INTEGRATED LONG-TERM CARE IN ESTONIA:
Providing health care, nursing care and social care services

1.1 Introduction:

The Constitution of the Republic of Estonia is the basis of everyone's fundamental rights and dignity. It is up to the public authority to guarantee the realisation of these rights. Providing welfare and health services, including nursing care necessary for different age groups should also be based on these rights.
The basis of European Social Charter and Estonian elderly policy include a number of specifying provisions that assist with successful aging both in general strategic planning as well as in the field of health care and welfare. These provisions are also the basis of developing and organising long-term care for the elderly.

1.2 Current situation:

Service providers:

nursing care: there are 47 institution-based service providers; 43 home nursing service providers;

adult welfare services: there are 112 general care homes (as of 2005), 94 seniors' day centres (2004), 697 providers of domestic services.

The main reasons for problems occurring in providing nursing services is the lack of common evaluation criteria for assessing the condition and needs of the care patient (placing RAI instruments into action is dragging on), partly due to that an inexpedient use of resources in using the different service levels (we really do not know whether all the patients in nursing care homes and nursing hospitals actually need it or whether a client in a care home is not in actual fact a patient in need of nursing care), insufficient financing of nursing care services and a lack of medical competence (geriatrics).
In general there is no co-operation between nursing care and welfare service providers and no regulated organisation of work.

1.3 Goal:

On an individual level the aims of the organisation of care services and integrated care system described in the current document are achieving the best possible quality of life for people with care needs, basing the assessments on everyone's individual needs and securing coping in one's habitual environment (home) for as long as possible.

With the services provided to the elderly, the elderly with health and coping difficulties should have also have a chance to continue a decent life and actively participate in public, social and cultural life.

The macroeconomic goals of integrated care are increased efficiency of care, expedient use of expensive care services (institutional care) and development of community-based care services.

1.4 Target group:

People in need of nursing care and welfare services.
People in need of integrated care services may be from all age groups, however the majority of them are elderly people.

2. The principles and possibilities of organising integrated care in Estonia

2.1 Background:

Integrated care is one of the central keywords in today's care conceptions. This term is well explained with the definition developed in the EU project CARMEN and which the current document is based on: "Integrated care is a well organised set of services and care processes, which is aimed at solving the problems and meeting the needs of people with multiple problems or groups of people with similar needs/problems."

Integrated care includes both the health care and welfare services.

Integrated care is a client-centred, not service-centred approach to care. Integrated care is not a solution to all the care related problems, but it does help to improve the quality of life of the elderly with long-term, complex and varied problems. At the same time such care is cost-effective in the long run, it reduces the need for institutional care and hospital care and enables family members to continue work.

Integrated care can effectively work when the following principles are guaranteed:

- complies with individual needs (of an elderly)
- individualised
- multi-disciplinary
- consistency of treatment, rehabilitation and care
- common information databases for different service providers
- flexible
- smooth running
- co-operation with informal caregivers

Integration in care means foremost a process and is aimed on the one hand at the availability of different services and on the other hand guaranteeing consistency of care. The target groups of integrated care are the elderly and the disabled. Integrated care can work in different models – either as integrated organisations or networks.

2.2 Implementing integrated care in Estonia (figure 1)

At the current development level the most appropriate model of integrated care for Estonia is the model of co-ordinating network. Co-ordinating model implies that the people and institutions in the network have focussed their activities clearly on co-operation, but their ties are not necessarily very strong and the partners may change. In case of such integration the relationships are formed based on actions and (repeated) agreements.

Family physician is the key person in referring patients to nursing care services and in referring a local government's social worker to welfare services. Should a person's need exceed beyond just nursing care or welfare services, the organisation of services to the person is solved through case management principle. In this model **case manager** i.e. **care co-ordinator** takes the central position, whose aim is to guarantee the people in need a package of services that would be as suitable as possible and economic and see to it working smoothly. The surveys in several countries have

proven the advantages of case management in guaranteeing continuity in providing services and the need for institutional care has shown a decrease by up to 50%.

Case manager has special training and is competent to assess the condition and the needs of a person and welfare and nursing care services necessary. Case manager must have access to the information concerning the services provided in the country, the list of service providers and be knowledgeable about the service organising principles. Case manager is a member of the service providers' team who is in contact with the client during the entire period when the services are needed and has an overview of all the data about the client concerning the care.
For case management on a proper level there must be a database of client evaluations and information on the possibilities of the region's care institutions.

The principle activities of a case manager:

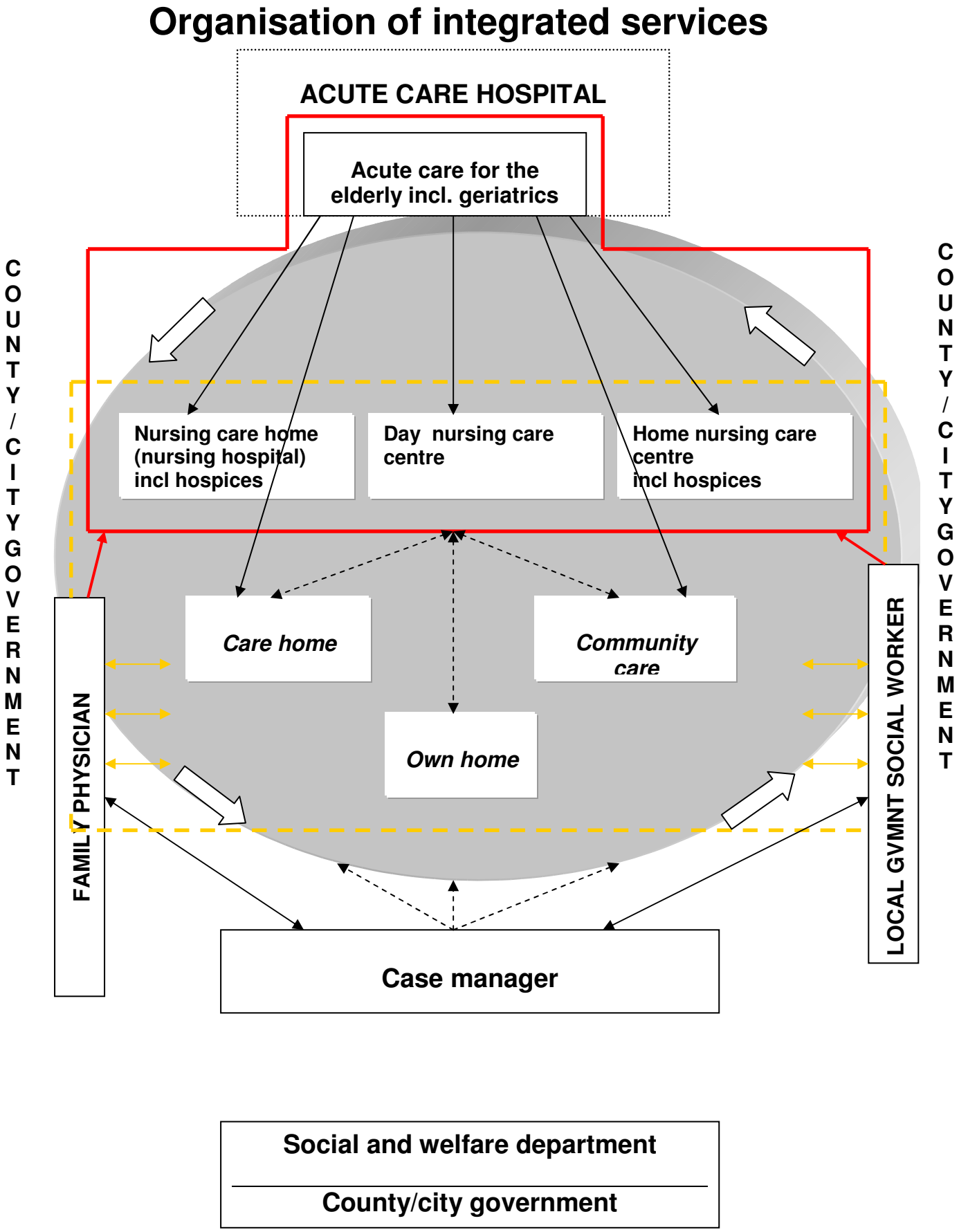
- receives information about a person in need and gets into contact with the client
- evaluates the client's needs with a recognised evaluation instrument (also uses prior evaluations if there have been any)
- if need be, uses a primary assessment team (family physician, family nurse, region's social worker) or help from the geriatrics team, family physician is a key person responsible for decisions regarding health
- plans the services (and support) package and organises the services to be provided to the client in the best possible way while following the principle of rational resource usage
- assesses the compliance between the services provided and the plan and organises re-evaluation and changes in the care plan pursuant to the client's needs
- organizes follow-up control and monitoring in his/her region
- provides services on the level of social counselling
- makes suggestions for planning and developing services

Needs assessment and referring to services can be done by the primary evaluation team (in co-operation with the region's social worker, family physician and family nurse), but the case manager must receive all the information concerning the evaluation and care plan.

In complicated cases when a person needs a more specific medical, functional and psycho-emotional assessment, an evaluation by a geriatrics team (in the geriatrics department) is carried out prior to drawing the care plan.

According to the practices already implemented in Estonia it is the best to start with case management on the county government level (also in bigger towns), which has the responsibility to organize and monitor primary health care. Central co-ordination is presumably neutral and guarantees a posteriori control and monitoring of higher quality, including the usage of finances. An alternative would be with the welfare institutions or local governments. The latter has welfare responsibility but lacks competency for monitoring each type of service.

Figure 1.


Organisation of integrated services
ACUTE CARE HOSPITAL
Acute care for the elderly incl. geriatrics
COUNTY/CITYGOVERNMENT
COUNTY/CITYGOVERNMENT
Nursing care home (nursing hospital) incl hospices
Day nursing care centre
Home nursing care centre incl hospices
Care home
Community care
Own home
FAMILY PHYSICIAN
LOCAL GVMNT SOCIAL WORKER
Case manager
Social and welfare department
County/city government

3. Principles of long-term care

Today's services system is person (client) centred and the provided services package is put together based on the individual needs with an aim to guarantee the client relative independence and an opportunity to use general public services. Long-term care for the elderly includes both healthcare and welfare services that can be financed from various sources, but providing the services has to be well co-ordinated.
The most important social welfare services for the elderly are social counselling, supplying prosthesis, orthopaedic and other technical aids, domestic services, housing services, care and rehabilitation in a care institution.
Nursing care services include nursing healthcare services that are provided as home-based, day care and institutional services.
In addition there are several services important for the elderly e.g. various rehabilitation services (including domestic rehabilitation), family physician and acute health care services, the need for which the welfare and nursing care workers have to be competent to recognize, but which will not be further discussed in the current document.

Nursing care services may prove to be necessary on all the services system levels and are added upon necessity to the service package of the welfare system, but care has to be distinguished from health service:

- The aim of care is maintaining, regaining or improving the capability of day-to-day life, either by living independently at home, being at home with domestic care or in institutional care.
- The aim of health care services is to improve, maintain or regain health or adjust to the developed health condition.

To provide both services the minimum requirements (legislation) and quality requirements have to be met. The criteria and measures for evaluating quality have to be clear, relevant, valid and measurable.

4. Responsibility

The person and his/her family have the responsibility to

- prevent the need for help,
- in case of need for help the right and obligation to participate in organising help,
- use one's own resources.

Local governments as the closest institutions to the person in need bear the principle responsibility in providing services – both in terms of organisation and resource usage (principle of subsidiarity).

The state designates in its legislation the obligations of the first level, lays down the list of minimum services, the requirements for providing services and the organisation of monitoring.

The local governments are advised to develop the guidelines for providing and developing welfare services:

- services provided on the spot
- services provided outside the jurisdiction of the local government

The volume of needed services varies and organising the availability of all the services in one local government or even county council would not be a reasonable use of resources.
It is recommended to provide the less frequent services or the special needs services in co-operation with different institutions and regions (care for the demented, rehabilitation).

It is the responsibility of the state structures to organise nursing care and it is planned and developed by the county governments (city councils). From the state and regional perspective it is expedient to consider the nursing care and welfare services in the same context of the development plans as the target group of the services is the same and the need for the services is often combined.

5. Institutions providing nursing care and welfare services and their competency

Welfare and nursing care services may be provided by institutions that hold an activity license pursuant to the current legislation. The criteria for applying for an activity license and the minimum requirements are laid down by the state.
In practice welfare services are becoming competitive services and therefore the planning of care homes and other institutions providing social services is a question of free enterprise.
Nursing care financed by the state is planned based on the size of the target group by counties, which is also the basis of financing nursing care by the health insurance fund. The new providers of nursing care services have to get a concord from the county in addition to the activity license.
When providing the service it is important to bear in mind the minimum volume of services for economic efficiency.

Community care services (home nursing, day nursing, home care, day care) can be provided by individuals (self-employed persons), independent community care units (subunits of local government's social departments, non-profit organisations, commercial enterprises based on private capital etc) or institutions providing care or nursing care services.

Below are the descriptions of institutions providing institutional services. Services can be provided in a so-called mono-functional institution, but successful operations are also such providers of different services that have joined in one centre: care centre/ health centre with a family health centre. The latter is very convenient from a client's perspective as the first level services are available in one location. A care centre can be made up of service providers located in geographically different locations.
From the point of view of resource usage it is sensible to provide several services through common administration (institutional care and nursing care, ambulatory nursing care and other combinations). Integrated co-operation based on agreements is also possible between institutions under separate administrations.

Institutional service providers in an integrated care system

Geriatrics department
Belongs to the list of departments providing specialised medical care, but functionally is tightly connected with nursing care and welfare as the patient target group is common for all of them. Geriatrics department is the centre with highest competency level of geriatrics services in the region (among the core specialists are doctor-geriatrician, geriatric nurse, health care social worker and a rehabilitation specialist).
Is located in an acute care hospital; service providing has a time limit.
Activities: diagnostics (including comprehensive geriatric assessment) and medical treatment.
Medical care, nursing aid, rehabilitation, social counselling.

Nursing home (nursing care hospital)
Operates as an independent institution / as part of a care centre / subordination of a hospital
Provides temporary and without time limit health care (including hospice) and welfare services (for the rest of the client's life if necessary): nursing aid, physiotherapy, action therapy, personal aid, accommodation, catering, social services, activating.
Does not include constant position of a physician (medical are is provided by consultants, including family physician if needed).
Service for the demented in a specialised department.

Care home
Operates as an independent institution or is connected with a care centre.
Provides temporary welfare services and services with an unlimited time.
Personal aid, accommodation, catering and social services (including activating)
Nursing care is provided as family or home nurse service (respectively either in case of short- or long-term need), in an institution connected with a nursing home the needs are satisfied by a nurse of nursing home.
Service for the demented in a specialised department.

Service home (assisted living, boarding house, home for the elderly)
Operates as an independent institution or is connected with a care centre.
Service without time limits (includes temporary service).
Adjusted living quarters, for which the client pays the user fee.
Possibility to use domestic-, personal- and catering-aid services and social services.
Nursing care as family or home nurse service, in an institution connected with a nursing home the needs are satisfied by a nurse of nursing home.

6. Proposals

6.1. Proposals for financing services

Health insurance fund finances all the acute care hospital services, the price of services also includes the social workers (health care social workers) working in health care institutions. In a nursing home the health insurance fund finances a short-term service (up to 2 months) in full, in case of long-term services the health

insurance fund finances the share of healthcare services (for the rest of the client's life if necessary).

Social welfare (local government, in the future perhaps care fund) finances the care costs (if necessary also the nursing home's social workers costs) of long-term services in nursing homes, the costs of other welfare services in the full amount.

Home nursing service description and its price are being specified – it should include the services provided by qualified nurses as well as nurses aids and carers.
It is also necessary to develop a separate price for home nursing service, which is provided to a large number of people living together (e.g. in a care home).
Health insurance fund finances the services of home nurses.

Clients' cost-sharing should be included in nursing care and welfare.
In either system the cost-sharing should not be dependent on whether the client has children/grandchildren. Differentiating cost-sharing based on the economic situation of the client should be discussed.

6.2. Proposals for organisation of service levels

Develop service descriptions, minimum requirements and quality requirements for all the care services (nursing care and welfare services) pursuant to the confirmed development plans.
Creating geriatrics department, bringing nursing hospitals into conformity with nursing home requirements.
Develop care client resource usage groups most suitable for Estonia, based on the methodology of RAI.

6.3. Proposals for creating care co-ordinator's (case manager's) service with the county/city governments

Develop care co-ordinator's (case manager's) qualification requirements and a sample work instruction. Develop the financing system for care co-ordinator.

6.4. Creating geriatrics departments

Authorise geriatrics specialty and launch the training of geriatricians.
Develop a geriatric in-patient fee per day, minimum requirements and quality requirements for geriatrics department.