NEED OF DOMICILIARY CARE
IN FINNISH RURAL DISTRICTS

ELINA HAAVIO-MANNILA

With the rising standard of living and the development of medical sciences man's mean expectation of life increases. At the same time the age structure of the population changes: the proportion of older age groups in the total population grows larger. The middle aged and the old are more susceptible to sickness than the young. Thus the general frequency of illnesses in the whole population shows no signs of decrease in spite of the greatly reduced mortality in connection with those diseases which formerly took a heavy toll on young life.

Work for the enlightenment of the public, advancement in the educational level of the population, higher standard of living and improved facilities for treatment increase continuously the number of those who appreciate the necessity of having their illnesses treated. People no longer resign themselves to sickness and death. The need of medical care increases rather than decreases.

In the Finnish health policy of the 'fifties the development of the hospital institution was set out as the primary task. The per capita number of hospital beds in our country is approximately the same as in the other Nordic countries. Nevertheless, there are not beds enough for all the patients who seek admission to the hospitals. On the other hand, hospital care is not necessary in all cases. It has been proved that domiciliary care is often more advantageous to both the patient and the community. But, in order to secure the domiciliary patient as good treatment as he would get at hospital, the number of personnel employed in extramural health activities must be sufficient to give the patient all the help he needs.

In Finland, the domiciliary patient can be attended by a physician (there is one physician per 1,500 inhabitants) and by a public health nurse or deaconess (one per 2,200 inhabitants). Home-aids employed by the local authorities (the present number of these posts is one per 3,200 inhabitants) assist to some extent in cases of sickness at home. There are, in addition to these professional public officials, neighbours, relatives, friends or lay healers who also often give help. Until now data have not been available in Finland as to the incidence of sickness among the population, nor how many of the patients seek treatment, nor what part of those in need of care cannot get it, nor what proportion recovers or dies without professional care. It is true that morbidity data are available for certain groups of diseases but they include the treated cases only. Of the untreated cases nothing is known. However, from the viewpoint of practical health policy such knowledge is of first-rate importance. The authorities responsible for the health planning of the country, like the sociologist, are interested in knowing the correlation between morbidity and social conditions and also how the social background of the patient is associated with his willingness to seek treatment and its availability.

Research Problem and Material

The goal of the present survey* which was carried out under the auspices of the Finnish Public Health Nurses Association and the State Medical Board was to

*Kotona sairastavien hoidontarve Suomen maalaiskunnissa (Need of Domiciliary Care in Finnish Rural Communes); 136 pages, Maalaiskuntien liiton kirjapaino, Helsinki, 1962.
find out what proportion of the total population of the Finnish rural communes* had been sick during a given time so that it would be possible to measure their need of care. The need of care was measured by adding the proportion of the patients attended to by a doctor, a nurse or a home-aid in the total number of patients, to the proportion of the patients who did not get the necessary** treatment. The rest of the patients did not need any treatment at all, according to the opinion of the public health nurse.

The study now under report is a part of a health survey of the Public Health Department of the State Medical Board for which the material was collected by the local public health nurses in four stages during the years 1959–60. The sample used was provided by a labour force survey. The sample included 6,130 households living and working in rural communes. The members of these households were interviewed for data on their illnesses during the two preceding months. Of the households, 5,491 or 90 per cent were reached. They comprised a total of 25,597 persons of whom 2,555 had, during the two preceding months, been so ill for at least three days that their capacity to work had been clearly reduced. The persons interviewed were not fully representative of the population of Finnish rural communes. The persons who were included in the sample brought along their whole households, and the material consisted of ‘too many’ members of large households and ‘too few’ members of small ones.

The aim of this medico-sociological study was, as already mentioned, to clarify how many of the persons who had reported to the interviewers as having been ill during the designated time had sought treatment and how many of those needing treatment** had not done so.

The starting-point was the presumption that the need of care and subsequent approaches to get it are dictated in the first place by medical reasons, that is by the seriousness and duration of the sickness. That some patients seek treatment while others with the same disease do not do so suggests that all patients do not have the same facilities for getting the necessary treatment or that the understanding of the necessity of treatment depends on social factors.

Nature of Illness and Need of Care

The degree of the seriousness of the illness could be measured only by the category of disease and duration of sickness. *With prolonged illness the proportion of the domiciliary patients treated by the physician and by the nurse grows larger.* At the same time the significance of the help of neighbours, relatives and communal home-aids increases.

When scrutinising the correlation between the number of sick days in bed of the domiciliary patient and the need of nursing care, it was found that only 5 per cent of the patients who were allowed to stay up suffered from the lack of nursing care, but if the patient had to stay in bed 30 days or more, the corresponding percentage is 13. The need of nursing care (care obtained and lack of care) increases correspondingly from 28 per cent to 42 per cent. Thus, in domiciliary care nurses are primarily needed for patients whose illness requires prolonged bedside nursing.

Categories of Disease

The illnesses were divided into three categories according to their mean duration

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*Finland is administratively divided into 67 towns and 481 rural communes. At the end of the year 1961 62% of the population of Finland (4.5 millions) lived in rural communes. The population of the rural commune varies quite a lot, it ranges from 157 to 57,000. Fifty per cent of people living in rural communes are engaged in agriculture and forestry (of the whole population 31%).

**Estimated by the public health nurse.
and the average quantity and type of treatment required. To the first group belong
the patients suffering from tuberculosis and mental disease of long duration who
often require institutional care and cause the household many problems. The second
group consists of the infectious diseases of short duration for which treatment is
seldom sought and is not even considered necessary. The third group consists of
the diseases requiring long rest in bed, i.e. diseases of the circulatory and nervous
systems, sense organs, and bones, tumours, etc. for which the domiciliary patients
generally resort to the aid of both the physician and the nurse and which also require
help from neighbours and other lay personnel. The need of domiciliary care among
this group of patients is generally quite considerable.

Social Factors and Need of care

The age and sex of the patient

The slight need of medical care by children and the small number of children
attended to by the doctor (Table I) is explained almost completely by the short dura-
tion of the great majority of the illnesses. Those children who have been ill at least a
month are treated by the physician as often as the adults.

Table 1.
TREATMENT OBTAINED AND LACKING BY AGE

<table>
<thead>
<tr>
<th>Age of patient</th>
<th>Treated by physician %</th>
<th>Lacked physician's treatment %</th>
<th>Attended by a nurse %</th>
<th>Lacked nursing care %</th>
<th>Assisted by neighbours, etc. %</th>
<th>Lacked domestic help %</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>46</td>
<td>11</td>
<td>35</td>
<td>10</td>
<td>9</td>
<td>10</td>
<td>515</td>
</tr>
<tr>
<td>15-64</td>
<td>68</td>
<td>10</td>
<td>23</td>
<td>5</td>
<td>25</td>
<td>16</td>
<td>1,639</td>
</tr>
<tr>
<td>65-</td>
<td>70</td>
<td>7</td>
<td>24</td>
<td>9</td>
<td>31</td>
<td>16</td>
<td>341</td>
</tr>
<tr>
<td>All</td>
<td>63</td>
<td>10</td>
<td>26</td>
<td>7</td>
<td>23</td>
<td>15</td>
<td>2,555*</td>
</tr>
</tbody>
</table>

*The age of 60 patients is not known.

Sick children are attended by nurses much more frequently than the adults. This is
caused by the history and principles of public health nursing in Finland. Health work
with children has always been one of its primary objectives. Thus when a child falls
ill the most natural thing to do is to consult the public health nurse with whom the
child has been registered as early as at the age of a few weeks. Children and old
people as well require much nursing aid: lack of treatment is greater among them than
among other persons notwithstanding that they are attended to more frequently
than the latter. The need of domestic aid is acutest when an aged person is sick.

Men do not seek medical and nursing aid quite as often as women (67 per cent of
the husbands and 70 per cent of the wives were treated by a physician, the difference
being statistically insignificant; 22 per cent of the husbands and 27 per cent of the
wives were attended by a nurse, the difference being statistically almost significant,
\( x^2 = 6.71 \)). In 60-luvun sosiaalipolitiikka (Social Policy of the Sixties) Pekka Kuusi
proves that mortality among the Finnish male population is very high as compared
with the corresponding figures in other Scandinavian countries. For Finnish women
the mortality figures do not differ as much from the international standards. That
men do not have their illnesses treated as often as women may perhaps be regarded

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as an explanation of this phenomenon.

The social status of the patient

Seeking medical aid decreases systematically with the lower social groups (Table 2) and the lower standard of living measured by household conveniences. The farmers differ from other social groups in that the small farmers, especially, ask for the aid of the public health nurse less often than other groups. Also, the ways in which the members of the different social classes get the necessary medical aid, vary. Home visits by the physician are the more frequent the higher the social status of the patient. The help of neighbours again increases with the lower social classes. In the cases of sickness the members of lower social classes must content themselves with the aid of laymen while the upper classes can afford professional medical and nursing care.

Table 2.
TREATMENT OBTAINED AND LACKING BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social class</th>
<th>Treated by physician %</th>
<th>Lacked physician's treatment %</th>
<th>Attended by a nurse %</th>
<th>Lacked nursing care %</th>
<th>Assisted by neighbours etc. %</th>
<th>Lacked domestic help %</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-II</td>
<td>69</td>
<td>5</td>
<td>31</td>
<td>4</td>
<td>23</td>
<td>7</td>
<td>283</td>
</tr>
<tr>
<td>III</td>
<td>66</td>
<td>7</td>
<td>33</td>
<td>2</td>
<td>20</td>
<td>13</td>
<td>291</td>
</tr>
<tr>
<td>IV</td>
<td>58</td>
<td>12</td>
<td>29</td>
<td>7</td>
<td>25</td>
<td>17</td>
<td>553</td>
</tr>
<tr>
<td>Farmers, field area (ha)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-66</td>
<td>66</td>
<td>11</td>
<td>26</td>
<td>6</td>
<td>18</td>
<td>10</td>
<td>417</td>
</tr>
<tr>
<td>5-9</td>
<td>61</td>
<td>9</td>
<td>21</td>
<td>8</td>
<td>21</td>
<td>16</td>
<td>503</td>
</tr>
<tr>
<td>-4</td>
<td>63</td>
<td>13</td>
<td>21</td>
<td>13</td>
<td>25</td>
<td>18</td>
<td>365</td>
</tr>
<tr>
<td>Unclassified</td>
<td>64</td>
<td>11</td>
<td>26</td>
<td>6</td>
<td>45</td>
<td>17</td>
<td>143</td>
</tr>
<tr>
<td>All</td>
<td>63</td>
<td>10</td>
<td>26</td>
<td>7</td>
<td>23</td>
<td>15</td>
<td>2,555</td>
</tr>
</tbody>
</table>

Lack of all kinds of care increases with lower social status of the patient. The lower the social status of the household, the greater grows the lack of medical, nursing or domestic aid that would be necessary in addition to the treatment the patient already enjoys.

The extent to which treatment is sought is clearly associated with the patient’s professional and economic status. As far as medical treatment is concerned economic reasons prevent the patients from seeking treatment. As a rule, however, the services of public health nurses are available free of charge to all alike which indicates that the extent to which treatment is sought depends obviously also on the patient’s attitude to the necessity of care.

Geographical factors

The geographical distances are associated with the treatment obtained, in two ways:

(1) living far from administrative and business centres goes together with weak economic and social conditions, and

(2) due to long distances, seeking treatment is more difficult for people who live in remote places.
Patients attended by the nurse and those who have not obtained the necessary nursing care in per cent of all patients, by distance to the nearest public health nurse or deaconess.

The longer the distances from the patient's home to the nearest physician and nurse, the smaller the proportion of those treated and the greater the lack of care. Long distance decreases more the frequency of nursing, than medical care, above all with diseases of short duration. Of those who live farthest from the public health nurse the majority suffer from lack of treatment while those treated by her are in the minority (Figure 1).

The proportion of patients treated by nurses does not vary very much by province. The percentage indicating the number of these patients is higher in the northern Province of Oulu (31%) and lowest in the most southern Province of Uusimaa (20%). This is probably due to the differences in the availability of medical treat-
ment. The lack of nursing care is greatest in East- and North-Finland. The need of nursing care is thus exceptionally high in the poor eastern and northern parts of the country. This may depend on the shortage of physicians—the nurse is expected partly to compensate for the doctor.

The proportion of patients attended to by nurses in extramural health work is associated with the number of inhabitants per nurse in the commune as is indicated in Figure 2. The fewer inhabitants there are in a commune per nurse the more the

<table>
<thead>
<tr>
<th>Inhabitants per nurse</th>
<th>% Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>—1,499</td>
<td>343</td>
</tr>
<tr>
<td>1,500—2,499</td>
<td>1,440</td>
</tr>
<tr>
<td>2,500—3,499</td>
<td>540</td>
</tr>
<tr>
<td>3,500—</td>
<td>141</td>
</tr>
</tbody>
</table>

Figure 2.

Patients attended to by the nurse and those who have not obtained the necessary nursing care in per cent of all patients, by the Number of Inhabitants in the Commune per Trained Nurse

Summary

In this article special attention has been given to the participation of the Finnish public health nurse in the domiciliary care of the sick.

It was found that her services had been used most frequently by patients with prolonged illnesses, by children and the aged. People in low occupational groups, especially small farmers, people living far from the public health nurse or in communes with many inhabitants per nurse, have not been able to gain from her services—which are available free of charge—as often as those living in more advantageous conditions.

The lack of nursing care, as estimated by the public health nurse herself, is great in three kinds of cases:

1. It is great among patients who often have been nursed by her: among long term patients and among the children and the aged. This reflects the public health
nurse's own image of her role. The members of the household, however, expect her help more often in the care of shorter illnesses and of patients of the working age.*

2. Lack of nursing care is acute in those social groups whose members have not been nursed by the public health nurse very often: in low social status groups, among people living far from the nurse and in communes with many inhabitants per nurse.

3. There is a lack of nursing care, notwithstanding the large amount of care obtained, in those northern and eastern parts of Finland, where a shortage of physicians prevails. The nurse is there expected, both by herself and by the members of the household, partly to compensate for the doctor.

The Author

MRS. ELINA HAAVIO-MANNILA took her Doctor's Degree in sociology at Helsinki University in 1958. Her doctoral thesis was about village fights in Finland. She worked as a research worker and teacher of social sciences at the State College of Nursing during 1956–1961, with some interruptions. In 1962 she became appointed as a junior research scholar by the State Committee for Social and Political Sciences. Her work place is now at the Institute of Sociology at the University of Helsinki. She is doing a sociological investigation, based on questionnaires sent to all 3,000 Finnish physicians, about the work load and working conditions, and occupational aspirations of the Finnish medical doctors.

The study on the Need of Domiciliary Care in Finnish Rural Districts was initiated by the Finnish Public Health Nurses Association in 1959. It was conducted with the help of State Medical Board. A study report of 135 pages was published in Finnish in 1962.