Introduction

The health and social systems have undergone important changes in the Czech Republic since the Velvet Revolution and the fall of communism in 1989 and the dissolution of Czechoslovakia into the Czech and Slovak Republics in 1993. In our article we focus on a discussion of the definition and model of long-term care, factors contributing to the demand for long-term care for seniors, challenges and opportunities for integrated provision of LTC services and description and development of the long-term care system in the Czech Republic.

Understanding the role and position of long-term care within the social and health systems

There are different approaches to understanding the role, scope and goals of the long-term care system. Discussion around long-term care shows that long-term care may be seen as an emerging concept or model of services or as a relatively new social protection scheme addressing growing risks of long-term care for the individual, family and society as a whole.

In a rather narrow perspective, long-term care may be seen as a professional service provided to frail seniors compensating for loss of functional independence and ensuring help with basic activities of daily life. In a broader sense, the long-term care system includes prevention, geriatric services, age-friendly design and policies as well as protection of the income and well-being of informal carers.

Different approaches to long-term care reflect the variety and diversity of social and health systems in European countries and around the world, their cultural traditions, as well as the position of geriatrics within health systems and the level of development of long-term care in the respective countries.

Based upon those differences in health and welfare systems, long-term care can be conceived either as an integral part of health services or, in a rather narrow perspective, as mainly a social service. It may be considered either as a universal public service or as a last resort or residual service in terms of citizens’ access and entitlement. It can also differ in whether it involves prevention or only post-acute care such as rehabilitation and nursing.

A long-term care system represents a continuum of services for persons who live with or are at risk of reduced self-care capability, mainly due to a chronic condition and frailty. Long-term care includes a “range of services” provided in different contexts and settings, coordination and fragmentation thus being a major challenge.

In our understanding, a long-term care system should be an integral part of the health care system. The scope of long-term care cannot be limited to help with ADL activities or “personal care” as persons with a chronic condition and frailty need a range of health services and interventions in some stage of their condition, among them for example those enumerated in the OECD definition: wound dressing, pain management, medication, health monitoring, prevention, rehabilitation or services of palliative care (OECD, 2011).
Long-term care focuses on the special segment of frail seniors and people with disabilities with a progressive condition, instability in health status and thus dynamic changes in their needs. The diversity of needs, of people and of situations makes it difficult to develop a comprehensive system of support and care which respects this diversity. Long-term care includes a special sector of professional health and social services provided in different settings (in the home, institution, special housing) and support of informal care as well as protection of carers.

An important aspect of long-term care is the length of time during which care is needed or provided. Duration of disease is an important factor for the organization and financing of services and has a different impact on the life and social situation of both carers and persons in need of care. There is no precise definition, however, of how long is long-term care. OECD definitions speak about an “extended period of time” (OECD, 2005, 2011) in relation to long-term care. Care provided for a period longer than 3 months is usually considered as long-term care within the Czech health system, though it is more important whether the patient is on an acute or long-term care bed. Such time limits and borders are however more important for insurance companies, financing and management of care rather than for the person in need of care and the carers. In any case, there is a need to differentiate between long-term care for frail seniors and persons with permanent physical, mental or sensory disability. Long-term care services are targeted at those who require support and care due to worsening health, chronic condition and frailty which usually lasts months or years in contrast to life-long disability.

The role of LTC systems, however, is not only to provide services to persons with loss or decrease in self-care capacity, but also to address other risks and needs related to long-term care and functional decline and growing dependence on a supportive environment and the help of others. Among such risks and functions of a long-term care system we can mention protection against costs of care (ability to pay for professional long-term care), protection against financial consequences for the carer (income protection and support during and after provision of care), protection against social exclusion of carers from the labour market, social exclusion of both persons providing and receiving care from social participation, protection of rights, dignity and freedoms of people dependent on long-term care, their protection against abuse, etc.

The situation of long-term care often affects several generations which are usually in different phases of their life-course, e.g. senior living on a pension and carer in a later stage of their career and still dependent on paid employment. The risks to be covered by the long-term system thus should include the well-being of the informal carer (spouse, partner, adult children, etc.), specifically of the health and income of the full-time or part-time carer, their access to employment and training, respite care, information and counselling, etc. The main instruments to fulfil these functions are provision of services, in-cash benefits and other measures in support of carers. Being fully or partially out of paid employment creates challenges for the carer and society as employment activity is often a necessary precondition for entitlement to participation in some welfare programmes.

Factors contributing to change in demand for long-term care

There is a range of factors contributing to the variation in demand for formal long-term care services, demographic development being only one of them and not the most important one. Among the range of factors which have contributed to the increasing importance of long-term care as a distinctive area of social protection, we can mention several long-term as well as more recent societal changes.

A rise in life expectancy and longevity translates into rising numbers of old and very old seniors. The risk of disability and frailty increases with individual and population ageing. Demographic development and its perception (demographic alarmism and fear of the economic impact of further structural ageing, fear of an ageing explosion and a “seniors’ wave”) is an important factor for politics and policy in long-term care. Nevertheless, decisive factors for explanation of
the paradigmatic shift in long-term care are probably to be found outside demographics.

Demographic ageing and fear of its consequences in developed countries appears together with other social changes in their health systems and society as a whole. Among many such changes we can mention early and better diagnosis, which improves survival and prolongs length of disease and potentially increases overall costs of care, and rising costs of acute care, mainly due to expensive technologies and pharmaceuticals.

Improved and more costly hospital care creates pressure to shorten hospital stays (McKee, 2002), which requires re-defining of boundaries between hospital care covered from health insurance and care to be covered from other sources (social insurance, state or municipal budget, etc.). Change in the definition of acute and post-acute care thus implies change in entitlements in terms of what conditions should be covered from health insurance. Hospitals in many industrialized countries have already transferred the long-term care of dependent older people out of hospitals into residential care and nursing homes. Thus, much of the cost has already been shifted from the health care budget to the social care budget (McKee, 2002).

Another factor contributing to the growing significance of long-term care is a rising specialization in medicine, which leaves more patients with chronic disease and frailty requiring non-medical or post-acute care such as rehabilitation out of the competencies of any specialty, acute geriatrics being largely underdeveloped in the Czech Republic and other countries as well.

Among factors influencing demand for professional LTC services is the changing role of the family. Together with the above-mentioned trends in health care and demographic developments there has been a rise in neoliberal orthodoxy and neoliberalization in recent decades (Harvey, 2005) with growing emphasis on market ethics, family values and morality. This shift in emphasis between the roles of the individual, family, community and society came at the same time as rising expectations towards public services, etc.

Availability of informal care depends on various cultural, social and demographic factors, including migration, urbanization, female employment, level of support to informal carers, access to public services (transport), etc. Moreover, shifts in emphasis on the family, family ties and values often come together with “verticalization” of the family and individualization of housing.

Much in the centre of the debate on long-term care lies concern about the future sustainability of long-term care as well as of health and pension systems. Future projections in some cases are based on a simplified presumption of constant costs and constant share of people depending on LTC within a given population and age structure.

The share of GDP spent on LTC services may be interpreted as a sign of development of the services and government priority, rather than as a level of dependence in an older population and demographic ageing. Moreover, very different traditions and forms of support in the situation of long-term care make it difficult to reliably compare countries with different social and health systems.

Similarly, it is difficult to interpret information about the percentage of older population living in various institutions as level of “institutionalization”. Institutional care can be defined as “long-term care provided in an institution, which at the same time serves as residence of the care recipient” (OECD, 2005). Information about the share of older persons in institutions does not say much about the level of disability. Cultural differences and different quality of residential care within the EU are more relevant factors for assessment of the situation in different countries. Whether people are cared for in families or an institution largely depends on culture, tradition, and the development and supply of social services. Between 2 and 5 per cent of elderly people were cared for in nursing homes in a study of 10 high-income countries (Ribbe et al. 1997). These differences can be attributed to policy decisions (with intended or unintended consequences) rather than to the characteristics of older populations or demographics in the respective countries.
The myth of escalating health care costs with ageing and blaming population ageing and the seniors boom for increasing costs of health and long-term care has been challenged and debunked by several authors and institutions (Friedland, Summer 1999; Gee, 2000; Mullan, 2002), although this myth is still uncritically accepted especially by some politicians and media. More recently, the myth of an extensive rise in health care costs in consequence of population ageing has been the subject of the ILC Policy Report called “Myths of the High Medical Cost of Old Age and Dying” which focused on the situation in the US. Rising health care costs are driven mainly by supply-side changes such as new and expensive pharmaceuticals and technology and their fast development rather than by demand-side factors such as demographics or patterns of disease. Among demand-side factors driving the increase in costs of health care, physician and patient expectations play a role (McKee, 2002).

As a recent OECD (Colombo, 2011) study on long-term care states, the most obvious way to reduce cost in long-term care systems would be to reduce potential dependency in later life through lifelong health promotion. And prevention is reflected in long-term care systems in some countries through financial incentives and benefits. In the case of Japan a community-based, prevention-oriented LTC benefit targeted at low-care-need seniors was introduced in 2006. In Germany the government introduced “carrot-and-stick financial incentives to sickness funds that are successful at rehabilitation and moving LTC users from institutions to lower-care settings” (Colombo, 2011).

Healthy ageing, effective hospital and ambulatory geriatric services, the responsiveness and age-friendlyness of the health system as a whole, including age-friendly primary health care (WHO, 2004) are key factors for reduction in demand for long-term care services. Pushing frail seniors out of the competence of the health care system and labelling them as “social” can be interpreted as a sign of age discrimination and unresponsiveness within the health care system.

As an approach promoted by WHO shows, the delay of disability should be a central part of any strategy for healthy and successful ageing (and thus long-term management of demand for LTC). The effort to increase positive health and health potential across the life course, reaching the maximum level of health and staying above the “disability threshold” as long as possible should be explicit goals of healthy and active ageing strategies. Moreover, as the WHO model of life course approach to health clearly shows the “disability threshold” is not an unchangeable, natural or universal level for all seniors, but very much a socially determined threshold which can be lowered by appropriate policy interventions (WHO, 2000). The WHO Age-friendly cities project is one example of a comprehensive approach to creating such an enabling and supportive environment in urbanized space. By such a strategy, policy intervention and integrated effort at local and community level can decrease dependence on the environment and the demand for informal and professional long-term care.

In recent years, much attention has been paid to the use of ICT in the provision of long-term care and in creating a supportive and safe environment for frail seniors. The issue of ICT in long-term care and ageing is often a part of the broader concept of e-health, e-inclusion, and digitalization of other important areas of society and life such as government, business or learning. Nevertheless it needs to be emphasized that most such ICT-based initiatives are focused on research and development of innovative measures and that broader use of ICT in wider parts of frail populations lags considerably behind. Interest in the use of ICT is often accompanied and driven by “commodification” of social and public services and is part of a broader movement of silver economy, which is often presented as a consumption-based antidote to the economic consequences of ageing and decreased labour participation of the ageing population. From the point of view of critical gerontology the prominence and rise in the use of ICT in policy and market-based solutions can be interpreted as a part of “aging enterprise” (Estes, 1976, 2001).  

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The ICTs have broad potential use in relation to long-term care and an age-friendly environment. It is not possible to review all ICT-ageing projects here, nevertheless we would like to emphasize the role of ICT in creating a safe home environment and its potential to help bridge barriers between the social and health services. One important aspect of health and social integration is connecting and sharing information between the two parts of the long-term care system and the contribution of ICT to seamless case/care management. ICT can significantly reduce the care burden in highly-intensive care in both a home- and institution-based setting and environment. One of the most challenging subgroups of frail seniors in this context is people with dementia. There are several projects addressing the needs of this group. Moreover, in some countries great attention is being paid to how dementia could be recognised in an early stage by technology and thus its progression slowed (e.g. Netherlands). ICT not only can increase and enhance labour productivity in formal LTC, but also ease the burden and mitigate risks for informal carers. CARICT is an example of a project seeking to explore and better understand how technology-enabled services and applications can allow informal caregivers and family-employed care assistants to better engage with the people they care for.\(^3\)

Although from a public health and life course perspective determinants of later disease and condition lie in early life and have life-long impacts, the possibilities of health promotion for and with older people are often underestimated due to scepticism and a culture of ageism (Killoran, 1997). Healthy ageing should start as soon as possible to have the greatest and long-term impact. Nevertheless it should end as late as possible as well. With an increasing longevity, we can argue that the scope for health promotion in later life is increasing as well.

The results of research on successful ageing are promising, providing knowledge for behavioural change, intervention and strategies to promote health in seniors. For example, Carmel et al. distinguish between proactive coping, which precedes the decline in health and functioning and constitutes preparation for potential scenarios of loss of health and functioning in later years, and reactive coping, which comes into play following such losses. Strategies of coping, its determinants and behavioural change need to be further researched, including the role of genetics, environment, etc. Life course approach remains prerequisite for any long-term strategy for healthy ageing, allowing for a decrease in social inequalities in health and disability and accumulation of disadvantage across the life course (WHO, 2000).

As the causes of death and disability change with rising life expectancy and longevity, the focus of medicine has to change and broaden as well. Its scope should move beyond disease-specific outcomes and be replaced with a primary interest in syndromes such as frailty as an era of diagnosis is over (Kalvach, 2008, 2011). Active effort for the creation of conditions for achieving dignity (“dignitogenesis”), self-respect and empowerment becomes a primary goal in health and long-term care (Kalvach et. al, 2011).

Although it is recognised that health problems are not manageable through clinical medicine and investment in prevention is critically needed, it remains a largely unfulfilled promise as there is a huge gap between political practice on the one side and research evidence and expert recommendations on the other. In the Czech Republic, e.g., only 4% of total public spending on health is used for prevention (Holčík, 2010).

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\(^3\) More information can be found at http://is.jrc.ec.europa.eu/pages/EAP/documents/ICTcarers4pageleaflet.pdf
Demography, healthy life expectancy (HALE) and need for long-term care

The number of people “at risk” of need for long-term care depends on health, chronic disease and disability. The risk for society and the individual is rising with ageing. Nevertheless, comparing differences and development in life expectancies does not provide sufficient information about the state of health. “Health-adjusted life expectancy” (HALE) or “healthy life years” (HLY) are becoming more widely used in relation to policy-making and health. For example, the EU uses HLY as a structural indicator to 1) monitor health as a productivity/economic factor, 2) introduce the concept of quality of life, 3) measure the employability of older workers, 4) monitor progress made in access, quality and sustainability of healthcare.

On a country level, for example, the United Kingdom has used healthy life expectancy (HLE) to monitor progress towards achieving targets in a wide range of policies, for example: 1) The Department of Health’s (DH) National Service Framework for older people includes targets to increase HLE for older people; 2) The Treasury’s work on long-term fiscal sustainability sees future HLE as an important demand driver; 3) The Department for Work and Pensions’ strategy for tackling poverty and social exclusion uses HLE as an indicator. Achievement of successful ageing requires that the onset of infirmity is delayed and healthy life expectancy increases more rapidly than average life expectancy, thus leading to compressing morbidity into a shorter period of life before death (Fries, 1980). In other words, it requires that we are able to prolong healthy life, not life itself, and that the focus should move to morbidity rather than mortality (Fries, 1980). Nearly all acute diseases have been replaced by chronic diseases, which can be approached most effectively with a strategy of “postponement” rather than of cure (Fries, 1980). According to Fries (1980) the end of the period of adult vigour will come later than it used to. Postponement of chronic illness thus results in rectangularization not only of the mortality curve but also of the morbidity curve (Fries, 1980). If the rate of progression of disease is decreased, then the date of passage through the clinical threshold is postponed; if sufficiently postponed, the symptomatic threshold may not be crossed during a lifetime, and the disease is “prevented” (Fries, 1980). Again, it is only possible and sustainable through prevention. As Fries stated in 1990 “the ability of society to pay ever-increasing costs for ever-more vegetative existence has been called into question” (Fries, 1990; in Baltes, 1993).

Robine et al (2011) focused on the relationship between longevity and health and the question of whether the increase in healthy life expectancy is slower or faster than the increase in total life expectancy. According to their analysis there is a north-south gradient in the functional health status of centenarians in Europe with better health in the north than in the south. An analysis of the correlation between life expectancy at age 65 and the number of healthy life years (HLY) in 2006 for the 24 EU member states having comparable disability data (EHEMU, 2009) suggests that the strong increase in healthy life expectancy is more a feature of countries that are catching up with the best countries in terms of population health, rather than a characteristic of countries leading the longevity revolution (Robine et al 2011). However, there is a clear trend showing that the higher the life expectancy, the higher the healthy life expectancy. They conclude that there is no strong evidence today of compression of morbidity and disability in the countries that lead the longevity revolution (Robine et al 2011).
The pattern of relationship between life expectancy and healthy life expectancy remains unambiguous and needs to be further clarified. Nevertheless, it is clear that an activity and social participation are key determinants for delay of disease and dependence as “inactivity and isolation accelerate physical and psychological declines, creating a negative spiral towards premature, preventable ill health and dependency.”

As regards life expectancy, Europe remains divided into West and East, with Eastern Europe lagging behind the West, which shows that “the past has a long future” (Holčík, 2011). For example, when comparing the Czech Republic and Sweden, in 2010 the Czech Republic lagged behind Sweden by 4 years (76.9 as compared to 80.9). However, in terms of delay in years, i.e. the time when the Czech level had been reached in Sweden, the Czech Republic lags behind Sweden by more than 20 years (Holčík, 2011). Such a gap cannot be attributed to difference in quality of health care, medicine or pharmaceuticals (the Czech Rep. is not 20 years behind Sweden in those factors), but to broader determinants of health such as life style (especially smoking, consumption of alcohol, diet, etc.) and environment. The latest available data for HLY (Eurostat, EHEMU) show that people in the EU-27 could at birth expect to live another 60.9 years of healthy life (i.e. without disability or activity limitation) for men and 61.6 years for women. Men spend a longer part of their life in health and experience a shorter time of activity limitation as female life expectancy is higher than that of men. Women could live nearly three quarters of their total life expectancy (74.5%) without activity limitations, while men approximately four fifths (79.4%) of their total life expectancy at birth. At the age of 65, men could expect to live another 8.2 years in health (without activity limitations) out of 17 years (total life expectancy at 65), while women another similar 8.3 but out of the total of 20 years (EUROSTAT, 2009).

Across the EU, differences among member states were much greater for healthy life years (HLY) than for total life expectancy (LE). In 2009, the maximum difference in LE within the EU was 12.3 years for men (LE ranging from min. 67.5 to max. 79.8) and 7.6 for women (min. 77.4 to max. 85.0). In contrast, the maximum difference in healthy life years (HLY) was 18.4 years (from 52.1 to max. 70.5) for men and 18.3 years (from 52.3 to 70.6) for women (EUROSTAT, 2009).

The lowest difference between healthy life expectancy (HLE) and LE in a given country, i.e. the highest percentage of life expectancy without disability, could be seen for Malta (88.9%), Sweden (88.8%), and Bulgaria (88.4%) for men and in Malta (85.3%), Bulgaria (84.8%), and Sweden (83.3%) for women, with Bulgaria having significantly lower values for both LE and HLE than Sweden (LE for men was 70.1 in Bulgaria compared to 79.4 in Sweden, and 77.4 compared to 83.5 for women). HLE for men in Sweden was even higher than total life expectancy in Bulgaria, which means that Swedes had a chance to stay healthy (without any limitation) until a higher age than Bulgarian men could survive. For the Czech Republic the values of HLE and LE are 60.9 and 74.2 years for men (82.1% of LE without activity limitations) and 62.5 and 80.5 for women (77.7% of LE without limitations). The Czech Republic thus lags behind Sweden in healthy life years for men even more than Bulgaria as Czechs could expect to live 10 years shorter healthy lives than Swedes (60.9 and 70.5) (Eurostat, 2009).

Provision of long-term care for seniors in the Czech Republic

At present, there is no integrated system of long-term care in terms of a distinctive system of services for a specific segment of the population requiring social and health services based on their chronic condition. Responsibility for long-term services is divided between the Ministry of Social Affairs and the Ministry of Health and is provided within both health and social care facilities.

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7 HEIDI data tool http://ec.europa.eu/health/indicators/echi/list/echi_40.html

However, “long-term care” is provided under very different conditions within social and health care facilities. Social services and health facilities have different systems of registration of providers, quality standards, system of financing, division of competencies between state, regions and municipalities, sources and ways of financing. Social and health care facilities usually do not coordinate their services, and there is no care manager at local level. Nevertheless some providers are able to provide both social and health services in home or institutional settings, but this ability largely depends on local support from municipal authorities. The division of competencies between the social and health systems, and unclear responsibility are considered by many experts to be the key obstacles to provision of integrated seamless long-term care aimed at improving quality of life and the prevention of functional decline and permanent “institutionalization”.

Long-term care within the health care system

Health care in the Czech Republic is financed through general public health insurance. There are 12 health insurance companies (1 public and 11 private), which are operating under very similar conditions (according to the law on health insurance). There is no private health insurance in the Czech Republic. Out-patient health care in the Czech Republic is provided by general practitioners and other primary care physicians such as dentists, gynaecologists, and ambulatory specialists. In-patient health care is provided in hospitals, “therapeutic facilities” (e.g. therapeutic facilities for long-term patients), psychiatric and rehabilitation hospitals. Under the law on health services (Law No. 372/2011), hospital beds are classified as acute hospital beds for intensive care, acute hospital beds for standard care, after-care hospital beds, and long-term hospital beds. Long-term hospital care is provided to “patients whose health cannot be substantially improved by therapeutic care and whose health would deteriorate without continuous provision of nursing care”. Beds for intensive hospital long-term care are for patients whose basic vital functions are compromised.

According to the law on health services health care provided in the “social environment of the patient” included visitation service of general practitioner and home health care. Home health care is defined within this law as “nursing care, curative and rehabilitation care, or palliative care provided in the home environment of the patient”. Home health care is provided by nursing agencies. In 2010, home health care was provided to 143 ths. people, 79% of them aged 65 and over. Home health care received 7% of all persons aged 65 and over in 2010. Patients with chronic conditions made up 85% of all patients. One worker (general nurse) made on average of 7 home visits per day; 92% of the care provided was covered by health insurance (ÚZIS ČR, 2011).

The General Practitioner as a primary care physician is authorised to prescribe home care and drugs according to the patients’ needs. Medical aids, including incontinence pads and other so-called induced services, such as specialist consultations, other auxiliary, laboratory, and imaging medical examinations, are also supposed to be prescribed and indicated by GPs and are included in GP’s hypothetical budget that is regulated by the insurance company. General Practitioner’s care is funded on a per capita basis which means that they receive regular payment according to the number of registered patients and their age. GPs are also supposed to visit their patients in their homes. In case of special care needs, patients are referred to specialists. If hospital care is needed, they are referred to acute care hospitals or long-term care hospitals.

Persons with long-term care needs are referred to long-term care hospitals. In such cases care provided is fully covered by the health insurance, even if patients stay there for several months or even years. Long-term care or “aftercare” units are parts of general hospitals or long-term care or psychiatric hospitals, etc. Despite the fact that they are part of a health care system, which has undergone important changes, received major investments and is relatively well developed, the positive changes do not apply to many of these units. Very often they are insufficiently equipped, located in decrepit hospital buildings, sometimes also with significant architectonic barriers. Very often the staff numbers and qualification are lower than necessary.
and the quality of care is insufficient and these departments are too “hospital-like” for long stays of persons with disabilities. Typically, people are required to stay in their beds even when it is not necessary and in consequence different restraints such as bed-rails, permanent catheters, etc. are overused there. Family members are not generally satisfied with the quality of care; nevertheless, it is easier for them to accept this as care is completely free, except for the “regulation fee” which nowadays amounts to 60 CZK (app. 2 Euros) per day. This might be one of the reasons why this inefficient and ineffective system has persisted for such a long time even after the change of political system and thorough changes in health and social care legislation.

Long-term care within the social services system

Persons with very similar health conditions and needs to those in health facilities can be found in homes for seniors (before 2006 called “pensioners’ homes”) or “homes with special regime” within the social care system. The law on social services stipulates different types of social services and conditions for entitlement to “care allowance” provided to persons with disability and decreased self-care capacity.

Persons with limited self-care capacity and in need of long-term care can apply for care allowance according to the law on social services. There are four degrees of “dependence on care” based on assessment of activities of daily life (IADL, ADL) by a physician (medical assessment service) and social worker (employed by the municipality) with four corresponding amounts of “care allowance” (800, 4,000, 8,000 and 11,000 CZK, which amounts approximately to 32, 162, 323, and 444 EUR).

As a mandatory attachment to their application, a GP has to provide a report on the patient’s (claimant’s) health status (which usually summarises diagnoses) as well as a report by a social worker. The social worker has to visit the patient in his/her home, not in a health care institution. The report by a social worker includes a check-list monitoring which activities of daily living are impaired. However, social workers do not have sufficient skills in self-care capacity assessment. Therefore, they often only fill in the check-list as a questionnaire, asking patients questions about their self-care capability. Sometimes the responses are relevant, sometimes not. Especially persons with dementia overestimate their capacity (e.g. an 87-year-old woman with dementia who lives in a residential home answered that she is capable of managing all activities of daily living and she also takes care of her mother) – this opinion is documented in the check-list of ADLs and IADLs. Based on this, often biased information, the physician of the social department (who does not meet the patient in person) decides which care allowance (degree of dependence) will be allocated.

The care allowance is financed by the state from the state budget (tax-funded) and is not means-tested. The care allowance is the main source of funding of care, both at home and in institutions. Persons who receive a care allowance may receive care either from their family caregivers or from registered social services. Social services are registered by the regional authorities according to the social services act. There are 14 regions in the Czech Republic, including Prague, the capital city which is one of the regions.

Persons with decreased self-care capacity and disability are supposed to purchase services from registered social care providers. Nevertheless, they may also be cared for by their family caregivers and other persons. In fact, the majority of receivers prefer to receive care given by a family member (app. 80 %). The share of care provided by family (informal) carers of course differs with dependence on care as people with the 4th degree of dependence have to rely more on professional services.

Homes for seniors are defined as social care institutions that provide care for seniors who need “social care” (personal care or help with ADL), whereas “homes with specific regime” are defined as social care facilities that provide care to persons with “specific needs”, which include people with Alzheimer’s disease. Both seniors’ homes and homes with specific regime have an obligation to ensure provision also of health care either by their own staff or by professionals from
health care services. This applies to availability of both physicians and nurses (medical and nursing care).

In comparison to long-term care health facilities, there are usually less staff available and also considerably less nursing staff in social care homes. It is difficult to find general practitioners and specialists for social care homes as their care is expensive and consumes much of their budgets. Due to the restrictions by insurance companies (and sometimes necessary out-of-pocket payments), difficulties may occur also in drug prescription which is sometimes very limited and does not respond to the needs of persons residing in social care facilities (e.g. very low prescription rate of cholinesterase inhibitors, antidepressants and also modern and effective analgesics, etc.). In general, we can draw the conclusion that people who live in social institutions have unequal access to health care and are disadvantaged in their opportunities to benefit from health insurance and health services.

People who stay at home are cared for by their family or other informal caregivers, alternatively they can purchase registered social services. Older people very often do not know and are not properly informed about what is the purpose of the money they receive as their care allowance and they tend to put it aside for themselves or their families without obtaining the necessary services.

Despite the fact that the social services act has brought about some important changes in the social care system in the Czech Republic, there are still many gaps and problems, especially in the care provision for persons with chronic conditions and need for long-term health and social care, most of them being older people.

Apart from that, another major problem is the availability of services. It is generally known that especially small communities do not have access to sufficient (or any) social services. The authors of the legislation on social services expected that the law would bring about the spontaneous creation of a market in social services. However, these expectations were not met and a boom in the creation of new services for frail seniors did not happen. Social services remain underdeveloped as people do not spend their care allowance on purchasing social services they were offered and in some cases those services started to erode.

Obviously, there are also many other factors necessary for care provision in the home environment – different types of support, education and respite care for family caregivers. These services are still unavailable to many seniors and informal carers. Despite the fact that most persons with long-term care needs (approx. 80%) stay in their home environment and are cared for by their family caregivers, the situation in formal care and comprehensive support of informal carers remains difficult.

Possibilities of integrated LTC provision in the Czech Republic

Despite the above-mentioned obstacles within the system of health and social care provision (especially in the field of long-term care where both components should be coordinated), some examples of integrated care provision already exist. Most of them have been made possible thanks to the active support from local authorities, and their interest in this kind of care.

The Gerontology Centre in Prague’s 8th District started its activity 20 years ago in 1992. The project of the Centre was designed in 1991 in close collaboration with the local authority of Praha 8 (a major district of Prague with 106 ths. inhabitants). At the beginning of the last decade of the 20th century, it became clear that there is an increasing demand for services for older people. In Prague 8 there was already a developed network of existing health and social services. However, it was clear that some services for older persons were still missing. After consultations with other care providers and local authority representatives, it was decided that the project should cover especially problematic and neglected areas – rehabilitation of older persons after their stay in hospital, and also situations when older persons are not able to stay in their homes because of their deteriorated health conditions and at the same time their condition is not indicated for acute care either. It was decided that “semi-mural” services (day-care unit) and domiciliary services would also be useful compo-
nents of the whole spectrum of care for older persons in the community. For the last two decades, the Gerontology Centre has been developing services in close collaboration with the municipal authority in Prague 8. Gradually, different types of services were established: a geriatric rehabilitation unit for 32 patients, palliative care unit for persons with dementia for 12 patients, day-care unit for persons with dementia (capacity 15 persons), home nursing care (60 clients), geriatric clinic, geriatric team visits and also auxiliary services such as meals on wheels, emergency button service for persons who stay at home, and home assistance. Collaboration with three neighbouring residential homes was established, in the framework of which the Centre provides the service of a general practitioner. These professional health and social care services are complemented by the services of the Czech Alzheimer Society (founded in 1996 in the same premises and working in conjunction with the Centre). The services of the Czech Alzheimer Association include respite service at home, consultations, counselling, providing written information materials, etc. Another NGO under the roof of the Centre is GEMA which organises leisure activities for seniors: dance courses (well-established and popular for more than a decade), internet café for seniors, various meetings, trips, teaching activities, petanque, nordic walking, voluntary activities “for seniors and others”, etc. The strategy is based on proactive and preventive measures rather than just easing the symptoms. Older persons are encouraged to be part of activities which promote health and mental well-being.

We aim to maintain their participation by building a community of interested individuals. In case of illness, interventions are designed to help the clients regain their self-care capacity through a short-term stay in the department and the case management approach enables them to return to their home environment with the option of using a variety of our services.

Conclusion

At present, the situation in the health and social services in the Czech Republic does not allow for an integrated seamless care provision oriented on functional status, quality of life and social inclusion. However, this might change when communities and municipalities acknowledge the importance of quality services for frail seniors and take appropriate measures to assure integrated services for their citizens. The feasibility of this prospect was clearly demonstrated by the example of the Gerontology Centre and the local authority of Praha 8.

New legislation on long-term care which is now being prepared by the Ministry of Labour and Social Affairs and the Ministry of Health will hopefully bring about some substantial changes in the long-term care provision and in coordination of services on the community level such as establishment of multidisciplinary teams, community nurses, introduction of comprehensive evaluation, etc. which are the declared main principles of this legislation. In our view, municipalities should play a crucial role in development of long-term care services. Their participation is not only indispensable for establishing a functioning system of integrated care services for older persons and other groups, but also for implementing an active ageing strategy and age-friendly policies at local level and thus increasing the quality of life of all generations.

References

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