JÓZSEF HAJDÚ*

Care management in long-term care

I. Adapting to evolving needs and increasing patients' choice and involvement

An ageing population also implies changing disease and morbidity patterns. Care systems have to adapt to this and rebalance various types of care (primary, secondary, long-term and social, both formal and informal). The complex needs of older people, often suffering from multiple illnesses and impairments, also mean that they need different forms of care at the same time. Assessing such needs and coordinating the different forms of care and the effort of different providers will certainly become increasingly important.

There is a general feeling that modern health and long-term care should take account not only of patient needs but also of their expectations including the desire for choice. Countries want to ensure greater system responsiveness to more autonomous clients. This can be attained by increasing patients' choice concerning care providers and/or insurers, by greater patients' involvement in the organisation of care and decision making (e.g. ensuring patient representation in committees / agencies), and by giving the patient the purchase control via e.g. use of allowances to patients or personal budgets. This in turn requires improving transparency and making better information available to users so as choices can be made based on knowledge and advice as well as the strengthening of patient rights. A broad implementation and an increased use of ICT can help meet the demands of society for accessible and efficient high-quality care. All this could help ensure that care providers respond appropriately to medical and social needs as well as to preferences and choices of individuals, while strengthening the responsibility of patients and care receivers.[1]

The meaning of the long-term care (LTC) is a variety of services which help meet both the medical and non-medical need of people with a chronic illness or disability who cannot care for themselves for long periods of time.[2] It is common for long-term care to provide custodial and non-skilled care, such as assisting with normal daily tasks like dressing, bathing, and using the bathroom. Increasingly, long term care involves providing a level of medical care that requires the expertise of skilled practitioners to

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[1] Review of Preliminary National Policy Statements on Health Care and Long-term Care, http://ec.europa.eu/employment_social/spsi/docs/social_protection/spc_ltc_2005_en.pdf (08.07.2008.)

[2] http://aging.ohio.gov/resources/publications/att1_2008-02-07.pdf

address the often multiple chronic conditions associated with older populations. Long-term care can be provided at home, in the community, in assisted living or in nursing homes. Long-term care may be needed by people of any age, even though it is a common need for senior citizens.[3]

1. The meaning of case management

It is also known as "care management". Case management is a comprehensive and systematic process of assessing, planning, arranging, coordinating and monitoring multiple long-term care services for the individual client across time, setting and discipline.[4]

A distinction can be made according to vertical and horizontal integration. "Vertical" integration means combining two or more organizations that have different positions in the distribution channel, e.g. a hospital and a home care organization. "Horizontal" integration, on the other hand, means combining two or more organizations that have the same position in the distribution channel, e.g. two home care organizations.[5] Obviously, the former strategy is more geared to building a continuum of care.

Case management activities are performed by an individual case manager, or by a team of health and social service professionals. It is also undertaken in a variety of organizational environments (e.g. in a freestanding local or regional entity with formal or informal responsibilities for 'brokering' long-term care services; an insurer or other funding agency; a provider institution like a home care organization, medical clinic or hospital; or supportive housing).

The case management function can stand alone, or can be bundled with other administrative and client management activities as, for example, when it is part of a "chain of care".[6]

Care coordination is seen as crucial in enabling a high level of quality and an efficient use of resources in the provision of long-term care services in an institutional or community setting, thus permitting an adequate continuum of care irrespectively of the different levels of long-term care provision (local, regional, national) and organisation.

Coordination problems at the interface between 1) medical, 2) social services and 3) informal care can result in negative outcomes for users and in an inefficient use of resources. It is often the role of the service providers to assess the individual needs and provide holistic services based on each individual needs assessment and offer coordinated, tailored and a patient specific continuum of care. It is reasonable to argue that there is no model for the provision of a continuum of care since each patient will require an individualised provision that should be tailored according to his/her needs. Care coordination is crucial in the provision of a care continuum for individual patients.

[3] http://www.healthinforum.org/Long-Term-Care-list-20776-3.html (07.07.2008.)

[4] KODNER, D. 1993. *Case Management: Principles, Practices and Performance.* Brooklyn, NY: Institute for Applied Gerontology, www.longwoods.com (07.07.2008.)

[5] http://www.raconline.org/success/success_details.php?success_id=527

[6] In J. BRODSKY, J. HABIB, & M. HIRSCHFELD (Ed.), *Key Policy Issues in Long-Term Care* (pp. 3–24). Geneva, Switzerland: World Health Organization.

The care continuum approach aims at promoting a uniform and coordinated provision of services.[7]

The perennial concern of governments has been to identify means of achieving coordinated and integrated long-term care. This may be examined at different levels in the care system:

1) interagency coordination;
2) interprofessional coordination; and
3) case level coordination[8].

None of these may be separated completely from the others. This part attempts to bring together material about the definition and specification, context and content of care management with a focus upon issues of implementation.[9]

There are major developments in long-term care occurring in many countries and some broadly similar trends can be discerned. There are, at least, three broad trends:

a) a move away from institution-based care;
b) the enhancement of home-based care; and
c) the development of mechanisms of coordination and case management.

In many developed countries the concern for coordination has been longstanding and took the form principally of attempts to improve interagency coordination, chiefly health and social care, through such initiatives as joint care planning and joint financing. The focus upon coordination at the client level came considerably later – being less evident in a setting where most services were provided by two main agencies, health and social services. However, the strategies focused solely on organizations are not enough. A human link is required. A case manager can provide this link and assist in assuring continuity of care and a coordinated program of services. [10]

1.1. Defining the nature of case or care management

The origins of care management then, lie in the immediate need for coordination of home-based care, albeit with a broader range of objectives including client-centred care and effective use of resources. Six criteria may be identified which together constitute a more precise definition:

1) the performance of a set of core tasks;
2) the function of coordination;
3) explicit goals for care management;
4) a focus upon long-term care needs;

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[7] *The OECD Health Project, Long-term Care for Older People*, OECD 2005, pp. 46–48.

[8] CHALLIS, D., DARTON, R., JOHNSON, L. STONE, M. and TRASKE, K. (1995) *Care Management and Health Care of Older People. The Darlington Community Care Project.* Arena, Ashgate: Aldershot.

[9] BRODSKY J, HIRSCHFIELD M, HABIB J, CHALLIS D.J. (2002). *Achieving co-ordinated and integrated care among long term care services: the role of care management.* in: Key Policy Issues in Long Term Care. pp. 34–37.

[10] BRODSKY J, HIRSCHFIELD M, HABIB J, CHALLIS D.J. (2002). *Achieving co-ordinated and integrated care among long term care services: the role of care management.* in: Key Policy Issues in Long Term Care. p. 140.

5) particular features which differentiate care management from the activities of other community-based professionals; and
6) the dual function of care management at client level and system level.[11]

From a different angle, they attempt to answer the following questions:
a) What is undertaken in care management?
b) Why is care management employed in the care system?
c) How is care management done?
d) For whom is care management provided?
e) What makes care management different from other community-based work?
f) What impact does care management have on the service system?
Each of these would seem to be an important component of the definition.[12]

1.1.1 The functions of care management

In overall functional terms, case management is defined as: 1) a mechanism for linking and coordinating segments of a service delivery system and 2) to ensure the most comprehensive programme for meeting an individual's needs for care.

This involves continuity of involvement and is based upon the comprehensive assessment of the individual's needs[13]; case management is usually defined as a dedicated person (or team) who organizes, coordinates and sustains a network of formal and informal supports and activities designed to optimise the functioning and well-being of people with multiple needs.[14] More generally, it is described as the achievement of a better fit between the person's needs and the resources available in the community.[15]

One of the simplest but very pragmatic views set by the United Kingdom Department of Health Guidance defines care management as: the process of tailoring services to individual needs. It then refers to specific core tasks.[16]

1.1.2. The goals of care management

Moxley[17] notes three goals of case management:
1) improving client utilization of support and services;
2) developing the capacity of social networks and services to promote client well-being; and
3) promoting service effectiveness and efficiency.[18]

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[11] M. SILBERBERG: *Managing to Care: Case Management and Service System Reform*, Journal of Health Politics Policy and Law, February 1, 2004; 29(1): 154 – 156.

[12] BRODSKY J, HIRSCHFIELD M, Habib J, CHALLIS D.J. (2002). *Achieving co-ordinated and integrated care among long term care services: the role of care management.* in: Key Policy Issues in Long Term Care. p. 142.

[13] Nancy N. FISCHER – Lucy Rose KANE, Rosalie A.: *The homecare worker: on the frontline of quality.* (Frontline Workers in Long-Term Care) Generations September 22, 1994. p. 87.

[14] MOXLEY (1989) in. http://www3.interscience.wiley.com/journal/119835565/issue (08.07.2008.)

[15] MODRICIN, RAPP & POERTNER: *The evaluation of case management: The case management.* Grid 1988, Social Work 35: pp. 444–448.

[16] David Challis PREFACE: *Achieving coordinated and integrated care among LTC services: the role of care management.* p. 144.

[17] MOXLEY (1989) in. http://www3.interscience.wiley.com/journal/119835565/issue (08.07.2008.)

1.1.3. Key differentiating features of care management

For example, in the United Kingdom, an obvious example of this is the role of the key worker within multidisciplinary teams. However, it is important to discriminate among different roles of different staff for people with different levels of need.

There are important differences between activities such as key worker approaches, which aim to coordinate a single service or team more appropriately to individual needs often on a short-term basis, and case management, which aims to coordinate multiple services and providers, usually on a long-term basis.[19]

Another key element is that case management is concerned with meeting the needs of people with long-term care problems or multiple needs.

Therefore, care management is concerned with providing services to a specific target group and need not be seen as the mechanism for providing all forms of care for those who need assistance in coping with everyday living.[20]

1.1.4. The organizational context of care management: a multi-level response

Case management is designed not just to influence care at the individual client level, but also at the system level through the aggregate of a myriad of care decisions at the individual client level which exert pressure for change upon patterns of provision themselves. An underlying objective is to render those patterns of services more relevant to individual needs.[21]

An UK Government review concluded that no single model suits all levels of need or service user groups and identified three types of care management, each necessary to an integrated and comprehensive approach:

1) an administrative type, undertaken by reception and/or customer service staff which provides information and advice;
2) a coordinating type, that deals with a large volume of referrals needing either a single service or a range of fairly straightforward services which should be properly planned and administered; and
3) an intensive type, where there is a designated care manager who combines the planning and coordination with a therapeutic, supportive role for a much smaller number of users who have complex and frequently changing needs.

The review concluded as follows: the crucial objectives are to ensure that long term care management is devoted to those people who need it and that decisions about the skills of staff to be deployed and about monitoring and reviewing arrangements reflect this.[22]

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[18] David Challis PREFACE: *Achieving coordinated and integrated care among LTC services: the role of care management.* p. 145.

[19] Jack ROTHMAN and Jon Simon SAGER: *Case Management: Integrating Individual and Community Practice*, 2/E Publisher: Allyn & Bacon, 1998, p. 306.

[20] David Challis PREFACE: *Achieving coordinated and integrated care among LTC services: the role of care management* p. 147.

[21] STEINBERG R.M. & G.W. CARTER: *Case management and the elderly Lexington* Ma (1983): D.C. Health p. 57.

[22] *Social Services Inspectorate*, 1997, p. 30.; http://www.dh.gov.uk (05.07.2008.)

1.1.5. The location of care management

According to the practice of several examined states, (see below) care management has been located in a variety of different settings. These settings include social service departments/units, hospitals, geriatric and psychiatric multidisciplinary teams, primary care, independent agencies, and even independent actors. It differs country by country. Effective implementation of care management will need to identify appropriate settings to provide case management for individuals with different kinds of needs.

2. Style of care management: brokerage or more extensive approaches

Some implementations of care management sometimes appear to consider the core tasks more as administrative activities (involving mainly brokerage and service allocation) rather than integrating these with tasks such as support and counselling (requiring staff with human relations skills). This is evident in discussions about the separation of purchaser and provider roles where a rigid distinction considers the provision of human relations skills and emotional support as only a 'provider' role.

Studies consistently indicate that more than brokerage functions are required in practice, even if this were not made explicit in the initial planning or job descriptions[23] and that case managers were successful in performing the core tasks through combining practical care with the use of human relations skills. It incorporates two central functions: (a) providing individualised advice, counselling and therapy to clients in the community and (b) linking clients to needed services and supports in community agencies and informal helping networks.[24]

2.1. Degree of role specificity

The extent to which the role of care manager has become specifically differentiated from other roles varies, probably due to contextual factors such as degree of rurality but also reflecting the form of care management development occurring. Thus some agencies may wish not to differentiate the role of care manager as a specific job, seeing it rather as a role within existing job descriptions.[25]

Another approach has involved some staff defined as having different jobs for different clients, for example as social worker for some and care manager for others. Some studies suggest that such role mixing or part-time care management could lead to a less effective functioning on the part of the case manager.[26]

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[23] DANT, T. & GEARING, B. (1990) *'Keyworkers for elderly people in the community: Case Managers and Care Co-ordinators'*, Journal of Social Policy, Vol. 19 (3): 331–360 – ISSN: 00472794.

[24] David Challis PREFACE: *Achieving coordinated and integrated care among LTC services: the role of care management.* p. 163.

[25] BUGLASS, D.: *Assessment and Care Management: A Scottish Overview of Impending Change*, Community Care in Scotland. Discussion Paper No: 2, 1993, Social Work Research Centre, University of Stirling. p. 56.

[26] KEITH J.: *„Care-taking in Cultural Context" Anthropological Queries.* in. Kending H.L. A. Hashimoto, L.C. Coppard (eds.) Family support for the elderly. WHO, 1992 Oxford: Oxford University Press pp. 154–157.

2.2. Balance of work

In order to maintain continuity of responsibility throughout all the phases of a client's "career" with the service, care managers could be made responsible for continued monitoring and review after entry to institutional care. While such an approach offers continuity, it could lead to increasing caseloads and a sharper focus upon institution-based work than upon community-based work. For example, in one setting case managers remained responsible for an elderly person after entry into a nursing or residential care home. Since the level of reimbursement to homes is based upon client dependency, there is an incentive for homes to request frequent reviews, with inevitable refocusing of staff time away from home-based care.

2.3. Staff mix

Training has been mentioned as indicative of the expected style of care management. However, staff mix itself could also indicate an important aspect of variation in care-management practice. For example, some Scottish authorities with predominantly rural catchment areas were developing primary assessment teams with staff from both Health Boards and Social Work to undertake assessment and care coordination.[27] In a number of care-management programmes for older people, staff tend to be mainly from social work and nursing backgrounds.

A mixed staff group can permit the targeting of particular staff types with particular client needs within programmes.[28] For example, in one British programme for older people, social workers usually managed cases where mental health and carer problems predominated, whereas nurses tended to manage those where physical health problems predominated.[29]

2.4. Caseload size

Clearly, there is a trade-off between caseload size and effective performance of these activities which will concern those implementing programmes. Caseload size is likely to determine the feasible style of case management. Caseload size is of course more problematic to define when a team approach to case management is adopted for particularly demanding clients in some mental health programmes.[30]

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[27] BUGLASS, D.: *Assessment and Care Management: A Scottish Overview of Impending Change*, Community Care in Scotland Discussion Paper No: 2, 1993, Social Work Research Centre, University of Stirling. pp. 37–38.

[28] Jack ROTHMAN and Jon Simon SAGER: *Case Management: Integrating Individual and Community Practice*, 2/E Publisher: Allyn & Bacon, 1998. p. 306.

[29] CHALLIS, D. CHESSUM, R., CHESTERMAN, J. LUCKETT, R. and TRASKE, K. (1990) *Case management in social and health care*, Personal Social Services Research Unit,Canterbury. pp. 139–143.

[30] Ronald J. DIAMOND, Robert M. FACTOR and Leonard I. STEIN: *Response to "training residents for community psychiatric practice"*, Community Mental Health Journal. Volume 29, Number 3, June 1993 Springer. Netherlands, pp. 289–296.

2.5. Documentation

Although documentation is not frequently discussed as part of care management practice, it is part of the practice environment and can contribute to setting horizons and parameters to activities. The right kind of documentation may facilitate improved practice in areas such as assessment, care planning, and review. In British surveys of assessment study there was little evidence of documentation which could assist staff in moving from the task of information gathering towards activities such as needs formulation and care planning.[31]

3. Logical coherence of care management arrangements

Four elements need to be coordinated in a fully coordinated system:

1) programmes;
2) resources;
3) clients, and
4) information.[32]

The rationale for any society in the implementation of care management as a mechanism to integrate care is also likely to vary. For example, when care management was introduced into the United Kingdom in the late 1980s, community services were nearly all provided by two public sector sources – the National Health Service and Social Services Departments. The need for coordination was not self-evident, since there appeared to be a simple situation of two providers of care. However, the internal divisions of service providers reflected through various professional and service hierarchies (social work, nursing, home care, day care, day hospital, etc.) caused the experience of service users to be fragmentary. Nonetheless, the environment made the establishment of care management in a lead agency relatively easy.

However, care management is no magic tool, but rather a mechanism which, if effectively implemented, can offer one way to manage the tension between social objectives and economic constraints in long-term care services. This can never be a comfortable process.[33]

[31] DOH, 1993. (05.07.2008.)

[32] AIKEN, Michael – DEWAR, Robert – Di TOMASO, Nancy – HAGE, Jerald – ZEITZ, Gerald: *Coordinating Human Services: Strategies for the Development of Service Delivery Systems*, Jossey-Bass, Inc. (San Francisco, CA) 1975. p. 36.

[33] CALLAHAN, Daniel: *Setting limits Limits: Medical goals in an aging society New York.* 1987, Simon and Schuster p. 67.

II. Policy examples related to care coordination

1. Health-care approach: primary care, referral systems and care coordination

The referral systems (from GP to specialist care) do not always function perfectly (sometimes large numbers of patients do not register or visit a family doctor). A large number of EU Member States draw attention to the importance of patients registering with a GP / family doctor who functions as their first point of access to the services. The family doctor can provide patients with preventive and curative care and serves as a professional guide to the patient referring him/her to other (correct) types of care, determining the number of places the patient has to appear and the order of appearance. This ensures the use of a coherent path of care via a GP referral system.

In various countries health and social welfare systems are separate institutional entities making it more difficult to move people between systems and to ensure a continuous and integral patient follow-up. This has negative implications for access as well as quality. Better care coordination in general is expected to have positive effects on care quality and financial sustainability, as it avoids overuse, in sometimes unnecessary care, in particular the doubling of procedures.[34]

2. Policy examples encouraging greater primary care use and care coordination in EU member states

A) *Primary care*

- Compulsory/ automatic registration with GP / family doctor (United Kingdom, Denmark, Estonia, Hungary, Netherlands, Sweden, Latvia, Slovenia, Finland for public health care system).
- Financial incentives, i.e. less favourable reimbursement or 100% of the costs borne by the patient if patients go straight to specialist care (France, Belgium, Germany).
- The no-claim scheme whereby patients are refunded if they have not spent above a threshold incentives primary care use as the latter is not included in the cost calculation (Netherlands).
- Training more staff and retraining existing staff to work as primary care physicians (Estonia, Latvia, Portugal). Primary care courses are offered as part of the medical curriculum (Hungary, Portugal). Introducing family physicians.
- Increasing the motivation of primary care staff through increased responsibility (Latvia, Portugal) and autonomy (Portugal), activity- and quality related remuneration (Portugal) and improving their working conditions (Sweden).

[34] SPC Health care & LTC review, final, 30 Nov. 2005. p. 15.

B) Care coordination

- GP playing a leading role in ensuring coordination of care (Poland, Germany).
- Implementation of health care districts i.e. joining district hospitals and primary care units in the area (Finland)
- Primary care trusts work with local authorities and local health and social care agencies to ensure the community's needs are met (United Kingdom). In Portugal health centres are to establish partnerships with social care organisations.
- Establishment of community health partnerships i.e. a multi agency and multi professional partnership to better integrate primary, specialist and social care at regional / local level (United Kingdom, Austria). In France system networks are being developed with the same aim.
- In Finland, as local authorities are responsible for the provision of both health and social care, integrated care can be provided.
- In Netherlands entrepreneurship is stimulated to improve the coordination of care, with professionals having to think about what is best for their patients and act demand-led.[35]

C) Information and simplification

Concern is also shown for the possible lack of information on the part of patients. In this context, internet services are being developed and its use encouraged as a way for patients to obtain information on access to services, as a means to book services and receive prescriptions, or as a way for patients to have access to their records on line (e.g. Netherlands, United Kingdom, Slovenia, Portugal, Poland).

Increasing use is also to be made of call centres and information telephone lines (United Kingdom – NHS direct, Portugal, Poland) and phone and email to directly contact the family doctor / GP. In Poland a guide for patients presents the rules and conditions of access to services. Finally, to improve migrants' access to care some countries refer to the presence of intercultural mediators at care institutions (e.g. Belgium).[36]

- Establishing medical files with patients' medical record for all patients (France, Belgium, Sweden, Finland, Luxembourg, Slovenia, Portugal, Austria, Netherlands). In some instances patients may be penalised when failing to have such a file (Belgium).
- Evaluating each patient's needs and defining each patient care plan (with the various needs and care specified) for those in need of long-term care (Belgium, Denmark, Germany, Estonia, Spain, Sweden, Slovakia, Finland, Latvia, Portugal, Italy).
- Provision of interdisciplinary care via interdisciplinary teams is to be established for long-term care patients and with disabilities (Poland) and more importance is

[35] CHALLIS and DAVIES: *Long Term Care for the Elderly: the Community Care Scheme.* Br Journal Social Work. 1985.; 15: pp. 563–579., http://bjsw.oxfordjournals.org/cgi/reprint/15/6/563 (05.07.2008.)

[36] Review of Preliminary National Policy Statements on Health Care and Long-term Care, http://ec.europa.eu/employment_social/spsi/docs/social_protection/spc_ltc_2005_en.pdf (09.07.2008.)

to be put on geriatrics and gerontology (e.g. Belgium, Spain, Estonia, Hungary, Finland, Italy)
- Collaboration between hospitals to explore synergies and to create of centres of competence (Luxembourg).
- Case manager at the district level helping GP and patient to find the most appropriate care to the patient (Italy). GP plays important role in ensuring integrated care (Poland, Germany)
- Coordination between public institutions and different levels of public institutions (national, regional, local) for the provision of services including long-term care and for the development of public health initiatives (Austria, Sweden, Finland, Latvia, Poland, Ireland namely with the redefinition of responsibilities). Cooperation also between municipalities, third sector organisations, voluntary workers and enterprises in the context of long-term care (Finland, Slovenia, Poland, Germany)
- Incentives for the delivery of the right care at the right time at the right place (Netherland).

D) Patients' involvement and patients' choice

In the context of greater patient expectations and demands the role of patients is often quite limited. It is thus important to strengthen the role of patients (e.g. via increased patient choice or patient involvement in the organisation of care) so as to render services more responsive to their views / wishes and to ensure an acceptable level of quality. Moreover, more and transparent information to users is a way to promote system responsiveness. In this context Member States are considering a variety of specific policies.[37]

E) Policy examples associated with patients' choice and involvement

- Developing user friendly contact points (incl. web) with information on access, patient rights and complaining mechanisms (Sweden, United Kingdom, Portugal, Germany).
- Enlarging patient choice of provider namely by: allowing choice of GP (Denmark, Germany, United Kingdom, Latvia, Slovenia, Portugal, Austria) and, after referral, choice of specialist and hospital (Denmark, United Kingdom, Latvia, Slovenia, Portugal); allowing the use of services close to the workplace as well as near the place of residence (United Kingdom). In Luxembourg, Italy, France and Belgium patients' choice of provider is part of the system organisation. Netherlands and Slovakia are introducing choice of insurer and of provider. Finland and Italy are giving services vouchers to patients to buy home help or home nursing services from whom/where they choose in the private sector. Personal budgets help choosing long term care providers (Netherlands).
- Choice of housing and choice of personal and practical help is also envisaged in the context of long-term care and disabilities after an assessment of patients' needs (Austria, Denmark, Slovakia, Germany).

[37] SPC Health care & LTC review, final, 30 Nov. 2005. p. 20.

- Insured persons represented in the Health Insurance Institute Assembly and other public health institutes (Slovenia, Germany). Consumers represented in regional advisory and planning committees (Ireland).
- Conducting patient satisfaction surveys (Denmark, Estonia, Hungary, Malta, Finland, Italy, Poland, Germany).
- Patient rights (to health and social services) and providers' responsibilities are being established and better enforced through legislation and the development / improvement of more easily accessible complaining systems sometimes involving patient councils or mediation service or the ombudsman (Germany, Denmark, Estonia, Austria, France, Hungary, Belgium, Netherlands, Slovakia, Finland, Luxembourg, Portugal, Italy, Ireland). A report with recommendations is to be submitted annually (Belgium, Netherlands).
- Patients are entitled to injury compensation associated with treatment (Finland, Portugal, Germany).
- Community representatives are part of various committees and agencies (e.g. Local Health and Social Care Groups in the United Kingdom, Malta) providing input to the planning and design of services in their areas. More involvement of consumer organisations (Netherlands).
- Patients' advocate (for example: Germany). Patients' discussion forum (For example: Malta).[38]

III. Country sheets

Austria

1. Professional first counselling for those in need of care and their family members

In model regions of Austria the recipients of long-term care benefits granted under the Federal Act are sent a voucher for free qualified counselling by certified nursing professionals together with the administrative decision regarding their entitlement to long-term care benefit or the application receipt. This voucher can be used for services of the member organisations of the Federal Working Community for Free Welfare.

Counselling focuses in particular on providing information on outreach services, aids, social insurance coverage or administrative procedures regarding long-term care benefits.

In the Länder registered inhabitants (older than 65 years) are informed on the range of social services as well as long-term care benefits in the framework of a home visiting service which partly has been in place for more than 30 years. For migrants this service is available as from the age of 55 years.

Furthermore, upon applying for care services (home help, meals on wheels, etc.) those in need of care and their relatives are provided comprehensive counselling in a

[38] Review of Preliminary National Policy Statements on Health Care and Long-term Care, http://ec.europa.eu/employment_social/spsi/docs/social_protection/spc_ltc_2005_en.pdf (07.07.2008.)

case-management framework in counselling centres for care and support at home. These services are offered in various languages. The extensive network of care counselling centres established in some Länder offers free, objective, confidential counselling and support not related to individual care providers in all matters concerning care; concrete information and proposals are partly sent out to persons applying for benefits or benefit increases by the pension insurance institutions.

2. Care hotline – counselling for caregivers

The care hotline is available during office hours under the Austria-wide toll-free telephone number and informs on all issues in the context of care. In addition, written queries sent by fax or e-mail are answered. In individual cases advice-seeking persons also request individual counselling sessions, which are held by appointment in the Federal Ministry of Social Affairs and Consumer Protection. The Ombudsperson for Care has been available on the care hotline for answering questions on care services every Wednesday since September 2006.

3. Internet platform for care-giving family members

In addition to the care hotline, the Internet platform for care-giving family members was set up in August 2006 to meet the requirement of providing comprehensive information to help carers in their every-day lives. Careproviding relatives are informed about long-term care benefits, social and labour law provisions concerning carers, mobile social services, technical aids for care, therapies at home, courses and self-help groups, financial benefits as well as institutional further care. They are also kept up-to-date on offers to ease the strain on carers, e.g. holidays for care-giving family members, temporary care and financial aid to support care-giving relatives.

In addition, the platform provides an open forum for tips and allows the exchange of experience on home care with other carers. The platform for care-giving relatives can be accessed at www.pflegedaheim.at.[39]

Belgium

In Belgium has been established the personalized patient-centred care. Many alternatives are available for long-term patients, but for lack of information or coordination, they do not always benefit from the most appropriate supply of care and services. In fact, too often, the various sectors (residential, non-residential and temporary residential care) are walled off. Breaking down these walls is needed and this means collaborating and setting up networks.

[39] http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/austria_en.pdf (06.07.2008.)

In this sense, approved institutions referred to as "Integrated Service for Care at Home" (*Service Intégré de Soins à Domicile* - (ISD), organize multidisciplinary concertation in a care zone around a person who needs complex care. This multidisciplinary concertation gives a concrete assessment of the patient's autonomy in the context of care at home, develops and monitors a care plan and breaks down the various tasks between professional care providers in different disciplines and those providing aid. In addition, in the Walloon Region, home care and service coordination centres have the job of ensuring the best combination of healthcare in the narrow sense of the word, and services needed to keep dependent persons at home (housekeeping, family, social services etc.).

Denmark

Quality contracts: With effect from 2010, quality contracts will replace the present local authority service strategies. Quality contracts are the local council's contract with the citizen and must include clear and measurable objectives for each of the local authority service areas. The aim is for citizens to get clear information about the service level they can expect in individual local authority service areas.

Family counsellor: A bill must be presented that provides families with disabled children a right to a family counsellor who will provide information and guidance on the possibilities of getting help across sectors.

Increased free choice of aids and dwelling layout: The Government intends to extend free choice in the aid area so that citizens whom the local authority has deemed eligible for personal aids or support for disability-friendly dwelling layouts are given the opportunity to choose other personal aids and an interior design provider other than the one offered by the local authority.

Information about the possibilities of free choice: If a person needs practical and personal assistance (home help) due to reduced functional capacity, he or she is entitled to choose between various home help providers. Usually, home help users can choose between a public home help provider and one or more private home help firms. Importance is attached to ensuring that citizens know their rights, including their options in terms of free choice of provider of personal and practical assistance. Many care recipients use their free choice options; however, some are still unaware of these options. Therefore, the necessary information must be available to all citizens in need of practical and personal assistance, and it must be easy for individual citizens to receive and retrieve information.

Dissemination of knowledge about care: Comparable user satisfaction surveys in the area for older and disabled people must be conducted to support local quality development. Comparability will enable institutions that do a particularly good job to be identified. In addition, the database *Good Social Practice* has been created to collect the best examples of good practice in the local authorities.

Latvia

One of the main targets is improving coordination between health care and long term social care services. As the necessity to provide social care services is often related to the consequences of the functional disorders of the persons, in order to assess the necessity of receiving a service, the social service workers of the local governments receive information from family doctors and assess the case in correlation with other documents testifying to the necessity of the social service. In case of necessity team meetings are held between various specialists to decide jointly with health care specialists on a service provision as well as in which sequence the services should better be provided in order to achieve the best possible result.

The municipality of Riga, for example, provides a social worker post in the hospitals in Riga municipality. In 2007 14 social workers were employed at 8 health care institutions in Riga. Also other local governments in Latvia are implementing this policy. The main objective of these social workers is to ensure that after leaving the hospital the necessary social service would be provided. In 2007 5753 persons in Riga received this service provided by the social workers at hospitals, from them 2367 men and 3385 women.

Netherlands

Overview of the intended changes to the AWBZ: There will also be more freedom of choice and diversity in living. Clients should themselves be able to choose how they want to live.

Participation policy and the Social Support Act: On 1 January 2007 the Social Support Act (Wmo) came into force. Pursuant to the Wmo municipalities have become responsible for providing social support. Social support includes activities enabling people to participate in society.

The Wmo has nine performance areas. One of the nine performance areas is aimed, for instance, at offering proper information and advice, family support and provisions including aids and domestic help. The starting point for these provisions is the obligation to compensate. Municipalities are instructed to provide facilities to compensate for the restrictions experienced by people in their ability to cope for themselves and to participate in society. The facilities concerned enable people to run a household, help them move in and around the home, move locally via a means of transport and meet other people and on that basis to make social connections. In order for municipalities to achieve proper coordination of access to the application for provisions pursuant to the Wmo when applying for and indicating long-term care, municipalities are laying down rules in a regulation to this end.

Slovakia

In the interest of respecting the social services recipient's choice, the draft act explicitly lays down their right to choose the type and form (the field, outpatient, inpatient) of social services provision and their right to choose its provider. This right enables a recipient to remain in the home environment as long as they wish and to choose a social service provided in their natural environment (e.g. a nursing care service).

Sweden

The increased use of direct customer choice between private providers for home care services as well as for care in institutions in the Swedish municipality Nacka was of great interest to many experts, as was the effects on keeping a higher number of smaller private care companies interested in providing home care services in Nacka. An important precondition for real choice by consumers of care is sufficient information about the available providers and services.

"One-stop shops" could draw the information together to help users and their families to arrive at an informed choice.

It was discussed if personal budgets could be an interesting complementary instrument between informal and formal care. Personal budgets can allow individuals to use a virtual account to buy care, employ care assistants or pay for personal services suited to the person's needs. The importance of linking the provision of health services and social services more closely with each other was also highlighted.

Hungary

In Hungary long-term care does not have a separate system. The long-term care services are supplied within the healthcare and social service system. Professional policies pertaining to long-term care are basically shaped by the ministries in charge of health (Ministry of Health) and social affairs (Ministry of Social Affairs and Labour). This means that there are two separate systems with different principles.

a) Healthcare is financed by contributions paid by employers and employees and by the state budget. (mandatory health insurance system).
b) The social service system is financed from the state budget.

There needs to be a careful balance between collective and individual arrangements and responsibilities, which is not easy to achieve. Individuals can be involved in collective arrangements (through co-payments; or personal budgets) while local authorities can help people to cope independently with long-term care.

Basically, the quality of the long-term care services is the same for every person. Of course, there are some differences between the different institutions (some are older or bigger etc.) but they have to meet the same (minimum) quality standards.

There are institutions that provide services in better quality but in those cases the user has to contribute (when the service would be free of charge) or contribute more to the costs of these services.

Evaluation process

1. Evaluation of applicant's dependency in case of social services:
   When evaluating an applicant's dependency a detailed evaluation exists for home care and elderly people's home. Daily activities, social and health needs are taken into account:
   a) if the dependency level is lower (the care need of the applicant is less than 4 hours per day) the person can receive only home care;
   b) if the dependency of the person is higher (more than 4 hours per day), he/she can receive care in an elderly home.
2. Evaluation in the case of patients who have mental illness or who are living with disabilities: there is a "committee of specialists", which is responsible to offer the best for the claimant.
3. Wealth evaluation:
   The users have to contribute to the costs of services provided (co-payment). The amount of co-payment is defined according to a means-test and is different in the various institutions. The amount shall be paid on a monthly basis. Services are provided free of charge in case the beneficiary does not have an income (besides that, in the case of elderly homes: does not have a property), and does not have any relative who would be responsible and able to fulfil his/her obligation to support and care for the beneficiary.
4. Clear boundaries need to be drawn between long-term care and related schemes like subsidised housing or home-help, so that people are aware of what services they are entitled to and how this is decided.

In the social service system, when we speak about long-term care services, residential care (institutions in which permanent care is provided) is considered as part of long-term care. The maintainer of a social institution has to provide care and also residence for the service users.

Medical treatment ("cure") is not part of long-term care. Some healthcare services are considered to be a part of the long-term care (for instance: home nursing; nursing beds). Healthcare is insurance based and each healthcare service is financed from the Health Insurance Fund.

In the near future Hungary's main challenge will be probably to retain the personnel in the long-term care services. If the average income level of the long-term care services will not be higher, other branches could attain the personnel. Besides, the attraction from abroad (where the income level is higher) is also a heavy challenge for Hungary.

The restoration of the appreciation and the prestige of the professional work is needed and the support of the workers has to be strengthened. The Government handles the immediate reinforcement of the retention ability of the professional workforce as a priority.

There are some programmes facilitating the adaptation of the personnel to the changing professional environment, restoration of the reputation and prestige of the profession and the retention of the personnel in the profession.[40]

Summary

Long-term care (LTC) is one of the fastest growing segments of the health and/or social care industry. Nursing homes, originally considered the root of long-term care, are no longer the sole providers of services to posthospital, aged, or disabled patients. The stigma once associated with nursing facilities seems for the most part to have dissipated. Today it is not uncommon to discharge a patient from the hospital to some form of long-term care. Economic reality has finally overcome the hesitancy to use postacute services. Restrictions on length of stay in acute care and reimbursement issues are contributing to the growth of this niche market. The practice of case management is one way in which patients and providers are assisted in navigating through our fragmented system of health care. In LTC, case managers must be an equalizing force, balancing quality and patient advocacy with cost efficiency.

"Extended care facilities offer a level of care below acute hospitalization, in which the client still requires skilled care from licensed personnel on a daily basis.[41] Alternative landscapes for those patients requiring care after leaving the acute or tertiary care settings are being created at a rapid pace. Rehabilitation and subacute centers along with skilled nursing facilities, home care, personal and custodial care centers have all joined the family of long-term care providers. Although the majority of their client base continues to be adult, predominantly geriatric, many suppliers are now capable of caring for newborn, pediatric, and younger adult patients. Levels of care range from assisted living to complex high-tech disease management. Services offered in LTC are designed in recognition of the multiplicity of problems that can be associated with protracted illness. The inherent nature of providing extended care shifts the goal of treatment in most instances from complete recovery to resumption or maintenance of relative wellness. This is a significant movement away from the acute care model which attempts to restore the patient to a state of total wellness.[42]

The responsibility of the case manager as patient advocate cannot be emphasized enough. As managed care pushes the envelope to achieve the most cost efficient methods of care, case managers (nurses, social workers, etc.) must remain staunch supporters of quality care. The potential for abuse to the LTC population has been realized in the past. It is crucial for case managers to remain actively involved in the process of change so that appropriate care is never compromised at the expense of the patient.

[40] http://www.ecosante.fr/OCDEENG/393020.html (08.07.2008.)

[41] Suzan K. POWELL: *Case management: A practical guide to success in managed care,* Baltimore Lippincot Williams & Wilkins, 1996 (1st edition) p. 216.

[42] GERBER, L. (1994). *Case management models; geriatric nursing prototypes for growth.* Journal of Gerontological Nursing, 20(7), pp. 18–24.; LYON, J.C. (1993). *Models of nursing care delivery and case management: Clarification of terms.* Nursing Economics, 11(3), p. 165.

HAJDÚ JÓZSEF

ESET-KOORDINÁCIÓ A TARTÓS ÁPOLÁS TERÜLETÉN

(Összefoglalás)

A tartós ápolás az egészségügyi és a szociális ellátás határterületén helyezkedik el. Igénybevevői legtöbbször testi vagy szellemi fogyatékosok, idősek és egyéb olyan csoportok, amelyek támogatásra szorulnak a mindennapi életben. Az ápolásnak ezt a formáját gyakran – legalábbis részben – nem hivatásos ápolók, hanem rokonok, barátok biztosítják. Az EU egyes tagállamaiban jelentős különbségek tapasztalhatók a tartós ápolás keretében nyújtott szolgáltatásokban, a tartós ápolás szervezetrendszerében és szociális védelmi rendszerben betöltött szerepében. Ennek oka a felelősségi körök eltérő megosztása a magánszféra, a család és a közszféra között, az egészségügyi és a szociális ellátás országonként eltérő szervezeti rendszere és e két terület határvonalának különböző meghatározása.

Az Európai Unióban a tagállamok maguk végzik egészségügyi és szociális védelmi rendszereik kialakítását, finanszírozását és igazgatását. A nemzeti ellátórendszerek manapság új kihívásokkal néznek szembe: elöregedő társadalmakban élünk, ahol a betegek egyre színvonalasabb ellátást igényelnek. Az Unió ezért azt javasolja, hangolják össze a korszerűsítés érdekében tett erőfeszítéseinket. Támogatva a tagállamok saját reformjait, az Unió a nemzeti ellátórendszerek tekintetében három hosszú távú, együttesen megvalósítandó célt szorgalmaz. Ezek a következők:

- az egészségügyi ellátás és a szociális szolgáltatások könnyű hozzáférhetőségének biztosítása;
- az ellátás minőségének javítása;
- a finanszírozás fenntarthatóságának biztosítása.

E célok csak úgy érhetők el, ha minden érintett fél együttműködik megvalósításuk érdekében. A tapasztalatcsere és a bevált módszerek egymás közti megosztása jó eszköz a szakpolitikai tevékenységekkel kapcsolatos ismeretek bővítésére, a kölcsönös tanulás és a fejlődés elősegítésére.

Magyarországon jelenleg az öregségi és betegségi tartós ápolásra vonatkozó szabályozás nem egységes. Nincs önálló ápolási biztosítás. Hazánkban az ápolási, gondozási ellátást az egészségügyi törvény és a szociális törvény, továbbá az ezek végrehajtására kiadott kormány-, illetve miniszteri rendeletek szabályozzák. Fontos megjegyezni, hogy bár a törvényi szabályozás meghatározza bizonyos lakosságszám feletti tele-püléseknél a helyi, illetve megyei önkormányzatok ellátásszervezési felelősségét, a házi ápolás, illetve az egyes ellátási formák felkeresése és az elhelyezés a hozzátartozók, főként a család feladata marad.

A tanulmány a tartós ápolás (előtérbe helyezve az időseket érintő ellátási formákat) megvalósításához elengedhetetlenül szükséges eset-koordináció elméleti kérdéseit és az egyes Európai Uniós tagállamokban megvalósított jó (követendő) gyakorlatokat és módszereket tekinti át.