UDC 364.4-053.9

СОЦИЈАЛНА ПОЛИТИКА
број 3/2014.
год. 49.
стр. 51-63.

Прегледни
рад

Monika Gabanyi

GUIDING PRINCIPLES FOR LONG TERM CARE OF ELDERLY PEOPLE AT HOME

Summary

Long Term Care at clients' home is one mosaic stone in the overall intention of mainly provided for elderly people, is a long lasting process within EU countries and promotes the paradigm shift from dependent living to independent living settings including right of self-determination how, where, with whom to share daily life without full physical and/or mental capacity. In Scandinavia, infrastructure of institutions which provide care was, by law, reduced drastically already 40 years ago. Other countries followed and nowadays it is not questioned whether a person should stay at home while being in need of support. Further, integrated care provision is the common approach. It would be an artificial distinction between health and social service provision since both services are interrelated. The distinction is sometimes made due to different financial sources and resources for one or the other service but not quite supportive for the beneficiary.

Key words: long term care, elderly, home care, integrated service provision, quality assurance.

1. INTRODUCTION

The population of Central and Western European countries is an aging population. The long term trends of raising standards of living, including improvements in health status and lower birth rates, are leading to a steady growth in the proportion of elderly people (defined as anyone over 65 years) in these populations. This development is the result of prior economic and health/social policies, leading to longer life in terms of quantity and quality. As it does, however, also raise

new questions whether the traditional social policy prescriptions for will continue to be sufficient.[1)]

The main social policy issue of the elderly has been seen as the need to create a sufficient income to avoid poverty which followed when people became sick and/or loss the employment. Later, and this was a change of paradigm, it was seen as essential that older people benefit from adequate and sufficient care services, as access for these services was extended to the entire population. All in all, this change of paradigm required a redistribution of income from the working population. Behind all these social policy efforts and changes was the wish to be sheltered when one is growing older and, it was the fundament of the social welfare (ideas) states.

Meanwhile these ideas and the fundament have been transferred into action through several models of financing long-term-care covering integrated services in or outside of institutions.

Focusing on Europe, countries with social insurance systems introduced mainly an additional pillar for long-term care and countries with National Health Systems incorporated this health/ social policy item in their local/national budgets.

It has to be mentioned that countries in EU Accession procedure[2)] are dealing with the search of methodologies for covering long-term-care services and, one can expect the implementation of either compulsory insurance and/or budget solutions. Since Long Term Care coverage should protect the whole population in a certain geographic area, private insurance solution is not on the agenda due to economic constraints for the population. And, it has to be mentioned that the trend is to finance integrated and coordinated services; means at least, medical and social care, rehabilitation and household support.

It is wise to be aware of the challenges towards the elderly and to prepare in time adequate solutions. In 1996 the Council of Europe adopted a revised Social Charter. The previous and revised rights include a number of documents which have contributed to the right and co-ordination of social protection for individuals, e.g. the Social Convention on social security and the above mentioned Charter. In addition to social security, the documents deal with the right to social assistance and health care and emphasize the right to independent life and social integration.

1) Monika Gabanyi, et al.: *Annual Reports on international Social Security Reforms for MoH*, BASYS, Augsburg, 1992 - 2000.

2) Monika Gabanyi, et al.: *Social Security Reforms in Light of Accession to the European Union*, Augsburg, 1998.

EU Member States are required to adopt social policies encompassing modern concepts for people dependant on social assistance and health care. Modern concepts take into account comprehensive measures related to care and social support and sustainable/reliable financial sources. [3)]

The guiding principles follow most common approaches in long term care settings in Europe but even in Japan which has used the German model for the implementation of their long term care system. Purpose of the article is to highlight most important segments while designing a long term care system. Focus is on the home care as the most appreciated and common system but sometimes institutional care is necessary and also taken into account.

It might be there is a basic misunderstanding in perception. The terminology "home care" services describes the location where the services are put in place and the terminology "long-term-care" describes the manner and the location where it will be put in place which is different and follows the infrastructure of a country, the patient needs, desires and social circumstances. Therefore the financing issues take into account both, long-term-care services and the location, at home, in day care centres, inpatient wards and/or rehabilitation facilities.

2. HOMECARE

Many countries, such as Belgium, France, Italy, Portugal, Spain and the United Kingdom, have an organizational model in which the "health" component of home care is part of the health system and the "social" component is part of the social system. In other countries, especially Denmark, Finland, Sweden, policy makers have recognized the advantage of providing home care within a single organization under the responsibility of one institution: the municipalities.[4)]

For example, municipalities have been providing home care in Denmark since 1992. In contrast to local governments-oriented single-agent solutions, Germany and the Netherlands, for example, have a single funding stream (insurance-based) that covers home nursing and social care services. In addition to these institutional actors, voluntary, charitable and for-profit providers of home care services have extensive roles."[5)]

3) http://socialprotection.eu/cgi-bin/render.cgi?__cms_page=en_asisp_reports&country=rs&__cms_object=7,http://oecd.org./health/longtermcare 2011.

4) Monika Gabanyi, *Absicherung des Pflegerisikos am Beispiel ausgewählter europäischer Länder (Statutory long-term care (social) insurance in selected European countries for the Ministry of Health, FRG)*, Augsburg, 1992.

5) Home Care in Europe, WHO report 2008, p 13

Homecare is an evident complementary service of PHC (Primary Health Care) and comprise integrated/coordinated service packages for clients living at home or in residential settings. Medical and social services are coordinated according to clients' needs and a care provider serves both.

According to international standards, one homecare service provider is considered per 25,000 inhabitants, not taking into account a certain age structure, because home care providers should cover everyone who can be discharged from a hospital to community care. Although it is evident that mostly elderly people benefit from the services provided.

Researches proof the positive outcome of integrated/coordinated home care services. Amongst them are reduction in hospital and nursing home use, cost effectiveness or cost savings and increased patients' satisfaction enhancing quality of their life.[6)]

3. SCOPE OF SERVICES

The services provided are to be distinguished in medical and social services including basic care and household support. Additionally, rehabilitation and terminated care are part of the offers as well.

The services offered by the health/social care system are described as follow, taking into consideration that they need to be integrated both within the different levels of care of the health system: vertical integration from hospital - to community care and horizontal integration within social services social and medical care.

3.1 Long-Term-Care Rights

Within the integrated and coordinated care settings eligible persons have the right for

- Medical Care
- Basic Care
- Social Care
- Household support
- Rehabilitation
- Remedies
- Terminal and palliative care[7)]

6) CPRN Research report *"Frameworks of integrated care for elderly; A systematic review"*, April 2008.

7) Monika Gabanyi, *Finanzierungsstrukturen für Rehabilitation in Europa (Financing structures of rehabilitation in Europe, Phare-project)*, Augsburg, 1994.; Gabanyi, M.: *Absicherung des Pflegerisikos am Beispiel ausgewählter europäischer Länder (Statutory long-term care*

Medical Care comprises services like injections, change of wound pads and wound treatment, whereas basic care comprises help to the client dressing, moving, getting out of bed or vice versa, help the client to eat and drink and support hygiene. For social care the clients must have the opportunity to take part either in social life or to get assistance in social support via social workers who support and advise them e.g. in benefit requirements. Early and continuously rehabilitation measures should be provided by speech-, physiotherapists and others and, remedies like wheelchairs, special beds should be dispatched to the households of the clients'.

One very important issue shall be taken into consideration. It is well known that family members are highly affected by caring duties because they take over duties of the entire care cycle. In order to ensure safe care, relatives and other informal carers have the right (sometimes obligation) to participate in training and learn how to handle daily requirements in the overall care cycle.

The client, who is entitled for the above mentioned rights (services), can often choose between benefits in kind and/or benefits in cash.

Benefits in kind are managed between the insurance or other financial institution (fundholder) and the provider in terms of service specification, number and duration of service provisions, quality assurance prerequisites for licensing and accreditation and remuneration of services.

Benefits in cash are managed between the financier and the client (beneficiary). Here the indication and assessment regarding type and length of service provision is a first step. Regarding cost containment and avoidance of "moral hazard", both, benefits in kind as well as benefits in cash, must have the same ceiling in terms of money that can be spent per client per month. In case a client opts for benefits in cash he/she has the opportunity to buy services directly contracting either a professional home care provider or engaging relatives or other private informal carers and pay them for. Such a system supports clients' individual wishes/decisions and it is in use in countries with long-term-care insurance, like Germany, Austria and The Netherlands.

3.2 Beneficiary and Entitlements

Who is eligible for long-term-care services and to what extent depends on the definition of the term "dependency on long-term-care" and the level of dependency that has been assessed.

(social) insurance in selected European countries for the Ministry of Health, FRG), Augsburg, 1992.

The term „dependency on long-term-care"is linked to the incapability of an individual to perform the activities of daily life in a frequent manner, at least for a certain period, e.g. the following 6 months. During the defined period should be taken into account that clients in the terminal phase of their life are as well in need of long-term-care.

Incapability can be characterized as:

Loss of movement, loss of functions of inner organs and other sensual organs, loss of functions of the central nerve system, endogen psychosis, neurosis or another mental handicap. Support can be given for hygiene, nutrition, mobility and maintain basic functions in a household in case the service will be provided at the client's home.

Usually, the assessment for the level of dependency distinguishes several degrees. These degrees lead to the entitlement of the number and type of services given for medical/social care, household support, rehabilitation and remedies. As a reference for services/allowances the degrees are also directly connected to the time of support needed.

For example, a client is assessed to

- level 1 when a service is necessary to be provided once per day (1.5 hours),
- level two when the services have to be provided 3 times per day (3 hours) and
- level 3 in case the support/supervision lasts up to 24 hours per day.

The minimum time consume for each level has to be defined because of the assessment of the dependency degree and for the calculation of staff needed. Those items have to be linked with emerging costs. And, last but not least to limit or extend the number of beneficiaries. In case the minimum time consume necessary for ADL (Activities of Daily Living) is reduced to one hour per day, the number of beneficiaries will increase dramatically, and vice versa. This time determination is one tool among others to run the system in terms of cost containment and planning arrangements.

The assessment itself, usually, is undertaken by independent professionals, not belonging to e.g. the financing institution in order to avoid conflict of interests. The assessment results include the level of dependency, but it should also describe appropriate measures for reducing the incapability or, at least to avoid further progress of dependency.

Rehabilitation is a keyword for the challenge and the effect is at least twofold. The client can keep his/her status and the funding institutions take into account cost containment in a long term perspective.

Also, because of rehabilitation the client can improve his/her status and becomes either independent or, it might be a follow up assessment comes to the result of lower level of dependency.

Referring back to the benefits in kind and cash the latter is less because it aims to internal family support and additional costs for remedies, like pampers etc.. Benefits in cash are only paid for home care, but not for long-term-care in institutions.

Example: Benefits in cash and in kind according to dependency degree in home care

Degree and time per Day	Benefit in cash/month	Benefit in kind/month
Level I – 1.5 hours	50 $	150 $
Level II – 3 hours	100 $	300 $
Level III – 24 hours	150 $	500 $

4. PROVISION OF SERVICES

4.1 Human Resources

The combination of medical-social services and the focus towards the clients that they are dependant from at least both, medical treatment and social support, but also rehabilitation and other services require specific staff composition.

Medical care is in the responsibility and supervision of a GP (General Practitioner) /Family Physician (Family Physician)[8)] and, usually the service provided in practice is managed as teamwork by different professionals, usually the physician and nurses. But also accompanied by others, like physiotherapists, speech therapists, psychotherapists etc. for rehabilitation, auxiliary staff and informal carers[9)].

Social care is sometimes seen as a service that can be done by everyone, regardless whether a person is a professional or not. This opinion is accurate to some point, but it bears danger. E.g. In case there is a client suffering on symptoms after a stroke and there is a layperson (informal care) taking care at home, both of them might be jeopardized due to the appearance of a bedsore. Laypersons are not aware of first signs and cannot take action in order to avoid this situation. The consequence might be worse condition for the client and lower quality of life and higher costs for the social security institution due to the intensive medical treatment needed.

8) Depending on the organization of a PHC system. In general, medical care is to be recognized by physicians.

9) Informal care, respectively layperson, is defined as a person who looks after a client and belongs to the family, or is a partner, friend or neighbor.

That does not mean that social care, managed by laypersons make no sense or, that auxiliary staff cannot take over ADL issues and basic medical care. First of all, the services needed and provided have to be defined by professionals for each individual client according to assessment indicators to be developed, and the process of care has to be assessed frequently as well. This is regardless, whether professionals, auxiliary staff or laypersons are involved in the care cycle.

Therefore staff needed for coordinated and integrated services at home consists at least of nurses and auxiliary staff. Depending on the service provision rehabilitation services need to be performed by professionals. As already mentioned, physicians have to take over the responsibility for medical treatment and, given the fact clients have both, medical and social services, the physician in close co-operation with the head nurse will be responsible for the entire process of treatment and care.

Despite of the composition of different professionals who are acting as team, the number of professionals and auxiliary staff has to be defined according to indicators taking into account geographic area, age structure of the population, epidemiological specifics, and clients' dependency level and, linked to these items, the time to be spent by a provider at clients' home.

Table 1:
Human Resources for coordinated and integrated care services at home

Profession	Task
Care Manager	Management of all client needs
Nurses	Medical care/ training for informal carer
Home carers	Basic care (ADL) and others
Rehabilitation Personnel	Rehabilitation
Social workers	Social needs
Psychologists	Psychological support for clients and staff

Care Manager: Care managers co-ordinate all client needs in order to guarantee integrated coverage of services.

Nurses: The nurses are responsible for medical care which is part of the integrated care services.

Home carer: The duties of home carers comprise assistance and support of activities of daily life (ADL).

Rehabilitation personnel: The rehabilitation personnel identify client's needs for recovery and needs of remedies and the training how

to use it adequately. The rehabilitation may also be undertaken by other professionals working with the client but under the supervision of the rehabilitation personnel.

Social worker: The social worker is the person educated to give assistance of social services to clients like legal advice, paper work.

Needs assessment itself should be conducted by independent professionals in order to avoid conflict of interests towards the funding institutions. The assessment results include the level of dependency and the care plan, but it should also describe appropriate measures for reducing the incapability or, at least to avoid dependency progress.

4.2 Public and / or Private Providers

Whether a home care provider should be, in legal terms, a private or a public entrepreneur is not the pivotal question. Both types of service providers should be in the network of home care providers. Among them are NGOs, foundations, none and for profit private entrepreneurs, as well as public providers.

Important is that all of them have to fulfill accreditation and licensing requirements in order to become part of the network of providers. This is the entry point for contracts with social security funds or institutions that manage local budgets and/or other sources.

As the providers must fulfill quality standards for contracting with the respective financing institutions, the following quality indicators have to be taken into account and have to be the basis for signing a contract, regardless whether the provider is public or private.

4.3 Quality Assurance

Quality indicators consist of quality of structure, quality of the process quality of outcome[10)]. This scheme builds the framework and represents an excellent instrument for measuring the quality of all care processes. Donabedian[11)] expressed:

"For now, all that is needed is to accept, provisionally, that there are three major approaches to quality assessment: 'structure', 'process', and 'outcome'. This three-fold approach is possible because there is a fundamental functional relationship between the three elements, which can be shown schematically as follows:

---

10) Avedis Donabedian , "An Exploration of Structure, Process and Outcome as Approaches to Quality Assessment" in: *Quality Assessment of Care* (Selbmann, H.K., Überla K.), Robert-Bosch-Publication, Gerlingen, 1982.

11) Monika Gabanyi, *Quality Assurance in social care*, BASYS, Augsburg, 1995.

Structure → Process → Outcome

This means that structural characteristics of the settings in which care takes place have a propensity to influence the process of care so that its quality is diminished or enhanced. Similarly, changes in the process of care, including variations in its quality, will influence the effect of care on health status, broadly defined."[12)]

1. Quality of structure:[13)]

Quality of structure emphasizes and focus on providers' personnel available related to the clients' needs and management capacities, the time to be on duty and skilled staff. Defined quality indicators are the professional background of the manager who has to have a solid professional education and exam plus additional education in home care requirements and specific management skills.

The provider should assure that the personnel employed are promoted to attend further education offers and internal supervision rounds.

2. Quality of process:

The clients have to be clearly informed about the time on duty and, in geographic areas with high dense population, the providers should go in co-operation with other providers for sharing "emergency" services outside of the normal working hours.

The so called terminus "quality of process" refers to the genuine care process and the work with beneficiaries. In order to provide services of high quality it is necessary to follow such a care cycle.

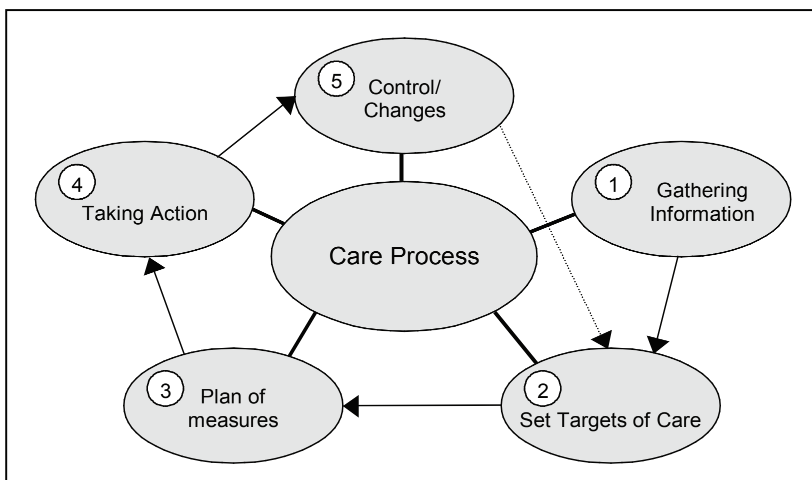
The cycle consists of:

a) Anamnesis and defining the targets to be achieved through the care, treatment and rehabilitation services. This has to be done and agreed upon by the client wishes as well.
b) The care plan has to be elaborated and a documentation on care measures has to be individually recorded to the professionals who are part of the care process (e.g. head nurse, auxiliary staff, GP, rehabilitation personnel etc.). One copy of the documentation has to be stored in the household and one at the services provider(s).
c) The measures have to include so called "activated care" which take into account the client's capabilities and these capabilities have to be stimulated. Prophylaxis and rehabilitation are part of the measures as well.

12) Gabanyi, Ibidem, 1994, 71 pp

13) The following examples are indicators that have to be fulfilled as minimum in Germany

d) The process has to be assessed frequently. In case the aims of the caring process are not achieved the measures have to be adapted and revised.



Scheme of the Care Process

Providing the indicated items for the quality of structure and quality of the care process the outcome to be determined depends on several facts.

One might focus on the costs others look at staff's satisfaction and again others determine client/clients' satisfaction as parameters for outcome quality.

All three mentioned items are worth to be taken into account and used as determinants for qualitative outcome(s).

Determination and fulfilment of these quality indicators is prerequisite for licensing and accreditation of providers but it is not important whether provider comes with services on the market as private entrepreneur, NGO, foundation or whether they are public.

The quality of services is the key element. The most important thing is to have:

- a clear set of quality standards elaborated in a large partnership with all actors (providers of services, clients, financiers);
- a process of implementing in practice and maintaining the quality of services where all staff is involved 24/7;
- a process of improving the quality standards by organising periodically e.g. every two years a new process of designing new standards based on the previous experience.

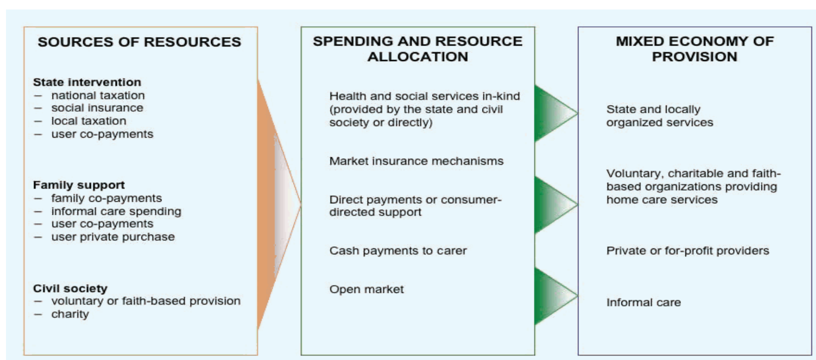
4.4 Funding Home Care

A range of potential home care funding mechanisms derives from state intervention, market purchases and the contributions of family members and resources of civil society[14].

Inputs and contributions for home care enter individual systems as services in kind and as various forms of financial resources, such as cash to service users and/or informal carers.

The combination of these public, family and private resources shapes the mixed economy of home care, which operates within each specific national setting. Hence, determining the precise quantity of public resources dedicated to home care is not easy, especially since they are often drawn from across health care, social security and social service budgets, and private purchasing of home care makes a major contribution to the overall levels and quality of home care packages."[15]

4.5 Funding, allocating and deploying home care[16]



REFERENCES

Gabanyi, Monika, *Quality Assurance in the high tensed situation between cost effective care provision and consumer satisfaction in home care*, BASYS, 1996.

Gabanyi, Monika, *Quality Assurance in social care*, BASYS, 1995.

Gabanyi, Monika, *Finanzierungsstrukturen für Rehabilitation in Europa (Financing structures of rehabilitation in Europe, Phare-project)*, Timisuara (Romania), 1994.

---

14) Monika Gabanyi, *Quality Assurance in the high tensed situation between cost effective care provision and consumer satisfaction in home care*, BASYS, Augsburg, 1996.

15) Home Care in Europe, WHO report 2008, p 18

16) Ibidem, p. 19

Gabanyi, Monika, *Absicherung des Pflegerisikos am Beispiel ausgewählter europäischer Länder (Statutory long-term care (social) insurance in selected European countries for the Ministry of Health, FRG)*, Augsburg, 1992.

Gabanyi, Monika, *Pflegeabsicherung in der Bundesrepublik (Long-term care insurance in the FRG)*, ZDF, 1993.

Gabanyi, Monika, et al., *Social Security Reforms in Light of Accession to the European Union (Barcelona), 1998.*

Gabanyi, Monika., et al., *Annual Reports on international Social Security Reforms for MoH (Germany)*, *1992-2000.*

http://socialprotection.eu/cgi-bin/render.cgi?__cms_page=en_asisp_reports&country=rs&__cms_object=7

http://oecd.org./health/longtermcare

Monika Gabanyi

ВОДЕЋИ ПРИНЦИПИ ДУГОТРАЈНЕ ЗАШТИТЕ СТАРИХ У КУЋНОМ ОКРУЖЕЊУ

Резиме

Дуготрајна заштита и подршка у кући корисника је само део целокупног процеса спречавања институционализације рањивих група. Интегрисана заштита у заједници углавном се реализује за старе особе и представља дуготрајан процес у земљама ЕУ, којим се промовише променама парадигме са зависног на независни живот, који укључује право на самоопредељење, односно како, где и са ким делити свакодневни живот без потпуне физичке и/ или менталне способности. У Скандинавији, сагласно законским решењима, институционални смештај је драстично смањен у протеклих 40 година. Друге земље су следиле овај пример, те се данас се не доводи у питање да ли особа треба да остане код куће уколико јој је потребна подршка. Пружање интегрисане неге је међусистемски, холистички приступ. Неприродно је раздвајати пружање здравствених и социјалних услуга пошто, ове услуге, као и људске потребе чине дијалектичко јединство. Разлике су углавном последица другачијих извора финансирања, односно средстава намењених за једну или другу услугу, што није увек повољно по корисника.

Кључне речи: дуготрајна заштита, старе особе, кућна нега, пружање интегрисане неге, квалитет осигурања.

* Овај рад је примљен 30. октобра 2014. године а прихваћен за штампу на састанку Редакције 25. новембра 2014. године.