Continuity of knowledge

Bridges of care

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EXECUTIVE SUMMARY

Finland is becoming one of the most aged societies in the world, placing increasing pressure on its healthcare and social care systems. One of the **key challenges** identified is a **lack of continuity of knowledge**, meaning that **patient information is not consistently shared across sectors, services, or professionals**. This fragmentation leads to care gaps, digital and physical disconnects, and unequal access for patients.

This project was developed in response to a **government brief on improving the continuity of knowledge in care systems**. It was carried out in collaboration with **Kela** (the Social Insurance Institution of Finland), with contributions from **THL** (Finnish Institute for Health and Welfare) and **HUS** (Helsinki University Hospital), as part of the *Design for Government* course at Aalto University.

Through 18 interviews, a hospital visit, and multiple policy reviews, our research found that **effective knowledge sharing still relies heavily on human relationships, informal support, and clear communication.** Elderly care does not begin in institutions, it happens daily in homes, through trusted networks and everyday interactions. However, this relational dimension of care remains undervalued in current service structures.

To address this, we propose a **long-term vision for integrated, relationship-centred elderly care** that moves beyond reactive, institution-led models. Grounded in **four key insights**, our proposal introduces **three strategic entry points**—practical levers to shift the system toward more compassionate, coordinated care:

- Activating the support network: Empower informal actors and social workers to intervene earlier through local reporting tools and community-based encounter programs.
- Designing for repetition and comprehension: Improve patient understanding with simplified summaries, visual communication, and timely reminders.
- Repositioning digital tools as supportive infrastructure: Refine technologies such as speech-to-text and wearable devices to reduce friction and free up time for human connection.

Each entry point identifies **key stakeholders and considers potential barriers**, such as system resistance, resource constraints, and unclear responsibilities.

This is not a call for isolated improvements but for a **broader shift in how care is understood and delivered**. One that moves beyond data systems and service efficiency toward a model of care grounded in trust, relationships, and continuity.

We hope this work offers a foundation for building **Bridges of Care.**

*This report was produced by a multidisciplinary team of students from Aalto University as part of the Design for Government course. The team includes **Francesca Martini** and **Paola Rapino** from the Creative Sustainability program, **Joni Lappalainen** and **Takashige Doi** from Collaborative and Industrial Design, and **Huang Tzu-Tai** from Sustainable Entrepreneurship.*

INTRODUCTION

CONTEXT AND CHALLENGES

Finland is becoming **one of the most aged societies in the world**. The share of the population aged 75 and over is expected to rise from 10% in 2022 to 17% by 2040, putting increasing pressure on the country's healthcare and social care systems (Finnish Institute for Health and Welfare, 2023). This demographic shift contributes to a **shrinking workforce, a reduced tax base, and growing care needs.**

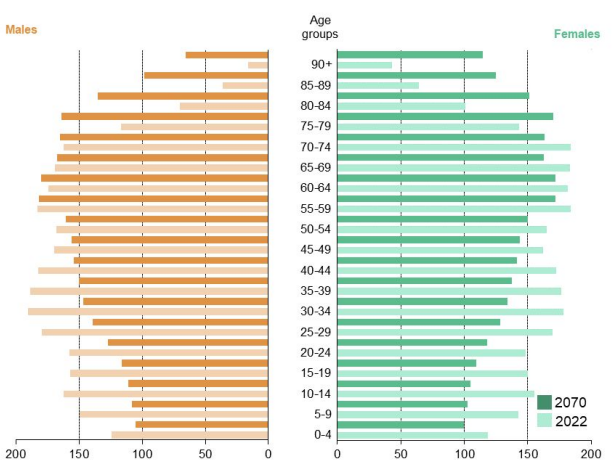


Figure 01. Finland's age structure 2022 vs 2070 *(Ministry of Finance et al., 2024)*

To respond, **Finland has invested heavily in digitalisation**, seeing it as a way to streamline services and ensure system-level efficiency. However, **this shift has also introduced new tensions** (Ministry of Social Affairs and Health, 2020; Karppinen, 2025). Municipalities have faced difficult trade-offs, cutting in-person services while pushing for digital solutions that may not always support the most vulnerable. Professionals report **growing administrative workloads and stress, often spending hours each day documenting in electronic systems** (Heponiemi et al., 2017; Thieme Medical Publishers, 2021). For patients, the transition has led to uncertainty, especially when care is fragmented or information doesn't flow across providers.

Tools like Kanta Services were designed to improve continuity of care by making medical records more accessible. Yet in practice, **professionals still rely on informal solutions, and patients struggle to access or interpret their own data** (Kanta.fi, 2025). Meanwhile, the fragmentation between health and social care persists, affecting both access and outcomes.

POLICY EFFORTS AND PROJECT FRAMING

Finland is proposing changes in prevention, integrated care, and digitalisation. Enhancing older adults' functional capacity can ease healthcare burdens (Ministry of Social Affairs, 2020). The **Health Care Act (2010)** aimed to integrate primary and specialised care but lacked financial and structural support for full implementation (Tynkkynen et al., 2022).

A major initiative is the ongoing **Health Reform (SOTE)** since 2005, establishing 22 autonomous **Wellbeing Service Counties (WSCs)** to organise health, social, and rescue services (Kunta Liitto, 2022). The reform also promotes a general practitioner model with shared digital databases. However, this requires more general practitioners, especially in underserved areas (Haapanen, 2024).

Continuity of care remains difficult to implement consistently—especially for elderly patients navigating multiple services and support networks. Against this backdrop, Kela issued a brief in collaboration with the Design for Government course, asking:

> *"How can the concept of "continuity of knowledge" help create a healthcare system that provides consistent, long-term care by tracking patients' health over time and allowing for personalized, proactive management?".*

We interpreted continuity of knowledge not just as the transfer of clinical data, but as the **meaningful flow of information between professionals, organisations, and patients.** We focused on knowledge that supports care, not only through documentation, but through shared understanding, relationships, and communication.

This framing guided our entire process, from research to proposal, as **we explored how continuity can be supported systemically and relationally**, especially for elderly people whose care needs extend far beyond institutional settings.

RESEARCH PROCESS

The findings in this report are based on a combination of **desk research, a field visit, and 18 semi-structured interviews**. This **qualitative approach** helped us examine how care is structured at the system level, while also learning from the everyday work of professionals. By combining policy analysis with direct observation and conversations across the care ecosystem, we aimed to **uncover both institutional patterns and the human side of continuity of knowledge in elderly care.**

01 DESK RESEARCH

Our desk research ran throughout the project, shifting focus as our understanding evolved. At the start, the class worked in two Supergroups—Continuity of Knowledge and Open Government—and later split into smaller **workstreams** within the Continuity of Knowledge group, each one researched one of the following topics:

- Ageing population and public services
- Digitalisation and Kanta
- Elderly health and social care
- Healthcare reform and Omalääkäri-model

As a group, we explored the structure of Finnish health and social services, the rise in the ageing population, and the goals of the national digital strategy. This helped us map out **where continuity of knowledge breaks down**—especially in the gaps between services, systems, and people.

02 FIELDWORK

02.1 Hospital visit

We visited **Raasepori Hospital** to **observe how care is delivered** (see Observation Script Appendix, p. 19) across different units and to better understand the challenges of real-time collaboration between professionals. We observed patient journeys and staff routines in five departments: the day unit, emergency department, dialysis ward, radiology, and geriatrics. These visits gave us valuable insights into **how work is organised and how time pressures shape interactions with patients and colleagues.**

02.2 Interviews

In parallel, we conducted **18 semi-structured interviews** with elderly patients, nurses, social workers, caregivers, service developers, and administrative staff (see Interview Script Appendixes, pp. 20-23). These conversations showed how continuity of care relies not only on information systems, but on relational trust, available time, and shared understanding between actors. They also highlighted how knowledge often gets lost across systems or remains unused, even when it's been documented.

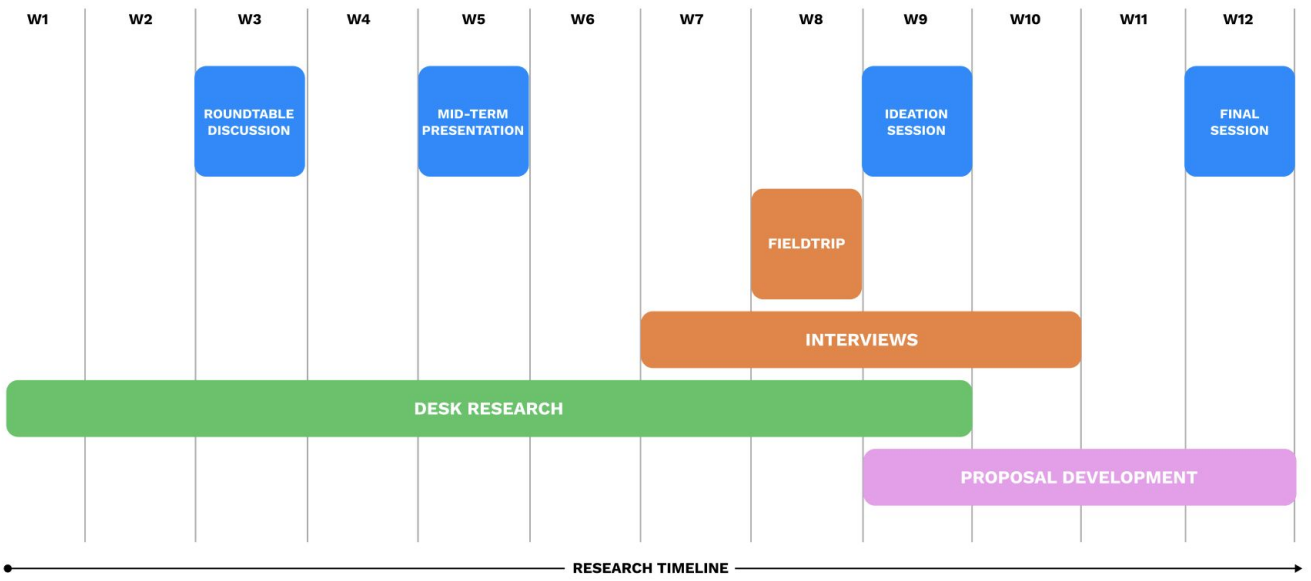


Figure 02. Timeline of our research process throughout the project

03 COLLABORATION

We collaborated with our institutional partners across **four key touchpoints** during the project: a roundtable discussion, a conceptual framing presentation, an ideation session, and a final session. Partners included professionals from Kela, such as the product owner of Kanta, as well as partners from THL and HUS.

These engagements provided **opportunities for expert feedback and validation**, ensuring that the approach remained aligned with ongoing efforts in the Finnish health and social care landscape. Their contributions also helped **iterate and refine the project's direction** based on real-world constraints and opportunities.

03.1 Roundtable discussion

Early on, we met with our partners to discuss their **understanding of continuity of knowledge**, **key challenges** they perceived in the current system, and **potential directions for change.** This discussion helped us better align our framing with real-world priorities and refine the project's focus based on their perspectives.

03.2 Mid-term presentation

We presented our **early research and system map** to partners for feedback. Their input helped us **refine the framing**, identify blind spots, and better align with ongoing reform goals.

03.2 Ideation session

Based on initial insights, we **co-developed entry point ideas** with partners. Their feedback helped us **narrow our focus** and guided us toward solutions that could be both systemic and feasible.

03.3 Final session

In our last meeting, we presented our **proposal: vision, narrative for change and entry points**, prompting discussion on how these ideas could complement current efforts. This conversation helped us reflect on the topic and discuss possible next steps.

FOUNDATION FOR INSIGHTS

Together, these research and engagement efforts helped us **identify the gaps that affect continuity of knowledge**, and the **opportunities to address them**. They highlighted **four critical breakdowns** (insights) in how knowledge is shared and used in elderly care. Each one points to a broader challenge, and a potential direction for change.

Figure 03. Fieldwork in Raasepori hospital

№	Role	Institution
1	Head of physicians	Leppäväära Health Centre
2	Social worker	LUVN
3	Social counselor	Kamppi Service Centre, Helsinki
4	Caregiver	*Informal caregiver*
5	Dialysis ward nurse	Raasepori Sairaala
6	Rheumatism ward nurse	Raasepori Sairaala
7	Department nurse (ER)	Raasepori Sairaala
8	Geriatrics ward nurse	Raasepori Sairaala
9	Day unit nurse	Raasepori Sairaala
10	Former nurse	Senior Centre Varsinais-Suomi
11	Team leader, nurse	Private company
12	Nurse	*Not disclosed*
13	Service unit manager	Raasepori sairaala
14	Special designer	HUS / Raasepori sairaala
15	Senior lecturer	Metropolia University of Applied Sciences
16	Patient 1	Member of Lions Club Helsinki
17	Patient 2	Dialysis unit, Raasepori sairaala
18	Patient 3	Day care, Raasepori sairaala

Figure 04. List of conducted interviews

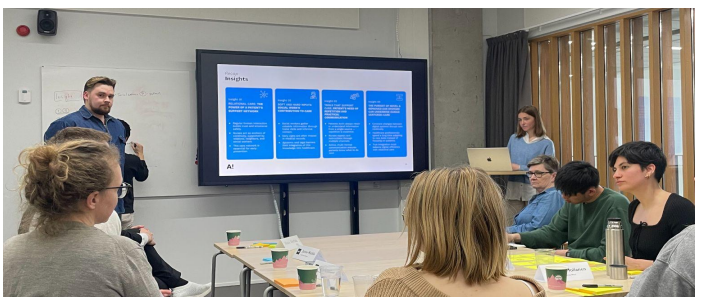


Figure 05. Ideation session with partners

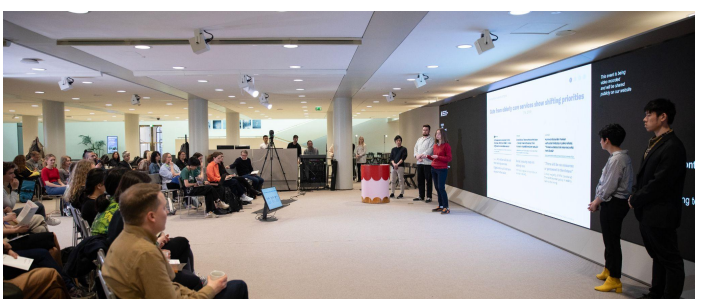


Figure 06. Final session

INSIGHTS

The research process helped us identify **four key insights: important dynamics that shape how continuity of knowledge is experienced in elderly care**. These insights highlight both challenges that need to be addressed and opportunities to support more connected, human-centered care.

The following section explains each insight in more detail.

Insight 01

Relational care: The power of a patient's support network

Insight 02

Soft and hard inputs: Social work's contribution to care

Insight 03

Tools that support care: Patient's need of repetition and practical communication

Insight 04

The pursuit of improved EHR systems can undermine human-centered care

Insight 01
RELATIONAL CARE: THE POWER OF A PATIENT'S SUPPORT NETWORK

While digital systems help store and manage medical information, the lived experience of healthcare depends heavily on human interaction. For many patients — especially the elderly — **regular contact with nurses, relatives, neighbours, or social workers shapes how they engage with care**. These interactions **build trust, create emotional safety**, and help patients **feel supported** throughout their health journey. Human connection is not an added benefit, it's a fundamental part of care.

CURRENT SUPPORT NETWORK: ROLES & DYNAMICS

Nurses play a central role in maintaining continuity across a patient's care journey. As the most consistently present professionals, they often become the **main point of contact**, building familiarity and trust over time. They act as a **bridge between medical care and social care domains.**

This relational continuity enables nurses to accumulate deep knowledge of the patient's condition, preferences, and emotional state. Patients often turn to nurses with questions and concerns, and nurses, in turn, act as translators of patient knowledge for other professionals.

Relatives and neighbours also offer crucial support, helping with transportation, reinforcing instructions, and encouraging follow-up. When these informal supports are missing, social workers may step in to assess the patient's broader needs and connect them with necessary services beyond the clinical sphere.

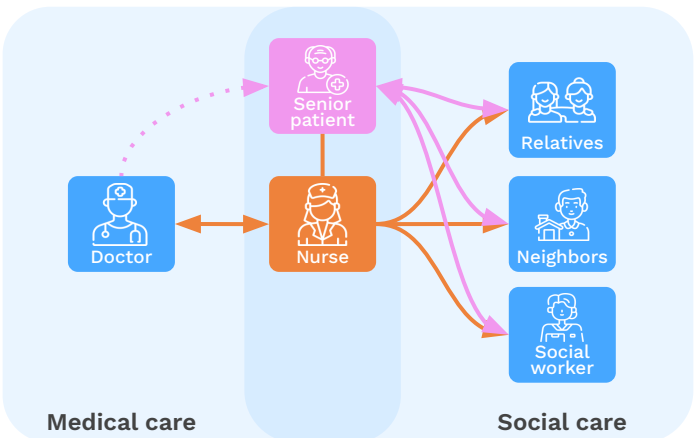


Figure 07. Current support network

▪ ▪ ▪ ▪ Reduced interaction
▬▬ Frequent interaction

UNTAPPED POTENTIAL FOR PREVENTION

Today, this care network functions informally and reactively, with nurses frequently stepping in once medical issues have already emerged. This care network holds **untapped potential for prevention.**

Early signs of decline are often first noticed by those in frequent contact. However, current structures tend to activate support only after medical needs are visible. There is an opportunity to empower the full network to support patients earlier, before issues escalate into emergencies.

Understanding and strengthening this care network is critical. This highlights that healthcare systems don't run solely on digital tools or clinical protocols. They also depend on the trust, presence, and attention of the people surrounding each patient – an aspect that is unsupported in the current care system design.

> *"**Human contact is extremely valuable.** The relationship between nurse and patient is huge, it may be the only human contact the patient has. **Social interaction with patients must be prioritized.** It also makes the work easier when there's a good care relationship. Elderly patients cooperate better when they're willing to engage."*
> – Nurse, interviews

> *"**Elderly people stay sharper when they're around others**."*
> – Nurse, interviews

> **Strong social relationships are associated with a 50% increased likelihood of survival,** indicating the profound impact of social support on health outcomes.
> – Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010).

Insight 02
SOFT AND HARD INPUTS: SOCIAL WORK'S CONTRIBUTION TO CARE

While medical care often relies on clinical data (symptoms, diagnoses, medications), **social work brings in "soft inputs"**: small details gathered through everyday interaction, home visits, and informal conversations.

SOCIAL WORKERS' PERSPECTIVE FROM THE EVERYDAY CONTEXT

Social workers often detect **early signs of health issues** through a broader, contextual understanding of a patient's life — such as social isolation, memory decline, poor nutrition, or changes in living conditions.

While nurses frequently adopt a holistic approach to patient care, their perspective is shaped by clinical interactions within healthcare environments. In contrast, social workers gain additional insights through home visits and informal conversations, gaining a deeper view of patients' everyday realities. These complementary perspectives, however, rarely connect in practice.

Collaboration between medical and social professionals remains limited, with referrals often marking the end — rather than the beginning — of coordinated support. **Communication is typically one-directional**: nurses may refer patients to social services, but continued interaction is rare. Legal barriers, system silos, and differing professional roles prevent social workers' insights from reaching doctors or nurses in a structured way — particularly due to the absence of interoperable systems or shared data platforms that would allow contextual knowledge to inform medical decision-making.

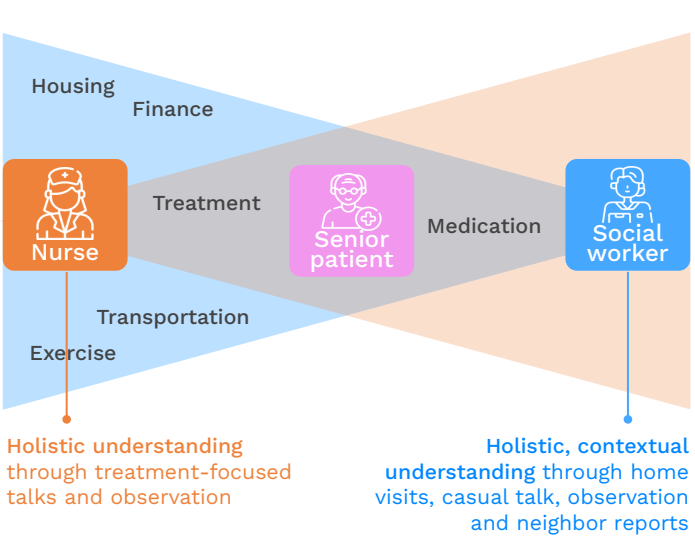


Figure 08. Social work's contextual view of health

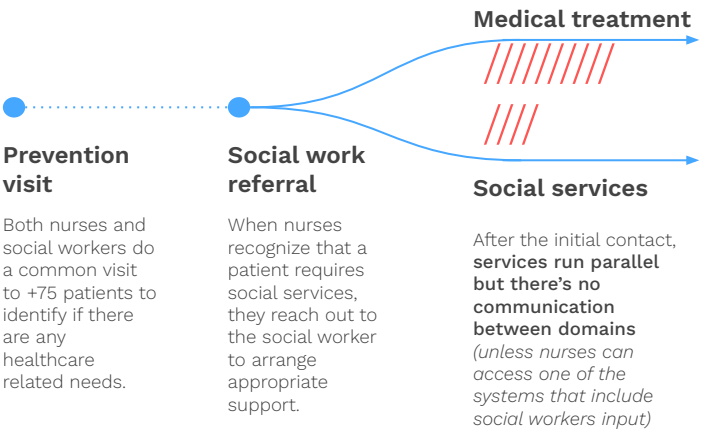


Figure 09. Touchpoints between nurses & social workers

THE MISSED POTENTIAL FOR PREVENTION AND BETTER COORDINATION

There is a **missed opportunity for better coordination and integration of social workers' insights** into healthcare. This gap in integration means that valuable early signs of declining wellbeing are often missed by healthcare professionals. In the context of ageing populations and limited resources, leveraging social workers' knowledge could help identify risks earlier, improve continuity of care, and enable more proactive interventions. To build more responsive and holistic systems, it's essential to **bridge the knowledge gap between social and healthcare domains.**

> *"The nurse is always looking like this narrow, [...] **the social workers are very different, because we look at the whole human**, we get more close and more understanding about the whole situation.*
> – Administrative staff, interviews

> *"The social worker is **an important stakeholder** in patient care but **Data Protection Regulation limits collaboration**."*
> – Doctor, interviews

> *"...[social workers] play an important role as **leaders in wider systems who can champion the social model... [bringing] a valuable diversity of thought, experience, skills and ideas to our... healthcare system**."*
> – Mark Nicholas, Clinical Director at NHS England

Insight 03
TOOLS THAT SUPPORT CARE: PATIENT'S NEED OF REPETITION AND PRACTICAL COMMUNICATION

Even when systems like Kanta contain care details, **patients often do not retain or act on the information effectively.**

Healthcare professionals shared that **patients typically remember only a few key points** from a consultation, especially when overwhelmed or emotionally affected by their condition. This is particularly true for elderly patients or those with memory issues.

REPETITION AS A CRITICAL PART OF CARE

To bridge this gap, professionals — mainly nurses — actively **repeat and adapt instructions across multiple formats**: during in-person consultations, over the phone, through Maisa messages (a Finnish EHR like Kanta), and even via handwritten notes. This repetition is not a redundancy; it's an **intentional practice that ensures patients understand** and follow through on what they need to do next. Nurses often involve relatives or caregivers to reinforce instructions at home, turning them into valuable extensions of the communication loop.

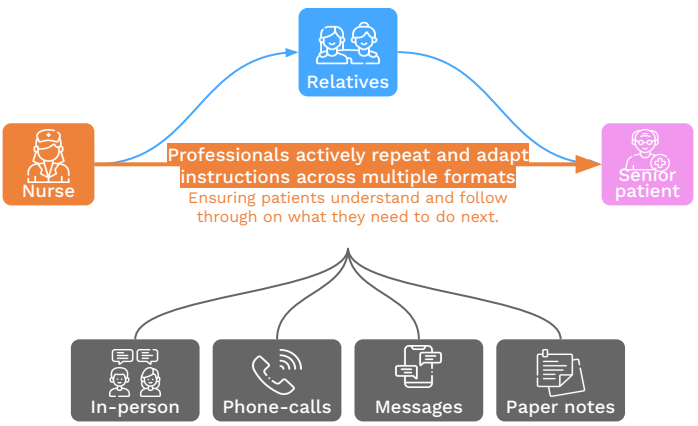


Figure 10. Repetition as a critical part of care

LIMITATIONS OF EXISTING PLATFORMS

Although Kanta stores medical information, it presents content in **static, text-heavy formats that may be too technical or abstract for many patients.** It does not currently support simplified or visual formats that aid comprehension, nor does it facilitate proactive communication like reminders or confirmations. This limits its role in everyday care.

Patients need timely, personalized, and accessible communication — not just information availability — **to translate a care plan into action.**

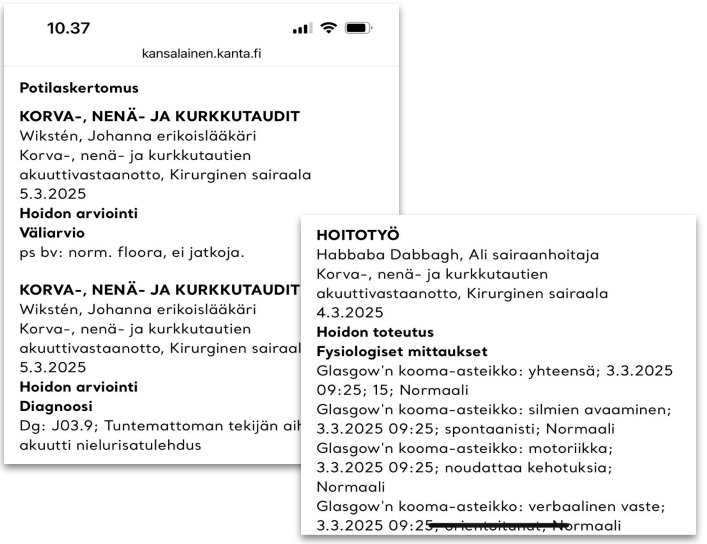


Figure 11. Screenshot of patient's diagnosis in Kanta

> ***"Patients usually remember only three things** that have been agreed upon when visiting for healthcare reasons [...] they are not necessarily nervous, but as these things are related to their health, **they might forget things**."*
> - Doctor, interviews

> *"[...] providing too much **information at once can overwhelm patients** and make it harder for them to remember key points."*
> - Nurse, interviews

> *"[...] **remind elderly patients** (mainly by text or phone calls) to take their medications and follow care instructions."*
> - Nurse, interviews

Repeated exposure to new information is essential to consolidate it into long-term memory, especially in older adults or cognitively vulnerable populations.
— Hasher, L., & Zacks, R. T. (2006).

Using visuals alongside verbal information improves learning by up to 400%. Learners retain more and understand faster.
— Henebery, B. (2022).

Insight 04
THE PURSUIT OF NOVEL & IMPROVED EHR SYSTEMS CAN UNDERMINE HUMAN-CENTERED CARE

The ongoing pursuit of improved and more comprehensive Electronic Health Record (EHR) systems can have a negative impact on staff workflow and patient care. Health professionals are often required to input and manage patient data across multiple EHR systems. These systems don't always communicate with one another, leading to **fragmented access to patient data and gaps in care continuity**. Decisions around system implementation are usually made at the organisational or governmental level, but their consequences fall heavily on frontline professionals.

DIGITAL BURDEN AND ITS IMPACT ON CARE

Improving healthcare does not always require adding or replacing systems. When time is taken away from patient interaction, it erodes the trust-building essential to person-centred care. **Digital systems are meant to support care, but in practice, they often absorb attention** that could be spent with patients. When professionals are preoccupied with system management, it becomes harder to build trust, notice early signs of decline, or respond proactively. Over time, the focus shifts from the patient to the platform — fragmenting care and undermining human-centred practice.

Continuity, usability, and human-centred processes must be prioritised alongside technical innovation to prevent gaps at the moments where trust and relational care matter most.

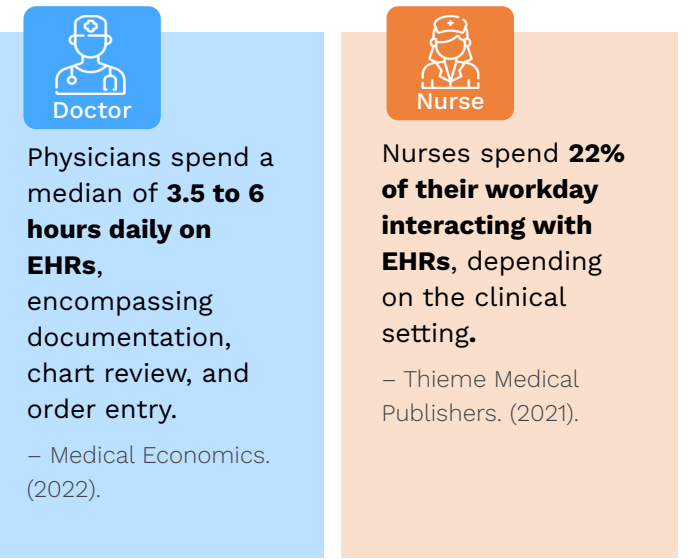


Figure 12. Time spent by care workers on EHRs (US)

> *"I've faced so many times in my life situations in which **some very important information escaped** and something happened because that specific information that would have been very important in that moment was in a **different system**."*
> – Administrative staff, interviews

> ***"Too much time** is spent **on tech and data handling**, and contacting different parties."*
> – Nurse

> ***"Technology must improve the interaction** with the patients, **not substitute** it."*
> – Administrative staff, interviews

Together, these four insights highlight critical **leverage points in the care system** — from strengthening relational networks to redesigning digital tools — which directly **informed the opportunities we identified and shaped the direction of our final proposal.**

PROPOSAL

This proposal section presents the project vision, the entry points for action, the strategic shifts that this would entail and the relevant stakeholders to address them.

The vision expresses a **sense of purpose and a clear and meaningful long-term goal** that guides the direction of our work. Each entry point **represents a practical starting place** within the elderly care system. For each one, we also considered potential barriers and proposed concrete strategies to mitigate them.

VISION

Elderly care goes beyond the hospitals, taking place in daily routines, home environments, and through personal relationships. While the current system remains focused on medical treatment, many elderly people rely heavily on informal care from family members or neighbours.

In fact, **over 90% of people over 75 live at home**, and **most receive little or no formal care** (Finnish Institute for Health and Welfare, 2024). Among home care clients, informal caregivers provide significantly more support, with an average of 15.5 hours per week, compared to just 4.8 hours from formal services (Haapanen, 2018). These figures highlight the **central role of informal care in the everyday lives of the elderly** and underscore the limitations of institution and treatment-centred approaches. Moreover, multiple interviews revealed that for many older adults, care is not solely a medical process, it involves being acknowledged, supported, and understood in the context of their daily lives.

To develop a more compassionate and effective elderly care system, **a structural shift is required: away from fragmented, digitally driven frameworks and towards integrated, relationship-centred approaches.** This reframing positions care not as an event triggered by diagnosis, but as **an ongoing process grounded in human connection and continuity.**

Care doesn't just happen in the hospital

We believe care should be:

- **Based on human-interaction**
- **Preventive, holistic, and integrated across social and health domains**
- **Supported by digital tools — but not defined by them**

ENTRY POINTS

Based on the four insights, we developed **three key entry points** for promoting more integrated and relationship-centred elderly care. Each entry point represents a **practical starting place within the elderly care system.** Together, they suggest **concrete ways to shift from reactive, institution-led systems toward more proactive and person-focused support.**

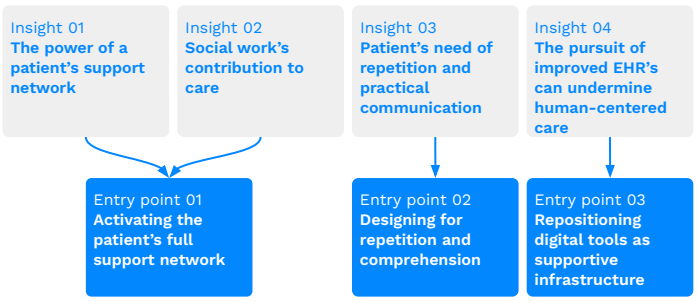


Figure 13. Link between insights and entry points

01 ACTIVATING THE PATIENT'S FULL SUPPORT NETWORK

As mentioned in Insights 01 and 02, there is clear **potential to empower and integrate informal care actors**—such as family, neighbours, and community members—as well as social workers already engaged in everyday care. By enabling them to recognise and respond to early signs of need, **care can begin well before formal diagnosis.** This shift from reactive to preventive care supports more holistic and timely responses led by those most familiar with the individual (Figure 13).

Concrete actions may include fostering **community-based communication channels**, such as youth–elderly encounter programs or **mechanisms for neighbours to report concerns before issues escalate** (e.g., through kiosks, apps, or local pharmacies). Such efforts strengthen integration and promote early intervention rooted in everyday social relationships.

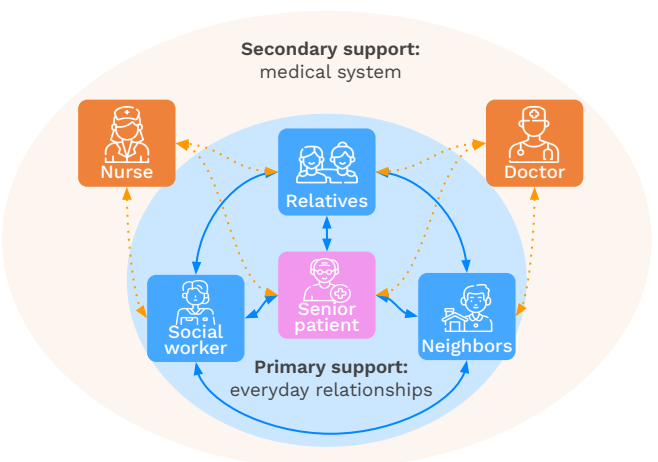


Figure 14. Ideal support network to reframe care

02 DESIGNING FOR REPETITION AND COMPREHENSION

The complexity of healthcare communication often places an excessive burden on both patients and professionals. Rather than treating communication as a purely digital task, it should be **reframed as a multichannel, human-centred strategy** that allows for repetition and comprehension from the patient. This involves **clarifying which channels to use, when to use them, and who should be responsible**, allowing professionals to focus on moments that matter.

This shift involves **improving digital systems like Kanta** by prioritising patient comprehension over text-heavy formats. Practical approaches include incorporating visual elements into written content, using AI to simplify medical language or generate easy-to-understand summaries, and programming automatic reminders across multiple channels (Figure 14).

The **goal is not to increase workload, but to design smarter workflows**. When tools actively support understanding, professionals can avoid the burden of bridging communication gaps on their own. Research shows that **combining visual and verbal communication significantly improves learning and memory**, particularly for older adults (Henebery, 2022).

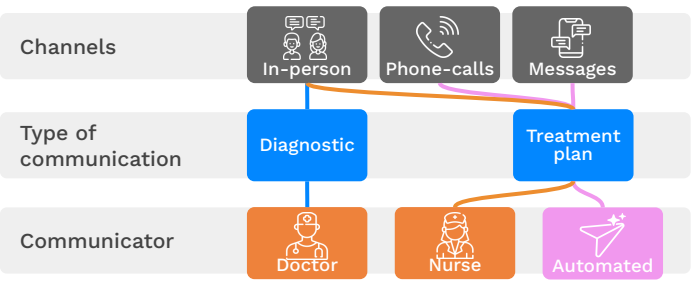


Figure 15. Exemplification of channel strategy

03 REPOSITIONING DIGITAL TOOLS AS SUPPORTIVE INFRASTRUCTURE

Digital tools should not be at the centre of care—they should function as **supportive infrastructure that reduces friction and enables professionals to focus on meaningful communication**. Rather than aiming for smarter platforms, the goal is to **create more space for human care.**

Entry points include **refining and scaling speech-to-text tools, automating documentation for routine procedures**, and integrating lightweight wearable devices that feed directly into patient records. These solutions can reduce manual input, streamline workflows, and reallocate time from screen-based tasks to meaningful interactions with patients.

STRATEGIC SHIFTS

To achieve our proposed vision **existing systems need to gradually shift toward more supportive and integrated structures.** Based on these entry points, we have reorganized the key directions for change into the following summary table.

STAKEHOLDERS AS ENABLERS OF STRATEGIC SHIFTS

To turn these strategic shifts into reality, we identified the stakeholders with the **interest, capacity, and positioning** to take action. This mapping is based on both our fieldwork.

We grouped actors into three levels—**strategic leaders**, **implementers**, and **civil society**—to clarify how each can contribute to different aspects of the transformation.

- **Strategic Leaders**
  National institutions like **THL**, **Kela**, and the **Ministry of Social Affairs and Health** set the direction for long-term change. They shape regulation, allocate resources, and steer frameworks for value-based care, digital development, and service integration.

- **Implementers**
  Wellbeing Services Counties (WSCs), **municipalities**, and **care professionals** are key to bridging policy and practice. They manage service delivery and are in a unique position to prototype new tools, workflows, and ways of collaborating across domains.

- **Civil Society and Informal Networks**
  Organizations such as **Valli ry**, **Eläkeläiset ry**, and **local memory associations**, as well as **relatives and community groups**, have proximity to people's everyday lives. They play a critical role in activating informal support, building empathy, and sustaining participation beyond formal systems.

This mapping is not only about identifying stakeholders—it's about encouraging commitment. Each actor has a specific strength and responsibility, but unlocking real change will require **collaboration across institutional and social boundaries**. Our proposal builds on what already exists and aims to bridge gaps—so that together, these stakeholders can make elderly care in Finland more connected, caring, and future-ready.

While these shifts present a compelling direction, turning them into reality requires acknowledging the practical and political barriers that might stand in the way.

Strategic shifts			Key Stakeholders	Role in Change
№	From	To		
01	Fragmented care	**Integrated collaboration across the support network** — including social, health, and informal actors	WSCs, THL	Coordinate multidisciplinary care and improve cross-sector communication
02	Reactive treatment	**Preventive support that starts with everyday relationships**	THL, WSCs, NGOs and elderly advocacy orgs	Support early detection and social care through community-based programs
03	Text-heavy, static communication through digital platforms	**Meaningful communication designed around patient comprehension**	Kanta (via Kela), WSC professionals	Redesign communication tools to better support patient understanding
04	Digital burden and complex systems	**Supportive digital tools that give time back to care**	THL, Kela, frontline staff	Improve digital systems to reduce administrative load and support care work
		Cross-cutting	Civil society, relatives, local communities	Foster empathy, co-care, and long-term engagement through informal networks

Figure 16. Strategic system shifts, strategic stakeholders and their role to address them

POTENTIAL BARRIERS & MITIGATION PLANS

In parallel with identifying opportunities for systemic improvement, it is **essential to consider the barriers that may hinder their realisation**.

Based on our findings, we outline **three key potential barriers and corresponding approaches to mitigate them effectively.**

Addressing these barriers proactively is essential not only to implement the proposed entry points, but to **create the conditions for a more integrated, human-centered care system.** By enabling collaboration across actors, reducing digital burdens, and supporting meaningful communication, we believe the system can shift toward earlier, more coordinated support rooted in relationships and trust.

These efforts aim to support a more connected and human-centered approach to elderly care — building what this proposal refers to as **Bridges of Care**.

	Complexity in Engaging Informal Actors	**High costs and slow pace of digital system upgrades**	**Technology alone does not guarantee more time with patients**
Barriers	One of the key barriers is the **lack of clear mechanisms for integrating informal caregiver**s—despite their crucial everyday role. This makes it **difficult to activate support networks without overburdening individuals or reinforcing existing inequalities,** such as gendered unpaid care work.	Comprehensive IT infrastructure upgrades often involve considerable financial investment, extended timelines, and, depending on the context, user training requirements. These factors can **hinder adoption and create resistance among both professionals and informal caregivers** involved in providing care.	Efficiency gains achieved through digital tools **may be absorbed by additional administrative tasks** unless they are accompanied by improvements in care delivery practices.
Mitigation plans	**Pilot Local Care Networks** By collaborating with municipalities or non-governmental organizations (NGOs), small-scale, low-barrier **pilot programs** can be developed to **map, activate, and evaluate informal care networks at the community level.**	**Leverage Existing Platforms** Rather than developing entirely new systems, **targeted improvements to Kanta** may provide more feasible alternatives. These **enhancements can be piloted in selected care units to assess usability and effectiveness** before broader implementation.	**Redesign workflows alongside technological updates** **Integrating workflow improvements**—such as speech-to-text documentation, auto-fill tools, and time-tracking systems—can help ensure that **time saved through technology is meaningfully reinvested in patient care and relationship-building.**

Figure 17. Potential barriers and mitigation plans.
Each column in the chart is related, meaning each mitigation plan corresponds to the barrier on top of it.

CRITICAL REFLECTION

Based on the whole process and the final presentation session with the project partners, the team reflected on **four key aspects.**

01 REFLECTIONS ON DESIGNING WITH GOVERNMENT

Throughout this project, we came to appreciate several key methodological lessons about what it means to design for — and within — government systems.

One of the most powerful tools we found was narrative: **the ability to frame care differently**, not just in terms of efficiency or service delivery, but as a relational and continuous process. This narrative shift helped us communicate a strategic vision that could resonate with institutional partners beyond isolated fixes.

Equally important was the need to **constantly zoom in and out — balancing individual experiences from patients with systemic structures** (Figure 17). This approach highlights how small design decisions are shaped by broader constraints. As a group, we repeatedly challenged ourselves to stay at an upstream level, resisting the urge to jump to solutions too early. Embracing abductive reasoning proved essential in this regard. It allowed us to **remain open to uncertainty, reframe assumptions, and navigate the inherent ambiguity** of designing for complex systems like elderly care.

02 AHA MOMENTS

Throughout the project, we encountered several aha moments: **instances where our assumptions were challenged or new insights shifted our perspective.** Early on, we hypothesized that human interaction would be central to care, and this was confirmed through our fieldwork. What surprised us, however, was the extent to which care is relational, not just clinical. Seeing elderly patients as whole human beings, whose well-being depends as much on social interaction and informal support as on medical treatment, reshaped our understanding of what continuity in care truly means. In line with this realization, we came to see **how easily informal actors can be overlooked in formal care structures**. Although they are deeply involved in the daily lives of older adults, their **role is often informal and lacks recognition or systematic support.**

Another unexpected realization was the **power of repetition as a design principle**. While repetition is often associated with childhood learning or seen as inefficient, we learned it plays a critical role in helping patients understand and follow care plans, especially when cognitive challenges or emotional stress are involved. Digital systems like Kanta are not designed to support this kind of reinforcement, which led us to reconsider how care communication could be made more intuitive, human, and supportive without adding complexity.

Lastly, we were **struck by the fragmentation of the system**. Although we had been told early on that integration was an issue, we didn't anticipate the depth of it. One professional mentioned there are twelve different digital platforms within a single Wellbeing Services County. This level of system saturation creates steep learning curves, constant friction, and a heavy administrative burden, especially for new staff. Beyond technical fragmentation, we also observed **organizational disconnects between health and social care**, where collaboration often depends on individual initiative rather than structural support. It became clear that despite Finland's push for efficiency and digitalization, underlying policy resistance and misaligned goals continue to produce fragmented, short-term solutions that force professionals to focus on immediate problems rather than long-term change.

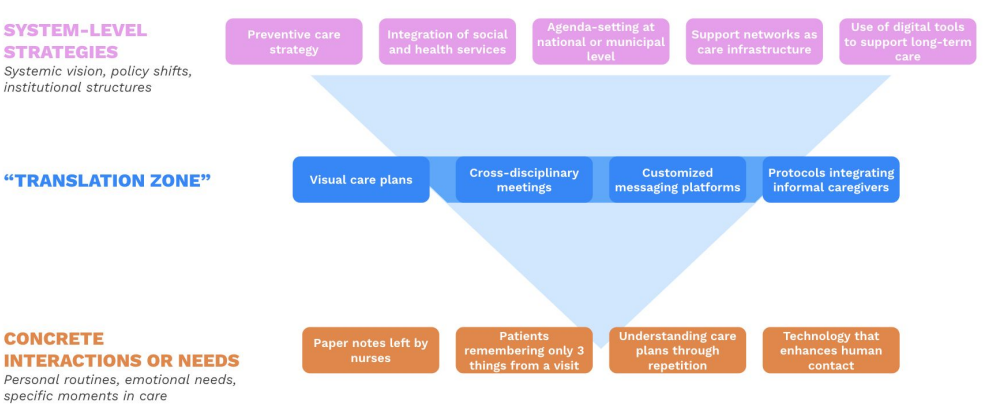


Figure 18. Connecting system-level strategies with everyday care through practical translation.

03 AVOIDING PITFALLS

Feedback received during our rehearsals and final presentation prompted valuable reflections on potential risks embedded in our proposal. One of the key concerns was the **possibility of placing too much responsibility on informal caregivers.** While activating and involving the support network is essential for more effective and preventive care, it must be done in a way that avoids overburdening those involved. This engagement should happen through **structured and supported formats** rather than shifting responsibility without oversight or resources.

Additionally, we recognise that **unpaid care work has historically fallen disproportionately on women**. Without careful attention, proposals that rely on informal care risk reinforcing gendered patterns of labour. For this reason, our proposal emphasises **community-based support models that are inclusive, coordinated, and designed to distribute care responsibilities more fairly**. The aim is not to outsource care but to foster empathy, local connection, and shared responsibility. This builds a culture where people are supported in caring for one another without being left to do so alone.

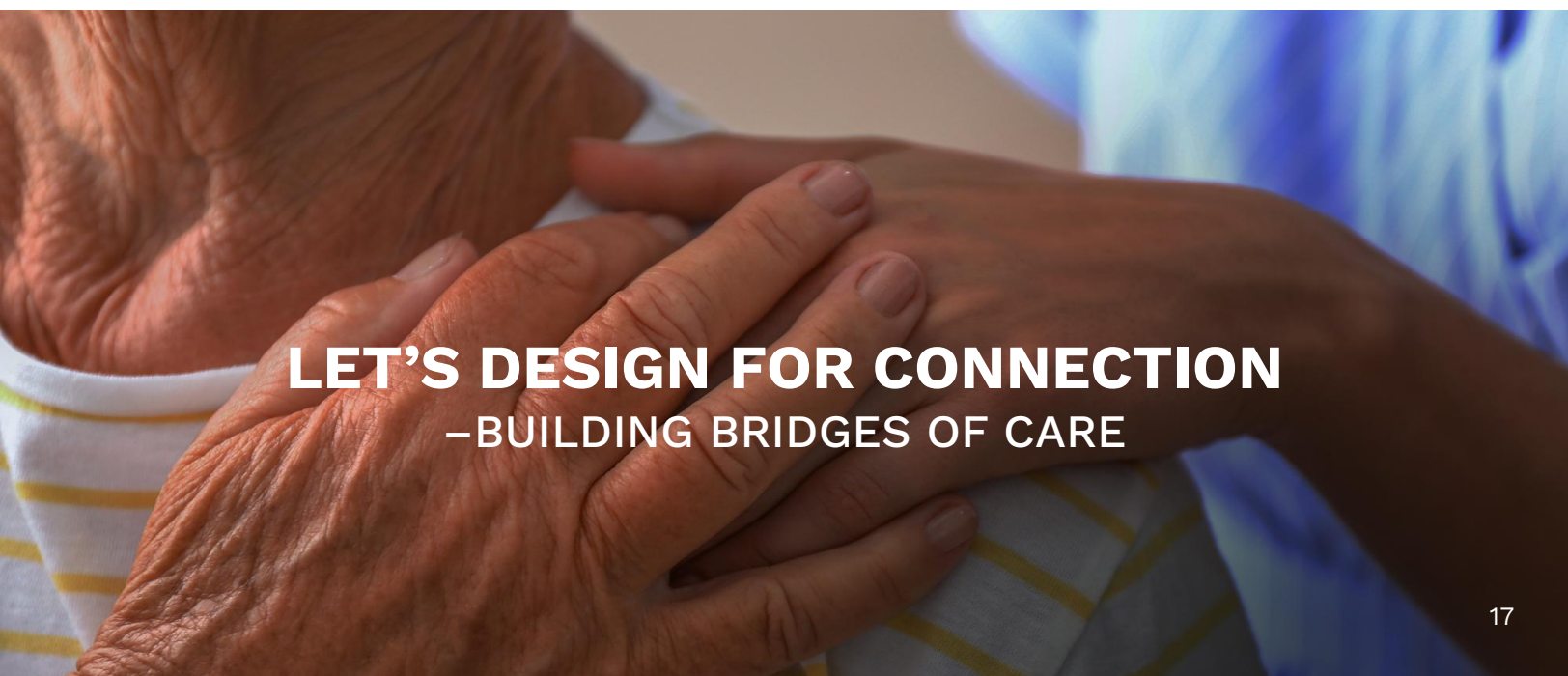
04 LOOKING AHEAD

Our final session helped us reflect not only on our proposal, but also on the broader potential of viewing ageing as a societal opportunity. Finland, with its advanced digital infrastructure and tradition of strong public services, is well-positioned to become a **frontrunner in responding to demographic change**. By embracing value-based care and encouraging the active participation of older citizens—through open government, inclusive design, and community engagement—the country could lead a shift in how ageing is understood and supported.

This demographic transformation opens space for meaningful service innovation and systemic redesign. However, moving forward will require a careful balance between regulation and experimentation, as well as between institutional frameworks and local empowerment. **Designing supportive care ecosystems raises important questions that remain open**—such as how to formally recognise and integrate informal support networks, or how to ensure equity and sustainability in community-driven initiatives.

We see this as an **opportunity to rethink care not just as a sector but as a shared social responsibility**, one that evolves with, and not just for, an ageing society.

Returning to KELA's initial brief, our work suggests that **continuity of knowledge is not just a technical challenge, but a relational one**. **Addressing it will require both systemic change and small design interventions that restore human connection.**



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Appendix 1.

OBSERVATION SCRIPT

Observation script

Social worker's visit

Observation of a social worker's visit to an elderly patient's home.
The objective is to **identify key human interactio**n, as well as the **knowledge** (or information) that is being **transferred**, and where it is currently being recorded.

Key questions

1. *What **systems, documents, materials or methods** is the social worker using...*
    a. *to inform the patient?*
    b. *to register key information from the visit?*

2. *What does the social worker do **before or after the visit**?*
    a. *Before: What kind of preparation is done? Are digital systems accessed?*
    b. *After: Are there follow-up tasks such as documentation, reporting, or coordination?*
        i. *Where does this documentation happen—immediately after, later, at the office?*

3. *Do social workers **share information or knowledge between professionals**? How?*

Context

- Observer:
- Date and time of observation:
- Location:
- Consent confirmed from social worker and patient (Y/N)
- General notes:

During the visit

A E I O U framework

Use the AEIOU categories to organize your notes. You can sketch layouts, quote interactions, or list details as needed.

Description	***Notes or sketches***
Activities *Identify and register the activities that are being done by the social worker, the patient, and any other person present in the visit.* *Document the actions and tasks being done.*	
Environment *Evaluate the environment where the activities occur.* *Consider the social elements like culture or norms.*	
Interactions *Analyze the interactions between the people, the objects and the environment (verbal and non-verbal).* *Observe how they communicate, what tools they use and how they relate with the environment.* *Identify the points of contact and the challenges they face.*	
Objects *Identify the objects present in the environment. Their shape, size, functionality and how they're being used.* *Register the objects designed specifically for the activity, as well as those improvised.*	
Users *Understand the users involved in the activity, examine their demographic characteristics, necessities, motivations and expectations.*	
Key insights or moments *E.g. most interesting interaction, friction point or breakdown in communication, example of good knowledge-sharing*	

Appendix 2.

INTERVIEW SCRIPTS Patients

Interviewees profile

- Name
- Age
- Area *(Municipality or WSC)*

Lifestyle, well-being and health

1. *Could you tell us a bit about yourself?* (Dig into work and social lifestyle)
    a. *Are you currently working, retired, or something else?*
    b. *What are your main interests or hobbies?*
    c. *Do you take part in any community groups, events, or associations?*

2. *What would you say are your **main needs or concerns** related to your health and well-being?*
    a. *What helps you stay in good shape—physically, mentally, or socially?* (Dig into an integrated perspective: social activities, nutrition, exercise, etc.)
    b. *What is most important to you when it comes to staying healthy?*

3. *Do you currently use any **health or social services**?*
    a. *Which services?*
    b. *How often do you use them?*
    c. *What kind of support do they provide?*

Continuity of knowledge

4. *Have you had **experiences with different** healthcare professionals or services? For example, a change from one doctor to another or between social and health services?*
    a. If the answer is no: continue with next section
    b. In case the answer is yes:
        i. *Did you feel the new professional had all the information they needed about you?*
        ii. *Did you have to repeat your story or information multiple times?*

5. Is there anything important about your life, preferences, or values that you feel **isn't captured in your healthcare records or systems**? *Something you often have to explain again or that professionals don't know unless you tell them?* (e.g., cultural preferences, routines, support systems, personal goals)

6. *How do you **usually communicate** with your healthcare or social care professionals?*
    a. *Is it mostly face-to-face, by phone, digitally?*
    b. *Do you feel heard and understood?*
    c. *Is there anything you wish could be different in how they communicate with you?*

7. *Do you use any **digital tools** to follow-up on your health?*
    a. *Which ones?* (e.g. Kanta, wearable devices, mobile apps)
    b. *What do you mainly use them for?*

8. *How do you **feel** about using these platforms?* (Dig in usability, accessibility, value of the information, language comprehension, etc.)
    a. *Are they **easy or difficult** to use?*
    b. *Is the information **clear and helpful**?*
    c. *Are there any issues with **language, accessibility, or understanding** what the data means?*

9. *If you had to choose, how would you **rank these 4 options for getting care**?* (1 = most preferred, 4 = least preferred)
    a. Going to a healthcare center or hospital
    b. Having a doctor or professional visit you
    c. Speaking to a professional through a live video service
    d. Using digital services by yourself (like checking records or renewing prescriptions)
    e. *Why did you choose that order?*

10. *Have you ever given **feedback** on the services or support you receive?*
    a. *Was it easy or difficult to do so?*
    b. *Do you feel involved in decisions about your care?*
    c. *Would you like to be more involved—and if so, how?*

Closing

11. If you could change one thing about how care is provided or how information is shared, what would it be?
12. Is there anything else you'd like to share about your experience with healthcare or digital services?

Thank you very much for your time and participation. Your insights are incredibly valuable to us, and they will help inform ways to improve care in the future.

Appendix 3.

INTERVIEW SCRIPTS Social workers

Interviewees profile

- Name
- Age
- Profession
- Institution and role
- Area *(Municipality or WSC)*

Background

1. ***How long*** *have you been working as a social worker?*
2. (If it applies) ***When*** *and* ***why*** *did you specialize in elderly care?*

Elderly care

3. *What are the* ***key issues*** *you address as a social worker specialized in elderly care?* (In other words, what are the main needs and concerns of your elderly clients?)
    a. *Can you give* ***examples*** *of typical cases you handle?*
    b. *Which* ***services*** *are most commonly requested or needed?*

4. *Could you describe what your* ***day-to-day*** *looks like?*
    a. *How many patients do you usually see in a day or week?*
    b. *How frequently do you visit the same patient?*
    c. *How long does a visit usually take?*
    d. *What does a typical visit entail—from arrival to follow-up?*

5. *In your opinion, what makes the* ***role of a social worker unique*** *in elderly care?*
    a. *What would happen if there wasn't a social worker involved in these cases?*

Care ecosystem

6. *Where does your role typically* ***begin and end*** *in a client's care path?*
    a. *Are there moments when you hand off responsibilities to someone else (e.g. nurses, doctors)?*
    b. *Are there areas where your tasks sometimes overlap or get unclear?*

7. *Besides professionals, who else supports your clients in their daily life? For example, family members, neighbors, volunteers, community services?*
    a. *How do they interact with your work, if at all?*

8. *In your experience, what kinds of* ***collaboration*** *between different helpers or support systems work well—and what doesn't?*
    a. *Are there patterns you've noticed with certain families or communities that make things easier or more difficult?*
    b. *Are there any dynamics or working relationships that stand out—positively or negatively?*

Continuity of knowledge

9. *What kind of* ***information*** *do you usually share with the patient during a visit?*

10. *What* ***systems, documents, materials or methods (ALSO PAPER, PHONE, ETC.)*** *do you use:*
    a. *to inform the patient?*
    b. *to register key information from the visit?*

11. *Do you use* ***Kanta or other digital systems*** *in your daily work?*
    a. *What do you typically use them for?*
    b. *What kind of information do you find most useful in these systems?*
    c. *Are there any limitations or challenges when using them?*
    d. *How do you think these systems could be improved to better support your work?*

12. *In your experience,* ***how do patients interact*** *with Kanta or other platforms?*
    a. *Do you think patients understand and use it effectively?*
    b. *Are there any gaps between what patients see and what professionals see?*

13. *Can you walk us through what you typically do* ***before and after a visit****?*
    a. *How do you prepare? Do you access a specific platform or past records?*
    b. *After the visit, what steps do you take to document or follow up?*

14. *Do you* ***share knowledge with other social workers or professionals****?*
    a. *How is this done—through meetings, systems, reports?*
    b. *Are there any formal or informal initiatives in place?*

Experience-based knowledge and human value

15. *What* ***barriers*** *do you face in capturing the knowledge you gather?*
    a. *Or transferring it into the broader healthcare system?*
    b. *Is there anything important that gets lost—especially qualitative insights that aren't recorded?*

16. *What would you say is the added* ***value of human interaction*** *in healthcare?*

17. *How could the knowledge from your experience be better transformed into* ***meaningful care insights****?*
    a. *Do current systems support this well—or do you rely more on informal ways of sharing?*
    b. *Are there changes in the system or practices that would help?*

Closing

18. *Is there anything else you think we should know that could help us better understand the current situation—or how the overall system could improve?*

Thank you very much for your time and participation, your insights are very valuable for us.

Appendix 4.

INTERVIEW SCRIPTS Health professionals

Interviewees profile

- Name
- Age
- Profession
- Institution and role
- Area *(Municipality or WSC)*

Background

1. ***How long*** *have you been working as a nurse?*
2. (If it applies) ***When*** *and* ***why*** *did you specialize in elderly care?*

Elderly care

3. *What are the* ***main needs or challenges*** *of the elderly patients you care for?*
    a. *Can you give* ***examples*** *of typical cases you handle?*
    b. *Which* ***services*** *are most commonly requested or needed?*

4. *Could you describe what your* ***day-to-day*** *looks like?*
    a. *How many patients do you usually see in a day or week?*
    b. *How frequently do you visit the same patient?*
    c. *How long does a visit usually take?*
    d. *What does a typical visit entail—from arrival to follow-up?*

5. *In your opinion, what makes the* ***role of a nurse unique*** *in elderly care?*
    a. *What would happen if nurses weren't involved in these cases?*

Care ecosystem

6. *Where does your role typically* ***begin and end*** *in the care process?*
    a. *When do you collaborate or hand over to others (e.g. doctors, social workers)?*
    b. *Are there any overlaps or grey areas?*

7. *Besides professionals, who else supports your clients in their daily life? For example, family members, neighbors, volunteers, community services?*
    a. *How do they interact with your work, if at all?*

8. *In your experience, what kinds of* ***collaboration*** *between different helpers or support systems work well—and what doesn't?*
    a. *Are there patterns you've noticed with certain families or communities that make things easier or more difficult?*
    b. *Are there any dynamics or working relationships that stand out—positively or negatively?*

Continuity of knowledge

9. *What kind of* ***information*** *do you usually share with the patient?*

10. *What* ***systems, documents, materials or methods*** *do you use:*
    a. *to inform the patient?*
    b. *to record care or observations?*

11. *Do you use* ***Kanta or other digital systems*** *in your daily work?*
    a. *What do you typically use them for?*
    b. *What kind of information do you find most useful in these systems?*
    c. *Are there any limitations or challenges when using them?*
    d. *How do you think these systems could be improved to better support your work?*

12. *In your experience,* ***how do patients interact*** *with Kanta or other platforms?*
    a. *Do you think patients understand and use it effectively?*
    b. *Are there any gaps between what patients see and what professionals see?*

13. *Can you walk us through what you typically do* ***before and after attending a patient****?*
    a. *How do you prepare? Do you access a specific platform or past records?*
    b. *After the visit, what steps do you take to document or follow up?*

14. *Do you* ***share knowledge with other professionals****?*
    a. *How is this done—through meetings, systems, reports?*
    b. *Are there any formal or informal initiatives in place?*

Experience-based knowledge and human value

15. *What challenges do you face in* ***capturing or sharing*** *the knowledge you gather?*
    a. *Is there anything important that gets lost—especially qualitative insights that aren't recorded?*

16. *What would you say is the added* ***value of human interaction*** *in healthcare?*

17. *How could the knowledge from your experience be better used to improve care?*
    a. *Do current systems support this well—or do you rely more on informal ways of sharing?*
    b. *Are there changes in the system or practices that would help?*

Closing

18. *Is there anything else you think we should know that could help us better understand the current situation—or how the overall system could improve?*

Thank you very much for your time and participation, your insights are very valuable for us.

Appendix 5.

INTERVIEW SCRIPTS Administrative staff

Interviewees profile

- Name
- Age
- Profession
- Institution and role
- Area *(Municipality or WSC)*

Background

1. *Could you briefly describe your **role** and your **main responsibilities**?* (Focus in understanding the role in more detail and how it could relate to continuity of knowledge)
    a. *What kind of **administrative tasks** are you involved in daily?*
    b. *Do you work directly with social workers, healthcare staff, or patients?*

2. How does your role **support the coordination of care** for elderly people?
    a. *Do you help manage appointments, data entry, documentation, or inter-professional communication?*

Systems & documentation

3. What **systems or platforms** do you use in your work?
    a. *For example, do you use Kanta, Effica, Apotti, or others?*
    b. *What are these systems used for* (e.g., scheduling, records, reporting)*?*

4. Are the systems you use **connected to other departments or professionals** (e.g., nurses, doctors, social workers)?
    a. *If so, how well does the **knowledge (or information) flow** between systems or actors?*
    b. *Are there common **gaps or bottlenecks** in that process?*

5. How do you **manage documentation or records** of patients or services?
    a. *Is this process mostly digital, paper-based, or a mix?*
    b. *Are there any **challenges** in keeping records up to date or accessible?*

Digital tools & Kanta

6. *Do you personally use **Kanta** in your work, or support others in using it?*
    a. *What kind of information do you access or manage there?*
    b. *Are there any limitations or challenges with Kanta or similar platforms?*
    c. *How do you think these systems could be improved to support your tasks better?*

7. *In your experience, how do **patients** use Kanta or other digital tools?*
    a. *Do patients ask for help or have trouble accessing information?*
    b. *Are there **gaps** between what patients see and what professionals or administrators see?*

Coordination & continuity

8. What are the **main challenges** you face when coordinating between different actors (e.g., social workers, healthcare professionals, patients)?
    a. *Are there specific points where information gets lost or delayed?*

9. Are there **formal or informal practices** that help improve communication or continuity?
    a. *For example, shared meetings, messaging tools, collaborative platforms?*

Closing

10. From your perspective, how could the **flow of knowledge (or information)** be improved?
    a. *Are there specific changes to systems, processes, or tools that could help?*
    b. *What would help professionals and patients stay better informed and connected?*

11. Is there anything else you think we should know that could help us understand the current situation or identify opportunities to improve the system?

Thank you very much for your time and participation. Your insights are extremely helpful for our research.

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