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CLINICAL STUDY

Comparison of long-term care in European developed countries to possible implementation in Slovakia

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Abstract: Long-term care within the public services system does not exist in Slovakia. Long-term care is a relatively closed system of health care and social care services. Initially, long-term care policies were formulated as a response to ageing of the population, which brought about growing needs of elderly people for social care and health care, and was associated with relatively rapid increases of necessary costs.
All industrial countries are facing similar problems when it comes to the integration of long-term care. In developed countries, current long-term care focuses on all age groups in need of assistance and support from others due to the limitations caused by their state of health *(Ref. 34)*. Full Text (Free, PDF) *www.bmj.sk*.
Key words: ageing population, health care, integration of long-term care, long-term care, social care.

The aging population is currently one of the main issues facing international health care systems. It is a recognized fact that with advancing age, the likelihood of developing health problems and chronic disease will increase and the demand for health care resources will escalate. This will impact hospitals and long-term care facilities (1).

In industrialized societies, the ageing process represents one of the major public health concerns, both ensuring an adequate level of care to satisfy today's needs as well as ensuring the system's sustainability in the near future (2).

The care for chronically ill and geriatric patients has become the key issue of the current health policy and will remain one of the top priorities in the following century, as well. More and more people are reaching good old age and they will experience a shift from an acute diseases to chronic ones and different causes of death (3, 4).

Long-term care for people with chronic illnesses and disabilities presents an urgent challenge around the world (5). The high costs of treating chronic diseases suggest that reducing their prevalence would improve Medicare's financial stability (6). The formulation of policies needs to reflect these countries' unique conditions (7). Some potential health and social policies take many years to implement. These include developing caregivers support structures, building up insurance funds to pay for long-term care or for training the healthcare professionals. The need for these must therefore be anticipated years or decades in advance (8). Long-term care within the public services system does not exist in Slovakia.

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Definition of long-term care

Individuals need long-term care (LTC) due to disability, chronic condition, trauma or illness, which limit their ability to carry out basic care or personal tasks that must be performed every day. Long-term care refers to the provision of services for persons of all ages who have long-term functional dependency (8–10). LTC is a range of services needed for persons who are dependent on help with basic activities of daily living (ADLs). This central personal care component is frequently provided in combination with help with basic medical services such as wound dressing, pain management, medication, health monitoring, prevention, rehabilitation or services of palliative care (11, 12).

Target population

The population in need of long-term care includes all those who suffer from any kind of physical or mental disability. The focus, derived from the above definition of LTC, is on the care of persons with long-term health problems who need assistance with the activities of daily living. This target population includes persons of all ages who are experiencing some degree of functional dependence, as well as their care providers (13, 14).

Current reforms of long-term care systems

All industrial countries are facing similar problems when it comes to the integration of long-term care: lack of coordination, shortcomings in continuity, less than optimal results and problems relating to controlling the costs.

Denmark, Germany, Holland and Sweden already have or are developing the most integrated long-term care systems, and developments in these countries, detailed in the WHO report, are summarized here to illustrate examples of a good practice (15). Although the examples given here are focused on elderly people, it is possible to apply many concepts to younger disabled people. However, it is important to be aware of major differences that exist between the older and younger population requiring long-term care. These differences include different perceptions of concepts such as dependency, consumer feelings and dispositions towards the formal system of "care" on one hand, and a stronger of ethos self-determination and independence on the other hand (16).

Denmark

Denmark was one of the first industrialised countries to adopt a community care policy. Strong emphasis is placed both on self--determination and de-industrialisation, the priority being a home care (17). Denmark operates one of the most progressive programmes for elderly people, with the population aged 65 years and above reaching nearly 15 % of the country's population of 5.3 million (18).

Health care is a public responsibility and 85 % of costs are covered from taxes. Access to services that are organised by 16 provinces is free of change. 275 municipalities are responsible for the system of social services. This system includes long-term care and housing for elderly and other age groups. The Social Services Act dates back to 1998. In 1987, the Act on Housing for Elderly and Disabled Persons was passed, which forbids the construction of new nursing homes. The clients are to be gradually transferred to the individual forms of "special housing". The costs of social services are funded from local taxes, contributions paid by clients remain low and the state provides various grants and compensation payments (19).

In Denmark, the municipalities are responsible for the planning, organisation, provision and funding of home care and assistance, for services paid for from the social funds as well as care paid from the health care funds, and also including care in day centres, nursing homes and in various forms of housing for the elderly. The community centre is the base for providing many services not only to persons with impaired health and disabilities but also to healthy persons. A comprehensive system of client assessment and care management is in place. At least twice per year, persons aged 75 and over receive a preventive visit from a case manager, paid by the municipality, in order to find out their individual needs and assist them in planning their independent life in the next period. People requiring a professional care are assessed by home care managers who prepare the plans of required services. Services are monitored by the home care teams. If necessary, the home care teams consult with geriatric teams. In the field of housing, the objective is to create non-institutional but supportive housing complexes for the elderly of various levels of independence. Such housing is often located near nursing homes or community centres in order to minimise the costs and improve utilisation of personnel and facilities (20).

Germany

Germany has a population of 82.2 million, of whom 15.4 % are aged 65 years and above (18). Prior to 1994, the German system was biased towards institutional care, means-tested and administered at the level of states (Länder) (21, 22). The reasons for implementing a fundamental change were:

– Increasing budgetary problems

– Demand was growing higher than the existing system was capable to handle, resulting in compromising the German perception of "social solidarity", and

– Perception that the quality and offered services were inadequate (23).

A universal social insurance programme, known as Social Dependency Insurance (SDI), was created for long-term care, which is based on compulsory insurance according to income. There are 70 million persons participating in the SDI through public insurance and an additional 8.5 million in private insurance. Insurance contributions represent 1.7 % of individuals' income, half of which is paid by the employer or a pension fund (on behalf of the retired persons). Access to benefits is based on the assessment by an examination committee which assigns the applicant to the one of the 3 categories. There are three types of payments in each category:

1. cash benefit for a client at home,
2. cash benefit for home care paid to the provider,
3. cash benefit for institutional care paid to the provider.

If benefits are not sufficient to cover the cost of needed care, the individual can receive a social assistance benefit after income testing. Home care was transferred to the SDI system in April 1995 and institutional care in July 1996. Priority is given to the home care.

The responsibility for administration of this system remains within health insurance companies. The insured persons must be insured in the same fund for both acute and long-term care. The funds operate commissions that evaluate services on the basis of criteria detailed by the law, and make contracts with providers. As the acute and long-term care are separate, coordination is not without problems, and there are concerns about possible cost-shifting between funding streams, in particular for rehabilitation services (20).

"Social stations" (in German, Sozialstation) have been played an important role in organising and providing community services for the elderly since 1970's, when they were built with a view to reduce a demand for inpatient care (19). The social stations usually employ nurses and social workers who coordinate a broad network of non-institutional care: consulting, transport, shopping, rental of aids, distribution of food, household care, day care (24). They are also able to organise nursing care or psycho-geriatric care prescribed by the insurance companies (on their own or via other organisations). There are approximately 4000 social stations in the country, with 20 000–50 000 inhabitants per station in towns and 15 000–25 000 inhabitants per station in rural areas (22, 25). The introduction of the SDI has changed the position of these stations as subsidies to the state

and municipalities for their operation have declined. Whereas previously non-profit organisations received preferential treatment in funding, SDI funds non-profit and private providers on an equal basis to give clients more choice of providers. Social stations have to adapt themselves to the trend of client-oriented programmes and become more market-oriented (20).

One innovation, complementing the insurance system, comes as "senior citizen cooperatives", which combine volunteers and paid staff (21). They mobilise neighbourhood assistance in housework, transport, visits, telephone reassurance, and self-help groups. Specific-purpose housing with necessary services is expanding. Housing costs are co-funded via direct housing benefits paid by the national government or combinations of these housing benefits and social assistance benefits from the states. Another type of the service enriched housing is represented by the complexes for medium and higher income elderly. These complexes are operated by non-profit organisations, but as the inhabitants do not receive housing benefits, the complexes are financed by resident payments. These complexes offer a wide range of services, varying from modest on-site services to fully-fledged social activities and care services. The main objectives of the SDI reform have been achieved. In 2001, less than 5 % of persons provided with home care were receiving benefits from the state above SDI payments, and less than 25 % of those who were living in facilities. Significant budget savings were achieved. The entitlement to benefits and payments has strengthened the influence of regulators, insurance companies and providers. As standardisation and consolidation of insurance funds' costs is preferred rather than looking for the most appropriate method of providing services, a rather inflexible system still prevails. There is a visible absence of case management and integration is a great challenge (20).

The Netherlands

In the Netherlands, reforms relating to long-term care have been on the agenda for 20 years (26). In 1994, the Commission for Modernisation of Elderly Care prepared the document *Care for Older People in the Future*, in which demanded a better and more coordinated system that would provide more individualised, community-based services. Later, government adopted many recommendations. In line with the Dutch consensus-driven nature, the government does not enforce cooperation but rather supports it via grants, subsidies and extra resources (20).

People in the Netherlands are compulsorily insured for routine health care (approx. 64 % of the population), on the basis on provided respective services (27). The retired persons pay lower fees. The remaining 36 % of the population is insured privately. Independently of his/her income or employment situation, each citizen is protected against catastrophic health risks via the Act on Extraordinary Health Expenses (AWBZ) approved in 1968 (28). This act is particularly important for the elderly and other people who require long-term care. This universal programme insures against high expenditures in nursing homes and since 1997 also in retirement homes, facilities for the disabled and stays in hospitals lasting longer than one year. The contribution reaches 8.8 % to 9.6 % of income, with the major share being paid by employers, while retired persons do not pay. Funding of this programme also draws on tax revenues and co-payments (20).

Assessments for home and institutional long-term care have been performed since 1998 by professional teams employed in the "Regional Assessment Organisation". The health insurance companies administer the AWBZ programme via regional care offices and the Netherlands enjoys a well-developed primary care. Although it seems that the primary health care and long-term care might be well coordinated, this is not the case. The provision of health care services is a joint responsibility of both the government and private insurers (23).

One particular feature of the Dutch system is that it expects that individuals will become members of the local organisation providing home care. Another feature is the "personal budget" programme that has paid cash benefits that enable certain groups of disabled clients to purchase their own necessary care since 1985.

The changing system of care provision is bringing increasing moves to vertical and horizontal integration of the health care and social sector. There are several recent examples of the mergers between hospitals, retirement homes and home care organisations and even housing providers under one umbrella organisation. However, mergers most frequently involve facilities of the same type. Ten years ago, the national organisations of nursing and home care agencies merged and this trend has seen more "continuous" care provided, with increased efficiency in an increasingly competitive environment.

Case management was imported to the Netherlands over a decade ago from Great Britain and USA, and many organisations perceive it as a key function (29). Care chains in the Netherlands take the form of "transmural care", which focuses on clients needs and is provided on the basis of cooperation and coordination between the general and specialised providers of care with separate and specified responsibilities. Transmural care centres are being created through partnerships of health and social care providers, in particular in relation to patients discharged from hospital (30). Further development of transmural care is expected mainly in relation to the patients suffering from the long-term chronic or disabling conditions. Other social care models develop cooperation on the basis of specifically created "care packages". Experts are however pessimistic, as funding is yet not integrated (31).

An unusually high share of elderly people in the Netherlands, approximately 10 %, live in institutions, including nursing homes and retirement homes, but since the 1970's, the government has advocated de-institutionalisation policies (32). Support for home and community-oriented services was enhanced, together with an expanded availability of sheltered housing in the form of rented or owned apartments with some on-site assistance. Mostly, the non-profit housing corporations develop them, but entrepreneurs are also entering this system. Experiments are taking place with regard to various combinations of housing and services in flexible care houses (23).

Sweden

Sweden is worldwide known as a country that has strong and generous commitment to public funding and provision of health care and social services to citizens of any age (33). In 1992, the Elderly Reform transferred the funding and management of nursing homes from the counties to the municipalities, which were already providing housing and social services. At the same time, municipalities were given financial responsibility for long-term inpatients. The aim of these measures was to consolidate health and social care at the local level, to de-medical elderly care and to enhance coordination of services. The goal of freeing hospital beds and increasing beds in long-term care facilities, or to replace beds with home care, has been substantially realized (20).

In 1998, a National Action Plan on the Policy for the Elderly was approved, on the basis of which 21 elected County Councils are responsible for funding, management and provision of the package of health care services. The majority of providers are public. The place of first contact is the district health care centre. Hospitals are organised hierarchically. Strong emphasis is laid on geriatric medicine and hospitals also provide rehabilitation and geriatric assessment of chronic health conditions services (27).

Under the Act on Social Services adopted in 1992, social care is a task of the 289 municipalities, which are responsible for funding, organisation, provision and delivery of care. They are relatively autonomous in what they provide and how they do things, and some have contracted delivery of services to not-for-profit and for-profit agencies. 80–85 % of expenditures are funded from local taxes, with the rest funded by the central government; municipalities are also gradually starting to introduce co-payments by clients (20).

The Swedish system is starting to diverge from the universal model of social care for the elderly. Swedes are living longer, with 17 % of the population now aged 65 years and above, and it is becoming more difficult to fund the growing costs of social services from taxes (18). One of the suggested possibilities is the creation of a quasi-market regulated by the government, in which clients will use vouchers to obtain needed services from a mix of competing providers. Sweden has managed to achieve decentralised administration of long-term care to a single location – the self-governing municipality. The main effects of the integration strategy have been:

– reduction by half in the number of blocked beds in hospitals, with more adequate and timely transfer of clients to long-term care facilities;

– increased supply of special housing; and

– enhanced capacity and quality of home services provided by municipalities.

Problems remain in the coordination at the intra-sectoral level with municipalities that did not take over of any nursing homes. The traditional fragmentation between the acute and long-term care also remains a problem. In some communities, home nurses employed by municipalities are also assigned to local health care centres. These district nurses cooperate with the attending physicians, and perform other activities such as night visits to medically unstable patients. Since the 1992 reform, multidisciplinary teams for care planning have become fully-fledged care management teams, and there is also a better training for case managers. The new challenge for the case management comes with the adoption of a "purchaser-provider" split in some municipalities that separates decisions on eligibility and access by local offices from delivery of services by contracted providers (20).

A service enriched housing is supported by both the local and central governments so that long-term care clients can remain within their community. Specific solutions and provision can differ significantly in individual communities and though the central government provide investment subsidies, 90 % of operating costs are usually paid by the municipality and 10 % by the tenant (34). The provision of services is divided between the managers of the housing and the municipality. There are some further experiments with non-profit, cooperative-owned housing complexes that are responsible not only for housing services but also for on-site medical and home help services (19).

Conclusion

A long-term care within the public services system does not exist in Slovakia. There is no single solution to the problem of integration of the health and social care components of the long-term care. Consolidation and decentralisation of administrative functions represents an important integration strategy. There are various models of organising and providing services that can bring services together "under one roof", and whatever model is selected, some form of case – management is usually necessary to ensure that services target the at-risk population.

Integrated home care is one of the linchpins of well-organised and efficient long-term care system. A critical element is the coordination of home nursing and home help services at both the administrative and client levels. Purpose-built housing and, to a certain extent also residential care institutions, may serve as a base for organising more integrated services not only for the tenants but also for elderly people living nearby. Volunteers, in particular older ones, represent an important, but largely untapped resource in long-term care.

Long-term care is closely interlinked with other programmes and systems, which can reduce the need for long-term care or complement it. Initially, long-term care policies were formulated as a response to the ageing of population, which brought about growing needs of elderly people for social care and health care, and was associated with a relatively rapid increases of necessary costs.

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