

Cardiac Rehabilitation in Finland

A Survey on the Rehabilitation Practices and Services for CAD Patients in Public Health Care Finnish Heart Association

Abstract

The Finnish Heart Association recently conducted a survey on the rehabilitation practices and services for coronary artery disease (CAD) patients in public health care. A questionnaire was sent in spring 2006 to all hospitals and health centres treating CAD patients. Similar surveys were conducted in 1991 and 1994. The survey excluded rehabilitation in private hospitals or run by the Social Insurance Institution of Finland.

The purpose of the survey was to establish the quantity, content, and organisation methods of CAD rehabilitation; secondary preventive interventions and resources; follow-up care and rehabilitation; and the implementation of exercise based rehabilitation.

A total of 382 questionnaires were sent out, including 55 questionnaires to hospitals and 327 to health centres. The questionnaire consisted of two parts: the first part was about rehabilitation practices ("the rehab questions") and part two was about exercise based rehabilitation ("the exercise questions"). Altogether, 199 (52 %) replies were received for the rehab questions and 169 (44%) for the exercise questions.

According to the survey, approximately 3,900 patients and family members participated in the introductory, rehabilitation and adjustment training courses during the year. It appears that less than eight per cent of discharged CAD patients have access to organised rehabilitation in public health care. This percentage is among the lowest in Europe.

While some fifty per cent of hospitals had the treatment chain instructions for an acute CAD patient, rehabilitation was included in the instructions in only one third of them. The follow-up care of patients treated in different ways depended on whether a health centre or a hospital responded. Everybody seemed to agree that the follow-up care of patients who had only been treated with medication was organised in health centres. In hospitals, follow-up care was only organised for patients with severe CAD and those who had undergone a CAD procedure. A little more than half of the hospitals assured follow-up care and rehabilitation in outpatient care. Usually it was the patient's responsibility to find follow-up care.

In principle, CAD patients received education and counselling during the entire treatment process, but it was often inconsistent. Hospital staff was more aware than health centre staff about how and when the patient should be guided. Systematic guidelines with outlines for patient education, follow-up care and task distribution between various professionals were generally not used. The hospitals and health centres that had such guidelines also informed their patients better about the various rehabilitation possibilities. As regards exercise based rehabilitation, written guidelines were used in hospitals, but not in health centres.

Education and counselling for CAD patients was chiefly the responsibility of nurses and doctors. The topics discussed in CAD guidance usually included smoking, medication, exercise, nutrition, and weight control, while topics such as social security, stress, working ability, retirement issues and sexual problems caused by the disease were rarely discussed. Guidance in hospitals was limited

by the short treatment period, which averaged two nights for balloon angioplasty patients and six nights for those who had undergone bypass surgery. Yet hospitals provided more comprehensive guidance than health centres. Patients were not informed sufficiently about rehabilitation possibilities, nor were they referred to a rehabilitation programme. Health centres in particular suffered from a lack of suitable material for patient education.

In 65 per cent of hospitals and 56 per cent of health centres, there was a heart nurse, a rehabilitation counsellor or another employee designated for heart patients. However, in health centres, these people had to perform this task on top of their other duties. They usually guided patients with severe heart problems, such as myocardial infarction, heart failure and heart surgery.

In only two per cent of the hospitals and one per cent of the health centres in the survey, all CAD patients received guidance from a nutritionist. In 25 per cent of the hospitals and over one half of the health centres, CAD patients received no guidance from a nutritionist at all.

All CAD patients received guidance from a social worker in nine per cent of hospitals and three per cent of health centres, while two per cent of hospitals and 41 per cent of health centres provided CAD patients with no guidance by a social worker.

Guidance by a physiotherapist was given to all CAD patients in nearly 50 per cent of hospitals but only seven per cent of health centres. One half of the hospitals and over 70 per cent of health centres provided some physiotherapeutic guidance to patients with myocardial infarction, balloon angioplasty or a bypass operation. In 19 per cent of health centres, CAD patients received no physiotherapeutic guidance whatsoever. Respondents found deficiencies in the referral of patients to exercise based rehabilitation; remedies suggested included a clearer treatment chain, better cooperation between various sectors, and the development of follow-up rehabilitation.

Approximately one half of CAD patients received an exercise stress test at some point in their treatment. In only 14 per cent of hospitals and seven per cent of health centres was an exercise stress test conducted on all CAD patients. Reasons for conducting the test included confirmation of diagnosis, assessment of working and functional capacity, and the evaluation of the need for follow-up care; the test was rarely used to support the evaluation of the level of exercise stress.

In conclusion, the supply and content of cardiac rehabilitation fails to meet the desired level in public health care. The rehabilitation and guidance services provided by hospitals and health centres vary a great deal and can only be offered to a small fraction of patients. Cardiac rehabilitation should be included in CAD patient treatment chains across organisational boundaries. Both the content and timing of traditional patient education should be changed to better meet patient needs. The provision of patient education should be agreed by all the organisations involved in the treatment. Similarly, it is time to prepare for coronary artery disease in the baby-boom generation, and to design self-care environments and interactive, computerised patient education. Cardiac rehabilitation services should be increased by developing new rehabilitation forms with lighter professional structures to complement the ideal multiprofessional model, particularly in basic health care. Doctors, nurses, physiotherapists and other professionals working in basic health care also need further training in cardiac rehabilitation.