risks and effects from living environment. Therefore, being aged and to be elderly need to co-exist with physio-mental "liveliness" by securing, on social effort, opportunity to be supported and encouraged by it.

To be elderly is also a state of completing the process of one's own life which is a long way to relate own holding resources to the community. Elderly people are resourced in experience, in social relationships, in knowledge of life, and even in their own existence in the surrounding social context. "Liveliness" is also enhanced by socio-environmental preparations towards participation and contribution in linking self with the community.

Wellbeing of the Elderly and Emerging Social Principle

Elderlization and being elderly are carrying higher probability of being supported by health and social care services in a biogerontological sense. On the other hand, elderlization increases social opportunities as a whole of penetrating life experience oriented knowledge/skill/ information into the community, should the elderly be embedded in a social context and those knowledge/skill/information be abundantly accumulated rapidly.

Wellbeing of the elderly carries three major aspects:

Firstly, it is both of policy justification and morally enhancing that the elderly is encouraged to live at home and within the community independently and autonomously as long as possible by receiving basic supportive services. This is the phase of socio-political adjustment for the more efficient and effective distribution of public resources. Secondly, because wellbeing is incubated in the social context of one's life, it should be a fundamental requirement for the elderly not to be excluded from or deprived of opportunities for accessing supportive social and care services with embeddedment in the community in socialization term. This aspect relates to the question of allocation of social opportunities to be socially cared on the fairer truck. Thirdly, in order to be integrated within the community, social infrastructure and circumstance surrounding daily life of the elderly should be such that afford them an existing condition as a community member. This is the requirement for keeping them out of being socially excluded.

Basic supportive services, social opportunities, and membership of the community are the needs of the elderly person to be a self. Nevertheless, those needs tend to be interpreted at risk of not having appropriately met the real necessity.

Dependency on the professional service management, regularity in service provision, or leaving service use simply on the client's self-determination can conflict with the needs to be an individual self. Needs for being supported coincide with many factors and the way of assessing those factors in which physiomedical impairments or social handicaps are defined and responded to both by individual and community (Cox 2005, preface).

The concept "individual" has become an issue for innovation in the post-market-individualism era of welfare reform. Dowsett, Fine and Gursansky (2009, 5) have sharply described contemporary welfare debate as "conflict between the idea of the subject of right as a self or as a will". They recognize that "freedom expressed as the capacity to will for oneself is the old idea of freedom understood in terms of the capacity for self-government". As frequently happened in the market, self-decision and choice of goods based on one's free will as a consumer is deemed as if a choice the market and supplier elaborately want him/her to choose. What is critical to the individual is self-respectability in that by choosing certain services or goods s/he shall be independent and confident in managing own living or even life and be a part of the society as an integrated self.

From the experience of the Japanese long-term care system for over the last decade which is the first experiment in the world of providing long-term care services for the elderly people who are in need through the mechanism of self-choice of necessary service on the list of a legislatively allowed menu with user contract between client and service provider, the model of individual freedom as a will has been poorly implemented as a leading policy discipline in the social and welfare reform. The experiment for only five years has already sufficiently suggested reducing usability of services by those cognitively impaired and dementiated, increasing claims and troubles because of lack of smooth transparency of information in the contract relations, and exclusion of those less afforded in monetary resource from the purchasing of basic services. This lead to further disturbance of the health operation of the market of itself; increasing short range competition, smaller sizing of care business, increasing costs, decreasing profitability, and segmentation of the service providers and labour market (Ogasawara 2007).

From a citizenship's point of view, interpretation on the needs of citizens has been changing under the pressure from a "dark aspect" of so-called structural reform during the past decades. At the initial stage of transition of the post-war welfare state, self-helping and confident individuals has broadly been advocated instead of the negative concept of citizen based on an objective assumption of their role under the welfare state's provision and allocation of role of citizens. In

the past decade, there has emerged a more dynamic conceptualization of citizen. Andersen, Guillemard, Jensen and Pfau-Effinger, together with Sennett (Sennett 1998) , put four dimensions, discourses, rights and obligations, participation and perception of one's role, as the examining references on the shift of citizen concept. Their "active citizen" is "expected to be autonomous and self-responsible, as well as flexible and extremely mobile" (Andersen, Guillemard, Jensen and Pfau-Effinger 2005,7).

These changes in interpretation of individual of freedom and citizen are the same expression, though in different angles, of the needs to be an individual self. There are two aspects of independence of humanity: self-independency (physio-mental independency of the individual) and independency within inter-dependency (phyco-social independency as a self). There was an individualism heavily shifted its emphasis on the former self-independency including independency of the will. At the level of service practice, this individualism fits for rationalizing the policy drive for enhancement of universal care work by which each client and family, by their necessity and within their capability, affords to cope with obstacles in their daily life management. This shift of policy emphasis on self-independency has been justified as a removal from publicly controlled distribution of welfare resources under the system of a welfare state. However, care work has been clearly devided from social work expectation for which is to integrate those who already receive support of care services into society as a community member and a contributor. Change in the interpretation on the individual is a move for integrating those two ideal independency of humanity into an array, so that the prototype of humanity and policy principle should be located closer to the real existence of social relations.

In the argument of 'successful aging', successfulness is assessed by subjective, even physiological satisfaction. There is also a kind of estimation on the human successfulness in life on the measurable scale of subjective liveliness to live. Subjective evaluation is effective in assessing outcomes of life from the view of the physiologically estimated distance between what would have been imagined beforehand and what is actually visible before you. However, wellbeing is not just about subjective satisfaction. Wellbeing is a complexity of subjective assessment on one's life which has been actualized within the specific context and conditions of his or her social circumstance. Therefore, even subjective successfulness is plastic comprehension of subjective liveliness and supportive services to needs which should be conceptualized as "cooperated successfulness". Because it has cooperativeness in nature, wellbeing is a categorical expression of

the social needs for substantiating autonomous human life and then it is a matter of social innovation.

Wellbeing and the key issues for social innovation

As wellbeing is a matter of social innovation, then improving wellbeing should be redefined as "risk" in life. Policies designed by physio-mental assessment on risks in life are targeting at improving health status and functionalities as a reflection of medical treatments or preventive health care.

Orthodoxy on the prevention from primary to the third or even fourth stages stresses preventive function necessitated by weakening health status for diseases or by increasing dependency on preventive services for impairments. This is also recognized on the physio-mental assessment of health status which focuses on the actual state of human functionalities. Although this concentration on the actual health status is indispensable for providing evidences to innovate clinical practice, interpretation on risk of life from socio-environmental perspective should also be critical to innovate approach and ways of allocation of policy resources much closer to the reality of causing various risks for the elderly to be well.

Unlike biogerontologists, psychological gerontologists emphasize cognitive and emotional happenings, which are closely affected by one's socio-cultural environment. Health psychologists more clearly watch behavioral reflections from human living circumstances (Aldwin and Gilmer 2004, 2). Recent studies in public health also recognize criticality of the environmental effects to the human health status. Manuck, Jennings, Rabin and Baum (2000, viii), the Pittsburgh University group, has already found the links of environmental conditions with quickness of people's aging and losing functional competence. Schultz, Heckhausen and O'Brien made close analysis on the tight relation between negative emotional experience and loosing functional competency or even an individual's sense of self in late life, by suggesting the importance of controlling one's environment (Manuck et al. 2000, 119-133).

More recently, Boylan extended other sorts of threats on health than just epidemiology concerning various microbes and sanitation. "These include human rights violations and unfairness in the allocation of the basic goods of human agency such as health care and the opportunity to protect one's self against threats against the same" (Boylan 2008, 1). Current assessment on "risk" category to health is therefore constructed as a dual circle map: risk as living envi-

ronment and conditions directly affecting biomedical state, and risk as affecting human existence as an individual self on a psycho-social dimension.

If the hypothesis that health promotion relates to social determinants of health and politics of policies is accepted, and the view that power and empowerment are central to health promotion (Labonte, Laverack and Baum 2008; ch.2) are accepted, then the risks to health and wellbeing (i.e. liveliness) are underlying in one's living environment and conditions. These are not only those socio-cultural related (human relationship, habitual pattern of behavior, context and experience in the past, lost and grief occupying one's sensory reflections, etc.) but also socio-politically related (universal/impartial allocation of health/social service opportunities to be empowered, participation in the community care as a stakeholder, affordance of basic rights and dignity in daily living, etc.) (Twohig and Kalitzkus 2008).

As risks are embedded in life environment, meaning of preventing actualization of these risks to such extent that risks shall reflect substantially and materially on the way of living should also be re-defined (Alaszewski, Harrison and Manthorpe 1998; Kemshall 2002, Petersen and Wilkinson 2008).

This re-definition goes hand in hand with re-definition of "prevention" as policy category. The bio-medical model focuses on an aspect of prevention of diseases or any other material cases to impairment. Health is deemed as a counter concept of illness and a by-product of preventive health care and medical/comedical cure and rehabilitation. While the socio-environmental model of prevention stresses health as the goal (Vandiver 2009). Health is almost conceptualized as the same meaning as liveliness, which is power and empowerment for living well and being an independent self even in the late age with need for long-term care. Preconditioned by pro-active social measures to prevent and decrease those environment related risks for being depressed, disadvantaged, and excluded, people will promote themselves to subjective behavioral transformation for lively living.

As "risk" in current thoughts on health promotion and social services is socio-cultural and socio-political, the purpose of health and social care system need to be adjusted to this historical transformation in social norms. As risks are embedded in life environment, the meaning of prevention against actualization of these risks to such extent that risks shall reflect substantially and materially on the way of one's living should also be re-defined. Even nursing practice in long-term care, there is tendency in policy challenge to move away from a health care system based on and around acute episodes of ill health to one that supports those

with long term illness in appropriate care settings (Denny and Earle 2005). This is the trend toward sociological integration of health related services and integration of health and social-care services in terms of preventing or minimizing actualization of risks. This is, in other words, to create a community based health promotion system which contains, beyond trod of ever existing public health and social services provision system, broader array of settings, partners both experts and volunteers, and points of continuous and comprehensive supportive intervention (Easterling, Gallagher and Lodwick 2003).

From the socio-environmental point of view, primary prevention for health is not just what prevents disease, infliction or impairment but enhance behavioral competence with liveliness to improve risky environment and conditions of life and living. Pro-action to enhance behavioral transformation in day-to-day exchange between the human subject and life circumstance is a thing which is embedded in daily life habitation and creates a regulatory effect to the state of unusualness. It may be conceptualized as "autonomous pro-action embedded in daily life" or APEDL (Ogasawara and Shimazu 2007).

Proposal of APEDL includes renewed interpretation on the primary prevention. If primary prevention is to enhance self-regulatory practices for promoting health in the physical sense, it is certainly a key part of setting behavioral transformation; the pattern and motivation of which may last through the life time even when he/she is in a state of illness or at the stage of long-term-care necessity. If motivated in behavioral transformation for being well and if motivated to be positive to life and to be lively, second and third and even forth preventions should have complementary effects to the primary prevention oriented liveliness. Especially detection and recovery will add renewed value to promote liveliness in life.

This interpretation of prevention also suggests importance of comprehensiveness of physical health and mental health. There are stages of risks in life where the gap in physical and mental health is critical or where depressing mental health affects physical health status in various ways or vice versa. Therefore, liveliness to live well depends on balancing physical-mental health comprehensively on the clinical service level.

Interpretation of "care" as a spontaneity of expertism

Integrated care within the community, whether it is for health promotion, supportive rehabilitation, or long-term care, is structuralized in an elaborately braided net of experts and voluntary participants as well as public administrators. There

is evidence that de-domesticity in the target and spontaneity of expertism within the networked social nodes are the key factors of emergence and continuous operation of social networks in the area of health and social care services.

Without de-domesticity of the target, in other words, without value to be shared within a range of nodes, the social net is hardly of existence. If key players involved in the challenge for creating the net are motivated for their own sake at the end and are driven by their own implicit meritocracy, social networks will face friction of merits fundamentally competing with each other.

De-domesticity of the target is based on the spontaneity of expertism to collaborate with experts of different specializations. Medical doctors will recognize necessity and inevitability to work in a coordinated way with physiotherapists and social workers to get his client with dementia symptoms rehabilitated and replaced safely to her own home. Networks in a specific range of a shared target is a kind of mechanism of collaboration in between different experts with mutual participation of knowledge to bring innovative solutions on the targeted social issues.

Securing APEDL in a substantial way is an integrated effort of different type of experts. It is an integrated cooperation of experts on the integrated provision of (1) identifying environmental risks, assessing them, and decreasing them, (2) providing supervision function for the intervening program, and assessing outcomes and following-up the program.

References

Aldwin, C.M. and Gilmer, D.F. 2004. Health, Illness, and Optimal Aging-Biological and Psychosocial Perspectives. Sage Publications.

Andersen, J.G., Guillemard, A-M., Jensen, P.H. and Pfau-Effinger, B. 2005. The Changing Face of Welfare − Consequences and Outcomes from a Citizenship Perspective. The Policy Press.

Austrian, S.G. 2002. Developmental Theories through the Life Cycle. Columbia University Press.

Beck, U. 1986. Risikogesellschaft − Auf dem Weg in eine andere Moderne. Suhrkamp.

Boylan, M. (Ed.) 2008. International Public Health Policy and Ethics. Springer.

Cox, C.B. Community Care for an Aging Society − Issues, Policies and Services. Springer Publishing Company.

Denny, E. and Earle, S. The Sociology of Long Term Conditions and Nursing Practice. Palgrave Macmillan.

Easterling, D.V., Gallagher, K.M. and Lodwick, D.G. 2003. Promoting Health at the Community Level. Sage Publications.

Labonte, R. and Laverack, G. 2008. Health Promotion in Action − From Local to Global Empowerment. Palgrave Macmillan.

Manuck, S.B., Jennings, R., Rabin, B.S. and Baum, A. 2000. Behavior, Health and Aging. Lawrence Erlbaum Associates Publishers.

Ogasawara, K. 2007. "New Way to Cost and Profitability of Health and Social Services", in Erjanti, H. (Ed.) Refurbishing Elderly Care −Strategy of Cost Efficiency in Theory and Practice. Laurea Publications.

Ogasawara, K. and Shimazu, N. 2007. Community Health and Long-term Care Networking (in Japanese), Chikura-Shobo.

Sundel, M. and Sundel, S.S. 2005. Behavior Change in the Human Services − Behavioral and Cognitive Principles and Applications. 3rd edition. Sage Publications.

Twohig, P.L. and Kalitzkus, V. 2008. Social Studies of Health, Illness and Disease − Perspectives from the Social Sciences and Humanities. Rodopi.

Vandiver, V.L. 2009. Integrating Health Promotion and Mental Health − An Introduction to Policies, Principles, and Practices. Oxford University Press.

Yeatman, A., Dowsett, G.W., Fine, M. and Gursansky, D. 2009. Individualization and the Delivery of Welfare Services − Contestation and Complexity. Palgrave Macmillan.

Some Thoughts on the Philosophy of Care − An Interpretation of Spirituality from the Viewpoint of Buddhism

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Preface

Palliative care concerns the total wellness of the client suffering from life threatening illness. Therefore it includes comprehensive care for not only physical pain, but also psycho-sociological, mental, religious and spiritual[8]. In this article I will examine spiritual care, especially from the viewpoint of Buddhism. Although it is not easy to define spiritual care, it can be explained as care which palliates the spiritual pain of the client in the dying process and supports him in recovering meaning and will for living. However, there still remains the question of what spiritual pain is, and even more fundamentally, what the meaning of "spiritual" is[9]. Answers to these questions will vary with the cultural and religious context,

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[8] In 2002 WHO defined palliative care as follows: Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

[9] Many have tried to translate the word "spiritual" into Japanese. However there is not a clearly proper Japanese equivalent for "spiritual," so it is often used "as is," as borrowed word without exact definition in Japan.

and I think it is worthwhile to examine the concept of spirituality in one such context − from the Buddhist viewpoint.

Analysis and opinions on spiritual care in Japan

In Japan, there are many researchers, theoreticians and spiritual care practitioners. Most of them have a western religious or philosophical bias, but some have a Buddhist background. First, I'll review representatives in Japan.

(1) T. Kubodera (former chaplain at Yodogawa Christian hospital, professor in the faculty of theology in Kansei University). He says that spirituality awakes when one confronts a crisis in life. Meeting this crisis the individual loses his "framework of existence" and his "identity." Such anxieties and suffering (spiritual pain) are common for all human beings. They are seen in the individual's loss of a sense of meaning, purpose and worth in life, anxiety regarding death and the afterlife, regrets regarding this life, and a sense of guilt. Facing this pain, we seek solace in the transcendental, which stands aloof from ourselves or stands inside in ourselves as the ultimate.

(2) H. Murata (Professor in Notre Dame University). He explains the existence of human beings from three viewpoints: existence in time, existence in relationship and existence in autonomy. Spiritual pain in a life crisis is pain caused by losing our sense of existence and meaning, which are sustained by these three viewpoints. From the viewpoint of time, life loses its meaning through loss of a future. From the viewpoint of relationship, life loses its meaning through loss of relationships with others. And from the viewpoint of autonomy, life loses its meaning through loss of autonomy and productivity. Murata introduces a concept of support in which care providers infer the spiritual needs of a client, assessing the structure of pain with the threefold framework of time, relationship and autonomy and making a care plan for relieving spiritual pain and providing holistic care.

(3) M. Tamiya (Representative of association of Vihara). He proposed calling a palliative ward based on Buddhism "Vihara" instead of "Buddhist Hospice." It is an old Indian word (Sanskrit) meaning "the place of healing." The purpose of Vihara care is "to keep one's eyes fixed on oneself and to be watched over." Focusing on the wishes of the client himself, the harmonious place for "Sitting close to the Dying (MITORI 看取り)" and "medical treatment" should

be provided in Vihara. His idea was realized in 1992 by setting up a Vihara ward in Nagaoka-nishi Hospital. Many Buddhist priests are in action as Vihara monks there. There are now courses for developing Vihara monks. The Buddhist Nursing and Vihara Society was founded at the end of 2004.

(4) D. Ohshita (Buddhist Priest, Professor at Koyasan University). He is a Buddhist priest in the Shingon School and is active in listening volunteer work in hospital and home care. He is also active as a spiritual care worker in a Takakuwa hospital. He regards the main principle of Buddhist care as "relationship in which both care-receiver and care-provider grow up." He writes, "Buddhist care is based on the concept of harmony of one's own benefit and another's benefit. Care-receiver and provider become one. We recognize that our life is integrated with the Buddha as universal existent and/or with the life as Universe. He opened a training school for spiritual care workers, and he is developing various care programs using meditation, introspection and music therapy.

The former two have Christianity as a background and the latter two, Buddhism.

Spirituality and spiritual care in early Buddhism

In early Buddhism, the reality of human beings is analyzed, and it is explained how suffering in life is caused and how it can be overcome. Our fear of death and unease is explained through the nature of our consciousness and attachment to self, and a way to accept dying is shown. What is spiritual, is explained differently than we saw above. Spirit, or the transcendental as commonly conceived in Christianity, doesn't appear in the context of spirituality. What corresponds to this is a form of conscious. Living things distinguish themselves from others and intend to preserve themselves and continue to exist. This is one form of consciousness, but there is believed to be another form of consciousness. It is called "the common consciousness with others," which overcomes the above mentioned inclination of all living things[10]. In Buddhism, several concepts can correspond to this common consciousness. These include "prajJā" (insight) which is origin of "karuNA" (compassion) and "maitrī" (friendship). And in Mahayana Buddhism there is " Buddhatā" (the nature of Buddha).

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[10] This concept of twofold consciousness owes to Haya (1999).

Twelve stages – How the problem of suffering arises

When Buddha was young, he saw an old man, a sick man and a dead man. This experience causes him to ask the fundamental question of why we are born and die and must suffer. He solves this question in his enlightenment. The content of his enlightenment is expressed as the stereological implications of causality in a series of twelve stages which show us how our suffering in life arises.

The twelve links in process are: (1) Ignorance (avidyā) → (2) Compositional forces (saMskāra) → (3) Consciousness (vijñāNa) → （4） Name and form (nāma-rūpa) → (5) Six sense spheres (SaD-āyatana) → (6) Contact (sparZa) → (7) Feelings (vedanā) → (8) Craving (tRSNā) → (9) Grasping (upādAna) → (10) Becoming (bhava) → (11) Birth (jāti) → (12) Old age and death (jara- maraNa).

This concept of twelve links explains how our reality arises as suffering, how the Self is created as fixed and substantial, how this "I" imagines it exists on its own without relationship to others, how the unquestioned cognitive frame in which we perceive our Self at the center, confronting the outer world around us, and how our Self stands apart from all other things, existing without relation to them and evaluating them according to its own standards.

I will explain the process briefly.

At the base of our reality lies "ignorance". We cannot recognize, see nor feel it. It is a root of delusion.

The next link, "compositional forces (saMskAra)" forms consciousness, namely a consciousness of Self. This consciousness is, "I am…" or "I exist" or self-consciousness. It distinguishes itself from others. It is convinced that it is fixed and substantial and exists perpetually by itself. It fears its death and doesn't accept that it will die in the future.

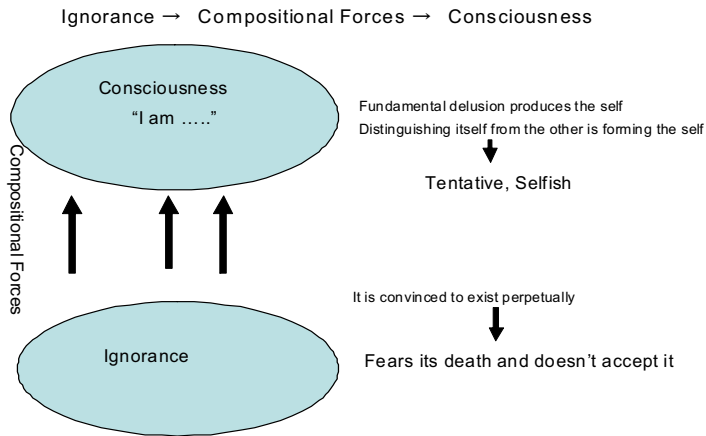Ignorance → Compositional Forces → Consciousness

Figure 1. Ignorance, compositional forces, and consciousness

The next links (3) Consciousness (vijJAna) → (4) Name and Form (nAma-rUpa) → (5) Six sense spheres (SaD-Ayatana) → (6) Contact (sparZa) are the forms of cognition and understanding that we regard as a matter of course. Separated in subjectivity and objectivity and centered on itself, Self recognizes the world as isolated.

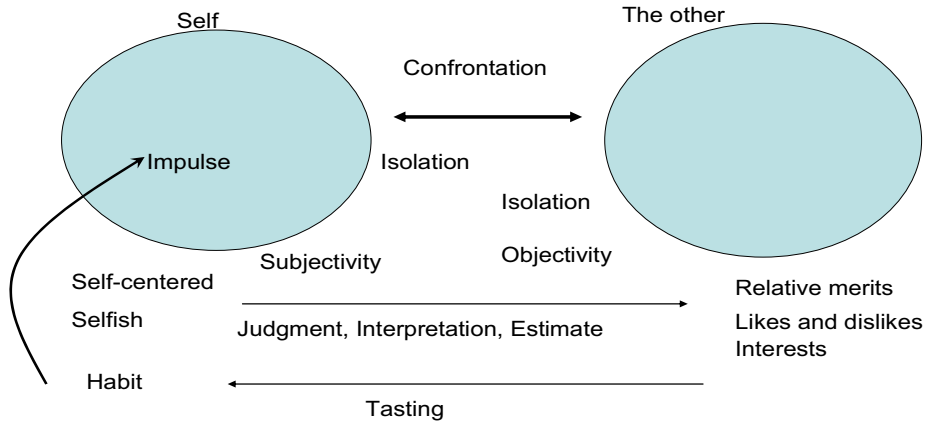# Indifference to the inside of others

Figure 2. Indifference to the inside of others

It judges, interprets, estimates and tastes the things that are recognized in the sphere of objectivity. Tasting gives rise to self-centered craving. It becomes an unconscious habit and mysterious impulse. This form of recognition is tentative. But we do not notice it and cling to ourselves and our existance. This, in turn, causes suffering in old age and death.

In the figure 3 below Ignorance is in dark zone, and old age and death are in the gray zone. Usually we have Perspective 1. Although it is impossible to recognize ignorance, we can perceive old age and death. However we push them out of our minds. For our Self fears, refuses and ignores old age and death.
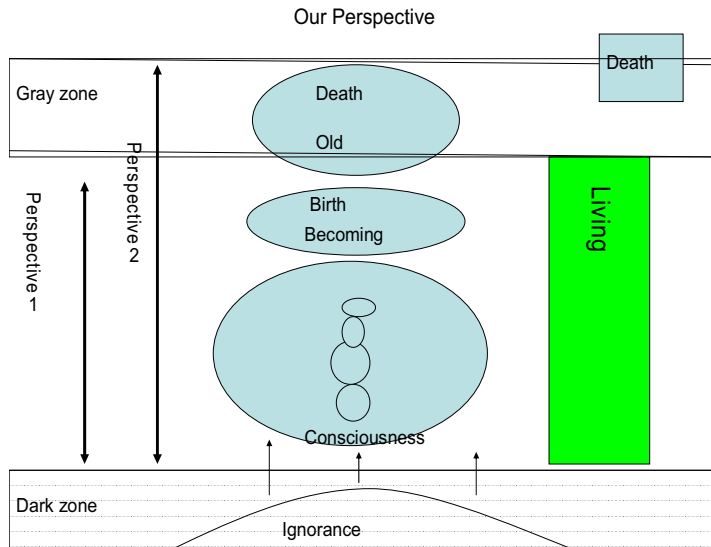
Figure 3. Ignorance, old age and death

Death and life are here entirely separated. Life is assessed as excessively posi-tive and death is assessed as defeat and anathema. In spite of our preference, we cannot help experiencing old age and death.

Attachment to life

Currently we tend to eagerly wish to be active and healthy. This is also an at-tachment to life; that is, an attachment to ourselves that makes us selfish and egocentric. After all, we cannot overcome death and thus die in defeat. This is not the way to have a peaceful and harmonious end of life.

From the Buddhist point of view, in our daily life we try not to recognize or notice existential pain, despite the shadows cast on us by the fear of old age and death. We may thus find in our usual life meaning, peace and/or fulfillment, but our life itself is conditional.

The reality of old age and death come into sight, whether we like it or not. "I" that should last forever gets ill and dies without knowing the reason. This a funda-mental reason for suffering in life.

Twofold reality

Our reality is explained as twofold. As explained above, our reality is formed by ignorance and saMskAra and so on. This reality is a "self-centered form of consciousness." It is one side of our whole reality. The other side is a "form of consciousness in common with others." This is not conditional on time and space. Usually it is hidden behind self-centered consciousness. But it is the origin of the force to overcome self attachment. Our usual senses do not recognize it, but when we experience the transitoriness of our life, we have the chance to realize it. This is very similar to the awakening of spirituality illustrated by Kubodera.
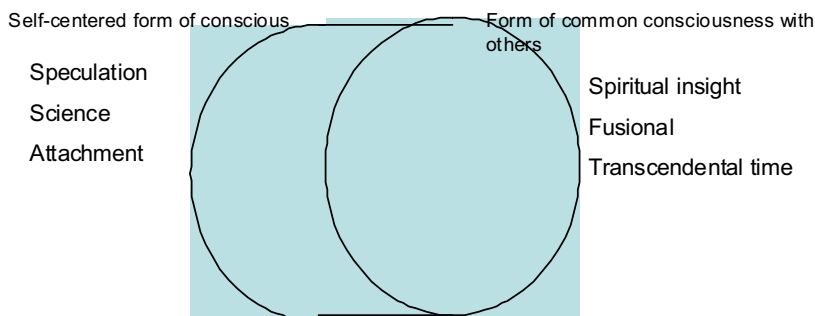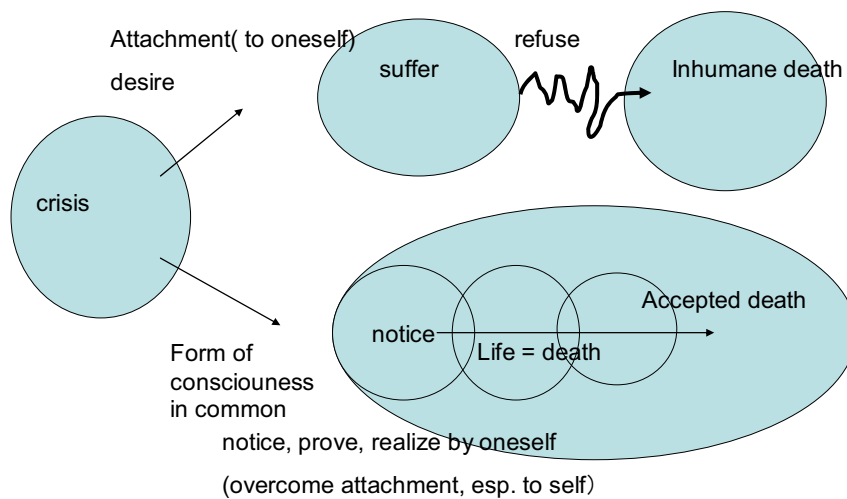
Twofold consciousness

Self-centered form of conscious

Speculation

Science

Attachment

Form of common consciousness with others

Spiritual insight

Fusional

Transcendental time

Figure 4. Twofold consciousness

A Buddhist spiritual care model and how it differs from the usual spiritual care model

In this Buddhist spiritual care model, the client must become aware of what his life is composed of. It is conditional and he must overcome his own attachment, to recover the meaning of his life and, most importantly, accept his death as a natural process. It means also that he chooses to live guided by his "common

Crisis and its relief

Attachment(to oneself)

desire

crisis

suffer

refuse

Inhumane death

Form of
consciouness
in common

notice

Life = death

Accepted death

notice, prove, realize by oneself

(overcome attachment, esp. to self)

consciousness with others".

I will illustrate as follows:

Figure 5. Crisis and its relief

After the crisis there are two ways to death. If he cannot/will not overcome/notice his attachment, he holds onto his suffering and proceeds to an inhumane death.

The other way is to accept death. He notices the conditional nature of his reality and the selfishness of Self. He notices, proves and realizes it by himself. So he gains the power to overcome his self-centered, automatically conditioned consciousness. He also gains the power to sympathize with others and share suffering in common with others. In this way of life, death is not separate from usual life. He lives accepting death.

Even a client in the palliative/ terminal care must do this by himself, if he is to accept his death peacefully.

Spirituality of care providers

Care providers in the field of palliative care frequently experience the death of clients. They cannot help feeling futility and vanity. They can easily fall victim to burn-out syndrome. Or they become insensitive to the internal suffering of clients. To avoid burn-out, remain open to a deep understanding of the internal suffering of clients and recognize the meaning of his care work, care providers must understand various views of life and death and know what spirituality is. Moreover, according to the Buddhist spirituality mentioned above, it is important for them to notice their own attachment to themselves.

Keeping an eye on themselves, noticing their own attachments and selfishness and trying to overcome these helps care providers to understand their clients and sympathize with their suffering. Thus they find deep meaning in their work. Care providers also must find a path to accepting old age and death. To accept death as a natural process is not in the sphere of understanding or recognition. We must keep an eye on ourselves, notice self-attachment and try to overcome it.

Conclusion

I have tried to examine how reality is explained in Buddhism. It may sound quite curious to the ears of Europeans. However this is one possible way to consider spiritual issues. Especially the concept of twofold consciousness is a key to illustrating spirituality in a non-Christian tradition. Our spirituality itself is not different. I agree with the view that there are universal spiritual needs in spite of differ-

ences of culture or religion[11]. Understanding other cultures and having inter-change with each other can aid in developing and practicing good spiritual care. Buddhist theories are often discussed in the framework of religion, but also provide a valuable point of view from which to examine modern medical treatment and care.

References

Haya, T. 1999. Gotama Buddha. Syunjushya, Japan.

Kubodera, T. 2002. Supirityuarukea Nyumon. Miwa Shoten, Tokyo, Japan.

Murata, H. 1994. Kea no shiso to taijinn enjo. Kawashima shoten, Japan.

Ohshita, D. 2005. Iyashi iyasareru Supirityual kea. Igakushoin, Japan.

Saito, H. 2007. Care and Buddhism – Another Viewpoint on the Concept of Caring. In H. Erjanti (Ed.) Refurbishing Elderly Care. Strategy of Cost Efficiency in Theory and Practice. Laurea Publications A-60, Laurea University of Applied Sciences. Vantaa, Finland. 29−40.

Smith, S.A. 2000. Hospice Concepts: A guide to palliative care in terminal illness. Research Press, Illinois, USA.

Tamiya, Hi. 2007. Bihara no teisyou to tenakai. Gakumonsya, Japan

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[11] For example, Smith (2000, 98) lists universal spiritual needs as follows: (1) Needs for belonging and relationships: a) To be cared for, not abandoned or isolated, b) To give and receive love, c) For comfort and peace, d) Relationship needs: family, significant others, deity, (2) Need to explore meaning of life, suffering and death: a) To experience affirmation of self worth, b) For acceptance − of self, of others, of human events, c) To recognize sources of strength to face death, d) To contemplate what gives a sense of purpose and fulfillment, e) To discover the personal meaning of pain and death, f) To define hopes and goals, g) To move on to detachment and solitude, (3) Need for reconciliation: a) To acknowledge unfinished/unresolved conflicts, b) To recognize nagging resentment and bitterness, c) To recognize feelings of guilt and blame, d) To be able to forgive and accept forgiveness.

Integrated Care and its Management: A Critical Review

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Introduction

Integration is frequently highlighted as a key target of high quality care management. However, it seems that the concept of *integrated care* lacks a unified theoretical and practical definition (Vaarama and Pieper 2005, Gröne and Garcia-Barbero 2001, Fleury 2006). The definition of this concept varies in different countries and among health and social care professionals (Leichsenring 2004). It has theoretical backgrounds in such areas as social science, gerontology, management and planning sciences, and welfare theory (Vaarama and Pieper 2005). Furthermore, integrated care has many closely related concepts including shared care, transmural care, intermediate care, seamless care, disease management, case management, continuous care, integrated care pathways, and integrated delivery networks (Gröne and Garcia-Barbero 2001). These concepts are often used interchangeably. The purpose of this paper is to critically review the concept of integrated care and to explore its practical use.

Defining integrated care

Definitions

The word "integration" comes from the Latin verb *integer,* that is, "to complete." Similarly, the adjective "integrated" means "organic part of a whole," or "re-united parts of a whole." (Kodner and Spreeuwenberg 2002)

Leichsenring (2004) defines integrated care as "providing care services in which the single units act in a co-ordinated way and which aims at ensuring cost-effectiveness, improving the quality and increasing the level of satisfaction of both users and providers of care." Similarly, Mur-Veeman et al. (2003) define it as the processes of coordination to achieve seamless and continuous care, tailored to patients' needs with a holistic view of the patient. Integrated care can therefore be defined through its goals (e.g. cost-effectiveness) and the means by which these goals can be achieved (e.g. coordination).

Vaarama and Pieper (2005, 9-32) specifically define integrated care as the means to pursue specific goals: "A good quality of life for the client and, where appropriate, his family is the goal to be achieved, whilst a high professional quality of both care, management, and the integration of care are the means to pursue this goal." Furthermore, they argue that "integrated care is a well-planned and well-organised set of services and care processes, targeted at the multidimensional needs/problems of an individual client, or a category of persons with similar needs/problems." Vaarama and Pieper view coordination and collaboration in networks as the key ingredients of integrated care. This idea is echoed by van Raak, Mur-Veeman, Hardu, Steenbergen, and Paulus (2003), who define integrated care as "a coherent and co-ordinated set of services which are planned, managed and delivered to individual service users." Similarly, Plochg and Klazinga (2002) view integrated care as "the methods and types of organization that aim to reduce fragmentation in health care delivery by increasing co-ordination and continuity of care between different institutions."

Even when it is defined in terms of means rather than goals, integrated care has specific targets. For instance, Vaarama and Pieper (2005) argue that the client should experience the resulting care as continuous, comprehensive, flexible, and responsive to their changing needs. The goals of integrated care may include reducing costs, and improving quality of care, access to care, and client satisfaction (Gröne and Garcia-Barbero 2001). Niskanen (2002) offers a more open definition in relation to both the goals and the means of integrated care:

"Integration means something that is sharing, reforming, transforming, negotiating, revolutionizing, collaborating, exchanging, etc. If the patients'/clients' benefit is the target, the obstacles should be overcome."

The concept of integrated care has many different definitions, changing from one professional to the other and from one country to another. For instance, Leichsenring (2004) examines how different EU countries have adopted the concept (see Figure 1).

Main concepts of integrated care in selected EU Member states

Key concepts of integrated care	A	D	DK	EL	F	FIN	I	NL	UK
Public health discourse	**	**	**			*	***		**
Managed care (health system)	**	**	*		*	*	**	*	***
Horizontal integration (provider mix)	**	**		**	*	*	*	*	*
Vertical integration						**	**		**
Seamless care/transmural care	*					***		**	*
Gerontological co-ordination/networking	*	*		***			*		
Whole system approach									*
Person-centred approach			***			**		***	**

***most important concept being followed and implemented in mainstream provision; **important concept followed (partly implemented); *concept being discussed and tried out in experimental (model) projects.

Figure 1: Main concepts of integrated care in selected EU member states (Leichsenring 2004)

The concept is in use also in Japan, as Matsuda and Yamamoto (2001) explain: "In policies concerning integrated care for the disabled elderly, care management has become an important topic for consideration. Standardised care, continuity of care, flexibility of care, and finely tuned co-ordination between the different kinds of care providers are a central part of care management in order to realize high quality care for the disabled aged and to enable them to continue to live independently in their own homes for as long as possible. This is the most important reason that the Japanese LTCI [Long Term Care Insurance] scheme has formalised the care management process." It is notable that also their definition of integrated care highlights the importance continuity and co-ordination between different care providers.

Dimensions of integration

There are a number of dimensions that relate to care integration. Gröne and Garcia-Barbero (2001) outline four major dimensions: overcoming professional and departmental boundaries, developing multi-professional teams, integrating different sectors of care (e.g. primary, secondary and tertiary care), and horizontal versus vertical integration. Similarly, Reed et al. (2005) define care integration as between service sectors (i.e. health and social care); between professions (i.e. nurses, social workers, doctors, physiotherapists); between settings (i.e. institutions and community, primary and secondary care); between organization types (statutory, private and voluntary sector); and between types of care (i.e. acute and long-term care).

Integration may also take place at different levels (Reed et al. 2005, Vaarama and Pieper 2005, 33). Integration at the micro-level consists of the client- or patient-centered care process. The mezzo-level concerns organizations, relations between organizations, and networks. The macro-level relates to the social and health care systems as a whole or the general policy framework.

From a network perspective, integrated care can be defined as the result of co-ordination within a network of actors, activities, and resources (Lega 2005, Page 2003, Kassler and Goldsberry 2005, Provan et al. 2005). In our previous work (Järvensivu et al. 2007), we identified 11 key dimensions of such integrated care networking: care process, scope of services, formality of care, pro- and re-activity of care, intensity of care, duration of care, centrality of activity care production, level of integration, values of the actors, empowerment of end-customers, and level of determination of value-creation. This list is quite extensive, but still surely indefinite. It is conceivable that we may identify unaccounted dimensions not only empirically but also theoretically. Further research on the dimensions is needed.

Managing integrated care

The management of integrated care concerns finding ways to increase coordination and cooperation along the various dimensions of integrated care. This is not only about finding the right structures of integration, as it has been shown that such structures alone rarely integrate the actual delivery of patient care (Burns and Pauly 2002). Managing integration is a more comprehensive issue that includes all possible aspects of management in general, such as human resource management, strategic management, network management, and information

system management. Vaarama and Pieper (2005) note that the process itself is important, since there is a learning curve in care integration.

Kodner and Spreeuwenberg (2002) view integration as related to organizational design and performance in general. They argue that all organizations, and more generally all value-creating systems, are comprised of separate but interconnected components. These components should be complementary, but division, decentralization, and specialization usually interfere with efficiency and effectiveness goals. Therefore, the fulfillment of goals requires collaboration between the various parts of the organization. In this sense, Kodner and Spreeuwenberg (2002) define integration as the "glue" that bonds the entity together, thus enabling it to achieve common goals and optimal results.

Integration is important to all kinds of value-creating systems. Along these lines, Vaarama and Pieper (2005, 44) outline four models of integration between agencies: markets, hierarchies, co-orientation networks, and cooperative networks. It is important to note that the optimum type of integration depends on the case. In some cases, integration can be achieved in a market, sometimes through a hierarchy, and sometimes through cooperative networking. However, Vaarama and Pieper (2005, 46) argue that cooperative networks are the preferred type of integration.

Fleury (2006, see also Whetten 1981) provides a similar framework by defining a continuum of inter-organizational relations with three schemas (Table 1). In this framework, she argues that mutual adjustment with informal structures works well when the context is preventive or when acute care requires little coordination. In care provisions dealing with chronic and non-complex or non-chronic and complex care, integrated service networks and virtual integration is optimum. Vertical integration and hierarchical arrangements work best when taking care of patients that have complex and chronic health problems.

Table 1: Continuum of inter-organizational relations.

CRITERIA	SCHEMA 1: Mutual adjustment	SCHEMA 2: Integrated service network, virtual integration	SCHEMA 3: Vertical integration
Governance:	Influence	Negotiation	Hierarchy
Formalization:	Informal	Average to extensive	Extensive
Sanctions:	None	A few	Many
Scope/range:	Little	Extensive	Extensive
Types of problems relating to care:	Prevention to acute care requiring little coordination of services	Chronic and non-complex or complex and non-chronic	Complex and chronic (multi-dimensional, multi-professional and multi-organizational)

Kümpers et al. (2002) provide further evidence that different situations require different governance modes. They show that differing political strategies and welfare states correspond to dissimilarities in the institutional structure and culture of health care systems. Markets, hierarchies, and networks function differently in relation to care integration in different countries. For instance, in England, the state health care system relies mainly on hierarchical steering, which creates tight network structures for integrated care on the local level. In the Netherlands, however, the health care system is based on a public-private mix and has a set of incentives for voluntary, loosely coupled, and partly market-driven cooperation on the local level. Thus, implications for success or failure of integrated care are mixed in different country-level configurations; the resulting policy recommendations need to be tailored for each context or system.

Discussion

Health care and social work is the product of one-to-one interaction between the service provider and the client (e.g. doctor and patient). From the perspective of integrated care, however, health and social care work is the product of many-to-

many interactions, with the client in the center of the network. These interactions have many dimensions that require integration.

The concept of integrated care seems to be more of a multi-dimensional philosophy than a definitive managerial concept with specific management tools. The philosophy rests on a few key concepts: client-centeredness, cooperation, care quality, and efficiency and effectiveness. This raises some critical questions: What does integrated care really mean in practice? How does the management of integrated care differ from management in the health care and social sector?

Client-centeredness, cooperation, quality, and efficiency and effectiveness are not merely related to health and social care. They are central to any high-quality management in any sector of value creation. Therefore, if integrated care is defined by these terms, then the management of integrated care can be equated with high quality management of care in general.

So, is the concept of integrate care useful theoretically and in practice? The answer is yes, at least to some extent, because management is not void of appearances. If the use of the concept of integrated care helps health and social care professionals to realize high quality care management, then it is useful. The concept reminds us that we need to improve cooperation in providing care, i.e. to "de-fragment" the care system. This is required in order to make the care system more client-centered and capable of producing high-quality, efficient and effective care.

However, there is a danger that the concept becomes a management fad. To truly benefit from the use of the term "integrated care," we must develop practical structures, institutions, capabilities, and networking tools that support the realization of this philosophy. As Leichsenring (2004) has put it, we may need "pathways to integration instead of a single definition." In other words, we might not need an all-encompassing definition of integrated care, but we need managers to define the pathways to realize integrated – coordinated and cooperative – care in practice.

As a concluding example or illustration of my argument, I propose an adaptation to the Hippocratic Oath that emphasizes the importance of cooperation in health care work:

Hippocratic Oath – Adapted for care integration

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

I will keep in mind that my work influences and is influenced by a wide network of actors, involving the patient, family, and community as well as other actors and service providers relevant to the patient's quality of life and to society at large. I will do my best to manage the patient's care in collaboration with this network.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Modern version of the Hippocatic Oath written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today

(Source: http://www.pbs.org/wgbh/nova/doctors/oath_modern.html). Addition in bold typeface by Timo Järvensivu in 2008.

References

Burns L.R. and Pauly M.V. 2002. Integrated delivery networks: a detour on the road to integrated health care? Business of Health Care, 21, 126-143.

Fleury, M-J. 2006. Integrated service networks: the Quebec case. Health Services Management Research, 19(3), 153-165.

Gröne, O. and Garcia-Barbero, M. 2001. Integrated Care: A Position Paper of the WHO European Office for Integrated Health Care Services. International Journal of Integrated Care, 1, 1-10.

Järvensivu, T. and Nykänen, K. 2007. Conceptualizing networked value-creation and its management in health and social care services in Finland. Paper presented at the 3rd Sendai-Finland Seminar, 2007, Japan. See the article in Part 1 of this volume.

Kassler, W.J. and Goldsberry, Y.P. 2005. The New Hampshire Public Health Network: Creating Local Public Health Infrastructure through Community-Driven Partnerships. Journal of Public Health Management Practice, 11(2), 150-157.

Kodner, D.L. and Spreeuwenberg, C. 2002. Integrated care: Meaning, logic, applications, and implications – a discussion paper. International Journal of Integrated Care, 2, 1-6.

Kümpers, S., van Raak, A., Hardy, B., and Mur, I. 2002. The influence of institutions and culture on health policies: Different approaches to integrated care in England and the Netherlands. Public Administration, 80(2), 339-358.

Lega, F. 2005. Strategies for Multi-Hospital Networks: A Framework. Health Services Management Research, 18(2), 86-99.

Leichsenring, K. 2004. Developing integrated health and social care services for older persons in Europe. International Journal of Integrated Care, 4, 1-15.

Matsuda, S. and Yamamoto, M. 2001. Long-term care insurance and integrated care for the aged in Japan. International Journal of Integrated Care, 1, 1-11.

Mur-Veeman, I., Hardy, B., Steenbergen, M., and Wistow, G. 2003. Development of integrated care in England and the Netherlands: Managing across public-private boundaries. Health Policy, 65, 227-241.

Niskanen, J.J. 2002. Finnish care integrated? International Journal of Integrated Care. 2, 1-10.

Page, S. 2003. "Virtual" Health Care Organizations and the Challenges of Improving Quality. Health Care Management Review, vol. 28, no. 1, 79-92.

Plochg, T. and Klazinga, N.S. 2002. Community-based integrated care: myth or must?. International Journal for Quality in Health Care, 14(2), 91-101.

Provan, K.G., Harvey, J., and de Zapien, Jill Guernsey. 2005. Network Structure and Attitudes toward Collaboration in a Community Partnership for Diabetes Control on the US-Mexican Border. Journal of Health Organization and Management, 19(6), 504-518.

Reed, J., Cook, G., Childs, S., and McCormack, B. 2005. A literature review to explore integrated care for older people. International Journal of Integrated Care, 5, 1-8.

Vaarama, M. and Pieper, R. (Eds.) 2005. Managing Integrated Care for Older Persons: European Perspectives and Good Practices. Stakes and European Health Management Association, Gummerus Printing, Saarijärvi.

van Raak, A., Paulus, A., and Mur-Veeman, I. 2005. Why do health and social care providers co-operate? Health Policy, 74, 13-23.

Whetten, D. A. 1981. Interorganizational relations: A review of the field. Journal of Higher Education, 52, 1-28.

The City-level Policies and their Targets in Vantaa

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Introduction

Vantaa is the fourth largest city in Finland and is located in the Helsinki metropolitan area. The population of the city is growing substantially and, although today it is demographically rather young, the proportion of older people is growing. The ageing of the population during the coming years will increase the challenges faced by the municipality in providing services as it has only limited resources. While today the city has to invest in schools and children's day care centres, it also has to start to increase its service provision for the growing elderly population. The speed of growth of the elderly population in Vantaa is high in comparison to other municipalities in Finland. The number of people older than 75 years will grow in the coming years by 5 per cent annually. In the next decade the rate of increase will accelerate[12]. In order to prepare for the coming demographic changes, a clear strategy with concrete objectives is needed.

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[12] Vantaa Statistics and Research:
http://www.vantaa.fi/i_perusdokumentti.asp?path=1;2075;6962;22200&voucher=50CB
D5E5-A5C3-4367-9089-7EC529D366B7

National Framework for High-Quality Services for Older People

Finnish public services are highly decentralised and municipalities have the main responsibility for providing health care services to their residents, as well as other basic services such as education and social services. In addition, municipalities have a large amount of freedom to decide how to arrange services. At the state level regulation takes place mainly through legislation. However, central government puts a strong emphasis on steering municipalities by providing them with information. One form of information guidance is the National Framework for High Quality Services for Older People[13], which was first issued by the Finnish Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities in 2001. Its publication was expedited by reports from different parts of the country, which revealed variations in the quality of care between municipalities and even severe shortcomings in the care of the elderly people, especially in institutions. A revised framework was issued in 2008.

The framework helps municipalities to develop their services for older people based on local needs and available resources. In particular, it emphasises co-operation between the various sectors of a municipality's organisation and social and health care service providers who work in the independent sector. It is meant to be used by decision-makers and managers in municipalities as a means for developing services for older people.

One of the cornerstones of the framework is a local old age strategy, which municipalities are required to draft and integrate into their municipal budgets and budget plans. The strategy should be developed in collaboration with clients, their relatives and other local residents. Its implementation must be regularly assessed and monitored.

A second cornerstone of the framework focuses on action that prevents illness and promotes health and well-being in general. The promotion of health and welfare means encouraging healthy lifestyles and preventing diseases, supporting independence and providing a sense of security. Early intervention to combat failing health and functional capacity combined with effective treatment and rehabilitation is emphasised. Municipalities will also have to build up their expertise in geriatrics and gerontology.

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[13] http://www.stm.fi/Resource.phx/publishing/documents/15164/index.htx

The framework sets quantitative targets for an ideal service structure for services for the elderly. Municipalities can use these standards when making their own targets and investment plans for the future. In addition, the guideline includes required minimum staffing levels for different forms of 24-hour care services.

Although the recommendations and the standards are not binding norms, regulatory bodies (State Provincial Offices) have based their decisions on the guiding principles set out in the framework. Thus, in practice the framework has stronger significance than traditional information steering.

Currently in Vantaa, there is no strategy for the elderly as outlined in the framework. It will be drafted during 2009.

The framework for Vantaa's strategic guidance

As there is no old-age strategy in the city of Vantaa, elderly care strategic objectives are included in the balanced strategy of Vantaa[14]. Vantaa's balanced strategy consists of its mission, that is, the city's obligations and tasks; its vision, that is, the future the city desires; the city's values; and a city-level balanced scorecard (Figure 1). This balanced strategy is part of the city's financial plan, which is approved by the city council annually.

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[14]

http://www.vantaa.fi/en/i_perusdokumentti.asp?path=110;11351;8074;8062;44868;73489

City of Vantaa's strategic objectives
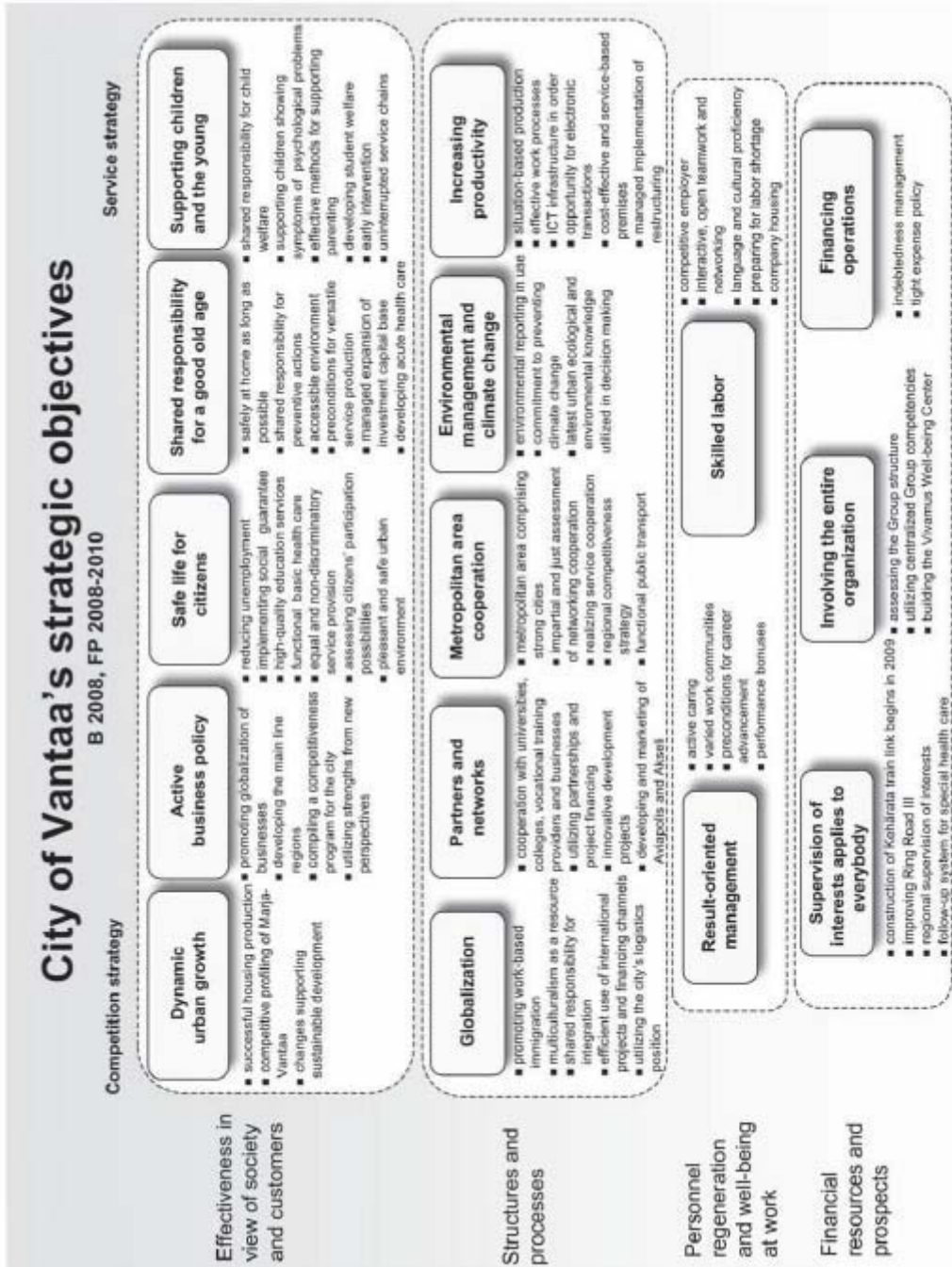
B 2008, FP 2008-2010

Figure 1. City of Vantaa's strategic objectives 2008−2010

The scorecard consists of medium-term objectives: critical success factors that are essential for the vision to come true. Critical success factors and annual target levels are assessed from four different points of view: Effectiveness as seen from the point of view of society and customers; structures and processes; personnel regeneration and well-being at work; and financial resources and prospects. Vantaa's balanced strategy is being implemented through each department's balanced scorecards.

In addition to the strategic planning included in financial planning, development plans (policy) and implementation programmes are being compiled. The strategy (or policy) for the elderly is an example of this type of policy document. Typical of these documents is the reassessment of present operations as well as the compilation of development proposals and outlines. In case of reallocation or the additional need for resources, development objectives are included in strategic planning, that is, as part of financial planning.

A shared responsibility for a good old age

The strategic goal of elderly care in the city of Vantaa is to ensure its elderly citizens a good and safe old age by respecting their independence and supporting their functional capacity and full participation in society

A shared responsibility for a good old age constitutes the core of the elderly care policy in the city of Vantaa. It means that all sectors and actors have to take responsibility for the ageing population in their plans and policies. Arranging services for the elderly population is not the sole responsibility of the social and health care sector as all sectors will have to contribute. This is due to the fact that resource increases will not match the growing needs of the elderly population. Thus, the social and health care sector has to focus on activities requiring its special expertise. This core objective also has to reflect the wide variety of needs the elderly population has.

The principle of normality means that all services that are available to residents of the city should be accessible to the elderly population as well. In fact, the majority of old people require similar services to the rest of the population. All normal services have to be customized in a way that they are suitable for the elderly. Normality also means that general needs come before special needs. Services that are available to all residents are primary and services that are specially designed for the elderly are secondary. In the future, this critical success factor will be guided by the strategy for the elderly. Regardless of preventive and multi-

sector work, the rapid rise in the number of the aged will significantly increase the need for special health and social welfare services. Home care services and housing services will also be provided to an increasing number of customers. Likewise, there will be a growing need for long term care services.

The criteria for the assessment of critical the success factor (A shared responsibility for a good old age) will be outlined in the following chapters.

Living safely at home as long as possible

The objective that elderly Vantaa residents should be able to live safely at home for as long as possible is an objective that is included in most elderly care policies and may sound obvious. However, until recently the proportion of elderly people living in institutions or similar settings in Vantaa has been high compared to other big cities in Finland (Kumpulainen 2007). The majority of placements into nursing homes and residential care homes usually takes place after an acute severe illness and a period of hospital care (see below). The care and rehabilitation that is given in hospital and the decisions thereafter have an important effect on whether the patient returns to his or her own home or is discharged to a nursing home. In addition, increased use of intoxicants, psychological problems, and a reduced feeling of security can constitute significant threats to old people's capabilities and ability to cope independently. Safe living at home is also promoted by services other than those provided by the Health and Social Welfare Department. The key services that play a central role in the everyday lives of the elderly consist of housing, transportation and local services, as well as sports and cultural services. In Vantaa, our goal for the coming years is that 92% of residents over 75 will live in their own home or in service housing. At the end of last year, the proportion was 91.1%.

A shared responsibility for preventive actions

One of the objectives for the budget for the year 2008 is that co-operation between departments should be increased in order to promote the well-being of the elderly. The city's meeting facilities are increasingly offered for use of the elderly. When planning services for the elderly, one must keep in mind that the needs of people at different ages and in different conditions vary to a great extent. Only a quarter of those over 75 years are included in special services, which can be la-

belled "for the aged". The task of the social and health care sector is to promote preventive actions within the area of its expertise, i.e. establish high (flu)vaccination coverage, reduce the known risk factors of cardiovascular diseases (high blood pressure, high cholesterol, smoking, obesity), promote healthy dietary habits (prevent malnutrition) and prevent falls. It is the Sports Sector, on the other hand, that has the responsibility of promoting elderly residents' physical activities. The co-ordination of service provision for the elderly must be developed, so that a customer's overall situation is always managed and the services provided are based on the customer's current service needs.

Accessible environment

The vision of the City of Vantaa's Accessibility Strategy, completed in 2007, is to offer every citizen a freely accessible environment, which supports living at home and independent coping. If services are accessible this enables participation and promotes physical, psychological and social safety. A general absence of obstacles in a local environment can allow older people to retain their independence and autonomy for longer. The accessibility strategy requires, among other things, that planning instructions are revised in such a way that the accessibility perspective is taken into account. One example of an inaccessible environment is a lack of lifts, which boosts the demand for service housing. In Vantaa, more than 700 apartment buildings with 3 to 4 floors have no lifts. However, the Housing Fund of Finland (ARA) and the City of Vantaa's housing loan fund grant subsidies for fitting lifts into old apartment buildings. The subsidy amounts to a maximum of 60% of the costs. During the past few years, 1 to 3 lift projects have been carried out in Vantaa per year, which is not sufficient to tackle the problem.

The preconditions for versatile service production

The city of Vantaa has the responsibility of arranging the services for its elderly population. There are several options for carrying out this task. The city does not have to produce all its services. However, there are services that the city will also finance and produce in the future. These are, in general, the core functions of social and health care. There are, however, services that are increasingly financed by the city, but are produced by an independent provider. Finally there are

services that the city only promotes, the service being produced by a private provider and financed by the residents themselves. The services must form a well-functioning, efficient, innovative and flexible entity where the services are managed at all times. Service provision should also search for regional solutions. Different actors should work together to ensure that elderly Vantaa residents are given enough information about the range of service options available.

Developing acute care

As mentioned earlier, the care and rehabilitation that takes place in hospital during an acute illness has an important effect on whether the patient returns to his or her own home. According to a study conducted in the Helsinki metropolitan area (Mäkelä et al. 2006), elderly patients returned less often to their own homes after an acute episode in hospital in Vantaa than in other metropolitan cities. In the Finnish two-tiered health care system, in-patient care is provided in secondary care as well as in the wards of health centres. As secondary care aims to raise the efficiency of its work it is attempting to reduce the length of patients' stay in its hospitals. It is known that the recovery of old patients takes longer than that of younger ones. Consequently, the ageing of the population means that a patient is more often transferred from a secondary care hospital to health centre wards for rehabilitation.

As a response to increasing pressures from secondary care hospitals, we have opened an acute geriatric care unit this year. It consists of a geriatric acute assessment ward and a 'hospital at home' arrangement. The work of the unit is based on quick assessments and effective care and rehabilitation from the very beginning. The 'hospital at home' will support a quick return to home for patients after a period of care in the acute geriatric ward. In some cases, hospital care can be taken, by the 'hospital at home', from the very beginning directly to the patient's home or, for instance, to a nursing home. The unit has geriatric expertise that does not exist in secondary care hospitals. The central aims of the new unit are quicker rehabilitation, the return to home of patients, a reduction in the number of needless hospital transfers and a reduced need for long-term care in an institution.

In conclusion

In addition to the challenges caused by the increasing service needs of the elderly population, the city will face new challenges as the financial outlook of the city and the whole nation is becoming gloomy. Vantaa has been steadily recovering from the mild economic depression of the early 2000s when its annual margin became negative in 2003. As state subsidies decrease, the municipality's economy becomes ever more sensitive to changes in local tax revenues because health and social care services are mainly financed by local taxes. Thus, while there are few economic buffers and raising tax rates is not an attractive option for decision-makers, taking out loans becomes the only alternative for the city. As a matter of fact, the municipal dept per resident ratio is much higher in Vantaa than in other cities of the Helsinki metropolitan area.

The social and health care expenditure of the City of Vantaa has increased by 5 to 7 per cent annually between 2001 and 2006[15]. The latest forecasts predict that the annual increase will be around two percent for the coming years, which does not even cover the average increase in wages and other costs, not to mention the rising service needs. It seems that, in addition to a strategy for the elderly to cope with the demographic challenge, we now need a survival strategy to overcome the financial challenge as well.

References

Kumpulainen, A. 2007. Kuuden suurimman kaupungin vanhusten sosiaali- ja terveyspalvelujen ja kustannusten vertailu. Kuusikko-työryhmän vanhuspalvelujen asiantuntijaryhmä. Kuusikko-työryhmän julkaisusarja 5/2007. http://www.kuusikkokunnat.fi/SIRA_FILES/VH2006.pdf. (In Finnish)

Mäkelä, M., Häkkinen, U., Juslin, B., Koivuranta-Vaara, P., Liski, A., Lyytikäinen, M., and Laine, J. 2007. Sairaalasta kotiin asti. Erikoissairaanhoidosta alkaneet hoitoketjut pääkaupunkiseudun kunnissa. Stakesin työpapereita 3/2007. Sosiaali- ja terveysalan tutkimus- ja kehittämiskeskus, Helsinki.

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[15] Approximately 5% in municipalities in Finland on average

http://www.stakes.fi/verkkojulkaisut/tyopaperit/T3-2007-VERKKO.pdf. (In Finnish)

City-Level Policies and their Targets in Espoo

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Introduction

The City of Espoo has actively reformed its elderly care in recent years. With 250,000 residents, Espoo is the second-largest city in Finland. Ten per cent of residents are aged 65 years or older, with one third living alone.

The first Elderly Policy Program of the City of Espoo was approved by the City Council in 2002. Its leading principles were:

– Living at home is a priority, regardless of the decline in handling daily activities.
– Service provision is based on preventive and rehabilitating efforts.
– 24/7 care is delivered in home-like living environments.
– Hospital care focuses on acute care and geriatric rehabilitation.

These principles are still of current interest. However, new basic principles have emerged for the development of services for the elderly (Table 1).

Table 1. Basic principles for the development of services for the elderly in the City of Espoo

Successful aging in a sociocultural context

Self-determination ("citizens have the right to decide")

Empowerment of the elderly (seeing the elderly as subjects rather than objects)

From organisation-centredness towards genuine client- and family-centredness

From narrow functional-capacity thinking towards a more holistic view aiming for high quality of life

Implementation of effective means for preventive care and new forms of care

Integration of services

Supporting elderly citizens living at home

Long-term care in home-like surroundings

Application of new technology

Continuous quality improvement

Involvement of senior citizens

Development towards a value-generating system

New Aging Policy Program

The process of updating the Elderly Policy Program lasted more than one year. Elderly citizens and all other essential partners were involved. The process has been described previously in more detail (Valvanne 2007).

The mission of the new Aging Policy Program is in line with the city's mission: "The City of Espoo creates opportunities for good quality of life". The program's vision is "Full life in old age". The aim of the program is to change the service culture. The frame of reference is shown in Figure 1.
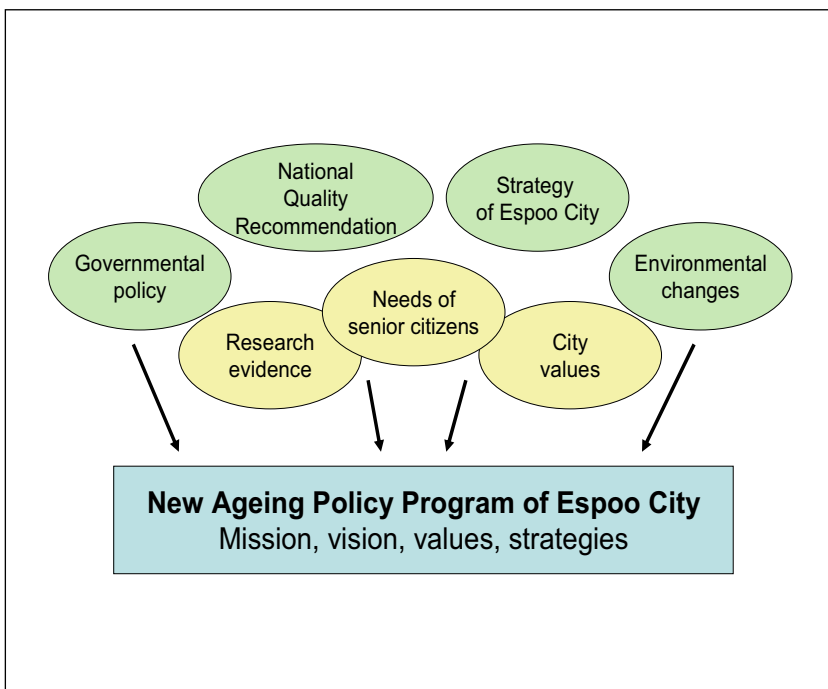
Figure 1. Frame of reference of the new Aging Policy Program

The new policy is based on the strategic values of the City of Espoo and on shared responsibility between different actors (Figure 2). Senior citizens and their families are at the centre. There will be a mix of municipal and private services (welfare mix).
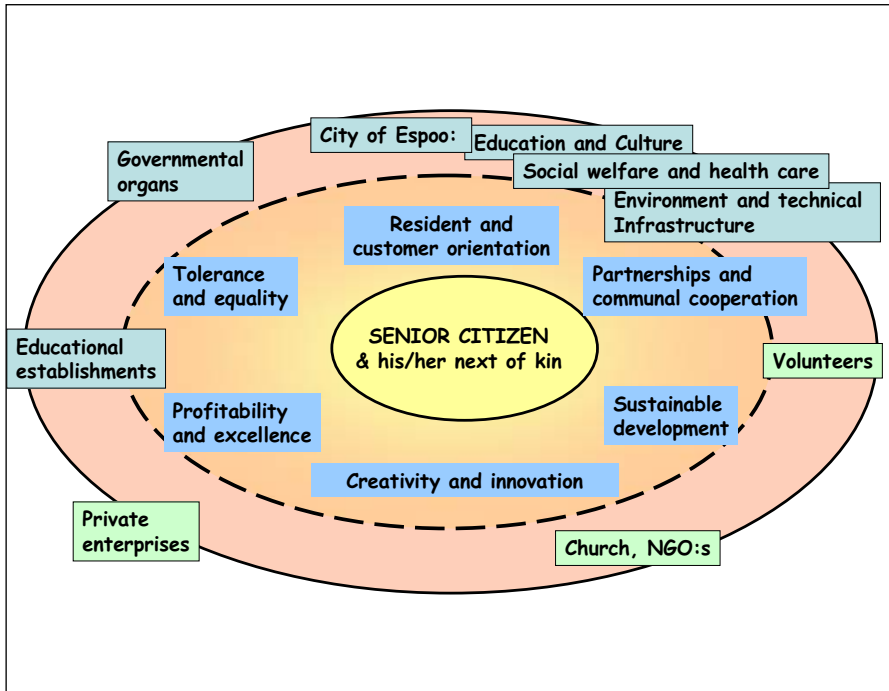
Figure 2. Values and actors of the new Aging Policy Program

The main strategies and goals of the program are shown with examples of planned actions in Table 2.

Table 2. Main strategies, goals and examples of planned actions of the New Aging Policy Program

Strategy	Goals	Examples of planned actions
Senior citizens build their own lives	Senior citizens choose between existing versatile services	New services are developed together with seniors.
		Ways to produce services are multiplied.
		The use of service vouchers is promoted.
The capacities and resources of seniors enrich the lives of fellow citizens	Seniors are encouraged to use their resources to benefit common welfare	Clear structures of voluntary work for seniors are developed.
		Expertise of senior volunteers is publicly available.
		Neighbourly help is activated.
		Foster grandparent services are developed for kindergartens and schools.
Barrier-free and functional environment	Living environment supports the independent life of seniors	Routes between services and living areas are surveyed and assessed.
		Citizens are actively informed about the possibilities of building elevators in old apartment buildings.
		The functionality of the home environment is systematically evaluated as a part of home care assessments.
Living at home is prioritised and supported by sufficient services	Enough services are provided for seniors to live at home longer than they do today	The service system for the elderly is reformed into a client-centred, flexible, integrated whole (Figure 3).
Living in Espoo is safe for seniors	Seniors get enough support not to feel mentally, socially or economically unsafe to an unreasonable degree	Safety of the physical environment is improved (traffic safety, fire safety, outdoor lightning, home safety assessments).
		Early intervention in mistreatment of seniors is emphasised.
		Adequate services of geriatric social work are ensured.

Health and well-being of seniors is systematically promoted	The quality of life of seniors in Espoo will improve	Preventive services are developed based on the needs and wishes of senior citizens.
		Early intervention in seniors' alcohol abuse is emphasised.
		Identification of symptoms and care of depression are improved.
Seniors get the information and care they need easily	Accurate information on services will be available through various channels	Information is easily available both on the internet and in printed form.
		Personal advice is readily available to seniors.
		Regional forums for senior citizens are held regularly.
Seniors participate and interact	The social networks of seniors will strengthen	Group activities and participation possibilities are promoted.
		Opportunities of seniors' organisations to have meetings are improved by offering rooms in public facilities.
	Seniors will have possibilities to make new friends and feel less lonely	Lonely elderly are actively sought out and early interventions are targeted to them.
Technology supports independent living	Technology is a part of everyday living and seniors use multiple welfare technology solutions	Implementation of welfare technology and related consulting are appraised systematically as a part of individual home care assessments.
		Virtual communication networks are developed and supported.

The elderly are encouraged and supported in maintaining their health and functional ability. The prerequisites of independent aging are shown in Figure 3.
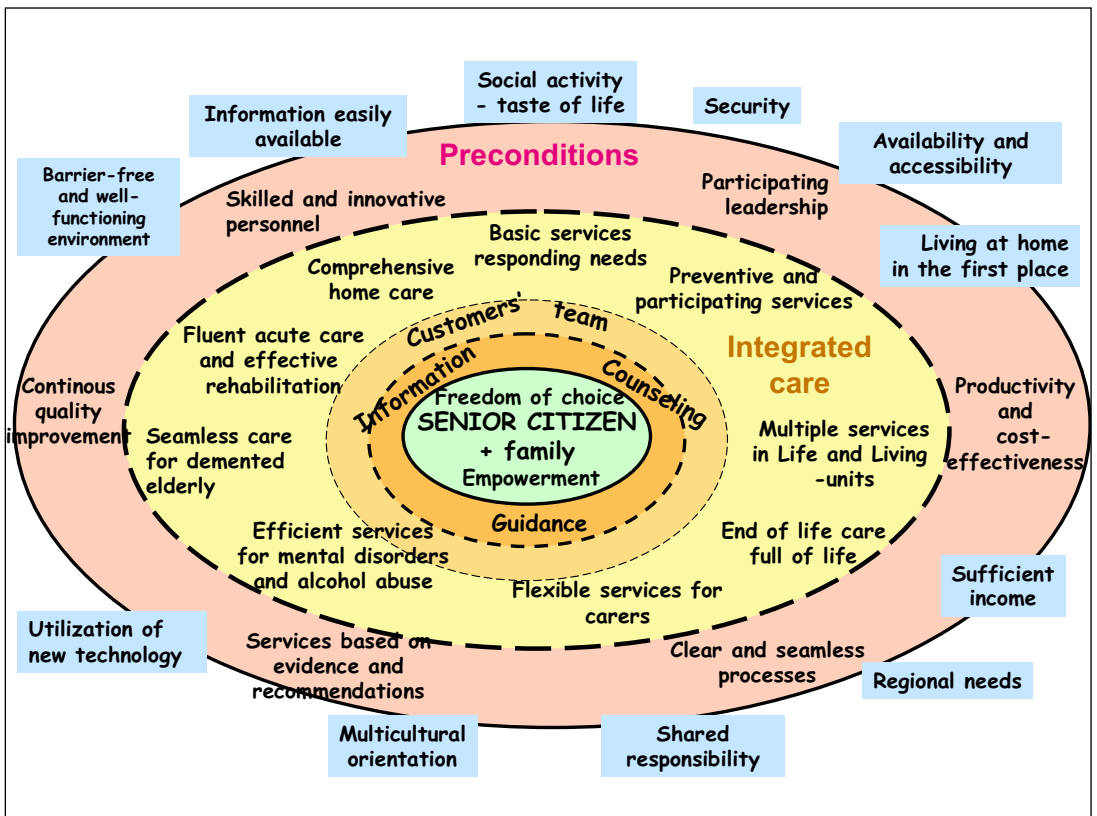
Figure 3. Preconditions for independent living in Espoo

The service system for senior citizens will be reformed into a more client-centred, flexible and integrated whole. The promotion of well-being and early interventions will be systematically developed. The acute care process should be fluent and rehabilitation, effective. Multilevel institutional long-term care will gradually shift to single-level housing and care under the name of "Life and Living". A service centre for the elderly will be included in the units, giving the residents more possibilities for participating in everyday life.

When aiming at high quality, productivity and efficiency, good leadership and skilled personnel are needed. The services should be based on evidence. Continuous quality improvement should take place throughout the system.

All elderly clients should be able to live a full life while using the services. To achieve this, the care and work communities should be full of life, and love should be the working language (Figure 4).

LOVE as working language

Working community: FULL OF LIFE
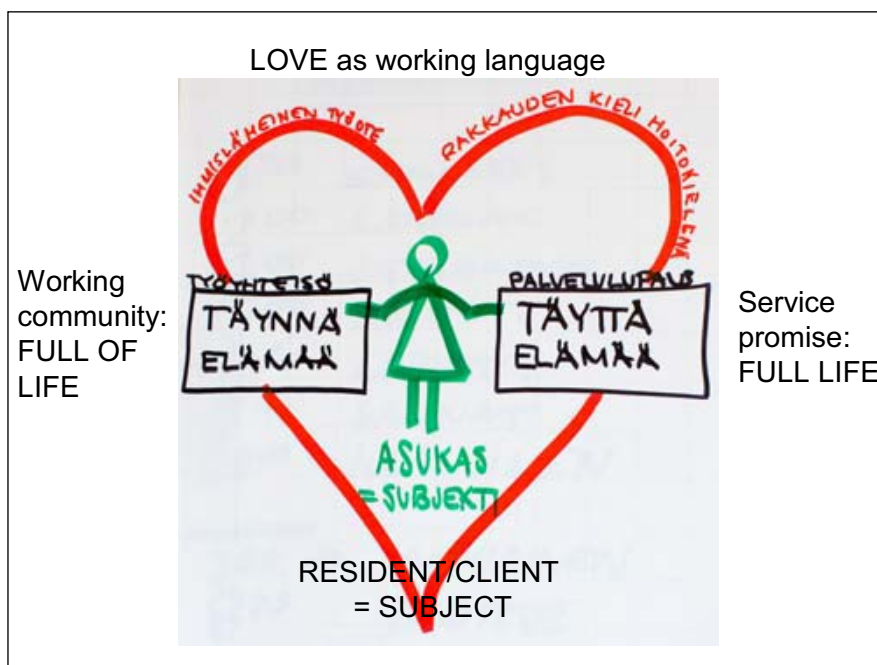
Service promise: FULL LIFE

RESIDENT/CLIENT = SUBJECT

Figure 4. New service concept

The new work culture will be created interactively, with contributions from everyone – clients, carers and employees alike.

References

Valvanne, J. 2007. Reforming Elderly Care in the City of Espoo. Paper presented at the 3rd Sendai-Finland Seminar, 2007, Japan. See the article in Part 1 of this volume.

Ageing Contributes to Ageing

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Introduction

In recent a hundred years, population of over 65 years old has been growing with unprecedented rapidly in human history accompanied with economy and ecology changing. It is said that, in step with the aging of the population, many advanced countries are facing various social problem[16].

In this work, we propose that the utilization of elder's resources based on their experience and knowledge is important to solve the problems and stabilize the aging society by using non-linear theory. The non-linear theory is used in complex system, where interactions between elements are non-linear, i.e., the interaction are not proportional to their actions. Social system is also nonlinear system, because element of the system and interaction among elements are also nonlinear and very complex. Thus, applying non-linear theory for the social system is pertinent.

First, we show that resource production by expenditure inhibits fluctuation of expenditure population and resources from the Lotka−Volterra model.

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[16] For example, "The Global Aging Problem",
www.terradaily.com/reports/The_Global_Aging_Problem_999.html

Next, applying the Lotka−Volterra model to aging society, we describe the resource from elder people from life-cycle of organism.

Result and Discussion

To make framework of aging society, we used the Lotka−Volterra model. The model is applied to the prey-predator relationship and represented as

dx/dt = Ax - Bxy

dy/dt = - Cy + Dxy

where x, y and t indicate number of resource, number of expenditure and time, respectively, and A is a creating resource rate by resource, B is a expending resource rate by expenditure, C is a dyeing rate of expenditure and D is a using resource rate by expenditure. Bxy and Dxy mean
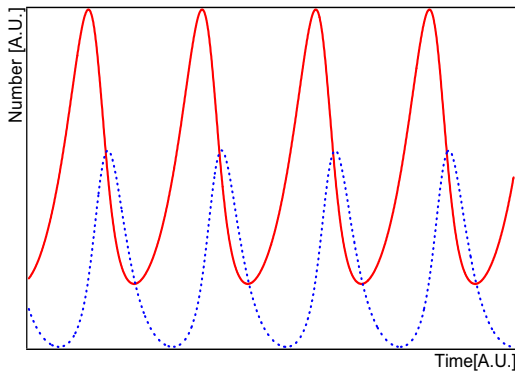

Figure1. The number of source and expenditure as a function of time. Solid and dashed lines indicate source and expenditure, respectively.
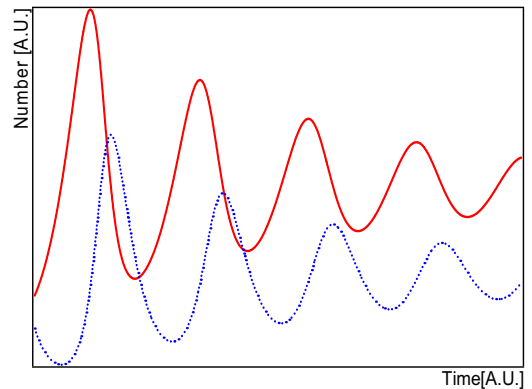

Figure2. The number of source and expenditure as a function of time. Solid and dashed lines indicate source and expenditure, respectively.

encounter rate of resource and expenditure and these are non-linear term. To calculate Lotka−Volterra equation, we employ the Runge−Kutta method[17]. The method is used to numerical calculation generally and we can get a relatively

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[17] See for example, "Numerical Recipes in C", W.H. Press et al.

high precise solution. A source of the calculation program is displayed in Appendix.

Figure1 shows the number of resource and expenditure as a function of time, which is the solution of the Lotka−Volterra equation. Solid and dashed line indicates the number of resource and expenditure, respectively. This solution is often compared to a relationship of rabbits and foxes. On the one hand, when there are a lot of rabbits, the number of fox increases by eating rabbits and thus the number of rabbit decrease. On the other hand, as rabbits decrease enough, there is no food for foxes and hence the number of fox begins to decrease and then the number of rabbit increase because the probability of eating by fox decrease. As a result, an oscillation of the numbers occurs. We believe that this model is very unfair because fluctuation of the resource is so large that there are great differences between generations.

To decrease the differences, we add a term of creating resource by expenditure to the Lotka-Volterra equation and the equations are represented as

$$dx/dt = Ax - Bxy + Ey$$

$$dy/dt = - Cy + Dxy$$

The last term of the upper equation is the creating term. This term is interpreted as productions of resource by expenditure. The solution of the equation is displayed in Fig.2. Figure 2 shows that the fluctuation of resource and expenditure decrease with elapsing time and saturate. This means that the fluctuations become suppressed by resource creating from expenditure.

We apply this model to the aging society, namely older people are expenditure and social resources produced by younger people are resource. In this model, the key for realizing a small fluctuation system is resources given by older people. Here after, we describe about resources from older people.

In generally, the purpose of an organism is to leave offspring. Thus, the most important phase of life cycle of organism is reproduce phase and hence all functional abilities become most developed in the phase. However, as one has passed the phase, since importance for leaving offspring decreases, functional abilities degrade and mortality rate increases with rising predation risks. It is important for next generations to die older from a point of view of strategy of resource distribution because the resources are limited and should be used in the reproduction phase. Is there no merit for existence of older? The answer is no. Elder's experiences are important source of knowledge for the next generation.(e.g. In migrant bird group, the oldest bird becomes the leader because of

its experience.) So, it is worth to leave a response number of older individual. In addition, human has the extremely long period after the reproduction phase (about 30 years) by comparing with other animals (e.g., crow has about 3 years and chimpanzee is 8 years). This means that humans may bring down more information for offspring than other organisms and the information are based on their experience and tradition. However, their knowledge is beyond modern technology because experiences are built upon complicated interaction between one and one's environment and thus those are non-linear. Therefore, utilization of the elder's experience-based knowledge is a key of optimizing social system.

This contribution from older to younger consists with a stabilization condition of a system in the non-linear theory, which indicates that, if a system can stabilize, "existence of a system" contributes to "existing to the system". In this case, the condition is that aging contribute to aging by giving knowledge form older to younger.

Summary

In summary, we describe a stabilized condition of aging society from a point of view of the non-linear theory. We show that knowledge based on elder's experiences and their tradition become very important resource for young generations and stabilize the aging society. However, since the knowledge is beyond modern technology, we can't use it effectively. Thus, it is important to find out the effective usage of the knowledge as resource.

Appendix

The source of the calculation program (Visual Basic 6.0)

```
Dim a As Double
Dim b As Double
Dim c As Double
Dim d As Double
Dim e As Double
Dim delta As Double
Dim deltaf1 As Double
Dim deltaf1a As Double
```

```
Dim deltaf1b As Double
Dim deltaf1c As Double
Dim deltaf1d As Double
Dim deltaf2 As Double
Dim deltaf2a As Double
Dim deltaf2b As Double
Dim deltaf2c As Double
Dim deltaf2d As Double
Dim f1 As Double
Dim f2 As Double
Dim total As Double

Dim Filename As String

Private Sub Command1_Click()
total = 0
a = Val(Text1.Text)
b = Val(Text2.Text)
c = Val(Text3.Text)
d = Val(Text4.Text)
e = Val(Text5.Text)

delta = Val(Text6.Text)

Filename = "C:\keisan\keisan" + Str(a) + Str(b) + Str(c) + Str(d) + Str(e) + "Runge.txt"

f1 = Val(Text7.Text)
f2 = Val(Text8.Text)

Open Filename For Append As #1
  Print #1, total; f1; f2
Close #1

Do
deltaf1a = fx(a, b, e, f1, f2) * delta
deltaf2a = fy(c, d, f1, f2) * delta

deltaf1b = fx(a, b, e, f1 + deltaf1a / 2, f2 + deltaf2a / 2) * delta
deltaf2b = fy(c, d, f1 + deltaf1a / 2, f2 + deltaf2a / 2) * delta

deltaf1c = fx(a, b, e, f1 + deltaf1b / 2, f2 + deltaf2b / 2) * delta
deltaf2c = fy(c, d, f1 + deltaf1b / 2, f2 + deltaf2b / 2) * delta

deltaf1d = fx(a, b, e, f1 + deltaf1c, f2 + deltaf2c) * delta
deltaf2d = fy(c, d, f1 + deltaf1c, f2 + deltaf2c) * delta

deltaf1 = (deltaf1a + 2 * deltaf1b + 2 * deltaf1c + deltaf1d) / 6
deltaf2 = (deltaf2a + 2 * deltaf2b + 2 * deltaf2c + deltaf2d) / 6
```

```
f1 = f1 + deltaf1
f2 = f2 + deltaf2
total = total + delta

Open Filename For Append As #1
  Print #1, total; f1; f2
Close #1

If total > 2000 Then End

Loop

End Sub

Public Function fx(ByVal fa As Double, ByVal fb As Double, ByVal fe As Double,
ByVal ff1 As Double, ByVal ff2 As Double) As Double
fx = fa * ff1 - fb * ff1 * ff2 + fe * ff2
End Function

Public Function fy(ByVal fc As Double, ByVal fd As Double, ByVal ff1 As Double,
ByVal ff2 As Double) As Double
fy = -d * ff2 + c * ff1 * ff2
End Function
```

Managing Integrated Care Networks (ICNs): Towards a More Contextual and Social Perspective of ICN Development

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Networks, network management and integrated care: A brief review of previous studies

In our previous studies (Möller et al., 2006, Järvensivu et al., 2007, Järvensivu and Nykänen, 2007, Järvensivu and Nykänen, 2008), we presented our conceptual understanding of networks, network management, and integrated care. In this section, we briefly summarize these core ideas.

Networks and network management

Networks are one of three general governance modes — along with markets and hierarchies — that govern social life (Thompson et al. 1995). A network may be defined as a group of autonomous actors that have repeated, enduring relations in order to achieve some stated or un-stated objective(s), while lacking a legitimate authority that resolves disputes that may arise among actors (Podolny and Page 1998). Networks are coordinated through trust-based relations,

whereas markets are coordinated through competitive exchange relations and hierarchies through contractual relations.

Networks, markets, and hierarchies differ in terms of how they are (and can be) managed. However, as we have argued previously (Järvensivu and Nykänen, 2008), the three governance modes are fundamentally similar in the sense that they are all value-creating systems. That is, the primary purpose of their existence is the creation of value for the actors involved. Improving effectiveness and efficiency requires four types of managerial activity:

1. Planning what value is to be created and how this value should be created;

2. Organizing patterns of actors, resources, and activities that are needed to create the value as planned;

3. Obtaining commitment from the actors to carry out the required value-creating activities; and

4. Controlling value efficiently as planned and carrying out corrective measures if needed.

We suggest that these managerial requirements are universal to any mode of governance, but they are resolved differently in each mode. In networks, management can be summarized as the functions of framing, activating, mobilizing, and synthesizing (Järvensivu and Nykänen, 2008) respective to the above managerial requirements. These functions cannot be enforced by a single actor in a network; rather, they are defined by continuous interaction, negotiation, and re-negotiation among networked actors. In networks, no one has final authority on how value creation is planned, organized, led, and controlled. Network management functions can be carried out using a wide range of management mechanisms or tools (Figure 1). Each tool can perform one or more functional roles at a time, and each function may be carried out using one or more tools.

Network management functions

Network management mechanisms/tools	Framing	Activating	Mobilizing	Synthesizing
1. Communication, decision and negotiation mechanisms	X	X		
2. Social coordination and control	X	X	X	
3. Integration and linking roles and units				X
4. Common staff			X	
5. Hierarchy and authority relations		X	X	
6. Planning and control systems		X		X
7. Incentive systems	X		X	X
8. Selection systems	X	X		
9. Information systems	X			X
10. Public support and infrastucture	X			

Note: X's are used here only as examples; in reality each management situation is different with regard to the X's. The purpose of this figure is to show that the management functions can be carried out through one or several several management mechanisms/tools, and that each mechanism/tool can perform one or several functional roles.

Figure 1. Relations between network management functions and mechanisms.

The manageability of each network depends on the characteristics of the network (Harland and Knight 2001, Möller et al. 2005). Some networks are more tightly coupled, involving a known set of players that have well-organized relations; these networks can be managed to a reasonably high extent. Some networks, on the other hand, are loosely coupled, involving a higher degree of uncertainty and lack of organized coordination; these networks are rather unmanageable.

Integrated care

Integrated care can be defined as the processes of coordination to achieve seamless and continuous care, tailored to patients' needs using a holistic view of the patient (Mur-Veeman et al. 2003). This definition of integrated care points toward a network perspective of value-creation: integrated care is the result of coordination within a network or value-creating actors, activities, and resources (Lega 2005, Page 2003, Kassler and Goldsberry 2005, Provan et al. 2005). In our previous work (Järvensivu et al. 2007), we identified 11 key dimensions of integration:

1. Care process

2. Scope of services

3. Formality of care (formal or informal)

4. Pro-activity and re-activity of care

5. Intensity of care

6. Duration of care (acute or non-acute)

7. Centrality of activity in care production (core and support activities)

8. Level of integration (macro-, meso- or micro-levels)

9. Values of the actors (similar or dissimilar)

10. Empowerment of end-customers as co-creators of value (customers as objects vs. subjects)

11. Search for efficiency vs. effectiveness; current value production vs. innovation

We argue that the integration of care can proceed along any of these dimensions. Quite often, integration is defined through Dimensions 1 or 2, but we propose that the other dimensions are as relevant, because each partly determines how effective and efficient the care production system can be. In other words, if integration is lacking in one dimension, then it is likely that the care production system will be sub-optimal in providing high quality of care and/or performing efficiently.

Key elements of ICN management

In light of the above discussion, managing an integrated care network (ICN) can be defined broadly as integrating a care service network — with its various value-creating dimensions — through the managerial functions of framing, activating, mobilizing, and synthesizing. Figure 2 illustrates an ICN management framework. Each cell in the matrix addresses a specific managerial challenge in the ICN. A variety of specific management tools can be used to resolve these challenges, and a single management tool can satisfy numerous managerial requirements of one or more cells simultaneously.

Figure 2. ICN management framework.

The challenge of an ICN manager is to use this management framework to gain understanding of the challenges of the specific ICN in question. The ICN manager must build an optimum portfolio of management tools to handle the various challenges – optimum in the sense that the portfolio needs to effectively address the key challenges of ICN integration while satisfying efficiency requirements (such as simplicity, cost-effectiveness, and measurability).

The ICN management framework described herein provides general guidelines, but we question whether the framework truly addresses the daily problems of a network manager. In the next section, we address some of the limitations of the framework through a few case studies.

Critical analysis of the ICN management framework: Case studies

The ICN management framework presented in the previous section is the result of both theoretical reviews and empirical studies (Möller et al., 2006, Järvensivu et al., 2007, Järvensivu and Nykänen, 2007, Järvensivu and Nykänen, 2008). Al-

though these reviews and studies provide support for the framework, it remains fairly general; we still lack understanding of how the framework can be applied in practice. To this end, Helsinki School of Economics (HSE), in collaboration with Laurea University of Applied Sciences and the elderly care units of the city of Espoo and the city of Vantaa, has started a new research and development project on network management. The project is called *Driving change in the welfare services for the aged* (translated from the Finnish name "Muutosvoimaa vanhustyön osaamiseen") and is funded by the European Social Fund (ESF) for the period of 2008 to 2010. The general aim of this R&D project is to develop elderly care services in Espoo and Vantaa, learn from this development work, and disseminate the results of the project to a wider practice-oriented and academic audience in Finland and abroad.

From the perspective of ICNs, the project aims to improve the integration of care service networks in the two cities as well as develop city-level network management capabilities. Methodologically, the project follows an action research perspective, which means that the researchers from HSE and Laurea are not mere observers but participate in actual development work in the cities of Espoo and Vantaa. The aim of this methodology is to tap into the potential of interactive learning: both the researchers and the city-level workers are expected to learn from working together; this should improve the quality as well as relevance of the R&D results. Although the R&D work is still at its beginning stages, we are already able to address some of the limitations of our ICN management framework. These limitations will be described in the following sections.

Case 1: Network management training in Vantaa and Helsinki

We conducted four separate training sessions for three different audiences based on our network management framework. Two training sessions were held for the staff of the city of Helsinki: one for its adult education center in January 2008 and one for its education department in March 2008. Two sessions were held for the elderly day care unit in the city of Vantaa, one in May 2008 and one in August 2008. These training sessions were actually held before the ESF-funded project began, so they were not included in the project. The general outline of these training sessions, however, followed the same principles as the ESF-project. The core ideas presented in these training sessions were the same: we introduced our basic conceptual ICN management frameworks and then discussed the need for and use of framing, activating, mobilizing and synthesizing networks, including how to use the different types of management

mechanisms and tools to achieve the targets of network management. Written feedback on these training sessions was collected to determine how the training was received by the audiences.

In general, the feedback was mixed. For instance, a reviewer from the January 2008 session called the training "spot on in terms of both content and presentation" for this particular group. The audience also appreciated the presentation of the management tools, which they found "suitable for this and other projects." In the March 2008 session, the primary feelings of the audience were the same, mostly appreciating the content, but they were puzzled in terms of how to apply the knowledge to their daily work.

In contrast, feedback from the May 2008 was mostly negative. While some participants appreciated the abstract level of the presentation, which gave a "birds-eye-view" into the phenomenon of networking, many clearly noted that they did not understand how the abstract frameworks would help them in their daily work, wanting "to get much deeper into the issue." Some further commented that "the presented ideas were too theoretical."

We used this feedback to make the August 2008 session more practice-oriented. The audience, which was the same as in the May session, was encouraged to discuss and apply the concepts to practice through a set of peer-to-peer discussions and problem-based group work. Instead of lecturing conceptually, the audience had the opportunity to contextualize the ideas into their own language and practice. Not surprisingly, the feedback from the August session was much more positive, with only a few participants voicing concerns about the "lack of theory orientation" in the session.

The feedback from the four sessions indicates that network management training must be tailored to the specific occasion and audience. For the January and March sessions, training focused on a general understanding of networks and network management; for the May and August sessions, the focus was on allowing the audience to apply the network management concepts to their own working context.

One plausible conclusion from this experience is that the ICN management framework presented in this paper works well as a general introduction to network management, but we need to work out the details of the framework for more practice-oriented audiences. More specifically, we need to address the following questions:

- What are the relevant contextual factors that one should study in order fully appreciate each unique networking context, so that managerial recommendations can be tailored to the occasion?

- How can the theoretical framework be effectively contextualized, so that it will be more comprehensible for the practicing manager?

Case 2: Networking workshops in Espoo and Vantaa

With our ESF-project partners, we organized three networking workshops in Espoo and Vantaa during Spring 2008. The purpose of these workshops was to develop the services and networks of the two cities. The first workshop was held in Vantaa in March 2008 for 60 persons belonging to Vantaa's elderly care network (public, private, and third-party representatives), with the aim of collecting feedback on the most important topics for our research project. The other two workshops were held in Espoo in April and June 2008 to develop the collaboration between Espoo's home care and disabled care units, which have mutual customers, but their services are not well coordinated.

The first workshop in Vantaa started with a presentation of our current R&D project, including its main targets and the development framework. The aim of this part was to familiarize the participants with the forthcoming R&D work. After the introduction, the audience was divided into five work groups based on four themes: family caregivers, home care (two groups), mutual responsibility for elderly quality of life at the city level, and day care for the elderly. The aim of the work groups was to discuss future challenges, possible remedies, and networks related to the themes. The purpose of the group work was to gather as many R&D ideas as possible to be addressed in the project. The results of the group work were recorded and summarized by a small task force.

The Vantaa workshop was successful in the sense that it introduced the project for a large group of people relevant for the success of the project; it also yielded many good ideas for further development. The workshop itself acted as a management mechanism to frame the network. Most importantly, many new social contacts were made in the workshop, implying a potential for commitment-building. As one of the audience members commented, "We hope to hear from you soon, so that the commitment built in this workshop and its fruits will not die because of lack of further contacts." The results of the workshop were thus mixed: on the one hand, it provided many good results in terms of a collection of R&D ideas, but its full potential in terms of utilizing the commitment and social networks built in the workshop has not been determined yet.

The April and June 2008 workshops in Espoo were organized to develop collaboration between Espoo's home care and disabled care units. These units have partially overlapping services and customers whose status as either a home care client or disabled care client is not always clear; this increases confusion among both the service providers and the clients and undermines care integration. The first workshop was held in April for twelve persons, including representatives from both units. The purpose of this workshop was to discuss key challenges as well as potential solutions. The identified challenges were grouped into six categories: challenges related to resources and services production; service definitions and case management; defining the customer and customer segmentation; collaborative structures between the units; values and attitudes; and external factors such as the legislation. The remedies for these challenges were grouped into four categories: developing the structures of inter-unit collaboration; defining the customer and customer segmentation; defining and developing the joint processes and resources of service production; and defining the responsibility boundaries between the units.

The first workshop was successful in terms of highlighting the mutual challenges and remedies of the two units. Furthermore, the workshop participants agreed that the next stage of collaboration should be to develop their joint service processes; this was selected as the topic of the next workshop in June. The increased awareness of the key issues and jointly agreed-upon next steps raised the participants' commitment toward the collaboration. The most important result of the first workshop, however, was the newly established social connections between the workshop participants, as evidenced by the positive feedback: "we discussed a lot of important issues, but the most important thing for me was to get to know the people in [the other unit] better." These connections will be instrumental in the future development of joint customer services. Some of the workshop participants reported that this was the first time that they had a chance to discuss their mutual problems.

The second workshop, held in June, involved a larger network of people to ensure that all relevant perspectives would be taken into account. The participants comprised eight persons from the disabled care unit, eight from the home care unit, and eight persons representing other actors in the network. As previously agreed, the aim of the second workshop was to define and develop the inter-unit joint process of service production. The second workshop proved successful to the extent that the workshop participants reassured their full commitment to continue the collaboration. Both units readily agreed to continue having monthly inter-unit workshops to further develop the collaboration. Again, the main argu-

ment was that "the personal contacts enabled by the workshops are strongly needed to improve the collaboration."

We can make at least three preliminary conclusions regarding the management of an ICN from these workshop experiences. First, ICN management requires key people to meet with each other. It is paramount to organize collaborative structures that enable continuing discussion. Such structures may include weekly or monthly discussion forums, meetings, workshops, or other events with an opportunity to discuss and negotiate. Other possibilities include employing joint staff and discussing online on the Internet. Second, the discussions between the meeting units require a well-prepared facilitation, including prepared topics for discussion. In our cases, we facilitated meetings as collaborative workshops based on the project framework. In each workshop, we had a different topic of discussion. In Vantaa, the goal was to gather ideas for R&D work. In Espoo, the goals were to discuss the challenges of cooperation and the inter-unit service production process. Well-prepared facilitation and discussion topics are needed to focus the collaborative events towards productive collaboration. Without preparation, the discussion may easily dissolve into non-productive chattering or, even worse, strengthening of misconceptions regarding cooperation.

Our third conclusion is critical to network management. The case studies clearly indicate that effective networking is not merely the result of using specific network management tools. When using a specific management tool, we must pay attention to the *social* network that is developing alongside. In fact, it seems that the use of management tools and the development of the social network are highly interrelated. They require each other and must develop in balance. The importance of social relations to network management is understandable, because the people/units/actors in these kinds of networks are fairly autonomous and cannot be forced to collaborate. The social relations induce commitment to collaboration in two ways: people will have more trust that their commitment will be reciprocated, and social contacts will help to communicate tacit knowledge that is always present in developing an ICN.

Towards a more contextualized and social view of ICN management

The case analysis provides a couple of key conclusions. First, we need to contextualize the ICN management framework for the practicing manager; other-

wise, the framework will not be comprehensible or readily adapted into practice. Based on a framework of network management levels presented elsewhere (Järvensivu and Möller 2008), we propose that there are at least four possible levels of network management (Figure 3). It is the institutional socio-economic context of organizing that determines what managers are endowed to do in an ICN network. In Finland, the socio-economic context in the health and social care sector is driven largely by the EU and national level regulation as well as municipality level organizing. These contextual factors determine how control, cooperation, and the search for efficiency and effectiveness drive management in hierarchies, markets, and networks.

There are also several contingencies that determine whether a hierarchy, a market, or a network is ideal for health and social care efficiency. Such contingencies are related to EU and national level regulation as well as to factors that determine how easy or difficult it is to control key resources under one hierarchy; what kind of efficiency gains can be obtained from relying on free markets to provide health and social care; and if flexibility and efficiency targets can be solved simultaneously through networked organizing. The characteristics of each network determine which kind of specific managerial tasks are required. Finally, the characteristics of each actor determine what kind of role each actor can or should play. In order to contextualize our ICN management framework, we must examine in depth the management tasks and roles that are needed in specific health and social care networks.
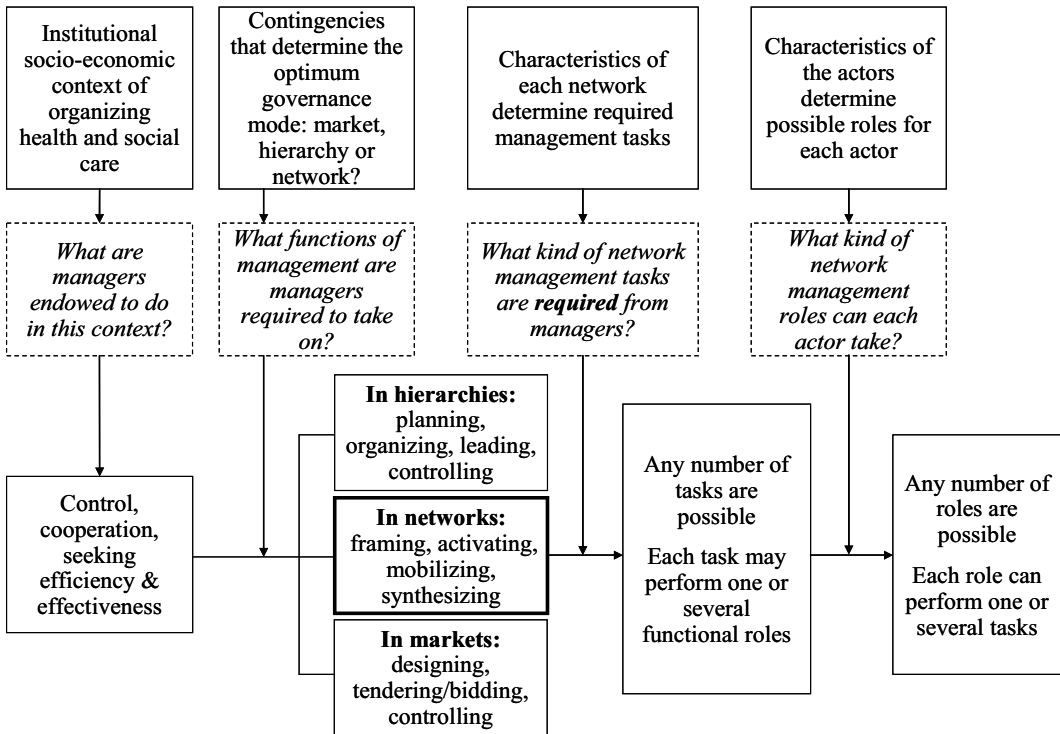
Figure 3. A contingency framework of network management.

We can also conclude from the cases that network management cannot be re-duced to the application of a set of particular network management tools. It is important to understand that networking is always a social process. The applica-tion of particular network management tools is bounded by the social setting in which the tools are used; this social setting is also influenced by the application of the tools. Therefore, network management is conditioned by constant adapta-tions between applying network management tools and developing the social network (Figure 4).

**Network development in terms of
management mechanisms**
• Mechanisms for planning and goal-
setting
• Meeting forums
• Etc.

Network status at time 1

Framing

Synthesizing

Activating

Mobilizing

Network status at time 2

Framing

Synthesizing

Activating

Mobilizing

**Network development in terms of the
social network**
• Trust-based relations
• Mutual language
• Collective culture

Time

Figure 4: A social perspective on ICN management.

As shown in Figure 4, the application of network management mechanisms or
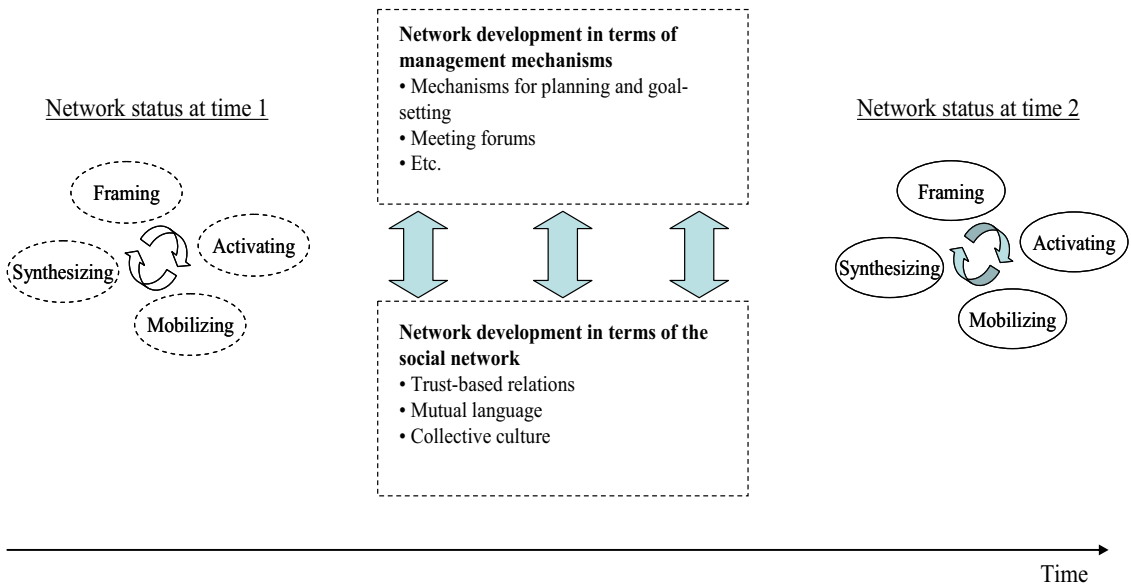tools is deeply interrelated to the development of the social network in question.
One cannot develop without the other. We therefore propose that a network de-
velops through simultaneous application of the ICN management framework and
the development of the social network.

In the next stage of research, we need to study how the concept of mobilizing is
connected to the concept of a social network. A potential research avenue is to
look at how mobilizing and the social aspect of the network are related to the
concept of trust. We see that the social network thrives from trust-based rela-
tions among people, so mobilizing should aim at building trust-based relations to
induce commitment. Therefore, mobilizing is a function that aims to build trust-
based social networks. If this idea is accepted, we could frame a social perspec-
tive of ICN management as shown in Figure 5. This idea requires further discus-
sion and analysis.

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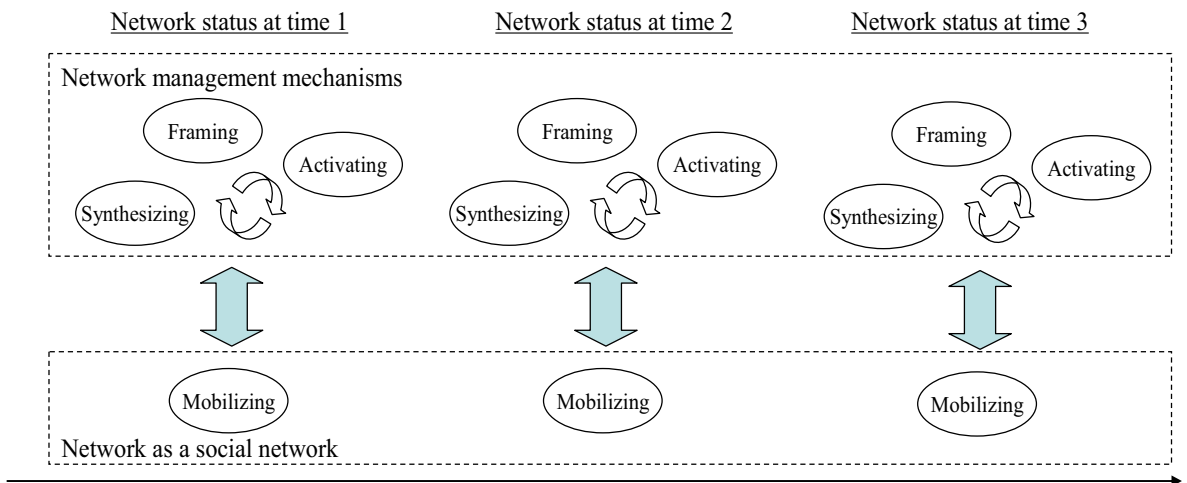
Figure 5. A social perspective on ICN management: An alternative view.

This paper is a step towards increasing the usability of the theoretical ICN management framework. We invite your comments and suggestions. We may be contacted at timo.jarvensivu@hse.fi and katri.nykanen@hse.fi.

References

Harland, C.M. and Knight, L. A. 2001. Supply network strategy. International Journal of Operations & Production Management, 21(4), 476-489.

Järvensivu, T. and Nykänen, K. 2007. Conceptualizing networked value-creation and its management in health and social care services in Finland. Paper presented at the 3rd Sendai-Finland Seminar, Japan. See the article in the first part of this publication.

Järvensivu, T. and Nykänen, K. 2008. Identifying Basic Elements of Network Management: Comparison between Managing Networks, Markets, and Hierar-

chies. In M. Anttila and A. Rajala (eds.), Fishing with business nets − keeping thoughts on the horizon, Helsinki School of Economics publications, Helsinki.

Järvensivu, T., Nykänen, K., and Möller, K. 2007. Understanding health and social care networks: A value-creation framework. Electronic conference proceedings of the 23rd IMP Conference 2007, August 30 - September 1, 2007, Manchester, UK.

Kassler, W.J. and Goldsberry, Y.P. 2005. The New Hampshire Public Health Network: Creating Local Public Health Infrastructure Through Community-Driven Partnerships. Journal of Public Health Management Practice, 11(2), 150-157.

Lega, F. 2005. Strategies for Multi-Hospital Networks: A Framework. Health Services Management Research, 18(2), 86-99.

Möller, K., Järvensivu, T., and Rajala, A. 2006. Networked value creation in health care services: Exploratory reflections. Special Issue: Refurbishing the Elderly Care - Evidences and Theoretical Targets, Annuals of the Kansei Fukushi Research Centre,Tohoku Fukushi University, August 2006, Japan.

Möller, K., Rajala, A., and Svahn, S. 2005. Strategic Business Nets - Their Type and Management. Journal of Business Research, 58(9), 1274-1284.

Mur-Veeman, I., Hardy, B., Steenbergen, M. and Wistow, G. 2003. Development of Integrated Care in England and the Netherlands: Managing across Public-Private Boundaries. Health Policy, 65(3), 227-241.

Page, S. 2003. "Virtual" Health Care Organizations and the Challenges of Improving Quality. Health Care Management Review, 28(1), 79-92.

Podolny, J.M. and Page, K.L. 1998. Network Forms of Organization. Annual Review of Sociology, 24(1), 57-76.

Provan, K.G., Harvey, J., and de Zapien, Jill Guernsey 2005. Network Structure and Attitudes toward Collaboration in a Community Partnership for Diabetes Control on the US-Mexican Border. Journal of Health Organization and Management, 19(6), 504-518.

Thompson, C., Frances, J., Levacic, R., and Mitchell, J. 1995. Markets, hierarchies & networks: The coordination of social life. Sage Publications, London.

Elderly Care Services in Transition: Increasing Value through Client-Provider Collaboration

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Introduction

The purpose of this paper is to identify the key issues that stand for better, more versatile, and more affordable elderly care services. In this paper, our theoretical understanding of the phenomenon is mainly founded mainly on service marketing and innovation management literature. We will also report the key results of studies carried out in Finnish and Japanese elderly care service units, with a focus on their main characteristics, business practices and service development activities. We expect that studying the development of elderly care services in the two most rapidly aging nations in the world (Japan and Finland) will provide valuable insight into how these services can be developed and provided efficiently in a customer-oriented manner.

It has been argued that elderly care is undergoing a shift from conventional institutional service provision to newer forms of intermediate and home-supported services (Djellal and Gallouj 2006). Traditionally, the development of elderly care

services has focused on minimising the costs of provision and, to a large extent, neglecting clients' genuine needs. However, service providers are today increasingly confronted with the challenge of developing care services that respond to the individual needs of elderly people. Since public financial resources for elderly care services are declining rather than increasing, the gap between the demand and supply of welfare services will rapidly widen. This raises the question of how to respond to the growing and increasingly complex demand for care services.

Our empirical findings indicate that, first of all, clients have to be deeply involved in new service development. If the views of the client go unheeded, only small improvements in services can be achieved. Secondly, the provider-dominated development of new services may produce more radical service innovations (better-quality and lower-priced services), but these innovations might not achieve a high level of perceived value for elderly people. On the basis of our empirical study we can argue that, when developing new elderly care services, it is important to achieve a balance between clients' and service-providers' interests and efforts, in order to achieve high-quality and cost-effective radical improvements .

Characteristics of Elderly Care Services

Having long been restricted to a choice between care at home, in the family or in large old people's homes, the market for care services for the elderly has undergone considerable upheaval. However, care services for the elderly form an activity that is not easily defined, since they cannot be put into a single accounting category and because they are located at the intersection of various other major groups of activities (Djellal and Gallouj 2006). This diversity makes it difficult to identify innovations in these services. In their article, Djellal and Gallouj (2006) suggest that, in order to produce a more precise definition and representation of the phenomenon, six targets for innovations in care services for the elderly can be identified: the types of assistance and residential provision; the technologies; the elderly person's family; the agents that provide services; the services provided; and the institutional environment. They argue that it is much easier for the professionals involved in the provision of care services to identify innovations in terms of these six targets than by using the traditional distinctions between product, process and organisational innovations. For example, the first target (types of assistance and residential provision) provides two innovation trajectories for elderly care services: horizontal and vertical. The horizontal one de-

scribes the evolution of the various forms of service provision along the continuum of 'home – intermediate forms of provision – institutions', whereas the vertical one reflects the diversification of provision within each group of services.

In many European countries, the horizontal trajectory has for several years been passing through a shift from institutional service provision to intermediate and home-supported services (Djellal and Gallouj 2006). Also in Japan, a drastic change in care-service thinking has been taking place since 2001, when the new elderly care service insurance, Kaigo Hogen, was launched. The target of social welfare began to change towards service marketing. Before this, care was defined by public ideology; it was publicly financed with less attention to its cost performance, the quality of services and customer satisfaction. After this change, care was no longer considered a limited service targeted only at the socially weak, but became a universal possibility open to all elderly persons. This created a rapidly expanding private market for elderly care services, and the sector is now a growing market for service innovations.

In Finland, on the other hand, the public sector still plays a commanding role in the organisation of elderly care services, partly due to the relatively large proportion of public financing. Municipalities have diverse and even contradictory roles in elderly care services; at the same time as they produce elderly care services, they also buy competing and equivalent services from the private sector. In Finland, private businesses in the elderly care service sector typically have problems with running their business profitably due to the complex client-provider situation, and also because the share of the working capital load is too high in relation to their turnover.

The major difference between the Japanese and Finnish elderly care systems lies in customer orientation. In the Japanese system, an elderly person is perceived as a genuine client entitled to buy services from the best possible supplier. In Japan, Kaigo Hogen has already opened a market with new business opportunities, although the supply, especially in home-care services and rehabilitation, is still comparatively limited. From the viewpoint of developing new services, the new definition of care is challenging in both countries. Care no longer refers only to the support provided in daily activities, but it is a method for achieving the well-being of individual elderly persons. An elderly person is not classified merely as "not ill" or "not sick"; they can be physically strong, intelligent, well-educated, with abundant social human relations, and mentally and spiritually safe. An improvement in quality of life can possibly be achieved through new types of service innovations.

Adopting a service marketing approach within the field of elderly care means that customers are not perceived as buying service functions as such, but as buying benefits. Elderly persons are now interested in the kind of comprehensive well-being which can be achieved through versatile care services. A care service itself is no longer an aim but the result of an innovative definition of well-being. Multi-party collaboration and networked co-creation of care services may be an innovative approach to the improvement of elderly care (Bettencourt et al. 2002). These issues will be addressed in more detail in the following section.

Client-provider collaboration in new service development

Services have become the engine of future growth for firms and organisations in the 21st century (Vargo and Lusch 2004, Matthing et al. 2004, Grönroos 2005). However, products and services can often not be distinguished so clearly (Cook et al. 1999). This is due to the fact that services or service elements are present in many of the market offerings even in traditional industrial sectors. In fact, it might be more useful to think about services and physical products as the extremes of a continuum (John and Storey 1998). In spite of the difficulty of defining the demarcation of services and physical products, announcements recently made by several companies (e.g. IBM) indicate that services have become core elements in their business models and represent an increasing share of revenues. For this reason, there is an increasing interest in innovating and developing services.

It has also been argued that in services there is a tendency to make small, scattered changes instead of proper innovations, meaning that the innovations in service firms are less radical, more rapidly implemented and copied (Cowell 1988, Scarbrough and Lannon 1989, Voss et al. 1992). Furthermore, Sundbo (1997) claims that these small incremental innovations may be difficult to differentiate from normal organisational learning processes. This can be the reason why it is sometimes claimed that service firms do not innovate, or that they innovate ad hoc and haphazardly (Kelly and Storey 2000, Dolfsma 2004).

According to Bullinger et al. (2003), the commercial success of a service offering also depends critically on its specification and design. A growing number of authors postulate that successful services can and must be systematically planned, thus preventing them from being ad hoc processes (Ramaswamy 1996, Cooper and Edgett 1999, de Brentani 2001, Froehle et al. 2000, Fitzsimmons and

Fitzsimmons 2000). To help with the systematic planning of new service development, we propose that a service organisation should look at the nature of innovation. In cases where the innovation is based on an existing value-creation system, including known technology, knowledge and architecture, the change is more or less an incremental one. On the other hand, the innovation can be a radical act, introducing a new element or a new combination of old elements (cf. Schumpeter 1934). These kinds of radical innovations may also change the whole value-creation system (Möller et al. 2005).

As several scholars argue, service innovations are co-created by a firm and its clients (Gadrey et al. 1995, de Brentani 2001). Furthermore, den Hertog (2000) points out that the nature of a service innovation depends upon whether it is supplier-dominated or customer-driven. It is the customers who typically lead their suppliers towards long-term, successful innovations. However, customers are not necessarily the best source of radical innovations (Christensen and Bower 1996). Accordingly, we can claim that customer- or client-driven innovations in services are more incremental in nature, whereas suppliers or providers stand for the more radical ones.

We suggest that the basic classification of innovations (either as incremental or radical) can be complemented by the level of service co-creation (low vs. high). By combining these dimensions, we are able to create a conceptual framework (see Figure 1) with a vertical axis representing the nature of the innovation and a horizontal axis portraying the level of service co-creation.
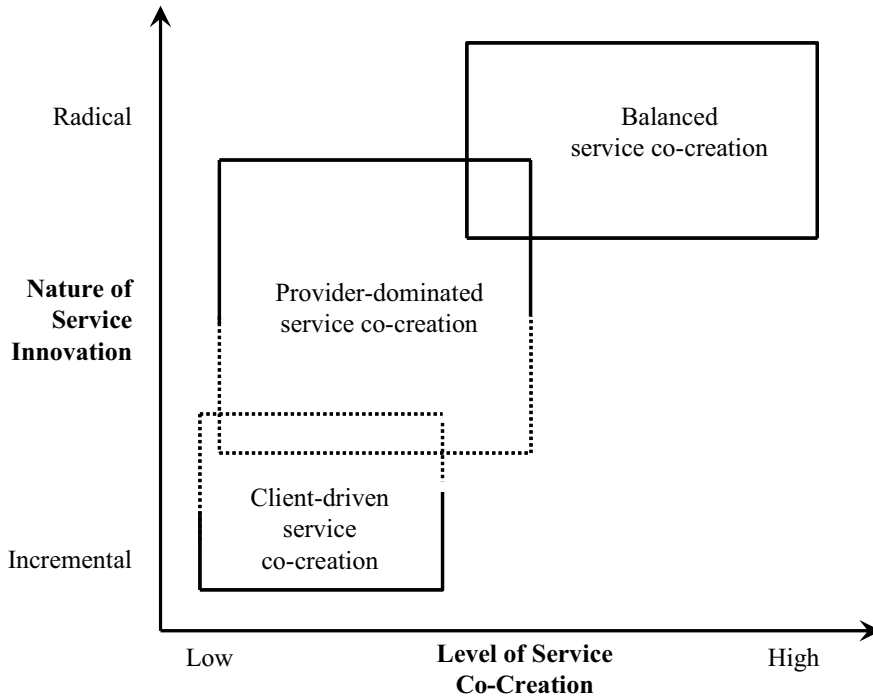
Figure 1. Framework for the study

By using this framework, we can identify three different modes of co-creation in new service development (NSD): a client-driven one, a provider-dominated one and a balanced one. These modes reflect the level and characteristics of client involvement or inspiration, and supplier (provider) domination in the innovation process. We argue that balancing the client's and service provider's participation and efforts, especially in radical service innovations, enables a high-quality and cost-effective provision of new elderly care services. Furthermore, it needs to be pointed out that this kind of balanced co-creation is not a mixture of the client-driven and provider-dominated co-creation, but a separate mode of collaboration (Möller et al. 2008).

Research methodology

In order to find support for service co-creation within elderly care, we need a large and versatile database including detailed description and analysis of various single phenomena within the comprehensive framework. The data collected from a single source or from a single case organisation can only provide limited enlightenment to our problem of comprehensive service co-creation. We need both qualitative and quantitative evidence from different sources and detailed descriptions and analysis of the Finnish-Japanese cross-cultural context. The data used in this study was based on multiple case studies carried out by Laurea's students Kuisma (2007), Ogawa (2007), Vilppo (2007), Kario (2007), Kahanpää (2007), Valkama (2007), Oja (2008) and Huhta (2008). The data set of these studies included a total of 14 organisations (12 in Finland and two in Japan). The data was collected during 2006-2008 through semi-structured, in-depth interviews. The interviewees were selected from among top and mid-level managers representing the best knowledge of service development in these organisations. In each case organisation, two to five persons were interviewed.

Empirical study – developing new elderly care services in Finland and Japan

As for the empirical study, we consider that the Japanese-Finnish context provides a good case because of the fast rate of aging in both countries and the efforts assigned to develop innovative care services for the elderly. Next, we report the main findings of studies carried out by applying our theoretical framework as an analytical tool for identifying the characteristics of service co-creation modes in the elderly care service context.

Client-driven NSD: Our findings indicate that the more the service provider takes into account the wishes and needs of the elderly when developing care services, the higher the perceived value of these services is from a client's perspective. Furthermore, it also seems to be valuable to incorporate employees (care personnel) and the elderly person's family in order to develop high-quality services. Our results indicate that increasing the variety of standardised services is not appreciated or valued as much as the client's own participation in the development process of new care services. To make this happen, the service provider needs to focus on establishing collaborative processes. This lends support to our proposal that customer-initiated improvements are important in the case of

incremental service innovation. Another interesting finding was that, in Japanese cases, the service providers were more eager to listen to their clients when developing care services. Finnish service providers, on the other hand, merely developed more standardised types of care services, which were offered to all clients regardless of their specific individual needs. Our results support our previous understanding that client-driven service improvements are typically incremental and the value creation achieved though them is limited to small-scale, new service improvements.

Provider-dominated NSD: Our results support our previous preliminary findings that the more radical changes in service offerings are typically provider-driven. Service providers tend to produce more radical changes and tolerate more risk than clients typically do. Consequently, service co-creation in the provider-dominated mode emphasises cost-efficiency and service quality aspects, thus achieving higher value creation than client-driven new service development. Our findings from the provider-dominated cases support the idea that service providers are willing to introduce even radical changes if they obtain any assurance that their decisions will lead to improvements on the service quality side and/or improve cost-efficiency.

Balanced NSD: We found case examples both from Finland and Japan to support our preliminary idea that balanced co-creation of radical new elderly care services results simultaneously in high perceived quality and high cost efficiency. However, an even better outcome is achieved when third parties such as family, care personnel and subcontractors are also involved in the development process. Thus, radical service innovations opening new opportunities to improve elderly care services can best be achieved when several actors with diverse abilities and complementary resources interact, generating clever innovation ideas. A radical innovation creating high value for customers with high cost efficiency, such as Caring TV (which provides comprehensive interactive care-related services via TV networks), was initiated and developed in collaboration with a number of different actors (a company providing the necessary technology, municipal authorities and a university). The clients' role in this development process was more or less that of testers, providing hands-on information about usability. The Japanese elderly care service provider, Sendan-no-Oka, offers rehabilitation services ranging from accommodation to day-care services and home visits. Through radical reorganisation of all major activities, facilities and working models, and through the creation of innovative instruments, Sendan-no-Oka has succeeded in raising the rehabilitation results of its clients to a completely new level. Despite an obviously higher service quality than the average,

cost-efficiency is also good. In this case, too, the service model was developed in collaboration with a number of different actors but initiated by a single person with strong authority.

Even in these radical, service-provider-dominated innovations, it seems obvious that client-tailored care services are perceived as better than standardised ones. Accordingly, we can conclude that client-provider collaboration is important in radical care service innovations. For example, the more open the family integration in the case of a totally new care service development, the higher-quality and more cost-effective the services provided can be.

These findings indicate that it is important to increase elderly people's involvement in service provision together with service providers. This kind of collaboration is valued more than the increase in the variety of services offered. This was an interesting finding and supported the importance of a high level of service co-creation in this specific care sector. Also, the importance of a new kind of space utilisation was an interesting finding because it also improved the level of client-provider collaboration. Family integration, organisation of personal services, employee satisfaction and the comprehensiveness of care also supported the importance of high-level collaboration within elderly care. Our findings indicate that successful radical service innovations need balanced client-provider co-creation, which is based on networked multi-party collaboration. Finally, our study also supports the argument that we cannot develop a single general service model with all positive characteristics, but we can benchmark the most interesting cases and adopt the best practices when developing new types of elderly care service.

Discussion

While comparing the differences and similarities between Japanese and Finnish elderly care service companies, we first need to understand cultural characteristics in service practices in both countries. Japan has a high level of social hierarchy, emphasising formal relationships between employers and employees, as well as authority. Finnish people, on the other hand, do not want others to be very dependent on them and value equality. At present, the most important practical difference between the Japanese and Finnish elderly care systems lies in their customer orientation. In Japan, an elderly person is given the right to buy services from the supplier he or she chooses. In Finland, an elderly person receives services from the municipality, and, if he/she is not satisfied, the only al-

ternative is to be without services or buy them from the private sector, which is much more expensive. From the viewpoint of our results, it is interesting that similar characteristics can be found in client-driven, provider-dominated and balanced co-created service innovations in both countries. This brings us to the conclusion that our findings could also be valid in other cultures and circumstances.

To summarise the managerial implications of the study, we suggest that, in order to increase or even maximise total value creation (high quality and high cost efficiency), we need to focus on the balanced co-creation of new elderly care services. In the balanced co-creation mode, we can distinguish between activities that improve efficiency/service quality and activities that improve both efficiency and effectiveness/service quality:

Improving efficiency/service quality:

-   *Customer orientation and customer search:* The more influence the customer has when making service-purchasing decisions, the more the service companies have to invest in customer searches and overall competitiveness.

-   *Service types:* Instead of increasing the variety of services developed by service companies' management and personnel, customer satisfaction could be better improved by increasing customers' own participation in the daily tasks of the care facility.

-   *Family integration:* The more compact and open family integration is at all stages of the care process, the more individual and respectful the services can be.

-   *Organisation of personal services:* While constructing the customer's own care plan, the influence of all specialists participating in the care of the customer increases the value of the service to the customer.

-   *Employee motivation:* Satisfied customers, open and direct communication between customers, managers, service personnel and specialists, as well as a fair salary policy, seem to have a positive impact on employee motivation.

-   *Comprehensiveness of care:* The obvious finding is that mass service production with the additional over-organising of special events may be even more expensive than customer-tailored service processes.

From the elderly care service provider's point of view, it seems important to consider the role of the client (elderly person) or even the 'extended client' (the eld-

erly person's family and relatives) when developing new care services, irrespective of whether it is based on an incremental or a radical innovation. Accordingly, increasing the clients' own participation in the development of new types of care services calls for broader collaboration, not only with the clients but also with other internal (care personnel) and external actors (complementary service providers).

Improving efficiency and effectiveness/service quality:

- *Partnering orientation:* Elderly care services that produce high value are typically radical service innovations produced in close interaction with various actors.

- *Key person's strong authority:* Radical service innovations of high value are typically generated under the command of a key person who enjoys high respect among subordinates and partners

- *Willingness to receive new ideas:* Radical innovations are not typically generated during well-structured and well-defined innovation processes, but rather by accident.

From the service marketing viewpoint, the results of our study in elderly care services provide important findings. The main general finding is that we can no longer exclude the elderly care sector from business and marketing discussions because of its huge and rapidly increasing financial value and because of its complex nature. Also, traditional service marketing modes need to be reconsidered and developed to meet the special needs of the elderly care sector. Combining service marketing and a new definition of care leads to more complex and more demanding service co-creation models in which a networking perspective with a high level of collaboration and radical innovations are of high value.

Our study provides some guidelines for the design and commercialisation of new services in areas such as elderly care services, where the previous understanding and the role and usefulness of customer involvement (collaboration & co-creation) are exiguous. However, we still have a fairly poor understanding of service development in a network environment (Syson and Perks 2004). Because of this, we suggest that future research should explicitly focus on the study of the role of partnerships and networks in this specific context. It has been suggested that a network-oriented approach is a valuable tool in the identification and nurturing of appropriate relationships, especially in radical innovation development processes (Möller et al. 2005).

Our findings clearly indicate the need to balance both clients' and service-providers' interests in the development of new elderly care services in order to achieve more radical and highly valued improvements in service provision. Thus, we encourage researchers, health care authorities, municipalities and private elderly care providers to explore possibilities and opportunities of integrating elderly people, their relatives and service personnel into new service development processes.

REFERENCES

Alam, I. and Perry, C. 2002. A customer-oriented new service development process. Journal of Services Marketing 16(6), 515-534.

Anderson, P. and Tushman, M.L. 1990. Technological discontinuities and dominant designs: A cyclical model of technological change. Administrative Science Quarterly 35, 604- 633.

Barras, R. 1986. Towards a theory of innovation in services. Research Policy 15, 161-173.

Booz-Allen and Hamilton 1982. New Product Management for the 1980s. Booz-Allen and Hamilton, New York.

Bowers, M.R. 1987. Developing new services for hospitals: A suggested mode. Journal of Health Care Marketing 7(2), 35-44.

Bowers, M.R. 1989. Developing new services: Improving the process makes it better. Journal of Services Marketing 3(1), 15-20.

de Brentani, U. 1989. Success and failure in new industrial services. Journal of Product Innovation Management (6), 239-258.

de Brentani, U. 1991. Success Factors in Developing New Business Services. European Journal of Marketing 25(2), 33-59.

de Brentani, U. 2001. Innovative versus incremental new business services: Different keys for achieving success. Journal of Product Innovation Management 18, 169-187.

de Brentani, U., Cooper, R.G. 1996. Developing successful new financial services for business. Industrial Marketing Management 21, 231-241.

Bullinger, H-J., Fähnrich, K-P., and Meiren, T. 2003. Service engineering – methodological development of new service products. International Journal of Production Economics 85, 275-287.

Christensen, C.M. and Bower, J.L. 1996. Customer power, strategic investment, and the failure of leading firms. Strategic Management Journal 17, 197-218.

Cook, D.P., Goh, C.H., and Chung, C.H. 1999. Service typologies: A state of the art survey. Product and Operation Management 8, 318-338.

Cooper, R.G. and Edgett, S.J. 1999. Critical success factors for new financial services. Marketing Management 5(3), 26-37.

Cowell, D. 1988. New service development. Journal of Marketing Management 13(3), 296-312.

Djellal, F. and Gallouj, F. 2006. Innovation in care services for the elderly. The Service Industry Journal 26(3), 303-327.

Dolfsma, W. 2004. The process of new service development - issues of formalization and appropriability. International Journal of Innovation Management 8(September), 319-337.

Fitzsimmons, J.A. and Fitzsimmons, M.J. 2000. New Service Development: Creating Memorable Experiences. Sage Publications, Thousand Oaks, CA.

Froehle, C.M., Chase, R.B., and Voss, C.A. 2000. Antecedents of new service development effectiveness: An exploratory examination of strategic operations choices. Journal of Service Research 3(1), 3-17.

Gadrey, J., Gallouj, F., and Weinstein, O. 1995. "New modes of innovation: How services benefit industry". International Journal of Service Industry Management 6(3), 4-16.

Gallouj, F. and Weinstein, O. 1997. "Innovation in services". Research Policy 26, 537-556.

Gavrilov, L.A. and Heuveline, P. 2003. "The Aging of Population", in The Encyclopedia of Population. New York, Macmillan Reference USA.

http://www.galegroup.com/servlet/ItemDetailServlet?region=9&imprint=000&title Code=M333&t pe=4&id=174029

Grönroos, C. 1990. Service Management and Marketing - Managing the Moments of Truth in Service Competition. Lexington Books, Lexington.

den Hertog, P. 2000. "Knowledge-intensive business services as co-producers of innovation". International Journal of Innovation Management 4(4), 491-528

Huhta M 2008. Private elderly care service homes and networking – a study of possibilities, Laurea University of Applied Sciences (unpublished thesis).

Johne, A. and Storey, C. 1998. "New service development: A review of literature and annotated bibliography". European Journal of Marketing 32, 84–251.

Jones, J. 1995. "Developing new services and products in flight catering". International Journal of Contemporary Hospitality Management 7(2-3), 24-28.

Kahanpää, H. 2007. Co-operation and networking in Well Life Center (WLC) - benefits to the participating organisations, Laurea University of Applied Sciences (unpublished thesis).

Kario, V. 2007. How to improve the operations of domestic service companies through business networking, Laurea University of Applied Sciences (unpublished thesis).

Kelly, D. and Storey, C. 2000. "New service development: Initiation strategies". International Journal of Industry Management 11(1), 45-62.

Kuisma, A. 2007. Analysing elderly care service providers' processes and cost management practices through case study. Case: Hopeakuu, Finland and Sendan-non-oka, Japan. Laurea University of Applied Sciences (unpublished thesis).

Matthing, J., Sandén, B., and Edvardsson, B. 2004. "New service development: learning from and with customers". International Journal of Service Industry Management 15(5), 479-498.

Möller, K., Rajala, R., and Westerlund, M. (2008), "Service Innovation Myopia? A New Recipe for Client-Provider Value Creation". California Management Review 50(3), 31-48.

Möller, K., Rajala, A., and Svahn, S. 2005. "Strategic business nets - their type and management". Journal of Business Research 58, 1274-1284.

Ogawa, L. 2007. Väestön ikääntymisen vaikutukset ja mahdollisuudet vanhus-palvelualalle liiketaloudellisesta näkökulmasta - tapauskohteina japanilainen Shisei Homer sekä suomalainen Vanhusten Tuki ry. Laurea University of Applied Science (unpublished thesis).

Oja, T. 2008. Private social service provider's financial challenges and municipality co-operation. Case: Terveyspalvelut Mendis Oy. Laurea University of Applied Sciences (unpublished thesis).

Ramaswamy, R. 1996. Design and Management of Service Processes. Addison-Wesley, Reading, MA.

Scarbrough, H. and Lannon, R. 1989. "The management of innovation in the financial services sector: A case study". Journal of Marketing Management 5(1), 51-62.

Scheuing, E.E. and Johnson, E.M. 1989. "A proposed model for new service development". Journal of Service Marketing 3(2), 25-34.

Schumpeter, J. 1934. The Theory of Economic Development, new ed. 1961. Harward, MA.

Sundbo, J. 1997. "Management of innovation in services". The Service Industries Journal 17 (3), 432-455.

Syson, F. and Perks, H. 2004. "New service development: a network perspective". Journal of Services Marketing 18 (4), 255-266.

Teece, D. 1998. "Capturing Value from Knowledge Assets". California Management Review 40 (3), 5-79.

Valkama, T. 2007. Knowledge creation in elderly care. Case: the municipal elderly care of Espoo. Laurea University of Applied Sciences (unpublished thesis).

Vilppo, T. 2007. Analysing elderly care service providers' business. Case: Sen-dan-non-oka, Japan and Hopeakuu, Finland. Laurea University of Applied Science (unpublished thesis).

Voss, C., Johnston, R., Silvestro, L., Fitzgerald, L., and Brignall, T. 1992. Measurement of innovation and design performance in services". Design Management Journal (Winter), 4046.

Support for and quality of life of the elderly bereaved

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Background

The aim of this article is to explain different ways of improving the quality of life of elderly persons who have experienced grief. This article will introduce the relationship between the processes of giving in (Erjanti 1999, 2004) and relieving the grief. The article will open discussion on the ways of helping and on support related to the experience of grief for the elderly.

Working with and helping the elderly bereaved

Helping the elderly bereaved is emotional work. It is a human activity affected by the personalities of both the caregiver and the bereaved. Helping also entails different positive and negative feelings and selective attachment between the individuals (cf. Paterson and Zderad 1976). Helping and supporting the elderly bereaved is linked with the concept of health and the comprehensive aim of the bereaved to reach a state of harmony, and with the ability to work satisfactorily with the bereaved's own resources. It is an individual and unique ability and function that, even in grief, aims at comfort (cf. Åsted-Kurki 1992). The aim of helping the bereaved is to support their health. Caring as an ethical action is emphasised in supporting the bereaved. It can become embodied as caring, taking responsibil-

ity, concrete care and the receiving of care, contributing to a feeling of belonging in the surrounding community and active functioning in everyday life (cf. Pesso 2004).

The interactive nature of grief makes evident the relationship between the bereaved and the caregivers, as well as the significance of working with the bereaved. The specific needs of the bereaved can be fulfilled, risk situations can be identified, help can be directed more accurately and individually than before, the health of the bereaved can be supported and illness can be prevented if the 13 categories of the giving-in process of the bereaved (emotional turmoil, physical protest, making the loss real, self-examination, breakthrough in thinking, transformed awareness of reality, grief modifiers, groping for meaning, breaking grief's dominance, self-regulation of grief, recovery, interaction and personal growth) are identified and their contents known. The health of the bereaved is temporarily threatened by grief (Erjanti 1999, 2004).

Individual characteristics of the bereaved and different factors relating to the age of the bereaved and the different natures of loss are usually emphasised in helping and working with the bereaved. There are differences in working with and helping a child, an adolescent, an adult and an elderly person, although there are also similarities. This article looks at work with the elderly bereaved.

Presence is central in helping an elderly person. Being present and available for the elderly bereaved is a way of helping them in the process of giving in. The caregiver can support the self-respect and self-acceptance of the bereaved by showing that the feelings related to grief are normal. Knowing that, especially in the Finnish culture, the elderly are often unwilling to discuss their emotions, caregivers are obliged to encourage the bereaved to show their emotions. A difficult experience cannot be forgotten; on the contrary, it will constantly come to mind. Occasionally it might be successfully hidden, but often it comes up as incomprehensible emotions and, among other things, psychic disturbances.

It is important to identify risk groups when working with the elderly bereaved. These groups are the bereaved with no support network, those who attach themselves to grief for a long time, those who fall physically ill, those who are threatened by the danger of self-destruction, deeply depressed or having financial difficulties, and those who have problems coping with the everyday life. Signs of depression in the elderly should never be ignored as expected expressions of grief. Caregivers should at all times be alert to the signs of permanent depression and refer the bereaved to professional help if necessary. For exam-

ple, an elderly bereaved person who has spent a long time in isolation can easily fall into depression.

Elderly bereaved persons might be afraid of their strong emotions. At the same time, they wonder how everyone around them regards their grief – how their surrounding people and loved ones allow their displays of grief. Many bereaved people resort to tranquilisers or sleep medication in order to control their emotions. Emotions inked with emotional turmoil do have a purpose in the process of giving in. They are the means for getting the grief out of the bereaved's system. If that process is inhibited, the emotions and experiences are left inside the person; that is why it is good to support the elderly bereaved in carrying and expressing these emotions by letting them out. Discussion and dialogue are good alternatives to medication, including sleep medication. An elderly bereaved person can be advised to wait for three nights; if they still suffer from insomnia on the third night, they can use sleep medication for a few nights and then try to sleep without it. This method aims to prevent addiction. Resorting to medication can easily lead the elderly to fear insomnia and trying to sleep without medication (cf. Saari 2003).

Some believe that the only treatment for grief is grieving (Poijula 2002). The most important task that the caregivers can engage themselves in is to help the elderly in their crisis to find some positive sides to the experienced loss. Positivity does not mean saying "It could have been worse" or "You should be happy this happened" or "Time heals all wounds". An ideal opportunity for support is offered to caregivers who are close to an elderly bereaved person living through the chaos of emotional turmoil (Lanara 1996). When human grief and suffering are seen in a life-sized context, the caregiver can handle the grief efficiently and comfort the distressed.

The elderly can be encouraged to use different survival strategies and identify the regulators of grief. According to Erjanti (1999, 2004), the strategies are 1) active outward strategy: talking openly about grief to others, 2) active inward strategy: being among other people without seeking contact with them, 3) withdrawn inward strategy: addressing grief in the short term by means such as writing or reading, 4) enveloping grief: temporarily encasing grief to accumulate energy. Problems in areas such as taking care of the house and financial matters can be anticipated. The recommendation to use outside help may relieve the unnecessary stress linked with everyday coping.

A key matter is to consider the extent and quality of the support network of the elderly. If the grief of the elderly is connected to shame, this will diminish through

dialogue. It is important to help the bereaved to put into words their feelings of shame, for example through reminiscing, music, poems, etc. Facing a difficult experience together with the caregiver and talking about it gradually diminishes the grief.

It is often difficult to recognise the elderly bereaved. Especially elderly people who have lost an adult child may be left unattended; the father's grief in particular is often unrecognised. The elderly bereaved do not consider themselves burdened by grief and therefore do not usually seek emotional support. However, it has been noted that emotional support plays a greater role in helping elderly adults than has generally been assumed. As with young bereaved persons, they need a supporter with whom they can share their grief, find relief from the agony and explore options for new plans and relationships. Possible support methods for the elderly include support networks consisting of family members and friends, and alternative living arrangements to prevent isolation, diminish loneliness and rediscover the meaning of life. Encouraging the elderly to prepare themselves for the possible death of their spouse improves their ability to adjust to new conditions. It is important to discuss financial matters and their possible rearrangement, which is often a sensitive issue to the elderly and can cause additional stress. Elderly people with health problems, as is usually the case, should be referred to medical attention. Caregivers should remember that the symptoms of the bereaved are real and should not be considered as mere consequences of loss. It would be good to teach and advise the elderly bereaved about ways to protect themselves from accidents, as they might face increased risk of injury during periods of intense stress.

In the process of giving in, the elderly bereaved have to rebuild their interactive relationships every day, because some relationships might have broken down or changed as a result of the loss of a loved one. The elderly bereaved need support in this demanding task. They need caregivers and other people around them to act as mirrors, containers and co-bearers of grief. Then they can analyse themselves in relation to others. Interaction with caregivers and also loved ones conflicts with the process of giving in. Interaction may increase the wellbeing of elderly bereaved persons when they feel accepted as a human being, their grief is encountered as it is, they are listened to and they receive compassion and care (cf. Averill and Nunley 1993). However, interaction may cause additional anxiety and stress (cf. Wortman and Siver 1989) when the elderly bereaved feel they are symbols of grief, when they see through people, when they encounter coldness or hurtful behaviour or when they are put in the position of caregiver in the midst of their own grief. It appears that the grief that surrounds

the elderly bereaved itself prevents caregivers and other people from approaching them. It is important to remember in a help situation that successful interaction demands a great deal from the elderly. If they conquer their fear of rejection and are able to face their emotions and vulnerability, they can be accepted and receive support. In most cases they long for interaction with others to function, regardless of the grief. The presence of caregivers is also essential, as is how they, as "mirrors", communicate their own expressions, gestures and calmness to the bereaved.

It is important to understand the type of shock that the death of an adult child can cause to elderly parents. It might pose a risk for their already weakened health and well-being. Elderly people who outlive their children should be included in discussions regarding the important decisions regarding their adult children. Despite the fact that elderly parents are in most cases not the primary decision-makers in their child's treatment, involving them in the decisions can relieve the pain of the elderly and improve their quality of life. If elderly parents can attach significance to their own lives, the image of the lost adult child in their minds will become real.

Helping, working with and supporting the elderly bereaved can be summed up as follows:

When encountering grief, it is important to:

- receive the grief of the elderly bereaved.
- give room for the emotions, thoughts and reactions of the elderly bereaved. Recognise all dimensions of emotional turmoil: chaos, dual realities, supernatural experiences, intense emotions, melancholy, desire to give up and the pleasure of grief.
- respect the grief of the elderly bereaved.
- receive the grief of the elderly bereaved as it is, without adapting it through professional explanation or analysis.
- treat the elderly bereaved as human beings, even if grief has altered their personal characteristics.
- consent to be a "mirror" for the bereaved so that they can reflect on their own existence and actions.
- remember that, due to the individual and unique nature of grief, it is not possible to grieve "incorrectly".
- be present and available for a long enough time and with no hurry.
- be sincere and open, and to listen.

In interaction, it is essential to:

- show compassion for the elderly bereaved, even if they are strangers, by touching their hand or shoulder or by holding them.

- respect the boundaries of your own intimacy and of the intimacy of the elderly, and remember that an elderly man may often need greater physical distance between himself and an unknown caregiver than an elderly woman.

- avoid clichés. They often only displease and irritate the elderly bereaved.

- use expressions like: "You must feel very bad" or " I am thinking of you" or "I'm sorry."

- listen to the stories of the elderly bereaved.

- refrain from making false promises, criticising and giving orders.

- state facts in a simple and clear manner, because the elderly bereaved are living in the chaos of emotional turmoil.

- be correct and stay within facts, because the world may feel unreal to the elderly bereaved.

- refrain from pity, because the elderly bereaved do not need to be pitied.

- encourage the elderly bereaved to show their emotions and to cry by saying such things as "It's natural for you to feel like this in this situation" or "Go ahead and cry".

- take seriously their expressions of fear, suspicion and emotional turmoil.

- remember your own limits as a caregiver: do not lose your presence of mind when faced with grief.

- accept the experience of the undivided nature of grief of the elderly bereaved, and not to verbally express knowledge of how the elderly bereaved is feeling.

- protect the elderly bereaved from additional distress.

- remember that the elderly bereaved do not wish to hear medical histories.

- remember that, in an interactive situation, the elderly bereaved has the role of the receiver of support and not the role of the supporter.

When giving concrete help, it is crucial to:

- ask whether they have anyone they can talk to about these things.

- avoid leaving the elderly bereaved alone; recognise the support network and the amount and quality of the relationships of the elderly bereaved, and strengthen and build their support network.

- make open offers: "Can I help?" or "What can I do?" The elderly bereaved will express their need of help.

- give a tissue, a glass of water and a chair, and create a peaceful and quiet place for the encounter. Quiet background music may calm the elderly bereaved.

- go through diaries or other memories together, or look at photographs and videos, because going through them is important for the elderly bereaved.

- accompany the elderly bereaved to important places.

- take seriously the physical and psychosomatic emotions of the elderly bereaved that are linked with the rebellion of the body.

- ensure that the elderly bereaved manage to eat and drink.

When looking at and touching a lost loved one, it is important to:

- recommend that the elderly bereaved look at the body of the deceased and tell them that they can then say their farewells. It is vitally important to let them make their own decisions as to whether to see the body or not.

- note that seeing the deceased has positive effects on the bereaved. Seeing the deceased will start the process of grief and giving in. Seeing the deceased will help to accept death as final, make the loss real and help to perceive the change in one's own reality.

- prepare the elderly bereaved for seeing the deceased. It is important to describe how the deceased will look and to describe the place where the body can be seen and how to act in that place.

- tell the elderly bereaved that it is possible to arrange such things as placing flowers on the deceased's chest and praying.

- tell the elderly bereaved that they can touch the deceased. Touching makes the unreal seem real.

- encourage the bereaved to express their feelings when seeing the deceased. Crying and shouting are a part of the process of giving in. It is recommended that the elderly bereaved should stay with the deceased until the strongest emotions subside.

When supporting management of the intensity of the grief, it is important to:

- recognise the individual factors affecting the grief of the elderly bereaved, and recognise the significance of the factors that connect the elderly bereaved to or separate them from the deceased, and that intensify the grief. It is essential to find the areas where the elderly bereaved need help. It is im-

portant to recognise the regulators causing distress and pain and the regulators that relieve grief. Then it is possible to influence them, to support the relief of pain, to prevent an increase in grief and to improve the management of the factors regulating the grief of the elderly bereaved.

When motivating the elderly bereaved it is important to:

- encourage and motivate them gradually to face challenges. Major changes may prevent giving in and the bereaved may regret them later.

- take into consideration the period of sensitivity that arises from the radical mental changes that may help to nurture health, and to encourage the bereaved to take care of themselves. By doing this, the health of the bereaved can be enhanced.

- support the personal growth of the elderly in metamorphosis, and encourage them to proceed bravely in creating their incipient identities.

- support self-contemplation and the radical mental changes of the elderly bereaved, as well as their perception of reality, so that personal growth can take place in a positive direction and the process of giving in can proceed.

- encourage the elderly bereaved to find their own personal resources and to support the implementation of recognised survival methods resulting from the change in their perception of reality.

- to recognise the survival strategies characteristic of the elderly bereaved, and support them.

- recognise the self-regulation of the elderly bereaved and its elements, and support spontaneous self-regulation, grief survival and self-nurturing.

- recognise what recovery entails and assist in the process of recovery, reducing the pressure caused by the permanence of the grief encountered by the elderly bereaved.

- encourage spouses to discuss the event of their death in advance, because, owing to inner demands during actual grief, significant items in their lives are often bypassed. Every day, the elderly bereaved may experience such a heavy feeling of loss that they are incapable of concentrating on significant matters in practical arrangements to the required extent.

The importance of supporting and promoting interaction is emphasised in sparsely populated Finland, where social contacts may be relatively few and the inability to encounter the bereaved is a common communication problem recognised by the bereaved. According to Kaunonen's (2000) study, support phone calls from the hospital after the death of a family member were considered to be

important and an appropriate support method. Shared experiences from the time of illness put the caregivers in a special position to support the elderly bereaved.

The ways of communicating, openness or uncommunicativeness of the surrounding society are factors in the survival of the elderly bereaved in the process of giving in. Calm and constructive reciprocal discussion contributes to recovery. Emotionally intense and problem-filled communication inhibits recovery from grief (cf. Poijula 2002). All loved ones have different relationships to the deceased, and, as a result, their ways of grieving may differ (cf. Lofland 1985). This may also be one barrier to the ability of loved ones to help each other, although it is commonly considered that it is the loved ones who are each other's best caregivers thanks to their familiarity with each other.

All elderly people should be directed to take advantage of existing support systems, which can be used in different ways. The use of support systems is considered to be a way of understanding emotional and social situations for the elderly bereaved. In addition to loved ones and friends, support systems include religious and other social rituals, values and beliefs, norms, the availability of caregivers and the ability to seek and receive support (cf. Osterweis et al. 1984).

In addition to emotional and social support, the elderly bereaved need support in many other matters, including:

- organising the funeral
- housekeeping
- controlling and assessing financial matters
- settling insurance, pension, estate inventory, testament matters
- receiving helpful information about grief and the process of giving in, and about where they can discuss religious and spiritual questions.

From caregivers, the elderly bereaved particularly expect honest and open information, maintenance of hope, individual treatment, caring and keeping in contact during the illness and after the death of their loved ones (cf. Laakso 2000). If the elderly who have experienced loss are dealt with and helped as described above, their grief can be expected to decrease and their quality of life to improve, and they may get closer to the comfort they seek. The challenges in helping the elderly bereaved are:

1. ensuring that a system of support and assistance is created.

2. developing ways of helping based on research and evidence.

3. forming bereavement support groups in social services and health care that help to solve problems.

4. providing active help and explaining what you are doing.

5. increasing the support available to the elderly bereaved and organising it by coordinating and combining forms of support in different directions.

6. developing cooperation in rebuilding deficient connections between health care services, social services and voluntary organisations, churches, schools and institutes of higher education, and offering non-institutional bereavement care services to the bereaved and their families.

7. the diversity of the problems faced by the elderly bereaved, which require multi-professional cooperation and competence to be solved.

8. recognising the risk groups of the elderly bereaved and offering and building services especially for them.

9. addressing the socio-psychological problems and risk factors of the elderly bereaved (lack or poor quality of support network, clinging to grief for a long time, physical illness, financial difficulties and dismissing legal and financial matters that are essential to continuing life).

10. training health care and social service professionals in order to familiarise them with the theory and practices of the process of giving in of the elderly bereaved.

11. taking advantage of the increased awareness of health matters by the elderly bereaved, which may help to improve their health.

12. developing ways to help the elderly bereaved where caregivers treat them as people, understanding their states of chaos and emotional turmoil, being present and receptive to their emotions, giving concrete help, being a "mirror", working as and offering a prepared surface, supporting the personal growth of the recovering elderly bereaved and encouraging them to face challenges.

Being familiar with the process of giving in and its 13 categories (Erjanti 1999, 2004) increases knowledge of the interactive nature of grief and of the entity formed by the elderly bereaved, caregivers, loved ones and those who have not

experienced grief. If the expectations of the elderly bereaved and their own assessments of the interactive situation are known, functioning support methods can be used effectively, and ineffective ways of helping can be avoided.

Conclusions

Being familiar with the laws that govern the process of giving in and recognising the factors that affect distress during the process are central when working with the elderly bereaved. Knowing what can be influenced from the outside is valuable, because, due to the unique and individual nature of grief and its constant variability, it is extremely difficult truly to understand the experience of grief of the elderly bereaved. However, as this article shows, it is possible to improve the quality of life of an elderly person who has experienced grief through different methods of assistance.

References

Averill, J.R. and Nunley, E.P. 1993. "Grief as an Emotion as a Disease: A Social Constructionist Perspective". In Stroebe M.S., Stroebe R. and Hansson R.O., (Eds.) Handbook of Bereavement. Theory, Research and Intervention. Cambridge University Press, Cambridge, USA. 77-90.

Erjanti, H. 1999, From Emotional Turmoil to Tranquility. Grief as a Process of Giving in. A Study on Spousal Bereavement. Acta Universitatis Tamperensis 715. Vammalan kirjapaino, Tampere.

Erjanti, H. and Paunonen-Ilmonen, M. 2004. Suru ja surevat ("Grief and the Bereaved"). Werner Söderström Oy, Porvoo.

Kaunonen, M. 2000. Support for a Family in Grief. Acta Universitatis Tamperensis 731. Vammalan Kirjapaino Oy, Vammala.

Laakso, H. 2000. Äidin suru alle seitsenvuotiaan lapsen kuoleman jälkeen ("The Mother's Grief after the Death of a Child under the Age of Seven"). Acta Universitatis Tamperensis 724. Vammalan Kirjapaino Oy, Vammala.

Lanara, V.A. 1996. Sankarillisuus hoitotyön arvona. Filosofinen näkökulma ("Heroism as a Nursing Value – A Philosophical Perspective"). Sairaanhoitajien koulutussäätiö SHKS. Hakapaino Oy, Helsinki.

Lofland, L.H. 1985. "The Social Shaping of Emotion: The case of Grief". Symbolic Interaction 8, 171-190.

Osterweis, M., Solomon, F. and Green, M. (Eds.) 1984 Bereavement: Reactions, Consequences and Care. National Academy Press, Washington.

Paterson, J. and Zderad, L. 1976. Humanistic Nursing. Wiley, New York.

Pesso, K. 2004. Terveydenhoitotyön viitekehys tutkimuskohteena ("The Framework of Health Care Work as a Research Subject"). Acta Universitatis 1005. Tampere University Press, Tampere.

Poijula, S. 2002. Surutyö ("Grief Work"). Gummerus, Jyväskylä.

Saari, S. 2003. Kuin salama kirkkaalta taivaalta. kriisit ja niistä selviytyminen ("Crises and How to Cope with Them"). Otava, Keuruu.

Wortman, C.B. and Silver, R.C. 1989. "The Myths of Coping with Loss". Journal of Consulting and Clinical Psychology 57, 349-357.

Åstedt-Kurki, P. 1992. Terveys, hyvä vointi ja hoitotyö kuntalaisten ja sairaanhoitajien kokemana ("Health, Well-Being and Nursing as Experienced by Citizens and Nurses"). Acta Universitatis Tamperensis ser A, 349. Tampere.

Senior Citizens as SeniorTrainers in Germany and Finland: Experiences of German and Finnish Participants in SeniorTrainer Education Programmes

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Introduction

The German and Finnish SeniorTrainer education programmes and their backgrounds are presented in the first sections. After that the article concentrates on describing the German and Finnish research findings and suggestions for future development.

Germany

A model programme of the BMFSFJ (Federal German Ministry of Families, Seniors, Women and Young People) was completed in Germany in 2006 under the title "EFI – Erfahrungswissen für Initiativen" ("Know-how for Initiatives"), for the purpose of using older people's know-how for the good of the society, thereby

increasing public recognition of seniors. Brainstorming, research and implementation were carried out in two directions: firstly, the intrinsic value of the know-how of seniors involved in the programme was to be confirmed to them; and secondly, strategies were developed to enable their knowledge to have a better overall effect on society, and especially on the NGO (non-governmental organisation) sector, allowing everyone to use it more extensively.

This model programme, which ran for five years between 2002 and 2006, incorporated an academic component as well as practical experience. In addition to project management, the academic element included the development of an educational concept for the further education of seniors conducted by the Neubrandenburg University of Applied Sciences (Burmeister et al. 2006). The final version of the concept includes 14 modules, in which participants are offered reflection and role-learning as well as skill-learning units.

Nearly 1,000 senior citizens, mostly aged between 55 and 70, representing all social, educational and professional backgrounds, participated in these courses (Engels et al. 2007).

Finland

The purpose of the Finnish SeniorTrainer programme was to diversify the regional development work of universities of applied sciences and offer alternative ways of action for citizens who have reached the third age. One part of the programme consisted of training volunteer work coordinators and team leaders. The purpose was to diversify the know-how and readiness of senior citizens for volunteer work. The SeniorTrainer programme included training, research and, at its later stages, joint projects between Laurea students and senior trainers.

The SeniorTrainer education programme in Finland consisted of eight modules, including practical training in associations or churches. The programme was carried out by Laurea University of Applied Sciences in cooperation with the Social and Health Affairs Volunteer Activities Support Unit of the City of Vantaa.

Seven women and three men took part in the first SeniorTrainer education programme in Finland. The age of the participants ranged between 56 and 68 years. The participants were either retired or on an early retirement pension. Almost all participants had experience of volunteer work and other social activities. As regards professional backgrounds, the participants were teachers, nurses, secretaries or other administrative workers. In addition, they had witnessed many changes in the society, including economic and educational changes and

also revolutions in the professional world. They had also held and did still hold different roles in families.

Overview of the starting points and objectives of the programmes

Germany

The main idea of the EFI programme was to access the know-how of seniors and emphasise its intrinsic value for individuals and society. Apart from historical examples regarding a "senior's" expert knowledge of life, it resorted to current social developments and considerations that are similar in many European countries. Here are just a few brief facts and insights:

- Demographic facts: The number of people above the age of 60 in Germany (and in many parts of Central Europe) is growing both in absolute figures and in proportion to the population. Since in Germany, at least, the birth rate is significantly decreasing and elderly people live longer (the average life expectancy for men is now 80 and for women approx. 84), the number of pensioners will increase rapidly in the foreseeable future.
- As life expectancy rises, the phase after the end of working life will become ever longer for a (rapidly) increasing number of seniors, and this period of life that is defined by very few general cultural guiding principles will actively gain importance. (Braun et al. 2004, Tesch-Römer et al. 2006.)

In recent years, both the demographic developments and the structural changes in old age led to new thoughts on the future role of seniors, resulting in the EFI Programme. The following thoughts on policies for seniors and on commitment played a decisive role in the justification of this model programme and the design of further education.

In terms of the policy for the elderly in relation to the programme, it is assumed that in the course of the social process of individualisation giving an important (and, compared with earlier generations, greater) freedom of action to all generations, as well as in the structural change of old age, the elderly themselves will be increasingly called upon to develop and design their participation in the society and the social involvement that is important to them. (Enquete-Komission 2002, Braun et al. 2004.)

These developments obviously pose opportunities as well as risks: it can be observed that, apart from the diminishment of family roles that usually results from aging and the retirement from professional life that occurs sooner or later, which often also involve a loss of social contacts, the change in forms of life and family may also include a risk of disintegration. Studies show that older people often wish to make up for the loss of contacts arising from retirement by intensifying the remaining family connections, but that this does not necessarily work due to changes in family structures (single households, mobility, etc.) or to diverging interests. (Burmeister 2005.)

The social changes that are (first) experienced by many older citizens as a loss of sense and orientation, of challenges and social affiliation, make it necessary for these people to re-orient themselves in the phase of life that follows after working life and that may last for two decades or even longer. Furthermore, many seniors are challenged with a search for tasks that would endow their life with meaning, beyond their families, hobbies and other possible local contacts. With regard to the EFI programme, such developments and changes in seniors' interests were taken into account in the development of a new, responsible role for seniors; the term senior trainer was – and is – used to describe this.(Burmeister 2006.)

The central idea here was a programme that would open up new forms of social participation for seniors, enabling them to integrate their experiences, abilities and interests into a commitment to and with other people, which, apart from endowing their personal life with meaning, (new) social integration and recognition, would also open a focus on the community. In its justifications with regard to commitment policies, the EFI programme assumed that senior citizens had a substantial (potential) interest in volunteering in community service and for the general good of the public. (Burmeister 2006.)

Surveys were conducted in 1999 and 2004, entitled "Volunteering in Germany", focusing on changes in honorary offices and interest in volunteering in Germany, on the expectations of volunteering and its potential, as well as on seniors' interests in further education in the phase after retirement. Their outcomes show that, at present, just under one third of all 60-year-olds volunteer in the most diverse functions. Furthermore, the generation that is retiring or has retired from professional life shows a great interest in receiving information on the possibilities for doing volunteer work; many of them would very much like to pass on their experiences and knowledge, and approx. 40% of them are interested in further education. (Gensicke 2005.)

The EFI programme assumed that an increasing number of people will be prepared to volunteer, with the will and ability to provide the society with the competence they have gained from their profession, family, daily life, hobbies, etc., as regards smaller societies, active initiatives and groups. Therefore, the EFI programme saw itself as a means of finding a new role for those seniors who wish to initiate new activities as senior trainers, and for all kinds of groups that are generally also volunteers, accompanying and guiding on a voluntary basis. (Burmeister 2005.)

Finally, the educational objectives of the model programme included the development and testing of further education courses in which seniors can ascertain their know-how, use different methods to determine their roles as senior trainers and enhance their knowledge and ability before committing themselves to voluntary work, either on their own or as a team together with other senior trainers. (Burmeister 2005.)

Finland

The Finnish SeniorTrainer education programme was based on the ideas of the German Government's SeniorTrainer programme. The goal of the Finnish SeniorTrainer programme was to diversify the regional development work of universities of applied sciences and offer alternative ways of action for citizens who have reached the third age.

The third age is usually defined as a time of retirement, when many citizens have a chance to fulfil their personal wishes and goals (e.g. Laslett 1989). The third age can be seen as a stage connected to a certain situation of life or as a turning point, rather than a chronological definition. Target-oriented activities and life management through actions are emphasised in the third age. Some people try to build their lives according to a model familiar from working life by taking part for example in training or volunteer work (Muhonen and Ojala 2004). This is the challenge to which the SeniorTrainer education programme tried to respond.

Third age citizens have a great deal of life and work experience and know-how. This experience can be put to good use through volunteer work. Finland has one of the highest numbers of senior citizens taking part in the activities of third sector organisations of the EU. Just over one half of 60-year-olds take part in activities arranged by non-governmental organisations or municipal councils (Vaarama et al. 1999). Approximately 28% of 65- to 74-year-old men and women, and 24% of 75-year-old men and 15% of 75-year-old women have reported taking part in volunteer work. This includes the activities of pensioners'

organisations, religious organisations, municipal councils and social service and health care organisations. (Koskinen 2004.)

The members of baby-boom generations (1945-1954) in Finland, our potential volunteer workers, have a lot of know-how. They are well represented in different social groups of society. (Koskinen 2004.) 29% of them are educated to university level, 39% to secondary level and 32% to elementary level (Koskinen 2004, e.g. Tiisanoja 2002). In addition to existing know-how, they need specialist know-how for volunteer work. The aging population, and probably also the number of those taking part in volunteer work, is growing, and thus there is a need to coordinate, guide and manage volunteer work.

Appreciation for the elderly as an empowering social capital is important, because the number of elderly people will grow substantially in Finland during the next few years. The proportion of people aged over 65 in the Finnish population is estimated to rise from the present 16% to 26% by 2030, and then remain level for the next decade. This means that the number of people aged over 65 will rise from today's 800,000 to over 1.4 million. The growth of the Finnish population will be low: from 5,276,955 to 5,443,000 by 2030. (Koskinen et al. 2006, Statistics Finland 2007.)

SeniorTrainer education programmes in Germany and Finland

Programme in Germany

Role-making

In learning processes which, in particular, motivate and assist in determining a new role as a SeniorTrainer, seniors are first offered the articulation of the know-how they bring with them ("who am I, what can I do"?), and a social process in which they discuss and compare ("who are the others"?) the various aspects of know-how (social and educational experiences, skills they have gained, etc.). From the very beginning, this exchange of experiences is regarded as more than a motivational method that closes the gap up to future commitment. In fact, it promotes a (self-)assuring discussion on topics of personal importance, particularly those that would probably be decisive anyway in the transition from a professional or family life to a "life after retirement": the experience of aging, experi-

ences of social transition, reflections on the entire life cycle "backwards and for-wards", especially with a view towards future interests in commitment and the responsibility being aimed at ("what would I like to do"?). (Burmeister 2005, Burmeister et al. 2007.)

The course concept offers participants practically oriented forms of learning (e.g. field research), which enable them in their (present) role of learners to follow up on their personal inclinations, "sound out" their aims onsite, make new contacts, pursue their first (small) projects and merge into teams.

Competences

Several learning modules are included here under the heading of "skills for spe-cific roles", with the help of which the prospective SeniorTrainers will broaden their skills for their future activities in the field. The course includes modules for this, which cover the topics of Contact/Discussion/Facilitation, assisting and counselling initiatives and associations, initiating and developing projects and events, motivating, supporting and linking civil commitment as well as organising oneself and coordinating teams. (Burmeister 2005, Burmeister et al. 2007.)

While these modules for determining the new roles assist and support seniors in their process of searching and reflection, tutors take on the role of facilitators. Learning about skills for specific roles deals in particular with practically oriented, useful skills, which seniors interested in civil commitment can use in their field of operation when carrying out activities related to community service, offering ad-vice or assistance, and developing projects. (Burmeister et al. 2007.)

The key thought behind this is that whoever wishes to offer advice for initiatives or projects should be able to offer advice; whoever wishes to motivate people in a community to greater civil commitment should be proficient in several methods and forms of motivation; and whoever wishes to make others aware of their new responsibility as SeniorTrainers or senior competence teams should have strategies at hand to achieve effective publicity, coordinate and promote net-working, or at least be able to research the appropriate information or know-how to obtain the appropriate knowledge. (Burmeister et al. 2007.)

Such practically oriented learning is based on having a course tutor who takes on the role of a coach to show learners "how it works" (e.g. how rules are to be applied during consultation), who acts out case studies and practical situations (e.g. dialogues or group consultation constellations, conflict situations) and re-flects with them on the possibilities and limitations of using a method in the field of voluntary work. The curricular recommendations offer corresponding topical notes as well as forms of practice, role play and projects. Course participants

use these to obtain and/or enhance their qualifications with regard to specific actions in connection with their civil commitment. (Burmeister et al. 2007.)

All together, this concept for further training offers arrangements for learning that enable the learners themselves to establish connections and links between the knowledge they actually bring with them and the possibilities for obtaining knowledge and perspectives arranged by the environment of further training. It also allows them to take a socially active part in this (Burmeister et al. 2007).

Programme in Finland

Collaborative and dialogic learning were emphasised in the Finnish Senior-Trainer programme. The chosen learning methods enabled the expression of different views and opinions. Learning was seen as the empowerment of people's intercommunication in the collaborative and the dialogic learning (Janhonen and Vanhanen-Nuutinen 2005). According to research by Lee, collaborative learning engages the whole person. Learning is appreciated as touching the affective, working with experiences, strengthening the cognitive and enhancing the social. This brings to the learning community a pulsating rhythm of learning. (Lee 2003.)

The SeniorTrainer programme focused on the SeniorTrainers adopting their role, which was treated during the education process. Through discussions, all group members could share their know-how and learn more from the other group members. In dialogic learning, participants can express their views without having to worry about being criticised by the other group members. (e.g. Kumpulainen 2000, Sarja 2000, Lee 2003, Janhonen and Vanhanen-Nuutinen 2005.) This kind of learning requires an ability to discuss, openness to criticism and the ability to listen to the views of others. A common objective in the collaborative and dialogic interaction is to provide a clear and understandable matter for discussion. With the help of questions and reflection on alternative solutions and views, the discussion can be taken forward. (Lee 2003, Janhonen and Vanhanen-Nuutinen 2005.)

The Finnish SeniorTrainer programme's curriculum was designed in accordance with the German curriculum. During training, the roles of volunteer work coordinator and team leader are built together by programme participants and teachers. The curriculum includes eight modules, of which one consists of a practical placement in a voluntary organisation and/or getting to know the different types of volunteer work. The content of teaching modules were as follows: 1) Orientation into the SeniorTrainer Programme and its content; 2) Example from the German SeniorTrainer Programme, "senior citizens as experts"; 3) Life histories and future challenges as senior trainers; 4) Finnish volunteer work, examples of

senior trainers in volunteer work; 5) Team membership and leadership, preparing for a practical placement; 6) Practical placement; 7) Evaluating practical placement experiences, own future as a senior trainer; 8) Final and assessment seminar — own well-being as a senior trainer (Havukainen 2007.)

Lectures, teamwork, reflective discussions and different types of assignments were used as teaching methods during the training in the Finnish SeniorTrainer programme. Teamwork and reflective discussions were regarded as teaching methods that advanced the learning. The group acted as a unit that empowered others and increased social capital. According to Siitonen (1999), in this process, knowledge, trust in one's own skills and self-confidence in particular can be realised through reflective discussions and also through inner speech. Empowered senior trainers have already found their voices. Empowerment changes the way senior trainers consider and perceive their actions (e.g. Robinson 1994, Siitonen 1999). In this process, teachers can strengthen the senior trainer groups' know-how and sense of control over their actions. Cooperation between teachers and students is emphasised in interaction. Empowering teachers can be seen as travel guides (Nupponen 1998).

Research Questions

The aim of the research was to describe senior trainers' views on the SeniorTrainer programme, as conducted in Germany and Finland. The main research questions were:

1) What motivation did the students have in seeking to participate in the Senior-Trainer education programme?

2) How did the SeniorTrainer students experience the training programme?

3) What kinds of knowledge, skills and competences did the SeniorTrainer students find they had learned during the training?

Research Methods

German Data and Methods

A quantitative approach was used in the German data collection and data analysis. Quantitative research is used when systemising quantitative properties and phenomena, and their relationships. The process of measurement is central to quantitative research, because it provides a fundamental connection between empirical observation and mathematical expression of quantitative relationships. (Metsämuuronen 2003, Valli 2001.) The German data came from various questionnaires. Questionnaires comprised questions concerning the content and learning methods of the SeniorTrainer education, as well as further development suggestions.

The German SeniorTrainer programme (EFI programme) was a follow-up study conducted in 2002-2004. The data collected by different organisers of the SeniorTrainer education programme was collated at ISG (Institut für Sozialforschung und Gesellschaftspolitik in Cologne). The research data consisted of responses from participants in three SeniorTrainer programmes. Altogether 701 questionnaires were sent out and the number of responses was 551 (78.6%). In the first SeniorTrainer education programme, data was collected at the beginning, in the middle and at the end of the programme, while in the two following programmes, it was collected at the beginning and the end (see Table 1). The questionnaires, which contained 20–40 questions, were Likert-scaled. The data was analysed statistically using frequencies and percentages. The data was illustrated using tables.

Table 1. Surveys of the participants in the seniorTrainer education programme

Education programmes	Questioning	Number of answers (N)	Response rate (%)
Programme 1 2002	after 1st part of education	175 of 221	79%
	after 2nd part of education	181 of 221	82%
	after 3rd part of education	174 of 221	79%
Programme 2 2003	after 1st part of education	205 of 240	85%
	after 3rd part of education	184 of 240	77%
Programme 3 2004	after 1st part of education	195 of 240	81%
	after 3rd part of education	161 of 240	67%

Finnish Data and Methods

A qualitative approach was used in the data collection and analysis of the Finnish education programme. Qualitative research is used in the exploration of understanding of social phenomena as experienced by individuals themselves (Malterud 2001). The qualitative approach is useful in cases where the participant group is small and the domain of study is new, as in the case of the Finnish SeniorTrainer education programme. Qualitative research involves the use of qualitative data, such as interviews, documents and participants' observations, to understand and explain social phenomena (Malterud 2001, Widebeck et al. 2007).

The Finnish data came from thematic questionnaires, diaries, feed-back forms and focus-group interviews of ten SeniorTrainer students. The thematic ques-

tionnaires focused on themes: useful life experiences for voluntary work as a senior trainer, reasons for taking part in SeniorTrainer education, expectations of the programme and ideas for carrying out voluntary work as a senior trainer. Students could answer the questions in brief or write a short story of their experiences and expectations. Thematic focus-group interviews in small groups of 3-4 participants were conducted at the end of the SeniorTrainer education programme. Focus-group research is a method in which a small group of participants gather to discuss a specific topic under the guidance of a moderator (Widebeck et al. 2007). The interview questions focused on the main themes of usefulness of the study programme, learning experiences during the education and ideas for developing the education. The use of thematic questionnaires and interviews is suitable especially when there is no exact theory about the issue, but one desires to find new viewpoints that had not been anticipated. Often the respondents will produce more new viewpoints than can be used. (Hirsjärvi and Hurme 2004.)

The data — the students' thematic questionnaires and focus-group interviews — were analysed using qualitative and inductive content analysis (Dey 1995, Kyngäs and Vanhanen 1999, Kylmä et al. 2004, Mayring 2007). A thematic entity was used as the unit of analysis. The aim of the research, themes and research questions steered the analysis. A progressive way of action was used in the SeniorTrainer data analysis. (Lamnek 2005, Mayring 2007) The data was divided into sections, which were grouped and built into integrated categories. With the help of the analysis, a description of the students' experiences of the SeniorTrainer programme was formed. (Kyngäs and Vanhanen 1999, Latvala and Vanhanen-Nuutinen 2003) The purpose of this qualitative research was not so much trying to find objective evidence of a truth as it was to identify views regarding the SeniorTrainer education programme (e.g. Kylmä et al. 2003).

Findings

The following chapters report the German and Finnish research findings according to the research problems and questionnaires used.

SeniorTrainer students' motivations for participating in the two education programmes

This chapter will answer the research question "What motivation did the students have in seeking to participate in the SeniorTrainer education programme?"

Germany

The motives and expectations regarding SeniorTrainer education remained constant over the years. Interest in civic activity, responsible roles for elderly people, interpersonal exchanges of information and experiences, preparation for senior trainer activities and sharing knowledge and know-how were the most common motives for participation mentioned by the students. In addition, the content of the SeniorTrainer programme and activities, and social motives were mentioned as motives. The participants wished to use their professional competence and broaden their know-how. Social expectations and further opportunities for activities acted as stimuli for engaging in the further education programme. (e.g. Burmeister et al. 2004.)

Finland

The Finnish SeniorTrainer students' motives for taking part in the SeniorTrainer education programme can be divided into the following categories: increasing know-how, life changes, personal activities, finding meaningful activities, desire to work for the common good in society, and the parents' example. In the following paragraphs, the categories are presented using senior trainers as examples (see Table 2).

Table 2. SeniorTrainer students' motivations for participating in the SeniorTrainer programme (views of students)

Subcategories	Main categories
- enquiry - to learn more - to learn more about voluntary activities	Increasing know-how
- time after retirement - divorce - death of a partner - unemployment	Life changes
- voluntary activities in associations - voluntary activities in churches - voluntary activities in the Army - participation in clubs	Personal activities (hobbies)
- to prevent loneliness after retirement - to use one's own know-how - to find a hobby	Finding meaningful activities
- mother's example - neighbourly assistance - peers' assistance	Parents' example
- worries over fellow citizens - to prevent social problems of the elderly - experiences of being old and helping elderly people	Desire to work for the common good in society

SeniorTrainer students expressed to increase their know-how and to learn more about voluntary work. After retirement, many SeniorTrainer students had time to participate in the programme. They had also experienced many changes in their lives.

My motives for participating in the SeniorTrainer education programme were a thirst for learning and the desire to learn more about voluntary work and Senior-Training. After retirement, I had more time for doing things. There had been

changes in my life — my husband/wife had died. I was divorced already some years ago. Unemployment gave me time to explore new possibilities.

Some students already had experience of voluntary work in associations, churches or the Army.

My previous experience of voluntary work was one of the reasons I decided to participate in seniorTrainer education. I have done voluntary work for the Red Cross. I for one have worked in retirement associations. Working in the church is also well-known. I have followed my family members and participated in the activities of the Army. For my part, I have worked for youth associations and the Martha organisation (Finnish home economics organisation) ever since my childhood.

The common motivation of the Finnish seniorTrainer students was to find new activities.

Although the threshold for participating in the seniorTrainer programme was high, I decided to do it. I wanted to find new activities. I also wanted to advertise new social contacts.

Worries about the aging Finnish population and the desire to find a new way to help fellow citizens were some of the reasons for participating in the programme.

Elderly people in Finland become easily isolated. As a consequence of loneliness and feelings of emptiness, the consumption of alcohol increases. Many aged have no relatives nearby. Children do not visit parents very often, and some young people are afraid of the elderly. We must also remember unemployment as a problem for elderly groups.

Some students had also become acquainted with voluntary work through their parents, who had pointed out the importance of neighbourly assistance and voluntary work in associations or churches.

My parents' example was very important. My mother was in the Women's Auxillary Service in the Second World War. My parents were also engaged in neighbourly assistance. My mother was in the friendship service of the Finnish Red Cross. According to her, a volunteer is like a breath of fresh air from the outside world. Therefore she always dressed well for her appointments with friends as a voluntary worker.
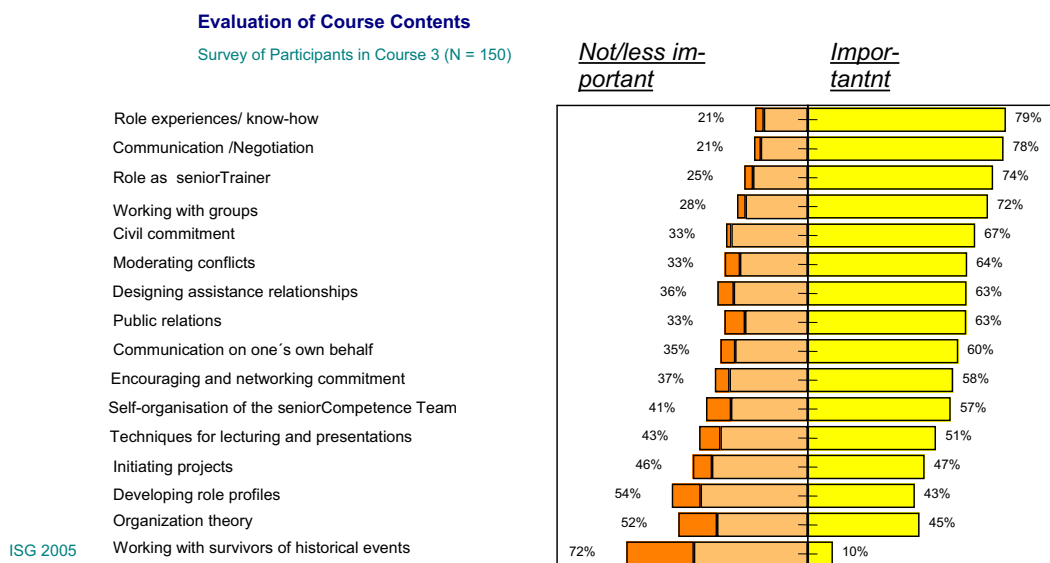
SeniorTrainer students' experiences of the SeniorTrainer education programme

This chapter will answer the research question "How did the SeniorTrainer students experience the training programme?"

Germany

According to the responses from the third SeniorTrainer education programme, 79% of participants considered role experiences, empirical knowledge and competence to be important. 78% mentioned communication and conversations as significant, 74% mentioned the role of SeniorTrainers and 72% mentioned working in groups (see Table 3).

Table 3. Evaluation of the content of the German SeniorTrainer programme (views of students)

Evaluation of Course Contents

Survey of Participants in Course 3 (N = 150)

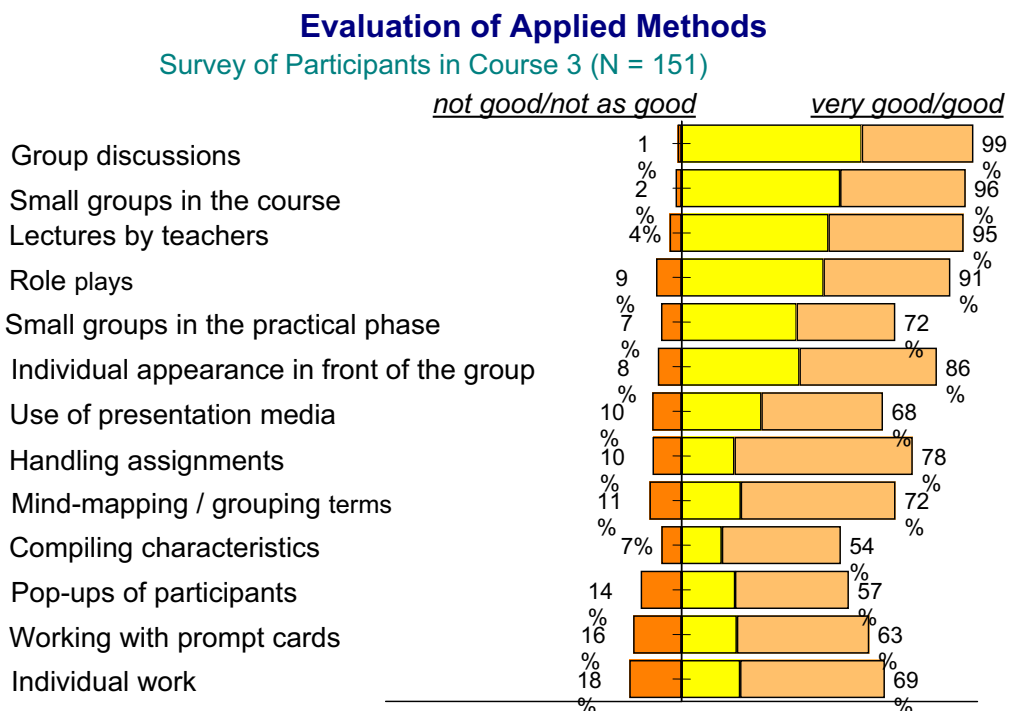|	Not/less important	Importantnt
Role experiences/ know-how	21%	79%
Communication /Negotiation	21%	78%
Role as seniorTrainer	25%	74%
Working with groups	28%	72%
Civil commitment	33%	67%
Moderating conflicts	33%	64%
Designing assistance relationships	36%	63%
Public relations	33%	63%
Communication on one´s own behalf	35%	60%
Encouraging and networking commitment	37%	58%
Self-organisation of the seniorCompetence Team	41%	57%
Techniques for lecturing and presentations	43%	51%
Initiating projects	46%	47%
Developing role profiles	54%	43%
Organization theory	52%	45%
Working with survivors of historical events	72%	10%

ISG 2005

63-67% of respondents considered conflict moderation, counselling and civil commitment to be the most important issues and methods.

71% of respondents thought that no content was missing from the SeniorTrainer education, whereas 29% reported some deficiencies, such as the lack of initiating projects and communication methods.

The answers showed that not all of the methods mentioned in Table 3 were used during the SeniorTrainer programme. According to given information, group discussions, group work and role play were considered to be very good. Lectures and lecturers were also appreciated. The participants' own presentations, mind-mapping and moderation cards were regarded as good, as were assignments and practical activities (see Table 4).

Table 4. Evaluation methods of the German SeniorTrainer programme (views of students)

Evaluation of Applied Methods
Survey of Participants in Course 3 (N = 151)

	not good/not as good	*very good/good*
Group discussions	1%	99%
Small groups in the course	2%	96%
Lectures by teachers	4%	95%
Role plays	9%	91%
Small groups in the practical phase	7%	72%
Individual appearance in front of the group	8%	86%
Use of presentation media	10%	68%
Handling assignments	10%	78%
Mind-mapping / grouping terms	11%	72%
Compiling characteristics	7%	54%
Pop-ups of participants	14%	57%
Working with prompt cards	16%	63%
Individual work	18%	69%

The accentuation and specification of the SeniorTrainers' role was important in the SeniorTrainer Programme. In an additional question, half of the participants answered that the exchange of experiences during the practical period, as well as preparing the presentation of their own roles had been successful.

The students highly valued team spirit, the teaching staff, the programme's organisation and the learning materials. They especially appreciated the possibility of sharing experiences. The possibility to create together, calling attention to earlier experiences and the practically oriented content of the programme were graded as "not as good". In the responses, "not as good" is a relative concept, because the students mainly used the grades "good" and "very good".

Finland

At the beginning of the Finnish SeniorTrainer programme, students expected to receive increased knowledge of voluntary activities, skills in promoting voluntary activities, skills in working for fellow citizens and finding new social relationships. At the end of the programme, the data from the SeniorTrainer interviews was divided into four main categories: content of training, learning methods, the teacher as a promoter of learning, and the SeniorTrainer group as a promoter of learning (see Table 5).

Table 5. The Finnish SeniorTrainer programme from the students' point of view (views of students)

Subcategories	Main categories
- adult learning - theoretical knowledge and statistics - communication - voluntary work	Content of training
- lectures - group work - practical training	Learning methods
- encouraging way of teaching	Teacher as promoter of learning
- sharing of experiences - compactness of the group - responsible participation of group members - functioning communication - positive atmosphere	SeniorTrainer group as promoter of learning

According to the data, students emphasised adult learning, theoretical knowledge, communication and voluntary work as the most important things in the content of the training.

I was most interested in learning things, especially finding out how adult people can learn. We learned about different learning styles. I can say that people are never too old to learn new things. The theoretical and statistical facts of aging, the structural developments of the population and the knowledge and diversity of voluntary work were also essential. During the programme we also learned about intercommunication.

The learning methods mentioned by the students were in the categories lecturers, group work and practical training.

The obligatory lecturers were well-founded to give us facts and statistical knowledge. Different exercises such as the map of Finland, postcards and treasury cards, role play and social games were motivators of discussions. They were good instruments of group work. Working in small and large groups was productive. Practical training was also very useful and educational.

The category of the teacher as a promoter of learning included the subcategory "encouraging way of teaching".

The teachers respected the students and encouraged us to be explicit. The teachers kind of "tricked us" to learn. The teachers were wise. They were not constantly talking, they allowed the group to act. They also created the necessary conditions for a positive learning atmosphere.

Four subcategories were identified in the category of the SeniorTrainer group as a promoter of learning: compactness of the group, responsible participation of group members, functioning communication and positive atmosphere.

The group members learned to know each other. The group was enthusiastic, colourful and dynamic. The group was also interactive, open, creative and spontaneous. You seldom meet these kinds of people and this kind of group. We were like a family. The group members shared their know-how, and it was possible to hear about others' experiences of voluntary work. The group also shared information on the practical placements. In the group, all members dared to speak and be themselves. Everybody contributed to the group work. There were no "downer" types. From the beginning to the end, the atmosphere was positive, with good team spirits.

Learning experiences of the SeniorTrainer students during the programme

This chapter will answer the research question "What kinds of knowledge, skills and competences did the SeniorTrainer students find they had gained from the training?"
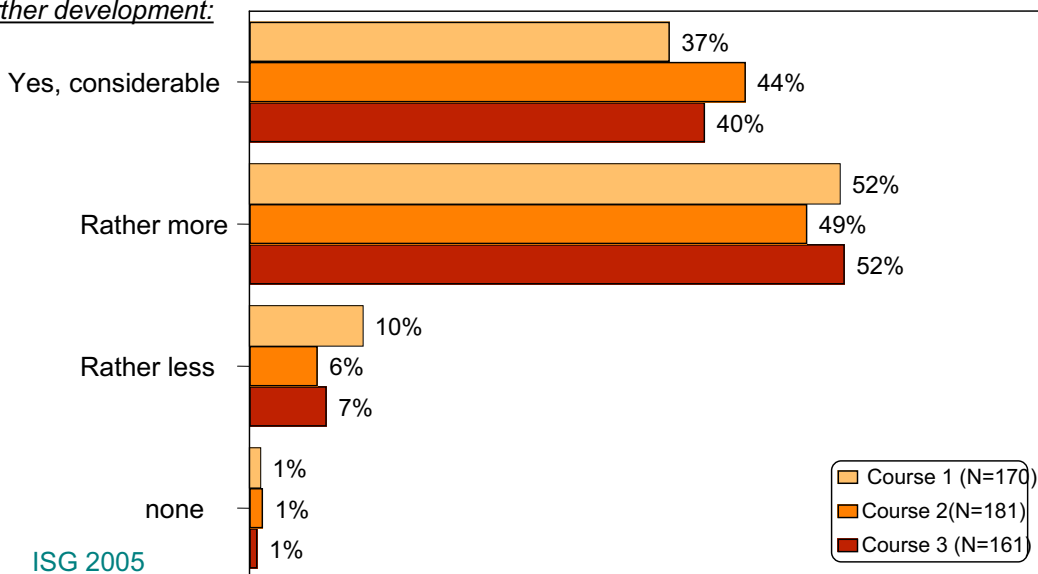
Germany

The main aim of the SeniorTrainer programme was the estimation/empowerment of the SeniorTrainer students' experiences and competences. According to the educational plans, the knowledge and competences of students should enlarge, so that participants can prepare for further practical activities in the voluntary sector. 92% of the participants gave a positive response to the question "To what degree did participation in the SeniorTrainer programme contribute to the development of your knowledge and the success of competences?". 40% considered their development to have been "considerable". Collating the positive responses and comparing them to the negative ones, it can be seen that the negative responses decreased from 11% to 8%.

Table 6. Knowledge and competences of SeniorTrainer students after the SeniorTrainer programme (views of students)

Knowledge and Skills after Attending the Course
Survey of Participants in Course 1 (2002), Course 2 (2003) and Course 3 (2004)

Further development:

Yes, considerable	37% / 44% / 40%
Rather more	52% / 49% / 52%
Rather less	10% / 6% / 7%
none	1% / 1% / 1%

Legend:
- Course 1 (N=170)
- Course 2 (N=181)
- Course 3 (N=161)

ISG 2005

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It is difficult to estimate to what extent the views of SeniorTrainer students strengthened or changed during the SeniorTrainer programme. On the one hand, it mostly dealt with experienced honorary citizens who had already proven their competences in earlier engagements. On the other hand, there was an attitude risk among the participants, because some were thought to be "all-rounders" and others did not take care of the new SeniorTrainer concept. In so far the view of the exchange has been conducted through the conception of the education programme.

This goal was increasingly reached during the education. The number of participants who felt that their competence as a SeniorTrainer had changed or sharpened through participation in the programme, increased from the first two courses to the third course from 56% to 79%. Only one fifth (21%) of the participants saw no change in their know-how. They were probably not well-informed before participating in the programme, or they might have considered the programme to have confirmed their earlier views. This may also show the participants' inability to change their views about SeniorTrainer activities. All in all, positive feedback increased considerably during the progress of the programme.

Table 7. Changes in SeniorTrainers' views regarding SeniorTrainer activities during the programme

Conceptions Changed by Attending the Course
Survey of Participants in Course1 (2002), Course 2 (2003) and Course 3 (2004)
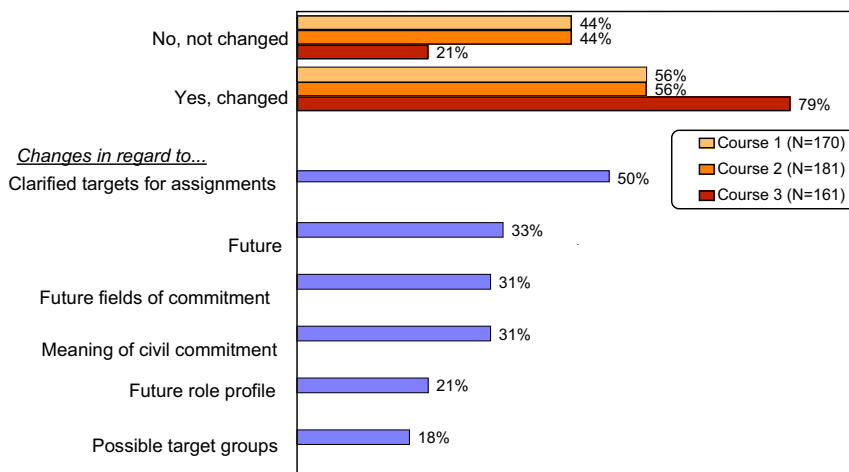
ISG 2005

With regard to the question of concrete changes during the programme, the clarification of the functions of a SeniorTrainer (50%) was mentioned. The further focusing of future activities (33%), the area of operation and the meaning of civic activities (31%) was successful (see Table 7).

In so far the change in views of SeniorTrainer activities has been brought up in the discussions with other SeniorTrainer students (59%). The lectures and advanced instruction in the chosen content (49%) made up the second most important cause of change. Thirdly, an improved recognition of the SeniorTrainer's role (44%) was pointed out. One third of participants changed their views concerning their actions as a SeniorTrainer thanks to and during the practical period.

Finland

The learning experienced by the SeniorTrainer students during the programme can be divided into three categories: learning meta-cognitive skills, learning the basics of voluntary work/activities, strengthening spiritual resources/empowerment (see Table 8).

Table 8. Learning experiences of SeniorTrainer students during the SeniorTrainer pro-
gramme (views of students)

Subcategories	Main category
- self-awareness - awareness of own learning styles - awareness of own orientation - action orientation - communication orientation - presence orientation	Learning of meta-cognitive skills
- repetition of voluntary work - strengthening of voluntary work - learning methods - increasing know-how	Learning the basics of voluntary work

The learning of meta-cognitive skills had subcategories in self-awareness and
awareness of learning styles and orientation.

*I have learned to know myself and my case. I began to tune in to the idea of
adult learning. I understood that old people can learn. I began to understand
how I learn — for example whether I learn by listening or by seeing.*

Three orientation types concerning voluntary work were found from the data,
which were action orientation, communication orientation and presence orienta-
tion.

*I became more self-assured, gained strength for action and learned to trust my
abilities and way of working. I also got the courage to continue as a voluntary
worker. The programme gave me power. I also found myself as an actor.*

Learning the basics of voluntary work contained two subcategories: repeating
and strengthening the knowledge of voluntary activities, and increasing knowl-
edge of the methods and actions of voluntary work.

*The content of the lectures was partially familiar to me, as I do have a basic
education in voluntary work. Things I had learned before came back to me. I
learned methods of operating, group-leading skills and intercommunication
skills. I also learned the best practices of the voluntary sector, for example how
to prepare contacts with voluntary units and arrange group events. I was also
able to mobilise my unused skills. Finally, I received a lot of experience of volun-
tary work.*

Discussion and Conclusions

The German and Finnish SeniorTrainer students appreciated the SeniorTrainer education programmes. In their view, the programmes increased their knowledge of teamwork, their project management skills and their awareness of SeniorTrainers' roles. Most students felt that they were well prepared for working as SeniorTrainers. Especially the German data showed that the students' competence had increased in dealing with conflicts in groups or organisations. According to follow-up research, the SeniorTrainer programme also had a measurable impact on personal development. (cf. Staudinger and Mühlig-Viersen 2007.)

In both the German and the Finnish data, the contents and activities of the SeniorTrainer programme and new social experiences within the learning process turned out to be strong motives for participation in the programme. The common motive for both countries' SeniorTrainer students was to find new activities and new ways to help fellow citizens after retirement. In addition, knowledge exchanges and sharing experiences and know-how were regarded as important motives by both groups. Especially the Finnish students wanted to learn more about voluntary work and to find new pastimes.

Major experiences and (sudden) events in the students' lives — such as retirement from work, the death of a spouse, divorce or unemployment experiences — increased the desire of Finnish SeniorTrainers to look for a good alternative and join the programme.

SeniorTrainer students emphasised the importance of theoretical studies. The Finnish students in particular pointed out the usefulness of adult learning and voluntary work. The German students stressed the methods of conflict moderation and counselling as interesting issues. The compactness and functionality of the group and the empowering attitude of teachers promoted the impact of learning on the levels of emotion, cognition and social enhancement (Lee 2003). In this process, handling information and know-how, and respect for peers deepened thanks to the use of collaborative and dialogic learning. It appears that the active exchange of ideas in the group increased interest in SeniorTrainer activities and promoted reflective discussion about activities (e.g. Gokhale 1995). In this process, the encouraging and empowering teachers acted as promoters and "learning pilots" for the SeniorTrainers' know-how (e.g. Nupponen 1998).

During the SeniorTrainer programme, Finnish students became aware of their learning styles and of themselves. Both the German and the Finnish students mentioned improved recognition of SeniorTrainers' roles. The Finnish data indi-

cated that students became conscious of their typical ways of acting as Senior-Trainers, and whether they were more oriented towards action, communication or presence. Students became empowered and started to trust their abilities and methods. They learnt, repeated or confirmed the basics of voluntary work during the SeniorTrainer programme. Their methodological know-how, their group leadership skills and their intercommunication skills increased, although more project leadership skills were longed for according to the German data.

The students stated that their knowledge and competences increased. According to responses, they became well prepared to work in the voluntary sector for the benefit of organisations, or to come up with their own projects. All in all, it is difficult to say whether their skills improved thanks to the programme or thanks to earlier experiences of voluntary work — or both together. In so far the view on the change of SeniorTrainer students' competences and way of acting has been conducted through the conception of the German and Finnish education programme.

The Finnish data indicated that the SeniorTrainers worried about the aging and loneliness of the elderly population of the Finnish society. The SeniorTrainer programme could be regarded as an unpretentious but new social investment to help the elderly generation. The aging of the population challenges the whole society to develop alternative ways of acting for citizens who have reached the third age (e.g. Government Resolution on the Health 2015, 2001; Havukainen 2007).

Although the new role profile of senior citizens as SeniorTrainers has become better-known during the runtime of the model programme (in Germany) and the education concepts (in both countries), this role should be clarified further in these two countries, both in education and on the societal level. More information and widespread discussions on the helpful role of SeniorTrainers in the voluntary sector and in the societies as a whole should also help in spreading awareness and appreciation of senior citizens' roles both in the voluntary sector and in the whole society.

Reliability and Ethics

The researchers' familiarity with learning theories and adult learning, voluntary work and participation in the SeniorTrainer education programme increased credibility. The reliability of the German findings was ensured by collecting the data from three different SeniorTrainer programmes. The response rate was

quite high (78.6%) in the German data. The findings of the four stepped Likert-scaled questionnaires with 501 responses might have been enriched by using for example multivariate analyses. However, the methods used gave a good picture of the German SeniorTrainer education programme. The findings were made understandable and informative with the help of percentage tables. The generalisation of the findings demands further research with the help of specific questionnaires. (cf. Metsämuuronen 2003, Valli 2001.)

The reliability of the Finnish research was ensured using data triangulation (different data). The data came from interviews and questionnaires. The diaries of SeniorTrainer students were used as support material. An attempt was made to prove the reliability of the Finnish research using tables and evidence-based examples. Interviews were recorded and transcribed word for word (Kylmä et al. 2003). The fact that only one researcher analysed the written data and interviews might reduce the reliability; however, it could be increased by similar findings in the teachers' data. The teachers' data will be reported in another article. The findings have not been transferred to other learning situations as they are. (Peräkylä 2006.)

Because of the late decision to connect the German and Finnish data, it was only possible to use a part of both partners' data. In spite of having different data and methods, very similar findings were produced. The research has produced very useful and valuable information for developing the Senior Trainer education programme in both countries.

Both the teachers and the students of the German and Finnish SeniorTrainer education programmes were aware of the research conducted during the programmes. The anonymity of students and teachers was ensured using outside help.

Implications for Future Development

The research part of the German SeniorTrainer education programme was a follow-up study, which was conducted in 10 (out of 16) federal states in Germany during 2002-2004. The Finnish SeniorTrainer programme was planned and realised with reference to modules out of the German curriculum and in cooperation with Laurea University of Applied Sciences and the City of Vantaa's Social and Health Affairs Volunteer Activities Support Unit.

The basic ideas of the content and confirmation of teaching methods developed during the programme. New roles for SeniorTrainers as voluntary workers, e.g. as leaders or coordinators of voluntary work, could be pieced together and strengthened. The German and Finnish SeniorTrainer programme and research produced knowledge concerning SeniorTrainers' learning and development ideas for the programme.

The German SeniorTrainer education programme and activities have gained a position in the German society, whereas the Finnish SeniorTrainer programme has only taken its first steps. The big challenge that still remains relates to making the SeniorTrainer education and activities evident and finding suitable channels for disseminating information on the new roles of volunteers as Senior-Trainers and as a social asset. The SeniorTrainer education programme must be directed towards NGOs and should recruit participants from them. There are a lot of know-how and potential participants out there. (Havukainen 2008a.)

Project leadership skills and construction of the SeniorTrainers' role profiles should be ensured and strengthened in further SeniorTrainer education programmes. In addition, one of the most important responsibilities in relation to SeniorTrainers is to support students after the programme. Further education would also be appreciated. In addition, peer group support and professional help is needed after the education. SeniorTrainers should be encouraged to build networks, such as those which have already been established in Germany under the name of "SeniorCompetenceteams". (cf. Engels et al. 2007, Havukainen 2008b.)

It is important to continue collecting data from SeniorTrainer students and their teachers. It is especially important to collect data concerning the growth of SeniorTrainers' roles from the point of view of students and teachers. An evaluation of the effectiveness and functionality of the SeniorTrainer education programme will be conducted from the point of view of voluntary placements and Senior-Trainers' future experiences (cf. Kirkpatrick 1996).

References

Braun, J., Burmeister, J. and Engels, D. 2004. S*eniorTrainerin: Neue Verantwortungsrolle und Engagement in Kommunen*. Leipzig: ISAB Institut.

Burmeister, J. 2005. *Weiterbildung älterer Menschen für bürgerschaftliches Engagement als seniorTrainerin*. Cologne: ISAB Institut.

Burmeister, J. 2006. "Senioriosaajakoulutuksen esimerkki Saksasta - The EFI-Model programme". Neubrandenburg (Paper presentation)

Burmeister, J., Heller, A. and Stehr, I. 2007. *Weiterbildung älterer Menschen für bürgerschaftliches Engagement als seniorTrainer/in. Ein Kurskonzept für lokale Netzwerke*. Cologne: ISAB Institut.

Dey, I. 1995. *Qualitative Data Analysis. A User-Friendly Guide for Social Scientists*. London, Guilford and Kings's Lynn: Biddles LtD.

Engels, D., Braun, J. and Burmeister, J. 2007. S*eniorTrainerinnen und senior-Kompetenzteams: Erfahrungswissen und Engagement älterer Menschen in einer neuen Verantwortungsrolle*. Cologne: ISAB Institut.

Enquete-Kommission "Zukunft des bürgerschaftlichen Engagements" (Ed.). *Bürgerschaftliches Engagement – auf dem Weg in eine zukunftsfähige Bürgergesellschaft*. Endbericht. 2002. Schriftenreihe: Enquete-Kommission "Zukunft des bürgerschaftlichen Engagements des Deutschen Bundestages". Bd. 4. Opladen: Beske and Budrich.

Gensicke, Th., Picot, S. and Geiss, S. 2005. *Freiwilliges Engagement in Deutschland 1999-2004. Ergebnisse der repräsentativen Trenderhebung zu Ehrenamt, Freiwilligenarbeit und bürgerschaftlichem Engagement*. Munich.

Gokhale, A. A. 1995. Collaborative Learning Enhances Critical Thinking. *Journal of Technology Education* 7(1), 22–30.

Havukainen, P. 2007. Teachers in Regional Development: Senior Trainer Programme as an Activator of Senior Citizens. In Helena Erjanti (Ed.) Refurbishing Elderly Care. Strategy of Cost Efficiency in Theory and Practice. Helsinki: Edita Prima Oy, 123–128.

Havukainen, P. 2008a. Senioriosaajaopiskelijoiden ja heidän opettajiensa osaamisen kehittyminen koulutuksen aikana opettajien arvioimana. *KeVer-verkkolehti* 7(2),1-19. http://ojs.seamk.fi/index.php/kever/issue/current (5 June 2008.)

Havukainen, P. 2008b. Experiences of SeniorTrainer Project in Finnish Society: The view of SeniorTrainer students and their teachers. The Third Sendai-Finland Seminar 13-15 November 2007.

Heikkinen, E. 2000. Elinajan piteneminen – onni vai onnettomuus?. *Gerontologia* 1, 27-33.

Hirsjärvi, S. and Hurme, H. 2000. *Tutkimushaastattelu*. Helsinki: Yliopistopaino.

Janhonen, S. and Vanhanen-Nuutinen, L. 2005. Asiantuntijuuden kehittyminen sosiaali- ja terveysalalla. In S. Janhonen S. & L. Vanhanen-Nuutinen (Eds.) Kohti asiantuntijuutta – Oppiminen ja ammatillinen kasvu sosiaali- ja terveysalalla. Vantaa: WSOY,12-53.

Kirckpatrick, D. 1996. Great Ideas Revisited. Training and Development 5(1),56-59.

Koskinen, S. 2004. Ikääntyneitten voimavarat. In *Ikääntyminen* voimavarana. Tulevaisuuselonteon raportti 5. Publications of the Prime Minister's Office 33. Helsinki: Edita Prima Oy, 24-90.

Koskinen, S., Martelin, T. and Sainio, P. 2006. Iäkkäiden toimintakyvyn kohentaminen välttämätöntä. Duodecim 122 (3),255-226.

Kylmä, J., Vehviläinen-Julkunen K. and Lähdevirta, J. 2003. Laadullinen terveystutkimus – mitä, miten, miksi?. *Duodecim* 119(7), 609-615.

Kyngäs, H. and Vanhanen, L. 1999. Sisällön analyysi. Hoitotiede 11(1), 3-12.

Lamnek, S. 2005. Qualitative Sozialforschung. Weinheim: Beltz Verlag.

Laslett, P. 1989. A Fresh Map of Life. The Emergence of the Third Age. London: Weidenfeld and Nicolson.

Latvala, E. and Vanhanen-Nuutinen, L. 2003. Laadullisen hoitotieteellisen tutkimuksen perusprosessi: Sisällönanalyysi 21. In S. Janhonen & M. Nikkonen

(Eds.) Laadulliset tutkimusmenetelmät hoitotieteessä. Juva: WS Bookwell Oy, 21- 43.

Lee, M. 2003. Engaging the whole person through the practice of collaborative learning. International Journal of Lifelong Education 22(1),78-93.

Mayring, P. 2007. Qualitative Inhaltsanalyse. Weinheim: Beltz Verlag.

Malterud, K. Qualitative research: standards, challenges, and guidelines. Qulitative Research Series, 358(11), 483-488.

Metsämuuronen, J. 2003. Tutkimuksen tekemisen perusteet ihmistieteessä. Jyväskylä: Gummeruksen Kirjapaino Oy.

Muhonen, R. and Ojala, H. 2004. Ajassa muuttuva kolmas ikä. Gerontologia 1,10-17.

Nupponen, R. 1998. What is counselling all about – Basics in the counselling of health–related physical activity. Patient Education and Counselling 33, 61-67.

Government Resolution on the Health 2015. 2001. Public Health Programme. Publications of the Ministry of Social Affairs and Health 2001:6. Available in electronic format at http://www.terveys2015.fi/images/health2015.pdf (29 June 2007).

Peräkylä, A. 2006. Reliability and validity in research in based on naturally occurring social interaction. In D. Silverman (Ed.) Qualitative Research. Theory, Method and Practice. London: Sage Publications, 283-304.

Robinson, H. A. 1994. The Ethnography of Empowerment. London: Falmer Press.

Sarja, A. 2000. Dialogioppiminen ryhmä- ja yksilötasolla hoitotyön kontekstissa. Aikuiskasvatus 20(2), 99-108.

Siitonen, J. 1999. Voimaantumisteorian perusteiden hahmottelua. Acta Universitatis Ouluensis E 37. Oulu: Oulu University Press.

Staudinger, U. and Mühlig-Versen, A. 2007. Lässt sich Persönlichkeitsentwicklung im Alter unterstützen?. In Engels, D., Braun, J., Burmeister, J. seniorTraine-

rinnen und seniorKompetenzteams: Erfahrungswissen und Engagement älterer Menschen in einer neuen Verantwortungsrolle. Cologne: ISAB Institut.

Tesch-Römer, C., Engstler, H., and Wurm, S. (Eds.). 2006. Altwerden in Deutschland. Sozialer Wandel und individuelle Entwicklung in der zweiten Lebenshälfte. Wiesbaden.

Tiisanoja, M. 2002. Työn sukupolvi parhaassa työiässä. Hyvinvointikatsaus. Tilastollinen aikakauslehti 1, 24-27.

Statistics Finland. 2007. Population Forecast 2007-2040. Available in electronic format at http://www.stat.fi/til//vaenn/2007/vaenn_2007_2007-05-31_tie_001.html (6 May 2007).

Vaarama, M., Hakkarainen, A. and Laaksonen, S. 1999. Vanhusbarometri. Reports of the Ministry of Social Affairs and Health 3. Helsinki.

Valli, R. 2001. Johdatus tilastolliseen tutkimukseen. Jyväskylä: Gummeruksen kirjakauppa Oy.

Widebeck, W., Dahlgren MA. and Oberg, G. 2007. Learning in focus groups: an analytical dimension for enhancing focus group research. Qualitative Research, 7(2), 249-267.

The elderly as an active part of the community

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In 2007 Laurea University of Applied Sciences, in Tikkurila, (Helsinki, Finland) offered an Educational Programme for Voluntary Senior Trainers. Part of the study presented below resulted from the author's personal and practical involvement in that programme.

Almost all of the elderly people in Finland live at home, not in nursing homes, The training programme revealed certain needs that elderly people, residing in the same resident's association, have with regard to social, physical, civic, cultural and attitudinal resources. As a result an organisation called The Active Seniors Association (ASA) was established during spring 2008. The ASA can be looked at as a social and cultural organisation aimed at creating new innovations and setting new challenges for local, small enterprises and entrepreneurs. Since May 2008 ASA has had more than 70 voluntary social gatherings on a variety of subjects.

In addition, monthly leaflets have been published and a home page set up. Educational connections with national, local and international organisations have been established. The role of ASA is important as an organiser and as an educator/trainer. So far, students from Omnia and Helsinki Business College and The Business Academy of Donaustadt in Vienna have been given a training platform for learning and for practising their skills and competences among elderly people, especially in their homes. This is important as elderly people are not iso-

lated and their homes can become a centre for all the activities they need to actively participate in a community.

Figure 1. Active Seniors travelling in August 2008.

State level objectives for old age service development

Under the Finnish Local Government Act (365/1995) people living in a given municipality must be given the opportunity to participate in and influence how local issues and matters are planned and prepared. Additionally, they should be able to obtain information on all matters currently under discussion. It is believed that providing an aging population with equal opportunities for participation and influence will help to ensure an active old age, whether they live at home or in

care, and irrespective of their need for assistance (The National Framework for High-Quality Services for older people. 2008:5, 14).

The main ethical principles of The National Framework (2008, 12-13) for ensuring an old age with dignity are:

- self-determination
- resource orientation
- equality
- participation
- individuality and
- security.

The method for obtaining these principles emphasises the responsibility society's private sector and elderly people themselves have in making the above happen. This raises the question: What kinds of partners are the state and municipalities? The existing patterns and the structure of culture have changed significantly. Most elderly people live alone. The distances to their relatives are long and their own children are busy with work and their own family. Thus, elderly people must manage their life alone. If they need services in Finland's welfare society, the public and private sectors are expected to take care of them. However, very few elderly can assess the quality of the services being offered or afford them. Consequently, low cost innovations are urgently needed.

Usually elderly people are looked upon as objects and a social burden. The media strengthens and is partly responsible for this view. Nevertheless, it is also possible to see the other side of the picture. In fact, old people are not helpless, and as a group could wield much power, especially if they can establish a movement for elderly people in the near future. Some of that the roots of that potential and future challenges, which can lead to structural changes and provide the elderly with a meaningful place in the society, are mentioned in the following:

- The elderly in Finland will soon have political power, as the majority of voters are going to be over 50 years old in the near future.
- The elderly will have economic power. For the first time in history elderly Finnish people will have wealth to redistribute. They are in a position to be able to help their own children and grandchildren. The current generation approaching retirement age are wealthier and healthier than any generation before and can even support their parents.

- The elderly have consumer power and can support the creation of new, innovative businesses that use new technology and ICT for their benefit.
- The elderly have social and cultural power. They are culturally and social literate and can collaborate effectively when needed. Crucially, they have a strong collective identity.
- The elderly have a sense of civic responsibility and see democracy as a tool that can manage and solve private sector and public sector problems in contemporary society.

Public sector
- State: legislature and recommendations
- Municipalities: strategy and policy documents

Private sector
- Ingo and Ngo organizations
- Small businesses and enterprices

Third sector
- Voluntary organizations and interest groups
- People's innovative movements

Figure 2. The actors who develop services for the elderly

Municipal level objectives for old age service development

The main trend in the development of municipal level objectives for old age service development is a shift in responsibility from the public sector to the private sector. The economic resources for developing public sector services are very limited and have an emphasis on health services for those old people that need them most. This covers about 1 to 3% of the aging population. Most other elderly people must manage by themselves or with minimal support.

The ability for self-renewal, in the existing private and third sector of non-governmental organisations service structure, on a municipal level requires creative tension. Tension refers to a state of anticipation characterised by insecurity as to the consequences of future events and action. Tension is born of opposite and sufficiently diverse forces existing simultaneously and calling into question the prevalent modes of thinking and operation and status quo. Creativeness entails producing unprecedented and original products, processes, ideas and modes of operation. Creativeness entails information in a manner that creates new and diverse ways of observing and interpreting familiar issues and phenomena. (Alueellisen innovaatiotoiminnan tila, merkitys ja kehityshaasteet Suomessa 3/2003). This tension is a reality in local environments.

The elderly population are looked upon by some as being outside mainstream society and social burdens who have no part in the decisions concerning their life. In order to correct this situation many municipalities have established a council for elderly people, in which the local, political parties, NGO's for the elderly people and municipal administrators are represented. This council can only give recommendations, statements and commentaries, but lacks real political power.

Thus to achieve real influence, the elderly must prepare, plan and give advice that positively affects the development of service provision or one's own area by having local councillors elected to represent them and by having pressure groups or lobby groups that can create meaningful change and development. However, political representative democracy tends to regard the elderly as objects, who are very reliable taxpayers that contribute to the budget of all the municipal and state sectors but in return receive very little. Due to that lack of representation and lack of services received in comparison to finances put in the case for creative tension would seem to have been firmly established.

Espoo is the second largest city in Helsinki. It has a population of 235 000 in-habitants of which 10% are elderly people, i.e. 65 or over. In the whole country about 16.9% are now over 65. The effect of such a large elderly population is that it emphasises a need for self-determination and customer-oriented services. Espoo has its own strategy and policy for its aging population. The main policy is that the needs of the elderly must be met, but the old person and his/her family have the main responsibility for their needs. The municipality of Espoo offers to meet the needs of groups that habitually face financial and other difficulties. For the elderly, the city has 8 service centres where the elderly can meet and eat lunch daily, if they need to. There are also a few public nursing homes that have 314 beds and employ 1,127 staff. There are 387 private homes that receive ser-vices, and in Espoo's care home for the elderly there are 372 residents. In 2007, the cost for services was 96 million Euros. The city regards the aging popula-tion's needs to be mainly health oriented.

Elderly people over 70 can have a very popular service card which allows them to use public swimming pools and gyms free of charge. They can also receive home services free of charge if their income is below 484 € (if they live alone), 892 € (if there are two people). If their income is more then the costs of receiving service at home are progressive based on how many hours per month a person needs services and on her/his monthly income. In practice, this means that most elderly people have no hope of having access to communal public home ser-vices. The only solution then is to rely on one's own resources, empowerment and creativeness. . .

Looking for local solutions – research before action

Pirkko Liikanen (2008) conducted a survey as part of her practical training during the Educational Programme for Voluntary Senior Trainers established by Laurea University for the Applied Sciences (Allahwerdi and Liikanen 2008). This took place in Espoo in a resident's association "Säästökehä AsOy" in order to find out what kind of services and activities the elderly wanted and needed. This resi-dent's association has 6 houses with 157 inhabitants in 90 owned flats. In total, 57 of the inhabitants were over 65 years old. She interviewed 40 senior citizen residents to find answers to the following issues and their resources:

- What are the factors that make up the well-being of an elderly person?

- What are the social relations of an elderly person?
- What kind of abilities and services are mostly required?
- Does the living environment create barriers to staying at home?
- What kind of participation exists and what is required?
- How do old people see the future?

The research found out that all the 40 people (37.5% were single, couples 57.5% and 5% living in a family) were satisfied with their human relationships. Almost all the elderly (92.5%) did not feel lonely. In addition, 75% felt that they were cared for. Single people felt lonely more often than those living with a spouse or with their children.

Social resources for these elderly people meant regular relations with relatives and friends, saying hello to people in the same building, wishing to find new friends in the same resident's asociation. A few elderly had friends in the neighbourhood, and 32.4% visited a friend outside their local environment during the interview day. Another 42.5% had a friend visiting them during the interview day.

Almost all were able to walk 400 metres, to take care of themselves, to prepare food and eat it without help, to go shopping and to clean their home without help. Some 47% of the elderly took care of their grandchildren. Only 2 people used the municipality's public help services. Furthermore, 52.5% of the elderly took care of other elderly persons outside their home. If an elderly person needed help, it was usually given by their children (72.5%), by their relatives (52.5%) or by the janitor (25%). One quarter of the elderly interviewed had help with cleaning their house. In conclusion, the elderly in this resident's association, based on this survey (2007), are independent, healthy and sociable.

In 2007 the elderly people interviewed for the survey:

- participated in family gatherings (birthdays, Christmas, holidays…) 97.5%
- participated in public, cultural meetings 82.5%
- travelled in Finland 80.0%
- used library services 64.5%
- participated in religious meetings (45%)
- followed sports (33%)
- travelled abroad (33%)
- were active in 67 organisations

- and only 9 elderly people did not belong to any organisation.

The elderly belonged to many different kinds of non-governmental organisations. Professional organisations were popular, as were hobby and social organisations. Many also belonged to other types of societies. There was almost no interest in attempts to influence political decision making. They had given up their role as political actors. Voitto Helander (2001) states that old people are not active in political lobbying as they are not given any official status or power in political organisations.

Table 1. What old people would like to do

Activity	Number	% of the elderly interviewed
Discussions	26	65,0%
Field trips	22	55,5%
Social issues	19	47,5%
Friendship activity	18	45,0%
Internet, ICT	15	37,5%
Playing cards	14	35,0%
Family studies	13	32,5%

Some people wanted to make their own stamp or to do physical exercise or do handicrafts or to sing together or read books. It turned out that the elderly in the Säästökehä housing association expressed

- an openness to new ideas
- trust in each other
- social and cultural ability and
- the motivation to be active.

Almost al (95%) of the residents wanted to participate in a voluntary senior citizens' organisation in their own housing company. The idea was positively received and they began a new venture (ASA) , which was going to be local and self directed.

A new, creative idea – establishing the Active Seniors Association

As a result of the survey the Active Seniors Association ASA (www.toimivatseniorit.palvelee.fi) was established during spring 2008.

- Its main objective is to help local residents so that everybody, regardless of age and health, can live in their homes and actively participate in society as responsible citizens.
- The members aim to cooperate with the public and private sectors in order to construct an innovative living environment and culture for the elderly and ensure that they are able to govern their own life.

Figure 3. The organisational structure of ASA

The association was lucky to have their own, meeting room, which was furnished collectively. In this room small groups could meet. The sharing of books, daily newspapers, journals and magazines takes place in this meeting room.
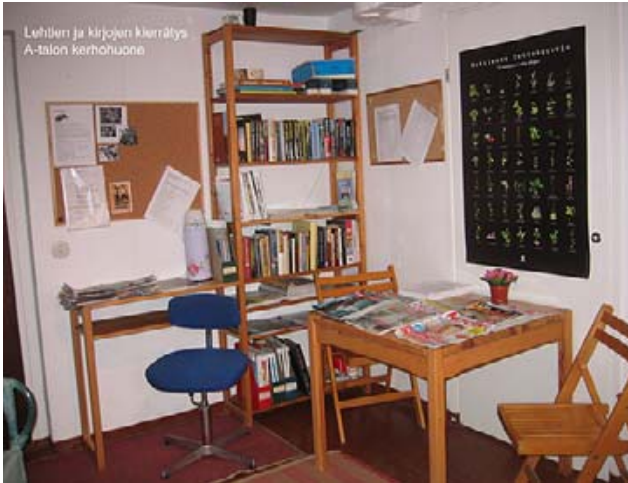
Figure 4. The sharing corner in the meeting room

Figure 5. Weekly morning coffee

Since March 2008 the meeting room has been in daily use and the social friendship networks have been active. Weekly coffee gatherings are a platform for information sharing and lively discussions. ASA has made 10 field trips to different places of interest, such as gardens, art exhibitions, museums and visiting artists' homes. There are several hobby groups, which meet regularly, such as the literature reading group, art group, well-being group and discussion group.

The association also cooperates with

- Espoo's municipal administrators and planners of the development of services for the elderly,
- Lähderannan Lystit – a local, residents' activity group formed in August 2008,
- OMNIA College, which is a training platform for students,
- Helsinki Business College, Leonardo da Vinci Innovation Transfer Project INNOVET 2007-2009, with whom ASA works as a mentor, and
- Business Academy of Donaustadt, Vienna (Mobility – receiving trainees).

Training the students

The gap between the young and the old in Finland is real. The old do not always understand the young and vice-versa. This is especially clear when the aging population is being looked at as a new area for innovative action, which can offer new roles and business possibilities for many citizens. One example is that vocational schools offer the possibility to specialise in the study geriatric care and the needs of the elderly, but there are only a few work training places available for students. To compensate for this lack of available work practice ASA welcomes cooperation with the educational sector in the community.

ASA has planned a mobility programme for those trainees who would like to do their work training at the residences of elderly people . The programme is based on the needs of the student and is called "research oriented training". Due to the fact that ASA is a voluntary, social and cultural organisation, which needs partnerships and services to be created by new entrepreneurs from the local community, it welcomes cooperation.

INNOVET Mobility " Educating European Citizens"

1.   *Prior to training abroad in the partner country*

- Finland Country Package is sent to the trainee.

- ASA assignments given to the trainee.

- Global Entrepreneurship course given online at the Business Academy of Donaustadt, Vienna.

2. *Training at Säästökehä resident's association by ASA, which acts as a mentor for the INNOVET project*

- A detailed programme is prepared by ASA.

- Guidelines and objectives for the training presented.

3. *After the training abroad*

- An evaluation is performed based on the European Reference Framework – Key Competences for Life Long Learning (LLL).

- A certificate is granted by the INNOVET mentor – ASA and the INNOVET educational institute (Helsinki Business College) responsible for MOBILITY's administration - based on the recommendations of the LLL programme and the demands of its core competences.

- Agreement about ECVET credits between the INNOVET educational institutes.

The assignments prior to the training consist of a report about the situation of the elderly in the trainee's own country. The trainee has the opportunity to share this information with the elderly and at Finnish colleges.

The general assignment to be included in the training report

- should study the Finnish lifestyle and the needs the elderly have with regard to services.

- should ensure the trainee understands and is able to analyse the role of public, private and voluntary NGO sectors in creating services for the elderly.

- should describe resources and the costs of services when the basic costs, such as rent, housing maintenance, food, basic health care, communication, transportation, electricity, telephone and personal computer costs per month have been covered.

- should suggest new business ideas on how to serve the elderly in their homes.

It seems that young students have very little experience of social communication with older people. Initially, old age doesn't interest them. Old people are seen in

a negative way i.e. as outsiders in a society and as people who are only waiting to die. The idea of active senior citizens is so strange that nearly all of the business ideas of the trainees are connected with health care. The custom made innovations aimed at supporting the specific needs of elderly people have been produced by the old people themselves not by the young trainees.

Further research and activities

Due to a lack of knowledge and motivation, research into the needs of elderly people remains poor. The establishment of new, creative businesses that produce products and services that support the elderly is a niche market waiting for ambitious entrepreneurs. The old cultural structures for elderly people are disappearing. Consequently, new local structures, organisations and business ideas are required. They must be developed to serve the aging population, especially those who are in their third age between 65 and 85 years old.

The public and private sectors of the society can offer new, political and social participation opportunities to this aging population. The responsibility and commitment is there in their local communities. Treating the old only as objects must be changed so as to find a new role in which they are seen as self-reliant subjects able to assume full responsibility. The monitoring of the achievement of the objectives of national and international recommendations and programmes, and their adoption by local communities, should be carried out and studied. The results should eventually pave the way for creating meaningful, economic and functional changes and innovation.

References

Allahwerdi, H. and Liikanen, P. 2008. Oma taloyhtiö senioreiden toimintakeskuksena, Toimivat Seniorit ry:n julkaisuja 1/2008.

Alueellisen innovaatiotoiminnan tila, merkitys ja kehityshaasteet Suomessa 3/2003. Finnish Local Government Act (365/1995).

Helander, V. 2001 "Ei oikeutta maassa saa…." Ikäihmiset poliittisina vaikuttajina. Vanhustyön Keskusliitto ry: Jyväskylä.

Key competences for Lifelong Learning – European Framework. European Communites 2007.

National Framework for High-Quality Services for Elderly People. 2008:5. Ministry of Social Affairs and Health. Association of Finnish Local and Regional Authorities. Helsinki: Helsinki University Print.

The European qualifications framework for lifelong learning: http://ec.europa.eu/dgs/education_culture

Clinical Art and Active Art – sketching out cultural context

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Preface

Since autumn of 2006, Laurea University of Applied Sciences' Tikkurila unit has cooperated with the City of Vantaa to develop the Active Art method. The model, sounding board and the basis of the clinical research data of the method is the Clinical Art-system , which was developed in Japan. The Japan Clinical Art Association coordinates activities that are deployed in a number of customer environments and further developed by means of various studies. The aim of this article is to present the Clinical Art system to a Finnish audience. In my text I will compare the backgrounds of Japanese and Finnish focuses and strive to understand the underlying reasons for their systems. As an Art Educator, my focus is on the background of art-concept systems. In this article I refer to Clinical Art as a system, not, for instance, as a method. The word "system" more aptly describes the entity and its extensive scope, which also entails Clinical Art's practical implementation, its approach and its concept of a human being, as well as the background research data (Oshiro 2008). Throughout the text, I will use the abbreviation CA for the system.

The article is based on a two-month induction into the subject, in early summer 2008, at Tohoku Fukushi University (TFU) , in Sendai, Japan. The university conducts studies in the Clinical Art system and offers university level education in the subject. My inductor was Assistant Professor and Clinical Artist, Taizo Oshiro. I also participated in the workshop instruction held by Clinical Artist, Yu-

kie Hosaka. I would also like to give my thanks to my inductors and all the members of TFU staff for the education they made possible.

As a result of the cooperation between Laurea, TFU and the City of Vantaa, an Active Art project was developed in the form of two pilot projects carried out in the spring of 2007 and 2008. Active Art constitutes part of the more expansive Active project. The interface for the Active Art project is the Laurea, Tikkurila unit's Bachelor of Social Sciences syllabus. The syllabus focuses on creative activities and is based on an art-oriented, multi-sensory approach. It aims to encourage future bachelors of social science graduates to adopt creative modes of operation that can be applied within the differing customer and work environments of the social services. Development takes place in everyday environments, albeit ones affected by the professional intentions and competences of several people. In the Active Art project, development has taken place in customer environments and been conducted by the senior teachers and students of Laurea University of Applied Sciences and the employees of the City of Vantaa's Services for the Elderly.

When describing activities carried out within the context of psychotherapeutic art therapy, the roles "therapist" and "customer" are usually referred to. However, in Japan, a person who steers CA activities is not called a therapist, but a Clinical Artist. As that title indicates a strong connection to art I will use the expressions clinical artist. Also, instead of customer I will use the term participant. By choosing these two terms, I wish to pinpoint their difference in relation to psychotherapeutic art therapy, and include the activities within the context of social services.

By "customer," I refer to the people participating in these activities as participants; I use the term to emphasize participation and activity. During the past few years, it has become increasingly common in Finnish health care and, especially, social services to speak of customers instead of patients. This is a positive development. As a consumer and recipient of services, the expression "customer" is appropriate. Nevertheless, as a subject living his/her life through activities, the term participant is, in my opinion, more descriptive. CA entails activities, concretely doing something so that one participates in an activity and that something becomes a part of both one's own life and the community being created around these activities. No doubt this selection of terms is dictated by my own professional ideology and approach, which are largely based on socio-cultural encouragement and a community art-related way of thinking. I want to make it clear to readers that I have been engaged in cultural translation and searched for the best terms to describe the nuances of CA within a Finnish operational environment.

International network of Clinical Art expertise

Japan Clinical Art Association was founded in 1996, and it has its headquarters in Tokyo. It shares the same building with the Center of Formative Art. The two actors also share three employees. The essential aim of the association is to maintain the same level of operation and provide its members with the latest research data. The association's operations consist of publications and different conference and seminar events that act as forums for the exchange of information. A lively network ensures the maintenance and continuous development of the clinical artists' professional skills. (Nishida 2008)

Finland is not the only international partner in the CA network. Chinese partners have shown an interest in the CA system. Likewise, Australia has shown signs of interest (Sekine 2008). In Korea, CA activities began in 2005 and operations there have become organized and spread at a fast pace. KACAT (The Korean Academy of Clinical Art Therapy) issues the Journal of the Korean Academy of Clinical Art Therapy publication a few times per year. The editor-in-chief of the journal, Sun-Hyun Kim is an enthusiastic supporter of developing Asia's own art-therapy tradition as well as having its own unique independence from Western art therapy (Sun-Hyun Kim 2007, p. 25). On the other hand, Sae-Il Chun finds great potential in combining the care forms of Western, Eastern and alternative medicine (Sae-Il Chun 2007, p. 15). This is a fine example of the unprejudiced atmosphere seen in combining and applying various systems that Taizo Oshiro regards as the key to the rapid expansion of Korea's CA operations and as an important resource of the Korean version. So far, the Korean version has been strongly focused on the foundations of medicine and psychology. Its application has mainly been carried out in the field of mental health, which means that in this sense the Korean version is art therapy in the traditional meaning of the word, whereas the Japanese and Finnish applications strive to clarify the focuses of their approaches by using different concepts. A stronger connection to art and expertise in the social services is only about to be established in Korean (Oshiro 2007, 9.5). It is interesting to note that for the Finnish version the next challenge is to find a theoretical basis and links for cooperation within the field of medicine. It can be argued that the development of CA in Finland and Korea are working their way to the same goal but from different directions.

Active Art activities in Finland are not organized around any association or as a study program of their own. In order to ensure continued operations and to further develop them, operators in Finland are currently searching for a frame most suitable for the situation in Finland. The pilot projects have included training pe-

riods for participating students and employees. This training has not led to any official title, but it has provided the basic facilities for implementing art therapy - consistent with the idea of CA - in everyday work on welfare for the aged. The need for a formal title and the scope of training required for it is being charted. In Japan, the title of Clinical Artist requires the passing of studies specified by the Japan Clinical Art Association, which are usually conducted within a year, either while working, or as part of a student's higher education degree. The study program of slightly more than forty units of study consists of approximately thirty meetings, and it also entails independent study and practice in the arts.

The connection between art and the brain

The CA method, which began in 1996, was initially implemented among elderly people suffering from Alzheimer's disease or from slight cognitive disorders. At a later stage, the method was further developed and applied to children suffering from brain damage and mental disabilities. Japan Clinical Art Association arranged a seminar in May 2008, in Nagoya, Japan, which discussed the application of CA in relation to working with children, including child welfare. Kansei education for schoolchildren has also developed activities where children and the elderly meet each other within the context of CA.

The objectives related to art therapy's psychotherapeutic approaches are not relevant in the context of CA. CA does not focus on treating mental diseases or on developmental tasks that remain unfinished in the customers' mental development. The separation from psychotherapeutic approaches is clear. Nevertheless, the theoretical approaches of psychotherapeutic art therapy have many issues that are valid when discussing CA. Therefore, in this article I strongly lean on a book called Taideterapian perusteet (freely translated into English as "The Foundations of Art Therapy"), by Mimmu Rankanen, Hanna Hentinen, and Meri-Helga Mantere. The book, published in 2007, is the first extensive overall presentation of the theory and practice of Finnish art therapy.

The focus of CA lies on supporting an individual's activities and cognitive skills (cp. Ranskanen 2007, 84). According to Professor of Psychiatry, Takashi Tasada, care programs for those with Alzheimer's disease too often contains forms of care that, in a way, paradoxically strive to revive brain cells that are already dead. In Professor Tasada's opinion, it is sensible to try to stimulate inactive neurons and those that are infrequently used (Tasada 2004). In other words, even on a cell-level, CA is based on resource-oriented thinking, on what the per-

son has left, not on what he or she has already lost. The aim of the CA method is that art activities should provide participants with feelings of pleasure and joy, which is ideal for promoting well-being.

This straight forward sounding connection between the pleasure gained from experiencing art and a person's well-being seems simple enough. The grounds for a cause-and-effect relationship between the two have been presented from the perspectives of different fields of research. For example, in recent Western art therapy, Cathy A. Malchiodi discusses the subject in her work Art Therapy Sourcebook. In Finland Physician Markku T. Hyyppä has approached the subject with the help of the concept of social capital (e.g. 2005). The same basic starting point has been present from the very beginnings of art therapy, which arose after World War II.

From the very beginning, Doctor Kimura has been involved in the development of the CA system. Dr. Kimura is an expert in brain research, and he has studied the impact of art activities on brain functions. By measuring the electric-field activity of the brain, he has devised profiles for four different emotions: joy, sorrow, stress, and relaxation. Dr. Kimura notes that when we name these kinds of emotions, we use metaphors, since the location or nature of emotions is not currently well understood. Nevertheless, Dr. Kimura has traced certain routes that are repeatedly traveled between electron centers in the brain when, for instance, a person experiences pleasure. According to Dr. Kimura's description, the electronic impulse route of joy, for example, is individual, and yet a signal is repeatedly sent between certain electron centers, regardless of the individual. Based on the above, it has been possible to record and graphically present values related to four different emotions. The results measured during art activities and afterwards show that the values of joy and stress are heightened due to art activities. According to Dr. Kimura, the simultaneous occurrence of stress and joy is the most favorable combination for rehabilitation. Furthermore, it was apparent that sadness diminished thanks to art activities. A longer-term analysis showed that changes in the vividness of the brain's electron functions in people suffering from dementia varied and took the form of an up-and-down motion. (Kimura 2008)

With regard to people with dementia, enjoying the making of art in a safe and approving atmosphere has been proven to be more efficient if the activities and positive atmosphere have been successfully transferred outside the scope of the actual art activities and into the participant's everyday life. Thus, CA's effectiveness is at its highest when art does not remain a once-a-week event, but succeeds in transferring the attitudes found as fully as possible into the participant's

normal life. In order to achieve the above, the CA system has paid special attention to supporting the relatives of those suffering from dementia and involving them in their activities. Strengthening their social environment and finding and holding a positive attitude during a challenging phase of life is considered to be of the utmost importance. In the CA system, art is deemed to prove an ideal environment for such a strengthening process. (e.g. 2008) Art Education Researcher, Tarja Pääjoki, aptly describes art as a meeting place (Pääjoki 2004), and it is exactly this kind of place that art can be perceived as operating in, within the context of CA.

Organized, multi-professional teamwork

CA is largely implemented by way of teamwork. The team consists of a specialist in medicine who is responsible for referral to treatment, research, and diagnostics; a Clinical Artist who is responsible for the actual art activities; and a supporter for the participant's family.

Art activities take place in groups, headed by four Clinical Artists. The number of patients with dementia in a group varies based on the MMSE test, so that there can be twelve people with slight dementia i.e. those who scored 20 to 24 points in the test. There can be eight people with intermediate-level dementia in a group. Group activities for people with severe dementia have been organized in such a way that, in principle, each participant has a clinical artist of his/her own. In all cases, four clinical artists share responsibility for guidance; one of the clinical artists is a clinical artist-in-charge and the others are assistant clinical artists with more active roles, for instance, tuning in to the activities at the beginning of each meeting. During art work, the assistant clinical artists support the clinical artist-in-charge by helping the participants whenever they need assistance and by distributing, for example, materials and tools. According to my experience and observations, the assistant clinical artists bring materials and tools to the participants even when they are physically capable of moving around the premises. This principle obviously aims to ensure as peaceful a group location as possible by ensuring as few people moving around as possible.

The structure of the meetings is always the same. At the beginning of a meeting there is an approximately 15-minute tuning-in period that includes music (e.g. singing together), light physical exercise, and discussion, which help to boost the participants' feeling of being present. The actual art work lasts for approximately 80 minutes, and each meeting has a different theme, which is introduced to the

participants during the tuning-in period. Every meeting ends in a thirty-minute discussion of the artwork completed. The purpose of the discussion is to enhance the participants' self-confidence and show an appreciation of the work done.

The CA program is divided into stages I to IV. The program progresses in stages in such a way that activities in stages I and II are slightly more structured, and the focus is on getting to know the materials and finding joy in creativity. Stages III – IV also include group work. Large jointly done wall paintings or circulating works, i.e. artwork continued by the next participant in line, are to be found during this stage. Stages III – IV entail more flowing i.e. liquid materials such as water colors, whereas the initial stages are more focused on oil pastels.

The clinical artist's control in CA activities is, in my opinion, fairly tight, because of the structured activities. Even though the activities are dictated by strong boundary conditions, one must, nevertheless, keep in mind that every participant can choose his or her way of creating the paintings and deviate from the clinical artist's instructions. In other words, CA's ideology creates space for individual solutions. The warmth of the atmosphere and the support shown to each participant by means of positive feedback constitute the core of the activities. The aim of the structuring and having a work process that progresses according to a step-by-step principle is that each participant can create aesthetically high-quality pictures. Harmony and beauty as aesthetic qualities are goals to be aspired to in CA. It is believed that creating an aesthetic work of art and looking at it brings pleasure and strengthens the maker's self-confidence. A work process that aims at an aesthetic end-result is accordingly strongly multi-sensory. Creating a picture often has its starting point in a concrete model that is viewed with all the senses and by talking about it together. The underlying starting point is that there is not just one way of describing observable objects; the solutions and selections of each person are important and need to be encouraged. The purpose of observation is to stimulate the participants to engage with their individual processes and to free them from superficial iconic expression.

Figure 1
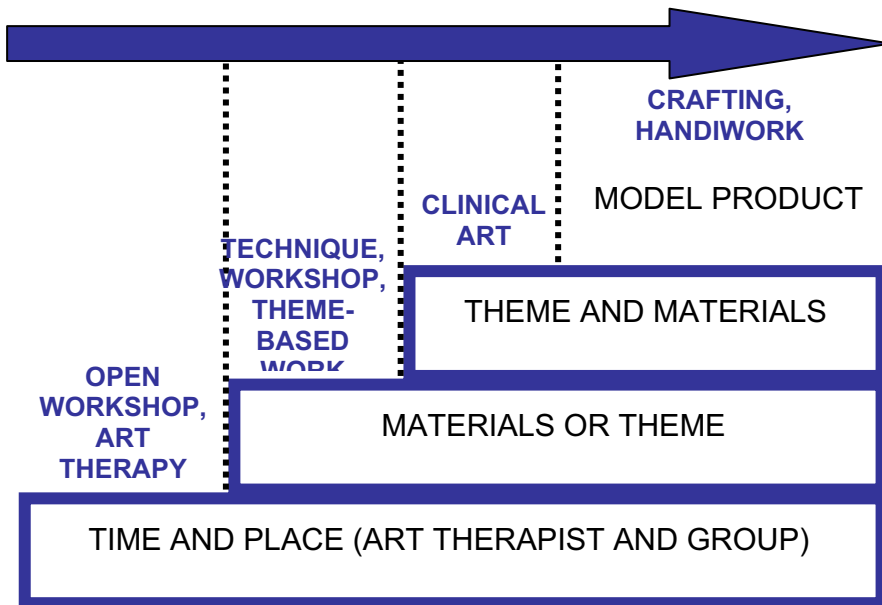
When the number of boundary conditions controlled by a clinical artist increases, limits are set for creativity and the amount of power exercised by the clinical artist increases. On the other hand, the matter can be viewed in this light: when the number of ideas and input given by a clinical artist increases, the work becomes increasingly more independent of the participants' management of working on the art processes.

Hentinen describes the creation of a safe and uncritical atmosphere as the essential task of the art therapist (Hentinen 2007, 105). The same challenge applies to a CA clinical artist. Balancing this need is, however, necessary in order for the end results to satisfy their makers. (Rankanen 2007 ->Jacoby 1999, ethics and aesthetics.) Mantere (2007, 190) has discussed the transference impacts that arise from successful art activities. Art products that arise from the making of something tangible and which can be observed in the form of a figure may signify to the makers that they are able to make choices. At its best, this attitude spreads into an actor's own everyday life and thus affects different individual areas of their life, creating the feeling of being able to manage one's life in the process.

CA continuously emphasizes the importance of making choices. A completed work is often finalized by choosing a background for it, which is made according

to the preferences of the maker of the work in question, e.g. by attaching colored paper into the background. Research shows that making choices boosts brain function in certain areas of the brain. In CA activities there are no right and wrong choices, the choices made are based on the maker's own aesthetics. A work of art arising from the continuum of choices enhances the maker's belief in him/herself as well as in his/her ability to make choices.

A three-month art program consists of nine two-hour meetings. During the three months, the team of physician, family supporter, and clinical artist meets on a monthly basis, or more frequently, if required. The family members participating in the activities are given two art-work sessions in the course of the program. The family supporter plays an essential role in ensuring the strengthening of the impact of the activities. The CA system does not treat a symptom, but supports the social environment of the person suffering from dementia. Pastor Kazuo Sekine, who works as a family supporter at Kimura's clinic, meets with the family members of the participants in the CA program three times a month in a peer group and, when required, he meets with the families separately. Sekine (2008) emphasizes that in these meetings a family supporter acts as a facilitator, not, for instance, as a teacher or counselor. At the beginning of each peer-group meeting Sekine asks the following two questions: 1) What is the most delightful thing that happened during the past week? 2) What is the saddest thing that has happened during the past week? A family-care provider or family-care providers from seven families are present at each meeting. The family-care providers answer the two questions during their own turn. The group discusses the arising themes, so that the families learn from one another. The aim is for the family members to find positive perspectives on a life situation that puts immense strain on most families' internal dynamics. In Sekine's opinion, he succeeded in his work when a couple that had separated, after one of the spouses had fallen ill, arrived at the reception hand in hand. Sekine describes Japan as being a performance driven culture where people are used to measuring their own human worth, as well as that of others, on the basis of the work they have done. The goal of supporting the families in the program is to help people find a perspective on humanity which allows them to accept mere existence as being sufficient for seeing self worth. Hence, art activities, which are liberated from a performance orientation, provide the framework for seeking this new attitude. It would seem that working while relying on one's senses increases an individual's ability to feel present in their environment and helps them to find sources of joy in their ordinary everyday life.

Kansei and Bigaku, on the connection between sensuality and well-being

The connection of art and a general sensory approach to well-being has received a laudable amount of attention in Finland during the past few years. The Taide hyvinvointiyhteiskunnan uudistumisessa (THU) network (freely translated into English as "Art in the regeneration of the affluent society"), maintained by Museum of Contemporary Art Kiasma, has assumed the main responsibility for this discussion by assembling a forum where professionals in art and the social services have been able to meet one another. In this discussion, defining a shared set of concepts has been translated into creating a territory that is combined. The Japanese concept Kansei is a complex concept that depicts well-being; it includes the idea of a human being as a sensory creature, a creature that must feed all its senses in order to feel well.

Bigaku is a broad and complex concept used for describing the Japanese sense of beauty. In Japanese aesthetics, beauty does not rely on only one sense, but has a kind of holistic dimension that is always present. Minna Eväsoja (2008, p. 23-24) outlines Japanese aesthetics through the following seven features:

1. having an aesthetical attitude
2. allusions and symbolism, the use of metaphors
3. bare compactness (note the difference between the Finnish word "pelkistys," which signifies "reduction")
4. a world of bright colors
5. a naturalness in which input from a human being is always present
6. a world of shadows
7. feminine softness.

When I was working as one participant among others, I repeatedly found myself thinking how interesting it is that a man over 80 chooses e.g. pink paper as the background for his work. These ordinary elderly people, familiar with making pictures within the context of CA activities, showed me how natural and free of stereotypes creating art is to them. Those workshops made me realize how full of clichés and mannerisms my own products were. I am stuck with certain colors and ideas of beauty. More often than not, I noticed that the elderly participants suffering from dementia created fresh and unprejudiced works of art. I was left wondering whether the aesthetic range they had acquired during the course of their life was far more extensive and varied than my own. Or maybe I was sur-

prised by the range of visual material that is natural for the Japanese concept of beauty, but was special for me, because I did not recognize the internal cultural clichés? Many of the participants used extremely bright colors, and feminine softness was present to an equal extent in the pictures made by men and women. I realized that the Western ideal of a strong, rough and masculine picture resides in my way of thinking. Why else would I have been surprised by a man selecting a pink background?

Kansei and Bigaku together cover a large part of the theoretical thinking about the connection between art and well-being that has been discussed in Finland. This is because these concepts leave room for associations, metaphors and a holistic approach, and thus they are worthy of additional attention. To some extent, the Western way of thinking is appalled by such concepts, which are inaccurate in their extensiveness and cannot be fully put into words and thus not explained. Based on my experiences in Japan, I propose that we should, at least to some extent, let go of this need for closed, rational explanation in order for us to be able to aspire to true well-being, or at least to touch art. In this difficult challenge of letting go, the Japanese way of thinking, logical in its illogicality, can offer us fresh perspectives.

According to Eväsoja (2008, 25-28), different senses are strongly present in the everyday life of Japanese culture. The difference between everyday routine and festival is not as clear as it is in Finnish culture. Life is, to an increasing extent, phased by repetition and ritual. Based on Eväsoja's work, one can say that the utilization of different sensory channels, which is emphasized in CA, is an integral part of Japanese culture. One can see the repeated structures and even the ritualistic forms of CA activities as emanating from traditional Japanese culture. Professor of Art Education, Helena Sederholm, has awakened us the possibilities of this approach to life in the following way: "Maybe a better life does not entail dreams and running away to different worlds or to special, significant experiences, but a better everyday life where one can sense, see and experience the diversity of everyday life." (Sederholm 2007, 149)

In a similar way to Japan, living one's life according to the seasons was typical of old Finnish culture. In my opinion, our current independence from the realities of nature has made us incapable of awakening to or sensing the reality around us. When waking up in the morning, only a few people go outside to sense the weather and gauge the temperature. It is common that people check the temperature from a thermometer or watch a weather report. It seems highly unnatural to walk inside a house dressed in a T-shirt, when it is freezing outside. Choosing the correct clothing is made on the basis of physical data; however,

only a few people sound out and utilize the senses of their own bodies. People enjoying the wonders of the welfare state hardly have any time to experience hunger before the next meal is pushed in front of them. Thus, I believe an estranging layer has arisen between our skins and the world, which can only be penetrated by art due to its unique nature.

Western phenomenology traditionally discusses people as sensory beings and aims to emphasize the body's relation to the world. Ossi Naukkarinen has noted that: "sensuousness cannot be definitely linguistically expressed or conceptualized" (Naukkarinen 1999). The characteristics of nature and art are such that they have the ability to stir people. Philosopher and Professor of Art Education, Juha Varto, has proposed that one of the strategies of contemporary art is to surprise us in a sensory manner. In this way, art surpasses intellect by directly affecting the body. (Varto 2007) When talking about the Japanese concept of kansei we move into a terrain that resembles a discussion of the senses.

Japanese thinkers and researchers are conducting a discussion to determine the concept of kansei, and the broader societal discussion about Japan's kansei can currently be heard all over Japan. TFU, the university I visited for a period of two months, has its foundation in Buddhism, whereas Christian backgrounds are recognizable in the CA system, because its "founder," Kanji Kaneko, was a confessional Christian. The background concepts of a human being and world ideas are, thus, flexible, ecumenical, and, viewed from the Western perspective, they rise to the surface in surprising ways in an academic context. Consequently, interpretations of kansei have their starting points within the different kinds of background philosophies and political foundations that have developed it. Nevertheless, TFU focuses its content on well-being, which is why this university has a certain kind of interpretation of kansei, even though the interpretation may differ, to some extent, between different professors and researchers.

At TFU kansei is regarded as the ability to simultaneously read one's own body and the environment. It refers to a competence that is required in not only meeting the world, but also in meeting another person. Kansei entails a kind of holistic ability to sense and draw conclusions. At TFU this is expanded to also cover activities that arise from observations made. In other words, Kansei does not merely refer to a sense-based holistic ability to passively observe and receive; it entails responsible and active actions in relation to other people and the environment based on one's own observations. This competence is seen as an essential competence for professions in the fields of social services. Some Japanese researchers have closely linked Kansei to our concept of tacit knowledge. Nevertheless, as emphasized earlier, kansei is a concept that is poorly put into

words and translated into other languages. Therefore, some Japanese researchers use the Japanese-language term in their texts in English as well.

Art develops and increases a person's kansei. Kansei is also deemed to be present in both practical and arts subjects. During the past few years, there has been a concern about whether the present Japanese curriculum and urbanized lifestyle can meet with peoples' needs and the development of kansei. In Finland Meri-Helga Mantere sums the matter up by saying that artistic activities are characterized by the fact that psychological intensity and sensorimotor integration take place simultaneously. A holistic approach and intuitive actions are typical of artistic work. In the expressive art therapy approach, art remains at the center, unlike approaches that lean more heavily on psychotherapy, which perceive art as merely a tool. Expressive art therapy deploys the approaches, techniques and materials of all different forms of art. It is, thus, multi-sensory. Consequently, expressive art therapy can be said to be connected to a person's kansei and cherishing kansei constitutes the basic starting point of the CA system.

These issues also constitute the essential elements of the pedagogical approach that the teachers at Laurea's Tikkurila unit apply to the syllabus for B.A. social science students when focusing on creative activities. The members of my team and I feel that we act within the context of marginal Finnish culture when emphasizing the above mentioned elements due to the fact that the roots of our approach lie outside or on the borders of Finnish mainstream culture, if one can talk about such a thing.

According to Levinen (1999), the human mind, images and imagination utilize all the senses and thus constantly create new meanings. An approach to CA that draws upon various forms of art can be justified by adopting Levinen's notion. (see Mantere 2007, 32). This is because the context of expressive art therapy enables poetic and metaphoric expression (Rankanen 2007, 42). This is the part where kansei and bigaku come very close to each other. Knowledge of art, or knowing through art, represent an alternative to linear thinking in Western thinking. This kind of indirect expression is characteristic of overall Japanese culture. Eväsoja highlights this phenomenon, typical of Japanese thinking, as the second feature of Japanese aesthetics. (Eväsoja 2008, 24)

Merja Karppinen addresses the same phenomenon, but with slightly different focus in her doctoral thesis, when comparing Finnish and Japanese thought and knowledge formation processes. She uses the metaphor-like term "an engineering way of thinking" for the Finnish process and a "poetic way of thinking" for the

Japanese one. (Karppinen 2006, 221) It should be noted here that a too literal interpretation of the terms will prevent the reader from understanding the larger picture. Therefore, the reader should agree to play along and be enticed by the intuitiveness, picturesque nature and richness of the metaphors that are typical of Japanese thinking. Karppinen separates the thought and knowledge formation processes into the basic structures of both languages. She describes the Japanese language and, through it, shows that Japanese thought and knowledge formation is strongly visual and based on associations Karppinen 2006, 225). For Karppinen, reading a Japanese text requires flexibility and an open mind, where even body memory has a role to play (Karppinen 2006, 227). Depending on the situation, a text is read from the top down, or from left to right. Correspondingly, a book can either start with the cover opening to the left or to the right.

According to Eväsoja, manga constitute a form of communication that is over 100 years old, the roots of which lie in the picture rolls of the Edo era. When discussing manga we do not just refer to the popular comics that have recently established themselves within popular culture of Finland. At issue is a means of visual communication that has its starting points in the Japanese way of thinking as well as in the essence of language. Eväsoja also addresses the criticism of manga, such as the suspicion that manga reduce the level of literacy in Japan, because they replace or temper different contexts like antenatal classes. Consequently, the visual channel holds an exceptionally strong position in Japanese culture, even though other senses are important, too. (Eväsoja 2008, 82-91)

This kind of a holistic approach cannot help but affect the way a picture is made. I would like to point out here that artistic learning and art's way to know things in Western culture also encompasses the formation of body knowledge and knowing things through one's body (see Räsänen, Sava, Merlay-Ponty, Burkitt, et.al.). Forming knowledge in Japanese culture and art also includes the use of the body but to a greater extent. However, approaching this kind of knowledge formation with logical thinking is not always constructive. In particular, insinuations of body-based knowledge being somehow inferior are, in my opinion, colonialist (see e.g. Karppinen on Nonaka, 287-288). Ian Burkitt has in his texts tried to dismantle the dichotomy between the body and the mind, which, according to him, has a Cartesian basis. (Burkitt 1999, 1-6, 67)

From doing to being

Clinical Artists meet as a peer team after each guidance session. The peer team acts as a forum for mutual consultation and feedback. The approach applied adheres to occupational instruction. This confidential forum is a place for sharing ideas, joys, and going through challenging situations. The team acts as the operational environment for professional development. (Oshiro 2008, 85)

The interaction between a clinical artist and participant plays a key role in CA activities. Mimmu Rankanen has structured the additional dimension brought by art into the context of art therapy. (Rankanen 2007, 35 -37, 48, 51-55). This could be termed a triangular model containing the participant, clinical artist, and art. In CA activities the clinical artist's main task is to give positive feedback on the works of art in order to strengthen the participants' well-being. The feedback is given verbally by commenting on the good qualities of the work. Therefore, Taizo Oshiro emphasizes that, even though art brings a new dimension into interaction, verbal expression has an essential importance in the clinical artist's actions within the context of CA activities. Finding the right words to say is a skill to be learned by a developing clinical artist. Family supporter, Pastor Sekine (2008), has underlined the importance of intonation in verbal interaction. Phrases with falling intonation are deemed more positive even when some of the skills used for verbal interaction are no longer available.

A participant's speechlessness and seeming inactivity does not necessarily refer to non-participation. The group member in question may just be seemingly passive. The mirror neuron system of the brain activates the same areas in the brain of the viewer as in the brain of the doer (Rankanen 2007, 122). This is one reason why forcing participants to take part in the activities is not advisable. Some of the objectives may be attained without engaging in actual activities; by letting the person do as he/she chooses and by demonstrating through warm, positive interaction that whatever he/she chooses is enough. Nevertheless, the clinical artist must be careful not to neglect or push away this type of participant. A quiet and inactive member is to be considered as much a member of a community as an active, extrovert member.

One of the dimensions of this interaction is that the clinical artist is responsible for the participants' safety. In CA activities, securing the participants' physical safety has its very starting point in the selection of materials and techniques. Art Therapist Mimmu Rankanen lists the materials on a continuum that passes from fluid to resistant. According to Rankanen, flowing materials are more likely to

generate emotions (cp. Rankanen 2007, 81). Rankanen's colleague, Hanna Hentinen, supports this idea by noting that e.g. wax chalks direct the participants towards more observation-based work, whereas water colors affect emotions to a much deeper extent (Hentinen 2007, 138).

Leaning on Rankanen's structuring (2007, 80-84), the figure below shows my adaptation of CA activities:

Figure 2 and translations)

vapaa työskentely - **free-form work**
juokseva materiaali - **flowing material**
ohjattu työskentely - **guided work**
vastustava materiaali – **resistant work**
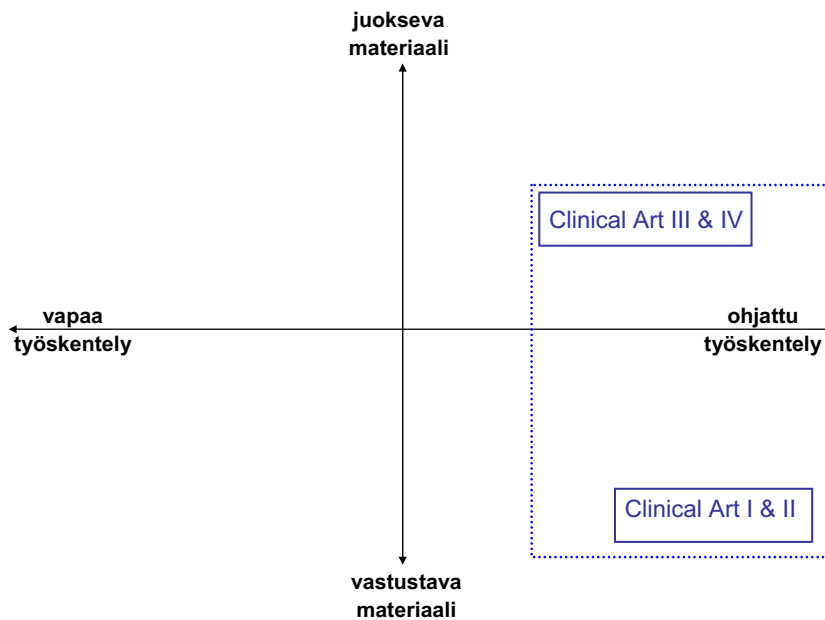
According to Mantere, structured drawing practices have a calming effect on customers of art therapy. In fact, describing the leaving of one's own style and the rhythm of repeated actions may be rewarding. Art work may provide a stressed-up person with the tools to face the world as it is, instead of desperately trying to control an environment that may seem chaotic. When attention is paid to things other than oneself when making or viewing a picture, one may be able to free oneself of the frustrations caused by conflicting desires that confuse one's consciousness. (Mantere 2007, 17) Saara Aalto justifies the use of creative therapies in a similar manner. She concludes that the justifications lean on the general significance of art and creativity to human beings, as well as on the well-being impacts that have been researched. (Aalto 2007, 174) Justifications for art work of the kind mentioned above can easily be recognized in CA.

Even though creating art brings pleasure, it sometimes entails frustration and performance pressure. The clinical artist must support people who are unused to making art and encourage them; this can be regarded as the privilege of only those who have been immersed in CA. In Japanese culture, Michi is a concept that describes the cultivation of the mind toward true mastery (Eväsoja 2008, 103). The cultural cliché of the relationship between apprentices and master in the creation of Japanese art has been revolutionized in the context of CA. The pioneer of the CA system, Artist Kenji Kaneko, strongly underlines the fact that art affects everybody, also on the level of making. Thus, instead of creating a picture striving at photorealism, he proposes an insightful and multi-sensory approach that strives to capture the essential nature of the object. In his opinion, this is the way to reach both concrete and abstract landscapes of the soul. He talks about work that is conducted by the right cerebral hemisphere.

Kaneko's texts underline how the CA system favors such tasks that support the functioning of the right cerebral hemisphere. Dr. Kimura (2008) reminds us that the "right cerebral hemisphere" and functions related to it are a popularized description of the functioning of the brain. In this connection, the right cerebral hemisphere does not refer to the physical right side of the brain, but an entity of such functions that are creative, holistic and intuitive by nature. According to Kaneko, these kinds of activities are encountered too little in the everyday life of modern man. Making a picture that attunes the senses and is based on observations dependent on several senses, as well as the resulting illustrated synthesis brings the most amount of pleasure and boosts the functioning of the brain in such a way that it more efficiently enhances rehabilitation.

Elderly Japanese people need to be encouraged to create art to the same extent as Finnish ones. According to Kaneko, seven out of ten Japanese claim that

they do not enjoy making art, because they feel clumsy or otherwise unskilled. We have seen the same phenomenon in Finland in pilot projects I and II. A consequence of this is that we must make room for expressions of modesty and incompetence, but also make participants see their own capabilities and, thus, open up the joy of art to them. This can be achieved with the help of determined encouragement.

In the world and right here and now

Karppinen's article points out the difference between Finnish and Japanese culture with regard to individuality and an individual's sense of community. The Finnish ideal is independence (Karppinen 2006, 248), whereas dependence provides the Japanese with desired safety. Even though showing one's emotions in public is not part of Japanese culture, sensing emotions and transferring tacit knowledge through them constitutes part of their communal communication ((Karppinen 2006, 249). Karppinen underlines this by noting that compared to e.g. the Chinese sense of community, acting in the Japanese community entails more side-by-side doing than doing the same thing at the same time. Thus, Karppinen describes the Japanese as more flexible actors in the community than the Chinese. (Karppinen 2006, 256 – 257)

Similarly, creativity in the Japanese mode of operation can be viewed as a characteristic of community level action or one that occurs in a group. Karppinen's study entailed the context of the corporate world where creativity (perhaps) has different focuses to that of the arts. According to the Western way of thinking being an artist in the romantic tradition is based on individualism. This focus is, however, being discarded in contemporary interpretations of art.

Signs of alienation from everyday life can be seen in contemporary Japanese culture to the same extent as in the Finnish one. The concept Otaku refers to separation, self-emphasis, and a consumer orientation as a lifestyle (Eväsoja 2008, 108-109). My own experience is that the territory of the Otaku people in Tokyo causes amazement among "ordinary" Japanese. Otakus live according to their own habits and they have strong preferences that, as a group of consumers, make them resemble some contemporary urban tribe. Cafés where girls dressed as waitresses serve the customers are the "fetishist altars" of Otakus. Automated vending machines sell noodle soups for nourishment, but there are no actual restaurants in this area. Whether the Otaku phenomenon constitutes

extreme individualism or a new sense of community would be an interesting research subject.

Within one's own culture, phenomena that are counter to postmodernism in relation to tradition probably enable mutual understanding between two cultures. However, tradition oriented cultural concepts may become alienated from present-day reality from time to time. Changes within cultures and counter reactions in the present-day exchange economy makes it challenging to claim that being Japanese is this and that being Finnish is something else. Interpretations of a culture are increasingly tied to contexts. It seems that any claim about culture must include an endless series of terms of validity. Consequently, extreme relativism prevents an interpretation of observations.

I see characteristics of individualism in contemporary Japanese culture that can be said to be forms of counter reaction to the traditional community orientation. Correspondingly, in Western (art) discussion, the sense of community has stepped up to challenge the image of an artist inhabiting the romantic cult of individualism. The paths of the two cultures thus cross on the axis between community and the individual. Nevertheless, in the background lie different concepts about what it is to be a human being, which may not alter as fast as postmodern mobility theorists would like to suggest. Pondering the different religious and philosophical starting points provides us with the possibility to understand something in the global flood of data and image, even if only for a short while. I would argue that people need kansei now more than ever. Moving around the global, the virtual and data-oriented information society puts an individual under tremendous pressure. Moreover, when we add the craving for experiences into the mix and the characteristics of the visual, eye-oriented era, people really do have cause to stop every now and then and consider how art serves this entity.

Marjatta Bardy has proposed that art can avoid the problem of instrumentalization. The elements of being involved in art are combined in a way that makes it difficult to reconstruct the generators of such impacts. (Bardy 2007, 29) This perspective is, of course, crushing for impact study. If there is a willingness to analyze the basic nature of art and its place in society more extensively, rather than just diminishing it to being a mere tool, then the situation may appear completely different. Bardy describes a way of thinking in which art is perceived as part of a system of human rights (Bardy 2007, 30-32). In developing her ideas Pia Strandman has strongly emphasized that the intrinsic value of art should not be questioned, even when it arises in a care environment and entails instrumental aspects (Strandman 2007, 163). I strongly agree with her and deem it important for us to think of art as a place rather than as a method, as Pääjoki has also

argued. In my opinion, we could also regard art as a way of being and as a way of relating to the world, instead of thinking about it as a means or an instrument. This would mean that we give up the idea of the arts being a decoration that is used solely for the purpose of pleasing. To begin with, we could start to perceive art as part of our everyday life, whether at home, work, or in a care environment. Consequently, it would become possible for a person to be present in the world exactly as he or she is.

References

Aalto, S. 2007. Luovuusterapiat hoitomuotona. In Bardy, M, Haapalainen, R., Isotalo, M. and Korhonen, P. (Eds.). Taide keskellä elämää. Nykytaiteen museo Kiasman julkaisuja 106 /2007. Like.

Bardy, M. 2007. Taiteen paluu arkeen. In Bardy, M, Haapalainen, R., Isotalo, M. and Korhonen, P. (Eds.). Taide keskellä elämää. Nykytaiteen museo Kiasman julkaisuja 106 /2007. Like.

Burkitt, I. 1999. Bodies of Thought. Embodiment, Identity and Modernity. Sage Publications. London.

Sae-Il, C. 2007. The Role of Art Therapy within East-West Medicine and Alternative Medicine. Journal of The Korean Academy of Clinical Art Therapy. Vol. 2 No. 2.

Eväsoja, M. 2008. Bigaku. Japanilaisesta kauneudesta. Tammi.

Hentinen, H. 2007. In Rankanen, M., Hentinen, H. and Mantere, M-H. (Eds) Taideterapian perusteet. Duodecim.

Kaneko, K. 2006. Text book B. Course for training clinical artist and clinical art basics. (Unofficial translation in English).

Karppinen, M. 2006. Cultural Patterns of Knowledge Creation. Finns and Japanese as engineers and poets. Helsinki School of Economics. Acta Universitatis Oeconomicae Helsingiensis. Helsinki.

Sun-Hyun, K. 2007. Comparative Study of Eastern and Western Art Therapy. Journal of The Korean Academy of Clinical Art Therapy Vol. 2 No.2.

Mantere, M-H. 2007. In Rankanen, M., Hentinen, H. and Mantere, M-H. (Eds) Taideterapian perusteet. Duodecim.

Naukkarinen, O. 1999. Populaarikulttuurin estetiikka ympäristöestetiikkana. Filosofinen N&N aikakauslehti 1/1999.

Pääjoki, T. 2004. Taide kulttuurisena kohtaamispaikkana taidekasvatuksessa. Jyväskylä studies in humanities; 28, Jyväskylän yliopisto.

Rankanen, M. 2007. In Rankanen, M., Hentinen, H. and Mantere, M-H. (Eds) Taideterapian perusteet. Duodecim.

Strandman, P. 2007. Taiteen soveltavaa käyttöä? In Bardy, M, Haapalainen, R., Isotalo, M. and Korhonen, P. (Eds.). Taide keskellä elämää. Nykytaiteen museo Kiasman julkaisuja 106 /2007. Like.

Tasada, T. 2004. Working in Art Therapy. In A Joyous Expression of Life. Art Therapy and Alzheimer's Patient. Harukashobo, Japan.

Unpublished sources

Kimura, S. 2008. Presentation 10.6.2008 Kimura Clinic, Ina-Chuo, Saitama.

Nishida, K. 2008. Excursion information 16.6.2008 Tokyo.

Oshiro, T. 2008. Interviews, 8.5., 9.5 and 27.5.2008, Tohoku Fukushi University, Sendai.

Sekine, K. 2008. Excursion information 10.6.2008 Kimura Clinic, Ina-Chuo, Saitama.

Varto, J. 2007. Lecture at the University of Art and Design Helsinki, Art Education.

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www.arttherapy.gr.jp (Japan Clinical Art Association)

www.zoukei.co.jp (The Institute of The Formative Arts)

The need to develop operations models in order to maintain health and prevent health problems in the elderly can be considered to be equal and parallel in Finland and Japan.

Most of the services for the elderly in Finland are produced as service production by the public sector. The purchasing of care, nursing, rehabilitation, and corresponding services from outside the public sector is currently significant in Finland, and it will most likely continue to increase in the future. On the other hand, the Japanese long-term care system is now just in the middle of a period of self adjustment to a more community comprehensive care system rather than the quasi-market model it used to be.

Comparative knowledge has contributed to the development of services in both countries and to guaranteeing a good quality of life for the elderly. This publication consists of presentations that explain the service structure for the elderly, the improvement of quality in the lives of the elderly, redefining the concepts of elderly care, innovations in service and organisation, and their analysis and researc

The articles for this book are based on papers presented at the third Sendai-Finland Seminar and the fourth Finland-Sendai Seminar. The seminars are the annual events for the Active Project entitled "Refurbishing Elderly Care", which is the joint R&D project agreed by Laurea University of Applied Sciences, Helsinki School of Economics, the City of Vantaa and the City of Espoo in Finland and Tohoku Fukushi University and Tohoku Fukushi Corperation from Sendai, Japan.

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