10.2478/nispa-2023-0019

The Alleged Culprit of Poor Coordination of Integration of Health and Social Care Services for Very Ill Older Persons in Sweden, 2000-2022

Iwona Sobis[1]

Abstract:

Despite numerous attempts to transform Swedish older adult care, similar problems regarding its coordination have persisted over the years. This literature review aims to identify which coordination mechanisms can be perceived as the alleged culprit of poor coordination of integrated health and social services for seriously ill older individuals in Sweden between 2000 and 2022. Classical and contemporary coordination theories are utilised to pinpoint these coordination mechanisms, and the analysis is based on the content of collected articles from this thematic area. This literature review reveals that the following coordination mechanisms are perceived as the primary cause of poor coordination in older adult care: (1) plans, programmes, rules, and standardised work processes. Research has confirmed that decentralisation, the autonomy of regional and local authorities, new regulations implemented in the spirit of NPM, and double principalship have hindered care integration for seriously ill older adults; (2) roles, standardisation of skills, and direct supervision. Neither organisational principal adequately addresses excess employee workloads and an insufficient number of employees providing care services, which generates stress, conflicts, and even occupational burnout among staff. They do not prioritise staff competency development; (3) proximity, feedback, and adjustments through mutual communication. Most studies have shown that communication among staff is crucial to achieving integration, but it could be more effective among staff members involved

1 School of Public Administration, Gothenburg University, Sweden.

© 2023 Iwona Sobis. This is an open access article licensed under the Creative Commons Attribution-onCommercial-NoDerivatives 4.0 License (https://creativecommons.org/licenses/by-nc-nd/4.0/).

in providing care. Knowledge about "objects and representations" and "routines and standardisation of outcomes" is somewhat limited and deserves further research.

Keywords:
coordination, dual principalship, older adult care, integration of health care and social care services

1. Introduction

The Elderly -Reform (Ädelreform), initially discussed by the social democratic political bloc in the mid-1980s, was eventually implemented in 1992 by the centre-right bloc. Despite numerous attempts to transform Swedish eldercare, similar coordination problems have persisted for decades. The main objective of the reform was to move older individuals, often perceived as 'bed blockers', from hospitals to their own homes, where they could receive care services of high quality, live with dignity, and remain independent (Lagergren, 2002; Carlström, 2005; Sobis, 2013). This reform involved the transfer of approximately 30,000 beds, along with the corresponding financial responsibility, from county councils to municipalities.

According to the Welfare Act (SFS 1993: 390) and the Health Care Act (SFS 1992: 567), regional and local authorities were expected to share responsibility for eldercare and integrate health and social services for older adults, which necessitated the need for a board representing both organisational principals. While the Parliament (Riksdag) and the government were responsible for all health and social care at the national level, they formulated main objectives for older adult care and strategies to achieve those goals, created legislation and oversaw the implementation of the planned reform, ensuring that changes were in line with the intended objectives. They were also responsible for additional regulations, directives, and policies towards eldercare for lower levels of public administration. They monitored whether the major objectives were achieved per regulations and whether funds allocated to eldercare were used correctly.

Since 1992, health and medical care provision has been decentralised into 21 regional authorities providing primary health and medical care, while 290 local authorities are responsible for providing social care. Following the Elderly-Reform, municipalities have become responsible for delivering primary health and social care services at residential care homes, inclusive sheltered housing, retirement homes, group dwellings for older persons, and older individuals' private homes. Regional and local authorities are autonomous and self-governing, and are expected to share responsibility for coordinating the integration of health and social care for seriously ill older individuals. However, Public Official Reports - SOU (see: SOU 2008: 51; SOU 2017: 21; SOU 2020: 80) have shown that the organisation of care for older adults has not worked

as expected. SOUs have emphasised that regional and local authorities should pay more attention to ethics, morality, and equality of access to care services for older adults to guarantee a 'worthy life,' 'well-being,' and 'high quality' of eldercare services for individuals with extensive needs of health and social care services.

Therefore, this literature review aims to identify which coordination mechanisms can be perceived as the alleged culprit of poor coordination of integrated health and social services for seriously ill older individuals in Sweden between 2000 and 2022. Classical and contemporary coordination theories will be used as analytical tools for identifying those coordination mechanisms. The analysis is based on the content of the collected articles from this thematic area.

This article is structured as follows: section 2 provides a theoretical framework after the introduction. Section 3 presents the methodological approach, while section 4 focuses on the institutional context of this research. Section 5 presents the empirical results, and section 6 answers the research question and draws conclusions.

2. Theoretical frame

Organisational Theory provides insights into coordination and coordination mechanisms, which are essential for the success or failure of coordination. Traditionally, two theories have been used: the first, created by March and Simon (1958), distinguished between coordination by plan or programme and coordination by feedback, while the second, created by Mintzberg (1979), described specific coordination mechanisms for both categories. Mintzberg's coordination mechanisms included adjustments by mutual communication, direct supervision, standardisation of processes and outputs, and standardisation of skills.

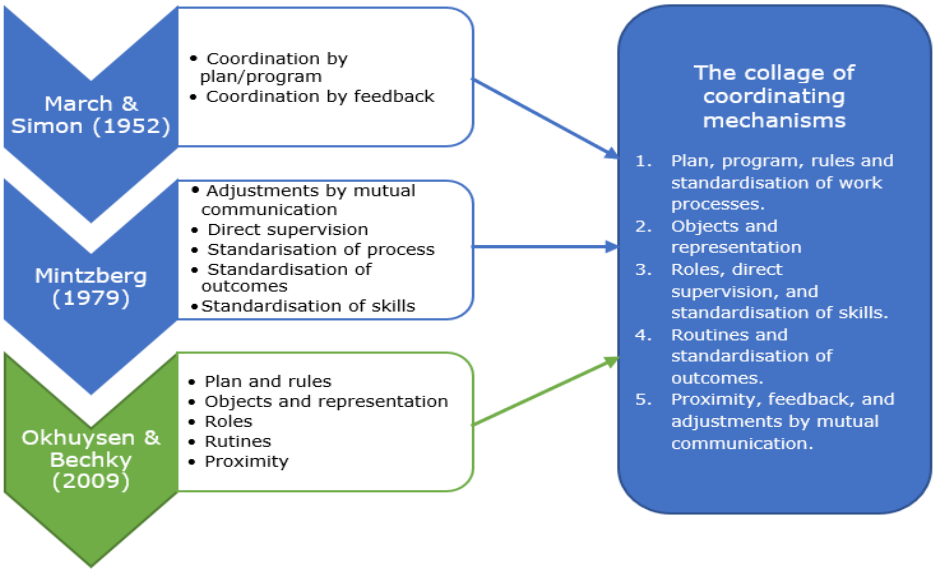
A modern theoretical approach by Faraj and Xiao (2006) emphasised the importance of "dialogic coordination" for interventions across professional boundaries. Prætorius and Becker (2015) suggest that coordination mechanisms occurring through standardisation of processes or outputs are suitable for situations characterised by low work complexity. Coordination by mutual adjustment works better when there is strong interdependence among staff.

Okhuysen and Bechky (2009) synthesised the traditional and modern theoretical views of coordination mechanisms and proposed an integrative framework with five categories: plan and rules, objects and representations, roles, routines, and proximity. Accountability, predictability, and shared understanding are additional conditions that are friendly for coordination of actions among interdependent professions participating in the work.

The theoretical collage presented below will be used to structure the presentation of research outcomes in section 5, which focuses on the poor coordination of health and social care services for seriously ill older persons in Sweden.

Figure 1:

The collage of coordinating mechanism used as analytical tools when selecting and analysing the empirical articles



Source: Authors' own, 2023.

3. Methodological approach

This integrative literature review aims to identify the coordination mechanisms contributing to the poor integration of health and social services for older adults in Sweden from 2000 to 2022. The theoretical framework presented in Figure 1 in Section 2 assisted the author in selecting empirical studies for this review and conducting the analysis.

Databases from three sources were utilised: (1) the Gothenburg University library, (2) Google Scholar, and (3) ResearchGate. Keywords such as 'care for seriously ill elderly,' 'elderly with severe illnesses,' 'dual principalship,' 'coordination,' 'coordination mechanisms,' 'integration,' 'healthcare services,' 'social care services,' 'tensions,' 'deficits,' and various combinations like 'coordination* + healthcare + social care, elderly + Sweden' or 'integration* + healthcare + social care' proved helpful in locating peer-reviewed empirical articles. Filters and keywords ('coordination* + healthcare + social care, elderly + Sweden, 2000 – 2022') were applied to narrow down the articles, resulting in 344 hits. All these scientific articles were collected between September 2022

and March 2023 and published in both Swedish and international scientific journals. Therefore, the issue of validity and reliability for empirical studies based on quantitative methods or internal credibility, external transferability, and dependability for qualitative research were addressed through the authors' work and the peer-review processes before publication.

The initial selection involved reviewing the titles and abstracts of the articles. The second selection was based on reading the introductions and presentations of research outcomes, which was decisive in determining whether an article was accepted or rejected. The accepted articles for analysis were related to one or more of the coordination mechanisms presented in Figure 1. In some cases, selected articles did not explicitly use the terms 'coordination' or 'coordination mechanisms'. However, the description of the research sheds light on the challenges of coordinating health and social care services for older adults.

The selected articles were primarily saved as PDF documents and analysed by coding and note-taking directly within these PDFs. Subsequently, the results were transferred to a separate document, a matrix previously prepared to categorise the coordination mechanisms illustrated in Figure 1. Occasionally, coding and analysis were performed online if an article couldn't be saved as a PDF document. The most relevant findings were directly recorded in the matrix in such cases. Ultimately, 22 articles met the criteria for inclusion in the analysis.

Additionally, Government Official Investigations (Statens Offentliga Utredningar - SOU), various public reports from the National Board of Health and Welfare, data from the Swedish Association of Local Authorities and Regions (SALAR), legal provisions, and information from Statistics Sweden (SCB) were collected to provide context for this review. All translations from Swedish to English were carried out by the author of this article when the empirical studies were originally written in Swedish.

4. Institutional context for the years 2000 - 2022

Sweden experienced a relatively favourable balance between its young and senior population from 2000 to 2022. However, during this period, there was an increasing number of older individuals in 2022 compared to 2000, while the number of young people decreased in 2022 compared to 2000. Many experts suggest that the gap between the young and the old may continue to grow in the future. Therefore, providing care for older adults is an important issue for national, regional, and local authorities who are responsible for coordinating the integration of health and social care services for very ill older individuals.

Table 1:

The Swedish population, 2000–2022

Population on 31 Dec.	2022	2020	2015	2010	2005	2000
Total	10 521 556	10 379 295	9 851 017	9 415 570	9 047 752	8 882 792
Men	5 298 324	5 222 847	4 930 966	4 690 244	4 486 550	4 392 753
Women	5 223 232	5 156 448	4 920 051	4 725 326	4 561 202	4 490 039
Number of persons, aged 0-17	2 194 785	2 189 403	2 025 077	1 919 094	1 934 239	1 937 779
Persons aged 0-17 in % of total population	20.9	21.1	20.6	20.4	21.4	21.8
Number of persons, aged 65 and older	2 147 137	2 088 086	1 947 227	1 737 246	1 565 377	1 530 887
Persons aged 65 and older in % of total population	20.4	20.1	19.8	18.5	17.3	17.2

Sources: SCB Statistics Sweden.

The proportion of public expenditure on care services, income support, pensions, and the like accounted for 33% of GDP in Sweden, the highest level among the OECD countries. In addition, direct and indirect taxes in relation to GDP for 2000-2022 were about 54%, resulting in the Swedish national, regional, and local authorities being obligated to provide care services for very ill older people in line with their needs so that they could live in dignity. It is worth noting that most older people contributed to the development of GDP over the years before retirement. In 2018, the share of expenditure on older adult care in GDP was 2.4%, and most of the cost was covered at the municipal level (Värja, 2022, p. 67f).

Although some progress in care service integration has been made, issues still need improvement because the eldercare did not work in line with the very ill older adults' needs during the investigated period. Even within the state legislation, there were some paradoxes. Table 2 below presents the major acts and regulations dealing with the restructuration of Swedish care for older adults between 1992-2022. The legislative changes aimed to improve the coordination of health- and social care integration at the local level. In 2000, around 20% of the entire country's operating budget was allocated to care for older adults, but twenty years later, in 2020, this share had decreased to 19%, corresponding to over 135 billion SEK (SCB, 2021).

Health and social care integration appeared ambiguous and left much room for interpretation, resulting in legal provisions that sometimes compelled staff to follow regulations without the ability to make exceptions, causing more harm than good to sick older individuals. A thorough examination of the legal acts revealed inconsistencies among the laws, creating a "Catch 22" situation. For instance, the Healthcare Act (1992:567) stressed the significance of introducing a Nurse with Special Medical Responsibility [MAS] for older adults at the local level.

A registered nurse (RN) with Special Medical Responsibility (MAS) was expected to coordinate health and social care interventions within municipalities. However, there needed to be more clarity regarding which domain the RN should belong to: health care or social care, or even the local authority. Additionally, there was a dual principalship towards care for older adults, with each principal organisation having its own values, professional norms, and organisational culture. Although the Act on Joint Boards in Health and Social Care for the Elderly mandated integration between the health care and social care domains, everyday practice showed a lack of cooperation. As a result, this integration posed a significant challenge for national, regional, and local authorities, and other stakeholders such as NGOs or Local-Regional Associations. It is worth examining the empirical outcomes of the shortage of coordination of care services for seriously ill older persons.

Table 2:

The major regulations concerning the coordination and collaboration of Swedish health and social care for older adults, 1992 - 2022

Basic legal provisions	Complementary legislative amendments	A restructuration of health care and social care services
The Health Care Act (SFS 1982: 763)	The Health Care Act (SFS 1992: 567)	According to § 24, municipalities were required to employ a nurse with special medical responsibility (known as a MAS) for older people. This regulation paved the way for what is now known as the Whole-Elderly Delegation Reform (Hel-Ädel)."
	The Government Bill of 1996/97:60 [Reg. proposition 1996/97:60]	"This bill helped to prioritise palliative and long-term care within the Swedish older adult care system."
	Act (SFS 2003:1210) on financial coordination of rehabilitation efforts, the county council may participate in financial coordination within the field of rehabilitation.	"The county council is responsible for contributing to the financing of activities that are carried out collaboratively."
	Act (SFS 2017:612) on collaboration on discharge from closed health and healthcare	Chapter 1, § 1 outlines how interventions should be planned for individuals who require interventions from multiple units within relevant operations after their discharge. It also specifies the municipality's payment responsibility for certain patients who are ready for discharge. Chapter 5 discusses the municipality's payment responsibility in more detail. According to § 1, a municipality must provide compensation to a region for a patient who is being cared for in closed care after their attending physician has determined that they are ready for discharge. This is subject to the regulations outlined in §§ 2-6, as specified by the law (2019:979).
	Act (SFS 2019:913)	§ 2 specifies that the region and the municipality or municipalities can only collaborate under this law if the joint committee's area of responsibility includes data from both parties.
	The Welfare Act (SFS 1993: 390)	The regulation made it mandatory for municipalities to plan their activities in collaboration with county councils and other communal agencies.

The Welfare Act (SFS 1980: 620)	Welfare Act (SFS 1997: 313) modernised the Welfare Act (SFS 1980: 620).	According to §§ 19 and 20, social welfare committees are responsible for ensuring that older people can live independently, safely, and with respect for their autonomy and integrity. Older adults should receive support and assistance at home initially, and only move to care facilities if absolutely necessary.
	Welfare Act (SFS 2001: 453)	Chapter 3, § 3 states that efforts within social services must maintain high quality standards, with staff possessing appropriate training and experience for their assigned tasks. The quality of the business should be systematically and continuously developed and secured. Chapter 5, § 6 mandates that the social welfare board should familiarise itself with the living conditions of older people in the municipality and provide information about social services activities through outreach programmes. Additionally, the municipality is required to plan initiatives for older adults in collaboration with the region and other community organisations and bodies.
	Act (SFS 2003:192) on joint boards in health care and social care	§ 1 specifies that municipalities and regions may take care of matters of general interest related to their respective areas or members. § 2 clarifies that regions and municipalities can only collaborate under this law if data from both parties is included in the joint committee's area of responsibility. §§ 36 and 37 include special provisions on joint boards and contractual cooperation, respectively. Specifically, § 37 allows a municipality or region to enter into an agreement to have its tasks carried out in whole or in part by another municipality or region.
Ministry of Social Affairs	S2011/11027/FST 2011-12-15	The Government has approved an agreement on integrated healthcare for the sickest older individuals.

Sources: The authors' own compilation of legal provisions, 2023.

5. Empirical outcomes

This section presents the results of a literature review on the coordination of integrated elderly care in Sweden between 2000 and 2022. During the review, several articles came to light that did not explicitly focus on coordination but, nevertheless had critical implications for it. After analysing the articles' content, they were classified into different coordination mechanisms. In some cases, it was challenging to decide which mechanism to assign an article to as it dealt with two or more coordination mechanisms. In such cases, the conclusions drawn in the article decided about assigning it to the appropriate category. The outcomes of the review are categorised into five categories, presented in Figure 1 in section 2: 5.1 Plan/programme, rules, and standardised work processes; 5.2 Objects and representation; 5.3 Roles, standardisation of skills, and direct supervision; 5.4 Routines and standardisation of outcomes; and 5.5 Proximity, feedback, and adjustments through mutual communication.

5.1 Plan/programme, rules, and standardised work processes

The selected empirical studies on plans, rules, and standardised work processes focused on various aspects, including programmes, strategies, task execution, and assigning responsibilities. This category also encompasses allocating financial resources (predictability) and the agreements between all parties involved in eldercare (shared understanding) regarding how to develop care services for the very ill older adults.

Øvretveit et al. (2010) conducted a qualitative investigation of an integrated health and social care system in Norrtälje, Stockholm Region, and how it was established. Their research aimed to answer three questions: (1) What are the specifics of the integrated care organisation that was created and how does it differ from the previous system? (2) Which actions were taken to establish the new organisation, and what facilitated or hindered them? (3) How has the organisation and its context evolved over time? The authors utilised a grounded theory approach and the Pettigrew context-process model to analyse their data, revealing various stakeholders' influence. Thus, all parties involved needed to be open to change. The authors discovered that initial coordination at the macro level, established through new laws and directives, was effective. However, these structural regulations did not introduce the integration of clinical care. It was necessary to foster health and social care integration at the micro level by altering the organisational culture to achieve this. Øvretveit et al. (2010) identified some structural changes that could potentially enhance clinical care and reduce healthcare costs, but they did not have evidence to confirm this. Therefore, the authors concluded that "coordinated action is needed at different levels and types to achieve coordinated patient care" (p. 120).

One year later, the same group of scholars, Hansson et al. (2011), described "the formation and structure of coordination within the consortium and assessed the intermediate impact on care processes and client outcomes" (p. e132). They aimed to answer the following questions: (1) What are the main arrangements established for client coordination in the consortium? (2) Which contextual factors helped and hindered coordination? (3) To what extent has the consortium resulted in new coordination arrangements, procedures, and ultimately, better client outcomes? The authors used Pettigrew and Whipp's model of strategic change. Hansson et al. (2011) conducted 12 structured interviews with key representatives of different organisational levels during the development of the consortium's formation and structure by planning its cooperative arrangements and observing the consortium's intermediate and final outcomes. They also studied administrative documents, plans, and service statistics to note changes. This study provided knowledge about developing coordination between health and welfare services for older adults. The authors concluded that client-level coordination roles should be used in each sector in cases where full structural integration between health and social care services did not work. Moreover, the county's central purchasing organisation focused more on the volume and cost of services and payments for specific services to various units than on improving the quality of services

for seriously ill older adults. The above proved to be a hindering factor for coordination. An additional lesson from the micro-level outcomes proved crucial: complete integrated care was possible if steering groups from both services applied a bottom-up approach that also included macro management levels.

Nyström et al. (2014) focused on large-system transformations (LST), their content, and facilitation strategies. Growing complexity over time required more structure and better coordination to improve the lives of the most seriously ill older people in Sweden. Large-system transformations (LST) were defined as "interventions aimed at coordinated, system-wide change affecting multiple organisations and care providers to improve the efficiency of healthcare delivery significantly, the quality of patient care, and population-level patient outcomes" (Nyström et al., 2014, p. 2). The results of this research were used to assess the impact of these strategies on the improvement of the lives of older adults. This research showed that

a) the programme management team involved very different groups of stakeholders and actors;
b) regional improvement trainers, regional strategic management teams, and national quality registers were applied;
c) financial incentives and annual updating of contracts were also used;
d) various training sessions were introduced;
e) participants within the programme intensively communicated with each other; and
f) monitoring and measuring the effects were also introduced.

All these efforts caused progress to be achieved in most of the target areas, but these strategies could not be translated into achieving well-coordinated care for older adults (Nyström et al., 2014, p. 13ff).

Rämgård et al. (2017) presented the findings of seven action research projects conducted in the Scania Region of southern Sweden. The projects involved various professional groups and aimed to improve older adult care at different administrative levels and geographical scales. Participatory health research (PHR) methods were used, including individual and group reflection phases with colleagues and mixed groups at the regional level, allowing for mutual learning and improved cooperation between health and social care professions. The PHR approach focused on values and empowering groups with a low professional status. The authors highlighted the importance of the autonomy of local and regional structures and the need for reflective dialogue between professional groups to improve older adult care. However, despite some policy changes at the regional level, the authors observed that the hierarchies for staff in the health and social care system for older persons remained largely unchanged. They argued that changes in national policy must be combined and coordinated with changes at the local level to achieve tangible improvements in care services for older adults.

Szücs and Kjellberg (2022) described three types of coordination used in public

administration: (1) hierarchy, (2) markets, and (3) networks. Depending on which political block was in power after the elections, these types of coordination were visible in daily practice. For example, before the 1991 general elections, the social democratic government prepared an eldercare reform. However, they lost the elections, and the centre-right party took over, introducing the Community Care Reform (CCR) in 1992, which decentralised and deregulated eldercare. After the 2006 general election, the centre-right party took over again and continued the reform initiated in 1992. This time, the government used the model of vertical coordination by markets. However, the transformation of eldercare coincided with the external influences of New Public Management (NPM), widespread worldwide. As a result, the centre-right government introduced the Act (SFS 2008:962) on Freedom of Choice system, which became the new coordinating mechanism.

Consequently, the vertical coordination of health and social care for older adults by markets turned into a mixed model based on centralised politics and deregulating NPM. In 2010, the centre-right party won the general elections and introduced a decentralisation model. According to the document issued by the Welfare Department (S2011/11027/FST) regarding the approval of the agreement on coherent care and care for seriously ill older people, the external check regulation of the national performance management system (PM) improved through central agreements with non-government organisations (NGOs). Subsequently, the government coordinated eldercare through networks. In the 2014 and 2018 general elections, the social democrats won and governed according to their ideology, entailing further centralisation through a hierarchical coordination model. The social democratic government introduced the Act (SFS 2017:612) on Cooperation on Discharge from Inpatient Healthcare, which may be viewed as a legal paradox. Stakeholders simultaneously demanded centralisation and decentralisation through cooperation at the local level. The study's authors aimed to analyse "how sustainable governance can be achieved by horizontally integrating care services for older people through collaboration in coordination bodies" (p. 72). They posed the following questions: "How is collaboration on integrating care governance for older people systematically achieved and sustained? How have monitoring and reviewing horizontal collaboration changed (due to increasing regulation and vertical coordination of health system policy through hierarchy, markets, and networks)? Why do some collaborations on integrating services succeed and others fail?" (p. 72). They concluded that for an endeavour to succeed, the coordinating body must (1) designate the target group, provide leadership, establish rules for communication within the group, inspire confidence among participants, and clearly identify the qualitative benefits of participating in horizontal integration; (2) have two types of democratic accountability in monitoring and systematic reviews: internal controls that hold board members accountable, and external controls that regulate democratic accountability vertically. There was evidence of a gradual increase in dependence between external and internal controls due to changes in centralisation policy. External hierarchical accountability became increasingly linked to internal political and administrative

behaviour for monitoring and review; (3) systematically achieve "management of the horizontal integration of care services according to the level at which the main leaders themselves, especially as political or administrative stakeholders, carry out monitoring and review" (p. 80). However, the COVID-19 pandemic showed the opposite effect, as strategic coordination bodies failed to hold local and regional governments accountable for failing to ensure the safety of older adults.

To summarise, five empirical studies meeting the selection criteria were found in this category. Øvretveit et al. (2010) and Hansson et al. (2011) demonstrated that while initial structural coordination at the macro level through state legislation or other regulations and directives was effective, it did not result in integrated care for seriously ill older individuals. Only the integration of health and social care at the micro level had a minimal positive impact. These studies suggest that if structural integration fails, client-level coordination should be implemented, and a bottom-up approach should be introduced into the macro-levels of older adult care management. Budget concerns should not compromise the quality of care services, but this was observed to be the case. Nyström et al. (2014) and Rämgård et al. (2017) found that while many stakeholders and financial incentives were involved in the programme to improve integrated care for older adults, hierarchies remained the same, negatively impacting on cooperation among professions. Szücs and Kjellberg (2020) identified that the coordinating body must designate the target group, establish its leadership, and set communication rules.

Furthermore, democratic accountability involved internal and external controls that complemented each other, especially within the policy of centralisation. A large coordinating body significantly impacted managing the horizontal integration of care services. However, integrating health and social care services for older adults needed to be better coordinated, and while some progress was made, more work is needed.

5.2 Objects and representations

Okhuysen and Bechky (2009) state that objects and representations refer to documents such as records, admissions and discharge forms, and clinical guidelines.

Kjellberg and Szücs (2020) focused on the introduction of the new Collaboration Act (2017: 612). They stated that "This legislation shortens the time before the relevant local municipality becomes liable for payment of hospital charges from five to three days" (p. 234). Their qualitative research aimed "to explore contemporary policy responses where coordination and collaboration are important features in dealing with the complexities of integrated social and health care for older people in Sweden" (p. 232). The study involved interviewing nine strategically selected stakeholders who shared their opinions on the new Collaboration Act, which regulates the discharge of older people from hospitals in need of both health and social care. This regulation "gave rise to a blame game" (p. 236) as hospitals "want to get rid of these patients, and there is someone else [the municipality] who must bear that cost" (p. 236). Kjellberg and Szücs (2020) emphasised the lack of a clear definition of the person perceived to be ready for

discharge from hospital. The authors applied thematic analysis, exploring sectoral and interorganisational collaboration while focusing on trust, defined as cooperative advantage. The article highlighted the lack of trust at political, strategic, and interprofessional levels. Respondents had two opposing lines of argumentation: some believed that one government body should be responsible for health and social care.

In contrast, others considered the recently implemented national policy that assumes greater cooperation between local governments and obliges them to sign joint local agreements as correct. The article investigated the cooperation of integration of health and social care services for older adults. The advocacy of restructuring the care system for frail older adults seemed paradoxical because, on the one hand, there was an expectation of increased centralisation. On the other hand, there was an expectation of increased coordination and broadly understood cooperation at the local level. These approaches were mutually exclusive.

In summary, the authors showed that even strategically selected stakeholders shared a critical view of this legislation and disagreed on its effectiveness in improving the coordination of care services for seriously ill older persons.

5.3 Various roles, direct supervision, and standardisation of skills

The collected studies identified coordinating mechanisms that Okhuysen and Bechky (2009) explained as distinct roles and by Mintzberg (1979) as the standardisation of skills and direct supervision. These theoretical concepts provided insights into how integrated health and social care services were coordinated when different professions worked together to provide services to the most seriously ill older persons.

a) The role of Registered Nurse

Karlsson et al. (2009) investigated the work environment experiences of Registered Nurses (RNs) in residential care homes for older persons, such as sheltered housing, retirement homes, and group dwellings for older persons with dementia (p. 265f). RNs are required to have completed at least a three-year programme resulting in a bachelor's degree. They are in a unique situation as they have an office in a special unit of the residential care home or in a separate organisation, making them subordinate to the residential care home manager or the manager of a separate organisation. They are also expected to pay visits to the elderly in their residences. The research shows that RNs positively experienced a work environment where the border between nursing care and social care was clearly defined. However, they often felt frustrated as they were expected to "be everywhere and to know everything" and coordinate work, making them feel like "lonely fixers" (p. 265-269). RNs also experienced difficulties in cooperating with physicians when they discharged older persons from the hospital without asking for the RN's opinion regarding opportunities for nursing care provision within residential care homes. The specialist education did not prepare RNs to provide nursing care for older adults living in residential care homes. Therefore, RNs needed comprehensive

development in many fields of nursing. The research indicates that RNs did not have enough time for this compared to other specialist nurses who have completed a master's degree. Thus, competency development in nursing addressed to RNs is a necessary condition to avoid frustration and ethical distress within a flexible organisation. In addition, the profession is heavily feminised, with only 10% of men working as RNs. It would be beneficial to encourage more men to work in nursing services.

This topic was further explored by Josefsson & Hansson (2011), who investigated registered nurses' (RNs) perceptions of their leadership, their first-line management, and the organisational prerequisites of leadership in municipal elderly care. Nursing leadership was found to be a key factor affecting care quality, but it was in crisis in municipal older adult care. The study aimed to answer three questions: What do RNs think of their leadership? What do RNs think of their immediate line management? What do RNs think of the leadership's organisational prerequisites? Using a systems theory approach, which focused on the organisational prerequisites of municipal older adult care, such as facilitating communication between different hierarchical levels, supporting those involved in cooperation, improving coordination, defining clear roles, transparent decision-making, and providing staff development opportunities, the authors conducted a questionnaire survey. The study found that the RNs' role needed to be clarified, and they needed opportunities for leadership development in clinical nursing. Instead of receiving support and coaching from their first-line managers, the participating nurses (approximately 24%) faced conflicts; furthermore, other organisational prerequisites generated more problems than solutions.

Claesson, Jonasson, and Josefsson (2021a) study explored the experiences of RNs' leadership by close relatives of older persons using municipal home care. It was found that the relatives were not always aware of the differences between the roles of registered nurses (RNs) and social workers in home care for older adults. The next of kin played an important role in the lives of older adults and needed to know who to turn to if any problems arose. The close relatives were critical of the RNs' leadership and their responsibility for organising home care services for older adults. They observed that the RNs followed routines to maintain patient safety, but home care assistants did not always follow current guidelines (p. 5). The RN was perceived by the next of kin as a team leader who delegated nursing interventions to care assistants. In this role, the RN was expected to ensure that care assistants were properly trained and could carry out their duties in line with guidelines. Claesson et al. (2021a) concluded that this knowledge was crucial for the municipal organisation of care services, and that the RNs' leadership needed to be developed because the organisational preconditions did not allow the RNs to coordinate health and social care interventions effectively. The RNs balanced their professional commitment with what they could realistically achieve in practice. Clear communication and availability of the RNs were found to be fundamental in creating mutual trust and cooperation with the next of kin. This conclusion should be taken seriously by decision-makers. The professional position of RNs deserves support through education and the systematic development of their

competencies if it is expected that they will coordinate home care for older adults.

Claesson, Josefsson, and Jonasson (2021b) provided a platform for older adult patients to share their experiences with registered nurses' leadership in municipal home care. The authors interviewed 12 older individuals who perceived RNs as "their nurses," partners, and leaders in community home care. The older persons trusted RNs to take care of their needs and ensure their satisfaction. However, the interviews revealed that RNs had to possess a variety of skills to cater to the individual needs of older persons.

b) Nurses in Home Health Care (HHC) and their opportunities for competency development

Andersson et al. (2017) described how nurses experience their competencies in home healthcare (HHC) situations. Nurses face many challenges in the homes of seriously ill patients where advanced care and treatment are very limited. Although each nurse wants to provide high-quality and safe service for older persons, service being in line with their competencies, neither their own strategies for transferring competencies between nurses nor organisational opportunities for competence development allow for that. Nurses have to share competencies with less experienced nurses to provide safe HHC. The interviewed nurses were critical towards managers' planning and following-up of competence development. It was up to nurses to take an initiative to increase their own competencies. Managers had never provided any feedback after the activities of completed competence development. The lack of appreciation and support from managers caused too many nurses to experience boredom, anger, despair, fatigue, and give up their ambitions to develop their competencies. Andersson et al. (2017) concluded that working in an unstructured and even chaotic environment could contribute to burnout and staff turnover.

c) Nurse assistant

Maneschiöld and Lucaci-Maneschiöld (2021) drew attention to the introduction of New Public Management (NPM) and its characteristic feature of decentralisation. They used Hood's (1991) theory on NPM, which aimed to improve the quantity and quality of services in public administration, including care services for older adults. This study shed light on the impact of NPM on working environments and indirectly on the coordination of integration of health and social care services. The authors combined Hood's theory with Antonovsky's (1987, p. 166f) theory on the sense of coherence, which suggests that employees feel confident in performing their job if the stimuli from the internal and external environment are structured, predictable, and explainable, and if there are enough resources available to meet the employer's requirements and solve professional problems.

The article showed that the budget allocated to eldercare was the main limitation of care services. NPM had forced all possible organisations to save money, meaning the municipal care budget for older adults did not allow for enough staff to be hired or for personnel competency development to be paid for. Additionally, the increased

administrative burdens and continuous documentation of care tasks significantly decreased the time available for high-quality care services for older adults. These limitations caused nursing assistants to perceive their working environment as very stressful. They needed to communicate with their frontline boss frequently, but the latter were busy with documentation and planning care tasks. These working conditions were unsatisfactory for everyone, causing unnecessary conflicts, frequent staff changes, and professional burnout.

d) The frontline managers

Hagerman et al. (2015) conducted a study based on semi-structured interviews. They found that male frontline managers (FLMs) were generally satisfied with their jobs, experiencing freedom within established limits, job satisfaction, and stimulation in their daily work. However, they lacked support from the structural conditions of the organisation to which they belonged, specifically regarding the budget. The FLMs could not influence the budget but could be held responsible for budget deficits. They also knew that any budget surplus would not be carried over to the next financial year but would instead be used to cover deficits in other units. FLMs perceived this as a conflict of interest over which they had no control. Those working in municipal aged care services claimed that the local board was politically driven, leading to unnecessary delays in decision-making.

Additionally, FLMs had no influence on the hiring of permanent staff, although staff were perceived as the most valuable and important resource for them. The frustration was mainly due to external conditions and conflicting goals. FLMs also received insufficient information from their supervisors about ongoing and planned changes, and the messages they received needed to be more incoherent. This left FLMs feeling confused, frustrated, and lacking in commitment while still responsible for running the unit. Thus, the organisational hierarchy and decision-making processes proved too long, highlighting serious coordination problems in the integration of health- and social care for seriously ill older persons.

e) Cooperation and boundaries between professional roles within the team

Duner (2013) investigated how professionals in two teams, one in a hospital ward and the other in the homes of older people, assessed and planned for the needs of older people. The study aimed to explore how the team members perceived their teamwork, professional roles, and boundaries to identify similarities and differences between the two teams. Both teams aimed for integration and a holistic assessment of the needs of older people, which was used to plan and provide appropriate medical and social care. Achieving this required integrating team members, including formal professional positions and informal team time, to understand better and reflect on each other's roles, share professional knowledge and experiences, and promote good communication between different professions. This integration allowed team members to balance their

interdependence with the desire for professional autonomy and recognition of their unique contributions to health and social care for older people (p. 252).

In summary, this category includes nine relevant empirical studies providing insight into the experiences of healthcare and social care personnel involved in coordinating the integration of health and social care for frail older adults. Whether the research focuses on roles such as registered nurse, nurse assistant, or social worker, a common theme across all studies is the issue of poor coordination, deficits, and tensions. Karlsson et al. (2009) noted that RNs working in a residential care home were frustrated as they felt like they had to be "lonely fixers," being everywhere and knowing everything. The cooperation between RNs and physicians during discharge from hospitals was also found to be ineffective in practice. Meanwhile, Josefsson and Hansson (2011), Claesson et al. (2021a), and Claesson et al. (2021b) found that the leading role of RNs needed to be clarified, and the organisational prerequisites generated more problems than solutions. RNs had to be "multi-artists" to meet the individual needs of older adult patients. Andersson et al. (2017) and Duner (2013) found that experienced nurses had to share their competencies with less experienced nurses to provide safe home healthcare, and that a holistic approach to patients needed to be improved.

Additionally, most studies emphasised the the need for more employees and a lack of time for competency development, especially for the lowest staff in the professional hierarchy. The need for more staff on site was also a common problem. However, frontline managers perceived the problems with coordination somewhat differently. According to the authors Maneschiöld and Lucaci-Maneschiöld (2021), the main limitation of care services for older adults is the budget allocated to eldercare. Hagerman et al. (2015) argue that frontline managers in aged care services are overwhelmed with scheduling services, paperwork, and record-keeping while facing challenges with decision-making due to the political motivations of local management, resulting in delayed decisions. Moreover, politicians and superiors have increasing demands, and frontline managers bear responsibility for subordinates and clients despite having no influence in hiring permanent staff or budget allocation. No articles specifically focused on standardisation of skills were found.

5.4 Routines and standardisation of outcomes

Below are presented the empirical studies focusing on routines, which are understood according to Okhuysen and Bechky's (2009) definition as the ways of performing a task. These can include templates for task completion or standards that unite people and allow for a shared understanding of how a task should be conducted. This approach is similar to Mintzberg's (1979) understanding of outcome standardisation.

Sundström et al. (2017) described how Collaborative Health and Social Care Planning (HSCPC) meetings were understood by older people, family members, and professionals. The study was qualitative, and the authors employed a hermeneutic approach, interpreting data from individual interviews (n = 10) and group interviews

(n = 22) from different perspectives. Their interpretations were based on the context and their prior understanding: (1) lack of inter-professional and inter-organisational collaboration could lead to care fragmentation, and (2) HSCPC was seen as a remedy to combat this deficiency. During the analysis, they identified four themes: (1) unspoken agendas and unpreparedness, (2) security and enhanced understanding, (3) asymmetric relationships, and (4) ambiguity about the mission and need for follow-up (p. 150ff). The authors found that professionals saw joint health and social care planning as a routine in their daily work. For older adults and their relatives, it was about the further life of an older adult person, about how a seriously ill older adult person dependent on health and social care can cope with everyday challenges at home. According to the authors, "HSCPC involving several people and organisations is a costly process and should not be used as a routine approach" (p. 154). HSCPC meetings should be carefully planned and detailed, starting with the appointment of a coordinator who should prepare the HSCPC meeting and present the meeting agenda to all participants. A chairperson with the ability to conduct such a meeting should be selected. It is also necessary to carry out follow-up, and then a contact person should be appointed.

Rydeman and Törnkvist's (2006) research addressed two important topics: (1) gaps in communication and coordination during the discharge process, and (2) lack of cross-discipline teamwork in this area. The qualitative research adopted a phenomenological approach, and the authors conducted focus group interviews in primary healthcare facilities, municipal facilities, social welfare centres, and geriatric wards in hospitals between 2001 and 2002. The interviews revealed that the most frustrating thing for respondents was the lack of necessary information about the patient when services other than the hospital took over the responsibility for the care of the discharged patient. Specialists were more focused on the organisational framework of the units they worked in, such as current regulations, resource constraints, and shared guidelines, with much less attention paid to the discharged patient. The patient's wishes were deemed less important, especially in situations where the patient did not understand the plan for further care. At that time, professionals treated the patient "in a standard way" according to learned professional values.

In summary, only two empirical studies were found in this category. Sundström et al. (2017) found that Collaborative Health and Social Care Planning meetings involving multiple people and organisations were a costly process and should not be used as a routine activity due to budget constraints. These budget constraints suggest that financial considerations take priority over the well-being of seriously ill older adult individuals. On the other hand, Rydeman and Törnkvist's (2006) study revealed that respondents were highly critical when they did not receive necessary information about the patient during the discharge process. However, there is limited knowledge about other routines, templates for task completion, or other standards used in older adult care. It is possible that researchers did not receive permission to conduct such research.

5.5 Proximity, feedback, and adjustments via mutual communication

Okhuysen and Bechky (2009) defined proximity as the level of interaction and communication among individuals that involves accountability, predictability, and a shared understanding of the situation. Interaction among interdependent professionals involved in eldercare can result from formal integration through plans and authority, or an emergent situation can informally cause it. Mintzberg's (1979) understanding of proximity is complemented by the idea of adjustments through mutual communication. Communication occurs between various actors involved in older adult care and is a driving force for potential adjustments. Therefore, communication and feedback are seen as coordination mechanisms that improve care services.

Kirsebom et al. (2012) conducted a descriptive qualitative study to investigate the "experiences of coordination and communication within and between care settings when older persons were transferred from nursing homes to hospitals and vice versa" (p. 886) among registered hospital and nursing home nurses. They found that poor communication between nursing homes and hospitals during the admission and discharge of older adult patients undermined continuity of care and negatively impacted the health of older adults. The study highlights the need for improved communication between nurses in nursing homes and hospitals and the need for nursing home care plans to prevent unnecessary hospital transfers and premature discharges. The authors concluded that better communication is necessary to improve coordination between hospitals and nursing homes.

Hansson et al. (2017) investigated healthcare professionals' understanding of obstacles and opportunities for collaboration within social care through three focus groups consisting of a hospital physician, a primary care physician, a hospital nurse, a primary care nurse, a municipal home care nurse or assistant officer, a physical or occupational therapist, and a patient or family member representative. They discussed obstacles and communication opportunities experienced in relationships with each other, patients, and their relatives using a story about a fictitious patient. The major obstacles identified were poor communication with patients and their relatives, delayed collaboration between caregivers, lack of a person responsible for care planning, and inadequate allocation of resources to patients' needs. Hansson et al. (2017) emphasised that the lack of overarching responsibility for the patient beyond organisational borders was the most frequently mentioned issue by focus group members, occurring at societal, organisational, and individual levels. The healthcare professionals were aware of the mentioned problems, and participants suggested that healthcare management should support employees' initiatives that benefit frail older persons.

Emilsson et al. (2020) conducted a study on teamwork and its impact on coordinating health and social care services for very ill older adult persons. The authors aimed to investigate the organisation of multi-professional teams, the involvement of different professions, the reasons for the failure to improve care, and whether teamwork, collaboration, coordination, or competition was the main problem. They used the

Corbin-Strauss matrix to map the complexity and structural social context of older adult care and the interactions between the actors involved in the case study. The study concluded that creating multi-professional teams did not improve care for older adults and was not sustainable. Territorial thinking and competition among employees from each organisation contributed to the disintegration of multi-professional teams. The solution to the problem became a consolidation of problematic structures.

In summary, three articles were found to fit this category. Kirsebom et al. (2012) drew attention to serious communication problems related to the admission and discharge of older adult patients from hospitals. Communication between registered nurses in nursing homes and hospitals did not work effectively, and the introduction of home care plans was deemed necessary. Hansson et al. (2017) also highlighted serious communication issues during the cooperation between staff caring for older adult, critically ill patients, and poor communication with patients' families. Additionally, no designated person was responsible for planning care, and resource allocation to patients' needs needed to be increased.

Regarding proximity, Emilsson et al. (2020) studied teamwork to improve health and social care integration. They found that even the creation of multi-professional teams did not improve care for older adults, as employees of each organisation competed and thought territorially. Many multi-professional teams ultimately fell apart, and old structures were reinforced, resulting in failed integration.

6. Conclusion

This literature review aimed to identify which coordination mechanisms can be perceived as the alleged culprit of poor coordination of integrated health and social services for seriously ill older individuals in Sweden between 2000 and 2022. The classic coordination theories by March and Simon (1958) and Mintzberg (1979), and the contemporary theory by Okhuysen and Bechky (2009), were used to identify potential coordination mechanisms responsible for the poor integration of older adult care. As every research it has its strength and weaknesses.

The strength of this literature review is its discovery that our current empirical knowledge regarding the coordination of healthcare and social care integration for seriously ill older people in Sweden is surprisingly limited. It also constitutes this research's weakness because pinpointing the alleged perpetrator appears to be a risky endeavour. There is an explanation for this situation. Scientists who receive government research grants often hesitate to address issues that might be inconvenient for state, provincial, or local governments. Nevertheless, most articles used in this review indicate that the primary suspects for poor coordination seem to be high-ranking political and administrative decision-makers at the state, regional, and local levels. The review also revealed that not everything can be subordinated to austerity and increasing effectiveness and efficiency, as recommended by NPM. Caring for very ill older adult

people who require extensive medical and social services is complex, and finding tailor-made solutions can be difficult. The high-level politicians aimed to implement decentralisation, deregulation, and New Public Management (NPM) as remedial measures in response to the economic crises of the 1980s and 1990s. This move inadvertently led to the establishing of a complex political and administrative apparatus, resulting in tragic consequences for the most vulnerable, particularly older adult individuals in poor health.

Certain aspects of public life that fall under public administration's purview, such as healthcare, social services, and even the education system, should not be decentralised, even during times of severe economic crises. Regardless of their political affiliations, politicians should keep this in mind and refrain from undermining the services meant to benefit the citizens. Elected officials play a crucial role in steering the state and safeguarding the welfare of all citizens, relying on the trust placed in them by the public to fulfil their commitments. In light of this, it becomes evident that a significant increase in the national operating budget may be necessary almost immediately. This increase is essential to support the seamless coordination of integrated health and social services for older adult individuals facing severe health challenges. For this reason, it is imperative for Swedish politicians to closely scrutinise the coordination mechanisms that have been identified as potential obstacles in the endeavour to enhance the quality of care available to these vulnerable individuals.

Taking advantage of the theoretical collage I could rank the coordination mechanisms perceived as the most serious alleged culprits. The first mechanism is the "planning, programming, rules, and standardisation of work processes." Most studies have confirmed that the plan of far-reaching decentralisation and the autonomy of regional and local authorities did not contribute to the successful structural transformation of health and social care for very ill older adult people. The new laws and directives were sometimes difficult to interpret, and the introduction of NPM and deregulation resulted in growing competition between health and social care services rather than promoting integration of care services for seriously ill seniors.

This gap was further deepened by the efforts of regional authorities responsible for health services and local authorities responsible for social care to give meaning to the legal provisions at the local level. They translated the state's major objectives into local goals, prepared regional and local strategies, projects, and financial incentives to achieve them, and created applicable policies, procedures, and guidelines for specific organisational behaviours. However, all these efforts did not work as expected. The double principalship also prevented the integration of care for seriously ill seniors.

The coordination mechanisms of 'roles, standardisation of skills, and direct supervision' should be mentioned in second place. The review suggests that both organisational principals must act regarding excessive employee workloads, insufficient numbers of employees providing care services, which lead to stress, conflicts, and even burnout. Additionally, both organisational superiors are not prioritising the

development of staff competencies, such as professional care skills and management/leadership skills, due to "economic austerity". Thirdly, 'proximity, feedback, and adjustments by mutual communication' should be mentioned, as this kind of coordination mechanism is crucial for cooperation on all levels. According to Okhuysen and Bechky (2009), 'proximity' and 'feedback', as described by March and Simon (1958), are necessary conditions for good communication, which can result in valuable adjustments of legal regulations and improvement of older adult care. However, this review showed that communication only worked effectively on some levels.

Surprisingly, there is limited research on 'objects and representations' and 'routines and standardisation of outcomes', coordination mechanisms that can reveal many absurdities in caring for very ill older adult people. This type of research deserves special attention from scientists.

References

Andersson, H., Lindholm, M., Pettersson, M., & Jonasson, L. (2017). Nurses' competencies in home healthcare: an interview study. *BMC Nursing*, *16*(1). https://doi.org/10.1186/s12912-017-0264-9

Carlström, E. (2005). *I skuggan av Ädel: integrering i kommunal vård och omsorg* [PhD thesis]. University of Gothenburg.

Claesson, M., Jonasson, L., & Josefsson, K. (2021a). Next of kin's experiences of registered nurses' leadership close to older adults in municipal home care in Sweden: an interview study. *BMC Nursing*, *20*(1). https://doi.org/10.1186/s12912-021-00745-6

Claesson, M., Josefsson, K., & Jonasson, L. (2021b). My registered nurse: Older people's experiences of registered nurses' leadership close to them in community home care in Sweden. *International Journal of Older People Nursing published by John Wiley & Sons Ltd.*, 1-10. DOI: 10.1111/opn.12399

Duner, A. (2013). Care planning and decision-making in teams in Swedish elderly care: A study of interprofessional collaboration and professional boundaries. *Journal of Interprofessional Care,* 27: 246–253. DOI: 10.3109/13561820.2012.757730

Emilsson, U. M., Strid, A., & Söderberg, M. (2020). Lack of Coordination between Health Care and Social Care in Multi-Professional Teamwork - the Obstacle for Coherent Care of Older People Suffering from Multi-Morbidity. *Journal of Population Ageing*, *15*(2), 319–335. https://doi.org/10.1007/s12062-020-09300-8

Faraj, S., & Xiao, Y. (2006). Coordination in Fast-Response organizations. *Management Science*, *52*(8), 1155–1169. https://doi.org/10.1287/mnsc.1060.0526

Hagerman, H., Engström, M., Häggström, E., Wadensten, B., & Skytt, B. (2015). Male first-line managers' experiences of the work situation in elderly care: an empowerment perspective. *Journal of Nursing Management*, *23*(6), 695–704. https://doi.org/10.1111/jonm.12197

Hansson, A., Svensson, A., Ahlström, B. H., Larsson, L. G., Forsman, B., & Alsén, P. (2017). Flawed communications: Health professionals' experience of collaboration in the care of frail elderly patients. *Scandinavian Journal of Public Health*, *46*(7), 680–689. https://doi.org/10.1177/1403494817716001

Hansson, J., Øvretveit, J., & Brommels, M. (2011). Case study of how successful coordination was achieved between a mental health and social care service in Sweden. *International Journal of Health Planning and Management*, *27*(2), e132–e145. https://doi.org/10.1002/hpm.1099

Josefsson, K., & Hansson, M. (2011). To lead and to be led in municipal elderly care in Sweden as perceived by registered nurses. *Journal of Nursing Management*, *19*(4), 498–506. https://doi.org/10.1111/j.1365-2834.2011.01228.x

Karlsson, I., Ekman, S. L., & Fagerberg, I. (2009). A difficult mission to work as a nurse in a residential care home - some registered nurses' experiences of their work situation. *Scandinavian Journal of Caring Sciences*, *23*(2), 265–273. https://doi.org/10.1111/j.1471-6712.2008.00616.x

Kirsebom, M., Wadensten, B., & Hedström, M. (2012). Communication and coordination during transition of older persons between nursing homes and hospital still in need of improvement. *Journal of Advanced Nursing*, *69*(4), 886–895. https://doi.org/10.1111/j.1365-2648.2012.06077.x

Kjellberg, I., & Szücs, S. (2020). Pursuing collaborative advantage in Swedish care for older people: stakeholders' views on trust. *Journal of Integrated Care*, *28*(3), 231–241. https://doi.org/10.1108/jica-01-2020-0001

Lagergren, M. (2002). The systems of care for frail elderly persons: The case of Sweden. *Aging Clinical and Experimental Research*, *14*(4), 252–257. https://doi.org/10.1007/bf03324447

Maneschiöld, P., & Lucaci-Maneschiöld, D. (2021). Nursing assistant's perceptions of the good work environment in municipal elderly care in Sweden –a focus group study. *Journal of Health Organisation and Management*, *35*(9), 163–177. https://doi.org/10.1108/jhom-07-2020-0290

March, J. G., & Simon, H. A. (1958). *Organizations*. Blackwell.

Mintzberg, H. (1979). The structuring of organizations: a synthesis of the research. Prentice-Hall.

Nyström, M., Strehlenert, H., Hansson, J., & Hasson, H. (2014). Strategies to facilitate implementation and sustainability of large system transformations: a case study of a national program for improving quality of care for elderly people. *BMC Health Services Research*, *14*(1). https://doi.org/10.1186/1472-6963-14-401

Okhuysen, G. A., & Bechky, B. A. (2009). 10 Coordination in Organizations: An Integrative Perspective. *The Academy of Management Annals*, *3*(1), 463–502. https://doi.org/10.5465/19416520903047533

Øvretveit, J., Hansson, J., & Brommels, M. (2010). An integrated health and social care organisation in Sweden: Creation and structure of a unique local public health and social care system. *Health Policy*, *97*(2–3), 113–121. https://doi.org/10.1016/j.healthpol.2010.05.012

Prætorius, T., & Becker, M. C. (2015). How to achieve care coordination inside health care organizations: Insights from organization theory on coordination in theory and in action. *International Journal of Care Coordination*. https://doi.org/10.1177/2053434516634115

Rämgård, M., Forsgren, A., & Avery, H. (2017). PHR in health and social care for older people – regional development through learning within and across organisations. *Educational Action Research*, *25*(4), 506–524. https://doi.org/10.1080/09650792.2017.1326963

Rydeman, I., & Törnkvist, L. (2006). The patient's vulnerability, dependence and exposed situation in the discharge process: experiences of district nurses, geriatric nurses and social workers. *Journal of Clinical Nursing*, *15*(10), 1299–1307. https://doi.org/10.1111/j.1365-2702.2006.01379.x

S2011/11027/FST (2011-12-15). The Government's decision: Approval of an agreement on integrated health care for the sickest elderly

SCB. (2021). Kommunernas finanser 2020 (Finances municipal 2020), 31 augusti 2021, Statistiska centralbyrån, Stockholm (Statistics Sweden. Stockholm).

SCB. (2023). *Befolkningsstatistik i sammandrag 1960–2022, (Summary of Population Statistics 1960–2022) 31 December 2022*. Statistics Sweden. Stockholm. https://www.scb.se/en/finding-statistics/statistics-by-subject-area/population/population-composition/population-statistics/pong/tables-and-graphs/population-statistics---summary/summary-of-population-statistics/

SFS 1980: 620. Socialtjänstlag. The Welfare Act. Available from: https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/socialtjanstlag-1980620_sfs-1980-620/ (2 April 2023).

SFS 1982:763 Hälsooch sjukvårdslag (The Swedish Health and Medical Services Act) SFS 1992: 567 Lag om ändring i hälso- och sjukvårdslagen (1982:763) (Act on amendments to the Health and Medical Care Act (1982:763)). Available from: https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/halso-och-sjukvardslag-1982763_sfs-1982-763/ (2 April 2023)

SFS 1993: 390. Lag om ändring i socialtjänstlagen (1980:620) (Act on amendments to the Social Services Act (1980:620)) Available from: https://www.lagboken.se/Lagboken/start/socialratt/socialtjanstlag-2001453/d_352463-sfs-1993_390-lag-om-andring-i-socialtjanstlagen-1980_620 (2 April 2023).

SFS 1997: 313. Lag om ändring i socialtjänstlagen (1980:620) (Act amending the Social Services Act (1980:620). Available from: https://www.lagboken.se/Lagboken/start/socialratt/socialtjanstlag-2001453/d_359629-sfs-1997_313-lag-om-andring-i-socialtjanstlagen-1980_620 (2 April 2023).

SFS 1997: 390. Lag om ändring i socialtjänstlagen (1980:620) (Act amending the Social Services Act (1980:620). Available from: https://www.lagboken.se/Lagboken/start/socialratt/socialtjanstlag-2001453/d_352463-sfs-1993_390-lag-om-andring-i-socialtjanstlagen-1980_620 (2 April 2023).

SFS 2001: 453. (2001). *Socialtjänstlag (2001:453) (Social Services Act)*. Sveriges Riksdag. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/socialtjanstlag-2001453_sfs-2001-453/

SFS 2003: 1210. (2003). Förordning (2000:628) om den arbetsmarknadspolitiska verksamheten (Ordinance amending the Ordinance (2000:628) on labor market policy activities). Sveriges Riksdag. Retrieved March 23, 2023, from https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/forordning-2000628-om-den_sfs-2000-628/

SFS 2003: 192. (2003). Lag (2003:192) om gemensam nämnd inom vård- och omsorgsområdet (Act on joint boards in the field of health care and social care). Sveriges Riksdag. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/lag-2003192-om-gemensam-namnd-inom-vard-och_sfs-2003-192/

SFS 2017: 612. (2017). Lag (2017:612) om samverkan vid utskrivning från sluten hälso- och sjukvård (Act (2017:612) on cooperation in the event of discharge from inpatient health care). Sveriges Riksdag. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/lag-2017612-om-samverkan-vid-utskrivning-fran_sfs-2017-612/

SFS 2019:913. Lag om ändring i lagen (2003:192) om gemensam nämnd inom vård- och omsorgsområdet (Act on amendment of the Act (2003:192) on joint committee within the care and welfare area). Available from: https://www.lagboken.se/Lagboken/start/forvaltningsratt/lag-2003192-om-gemensam-namnd-inom-vard--och-omsorgsomradet/d_3805799-sfs-2019_913-lag-om-andring-i-lagen-2003_192-om-gemensam-namnd-inom-vard--och-omsorgsomradet (2 April 2023).

Sobis, I. (2013). Nothing but trouble: Studies on the effects of reforms in elderly care in Sweden and Poland. *Nispacee Journal of Public Administration and Policy*, *6*(1), 31–60. https://doi.org/10.2478/nispa-2013-0002

SOU 2008: 51. (2008). *Statens Offentliga Utredningar 2008: 51. Värdigt liv i äldreomsorjen. Betänkande av Värdighetsutredningen.* Sveriges Riksdag. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/statens-offentliga-utredningar/vardigt-liv-i-aldreomsorgen_gwb351/

SOU 2017: 21. (2017). Statens Offentliga Utredningar 2017: 21. Läs mig! Nationell kvalitetsplan för vård och omsorg om äldre personer. Betänkande av Utredningen om nationell kvalitetsplan för äldreomsorgen. Sveriges Riksdag. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/statens-offentliga-utredningar/las-mig-nationell-kvalitetsplan-for-vard-och_h5b321/

SOU 2020: 80. (2020). *Statens Offentliga Utredningar 2020: 80. Äldreomsorgen under pandemin. Delbetänkande av Coronakommissionen.* Sveriges Riksdag. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/statens-offentliga-utredningar/aldreomsorgen-under-pandemin-_h8b380/

Sundström, M., Petersson, P., Rämgård, M., Varland, L., & Blomqvist, K. (2017). Health and social care planning in collaboration in older persons' homes: the perspectives of older persons, family members and professionals. *Scandinavian Journal of Caring Sciences*, *32*(1), 147–156. https://doi.org/10.1111/scs.12440

Szücs, S., & Kjellberg, I. (2020). Achieving sustainable governance of horizontal integration of care services: progress and democratic accountability of strategic coordination bodies for older people. *Journal of Integrated Care*, *30*(5), 69–82. https://doi.org/10.1108/jica-06-2020-0042

Värja, E. (2022). Äldreomsorgen – politikens problembarn? - "Elderly care - politics' problem child?" *Ekonomisk Debatt*, *3*, 67–72.