



Services for the Aged at Risk of Marginalization in Estonia

State of the Art

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Introduction

Essential changes in the political, economical and social life of Estonia have been taking place during the last decade. In Estonia the rate of the population ageing is very high due to two reasons, firstly, the low birth rate and secondly, the ageing of a big wave of post-war immigrants. The development of elderly politics and elderly care are challenges for Estonian society today.

1. Demographics

Life expectancy at birth (2001): Men 64.7 Women 76.2 years.

Percentage of population older than 65 (1 Jan 2002): 15.5%.

Percentage of population older than 85 (1 Jan 2002): 1,2%.

Average monthly gross wages and salaries (2002): 374 EUR.

Average monthly old-age pension (2002): 112 EUR.

Birth rate (2001): 12 632 live births.

Death rate (2001): 18 516 deaths.

Total fertility rate (2001): 1,34.

Gender differentials (1 Jan 2002): Men 46%, Women 54%.

Percentage of single households among older persons: 30% (in Tartu).

Prognosis on further development: in 2030 19-20% of the population 65+ years old.

Immigrants: many post II World War immigrants, no problems with new immigrants.

Ethnicity among older population: Estonians 73%, Russians 22%, other 5%.

Political situation: integration of non-Estonian population into the social life of Estonia; legal status of non-citizens; referendums on joining the European Union and NATO.

Data from: Statistical Office of Estonia; Population Ageing in Estonia 1999; Study of Health and Coping of Older Population of Estonia in 2000; Survey of Seniors of Tartu in 2002

2. Pension system and allowance system

Types of state pension: old-age pension; incapacity pension and caregiver's allowance; survivor's pension; national pension.

2.1. Old-age pension

An Old-age pension is entitled to Estonian permanent residents and aliens residing in Estonia on the basis of temporary residence permits; a person is entitled to receive an old-age pension if their accumulation period or pensionable service earned in Estonia is at least 15 years; to women who are 58 and men who are 63 years of age in 2003. Within the next few years the pensionable age for women will also increase to 63.

In Estonia the three pillar pension system has been implemented.

The three-pillar pension system has been developed to conform to the pension reform conceptual basis, approved by the Estonian Government on 3 June 1997. The State Pension Insurance Act that was passed by Parliament (Riigikogu) on 26 June 1998 and took effect on 1 April 2000.

The I pillar (state pension insurance) – The I pillar is a mandatory state pension insurance based on current financing, its source of revenue is social tax and the main purpose is to provide all pensioners with a basic income level. The state pension system redistributes income (is "solitary") both inter- and intra generations.

The I pillar of the old-age pension consists of three components:

- the base amount (444 EEK, *i.e.* 28 EUR from 1 April 2002);
- a component calculated on the basis of years of pensionable service, the amount of which equals the number of years of pensionable service multiplied by the value of a year of pensionable service;
- an insurance component, the amount of which equals the sum of the annual factors of an insured person multiplied by the value of a year of pensionable service.

The average old-age pension in the year 2002 was 1758 EEK (112 EUR). In 2002 the number of people who received an old-age pension in Estonia was 298 490.

The II pillar (mandatory funded pension) – The Funded Pensions Act was passed in the Riigikogu on 12 September 2001 and took effect on 1 October 2001. The purpose of this Act was to create the opportunity for persons who have made contributions to a funded pension to receive additional income, besides state pension insurance, after reaching retirement age. The II pillar is a funded pension determined by contributions, its source of revenue is the mandatory contributions to individual accounts made by the employees. The primary purpose of the II pillar is to create supplementary savings for old age. The tasks of administering the II pillar have been divided between the public and private sector.

The III pillar (voluntary funded pension) – Pension Funds Act was passed in the Riigikogu on 10 June, 1998 and took effect on 1 August, 1998, which has been annulled by the Funded Pensions Act, since the provisions on pension funds are reflected in the

Funded Pensions Act. The III pillar is a private and supplementary pension that is based on the accumulative principle and determined by contributions. Its source of revenue is (with limited tax incentives) voluntary contributions and the main purpose is to enable additional saving.

Pension supplements

Right to receive pension supplements:

- 1) 100 per cent of the national pension rate to participants and widows and widowers of participants in the Estonian War of Independence;
- 2) 10 per cent of the national pension rate to persons declared permanently incapacitated for work as a result of a nuclear disaster, nuclear test, or an accident at a nuclear power station if the percentage of the loss of their capacity for work is at least 40 per cent;
- 3) 10 per cent of the national pension rate to participants in the Second World War and members of the Self-Defence Force.
- 4) A pension supplement of 20 per cent of the national pension rate shall be added to pensions for incapacity for work of unlawfully repressed and rehabilitated persons who have been held in a custodial institution or in exile, persons held as prisoners of war, or persons held in concentration camps or ghettos during the Second World War.

Persons who have the right to receive several of the pension supplements listed in this section shall be granted one pension supplement of their choice.

The old-age pension is calculated on the basis of the national pension rate, to which 6.4 per cent of the national pension rate are added for each pensionable and accumulation period year.

2.2. Incapacity pension and caregiver's allowance

Persons between the age of 16 and the pensionable age have the right to receive a pension for incapacity for work if they are declared permanently incapacitated for work with the 40 to 100 per cent loss of the capacity for work pursuant to the procedure established by the Government of the Republic. Permanent incapacity for work, the time at which permanent incapacity for work arises and the reason for and duration of permanent incapacity for work shall be established by a medical examination for incapacity for work, who will also declare the level of profoundness of the disability. The levels of disability:

- 1) profound disability is a loss or abnormality of a person's anatomical, physiological or psychological structure or function, as a result of which the person needs constant personal assistance or supervision twenty-four hours a day; (100 % loss of the capacity for work)
- 2) severe disability is a loss or abnormality of a person's anatomical, physiological or psychological structure or function, as a result of which the person needs constant personal assistance or supervision every twenty-four hour period; (80 – 90 % loss of the capacity for work)

3) moderate disability is a loss or abnormality of a person's anatomical, physiological or psychological structure or function, as a result of which the person needs regular personal assistance or supervision at least once a month. (40 – 70 % loss of the capacity for work)

The allowance is paid monthly to people with profound disability in the amount of 160 per cent (in 2001 on average 640 EEK i.e. 41 EUR a month), to people with severe disability in the amount of 105 per cent (420 EEK i.e. 27 EUR a month) and to people with moderate disability in the amount of 50 per cent (200 EEK i.e. 13 EUR a month) of the social allowance monthly rate.

According to the data of the Statistical Office of Estonia, there were 47,140 receivers of the incapacity pension in Estonia in 2002.

Caregiver's allowance is paid monthly to

- 1) one non-working parent raising a 3-16-years old child with a moderate, severe or profound disability;
- 2) one non-working parent or non-working step-parent or non-working guardian of a 16-18-years old child with a severe or profound disability or to a non-working caregiver or guardian designated pursuant to the Family Law Act of an 18-year old or older person with a severe or profound disability.

The caregiver's allowance is paid in the following amounts:

- 1) 75 per cent of the social allowance rate to one non-working parent raising a 3-16-years old child with a moderate, severe or profound disability;
- 2) 100 per cent of the social allowance rate to one non-working parent or non-working step-parent or non-working guardian of a 16-18-years old child with a profound disability or to a non-working caregiver or guardian designated pursuant to the Family Law Act of a 18-year old or older person with a profound disability;
- 3) 60 per cent of the social allowance rate to one non-working parent or non-working step-parent or non-working guardian of a 16-18-years old child with a severe disability or to a non-working caregiver or guardian designated pursuant to the Family Law Act of a 18-year old or older person with a severe disability.

In 2001 a caregiver's allowance was:

- for one non-working parent or guardian of a 16–18-year old child with a severe disability and the allowance for a caregiver or guardian of a 18-year old or older person with a severe disability 240 EEK, i.e. 15 EUR a month
- for one non-working parent or guardian of a 16–18-year old child with a severe disability and the allowance for a caregiver or guardian of a 18-year old or older person with a severe disability 400 EEK, i.e. 26 EUR a month.

2.3. Survivor's pension

Upon the death of a provider, family members who were maintained by him or her have the right to receive a survivor's pension. The right of the provider's children, parents and the widow or widower to receive a survivor's pension does not depend on whether they were maintained by the provider or not.

Aliens residing in Estonia on the basis of temporary residence permits are eligible to survivor's pension during the period of validity of the temporary residence permit if the right to the survivor's pension was brought into being in Estonia.

Family members who have the right to receive a survivor's pension are:

1) a provider's child, brother, sister or grandchild who is under 18 years of age (or who is under 24 years of age and is a student enrolled in daytime study or who is older if he or she was declared permanently incapacitated for work before he or she attained 18 years of age (or in the case of a student enrolled in daytime or full-time study, before he or she attained 24 years of age). A brother, sister or grandchild has the right to receive a pension if he or she does not have parents with capacity for work;

2) a provider's parent or widower who is permanently incapacitated for work or of pensionable age and whose marriage to the provider had a duration of at least five years;

3) a provider's divorced spouse who attained pensionable age or was declared permanently incapacitated for work before the divorce, or within three years after the divorce and whose marriage to the provider had a duration of at least twenty-five years;

4) one of the parents, widower or guardian of a provider's child who is not employed and is raising the provider's child, brother, sister or grandchild who is under 14 years of age in his or her family.

In 2002 in Estonia 14,017 families received survivor's pension. The number of 65 year olds and older receivers of the survivor's pension in 2002 was 1,094. The average survivor's pension in 2002 was 1,028 EEK (66 EUR).

2.4. National pension

A person has a right to receive a national pension if he or she has not earned a pension-qualifying period required for the grant of an old-age, incapacity or survivor's pension. The number of people who received a national pension in Estonia was 7,481 in 2002.

The following have the right to receive a national pension:

1. persons who have attained 63 years of age and who do not have the right to receive an old-age pension due to not having earned the required accumulation period and who have been permanent residents of Estonia or have resided in Estonia on the basis of a temporary residence permit for at least five years immediately before making a pension claim.

The pension amount is 100% of the national pension rate (867 EEK i.e. 55 EUR).

2. Persons who have attained a pensionable age who are paid the national pension on the basis of incapacity for work until the persons attain a pensionable age.

The pension amount is 100% of the national pension rate (867 EEK i.e. 55 EUR).

3. Persons who are declared permanently incapacitated for work, the percentage of whose loss of capacity for work is at least 40 per cent, who have not earned a pension qualifying period required for the grant of a pension for incapacity for work and who have been permanent residents of Estonia or have resided in Estonia on the basis of a temporary residence permit for at least one year immediately before making a pension claim;

A national pension to people permanently incapacitated for work is a percentage of the rate of national pension corresponding to the loss of the person's capacity for work.

Depending on the percentage of the loss of capacity for work the amount of the national pension in the case of permanent incapacity for work is as follows:

loss of capacity for work 40% x 867 = 347 EEK (22 EUR);
loss of capacity for work 50% x 867 = 434 EEK (28 EUR);
loss of capacity for work 60% x 867 = 520 EEK (33 EUR);
loss of capacity for work 70% x 867 = 607 EEK (39 EUR);
loss of capacity for work 80% x 867 = 694 EEK (44 EUR);
loss of capacity for work 90% x 867 = 780 EEK (50 EUR);
loss of capacity for work 100% x 867 = 867 EEK (55 EUR).

3. Description of services – review of databases

3.1. Health care services for seniors

3.1.1. Health care reforms in Estonia over the past decade

Since Estonia regained its independence in 1991 there have been two major health care reforms, the third is almost complete and the fourth is being planned. The first two – a decentralisation of national health care administration and the establishment of solidary health insurance – were effected in the years 1992...1994. The direction adopted during the third reform that started in 1997 was first contact care and the development of public health care; by 2003 the transfer to family physician care was practically complete. The next stage is organising the hospital system, where in order to ensure the quality of health care, high-tech health care is concentrated in the reorganised large hospitals and a care and after-care system is established where the development in Estonia so far had been uneven and uncoordinated.

The management and planning of health care in Estonia is the responsibility of the Ministry of Social Affairs, except for in the Defence Forces and penal institutions. The Health Insurance Act effective since January 1, 1992 started the financing of health care based on the principle of solidarity, which covers almost 95% of Estonian residents. Compulsory health insurance covers 80...90% of the health care costs of insured people. These two reforms created a situation, where the overwhelming majority of Estonian residents have equal financial access to all medical care services and the health services are paid for based on common principles from resources guaranteed by the state.

Voluntary health insurance has been available since 2002, but is still not widespread. Private medical services, where the patient pays for the whole service or the payment is a combined payment by the health insurance fund and the patient, are used far more frequently.

3.1.2. In Estonia health care is regulated by the following acts:

Health Care Administration Act
Health Care Services Organisation Act
Public Health Act
Health Insurance Act
Estonian Health Insurance Fund Act
State Pension Insurance Act
Pension Funds Act

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Social Tax Act

Accumulation period accounting instructions

Insurance Act

3.1.3. Health care services financing

Only those people who have state health insurance receive medical care fully financed by the health insurance fund. This includes all employees from whose wages the social tax is withheld, also pensioners, invalids, the registered unemployed and children. This aid includes health care costs of the insured persons for the prevention and treatment of illnesses, the purchase of drugs and medicinal products and payment for temporary incapacity for work and other damage to health related compensatory allowances.

In monetary terms the share of health care expenses has stayed stable at around 6% of the gross domestic product (GDP) over the last decade. This is slightly less than in the EU countries, where the health care expenses form 7...9% of the GDP, but is on a par with the other applicant countries. However, in absolute figures the money in health care has increased by many times in the past few years. The budget of health insurance was EEK 1.05 billion (EUR 67 million) in 1993 and EEK 4.91 billion (EUR 314 million) in 2002. The private sector's share in financing the running costs of health care in 2001 was 22.5% and the local government's share was 2.1%.

The resources for health services in 2002 were divided as follows: 62% to health services, including 8.5% to general medical care and 47% to specialised medical care, 16% to drugs.

The health insurance fund pays the insured for hospitalisation. Hospitals have the right to charge the sick persons extra for up to 10 days in treatment (usually EEK 25 per day, i.e. EUR 1.6). This charge can not be claimed from persons in intensive or nursing care. In the case of ambulatory care adults as a rule have to pay a small visit fee (EEK 5-50 i.e. EUR 0.3-3.5). The greatest public expense is for dental care and the purchase of drugs. Patients have to pay most of the dental care costs and for approximately half the price of prescription drugs at a chemist. The cost of making dentures is compensated for seniors once per three years and they can get certain drugs at a bigger discount than working-aged people can. The expenditure on prescription drugs formed 75% and the expenditure on non-prescription drugs formed 25% of the total expenditure on drugs bought at the chemist in 2001. The health services costs for people older than 65 years old form 29% and the subsidised drugs expenditure forms 42% of the total respective spending.

Emergency health care of the uninsured people is paid for from the state budget resources via the local governments; the rest of the health care costs have to be paid by the uninsured themselves.

3.1.4. Types of health care services

Pursuant to the Estonian legislation, health care services are divided into general medical care and specialised medical care (the latter also includes dentists). In addition to the above there is emergency medical staff for emergencies.

General medical care

General medical care is ambulatory, i.e. a health care service provided outside the in-patient unit of the hospital by family physicians and health care professionals working with him/her. Family physicians provide general medical care in a consistent manner,

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organise care and treatments that prevent illnesses to all the persons on the practice list of the physician. In case of an acute illness the sick person has to be able to get to the family physician's consultation on the same day, in case of a chronic illness within three days. Family physicians also make home visits and consult people over the phone. At the moment there are over 700 family physicians in Estonia.

People can select the family physician on whose list they would like to be registered. Family physician can be changed once a year. In case a person, who has a national health insurance fund insurance has not been registered on a family physician's list, he/she will be appointed to a family physician based on the regional principle.

The financing of a family practice doctor is done in the following components:

1. base fee;
2. capitation fee;
3. additional remuneration;
4. health service compensation.

1. The base fee is a certain annual fee that is paid to family practices on a monthly basis. The base fee is meant for the following expenditures: the purchase of equipment; information technology costs (hard- and software and maintenance); the purchase or rental of a car; annual training of a doctor and a nursing professional working with him/her at least in the scope specified in the work instructions of family physicians. The base fee in 2003 is EEK 5,290 (EUR 338) per month.

2. Capitation fee is a certain sum per person per month approved by the minister of social affairs, that includes work on fostering health and preventing illnesses and from which the family physician covers the costs of the practice, the salary of the nurse and all taxes. The capitation fee depends on the age of the registered person and in 2003 is EEK 27.55 (EUR 1.8) per 0 to 2-years old per month, EEK 21.05 (EUR 1.3) per 2 to 70-year old (1.3 EUR) and EEK 24.60 (EUR 1.6) per over 70-year old per month.

3. The additional remuneration for the distance of the practice is a certain sum per month that is paid to the doctor depending on the distance of the nearest health institution providing the medical basic examinations at the 2nd or 3rd stage and specialised consultation. In 2002 the additional remuneration for the distance of 20-40 km between the practice and the specified health institution was EEK 700 (EUR 45) per month, practices that were located further than 40 km away were paid EEK 1,400 (EUR 90) per month.

4. Health service compensation is paid for the health care provided to the insured people, which is not included in the capitation fee.

The work of family physicians with senior patients *(based on the data of Study of Health and Coping of Older Population of Estonia in 2000)*

In 2000 the practice list of a family physician on average contained 1,902 persons (2,105 in urban, 1,462 in rural areas), out of whom 18% were 65-years old or older (on average 351 persons). On average 33 persons on a family physician's practice list need regular home visits. Seniors' visits formed 39% of the total number of visits, home visits to senior patients formed 43% of all home visits (thus about 2.5 times the share of the seniors on the list). Approximately 14% of the registered seniors visit their family physician once a year or not at all, 15% of seniors need health care from their family physician more than ten times a year.

The most often mentioned additional problem of treating the seniors in comparison with younger people is increased time (76% of the doctors), difficulties with organising home nursing (61%), lack of social support (59%), difficulties with appointing patients to hospitals (38%), difficulties with diagnosing due to the appearance of several diseases (37%), low motivation of patients (25%), difficulties with appointing patients to a specialised doctor's consultation (24%), more frequent side-effects of drugs (13%). Communication difficulties with senior patients was generally not a problem (it was mentioned only by 4% of the doctors).

Out of the medical rehabilitation services available, the family physicians missed home medical rehabilitation most – just 16% of family physicians thought the service to be available. Other medical rehabilitation services (in the general hospital, rehabilitation unit, long-term treatment hospital, sanatorium or ambulatory) are available to the seniors in the eyes of approximately half of the family physicians in Estonia.

Practically all the family physicians (99.5%) regarded the services of geriatric aid (is not yet available in Estonia) as necessary. 45% of the family physicians would use the services of an in-patient geriatrics unit, 42% would use geriatric consultations and 12.5% would use geriatric services in a long-term treatment hospital and nursing home.

The work of family nurses with senior patients *(based on the data of Study of Health and Coping of Older Population of Estonia in 2000)*

On average family nurses spend a third (33%) of the reception time on the seniors. A nurse makes regular home visits to an average of 15 senior patients. In a single month a nurse makes an average of 18 home visits to senior patients. One home visit takes on average half an hour. On average there are 11 non-ambulatory senior patients in a region. Nurses deal with the following activities during the reception of the senior patients: 92% of the nurses do treatment and basic nursing care procedures, 90% assess the functional situation (blood pressure, vision, hearing etc.), 77% give health consultations, 69% have independent reception for patients with less serious illnesses, 68% give health fostering consultations, 67% train the family members of the senior patient on nursing, 64% assess the necessity for basic nursing care, 60% draw up documents, 59% teach the use of medical devices, 58% teach the more simple medical rehabilitation steps, 43% assess the coping with everyday life, 37% assess the necessity for care.

The most often mentioned additional problem of treating the seniors in comparison with younger people is the larger amount of time spent, which was mentioned by 77% of the nurses, 54% mentioned difficulties in organising basic nursing care at home, 49% the lack of social support and a weak support network, 13% communication problems and 10% low motivation of the patient.

Specialized medical care

Specialised medical care is an ambulatory or in-patient health care service provided by a medical specialist or stomatologist and health care professionals working with him/her. In Estonia the list of medical specialists contains 33 specialities. This list is the responsibility of the minister of social affairs. Geriatrics is not on the list of medical specialities in Estonia and there are no geriatric specialist aid services. The people with an illness can go to a medical specialist's reception financed by the health insurance fund with a referral from the family physician, as an exception people can go directly to the

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reception of a psychiatrist, gynaecologist, dermatovenerologist, eye specialist, lung specialist, stomatologist and in case of traumas to a traumatologist or a surgeon. In the case of self-financing a person can turn to a medical specialist without a referral from the family physician.

Recently the queues to the medical specialists have increased sharply. For example in April 2003 the queue to a gynaecologist in Tallinn was 21 days, the queue to an eye specialist was 11 days, to a stomatologist 26 days and to a cardiologist 7 days.

Day-time in-patient medical unit

A day-time in-patient medical unit is a unit in an ambulatory or in-patient medical institution, where day surgery and treatment procedures are performed that require the hospitalisation of a patient for 6 to 12 hours. This is for example for hemodialysis and peritoneal dialysis patients, for otorhinolaryngology, head and neck surgery and gynaecology.

The share of day-time in-patient medical units in the running costs of health care is small, in 2001 it formed just 1.3% of the total hospital costs.

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Hospitals

Hospitals are divided in Estonia as follows: regional hospital, central hospital, specialist hospital, general hospital and nursing hospital.

In 2001 the share of over 65-year old patients in hospitalisation was 33%. Admission to a hospital is based on a referral by a doctor (mostly a family physician or an emergency doctor). A person with an acute illness can go to the hospital reception without a referral. The average hospitalisation in the first half of 2002 was 6.6 days.

In 2001 the hospital costs formed 30% of the total running costs of health care.

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Nursing care

Nursing care is mostly provided in nursing hospitals or nursing units.

One can be admitted to a nursing hospital based on a referral of a doctor and the health insurance fund pays for the insured patients for up to 60 days of nursing. A longer stay in the nursing hospital is possible in case of vacancies and it has to be paid for by the client/the client's family. The cost of one day in a nursing hospital in 2003 is EEK 233 (EUR 15). There are regions where there is no waiting period for the admission to nursing care, but for example in Tartu in 2001 the waiting period for nursing care was up to 90 days.

The share of long-term nursing care formed 2.8% of all hospital expenses and just 0.8% of the total health care costs in 2001.

In 2002 the home nursing service was started in Estonia. The service is financed by the health insurance fund and the price of the service in 2003 is EEK 146 (EUR 9). Initially the supply of the service is very limited as the re-training in home nursing started only in 2002.

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Medical rehabilitation

Medical rehabilitation is provided in hospitals, ambulatory and in sanatoriums. The daily cost of medical rehabilitation in hospitals is EEK 286-462 (EUR 18-30), the daily cost of ambulatory medical rehabilitation is EEK 154 (EUR 10). The availability of medical

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rehabilitation services is quite limited and often the clients have to pay for it themselves. The health insurance fund does not finance home medical rehabilitation. In 2001 the in-patient medical rehabilitation costs formed 3.3% of hospital costs and ambulatory medical rehabilitation formed 0.9% of the total ambulatory treatment costs, in total the medical rehabilitation costs formed 1.3% of the total health care costs.

3.2. Social services

The principles of social welfare in Estonia are:

- 1) acknowledge human rights;
- 2) a person's responsibility for oneself and one's family coping;
- 3) a commitment to help if the possibilities of the person and the family are not sufficient to cope;
- 4) developing the ability of the person and the family to cope.

The task of social welfare is to provide help in preventing, eliminating or alleviating the difficulties of a person or a family and to assist a person with special needs to achieve social security, development and adaptation into society.

The following persons have the right for social services, social benefits and other support:

- 1) permanent residents of Estonia;
- 2) aliens living in Estonia on a legal basis;
- 3) refugees staying in Estonia.

Every person staying in Estonia has the right to emergency social care.

Social service is a non-monetary support fostering the coping of a person or a family.

Pursuant to the Social Welfare Act, a social service is:

3.2.1. Social counselling – Social counselling is giving a person necessary information on social rights and the possibilities of the protection of lawful interests and helping to solve a concrete social problem in order to improve future coping. A social counsellor is a social welfare professional who has received special training for this job. Social counselling is organised in a rural municipality or a town by a respective rural or town government.

3.2.2. Giving prosthetic, orthopaedic and other appliances

A person who needs a prosthetic, orthopaedic or other appliance due to an illness, old age or a disability has the right to receive a respective appliance. It is within the competence of the minister of social affairs to determine the list and the rules and regulations for obtaining the prosthetic, orthopaedic and other appliances at a discount. The appliances include basic nursing and caring appliances, orthopaedic and prosthetic appliances, mobility support devices, hearing and vision aids, and entertainment devices (the latter was received by one person in 2002). In comparison with 2001 the number of people needing basic nursing and caring appliances, orthopaedic and prosthetic appliances and vision aid grew in 2002 (respectively by 860, 420 and 35 persons). The number of people

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who have received mobility support devices and hearing aids has decreased (respectively by 955 and 13 persons). Most of the people who received technical aid in 2002 were still seniors – 13,537 persons, i.e. 62.4% of the total number of people who received technical aid. Most of the technical aid is not free for the clients, but at a discount.

3.2.3. Domestic services

Domestic services are services provided at the client's home, that help him/her to cope in their familiar surroundings. Domestic services are first and foremost provided to those families with children, disabled persons and seniors, whose coping depends on personal assistance.

Local governments determine the list of domestic services and the terms and conditions for rendering the services. In 2002 domestic services were provided to 5,964 people in need, of whom 2,927 i.e. 49% were disabled. The majority of consumers of the domestic services are women – 73.8% of the total domestic services consumers. In comparison with 2001 the number of domestic services consumers has increased in 2002 (by 411 persons i.e. 7.4%). In particular the share of disabled people has increased among the service consumers (by 558 persons, i.e. 25.1%).

The biggest consumers of home services were senior people, at the age of 65 and older, who do not cope with their everyday life without personal assistance. There were 4,699 receivers in that age, forming 78.8% of the total number of domestic services consumers, which is slightly over 2.2% of the 65-years old and older population.

In order to apply for domestic services the client has to turn to the social assistance of their respective district. Thereafter, a domestic services specialist from the social welfare department visits the client at his/her home. There, the state of health and living conditions of the client are established. Together they will determine the types of services the client needs and how frequently the welfare worker should visit the client. When appointing the welfare worker the client's place of residence is taken into account. The agreements are confirmed with a domestic services rendering contract for one year. Thereupon the contract is reviewed in compliance with the needs and if necessary the domestic caring is continued based on the new contract.

On average a domestic care worker visits the client 2-3 times a week. The customary tasks include various maintenance and food-related services. In case of stove heating the client is helped with bringing in the firewood and heating the stove. Usually the domestic services are paid for by the local government, but in the case of seniors only to the childless seniors. In the case of children or grandchildren it is up to the local government to decide on whether and on what terms and conditions the senior can receive domestic services.

In 2002 there were 1,497 people in Tallinn who received domestic services (2.6% of the seniors, 65-years old and older Tallinn population), 281 people in Tartu (1.7% of 65-years old and older Tartu population). The most highly demanded services included:

- 1) taking orders, buying and bringing home food products and primary household items;
- 2) organising the payment of utility costs;
- 3) housing cleaning service, including taking out refuse, wiping and washing the floors, dusting;
- 4) buying drugs;
- 5) talking to the client and forwarding information, including listening to the client,

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forwarding information and legal counselling;

6) helping with housecleaning, including organising window cleaning, changing curtains. Additionally a service of bringing ready-made food home is provided. There are over 200 consumers of this service in Tallinn, 25 in Tartu and the number of clients is on the increase. The clients are brought home warm food on average three times a week. There are many more people who would like to receive this service than it is possible to supply at the moment.

3.2.4. Housing services

The local governments are obliged to supply those persons or families with housing who are unable to provide it for themselves or their families, and if necessary create an opportunity for them to rent social housing. People who have difficulties with mobility in their living quarters, coping or communications are assisted by the rural or city government with customising their current accommodation or getting a suitable accommodation. The tenant pays for the housing expenses related with using social housing. The following examples are the established requirements for receiving housing services in the two biggest cities in Estonia.

In Tartu those residents can apply for social housing as a housing service, who are unable to provide themselves or their families accommodation due to inadequate physical capability or mental special needs or who can not provide the accommodation to themselves or their family due to their material status.

In Tallinn the following permanent residents can apply for social housing: seniors living on their own and senior couples, people with a disability who do not have a statutory caregiver, who need personal assistance, who live in an accommodation restituted to the owner, who live in a residential building in danger of collapse or restricted in habitability, or in whose accommodation it is impossible to organising caregiving. In addition the least privileged families and families with problem children permanently living in Tallinn can apply for regular social services, including child welfare.

Social housing can also be applied for by people who are not permanent residents of Tallinn, who have returned from children's home, special or reform school, who were permanent residents of Tallinn before being referred to a children's home or a special or reform school and persons released from a custodial institution, who were permanent residents of Tallinn prior to being sent to a custodial institution.

3.2.5. Care in a family

Care in a family is caring for a person in a suitable family he/she is not part of. The care in a family is based on a written contract between the rural or city government and the caregiver.

The obligations of a caregiver to the person under care are stipulated in the order by the Tartu City government:

1. From the date the Tartu City government order of appointing a caregiver enters into force the caregiver is to take the person specified in the order under care.
2. Provide personal assistance to the person under care, who cannot cope with eating, hygiene procedures, dressing, moving around and communicating.
3. Ensure the safety of the person under care if the person might cause harm to one's own or others' life, health or property by his/her activity or inactivity.

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4. Notify the care's supervisory agency (the social assistance department of Tartu city government) of any problems arising from the care.
5. Notify the supervisory agency of the termination of the need for caring, the circumstances that make further caring impossible, the death of the person under care.

3.2.6. Care and rehabilitation in welfare institutions

A welfare institution is a day or a twenty-four hour institution, where the persons staying there are ensured care, including treatment, basic nursing care, rehabilitation, raising and development corresponding to their age and status. A day welfare institution is an institution that fosters the independent coping of the person or his/her member of the family by providing day care. Twenty-four hour welfare institution is an institution, where the people staying there are unable to live independently due to special needs or social situation and their coping can not be ensured by other social services or providing other support. The cost of a place in Estonian care homes varies between EEK 3,500 and 7,000 a month (EUR 225-445). The cost of a place is divided into caring and nursing costs. In 2001 there were 97 general care homes and 20 special care homes (for clients with mental problems) in Estonia. In 2001 there were 3,356 clients in the general care homes and 2,469 in special care homes.

Welfare institutions are state or local government institutions, public law or private law legal persons or their agencies. State welfare institutions can be residential educational institutions, social rehabilitation centres and special care homes.

The types of welfare institutions

Welfare institutions for adults include:

Day centre (senior centre)

An institution providing day care and recreational activities, in 2000 there were 65 day centres in Estonia. The activities of day centres for the seniors have three directions: recreational activities, providing social services and bigger one-time events. The recreational activities in the centres are free of charge or for a small fee. These include singing and dancing clubs, handicraft and sewing hobby groups, exercising, language learning, panels, hiking, etc. The services provided in the day centres are free of charge or at a discount. The services and prices vary in different centres. Borrowing books, the possibility to read newspapers and magazines, watch television, get legal and social counselling and a records management service is free of charge at the centres. In many places there is access to a medical nurse, taking blood pressure, concerts, coping courses, distribution of second hand clothes, Question Time, photocopying, etc are also free of charge. The following services are at a discount in the day centres: hairdressing, manicure, massage, sauna, washing laundry, alimentation, petty maintenance of household appliances, mending clothes, etc.

Support home

An institution providing day or periodic twenty-four hour care to disabled people living at home;

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Asylum

An institution providing temporary twenty-four hour aid, support and protection;

General care home

An institution, where seniors and disabled people can live, are cared for and rehabilitated;

Example:

Iru Care Home is a 385-place general care home, where 35 are for the paying clients and 350 places for seniors, who do not have statutory maintenance providers and who are unable to pay for the cost of living themselves. The care home has a 40-place unit for the demented seniors.

When a person registers to live in the care home, he/she assumes the obligation to pay either in full or partially for the maintenance expenses. For these purposes the person has to pay the care home at least 85% of the monthly pension or other income, but not more than the confirmed care cost.

The fee-charged places are divided into full-fee and town-participation places. A client is put into the fee-charging department either permanently or temporarily based on the application of the client (or a representative) or the decision of a referral commission.

Day care: Seniors have the opportunity to spend up to 12 hours per day under supervision use the services provided.

Interval care: Seniors have the opportunity to be monitored from one twenty-four hour period to an agreed time and use the services provided should they wish or need to do so. This service is suitable for families, who plan a vacation and whose senior relative could be under short-term care while the family is away.

Iru Care Home provides the following services: care, basic nursing care, giving medical assistance, catering, recreational activities, movement exercising under specialist supervision, massage, technical aid, counselling

Social rehabilitation centre

An institution for active rehabilitation of people with special needs; special care home – an institution where persons of unsound mind and serious mental disability can live, are cared for and rehabilitated.

3.2.7. Other social services needed for coping

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Personal assistance service

Personal assistance service fosters a person's active participation in the society and coping with everyday life. Personal assistance service is available in Tartu to people with severe physical disability and people who are severely visually impaired. Personal assistance is a paid worker, who assists the person with a disability according to their contract physically in everyday activities that the client can not cope with independently due to the disability. A personal assistant proceeds from the specific needs and job instruction in the case of each individual client.

Services provided by a personal assistant:

- assistance with mobility;
- assistance with eating;
- assistance with dressing;
- assistance with communication (in the case of a client with a severe speech

impairment);

- assistance with hygiene procedures;
- assistance with reading and writing;
- assistance with tidying the work space.

The service is financed from the town budget. The client's contribution is EEK 2 (EUR 0.13) per one service hour.

The seniors' associations

In 2001 out of the non-profit associations, religious societies and foundations registered in Estonia 130 were linked with pensioners, unlawfully repressed and/or war veterans. A total of 390 societies were active in welfare. Voluntary associations offer opportunities that support the everyday activities of seniors in addition to providing possibilities to maintain an active attitude to life. The majority of voluntary associations aimed at the seniors are engaged in forwarding information, offering cultural events and entertainment, but there are also associations that support and supplement the services aimed for the seniors.

Examples

Seniors' Self-help and Counselling Association – a voluntary seniors' day centre, that offers the seniors self-realisation and participation opportunities in hobby club activities and supporting each other

Disabled Ex-Medics' Association „Mercy“ – the association operates on the principle „senior helps senior“, uniting the former medical workers, who assist the seniors through domestic care and records management.

Estonian Pensioners' Association – organises cultural events and the fight for an increase in pensions has become an important issue.

Estonian Geriatrics and Gerontology Association – the main goal is to improve the knowledge on ageing among the professionals working with the seniors and in the society

Information sources:

Statistical Office of Estonia homepage www.stat.ee

Social Welfare Act

Pension Act

State Allowances Act

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4. Welfare and health care services aimed at the seniors in Estonian counties. Qualitative survey

The goal of the survey

The goal of the current paper is to examine the health care and social services and services for seniors living at home (including day centres, domestic care etc) provided in Estonia for seniors and for the families providing care to the seniors; what are the conditions to receive these services, what are the biggest problems and what are the possibilities to further develop the situation.

The sample

There are 15 counties in the Republic of Estonia. The specialists of the respective field from the two counties located on the islands were excluded from the current sample. When compiling the sample the authors followed the principle that the sample would include the social field specialists from each county government and additionally from two bigger towns. If necessary several people were involved from one county (group interviews), since in many county governments health care and social welfare problems are handled by different people. The target group was formed of voluntary specialists, according to the proposals of the counties' social field managers.

The sample includes 14 experts. The experts' average length of employment in the area is 8.5 years.

Research method

The current survey was carried out using qualitative method. For the collection of data semi-structured interviews were used, where the survey outline was planned by topics and key questions. The outline comprised of four main topics: social assistance and health care services in the respective counties, future perspectives and co-operation on several levels. The interview was planned by topics, but the phrasing of the topics and the sequence was free.

The collection of data and analysis

The survey was carried out in the period 01.04.2003 – 30.04.2003, during which 14 interviews were conducted. 11 of the interviews were individual, 2 were group interviews and one was made in written form. The interviews were conducted in the participants'

offices at a previously agreed time. The authors were granted an informed consent from all the participants. Before the start of the interview all the interviewees were introduced to the conditions of the interview: the goal of the research, confidentiality principle and the usage of the interview in the research process. The duration of the interviews varied between 40 minutes and 2 hours. The interviews were recorded on a dictaphone tape and later a word-to-word transcription was conducted.

The interviews were conducted and coded by Kristina Oja and Sirli Soots, in addition to the interviewers Kai Saks participated in analysing the data.

Before the start of the interviews there was a pilot interview with one expert in order to determine the adequacy and objectiveness of the topics to solve the given research tasks.

The data collected during the research was used following the grounded theory and cross-case methods.

Results

Analysing the data using the above-specified methods, the following main and subcategories transpired:

Main category I: Health care services

Subcategories: I₁: Family health care
I₂: Hospitalisation
I₃: Nursing care
I₄: Home nursing
I₅: Subsidised drugs and technical aid
I₆: Rehabilitation
I₇: Special medical care
I₈: Special services for the demented

Main category II: Welfare services

Subcategories: II₁ Domestic care service
II₂ Counselling service
II₃ Day centres
II₄ Care home service
II₅ Welfare services for the demented
II₆ Temporary care
II₇ Social housing service
II₈ Sauna and shower service
II₉ Laundry service
II₁₀ Meals on wheels service
II₁₁ Possibility to eat under favourable conditions
II₁₂ Discounts for technical aid
II₁₃ Customised accommodation service
II₁₄ Asylum service
II₁₅ Transport service

Main category III: Conditions for receiving a service

- Subcategories: III₁: Who refers
III₂: How is it decided

Main category IV: Acknowledged problems

- Subcategories: IV₁: Transportation problem
IV₂: The demented with the non-demented seniors
IV₃: Information and training problem of the caregivers
IV₄: Severe health condition (clients of care homes)
IV₅: Lack of cooperation
IV₆: Waiting lists
IV₇: Fast ageing of the population
IV₈: High cost of a place in a care home

Main category V: Possible solutions

- Subcategories: V₁: Financing from different sources
V₂: Providing services for seniors living at home
V₃: Developing a cooperation network

Main category VI: The role of the family in caring for the seniors

- Subcategories: VI₁: The importance of children in receiving the service
VI₂: Own contribution
VI₃: The basis for determining own contribution

Main category VII: Non-local governmental support structures

- Subcategories: VII₁: The role of the private sector is small or missing
VII₂: The role of the volunteers
VII₃: Assistance from the family and friends

Main category VIII: Readiness for cooperation

- Subcategories: VIII₁: Cooperation between the family physician and the social worker
VIII₂: Inter-agency integration
VIII₃: Gap between the health care and welfare services on a county level
VIII₄: Social counselling in hospitals
VIII₅: Interdisciplinary assessment
VIII₆: Networking

Main category IX: Vision for the future

- Subcategories: IX₁: The development of services for the seniors living at home
IX₂: Implementation of reforms
IX₃: The geriatric assessment of the situation
IX₄: Development plans

Main category X: Availability of information

Subcategories: X₁: Community and town newspapers
X₂: Other people
X₃: The local government, family physicians and social counselling
X₄: The Internet

Main category XI: Support for the families

Subcategories: XI₁: Single allowances
XI₂: Possibilities for temporary care (with own contribution)
XI₃: Training and information

The main categories are built deductively (extracted from generalisations). The subcategories are derived by extracting similarities and differences from the database, i.e. inductively (from single to general).

Data analysis

Main category I: Health care services

I₁: Family health care

The availability of family health care to seniors was regarded generally as good in all counties. However, several interviewees brought out the availability problems in the peripheral areas of the rural municipalities, but also problems incurred with the cost of home visits and the efficiency of health care. For example that the doctor does not have a command of the Estonian language or does not send the patient to be examined.

R: *Family physicians are overloaded with work and they do not make home visits ---. Other than that seniors often cannot afford home visits as they cost EEK 50. --- now when there is a need, the family physicians and family nurses do not come to the home of a client. A care worker contacts the family physician, but the family physician does not react to the necessary extent (R7).*

R: *In the rural areas the seniors are scattered around groves and family health care does not reach there, --- and thus the seniors are dissatisfied that family physicians do not make home visits (R11).*

R: *Yes, we do have family physicians ---, our problem is that most of our doctors are Russian-speaking --- the ones who were more active and had a good command of Estonian were among the first who went studying, but of course many do have difficulties, --- (R12).*

R: *Seniors --- complain that the doctors do not send them for a procedure or an analysis of one kind or another ---. (R6).*

I₂: Hospitalisation

Hospitalisation is possible in all counties. Several expert opinions reflected a concern about the future continuation and quality of hospitalisation on a county level.

R: *Using the health insurance fund, people can go for examinations to Tartu or Tallinn where the possibilities are better. --- this is a great advantage. I have heard that it is very difficult in some counties, but we do enable that (R11).*

R: *--- the future of the hospital has been unclear for a while already, which services will it be providing, what will and what won't remain here. --- that smaller problems and illnesses that often go hand in hand with ageing would be solved on the county level. (R3).*

I 3: Nursing care

The situation in nursing care varies by counties, in some places the number of places is sufficient. Most of the interviewees bring out the following problems: the lack of bed places in nursing care and limited period for being under nursing care (maximum of 60 days). The patients are written out of the hospitals too early or they are not taken under the nursing care at the right time.

R: *There are nursing hospitals in the northern and southern region of the county, which means that the patient stays near the home. And the local governments play a part in nursing care; they have made nursing bed contracts with the hospitals to assist the seniors who do not have relatives or could not cope by themselves (R5).*

R: *Since our small hospitals were turned into care homes already years ago we don't have nursing hospitals any more (R10).*

R: *The number of nursing care and long-term treatment bed places is insufficient, the health insurance fund does not finance providing long-term and nursing care in sufficient amounts. (R14).*

R: *--- people are there in active treatment --- and the after-care possibilities are so slim --- then the patient goes home where the network and team ought to be waiting --- but seniors go back to their farm houses --- and nobody helps them there --- and they remain helpless. --- this intermediate stage is very important before the senior returns home. --- then they are well enough to cope on their own. At the moment they don't (R8).*

I 4: Home nursing

Home nursing is a new service in Estonia. A home nursing service has been available for a longer period (2 years) only in two regions; in the majority of regions the service has just been started or is being started. In four out of the questioned counties the service has not been started yet.

R: *Home nursing is a highly demanded service and it is doing very well. People are very satisfied with it, both families and seniors --- who are provided the service, but also family physicians, everyone is pleased with it (R7).*

R: *Since April 2002 the home nursing service is provided by the nursing department in cooperation with the city government, who pays for the service, the service is free for the receivers. The home nursing service is not available in the rural municipalities (R14).*

R: *There are plans of introducing the service, but it is unclear as of now when it will get under way, but we already have the nurses who are willing to provide the service (R11).*

R: *As far as I know we do not provide this service (R13).*

I 5: Subsidised drugs and technical aid

The interviewees mentioned technical aid both talking about the health care services and welfare services. In our analysis we will also cover the technical aid related topic in the context of both types of services.

The interviewees regarded the availability and compensation of technical aid and drugs as very important for the seniors and the local government participation in it as normal. Several respondents did say, however that compensation depends a lot on the resources of the budget:

R: *By compensating drugs, spectacles and technical aid many local governments help the seniors to pay for their own contribution (R2).*

R: *--- we have organised the renting of technical aid ---, in this sense we have done quite well in that we have got all the technical aid that seniors tend to need, we have coped in our county with the money that has been allocated from the state budget, -- - there have been applications for an electric wheelchair, but --- they are very expensive (R3).*

R: *senior people who need minor assistance often do not get it, and there are many of them. --- the technical aid, for example diapers --- are very limited, everything is limited. Of course you can apply for them --- and get them subsidised (R11).*

I 6: Medical rehabilitation

The medical rehabilitation service is seen as important for the seniors and availability was viewed quite well in several regions. However, the questioned from some regions were concerned as the medical rehabilitation service has been discontinued recently or has become a fee-charging service.

R: *We have a big health centre and with the monetary resources allowing, the medical rehabilitation procedures are possible there. --- the local government helps to pay for the service. --- it has become quite popular. --- there are special times for the seniors, they get cheaper tickets and there is a trainer who trains them and helps to develop muscles --- they can keep their bodies healthy --- from the feedback so far people are really satisfied (R11).*

R: *--- the third hospital is the medical rehabilitation hospital, it is with own financing --- (R9).*

R: *--- it is a great pity that medical rehabilitation was discontinued, it was very important, likewise we do not have geriatrics. --- I suppose they will be considered, --- it is possible to put them down in the development plan (R10).*

I 7: Specialised medical care

Specialised medical care is in principle available to the seniors everywhere and according to many respondents there are no major problems with it. Still, the problem mentioned was long waiting lists for an appointment with a medical specialist. It was also mentioned that seniors have difficulties in getting the appointment or hospitalisation, especially if the service is not provided in their region.

R: *--- there shouldn't be any problems with specialised medical care in the county hospital, --- in addition it is possible to seek higher medical care (R5).*

R: *There are long waiting lists to cardiologists, ear doctors. --- people are more ill in the winter than in the summer and no doubt the waiting lists in the hospitals are*

longer then as well. And if the health is very poor, --- the patient is brought to the hospital by emergency (R4).

R: *Still, it is difficult for the seniors to get to the active treatment department (R14).*

R: *The problem is that health care services have been distanced from the public and that specialised medical care has been concentrating in towns. From time to time certain medical specialists should provide services in rural municipalities (R14).*

I 8: Special services for the demented

In the answers given to the questions about services to the demented none of the respondents mentioned health care services. They mentioned services to the demented when talking about welfare services and these will be analysed in the social services part (see II₅).

Main category II: Welfare services

II 1 Domestic care service

Domestic care service is provided in all Estonian counties, only smaller rural municipalities lack the service. Domestic care service includes supplying the client food products and household appliances, household duties, courtyard jobs, client's caring, paying for the utility costs, applying for allowances, organising one-time procedures, assisting with organising funerals, referring to a welfare institution and forwarding information, transport and escorting service, family aid service. The domestic care service is free for the user; it is financed by the local government if the senior does not have a legal maintenance provider.

R: *In principle we have domestic care service in 10 out of 12 local governments (R6).*

R: *Domestic care workers are used everywhere in rural municipalities. Services for seniors living at home are missing only from 5 small rural municipalities (R6).*

II 2 Counselling service

The interviewees brought out two types of counselling services: social counselling and psychological counselling.

II 2.1 Social counselling

A social counselling service is provided in most of the Estonian counties. The social and psychological counselling is mostly provided in day centres in county towns. In towns there are also social consultants, in rural municipalities social counsellors who have the respective information. Social counselling is free of charge for the seniors. The local government finances social counselling and also buys the service from non-profit associations.

R: *In most of the day centres counselling is listed as one of the services, either social or legal counselling (R10).*

R: *--- social counselling is provided to everyone in the local municipality (R11).*

R: *--- the local government signs favourable contracts with the lawyers, because otherwise seniors would be unable to pay the fees (R10).*

R: *--- the town buys the service from non-profit associations (R7).*

II 2.2 Psychological counselling

This service is only provided in bigger towns. In three out of the 14 interviewed counties the counselling service is lacking or they only have social counselling.

The primary counsellor is often a social counsellor, a day centre worker. In bigger towns the local governments pay for the psychological counselling of people in risk groups and in economic difficulties. Elsewhere counselling is a fee-charging service that the seniors use rarely.

R: *Social counselling is provided to everyone in the local municipality, but not the psychological counselling that many people would need. --- we do not have the people who could do the job. Many social counsellors have educated themselves in the area. There are day centres where psychologists have seminars about illnesses and on how to overcome them both mentally and physically (R11).*

R: *Counselling costs EEK 30 to families. In our rural municipality the local government pays for the local families' sessions at family physicians (R2).*

R: *There is also the psychology service, but as far as I know seniors use it rarely (R3).*

II 3 Day centres (senior centres)

All the representatives of counties mentioned their day centres. The following services offered by day centres were brought out: recreational activities – singing choirs, dance clubs, glass-painting, handicraft hobby clubs, cloth weaving, exercising, book clubs, the opportunity to read newspapers, use the Internet, watch TV, model clay; hairdresser's service, cosmetician, pedicure, laundry service, the possibility to bring drugs. Day centres are financed by local governments and are located in the bigger county towns. This makes the day centre services' availability more difficult for seniors living in smaller towns, mostly due to transport-related reasons (e.g. only one bus per day).

R: *There are 8 social or day centres for the seniors living at home. There is one in each district (R7).*

R: *Our transport is very poor and if there is just one bus a day then the availability of the service is non-existent (R9).*

II 4 Care home service

Care home service is provided in all Estonian counties. The price of the care home service is between EEK 3,600 – 6,000 per month. If a senior does not have any relatives, then he/she has to pay 85% of the pension towards the care home service; the local government finances the rest. If the senior has children, then the children pay for the service. Exceptions are possible based on the decision taken by the care commission. There are also options when a son takes his mother to a care home and gives the local government her apartment. Thereafter the town will pay for the service provided to the senior. Pursuant to the law the fee for special care home services is paid for by the state. There are general care homes that are owned by the state, local government or are privately owned. This varies by counties. In some counties there are waiting lists for care home service.

R: *EEK 3,600 to 4,100 per month at the moment, but the price might go up in the summer (R10).*

R: *--- the monthly fee is around EEK 6,000 (R13).*

R: *pursuant to the law the special care home for the mentally ill is paid for by the state (R5).*

R: *As of April 17 there were seven people on the waiting list of the care home (R14).*

R: *--- there are waiting lists sometimes for the care home. But the waiting lists aren't overly long and in case of real need the senior can be referred to another special care home in Estonia (R5).*

II 5 Welfare services for the demented

Day care services for the demented are available in three regions. The fee per day is EEK 20 – 30 (the price of food). People have to bring their own toiletries – for example diapers. The day care for the demented is financed from the budget of the city government.

There are too few special units for the demented in care homes. Still, several counties plan to start developing these services or expand the current ones. However, in several regions the special services for the seniors are still lacking.

R: *--- in the town there is a non-profit association ---, where they organise --- day activities for people with mental disability and mental illnesses. And the plan is --- to expand it in the future (R5).*

R: *The only day care is for the demented. The service for the demented started on 1 January --- we have 20 places. --- and it works --- very well. --- the town pays for everything ---. Except for the food, which the patient has to pay for, it is EEK 30 per day and this gives 3 meals a day (R7).*

R: *There isn't a special one for the demented. --- home cares do accept the demented based on agreements between the home care and the client. --- general home cares --- usually do not accept them because their staff has not received special training (R10).*

R: *The situation is quite sad for the demented, there are no care institutions for the demented. And often they are left --- at home. General care homes generally do not accept the demented, but it depends on the situation (R13).*

R: *--- there are none for the seniors. Although it is on the agenda (R6).*

II 6 Temporary care (respite care)

Temporary care is available in most of the counties. In some counties the temporary care is provided in nursing care departments, social centres or in the form of other services provided by the care and health centres in the county. One of the counties offers an alternative option by signing a one-month contract with the care home. The average price of temporary care is EEK 6,000 per month. The family of the client has to pay for the temporary care. There are different price packages depending on the extent of the care needed. Support from the local government is possible.

R: *The care and health centres in the county provide temporary care, which also provide short-term care depending on the needs of the client (R14).*

R: *We do have temporary care, but since the number of places is limited, it is wise to book the place in advance (R10).*

R: *It can be done. If a person signs a contract, say for one month, it can be done at any care home (R4).*

II 7 Social housing service

A social housing service is provided in all bigger county towns. This service is not very widespread in all counties due to the financial problems of the local governments. The seniors form a small percentage of the users of the social housing service. In one town there is a seniors' house thanks to the ties of friendship with Sweden. In some counties the social housing service is available only during the winter months so that the people could return home for the summer. The contracts with the clients are signed for one year. The responsibilities of the towns include finding accommodation and repairing the apartment. People have to pay the rent and utilities costs. If the financial situation does not enable the person to cover these costs, he/she can apply for subsistence benefit.

R: *Quite a large share of social housing applicants are seniors, but I can safely say that they do not form the majority (R14).*

R: *The town has renovated a building for these purposes and created an entrance for people in wheelchairs. It must be a problem in small municipalities, since there is a lack of social housing and the repairs are costly (R5).*

R: *Yes, we do have social housing, but they are more meant for the disabled and I found from the books that there is just one senior living in the social housing. Of course there is a lack of social housing, we only have around ten...(R 13).*

II 8 Sauna and shower service

12 out of the interviewed 14 counties provide sauna and shower service. There is no subsidised sauna and shower service in two counties. In these counties there is a town sauna in the county towns, but there are no discounts for seniors.

In some county towns the sauna and shower service is provided by day centres, in some counties the town saunas and in some rural municipalities the local care homes. The sauna and shower service is partially financed by the local government and partially by the seniors. The price for the clients is quite favourable, around EEK 10-25. The domestic care workers take care of the availability of the sauna service to the domestic care service clients.

R: *A shower-room is being currently built, so that the day centre clients could have showers for a minimum fee. That was the problem the day centre had – people often came and asked whether they could have a shower (R2).*

R: *Some places do have the service and some places don't. In one town you could even take a bath. In one town there is a social house with social apartments and one of the two-room apartments is equipped for doing laundry and taking baths (R12).*

II 9 Laundry service

All counties except for one have a subsidised laundry service. The laundry service is provided at day centres in all counties. People are charged a symbolic fee for the service (from free of charge to EEK 25), depending on the economic situation of the person. In addition to this contribution the laundry service is co-financed by the local governments. The laundry service is highly demanded and there are often queues.

R: *It costs no more than EEK 10. Several local governments do say that there should*

be own-contribution, even if it was symbolic, but that it shouldn't be free of charge. But of course if a person could not afford it at all, no one will charge them (R11).

R: *It costs EEK 12 if the person brings their own washing powder and 15 if the washing powder is from the centre (R 12).*

R: *I know that people have to pay part of the fee. Generally seniors do not want to accept anything completely free of charge (R6).*

II₁₀ Meals on wheels service

The service of bringing warm food to the home is available in bigger county towns and rural municipalities, where they have care homes, but it is not very widespread even there. The service is not available in three counties. One of the reasons for the service not being very widespread is the lack of transport.

The service of bringing warm food to the home is free of charge for the clients; the local government of the client pays for the food. The cost of food for the seniors is EEK 20-25.

R: *It is done in two ways – one of them is a non-profit association that operates without town support, we only support the delivery. It is warm soup meant for single seniors in one district. The soup is meant for a certain period, one or two months and then some other senior will be getting it, but the clients do not have to pay for them at all. The other place is a day centre; the town pays for the wages of the deliveryman. The food is paid for by the client (R8).*

R: *Soup kitchens operate, food is delivered home and the seniors come for food at the location (R7).*

II₁₁ Possibilities to eat under favourable conditions

The day centres in bigger county towns provide the possibility to eat under favourable conditions. The possibilities to eat under favourable conditions lack in four counties.

The subsidised food for the seniors is financed by the local government. Self-participation in getting a subsidised lunch starts from ten kroons. In addition there are soup kitchens in the counties, where seniors who have economic difficulties can get warm food for one or two kroons, or free of charge for a coupon issued at the social department.

R: *One can have lunch at the day centre, but the person has to pay for it (R4).*

R: *This subsidy is very important for pensioners in the day centres (R8).*

R: *There is a soup kitchen in the welfare centre, where the seniors can have soup for one or two kroons, in case of coping difficulties, a person can have soup free of charge for a coupon issued by the social department. There are no soup kitchens in rural municipalities, but they have neighbour support (R14).*

II₁₂ Discounts for technical aid

Technical aid is financed by the state and is allocated through private companies. These companies have their own technical aid centres and sales facilities in towns. People, whose salary of the first family member does not exceed the minimum wage, i.e. EEK 2,169 have the right to get technical aid at a discount. The discounts for technical aid are regulated by the state. If the cost of the technical aid exceeds the financial possibilities of seniors or disabled people, then depending on the cost of the technical aid the local government supports the purchase from its budget. The local governments support

technical aid and if possible also the purchase of basic nursing aid and incontinence appliances. Depending on the price of the technical aid and the local government, people get compensation for the cost of technical aid in the amount of EEK 200 – 1000 or 50% of the sum. The social commission of the local government decides the compensation of own contribution. In some rural municipalities the technical aid is delivered home in case of available transport.

R: *We have small compensations for technical aid. Of course there isn't enough to pay out maximum amounts to everyone, but there is enough resources for technical aid and also up to a thousand kroons per year can be refunded for the cost of drugs (R7).*

R: *Technical aid is financed by the state and the allocation is through private companies that have their own technical aid centre. People can buy wheelchairs at a discount or rent them (R5).*

R: *Many local governments help the seniors to pay for their own contribution when purchasing spectacles and technical aid. But these decisions are taken by the social commissions. Usually the own contribution is compensated to the extent of around 50% (R2).*

II₁₃ Customised accommodation service

A customised accommodation service is provided in just one bigger Estonian town. In the rest of Estonia a total of five apartments have been customised for the disabled. In addition there are a few cases, where a rural municipality has arranged the accommodation so that a person could live there. Customised housing has been mainly done in social housing. The reason for the lack of service is financial constraints.

R: *These are relatively rare cases, where a rural municipality has customised accommodation (R3)*

R: *It is available for the disabled. The town has had resources allocated for these purposes for seven years. We decided at the meeting with the head of department that accommodation customisation for the seniors can be up to EEK 10,000. These limits varied a lot last year, from EEK 300 to 10,000, but we don't do repair work (R7).*

R: *The town customised two accommodation places for the disabled (R8).*

R: *This requires so much resources that none of our local governments could afford to do it with their revenue base. It is beyond our possibilities (R13).*

II₁₄ Shelter service

The shelter service was brought out in just one county. The cost of the service is EEK 150 per twenty-four hour period.

R: *Shelter service is available for EEK 150 for twenty-four hours (R13).*

II₁₅ Transport service

Transport service in the form of taxis for the disabled are provided in three county towns. The service is partly paid for by the local government. In some places the seniors are provided transport to the hospital or doctor. The problem is the high cost of the service to the local governments as well as the seniors. The problem with using public transportation is that the steps to get on to buses and trains are too high, which makes it difficult for the seniors.

R: --- when the seniors are sometimes brought to town to the doctor --- as taxis for the disabled are only available in bigger towns, in other cases it is a one-time help, which is not regular and depends on the person, not everyone can be helped (R1).

R: The biggest problem for the county is renting taxis for the disabled and seniors, it too expensive. --- and for example in the case of bigger events it has been a problem to organise transport for those people from different regions who can not take the public transportation and often those people end up staying at home (R2).

In addition to the services described above, there are various active hobby clubs in the counties led by the seniors and the Pensioners' Associations movements. Their main aim is to organise cultural events and entertainment for the seniors:

- meetings with medical professionals, members of the parliament, civil servants of the local government
- sport events: hikes, exercising, sport games
- excursions in Estonia,
- concerts
- amateur activities
- handicraft clubs

Some organisations use the help of volunteers – lecturers and leaders for amateur activities. The associations in a rural municipality are sponsored by companies in the rural municipality.

The service of security telephones is not provided to the seniors in any of the counties.

Main category III: Conditions for receiving a service

In the majority of cases the decision-makers hear about the recipient of a service either from the relatives or neighbours, from a social worker or a family physician. Pursuant to the type of needs the person is referred to the health care or social service. The health care services are financed regardless of the existence of children or grandchildren. The receiving and payment for the social services does depend on whether the patient has children or not. Should the children or grandchildren be unable to pay for the services, the local government assumes the responsibility of caring for the senior.

III₁: Who refers

A doctor, often in co-operation with a social worker refers a patient to health care services. To be admitted to social services, a referral from a social worker is needed. The initial application is often from the person, the relatives or neighbours.

R: (For nursing care) *City medical officer --- has certain registers and information on the waiting lists of the region and is able to make certain corrections, for example if there is a waiting list for nursing care and someone's situation worsens, then that person is moved forward in the list.* (R1).

R: *The specialised doctors and family physicians and in some cases the local government have referred, they all co-operate. Earlier there was a chief doctor, now there is a head of the department, it all goes through him/her* (R2).

R: --- the active treatment hospital contacts the nursing care hospital. --- provided that there are vacancies in the hospital (R13).

R: The person or a representative or neighbours can apply and let the respective institutions know that there is a person in need of help. In case of a single senior, then he/she will be paid home visits (R9).

III 2: How is it decided

The social commission of the respective local government or an appointed social worker determines the need for a service, in particular a social service. There is no standardised method for determining the needs. However, it transpires from the description of the respondents that the referral to the service in different regions is conducted following the same principles. The condition for referral to some services is that the senior does not have children (or adult grandchildren) or that the children live far. In case of other services (for example care home service) the own contribution depends on whether the senior has children or grandchildren.

R: They try to find out whether the children and grandchildren could support the senior in terms of their economic, health and other conditions, if so, we do not provide this service. Only to those who are childless or whose children for some reason are unable to (R8).

R: The first criterion is that the senior is in the town/rural municipality register and the second is that there is a real need for care and personal assistance (R14).

R: We have a specialist, who visits the seniors at home, gets acquainted with the situation, but the contract with the social welfare department of the district will be signed by the head of the department (R8).

R: The social housing service is received by a person, whose income is below the limits set by the regulations. If a senior's income remains below the limit, then the senior is entitled to get the accommodation. (R8)

Main category IV: Acknowledged problems

IV 1: Transport problem

The availability of services is complicated by the transport problem, which mainly concerns people living in the peripheral area of rural municipalities, but also commuting within bigger towns. There is a transport problem not only in the availability of services to the client, but also difficulties from the aspect of bringing the service home to the client. On the whole the transport problem was one of the biggest issues.

R: Rural dwellers --- cannot commute, their incomes are low and there is a real problem with the transport. The buses run in the morning and in the evening --- there are no busy schedules between the different regions of a county (R2).

R: --- in a bigger town, seniors who have difficulties with mobility, find it quite difficult to use public transport and in some places they might even have to walk for several hundred meters (R7).

R: --- in many cases the difficulties are rooted in the lack of transport, because we have a very poor situation transport-wise and if there is just one bus per day, then the availability of the service is close to nil. --- if the senior does not have a car then it is impossible to receive some services (R9).

R: *It does pose a real problem to get to the senior if there is no transportation. Some care workers cycle, which makes it more complicated in the winter, but they do their job well and put a lot of heart into it (R11).*

R: *--- in the regions with a sparse population, --- home nursing and domestic care becomes very expensive (R9).*

IV 2: The demented with the non-demented seniors

The problem is that the same units and institutions have to provide care for seniors and the severely demented seniors. There is a lack of services for the demented seniors in the majority of regions.

R: *It is not normal that a senior, who would like to enjoy peace and quiet in their old age, has to be next to those who cause new problems and stress (R1).*

R: *The general care homes have difficulties --- if a senior becomes demented or has been brought there as demented, he/she will cause problems. There are not so many demented seniors that each care home should have a special unit --- just in some care homes ... (R5).*

IV 3: Information and training problem of the caregivers

Often a caregiver is a member of the family or a friend, who have not had any preparation. Recently several projects have been started that train the caregivers (both the formal and informal caregivers); also various printed information materials are available. There is also a lack of information forwarding to the necessary target groups.

R: *--- there have been a few giving advice and training sessions --- the managers of day centres have invited the people in and trained them --- but --- there hasn't been enough and the information has not reached everyone doing this hard work (R10).*

R: *In principle they could get advice, and they use it a lot, --- we received caring manuals, ---, so that people who need them could have them (R6).*

IV 4: Severe health condition (clients of care homes)

This subcategory contains the descriptions of the experts, who talked about the qualification problems of the staff and the possibilities for medical care, since there are severely ill patients in the care homes. There are medical assistants, general nurses, basic care providers and care workers working in care homes and if necessary the family physicians can be called in. Based on the types of patients brought to care homes over the past years and on the assessment of the experts, it could be brought out that there is a big demand for medical care services to be provided in care homes. According to some experts the need to provide medical care services in care homes is not a problem.

R: *There are many seniors in the care homes in the rural municipalities who could be in the nursing care units or nursing homes instead of care homes (R14).*

R: *Some care homes have nurses and some don't. If a care home does not have nurses, family physicians are called in, if a care home does have nurses, then a nurse consults the patient and in case of a more serious case the family physician is called in (R10).*

R: *Since we have a family physician, then in every local government ---, the care home and a family physician sign a contract, according to which the family physician visits the care home on certain days, --- for example twice a week at certain hours. There*

is always a possibility to call for a doctor, but a care home has its own medical staff – medical assistants, nurses. Care homes organise it if a patient has to be taken to a hospital for examination (R11).

IV 5: Lack of cooperation

Both parties complain about the lack of cooperation between the health care and social services providers. The separation of the two in one big system is stressed, especially in financing although often a client needs help from both systems.

R: *Problems arise when a health care service becomes a social assistance service. --- there is an ongoing debate over where does the line between the two run and who should be financing what, how much should the health insurance fund finance and how much should the person or the social assistance system of the local government pay (R5).*

R: *--- there is not much cooperation with the social service. --- when a patient returns from the hospital and needs assistance ... home nursing, but it can't be obtained. Social workers have a huge workload as it is (R9).*

R: *There is no integrated system (R14).*

IV 6: Waiting lists

The interviews showed that there are waiting lists for various services in several regions. The main concern reflected in the experts' answers was the timely admittance to nursing care. They also point out waiting lists to care homes, which is the greatest problem in some regions. Waiting lists are also a problem for specialised doctor consultations or operations.

R: *There is a several month waiting list to the care hospitals (R7).*

R: *The waiting list for nursing care is about two months --- I'm not fully familiar with all the stages, but as I've understood from the clients I've met --- the waiting lists to the hospital are a week to a fortnight (R1).*

R: *There are no waiting lists for home nursing, about a month for nursing care, but not in every hospital (R14).*

R: *There are and there aren't (waiting lists to the care homes). It depends on whether seniors die in there ... But even if you have to be on the waiting list, people usually can wait, it is not such a long time (R11).*

R: *Generally it is so that if there is a need, people do get a place in the care home. I have not heard of waiting lists (R6).*

R: *There are long waiting lists to the cardiologist and to the ear doctor. --- there are more illnesses in the winter and thus the hospital waiting lists are longer (R4).*

IV 7: Fast ageing of the population

The respondents bring out that it is necessary to start dealing with the problems that arise from the ageing of the population immediately. For example to expand and strengthen services for the seniors living at home (including day centres, domestic care etc). The experts have also mentioned a problem related with the non-covering of income tax, since then there is no monetary cover for supporting the seniors and paying pensions.

R: *The decrease in the working-age population and the increase in the cost of health services in relation to the increased share of seniors in the population are*

problems. It is important to strengthen the provision of services for the seniors living at home so that the seniors could cope on their own at home and would not need so much expensive medical care and institutional care services (R14).

R: *The main problem is --- that not enough income tax is received. So there aren't enough resources to support the seniors and pay pensions. The share of seniors in the population has been increasing. This in a way causes poverty, which is the worst thing (R8).*

IV 8: High cost of a place in a care home

The monthly cost of a care home place is very high, which is why every case is very carefully analysed and the final decision making is postponed for as long as possible, trying to find other solutions. Paradoxically these are sometimes even more expensive if they are financed from a different source (for example health care services).

R: *If seniors live in country houses on their own, where heating is difficult, --- a place in a care home is a bigger expense for the rural municipality, but it is financed by the health insurance fund --- a place in a county hospital usually does not cost much to the rural municipality, perhaps just the transportation to and from there, the in-patient fee and they are currently looking for cheaper options (R1).*

R: *It is easier to send the bed-bound patients to the care homes, but many seniors do not have the financial means to pay for it, although here --- the care home has been trying to keep the prices down, it is still a problem for many (R11).*

R: *--- the clients are a huge burden to their families. And often there are illnesses and dementia-related problems and --- it is too much for the families (R8).*

Main category V: Possible solutions

V 1: Financing from different sources

Most of the experts brought up that the different nursing care services could be financed from two or even three sources – the health insurance fund, local governments, the client of the client's family – since the problems are not just of social nature, the financial resources of the local governments are limited and the role of the family cannot remain too big either.

R: *Definitely all parties should contribute, for example the medical treatment costs of the nursing care are financed by the health insurance fund, but the bed-related costs should be covered by the relatives ... and the salaries ... Certainly there should be financing from different sources (R9).*

R: *This financing from different sources --- it seems important that the health insurance funds, the local governments and the children of the patient ... (R1).*

R: *I think that the health insurance fund and the local governments should be the main sources, it would be good if the client could pay a certain share for the drugs, but the seniors use so many drugs and they spend so much money on them (R12).*

V 2: Providing services for the seniors living at home

The key issue based on the respondents seems to be the development of domestic care to customise the country houses more suitable for the seniors so that people could continue living at home for as long as possible. Also there should be more services provided, for

example main experts think that the development of home nursing services is very important since home nursing helps to improve the co-ordination between welfare and health care. The services for the seniors living at home (including day centres, domestic care, etc) have to be developed since caring at home is the least expensive and it is important to the seniors that they get this service and can remain living at home.

R: The services like that are more important to the seniors than trying to activate them and the EEK 500 promised during the pre-election campaign. --- dealing with them is more important than the money (R5).

R: Seniors want to be at home and if the family is in a difficult situation, then the day care services would be very good, if they could be there for a little bit ---. If they had to choose between a care home and day care ---, many would probably go for the latter (R6). R: Primarily --- family nursing, --- which would help a lot. When a family physician prescribes a treatment that can be done at home, the person should not be taken to the hospital. And the services for the seniors living at home help too (R6).

R: The home nursing helps to co-ordinate the situation between the welfare and health care ... (R7).

R: --- if there were a home care service, where a worker would help the senior at home, say the home customisation ---, so that the country house would be customised according to the senior's needs. ---, that there would be a support person, --- who would stop by at least once a day (R13).

R: The persons who do not cope independently anymore due to their old age and whose children live very far --- there should be a domestic care system. --- while we have foster families for children, then in Finland they have them for seniors too. --- this would also be an option, where a person could continue living at home and the caregiver would move in or the senior would move in to live with the caregiver (R5).

V 3: Developing a cooperation network

Developing a social care network would be a great resource.

R: If the social welfare network would be better developed, it would mean that social workers would go to visit the seniors and they would get help earlier, ---. All these things should be well-established (R4).

R: The development of cooperation network. Health care plus social welfare plus local governments (R14).

The experts brought our various solutions to improve the current situation. For example many of them think that it is important to help to keep the seniors active, improve the training and information retrieval possibilities of the seniors and their family members, enable the seniors to work should they be capable and wish to do so.

R: Every kind of keeping the seniors active and involved in various activities is very important, as it helps the seniors to keep healthy and happy. It is possible to keep the seniors active through hobby clubs, lectures, and health projects. Several seniors' projects have been drawn up and financed (R14).

R: The seniors themselves should be more socially active, they as a pressure group, should influence social politics, guarantee their coping by getting higher pensions. That's all they can do (R12).

R: *I think it would be normal that personal caregivers, who have been appointed -- would get regular information --- or some sort of training, for example on caring technical aid – what are they like and what kind of maintenance do they require ---, so that they wouldn't wear out so fast. And people don't know how to look after themselves, so that they wouldn't get back aches etc (R1).*

R: *--- they have employed care workers, volunteers, but they have no skills, experience and practice base. --- it is not enough if we just give them lectures. People need the experience (R11).*

R: *65 year olds ---, they are quite capable to continue working. --- to a certain extent life stops for them. Of course there are people who are quite content with retiring at the age of 65. --- and the problem is that men do have jobs at that age, but women don't. And those jobs that are available, --- not everyone would like them, for example cleaner. --- if a person is healthy and willing, --- why does the age limit have to be so strict (R11).*

Main category VI: The role of the family in caring for the seniors

VI₁: The importance of children in receiving the service

The common general attitude was that children should care for their parents within their possibilities, but the opinions on relating the own financing with having children differed drastically.

R: *Our traditions are that children look after their parents. Traditions are --- the main resource ... (R13).*

R: *--- all the cases are different. When a patient says that he/she does not have any contact with the children and in some cases it is true, then there can be no support expected from the children (R8).*

R: *Of course the social workers make sure that if a senior does have children, then they need to turn to children for help (R11).*

R: *My opinion is that children should not have to carry the full burden of covering the caring costs for their parents. Because I think that that would be completely unfair (R10).*

R: *In reality there should be different parent financial supporting systems for the families where they have for example one child or families where they have seven children. At the same time, what about ethics then. Or would it be more fair if the senior would have to pay part of the pension and that would be it (R13).*

VI₂: Own contribution

Own contribution is seen as important mostly so that the clients would not demand unnecessary services. The problems brought out with own contribution were that the payment for own contribution is becoming more and more difficult because the application of own contribution is expanding and the rates increase so that the seniors might have difficulties with paying even for a small own contribution. Often the client's children are unemployed or are subsistence benefit applicants; in that case the payment is combination (one part from the family, the other from the local government).

R: *All the technical aid that is partly compensated by the state, but the client still*

has to pay as well, sometimes 10% and sometimes more. If the family really can't afford to pay the own contribution, they turn to the local government for help and there are plenty of examples where the local government compensates the client's own contribution (R1).

R: *Own contribution has increased year on year, also due to visit fees, hospitalisation and bed-day fees. And an extra cost for the clients from the rural areas is the transport (R1).*

R: *Yes, we do have bed-day fees --- one of the first to have implemented it in our region, so the county has been divided into zones and the clients go to whichever is the closest (R1).*

R: *Yes, certainly own contribution is important. I believe the bed-day fee is EEK 25. Yes and there is a fee-charging service as well (R2).*

VI 3: The basis for determining own contribution

It transpired from the answers of the interviewees that if the children do not live in the same local municipality, people are not left without a service because of that. But if the children do live in the same municipality, then the decision is taken based on each separate case, because if the child is unemployed and has own children, then it would not be realistic to expect that they would have money. Especially if the child is an applicant of subsistence benefit. These sums go from the resources of the municipality. This is why all the cases are looked into individually in most of the regions and the decision depends on the agreement. But if we take the Family Act for example, then pursuant to the Family Act the children should be caregivers to their parents. In case there are no relatives, the local governments have to pay.

All the questions concerning applications of all sorts for various benefits and care homes, monetary allowances or technical aid support will be decided by the social commission.

R: *The determination of own contribution should be equal because --- people are equal. Now the next question is how can a person manage to pay for the own contribution, whether the pension would cover it, would children help and of course there is always the local government, where one could apply for a single allowance. It is very difficult to separate the own contributions. Like there was a problem during the reform of child benefits that families vary by their income and so let's have child benefits with different rates – it was under discussion for years in our society --- we were not ready to make such decisions, where we would have different prices, having people differentiated according to their origin, family --- this won't go with the seniors either (R1).*

R: *In the rural municipalities the municipality/town only organises and pays for the services of the childless seniors, if the senior has relatives, then they will contribute towards the payment of the service. Every case is analysed individually. The social commission takes the decision (R14).*

R: *If the senior does not have any money, there are a few, then --- the rural municipality has to pay, but if the senior has children, then they are expected to pay. But in some cases the children are unable to support financially, then an agreement would have to be reached (R11).*

Main category VII: Non-local governmental support structures

VII₁: The role of the private sector is small or missing

There are virtually no private companies in social welfare and nursing care. The reason is rooted in the small number of clients who could afford to pay. Several companies have started but soon given up. Several interviewees mentioned that probably several services are provided unofficially (is that the right word for it, Doosh, a kind of services black market?) and the caregivers paid in cash. At the same time there are no concrete data.

R: *The town can provide for the elementary needs --- domestic care --- to its own clients, there are not long waiting lists here. --- could not get the company started, because they could not find enough clients who would be willing to pay additionally --- the price can't be very low, the costs must be high at least during the first years (R1).*

R: *--- several years ago, --- one private company --- started to provide domestic care services. --- and the company had to discontinue because it didn't find enough clients. And I'm sure there were enough clients that they were sought via relatives --- it was only a very short period (R8).*

R: *It seems that the system would work if the private company providing basic nursing care would have a party with whom they have a contract, who would pay for the service. Otherwise the company would not survive; the staff would not cope (R10).*

R: *The black market for the services definitely exists and you could find it in the newspapers. There are people who advertise that they need a domestic care worker, others try to find them via labour offices (R8).*

R: *I have a few addresses --- and I have been able to give the addresses on several occasions. And I've read the newspaper ads, --- "offer jobs", it is obvious that there is a market, but it is not constant (R1).*

VII₂: The role of the volunteers

There are a few associations that offer support to the seniors, also a few social work students, who would like to work in this field. In general the volunteer work, especially in senior welfare has not got going properly in Estonia. The situation in this area is much better in children welfare.

R: *--- they do have a certain work load --- a circle of active friends, former medics who, in addition to their home life can visit other seniors, bring them food and make them Christmas presents etc (R1).*

R: *Sometimes the students from the faculty of social sciences agree to do the work (R1).*

R: *Some earn their wages doing the job and some are volunteers, --- they all have their own regions (R11).*

VII₃: Assistance from the family and friends

The majority of seniors, who don't cope on their own get initial help from the members of their family, neighbours or friends. The unemployed non-official caregivers can be confirmed as official caregivers and receive a small pay for it.

R: *It is more difficult in the urban areas, --- but --- usually the seniors have their acquaintances, or contact persons, who keep an eye on them whether everything is alright or whether anything is needed. And if so, they will inform the social department. Of course if a person has fallen ill, they will inform the doctor (R10).*

R: Seniors living in the rural areas with the children living in urban areas ---, they have agreed that the neighbour helps the senior, makes food and cleans (R9).

R: Usually the seniors try to find a caregiver themselves, someone they know and can trust and then they turn to the town or rural municipality to confirm the person as an official caregiver ... (R10).

Main category VIII: Readiness for cooperation

VIII 1: Cooperation between the family physician and the social worker

All the interviewees thought that the cooperation between family physicians and social workers has to be practical and dense. The opinions on the current status of the cooperation varied greatly.

R: At least I expect --- that the social worker and family physician would cooperate (R1).

R: The cooperation has some short-comings, --- especially in a small rural municipality it remains unclear why can't a social worker and family physician cooperate smoothly. For some reason they keep very separate. But there are local governments, where the cooperation is very good. --- if a problem has occurred then the family physician let's the social worker know immediately and vice versa, but this is quite rare. More often they work separately (R2).

R: The cooperation between family physicians and social works functions very well. Should the need arise, one contacts the other immediately. If there's any new information from the doctors, then the family physicians and social workers exchange it very fast --- (R6).

R: Social workers are the more active party, it is very difficult to communicate with the family physicians, they are a very closed circle (R11).

R: --- the cooperation is very good, we haven't had any problems (R10).

R: The cooperation is spontaneous. --- the work gets done (R13).

VIII 2: Inter-agency integration

The cooperation between different agencies, the health care and social welfare agencies is regarded as very important, but the assessments on the current situation are not very good.

R: It is certainly very important. Even from the evaluation point of view. --- maybe the head of the local social assistance department would refer the client to a care home to prevent bigger problems, but with a few adjustments, domestic care or a support person the person could remain living at home (R13).

R: The cooperation could be better, more co-ordinated, at the moment a lot depends on personal contacts. The cooperation has some shortcomings on the level of different agencies (R14).

VIII 3: Gap between the health care and welfare services on a county level

The problem is that the health care and welfare services are separated already on the ministry level, which is the reason for the trend to continue in counties and local governments.

R: This separation is on the county level, because our ministry, who gives us the tasks --- keeps the health care and social welfare separate. We keep them separate in our

department as well, and I'm not sure whether it was caused by a need, it seems we can cope with our tasks without having to use the help of our medical colleagues (R1).

R: Generally it is quite difficult if it doesn't start to function from the very beginning, we don't have any documents that would oblige either party to improve the cooperation (R7).

R: There are problems with it throughout Estonia, it is already coded in in Tallinn, and the cooperation is not very smooth. --- it starts from the ministry, the two parties – the social welfare and health care do not have a constructive, smooth and functional cooperation and it seems to be the same in the counties. Probable the smaller the local municipality, the better the cooperation ---. I'm not saying that the cooperation is bad, just that it could be better (R3).

VIII 4: Social counselling in hospitals

So far it is an exception rather than a rule that social workers work in a health care system. The bigger hospitals (especially the nursing hospitals) have social workers. The problem often is that it's not so much social counselling expected of them, but helping the patients to leave the hospital fast. The hospital staff can also contact the social worker of the patient's residence and ask for assistance.

R: Hospitals have social workers – in nursing hospitals as well as others. --- the doctors insist on them that they want to get the senior patients out of the hospital as fast as possible (R7).

R: We had a social worker, but not any more. --- since they are self-managing. Although it is stressed a lot that the doctors say that they cannot deal with social work, which isn't so easy, as well as their own work ---, but the hospital management figures that they don't have enough money for a social worker (R10).

R: There are no social workers working in hospitals or nursing hospitals. People can get social counselling from their local social assistance department (R13).

R: --- I can't stress it enough --- we need more social workers. We only have one social worker for the massive hospital complex --- this is just not normal (R8).

VIII 5: Interdisciplinary assessment

The interdisciplinary cooperation has functioned in the making of rehabilitation plans, in other areas it is spontaneous and with no common methodology.

R: Now the minister has written down that the rehabilitation teams ought to include a social worker, --- in this sense the ministry of social affairs obliges the medical and social workers to cooperate (R1).

R: There are rehabilitation teams ---. The demented seniors who happen there are usually excluded, --- not sent to the special care homes (R13).

VIII 6: Networking

The experts brought out that there is no proper inter-specialist network, no common databases and that the use of databases is not regulated.

R: Social work in the general sense is networking, meaning that the social worker of a local municipality can't be sitting in the office and taking all the decision on one's own, but ---, the teachers, doctors, local police constable, social worker etc, not to

mention the family and other relatives would be all networking. There should be a network like that around every person, but this is an ideal and not the reality yet (R2).

R: *It is very important as the different organisations/agencies/service providers have different information about the client. To make the cooperation function better the networks should be developed on the level of each rural municipality/town. From time to time there should be county seminars, where the networks meet and exchange information (R14).*

Main category IX: Vision for the future

IX 1: The development of services for the seniors living at home

It is regarded as very important that the person needing assistance could stay living at home for as long as possible. The specified topic was analysed under V₂.

IX 2: Implementation of reforms

The attitudes towards the current reforms in the nursing care and welfare systems were quite positive yet cautious. The changes in the seniors' care are regarded as important and inevitable.

R: *Reforms are of course necessary, otherwise we'd just have to close down the hospitals (R13).*

R: *They are great and necessary, especially what concerns nursing. I think it is very good, another step forward, it is very humane and necessary (R3).*

R: *It will probably be implemented in a simplified form, and it will probably work better in bigger towns. But then again to think about the distances and who will pay for the transport and the wages and ... --- I have doubts in it, of course it is necessary to make plans and in that sense it is necessary, however it is a different kettle of fish whether it will actually be implemented and how much extra money is needed (R10).*

IX 3: The geriatric assessment of the situation

All the respondents agreed to the need of comprehensive geriatric assessment of the situation for planning the treatment and caring of the people who need further care. The experts were aware that such service is provided in the world, also some of the respondents brought out the possibilities to economise on the further care costs.

R: *--- it would be necessary. But this is again teamwork, --- it works in the rest of the world. It is undoubtedly necessary (R8).*

R: *I regard the service very important (comprehensive assessment of the clients situation) (R14).*

R: *Isn't it (geriatric assessment of the situation) a possibility to cut down costs, if we know exactly the services we need to provide. --- we provide equal services to everyone, then it can be more expensive than necessary. --- But I assume very optimistically that it should give an effect of some sort, every person is so individual in the illnesses, life and family that they should receive an individual approach (R1).*

R: *It has to be done. --- when a person comes to the hospital then the situation is assessed and after a while it is reassessed. As far as I know it is not done in the hospital yet. And I can't say whether the hospital has taken that course or not. But it has already been started in the social area, with the people who come to the day centres (R2).*

IX 4: Development plans

The development plans in health care and social welfare are either in the process or just finished in several counties. Still, people do not have a good overview of the contents of the plan and many are concerned that the seniors will be left out of the plans. Some respondents are well acquainted with the development plan and very pleased and see development potential in seniors' welfare.

R: *The nursing care development plan of the county has to be ready by November 2003 (R14).*

R: *The development plan is certainly necessary. Only when --- the author of the development plan, a head of a care institution --- it is difficult to keep it objective (R5).*

R: *We do make plans, ---. In fact we do have a development plan (R6).*

R: *The development plan of our town --- respectively the development plans of the social and health care services. --- in the care of seniors the priority is to --- enable the senior to live at home for as long as possible. First of all people want that and secondly, it is much cheaper for the town (R7).*

R: *Seniors are not the first interest of the state in a development plan, it is just a part of the local government development plan, as much as it is represented at all. On the county level there is no document that would analyse the current situation and the future vision of the seniors, possibly bigger local governments do have them (R1).*

R: *They concentrate on reforming the hospital and reorganising the services for seniors living at home. In reality the county development plan is still in the initial stages, every local municipality was asked to write down their vision of the development plan of their municipality, but not all have been submitted yet and ... (R13).*

Main category X: Information availability

The information meant for the seniors can be reached mainly from the local newspapers, the homepage of the local government, the Internet, family physicians and social workers counselling. Information got from other people also has a big role. People also get information from newsletters, information days, and also the media. The distribution of information has its shortcomings. Although the spreading of information is regarded as important and people are working on it, the problem often is rooted in the information not reaching the right target group.

R: *In a way there is a lack of information, and people hear information selectively, people acknowledge what they want to know. But seniors only hear what they want (R7).*

X 1: Commune and town newspapers

The regions that have their own (free) town or rural municipality newspaper are generally satisfied with the spreading of information. The regions that do not have their own local paper have difficulties with spreading information in newspapers because the selection is wide and they are relatively expensive.

R: *Local municipality paper --- it reaches everyone at home, free of charge --- (R11).*

R: *The majority get the local municipality paper that is posted to them free of charge. But varies by local governments. --- they contain --- forthcoming information on the events, the presenters, the transport arrangements, sometimes also articles on new acts (R9).*

X 2: Other people

R: *Some time ago, when the post was distributed by the postmen they also performed the duties of distributing other information and some were like social care workers. As they had to go from house to house anyway, they also brought bread or drugs. --- but of course information is best spread in places where people like to gather, like shops or to a certain extent bus stops (R1).*

R: *Information is spread in the day centres, it also spreads through various pensioners' associations. --- in fact they are most efficient (R4).*

X 3: The local government, family physicians and social counselling

R: *This information is spread by the social and health care department of the county government, who communicates with the social workers of local governments, --- who in turn communicate with the organisations of the seniors and disabled people (R5).*

R: *--- in the community house all the information is on the walls. The other question is how often do people go there. In bigger communities they have reception days --- there are certain reception hours of the social counsellor of the community --- and in different locations. They all work on making the information more available and they need to continue working on it. And of course the family physicians too help to distribute information (R1).*

X 4: The Internet

R: *We got it started again --- the county homepage has a huge amount of information, if you have a chance ... (R11).*

Main category XI: Support for the families

More and more specialists realise that the family caring for the senior needs support. However, there are very few real possibilities to support them.

XI₁: Single allowances

R: *The transport service to the hospital and back home is provided. But also drawing up documents and communication, both for the pensioners as well as the disabled people. People, who have problems with drawing up documents or legal counselling, get help --- (R2).*

R: *--- in the social department they issue the personal technical aid coupons to get the accessories for basic nursing care at a discount --- people with severe vision or mobility disability can use taxis for the disabled people at a subsidised rate (EEK 1.50 per km, the town pays EEK 8.50 km), the families living on the coping line can apply for single allowance to pay for drugs (R14).*

R: *The allowances and things that are determined by the state, --- the local governments do not have the resources to provide services like that ... (R4).*

XI₂: Possibilities for temporary care (with own contribution)

R: *Temporary care is provided by the county's care and health centres, who also provide short-term fee-charging care according to the needs of the client. --- usually the client has to pay, but in exceptional cases the payment for the caring costs can be applied from the social department (R14).*

R: *Interval care is provided --- by the care home. --- this is a fee-charging service. --- we have 25 paying places, 15 of them are with town contribution, but 10 places are paid fully by the client and usually we take interval care clients who can fully pay for themselves. And there were no vacancies. In the summer the service is very highly demanded (R7).*

R: *We also provide fee-charging nursing care service if people pay for it. --- people can buy the service for an unlimited period (R4).*

R: *We also have a service that is only available for the seniors in the summer months. Or when the members of the family bring the senior for a temporary care. --- they are accepted based on a contract --- some seniors want to go home for the summer -- and then return in the autumn. This is not very typical (R12).*

R: *No, I haven't heard of the support services, pursuant to the Family Act children have to look after their parents, this is emphasised (R12).*

XI₃: Training and information

R: *In principle they could get training and advice and it is used a lot, --- people with a disability can get support ---. --- we received the books, care manuals, ---, so that people who need them could have them (R6).*

R: *--- there have been a few giving advice and training sessions --- the managers of day centres have invited the people in and trained them --- but --- there hasn't been enough and the information has not reached everyone doing this hard work (R10).*

R: *There is advice available in the hospital on how to use technical aid (R14).*

Summary

Estonia is one of the fastest ageing nations in Europe. At the beginning of the year 2003, 15.6% of the population was 65 years or older. According to the prognosis the proportion of seniors will exceed 19% by 2030. In the context of senior citizen policy, attention is mostly paid to citizens entitled to an old-age pension. Reforms in the old-age pension system which have been carried out during the past decade will have a much bigger impact on the future pensions of today's young or middle-aged persons than on those who are already retired. The average old-age pension is less than 40% of the average salary.

Services for seniors aimed at preventing marginalisation are provided by two systems – health care and social care –, which are quite separate, causing problems for the regional and local management in elderly care. Better cooperation, improved networks and a common database for health and social care are needed. Implementation of an interdisciplinary geriatric assessment would optimise allocation of resources and reduce the unmet needs of seniors.

Health care reforms carried out since 1992 have concentrated on the decentralisation of the health care administration, the establishment of a solidary health insurance, development of family physician care and reformation of acute hospital care. Nursing care development started only in 2001. Primary health care by family physicians, specialised medical care and hospital care are available for older persons all over the country. Nursing care, especially home nursing is less developed and there are big regional differences. Geriatric medicine is not available at all. Financial availability of health care services is quite good for Estonian seniors. Some of the biggest problems are long waiting lists for some health care services, limitations in the financing of rehabilitative, nursing care and dental care services, and also the high cost of medicines.

The development of the social care services is characterised by the prioritisation of supporting independent coping. Persons with special needs can apply for a small allowance for themselves and for a personal non-professional helper. Senior centres (day centres) which provide social counselling, recreational activities and services like a sauna, laundry washing, massage etc at a discount, and also home help services are available in all cities and bigger villages. The availability of places in general care homes varies by regions. In big cities long waiting lists are common. Residents of care homes quite often have serious health problems that need intensive nursing and are placed into care homes only because of the time restrictions in nursing hospitals. There are very few intermediate care services (intensive home care, supported living houses, care of older persons in a family, day care centres for demented persons etc) in Estonia. The financing of social care services includes almost always a person's own contribution, which is small for seniors not having children but is rather big and often beyond the means for those with children.

In conclusion, to prevent the marginalisation of seniors a better assessment of needs, more diverse services, flexible financing system and cooperation between the health and social care systems is needed in Estonia. In addition a lot more attention should be paid to the families caring for older persons.