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HEALTHCARE

Analysis of the structure of services provided in the healthcare facilities in long term care in Slovakia

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Abstract: *Background:* Long-term care for people with chronic illnesses and disabilities present an urgent challenge around the world.
Methods: For the data collection from health care facilities, we used questionnaire method.
Results and conclusion: The return rate of questionnaire was very high, 70 % questionnaires from health care facilities were returned. In health care facilities, the age structure of clients was highest in 76–85 years (41 %), the length of stay of a patient in a healthcare facility was in 73 % patients up to 3 weeks. The most frequent performed activities at employees were health-nursing care (72 %). For 31 % health care facilities, the waiting time is 1 week. The length of stay of patient in healthcare facility is impacted in 63 % by combination of health and social problems. For diagnosis structure of patients, the most frequent is ischemic heart disease, heart attack, hypertension (37 %), sudden cerebrovascular accident (25 %), locomotive disease (25 %) and dementia (22 %) *(Tab. 7, Fig. 1, Ref. 16)*. Full Text (Free, PDF) *www.bmj.sk.*
Key words: chronically ill, long term care, social care, health care, elderly people.

Throughout the developed world, numbers and proportions of elderly people are growing rapidly (1). 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 (2). In industrialized societies, the ageing represents one of the major public health concerns in ensuring an adequate level of care to satisfy today's needs as well as ensuring the system's sustainability in the near future (3). The high costs of treating chronic diseases suggest that reducing their prevalence would improve Medicare's financial stability. The formulation of policies needs to reflect these countries' unique conditions (4).

Individuals need a long-term care (LTC) due to disability, chronic condition, trauma or illness, which limit their ability to carry out basic self 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 (5–11). This analysis includes survey on the structure of services provided in selected health care facilities.

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Methods

The survey on structure of provided services includes health care facilities providing services to the target groups involved in this analysis: Elderly people in retirement age; Disabled and chronically ill citizens in working age. On the basis of the „target group", questionnaires were sent to Providers of health care services: Geriatric clinics and departments, health facilities and departments for the long term ill. For data collection, we use questionnaire method. The data were obtained from the managements of 119 health care facilities.

Results

The return rate of questionnaires was very high. Overall, 83 (70 %) questionnaires from health care facilities were returned. Basic client data – age structure of clients was following (Fig. 1).

Health care practitioners often declare that health care facilities must provide their clients with social care due to a lack of social services. However, few people in health care facilities are acquainted with the Act on Social Assistance and with specific social care activities. To avoid potential misunderstandings in the introductory part of the questionnaire we defined a "social bed in the health care facility" in several ways. We asked all respondents involved to mark what they understood by the term.

The question was: So called "social" beds or social clients, who are a burden to health care sector, are often mentioned. What is a social bed/client in your facility?

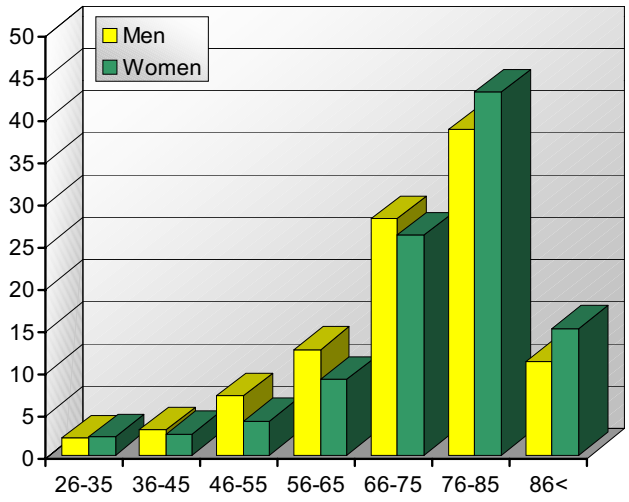

Fig. 1. The age structure of clients in health care facilities in Slovakia, 2007.

1) A client who is no longer in need of in-patient healthcare, but no social service or facility is available where he/she could be transferred on completion of treatment.

2) A client whose condition does not necessarily require admission to our facility, however, he/she requires long term care and there isn't anybody to take care of him/her.

3) Basically all of our clients who on completion of treatment cannot move to the care of out patient physician due to a lack of supporting social services and therefore they have to stay with us.

4) Other (specify)

This question was answered by 79 out of 83 health care facilities. The structure of answer was following (Tab. 1).

The level of identification of what "social" means in health care was therefore quite good. However, 80 % of health care facilities reported zero when asked how many such clients they had. This information does not confirm our original hypothesis that there are many patients in health care facilities provided exclusively or mainly with social care.

Tab. 1. So called "social beds" or social clients, who are a burden to health care sector, are often mentioned. What is a social bed/client in your facility/department?

	%
There is no place to go on completion of treatment	68
Was admitted, no place anywhere else	58
No supporting services, must stay	25
Other	10

Tab. 2. Structure of employees of social facilities by the performed activities (not by education or qualification) in Slovakia, 2007.

Health care nursing	Social care	Other professional activities in the area of social services
72 %	25 %	3 %

Tab. 3. The reasons for the stay in health care facility after the completion of treatment.

	%
There is no place to go on completion of treatment	35
Was admitted, no place anywhere else	21
No supporting services, must stay	42
Other reasons	2

Tab. 4. The length of the stay in health care facility in Slovakia, 2007.

	%
Stay up to 3 weeks	73
3–4 weeks	22
4–6 weeks	4
7–12 weeks	1

Tab. 5. Social services are in short supply and therefore health care practitioners claim they "have to" substitute for social sector. Exist this in this instance too in your case?

	%
Yes	83
No	17

The task of identifying the structure of individual activities of the facility by the activities of individual employees proved impossible to complete. For social services we tracked the following structure of activities by asking.

Try to assign employees of your institution by the performed activities (not to by education or qualification) to these four groups:

1) Health care nursing: physicians, nursing staffs

2) Social care: Employees perform direct utility activities, mainly routine, simple daily activities, help with personal hygiene and support self-sufficiency in individual life activities, provide assistance in creating basic social and societal contacts, and support social integration of clients.

3) Other professional activities in the are of social services: Pedagogic, psychological, medico-pedagogical, pastoral, economic and managerial.

From all facilities reported related activities and services amounting to more than 3 % of all work performed, social care 25 % and health care nursing 72 % (Tab. 2). The following (Tab. 3) sums up the reasons for their stays in health care facilities, and the next (Tab. 4) shows that more than 70 % of these patients stay in the health care facilities for several weeks (Tab. 5).

The question concerned the preferred format of payment for health care. More than a half of social facilities (76 %) prefer

Tab. 6. What format of payment for the healthcare provided in your facility would, to your mind, best reflect its scope.

	%
Payments for individual health care services	2
Lump-sum payments for health care services to clients with specified diagnoses	16
Combination of a) + b)	76
Other	6

Tab. 7. The diagnostic composition of clients in social services homes in Slovakia, 2007.

	Average (%)
Sudden cerebrovascular accident	25
Diabetes mellitus	16
Ischemic heart disease, coronary thrombosis, hypertension	37
Locomotive diseases	25
Senile dementia	22
Oncology diseases	14
Other (Alzheimer, schizophrenia…)	17

combined payment for services and by diagnosis. 2 % prefers payment for services and 16 % prefers payment by diagnoses (Tab. 6).

The diagnostic composition of clients in social services homes for adult was following (Tab. 7).

Discussion

Long-term care is closely interlinked with other programmes and systems, which can reduce or complement the need for long-term care. 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 (12). Old people are now the most rapidly growing segment of the population (13) and represent 20 % of all Slovak inhabitants (12). An important additional consequence of population aging is the increasing needs and costs of long-term care (13).

Co-morbidity has an additional impact on disability as well as on the use of medical care and long-term care. The general impact of chronic conditions is described by calculating healthy life expectancies and assessing the loss of healthy life resulting from chronic morbidity, disability and long-term care (14). As the public expenditure on long-term care is likely to increase with the ageing of the population, a better understanding of the factors related to long-term care institutional care is of particular interest. Several population-based prospective studies have shown that functional disability and cognitive impairment are associated with institutionalization, but systematic evidence on the effects of different chronic diseases on institutionalization is scarce (15).

There is no single solution to the problem of integration of the health and social care components of 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 (12). The respective public administration bodies – the Ministry of Labour, Social Affairs and Family, self-governing regions – and social service providers expect that legislation and organisational issues connected with financing health services in social service facilities by health insurance companies will be solved. They expect subsequent increase in financial resources in this area. At the moment, public administration and social service providers are not able to specify exactly all the obligations they will have to take over with respect to long-term care. At this time nobody in the social or health care area is concerned with the question of long-term management of the citizen who is provided social and long-term care. It is hard to estimate the scope and financial representation of health services executed in social facilities, as they do not pertain to all social care facilities.

In general it can be stated that the high degree of readiness of both sectors to prepare and implement an integrated model of social and long-term care does not stem from the adoption of a holistic approach to the human being in Slovakia; rather it means that an improvement of financial situation of both is expected. The social sector needs to resolve resources in order to extend the supply of services which are still in short supply. The health sector, on the contrary, needs to take another step towards the rationalization and reduction of the supply of in-patient healthcare.

There are at least three reasons for creating an integrated model of long-term care and recognize it as a new public service for citizens:

1) The current organisation of providing and financing the health care and social support to individuals with long-term functional disabilities is non-transparent, uncoordinated, and of low quality and effectiveness. Such an ineffective system poses barriers to the implementation of health system reform, and as a consequence, appropriate correction measures will not achieve the desired solutions for the population.

2) The existing system of health care and social support in terms of accessibility and service quality is insufficient to satisfy current demand and cannot meet future growth in demand for long-term care due to rapid aging of the population and increasing requirements of severely handicapped citizens.

3) Following the decentralisation of powers to regional and local governments, from 2002, and decentralisation of financing from 2005, the authority for coordination and responsibility for public services for citizens on nation-wide, regional, and local level becomes the most critical question.

Key factors enabling and obstructing advances in public health include overall macroeconomic and social conditions, lack of multisector collaboration, and better consideration of policy options (16).

Conclusion

Long-term care within the public services system does not exist in Slovakia.

The long-term care model will provide the foundation for legislation and associated regulation of the new system. The goal of the long-term care legislation will be:

– to define material, organisational, and financial aspects of the service system, aids, and benefits that will integrate health and social care, aids, and other supportive tools necessary for provision of essential support to individuals suffering from long-term functional disabilities, a system that would focus on improving their quality of life as well as the quality of life of their families who render much needed care and support;
– to guarantee effective accessibility to long-term care for citizens and concurrently to define the conditions for financial sustainability and efficiency of the system;
– to interconnect the formal system of long-term care provision with informal support of families and relatives in the most efficacious manner.

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