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CATALOGUE OF GOOD PRACTICES

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INTRODUCTION

The world's population is aging rapidly, resulting in unprecedented public health challenges for most of the world's countries. The demand for diverse healthcare needs is rapidly increasing with the complexity of providing healthcare to older populations. Despite demographic changes, the social and healthcare system in Slovakia has been slow to adapt to the new conditions. As a result of challenges in the formal care system, the number of unpaid carers is growing rapidly, accounting for almost two-thirds of care provided.

As the population ages rapidly, there is an increasing demand in the long-term care sector to provide care to more older people with complex illnesses and increased specialist care needs. This places an enormous burden on long-term care systems, which is projected to increase in the coming years. In more than half of OECD countries, population aging is outpacing the growth in long-term care supply. OECD countries have recently been pushing for deinstitutionalization and community care policies for older adults. These policies respond to the common pressure on the costs of aging populations and the challenge of providing better care for older adults. They aim to replace institutional services with less costly ones, to increase citizen satisfaction, and to reduce spending. The number of long-term care workers is stagnating or declining, even in countries where the supply of long-term care is much higher than the OECD average (e.g., Norway and Sweden). As the population continues to age, the

demand for long-term care workers is likely to increase (OECD, 2020).

The health and social care system in the Slovak Republic is struggling and to some extent failing to meet the needs of care and support for independent living of older adults. Health problems of older people are often addressed in a disjointed and fragmented manner between different care providers. There is persistently little coordination at the municipal, community, or national level. The involvement of many health and social care professionals and the implementation of multiple clinical interventions requires a high degree of coordination between professionals as well as across levels of treatment, settings, prevention, and health promotion. Supporting citizens in need of care and social assistance is an essential measure that delivers long-term results. It is a clear challenge for the Slovak Republic to meet the care and support needs of an aging population now and in the future. In this guide, we offer examples of good practices from selected countries around the world. Different national approaches to the integration of health and social care are analyzed in the context of different discourses of integrated long-term care.

BELGIUM

The social protection system for the elderly is well-developed in Belgium. Healthcare costs in old age may be high in the future, which is why the Flemish government introduced social care insurance in 2001. This form of insurance does not exist in Wallonia. From the age of 26, every person residing in Flanders must contribute 25 euros per year to finance the scheme. Social care insurance provides contributions that cover medical expenses only. The allowance can be used for home and community care, compensation for individuals providing regular assistance to another person, as well as for support measures needed by the person requiring care. Belgium provides all types of social services for the elderly. The Belgian Government is seeking to strengthen social assistance geared towards the elderly to ensure that they can remain in their family home environment for as long as possible. There are various options to help seniors at home, e.g. Financial assistance and help in different types of healthcare facilities (Long-term Care Report, 2021), as well as services for maintaining the senior‘s home, cleaning and household chores, staying in sanatoriums for the elderly (medical institution, facilities for the treatment of certain illnesses or the treatment of protracted illnesses), physiotherapy, social loans, palliative care, social assistance, delivery of daily meals, monitoring, and signaling systems for senior households, hairdressing services, etc. Seniors have access to an extensive network of social centers for local and regional home

care assistance.

An example of practice in the provision of care for the elderly at the municipal level is the ***"De Weister (Woonzorgcentrum De Weister) Residential Care Centre***" in Aalbeek, Belgium. This model is based on the provision of services in residential care facilities. The De Weister Residential Care Centre consists of 46 residential units in three residential houses. Two of them are for seniors with dementia and the third offers a home for seniors who need physical care. The center helps to create a safe and peaceful atmosphere with an emphasis on the ‚ordinary' aspects of everyday life. It was created to maintain small group living and to make it as close as possible to the feeling of living at home. Since December 2012, it has been working based on the principles of ‚normalized small-scale living' (World Bank, 2020).

A large part of the cost of many of these services is covered by local regional funding. In addition to the public system, private organizations are also involved in the provision of social services for the elderly. In both cases, i.e., in the public and the private sector, the reimbursement for assistance usually depends on the income of the elderly person. Community care for the elderly can be provided by a responsible person, a volunteer, a partner, a parent, a child, a friend, or a neighbor. Care providers have the right to use social health assistance from their insurance (European Union, 2012). Belgium has day centers, residential day centers, and short-stay centers for the institutional care of the elderly. If home care for the elderly is not sufficient, there is the

possibility of placing the elderly in a day center or residential care center. These centers provide services for the elderly, such as staff supervision throughout the day, medical supervision, and the organization of leisure activities. These centers are suitable for seniors after a stay in the hospital who need support during their convalescence before returning home. Seniors can be placed in these facilities for short-term stays, up to three months in any one year. A nursing home or retirement home provides a safe and stable environment for seniors to live.

CZECH REPUBLIC

In the Czech Republic, care for the elderly in the home environment is widespread. In general, social services are primarily for people whose self-sufficiency and ability to take care of themselves and their household is limited for some reason. Social services are intended for families with children, people with severe disabilities, the elderly, and socially disadvantaged groups. There are three basic types of social services: (i) social counseling, (ii) social care services, and (iii) social prevention services. They take three basic forms: residential, outpatient, and outreach social services. The provision of social services is regulated by Act No 108/2006 Coll. on Social Services, as amended. Social services can be financed regionally, by the government, by municipalities, and by EU grants. Care for the elderly in the home environment can also be provided by a non-public provider. Thus, the provider can be any legal or natural person who is registered. To individualize and improve the quality of social services, in 2002 the Ministry of Labor and Social Affairs of the Czech Republic developed the Quality Standards for Social Services, which meet most of the recommendations of the Voluntary European Framework for the Quality of Social Services. The Standards were initially only of a recommendatory nature, but since 1 January 2007, they have become a binding document as an annex to Decree No. 505/2006 of the Ministry of Labor and Social Affairs. According to this law, the social assistance provided shall be accessible, efficient, of high quality,

safe, and cost-effective. To raise awareness of the availability of social service providers, a Register of Social Service Providers has been established. Social services are provided in three forms - residential, outreach, and outpatient. There is also diversification and increased specialization of social services. The law has distinguished 20 different types of social service establishments. In addition, personal assistance, nursing care, emergency care, guide and pre-reading services, support for independent living, and respite care are provided in the field of social care services. Perhaps an even more significant element is the introduction of the so-called care allowance. The allowance is paid in amounts ranging from CZK 2,000 (light dependency) to CZK 11,000 (full dependency) per month. The allowance should financially help to provide care within the natural community and thus increase the share of outpatient and outreach services at the expense of residential services. Another significant change is the obligation to draw up medium-term development plans for social services for the regions and the Ministry.

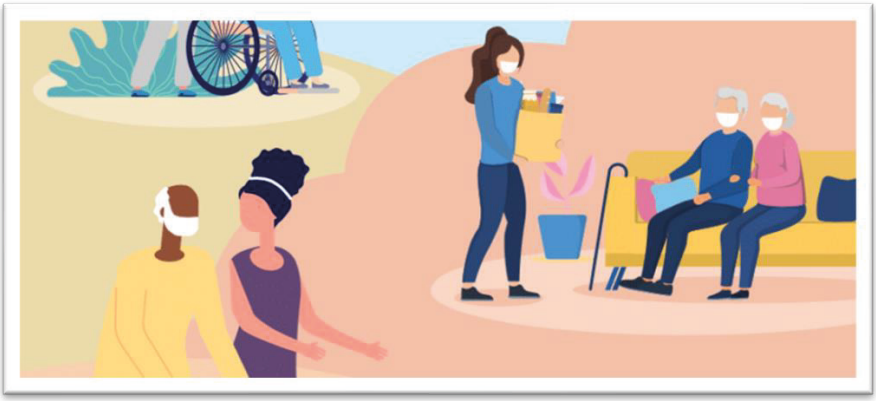
The Czech religious non-profit organization Silesian Diakonia provides high-quality services and focuses on implementing best practices through international cooperation. In addition, it strives to provide high-quality community-based support services through personal assistance and respite care. One of its activities is the training of caregivers in providing appropriate care for the physical and psychological well-being of those in need. This support is based on multidisciplinary and tailored care in the home environment (World Bank, 2020).

Municipalities and counties shall ensure that appropriate conditions are created for the development of social services, in particular by ascertaining the actual needs of the people and the resources needed to meet them; they shall also set up organizations providing social services themselves. Non-state non-profit organizations and individuals offering a wide range of services are also important providers of social services.

Home care is a service provided, among other things, to people who are no longer self-sufficient because of their age. The service helps with special tasks: assistance with daily activities, assistance with personal hygiene, assistance with meals and catering, assistance with household management, and contact with the social environment. The following types of care can be provided to the elderly in the home environment:

- Home care. The service aids with hygiene, provides meals, and helps people with limited personal hygiene and home care skills in the home. It is provided in the home and the user contributes to the funding of the service.
- Personal assistance. This service is for people whose abilities are limited due to age (for example, in personal hygiene, use of public spaces, household care, contact with family or wider society, among other things). The service is provided in the setting where the person lives. Personal assistance services also include reading, interpretation, and counseling. The user contributes to the funding of the service.

- Respite Care. This care is otherwise known as relieving or respite care, it is care for the caregivers. It helps people care for a person with a disability or an elderly person (often a family member) for a long period. It aims to make things easier for carers, giving them a place to recharge and regain their strength and energy.



DENMARK

In Denmark, health and social care is available on a universal basis, depending on need and not on age or ability to pay. Health services, hospitals, and social care are free of charge for older people and financed by general taxation. The concept of Danish aging policy assumes that a wide and varied range of services and activities are available to older people. Services relating to integrated health and social care include home help, home nursing care, rehabilitation, and retirement homes. Apart from nursing homes, Denmark has almost no institutions outside the hospital system to care for the frailest elderly. Their needs are met through integrated health and social care within the municipalities. The provision of integrated health and social care for older people is based on the concept of self-care. The concept of self-care involves the acceptance of the person as a free, independent thinking and acting individual with the ability to make decisions about his or her life. The aim of Danish long-term care (LTC) is to improve the quality of life of people in need of care and to increase their ability to take care of themselves. LTC is organized and provided by 98 municipalities and 5 regions. Long-term care is financed through general taxation and is generally provided free of charge. This system is probably the most universal and comprehensive in the world. Most long-term care is provided in the form of residential care or special housing with professional staff or in-home assistance. Most of the system is organized and funded at the local level, with 98

municipalities receiving and providing most long-term care services.

The regional level is responsible for primary health. There are no long-term care policies at the central level, although national politicians agree on general regulation and often conclude budget agreements that set the economic conditions for local policies. While national politicians define the main elements of long-term care, local politicians define how much care should be provided, by whom, and under what conditions. In layman's terms, this leads to 98 municipal versions of the Danish LTC system (Kvist, 2018). The LTC system consists of five elements (Kvist, 2018):

1. preventive measures
2. rehabilitation
3. domestic help
4. homes for older adults
5. other measures, including personal assistance and catering services

The implementation of assisted living technologies in private homes and nursing homes plays a key role in addressing this challenge in partnership with citizens, enabling solutions that are sustainable, viable, and do not compromise the quality of care. In Denmark, care for the elderly focuses on the involvement and empowerment of each citizen, considering their individual needs and preferences. The aim is for older citizens to maintain their independence, to have control over their own lives, and to remain healthy for as long as possible in

their homes. For example, about one-third of Danish municipalities have introduced an electronic civil record. This solution meets the needs of professionals for mobile support in-home care and involves citizens in their treatment. Home care professionals and citizens work together to record information about ongoing care and treatment, giving professionals more time for actual care, while citizens are more involved in their health and treatment (Elderly Care, Denmark, 2023).

ESTONIA

In the Social Welfare Act, the state obliged local governments to provide social services. These services include home care, which under the Act is a social service organized by local authorities. It aims to ensure the independent and safe functioning of adults in their own homes by maintaining and improving their quality of life.

The local authority, in cooperation with the recipient and the service provider, prepares a contract that sets out the activities that the recipient needs help with to be able to function independently in their own home. Home care providers can be local authorities, private and non-governmental organizations, as well as tradesmen. According to the Social Security Act, each local authority is responsible for the provision and financing of social services. Home care services are provided in the home environment and include assistance with activities of daily living related to home and personal life. Home care services include help in the home (cleaning, delivering food, medicines, etc.) and personal assistance (help with washing, dressing, eating, using the toilet or changing incontinence nappies).

Depending on the economic situation of the client, services are provided for a fee or partially or completely free of charge. Home care services are free of charge for people whose income is below the minimum wage (€500 in 2018). Each case of need for home care is assessed individually. Regarding the financing of home care, most local authorities assess each case

individually to determine the amount of the co-payment, which depends on the income of the recipient and his/her family, or on other options to pay for the service. Some local authorities do not require any co-financing. This is therefore a matter for the local authority (Long Term Care Report, 2021).

FINLAND

In Finland, home care and nursing services are provided for seniors in the home in the event of reduced functional capacity or illness. In many municipalities, these services are combined under the term home care, which is complemented by support services.

Social and nursing services provided at home include:

- help with daily activities,
- assistance with meals, transportation, and escort services,
- home nursing and medical services,
- home rehabilitation,
- Sanatorium helps in acute situations or at the end of life.

In addition, the municipality may provide support to a relative who is caring for an elderly, disabled, or sick person who is dependent on the care of another person. This is the informal carers' support service, which consists of any services needed by the care recipient, care and leaves allowance for the carer, and support services. Another way of supporting care at home is through care within another family. In this case, the senior moves in with a carer within the family. These carers do not have to be social or health care professionals, but they do have to complete a preliminary course during which their ability to provide the care is assessed. A family care agreement will be concluded between the carer and the local authority. However, this form of care does not seem to be sufficiently well known.

In Finland, the municipality is primarily responsible for organizing social and healthcare services. These services include social and health services for the elderly. They are mainly financed by the public sector. Funding for social and health care is primarily provided by taxes collected by the municipalities and transfers from the central government. In addition, some fees are also paid by the clients/patients themselves. Municipalities are free to decide on the level of client fees to the extent provided by law. According to the Law on Planning and State Subsidies for Social Welfare and Health Care, municipalities may provide social welfare and health care separately, together with other municipalities, as members of a joint municipal authority, by purchasing services from the state, by purchasing services from another municipality, by purchasing services from a joint municipal authority, or by purchasing services from a private service provider approved by the municipality. Regardless of the method of provision, these services must be provided by law. Thus, all of the above services can be purchased from a private service provider if the municipality chooses to do so (Long-Term Care Report, 2021).

FRANCE

Over the last decade, public spending on long-term care has increased significantly in France. With these resources, nursing homes have been modernized and the level of home care and social workers has increased. The main aim of long-term care is to achieve an increase in employment, as long-term care, especially home care, is considered to be the most promising sector in terms of its potential for further growth. This strategy is combined with the introduction of market mechanisms to strengthen quality through competition and choice for users and their families. The number of providers and, in particular, the proportion of private for-profit organizations has increased substantially.

In France, centers linking social and health services for the elderly have been set up under the name: ***"Centres Locaux d'Information et de Co-ordination"*** (CLIC). CLICs are places where older people, their families, and professionals working in the field of gerontology and home care can find information and advice.

CLICs provide a free, confidential, and individual service regardless of the origin of the request, whether it comes from the older person, their family, social services, the treating doctor, the health and social care structure, or the hospital. It was initially launched on an experimental basis in 2000 with 25 pilot sites (Leichsenring, 2004). The vast majority of older people want to remain in their own homes for as long as possible. To do this, they need easy access to information about existing activities,

assistance, and services. To meet this expectation, the CLIC is the local coordination center: at the first level, the CLIC must be a place that people identify with, that is easily accessible, offers welcome, a listening ear, and provides the most comprehensive information about existing services in all areas of life. In addition to this first mission, the CLIC must be able to comprehensively and individually assess a person's needs, advise them, and help them to develop and implement a support plan. This means that the CLIC should not be limited to persons who are losing their independence but should be aimed at all citizens who are involved in a supported project to access their rights. This is a very concrete and at the same time extremely ambitious goal that will require the development and dissemination of tools that can be shared within the future national CLIC network (Le CLIC vous guide, 2023). Services provided by:

Free information about:

- home help associations,
- types of services (service providers, intermediaries, direct employment),
- domestic services (telecare, meal delivery, night care, etc.)
- medical equipment (walker, bedside table, medical bed, etc.),
- adaptations in the home (bathtub turned into a shower, stepladder, etc.),
- institutions (lobbies, EHPAD - Etablissement d'hébergement pour personnes âgées dépendantes - accommodation for dependent elderly people),

- professionals (SSIAD - services de soins infirmiers à domicile - home nursing services, physiotherapists, nurses, etc.),
- General Council,
- pension funds,
- possible assistance (APA - de I'Allocation Personnalisee d'Autonomie - personalized autonomy allowance, social assistance, housing improvement assistance, etc.),
- recourse to inheritance, etc.

Dependency assessment:

- assessing the older person's dependency,
- designing an assistance plan tailored to the person's health, social and environmental situation,
- Carrying out all the necessary administrative procedures (or assisting families with these procedures) to fund the proposed assistance plan.

Monitoring and coordination:

- promoting the exchange of information between different stakeholders and users,
- Improving the coherence of activities targeted at older people,
- reporting on the measures taken to keep the person at home in a safe environment to all health professionals working with the person and, in particular, to the professional who reported the situation to C. L. I. C. (Le CLIC vous guide, 2023).

As Frossard et al. (2004) suggest, "... integrated services are a set of services that are available to a particular population in a given geographic area, or to the population of a given geographic area, by a single company or organization, grouped under a single decision-making body." For "true integration" to occur, a stable organization must be established to ensure that the health care needs of a given population are fully covered, presumably within the health care system. An accompanying concern is that social services would either lose their identity and autonomy or become further "medicalized." Given the existing fragmentation of the health and social care systems, individual units would be unlikely to be prepared to accept unique, vertically integrated decision-making authority.

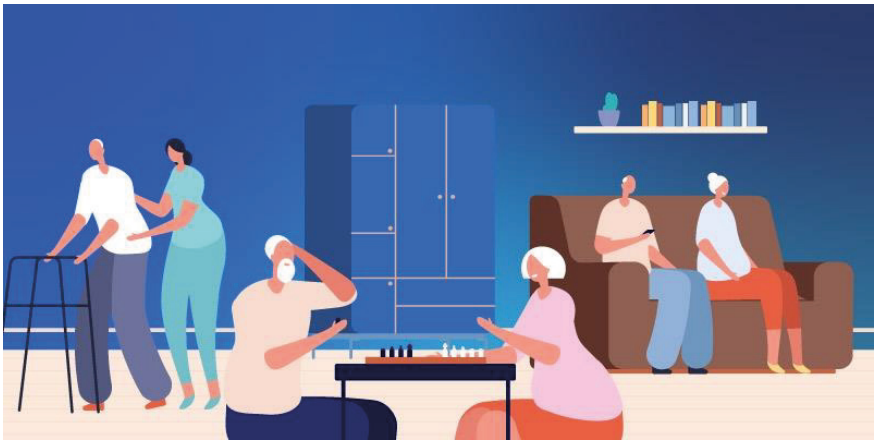
Therefore, in France, for example, the concept of integration in the form of a 'consolidated direct service model' (Leichsenring, 2004) is rather undesirable. Instead, we can observe a long history in that country in the theory and practice of "gerontological coordination" and networking: "Network or coordination refers to a voluntary organization of professional people (who may include volunteer workers) who pool their resources and assets to develop information, social, health and prevention services designed to address complex or urgent problems that have been identified as priorities in a specific geographical territory."

CROATIA

Home care in Croatia is, according to the Social Welfare Act, a social service for seniors who need help from another person. Home care service includes preparing meals, performing household chores, maintaining personal hygiene, and performing other daily activities.

Home care is provided to a senior who, according to the social center, needs help from another person. The right to assistance and care is granted to a person who is unable to meet his/her basic needs and as a result, needs immediate assistance and care from another person in preparing and eating meals, buying food, cleaning the house, dressing, and undressing, personal hygiene and other vital activities.

Home care is provided by home care centers, social institutions, community service centers, associations, religious communities, other legal persons, and small enterprises providing social services, but also by natural persons providing home care as a professional activity. The granting of the right to provide home care shall be carried out by the responsible social care center according to the place of residence of the recipient of the service. Social care is carried out in accordance with the general legislation of local and Zagreb municipalities, which define social programs in their territory and their content, scope, and financing (Report on Long-Term Care, 2021).



JAPAN

In 2000, Japan introduced a new social insurance system for the frail and elderly - long-term care insurance. This was an epochal event in the history of Japanese public health policy, as the country moved towards the socialization of care and changed its tradition of family care for the elderly. One of the main ideas behind the creation of long-term care insurance was to 'de-medicalize' and rationalize care for older people with disabilities, which is a characteristic of the aging process. Due to the aging of society, Japan's social insurance system needs fundamental reform. The introduction of long-term social insurance was the first step in further reforming the country's health care system. The long-term care insurance system requires each citizen to take greater responsibility for financing and decision-making in social security. The key concepts of a long-term care system for the elderly are self-determination and self-sufficiency, eligibility assessment, care management, consumerism, and integration of social and health services. According to Matsuda, and Yamamoto (2001), the services covered by the system are as follows:

- Home care: home help services, visiting nurse services, visiting spa services, visiting rehabilitation services, etc.
- respite care: day care services, day health care services, short stay services;
- institutional care: nursing home, health care facility for the elderly (rehabilitation facility), and geriatric ward within the system of integrated care for the elderly.

Based on the above examples, we can say that integrated care has long been shown to be a viable approach to overcoming gaps in care management for people with complex health and social care needs. However, it has been shown that to provide truly population-focused services that improve health, the scope of integrated care needs to be expanded to bridge gaps not only within the health system but also between the health and social care systems. As a result, initiatives are emerging at the international level that have a broader focus than healthcare integration. These initiatives focus on the merging of health care, prevention, welfare, and social services and are often referred to as population or health management (Struijs et al., 2015).

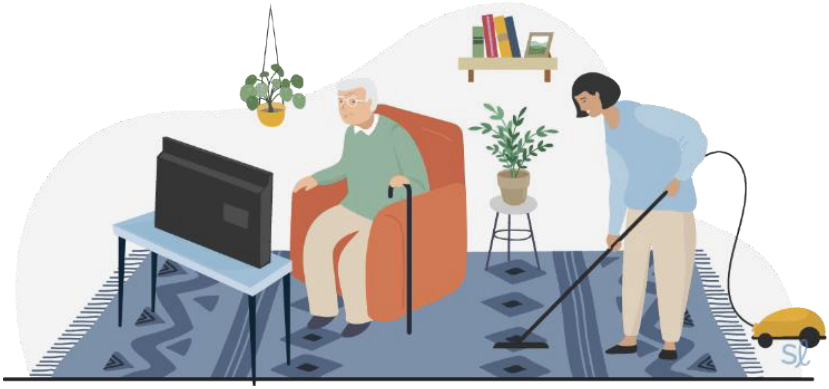
LITHUANIA

In Lithuania, home care can be provided by a public provider (municipality), but also by other providers. Social services can be provided by licensed providers from Lithuania or any other EU or EEA country. The Law on Social Services does not specify the legal form of a non-public provider. Services provided by non-public providers are the same as those provided by public providers, i.e., general social services or special social services. General social services are intended for those persons who do not need the permanent assistance of social services staff. Special social services are intended for those persons who are unable to look after themselves and who need temporary or permanent assistance from social services staff. Special social services are further subdivided into social visitation (socialinė priežiūra) and social care (socialinė globa) (Report on long-term care, 2021).

The degree of independence of a person depends on the assessment criteria set out in the methodology developed by the Ministry of Social Affairs and Labour. Attention is paid to the living situation, adaptability to the environment, ability to receive any assistance (from relatives and other people), the person's state of health, and the person's needs. Seniors staying at home may be assigned special permanent care and may be granted special transport costs. They may also be allocated special technical assistance and special medical assistance resources. If daily social care in the home environment is required,

they may be allocated total care (nursing and social).

Social services can be funded by municipalities, the state (through state subsidies to municipalities), and the people who need the services. However, if the service is funded by the recipient of the service, the amount paid by the recipient of the service may not exceed 20% of his/her income in the case of a social visit or 80% of his/her income in the case of social care. Home care is financed from the municipal budget and, in certain cases (depending on the state of health), from specialized allowances from the national budget.



HUNGARY

In Hungary, care for the elderly at home is regulated by the Act on Social Administration and Social Benefits. The provider of home care can be the local municipality, but also a non-public provider such as a sole trader, private and non-governmental organizations, a church, associations, or foundations. The only difference is that local authorities are obliged to provide social services, while NGOs and churches can decide whether they want to be involved in the provision of these services as well. Home care is a basic service provided by local authorities to residents with care needs to ensure that the recipients of this service remain living in their home environment. Care is tailored based on the age and health of the person concerned. Domiciliary care is a social service that includes care and nursing.

Since 1 January 2008, eligibility for residential care in Hungary has been limited to persons who need care for more than 4 hours a day. Persons requiring 2-4 hours of care per day are entitled to home care services. Care needed for less than 2 hours a day is not publicly funded. Care needs are assessed in a very comprehensive way. Applicants for care are assessed in 16 different activities and are assessed against 8 larger assessment criteria. For example, independence in activities of daily living (eating, washing, dressing, using the toilet), self-sufficiency (handling household tools and money), walking, mental health (orientation in time and space, communication), vision and hearing, need for health care, etc. are assessed. These abilities

and skills are measured on a scale from 0 to 5 and an algorithm converts the resulting values into the length of time the person needs care. This assessment reduced the number of people receiving this help by 10%.

Home care encompasses a wide range of activities that meet the physical, mental, and social needs of the recipient. Home care is intended to provide the recipient with hygiene maintenance, assistance with household chores, help to prevent emergencies and help when emergencies arise, and, if necessary, assistance with moving to a residential social care institution, etc. (Long-Term Care Report, 2021).

Social services can be funded regionally, by government, municipalities, and EU grants. Local authorities are obliged to provide or organize home care services mainly from their budget. As far as social benefits are concerned, local authorities receive support. The specific forms, scope, and conditions of this support are laid down in the relevant budget law. Support to local authorities depends on the number of beneficiaries of the service in the local authority. Local authorities often supplement this support with their revenue, depending on the resources available. Local authorities have the right to request co-financing from the beneficiary.

GERMANY

The internationally recognized integrated care model "Gesundes Kinzigtal" operates a regionally integrated care system in the town of Haslach im Kinzigtal in southwestern Germany. Its main philosophy is to create and maintain a healthy population on a regional scale. Gesundes Kinzigtal currently works with more than 260 institutions and organizations, including doctors' surgeries, hospitals, nursing homes, local municipalities, and local SMEs. Care providers are encouraged to identify patients who are at risk of certain diseases and enroll them in appropriate health programs. Gesundes Kinzigtal's intervention includes approximately 20 preventive health programs for specific diseases. The main aim is to improve the patient's overall health and quality of life. The integrated care applied at Gesundes Kinzigtal appears to be a promising approach to achieve the twin goals of, on the one hand, significant population health benefits and, on the other hand, substantial comparative savings compared to more traditional forms of care (World Bank, 2020).

Long-term care in Germany is covered by insurance. All residents are obliged to pay compulsory long-term care insurance premiums. Long-term care benefits are provided under the statutory long-term care scheme in the event of care needs or dependency. Long-term care social insurance is an independent part of social security that covers the risk of long-term care, similar to sickness, accident, unemployment, and old-age insurance.

The extensive list of long-term care benefits is intended to help alleviate the physical, mental, and financial burdens of care recipients and their family members, and to help them live the life they want to live with dignity despite their need for care. Anyone who is covered by statutory or private health insurance is automatically and compulsorily covered by statutory or private long-term care insurance. A qualifying period of two years is required to qualify for benefits under statutory long-term care insurance. Under the requirements of statutory long-term care insurance, a person who, as a result of a physical, emotional, or mental illness or disability, requires long-term care of at least 6 months to carry out activities of daily living needs this care. The relevant need for assistance extends to the areas of personal hygiene, food, mobility as well as general care and assistance in the home. The amount of long-term care benefits shall not be determined based on age or income but based on the extent of care needed, as determined by the medical department of the health insurance undertaking. Persons with less demanding care requirements (up to 90 minutes per day) or persons with partial insurance coverage (Teilkaskoversicherung), for whom the defined benefit amounts are insufficient to cover actual costs, may in special cases receive care benefits under the social assistance system (Long-term care report, 2021).

NORWAY

Municipalities are responsible for long-term care in Norway, and the right to receive care is regulated by the Municipal Health Services Act. Municipalities finance these services through their general tax revenues, block grants from the state, and also through user payments for some services. The state influences legislation, standards, regulations, and guidelines and also uses "soft power" such as referrals, education, oversight, and targeted grants to achieve the provision of appropriate care. Within this, services may vary from community to community. Long-term care is usually associated with care for the elderly, but long-term care needs can occur and be provided at any age. Care services in Norway focus on the entire population over the age of 18.1. The elderly are over-represented among the recipients of social services, but the number of users under the age of 67 is also increasing significantly. Norway does not have an 'elderly care sector', but care services for the entire population in need of long-term care (Gautun and Grødem, 2015).

Discrimination or unequal treatment based on age is illegal, but there are several age-related differences:

- It is very rare to grant a personal assistant to a person over 67 years of age based on social contact needs;
- unlike older people, people under 67 with extensive care needs have a legal right to a user-led personal assistant;
- Nursing homes are reserved for the elderly.

The boundaries between state-run specialized health services (hospitals) and municipal health and care services have changed over time, especially in 2012 after the introduction of the Co-ordination Reform (Samhandlingsreformen). This reform aimed to achieve better coordination between primary and secondary health services, among other things by strengthening the roles of municipalities in the overall system. For municipalities, the most important aspect of the reform is that they take full responsibility for patients after they are discharged from the hospital. If municipalities are unable to offer services to 'discharged' patients, they may be required to co-finance their next hospital stay. This has motivated municipalities to expand their services for somatic patients with significant care needs and has encouraged them to communicate more systematically with hospitals. Users pay for some of the services provided, but not all. User payments are regulated by national guidelines. The general rule is that user payments must not exceed the cost of providing the service and that 'caps' apply to low-income users. About 90% of nursing homes are run by municipalities and 97% of the cost of home care is for services provided by municipalities (Sivesind, 2016).

Home care has been the dominant approach in Norwegian care services since the early 1990s. Helping recipients of long-term care and support services to remain in their own homes for as long as possible and to live independent lives has become the dominant goal of social service provision. Contracting, especially with commercial actors, is still a controversial topic at the political level.

POLAND

In Poland, care for the elderly at home is provided by both public and private institutions. The legal forms of non-public providers can be sole traders, private companies employing caregivers with different specializations (including medical care), foundations, and employment agencies bringing together persons in need of care and persons providing such care. The cost of care is borne by the person in need or the person's family, and the municipality also contributes.

Care for the elderly in a home environment includes the following services:

- keeping company, reading, going for a walk,
- help with everyday activities,
- help with personal hygiene,
- care recommended by your doctor,
- special care adapted to special needs arising from illness or disability, provided by people with specialist skills.

If you are unable to work and live independently or have reached the age of 75, you receive a care allowance along with your old-age pension. Financial support for the elderly is also provided by foundations working in this field (Long-Term Care Report, 2021).

An example of good practice is the Rodzinny Dom Pomocy (Family Help House) in Krakow, run by the Archdiocesan Charity of Krakow. It is a residential service designed for seniors who

need support in the activities of daily life, without the need for constant care by a doctor or nurse. The capacity of the facility is 8 seniors, who are cared for around the clock by the family that runs the house. The residents are provided with a stay in very good condition.

The family that runs the house helps with accessing health services and buying medication, organizing celebrations, outings, and leisure activities together. Residents are visited by their families, maintain telephone contact with them, and make visits. Where possible, family members are invited to participate in the daily life of the home (preparing meals, shopping, cleaning, gardening). Volunteers also work with the home. The operation is financed by the Municipality of Krakow and from the clients' fees. It is a social service in a small-capacity, family-run facility, which is not demanding in terms of staffing and is a form of home-sharing by seniors, under the supervision of the family that runs the house and lives in the house itself.

AUSTRIA

The Austrian long-term care system has two parts, consisting of cash benefits on the one hand and publicly organized services on the other. The care system is mainly based on three pillars. The first pillar provides allowances for care, the second pillar consists of measures to support carers and the third pillar consists of care services. The first two pillars are the responsibility of the federal government and residential, mobile and other social care services are the responsibility of nine federal provinces, called 'Länder'.

The long-term care system should enable people in need of care to lead independent lives that meet their needs. Most people in need of care prefer to live in a private environment and receive informal care from relatives or family members rather than formal care. This is why around 80% of care leavers receive informal care in a variety of settings. In Austria, cash benefits are also provided in the area of long-term care, based on the Long-Term Care Benefits Act. The benefit is provided at seven levels (from EUR 157,30 to EUR 1 688,90), according to the extent of the care required and irrespective of the cause of the need for care, also irrespective of the income or assets of the person in need of care. These long-term care cash benefits are financed exclusively from tax revenue and are paid for by the federal State.

For some relatives, caring for a close family member takes up time in which they might otherwise work, either fully or

extensively. In these cases, it is possible to count the time spent caring for the family member towards pension and health insurance without paying a premium. In this case, the federal government will pay for it. Immediate family members who are the primary caregivers of the person in need of care may also receive support for the cost of a substitute caregiver or a nursing leave allowance under certain conditions. However, non-public providers can also provide home care for the elderly in their own homes. The legal form of non-public home care providers varies. For example, they can be religious institutions, but also (non-profit) associations or (non-profit) limited liability companies. To support 24-hour care, the Federal Ministry of Labour, Social Affairs, Health, and Consumer Protection has developed a funding model that can be used to support care services for persons in need of care and support (from the Disability Support Fund). This model, which has been in place since 2007 and supports 24-hour care in private households, has been very well received by the people concerned. 24-hour care is provided by carers, mainly tradespeople. Cash benefits for long-term care and measures to support carers within the family are financed by the Federal Government, while residential, mobile, and other social care services are financed by the Länder. 24-hour care is paid for jointly by the Federal Government and the Länder (in a 60:40 ratio).

In 1990, the Austrian government declared the introduction of integrated health and social care districts ***("Integrierte Gesundheits- und Sozialsprengel", hereafter referred to as IGSS)*** to be the main objective of future health policy. The Austrian

Federal Institute for Health (Österreichisches Bundesinstitut für Gesundheitswesen, ÖBIG) developed a relevant theoretical concept (ÖBIG, 1993) with the idea that IGSSs should be regional organizations for the coordination and cooperation of health and social care organizations within a defined geographical area. The specific activities of IGSSs should be guided by the regional situation. They should also analyze existing provisions, guarantee the existence of health and social care organizations, and act as partners for patients and their families by helping them find organizations that will meet their specific needs. The IGSS was to be composed of a part of a city or several municipalities with a population between 10,000 and 20,000 people in all 9 districts. Health and social care districts need to collaborate with public services on funding, oversight, and strategic arrangements (Wolf et al., 2003).

The objectives of the concept are:

- Improve and guarantee the provision of health and social care in the district,
- coordinate and align the services of health and social care organizations,
- Optimise cooperation and exchange between health and social care organizations,
- Increase the effective performance of health and social care organizations in the district,
- To help patients and their families find the right organization for their needs,
- Initiate and develop health programs.

The IGSS concept improves and expands health and social care systems in the region. It also improves the situation of elderly people who need care in the home environment. It will enable them to find the best organization(s) to meet their specific needs and requirements. It also helps to improve the quality of care by ensuring continuity of care and avoiding over-provision of duplicated services. Preventive and rehabilitative health programs should be developed to prevent and/or delay the onset of diseases or disabilities that are responsible for the increased need for care.

SWEDEN

In Sweden, there are several options for care for the elderly, such as home care services or home health care services. Seniors who need home care can apply for it from their local authority. Home care allows people to stay in their own homes, even if they need help with daily activities or hygiene. Home care workers can also visit seniors at night if round-the-clock care is needed. Seniors who need medical care and want to stay at home can receive home health care. In some parts of the country, the municipality oversees home health care, in other parts the county council is responsible for this service. The care is provided by doctors, nurses, or other medical staff and may include specialist care that would otherwise take place in a hospital. When a senior is no longer able to cope with activities of daily living, he or she can apply for home care, which is funded by the municipality. The extent of this care is assessed according to the needs of the individual. Seniors with disabilities can receive round-the-clock care, which means that many of them can live out their lives at home. Seriously ill people can receive health and social care in their own homes. Municipalities and district or county authorities are empowered to provide a large part of all public services. The district authorities and counties are responsible for ensuring that everyone living in Sweden has equal access to good health care (Long-term Care Report, 2021).

Long-term care in Sweden is the responsibility of municipalities and the right to care is regulated by the Municipal Health

Services Act. Municipalities finance these services from their general tax revenues and block grants from the state, and also through user payments for some services. Caring for seniors and persons with disabilities is one of the important responsibilities of a municipality. Municipalities have a considerable degree of autonomy and independent fiscal competence in this area. They can also procure services from private providers. Private yet publicly funded providers, also known as non-public providers of social services, must provide the relevant service to citizens under the same conditions as public providers. However, in Sweden, only municipalities can make decisions regarding the assessment of the need for social care. Other bodies, once the municipality has taken this decision, may provide home care. Non-public social service providers can take different legal forms. The municipality may entrust private companies (such as limited companies) and foundations with the provision of social care based on a contract with the municipality. The same applies to health care. Municipalities and district/county authorities have the main responsibility for health care, but companies and foundations can carry out this service. Regardless of who is responsible for the provision of health and social care, the same rules regarding confidentiality, confidentiality, and supervision apply to all. Municipalities and county/county authorities are responsible for the provision of a large part of public services in Sweden, which are financed through local and county taxes, intergovernmental subsidies, and fees paid by citizens for various services. Each municipality decides its contributions to care for

the elderly. The amount of the contribution depends, for example, on the level or type of assistance provided and the income of the person.

GREAT BRITAIN

In the UK, there are several examples of integrated provision of precisely 'tailored' services for older people in the form of multidisciplinary teams of nursing staff in practice with a shared budget and a shared management structure. In practice, activities have been designed to address specific objectives:

- facilitate the coordination of the health and social services network, allowing a flexible response to any gaps in care provision,
- ensure the best use of resources by reducing duplication and achieving greater savings,
- enable service providers to be more responsive to users' needs and views, without the distortions caused by different financial resources for different services.

In the UK, an example of integrated care for the elderly is the ***'Community Assessment and Rehabilitation Teams (CART)***, which has been operating since 2011. Community Assessment Risk and Treatment Strategies (CARTS) is an evolving integrated care pathway for older people living in the community, designed to screen and prevent through innovative, new targeted risk screening tools, comprehensive geriatric assessment, tailored interventions, and integrated patient-centered multidisciplinary monitoring. CARTS tools have been piloted in Ireland as well as in Portugal, Spain, and Australia.

The expected CARTS outcomes for an older adult living in the community are:

- Prolonged periods of relative functional independence in the preferred home or care setting (reduced incidence of institutionalization).
- Maintaining a safe level of ADL (Activities of Daily Living) and exercise, leading to fewer falls and therefore fewer injuries.
- Reduced susceptibility to acute illnesses that can lead to adverse outcomes (e.g., falls, hospitalization, hospitalization, and death).
- Knowing the likely consequences and then planning appropriately (lifestyle advice will be given to patients in all groups).
- Better coping and reduction of multiple comorbidities.
- Empowering patients and carers by alerting them to their risk profile and possible interventions to minimize risk. Patients and carers will be informed of their RISC (Risk Instrument for Screening in the Community) score and vulnerability status.
- Increased satisfaction and quality of life (QOL); key outcome indicators of success for ICP (Integrated Care Pathways) (O' Caoimh, 2015).

Long-term care is a combination of health and social care provided alongside residential and community-based care. Some care is provided by the NHS, but much of it is provided

by the private and voluntary sectors. Funding is a combination of public and private sources.

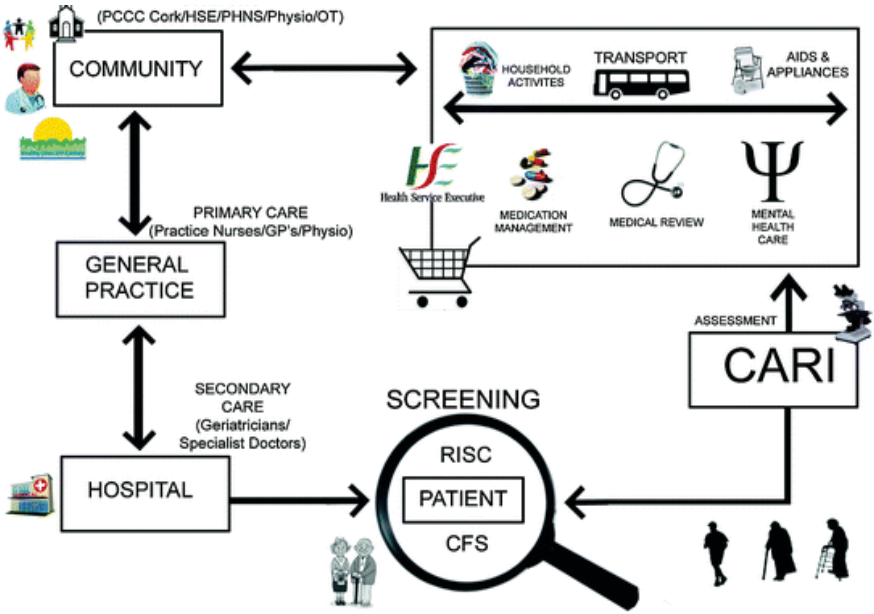


Figure 1: Graphical representation of the community screening and assessment model for risk assessment and treatment strategies. Source: O' Caoimh, 2015.

The provision of integrated care through CARTS in the UK has the potential:

- Demonstrate the potential that simple ICT systems have in delivering integrated care and reducing organizational barriers.
- Increase more appropriate targeted assessment in different settings; facilitate greater integration between community services and hospitals.

- Enable prompt and accurate referral of clients for assessment of social service dependency, potentially reducing waiting lists, length of stay, and delayed discharge; potentially reducing demand on care homes and hospitals from this high-risk group.
- Increase early use of rehabilitation services (e.g. cognitive rehabilitation, occupational and physical therapy).
- Support institutional policies/programs that promote functionality, e.g. educational activities for carers, etc (O' Caoimh, 2015).
- Provide evidence of ongoing interdisciplinary and care assessments.

The above examples from practice are promising indications that pooled budgets are delivering positive outcomes for service users. Integration at the local level is highly recommended in the UK and means improving access to intermediate care, occupational therapy, rehabilitation, and district nurses providing nursing care. It also means quicker assessment processes, faster delivery of care, and embedding into the home support system, as well as reducing acute hospital services.

SUMMARY

Long-term care systems in Europe have evolved gradually over the last 50 years, although in many countries it is difficult to identify clear and coordinated strategies towards a coherent design of relevant structures and policies. The general pattern of development could be described as follows: after recognizing a social problem that cannot be considered exclusively a family matter, most countries followed a model of 'institutionalization', which was then complemented by community care services and the emerging differentiation of other services. This model has begun to evolve at different points in time and different contexts in different countries. While the Nordic countries defined long-term care services as an integral part of the social and health system as early as the 1950s, it was not until the 1980s that these services became an issue in southern Europe. This has been explained because of various factors such as different social security regimes (Leichsenring, 2004), different family ethics and policies on old age (Leichsenring, 2004; Walker, 1998; Philip, 2001; Pijl, 2003; Pacolet, 1999) or the nature of the 'social and health care divide'. In addition, general social trends such as an aging population, a reduction in informal support from families due to increased economic migration, and the increased participation of women in the labor market, with male breadwinners unable to bridge the growing 'care gap', need to be considered.

We can distinguish several 'discourses' or sets of academic and policy perspectives and approaches to integrated care as

a concept of care service delivery in which the different units operate in a coordinated manner and which aims to ensure cost-effectiveness, improve quality, and increase the level of satisfaction of both users and providers of care. Means to achieve this include reducing inefficiencies within systems, strengthening continuity, adapting services within the care delivery process, and empowering service users.

The aim of the integration process may be to link parts within a single level of care, e.g. the creation of multi-professional teams (horizontal integration), or to link different levels of care, e.g. primary, secondary, and tertiary care (vertical integration).

Elderly patients are usually chronically ill and suffer from several diseases at the same time (multimorbidity), so a wide range of needs of these patients need to be met in the long term. There are several options to choose from to meet this challenge: health and/or social care, formal and/or informal care providers, and services provided in the home environment (Wendt, 2001, AUDIT COMMISSION FOR LOCAL AUTHORITIES AND THE NATIONAL HEALTH SERVICE IN ENGLAND AND WALES, 2002). Given this scenario, the necessity for integration, as well as the diversity of approaches to achieve it, becomes inevitable.

The concept of integrated care can be found in different countries and under different names, as we mentioned in the text above, e.g., seamless care, transmural care, case management, care management, and networking (Gröne, 2001; Delnoij, 2002). In general, two larger currents can be observed

within the discourse of integrated care. On the one hand, developments in the field of health care, in particular, the 'managed care discourse' and the 'public health discourse', have begun to emerge. On the other hand, there is a broader approach that places increasing emphasis on social services and social integration, such as the 'person-centered approach' and the 'whole system approach'. These approaches are complemented by the 'institutional discourse', which focuses mainly on organizational strategies to implement integration and/or coordination of services.

The terms coordination, cooperation, and networking are commonly used to describe ways of working together within and between different sectors. The difference between the three terms is the extent of cooperation, which increases from coordination through collaboration to networking: while coordination may still imply the existence of a hierarchy, collaboration implies somewhat more cooperation at the same level, while networking additionally requires certain proximity and continuity (Leutz, 1999; Mutschler, 1998).

It should be mentioned at this point that neither 'seamless care' nor 'person-centered' approaches aim at a 'hostile takeover' of the social sector by the health system. Even coordination aims at some level of structural integration, e.g. a one-stop shop or front office with case management functions (intermediary agency).

Another aspect of institutional (horizontal) integration relates to the integration or coordination of different types of

providers, an issue that has been discussed in most countries under the name of the 'mixed economy of social care' (Evers, 2013). This is particularly evident in those countries where market mechanisms and choice are part of the equation (e.g., Austria, Germany, and increasingly the UK, Italy), and there is a strong argument that the many different types of providers only add to the complexity of a sphere that has already been described as "one of the most complex and interdependent entities known to society" (Leichsenring, 2004). Governance mechanisms about the third sector and other private providers have evolved in recent years, e.g., in Italy (Nesti, 2019).

Many countries have established interdisciplinary assessment teams and/or agencies responsible for assessing social service providers. The multidimensional 'geriatric assessment units' within the Italian health system are one example, but in reality, they often only start their work when older people request a placement in a residential facility and on the recommendation of other health or social workers. In the Netherlands, the most important starting point for integrated care strategies is the Regional Assessment Boards (RIOs): their interdisciplinary members decide what kind of care, facilities, or support a person is entitled to. The single assessment process in the UK has a similar function, exemplified by an improved version called 'Community Assessment and Rehabilitation Teams (CARTs)' (Ex, 2019) and 'Centres Locaux d'Information et de Co-ordination' (CLICs) in France (Frossard, 2019).

In most other countries, assessment processes regarding long-term care needs remain relatively fragmented and based on medical expertise. In Austria and Germany, for example, the needs assessment, i.e., the checking of entitlements to long-term care insurance benefits (Germany) or the Austrian long-term care allowance, is carried out by specially trained physicians. Eligible persons who choose services to support family care often have to undergo further 'duplicative' assessments regarding service needs and individual planning. An integrated approach, i.e., a "single assessment process", could serve to reduce this type of "parallel activities".

In practice, we can observe quite different approaches at the level of funding as well as about entitlements, which range from lump sums of €150 to €1,700 per month, depending on the assessed needs, and the type of services or institutions used. In Germany, beneficiaries can choose between cash allowances, in-kind services, or a combination of both; most users choose cash allowances. In Austria, it is entirely up to the beneficiaries to decide whether to use the allowance to purchase services or to 'pay' informal or family carers. In France, the APA (de I'Allocation Personnalisee d'Autonomie - personalized autonomy allowance) is more like a voucher system, as the allowance has to be used to pay for (informal) carers or to co-finance residential care. Also, the various forms of the Dutch 'individual budget' are more or less dedicated to care - only a small part of this individual budget can be used at the discretion of the recipient, while the main part should be used to purchase services,

usually with the support of an insurance company. Nevertheless, this form of allowance is intended to increase the beneficiary's choice and independence.

Regarding integrated care for the elderly, this mechanism could lead to a situation in which the person in need of care (and/or the family caregiver) becomes a kind of case manager, thus shifting the burden to the family. Another consequence could be that the allowance ends up as part of the household's normal income, so that its specific use for care expenses cannot be traced, thus giving rise to an alleged 'abuse' of public funds, perhaps even by encouraging 'black labor'. At the same time, cash allowances could be a first step towards a more generalized, demand-driven, and differentiated approach, rather than focusing on supposedly homogeneous target groups such as 'older people'.

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