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Assessing Needs of Care in European Nations

LONG-TERM CARE IN ESTONIA

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1.1. Overview of the system

In 2001, the Ministry of Social Affairs (MoSA) prepared the Nursing Care Master Plan 2015 in order to provide nursing care targets to match the hospital targets set out in the Hospital Master Plan 2015. The main changes recommended by the Hospital Master Plan 2015 were to turn small hospitals (mainly owned by local governments) into nursing care homes and to develop non-institutional nursing care services that provide home nursing and day care nursing.

Reforms in the healthcare system are closely linked to the social welfare system. However, the health care and social welfare systems are relatively separate from each other, which cause problems in terms of the transfer of people between the different systems. The accessibility and quality of long-term care services is limited, due to the fact that the welfare and healthcare systems are financed from different sources - from the state budget and through the Estonian Health Insurance Fund (EHIF), respectively. Many social care home residents also need long-term care, but the amount of care provided is constrained by limited municipal budget resources. As the target group for long-term care and welfare services largely overlaps, integration and better coordination of services are required to respond more effectively to the varying needs of elderly and chronically ill people.

Strategies to optimize integrated care in Estonia are developed by interdisciplinary working groups, but at the time of writing have not yet been implemented. For successful implementation, consensus between the different care sectors is required, along with legislative support from state bodies. Changes are also needed in financing: both combined financing from the EHIF, municipalities and personal resources; and at the service organisation level, in terms of descriptions of minimum requirements and quality requirements for all long-term and social care. A 2007 amendment of the Health Services Organisation Act (entering into force in 2008) provides an opportunity to arrange long-term service provision by the family doctor. This should bring home nursing care service closer to the patient.

The strategic aim of the welfare system in Estonia is to increase decentralisation, focus on individuals and to provide a flexible system of services. Since 1995 the Social Welfare Act *(Sotsiaalhoolekande seadus)* regulates the issues related to social care. The Social Benefits for Disabled Persons Act *(Puuetega inimeste sotsiaaltoetuste seadus)* from 1999 regulates issues related to disabled persons. The care system is person-/client-centred and the service package provided is put together based on the individual needs with the aim to guarantee the client relative independence and an opportunity to use general public services. Social insurance and social welfare both offer guarantees for the risks of sickness, invalidity and disability. Benefits both in kind and in cash are granted to all residents in Estonia. Still, there is no specific long-term care (LTC) scheme in Estonia.

LTC is provided by the Social Welfare Act to residents of all ages (depending on their needs), but most of the services are provided to elderly people and to persons with permanent physical or mental handicaps. LTC services are financed by the local government and also by the person and/or their family.

LTC is continuous health and nursing care given to persons who need assistance on a regular basis because of chronic impairments and a reduced degree of independence in their daily activities. Constant (24 hours) long-term care is applicable to all age groups; however the majority of the service users are elderly persons.

On an individual level the aims of the care system are to achieve the best possible quality of life for people with care needs, basing the assessments on everyone's individual needs, and to secure coping in one's habitual environment (home) for as long as possible. LTC for the elderly includes both healthcare and welfare services, that can be financed from various sources. The services provided to the elderly with health and coping difficulties should ideally give the chance to continue a decent life and actively participate in public, social and cultural life. The macroeconomic goals of integrated care are to increase the efficiency of care, the expedient use of expensive care services (institutional care) and the development of community-based care services.

LTC is provided as an in-kind social service and is organised regionally. It is provided as need-based social assistance by the Social Welfare Act. Care services can be provided by the state, local municipal institutions, public or private legal entities or their offices. Ideally the people in need of care have family members to look after them. There is also a caregiver's allowance paid by local municipalities to caregivers. Local municipalities are not required to pay caregivers' benefit. The services are financed by the local government and by the person or their family.

LTC is usually provided to elderly people with several chronic illnesses, who require help with treatment procedures and who cannot cope with the tasks of everyday life; and to adults with multiple conditions and a partial incapacity to cope with everyday life, such as geriatric patients. This type of care is often of insufficient quality and does not meet contemporary requirements and expectations due to an inadequacy of premises, lack of trained personnel (nurses, caregivers) and lack of appropriate financing for the services. Many LTC hospitals and welfare institutions are faced with an acute shortage of space and the standards are relatively low. In addition, there is still a shortage of long-term care beds. In terms of future challenges, appropriate facilities are needed to support the development of new service delivery models. Financial support worth 27.5 million euro from the European Regional Development Fund (ERDF) for the period 2007-2013 should facilitate the development of LTC facilities and improve the quality of services.

1.2. Assessment of needs

The criteria for the determination of LTC are: the state of health, and the need for personal assistance, guidance or supervision. Case managers have special training and are competent to assess the condition and needs of a person and of any necessary welfare and nursing care services. The case management model is now being introduced. The assessment of the need for nursing care is done by a doctor (either general practitioner or a medical specialist). Assessment of the need for welfare services is done by a local social worker, who takes any necessary action considering the needs and wishes of the person and their family.

The assessment of care needs is a part of the case management process which includes full assessment of a person's condition and capability. Physical (eating, hygienic procedures, doing chores, etc.), psychological (mental health) and social (ability to work, communicate, etc.) capability is considered. There is a special questionnaire that must be filled in, an interview between the person and a specialist and/or an observation (a specialist observes the person's daily activities). A personal care plan will be set up. If a person has to cover part of the expenses of the care services (especially in the case of care homes), an income test has to be passed to establish the amount of payment for that person. An income test is necessary only if a person needs welfare services and is done by the local government. Nursing care services do not require an income test.

Since 2004, geriatric assessment has been offered. An interdisciplinary (geriatric) assessment team performs the assessment of the needs of clients and draws up individual plans of nursing care. The team includes a physician (geriatrician or an internist trained in geriatrics), a nurse, a social worker and other specialists if necessary. As a rule, the primary assessment of needs is carried out in the geriatric departments of hospitals, but also at day-time nursing care or at the place of residence of the person with the referral of a family doctor, a specialist doctor or a social welfare worker. Thus more exact assessment of the needs helps to secure the expediency and cost-efficiency of services.

The need for LTC is connected to a person's degree of disability. A person with a profound disability has a need for constant personal assistance, guidance or supervision 24-hours per day. A person with a severe disability needs personal assistance, guidance or supervision in every 24-hour period and a person with a moderate disability needs regular personal assistance or guidance outside his or her residence at least once a week. At the end of 2008 there were 118,000 people with disability - 8.8% of the total population, 61% of whom were 63 or older, 34% were aged 16-62 and 5% were younger than 16 (MoSA, 2009).

Benefits provided by the state are not means tested, although at local government level it depends on the decision of the local government. The Estonian system follows a principle whereby domiciliary care has priority over residential care.

1.3. Available LTC services

A person in need of assistance can receive various care services according to the needs and available resources. Long-term services comprise welfare and nursing services. Welfare services, according to the Social Welfare Act, are the following:

- *Care by relatives/informal care* – care or basic nursing care of an elderly or disabled family member or a relative in home conditions. Local governments offer supporting services to assist persons taking care of their relatives, e.g. domestic help and interval care, and assistance for the establishment and activities of various support groups;
- *Family care* – care of a person in a suitable family where he/she is not a member of the family. Local governments offer supporting services to help the carers and to pay compensation to cover the costs related to caring, which is not a remuneration/salary;
- *Home services* – services offered to persons at home, helping them with coping in their usual environment; excluding the care that requires physical contact. The local government is responsible for assuring long-term aid to those living at home, making sure they have access to general public services. Home services comprise, for example, household chores, procurement of food, pharmaceuticals, other necessities and firewood or other fuel, information and assistance in administrative matters, etc. (for more information see 3.4.2);
- *Accommodation or housing service (including adaptation)* – supplying facilities for 24 hour accommodation, including rental of accommodation. Service providers are either a local government or a private company. Services include making necessary adaptations for more comfortable mobility in the room. In institutional welfare, the provision of security must also be offered. In 2006, 1,070 disabled persons used different accommodations provided by local government, 142 of these accommodations were adapted to special needs;
- *Personal assistance service* – helping persons with low coping ability to perform activities, helping them to move around, in issues of personal hygiene, administrative matters at home and outside. Local government is the service provider. Help is also provided in procedures that require physical contact with the person. The main purpose of the service is to enliven the person or maintain their capacity to cope. In 2006, 22,289 persons (61% women) with special needs were assigned personal care;
- *Day care in a welfare institution* – supporting a person's or their family's coping ability in institutions where the person spends their day. This service is also provided by the local government. Day care is provided by day centres where social services, developmental and hobby activities are offered during the day. An elderly or disabled person can visit the day centre as often as they wish (have a need to). These institutions have specialists who are also trained to look after mentally ill people. The purpose of day centres is to maintain the welfare and activity of their clients. The majority of the visitors are disabled children (75.85%). In 2006 there were 20,614 visits made to 103 day centres on a weekly basis.

- *Long-term care in institution* – provided for people who due to their special needs or social circumstances are not able to cope independently because they require 24-hour care and assistance, and their coping cannot be secured with other welfare services or by providing other kinds of assistance in the usual social environment. The responsible quality and service providers are the local government, MoSA and the EHIF (for more information see 3.4.1);
- *Strengthened support care service* – improving the ability of a person to cope independently and/or maintain the quality of life of a person with strong multiple disability by means of treatment, rehabilitation and assistance in everyday life. This service is also provided by the local government;
- *Strengthened supervision care service* – maintaining the quality of life of a person with an increased level of danger by means of assistance in daily life procedures, in a care unit with enhanced supervision and assistance. The local government provides this service.

In addition, rehabilitation is provided. Rehabilitation is a social service with an aim to improve independent life, improve social inclusion and enter the labour market. The service includes assessing the needs, drawing a personal rehabilitation plan for 6 months to three years and providing services described in the personal rehabilitation plan.

LTC services are mainly financed from two sources: local government budgets and persons themselves and/or their family. Cost-sharing is maintained mainly for constant care services; community care is provided with no or symbolic cost sharing. Half (50.3%) of the cost of 24-hour care was covered by the service customer or their families, and 47.6% by local governments.

LTC is provided as in-kind social service and is organised regionally. Vocational rehabilitation is provided by the Labour Market Board. Local authorities are responsible for the provision of social rehabilitation (e.g. special transportation for disabled persons, adaptation of the dwelling, personal assistants).

According to the Act of Organisation of Health Services (*Tervishoiuteenuste korraldamise seadus)*, nursing services include nursing healthcare services and are provided as home-based, day care and institutional services. Geriatric assessment service is part of the nursing services provided by 7 hospitals. Stationary nursing care service, provided in nursing care hospitals, is limited (120 days, if a person wants to stay longer he/she has to pay for services by himself/herself). Medical personnel are included in the process. Nursing care services may prove to be necessary at all levels of the services system and are added upon necessity to the service package of the welfare system, but care (welfare services) has to be distinguished from health (nursing) services. The aim of care is maintaining, regaining or improving the capability of day-to-day life, either by living independently at home, being at home with domestic care or in institutional care. The aim of health care services is to improve, maintain or regain health or adjust to the developed health condition.

According to the Social Welfare Act, all social (welfare) services have to be improved to common standard indicators by 2010.

Welfare and nursing care services are provided by institutions that hold an activity license pursuant to the current legislation. The criteria for applying for an activity license and minimum requirements are laid down by the state. In practice, welfare services are becoming competitive services and therefore the planning of care homes and other institutions providing social services is a question of free enterprise.

The development of quality in the field of nursing care has been facilitated by the Network of Health Promoting Hospitals uniting hospitals. The quality of nursing care services can be assessed as one part of the quality system based on the document "Standards for Health Promotion Hospitals". The quality of nursing care services relates to the tradition of quality assurance and quality improvement of core processes in hospitals – starting with the education of professionals, and developing the quality of nursing care services, including the quality of knowledge and professional activity, patient satisfaction surveys, and auditing of the activities and documentation. Practice directions (e.g. in case of the death of a patient) and psychosocial support skills offered to the patient by the personnel help to raise the quality of nursing care.

1.4. Management and organisation

The person and their family have the responsibility to prevent the need for help. In case of the need for help, the family has the right and obligation to participate in organising help and financing. Local government, as the closest institution to the person in need, bears the principle of responsibility in providing services – both in terms of organisation and resource usage (principle of subsidiary). The state designates in its legislation the obligations of the first level, and lays down the list of minimum services, the requirements for providing services and the organisation of monitoring. The local governments are advised to develop guidelines for providing and developing welfare services: services provided on the spot and services provided outside the jurisdiction of the local government. The planning and supervision of the entire LTC system is carried out by MoSA and local governments.

The amount of services needed varies and organising the availability of all services by one local government or even county council would not be a reasonable use of resources. It is recommended to provide less frequent services or services related to special needs in co-operation with different institutions and regions (e.g. care for the demented, rehabilitation). It is the responsibility of the state structures to organise nursing care and is planned and developed by the county governments (city councils). From the state and regional perspective it is expedient to consider the nursing care and welfare services in the same context as the development plans as the target group of the services is the same and the need for the services is often combined.

As mentioned above, organisation of LTC in Estonia has been divided between health and welfare system.

Benefits in cash are provided by the state or local municipalities, benefits in kind are provided by the local municipalities. Social welfare services are organised by municipalities, because they are best acquainted with local life. The local government can provide services itself or purchase the services from private or public sector organisations. The care service provider can thus be an establishment or organisation of any ownership form, but the service it provides must meet established requirements. From the point of view of increasing service efficiency, it is advisable that local governments co-operate to supply certain services together. As there are over 200 municipalities in Estonia, many local governments are relatively small. Accordingly, it is not financially possible or even feasible for them to offer all the services in each municipality alone.

State welfare institutions provide the service in home-schools, in social rehabilitation centres, in orphanages and in special nursing homes. Local municipalities provide the service in general nursing centres, day centres of nursing care, home services, etc. Non-profit organisations and private companies may provide the service in boarding-houses, as regards home services, etc. The independent provision of nursing is provided by companies, foundations or sole proprietors working under the law of private companies.

As regards benefits from the specific status of the family carer, either member of the family or volunteer carer, working under the contract entitles the carer to an old-age pension and health insurance. If the carer works in the welfare institution, there is an employment contract in written form between the employer and the employee. If the carer works at the dependent person's home, there is a service contract in written form between the local municipality and the carer.

County administration is responsible for ensuring the quality of care services and monitoring the care system (care services, benefits, etc.). County administration also processes the complaints of service users.

MoSA develops national care policy, regulates the legislation of accessibility and quality of care (also the quality standards for services). MoSA also collects and analyses care statistics. MoSA develops and applies development programs of care.

1.5. Integration of LTC

In 2008, Tallinn's City Government decided to participate in the project "Future Care - Integrated Model of Care for the Aging Europe" as a regular partner to INTERREG IVC (ERDF). The project is expected to last until 2011. By now, the document "Integrated long-term care in Estonia: Providing health care, nursing care and social care services" has been prepared.
On an individual level, the aims of the organisation of care services and the integrated care system described in the current document are:

- To achieve the best possible quality of life for people with care needs,

- To base the assessments on everyone's individual needs, and
- To secure coping in one's habitual environment (home) for as long as possible.

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

Integrated care is one of the central keywords among today's care conceptions. This term is well explained by the definition developed in the EU project CARMEN and which the current document is based on: "Integrated care is a well organised set of services and care processes, which is aimed at solving the problems and meeting the needs of people with multiple problems or groups of people with similar needs/problems." Integrated care includes both health care and welfare services. Integrated care is a client-centred, not service-centred approach to care. Integration in care means foremost a process and is aimed on the one hand at the availability of different services and on the other hand at guaranteeing consistency of care. The target groups of integrated care are the elderly and the disabled. Integrated care can work in different models – either as integrated organisations or networks.

There is a model of co-ordinating network in Estonia. This model implies that people and institutions in the network have focussed their activities clearly on cooperation, but their ties are not necessarily very strong and the partners may change. In case of such integration the relationships are formed based on actions and (repeated) agreements.

Integrated co-operation based on agreements is also possible between institutions under separate administrations. The case manager is a member of the service providers' team who is in contact with the client (and each other) during the entire period when the services are needed and has an overview of all the data concerning the care of the client.

In 2006, MoSA started developing a conception of integrated care – care (nursing and welfare) services are considered as one package.
Integration between the health care and welfare system is low and arbitrary now. Consistent and need-based provision of service is not ensured to everyone. Those two systems are funded and organised differently, but the target group is the same and often uses different services in different systems at the same time.

Accessibility and quality of services is uneven in different counties. Co-operation between local governments is arbitrary.

1.5.1. Implementing integrated care in Estonia

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

The family physician is the key person in referring patients to nursing care services and in referring a local government's social worker to welfare services. Should a person's need exceed beyond just nursing care or welfare services, the organisation of services to the person is solved through the case management principle. In this model a case manager, i.e. care co-ordinator, takes the central position, whose aim is to guarantee the people in need a package of services that would be as suitable as possible and economical and see to it working smoothly. Surveys in several countries have proven the advantages of case management in guaranteeing continuity in providing services and the need for institutional care has shown a decrease by up to 50%.

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

For case management on a proper level there must be a database of client evaluations and information on the possibilities of the region's care institutions.

The principle activities of a case manager are:

- To receive information about a person in need and get into contact with the client;
- To evaluate the client's needs with a recognised evaluation instrument (also to use prior evaluations if there have been any);
- if need be, to use a primary assessment team (family physician, family nurse, region's social worker) or help from the geriatrics team, family physician is a key person responsible for decisions regarding health;
- To plan the services (and support) package and organise the services to be provided to the client in the best possible way while following the principle of rational resource usage;
- To assess the compliance between the services provided and the plan and to organise the re-evaluation and changes in the care plan pursuant to the client's needs;
- To organise follow-up control and monitoring in their region;
- To provide social counselling services;
- To make suggestions for planning and developing services.

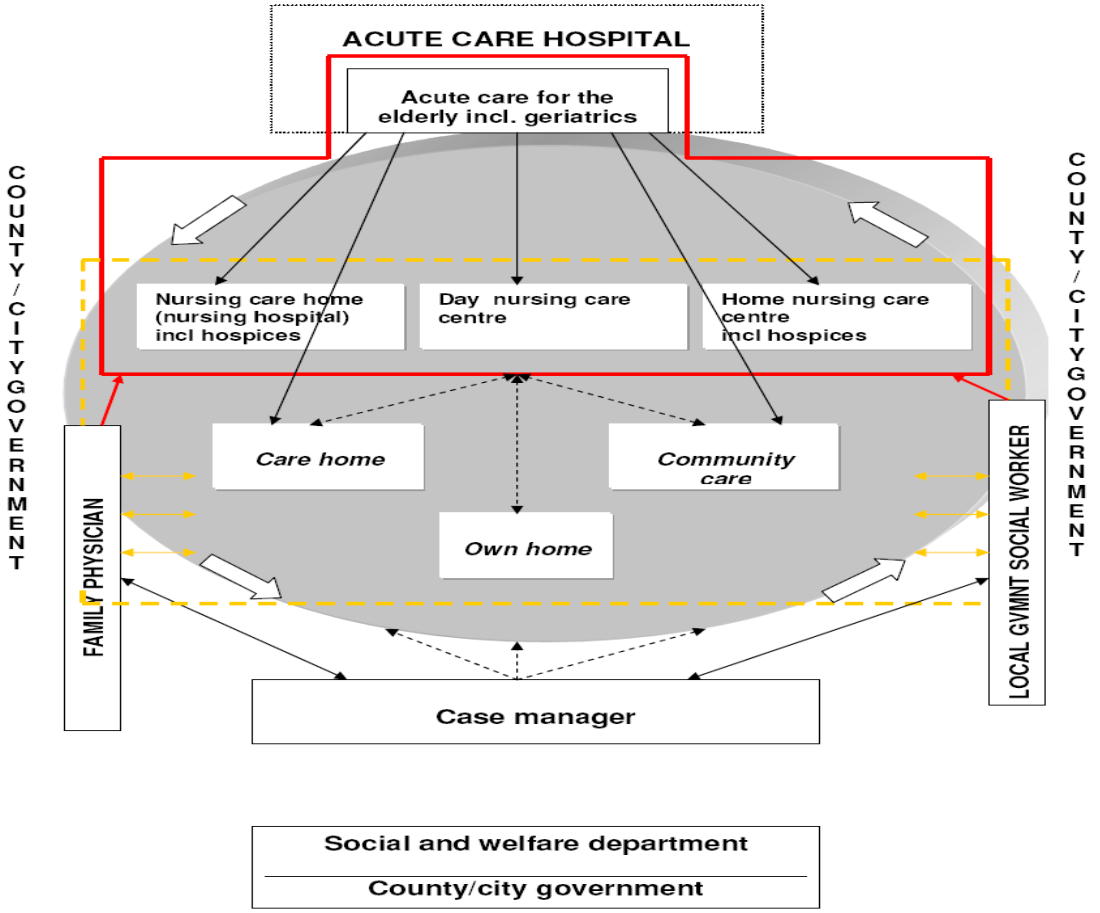
Needs assessment and referral to services can be done by the primary evaluation team (in co-operation with the region's social worker, family physician and family nurse), but the case manager must receive all information concerning the evaluation and care plan.

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

According to the practices already implemented in Estonia it is best to start with case management on the county government level (also in bigger towns), which has the responsibility to organise and monitor primary health care. Central co-ordination is presumably neutral and guarantees a posterior control and monitoring of higher quality,

including the usage of finances. An alternative would be with the welfare institutions or local governments. The latter has welfare responsibility but lacks competency for monitoring each type of service.

Figure 1. Organisation of integrated services



2. Funding

2.1. Formation of the price of care

There are two major expense items which serve as a basis for the formation of the price of care and care services:

- the cost of satisfying the basic needs of a human (e.g. food, housing, safety, hygiene);
- the cost of providing assistance (mainly the salary of nurses and carers, but also the cost of using instruments, transport, administration, guarding, etc.).

The first expense is quite steady, depending only on changes in economic conditions and is usually the cheapest part of the cost of care. It is reasonable that if necessary and possible, care service users may pay for satisfying their basic needs.

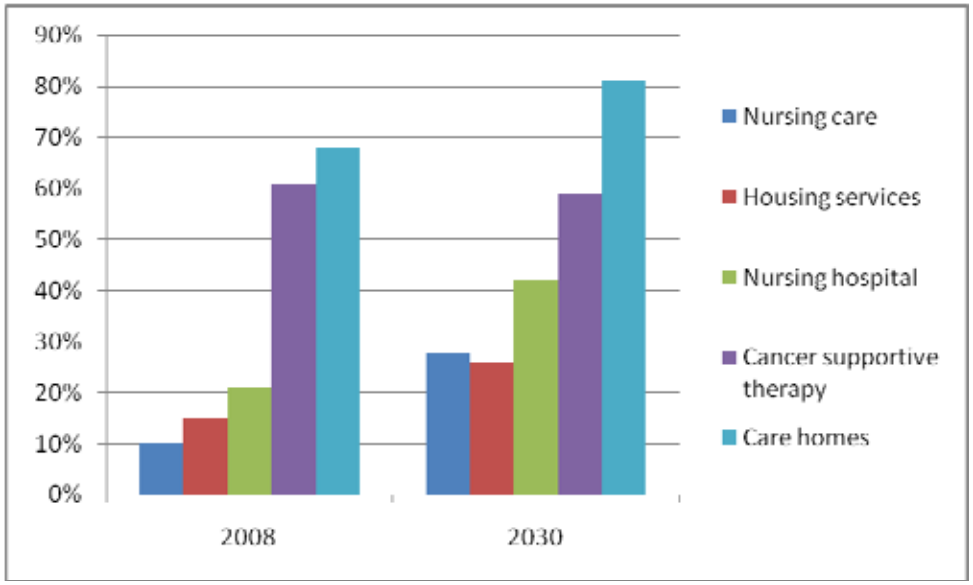
2.2. Nursing care services

Public health insurance plays a significant role in funding nursing care (in institutions and at home), based on the principle of providing services tailored to the needs of insured persons, regional accessibility to treatment and expedient utilisation of insurance funds. Health insurance is 13% of the earmarked social tax (33%) and is paid by employers for the employees, while the self-employed pay the social tax from their income. Estonian health insurance functions on the solidarity principle: in case of illness, provision of the range of health care services does not depend on the amount of social tax paid for the person. The EHI F *(Eesti Haigekassa)* also pays for the services provided to non-working insured persons from the social tax paid for the working population. In Estonia, about 96% of the population is covered with health insurance.

Nursing care services are mainly funded by the EHIF. Nursing care hospital services may be marginally paid by service users. Home nursing services may also be paid by the local government and/or service users. Geriatric assessment is fully paid by the EHI F.

Home nursing care has a large financing gap in Estonia (home nurses, home nursing services). The development of such services is still in the embryonic stage. The following figure describes the coverage of care services with financial resources. For instance, the financing of home services is only 15% of the total need – the demand for such services is estimated at seven times higher than the volume currently provided. The projections for 2030 imply that the coverage should increase, as due to welfare effects the need for such services is expected to decrease and the share of local government financing increases.

Figure 2. The estimated coverage of home care services in 2008 and 2030



Source: PwC 2009

According to the Nursing Care System Strategy of Estonia for 2004-2015 *(Eesti hooldusravivõrgu arengukava 2004-2015)* the proportions of total expenses for nursing care

for 2015 are pointed out in table 1. The aim is to provide all services free of charge for service users, except care home and nursing care home.

Table 1. Funding nursing care services, aims for 2015 (%)

	Health insurance	**Local government**	**Service user**
Geriatric department	100	-	-
Nursing care home	35	49	16
Care home	-	71	29
Nursing day care	100		
Home-nursing care	100		
Total	***56***	***31***	***13***

Source: The Nursing Care System Strategy of Estonia for 2004-2015

Table 2. The distribution of total expenditures on nursing care, aims for 2015 (% of total expenditures)

	Percentage of total expenditures on nursing care
Geriatric department	10
Nursing care home	36
Care home	32
Nursing day care	9
Home-nursing care	13
Total	***100***

Source: The Nursing Care System Strategy of Estonia for 2004-2015

2.3. Welfare services

The majority of welfare services are financed by local government budgets. There are also other funding possibilities: service user's out-of-pocket payments, donations, private sector investments, etc. Indirect financing ways are caregivers' allowance (from local government budgets) and allowance to people with disabilities (from the state budget). Care home services are the only services where direct payments by service users are the main source of funding. About 58% of the costs of services were covered by service users in 2007 (see table 3).

Table 3. Share of local governments and service users payments funding welfare services (% of total cost) in 2007

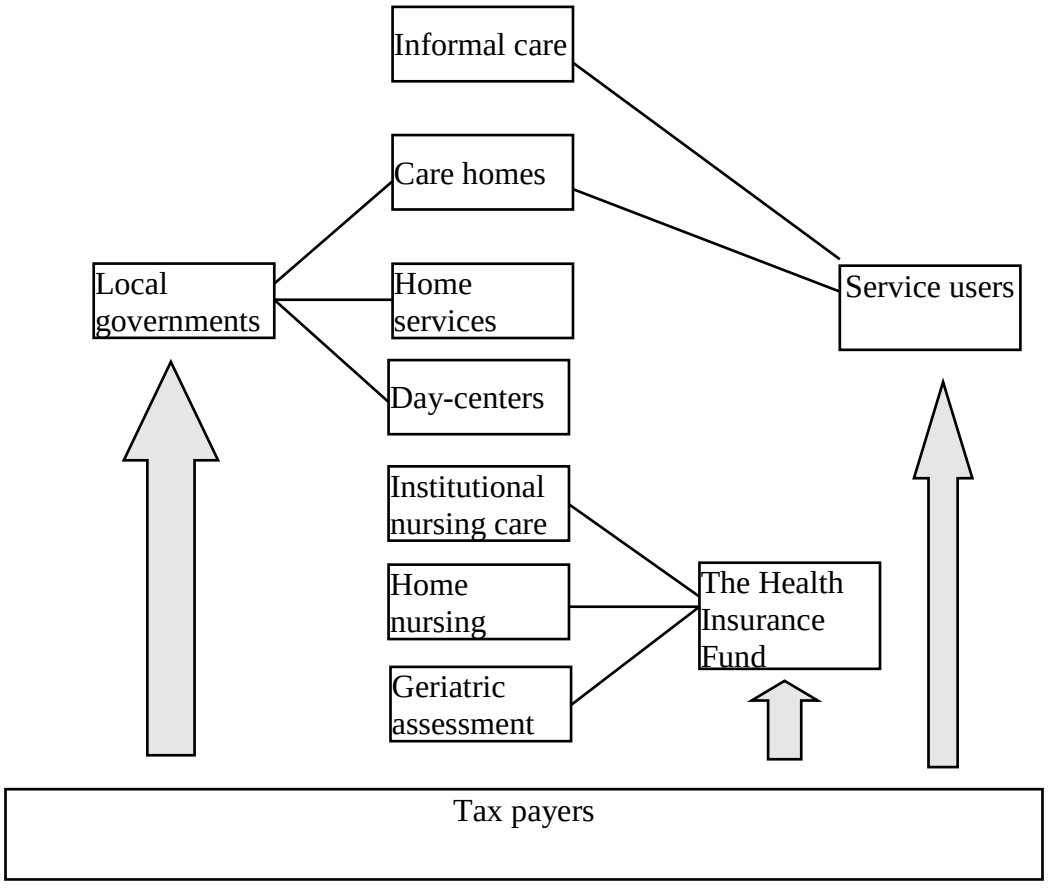
Service/ Financing source	Local governments	Service users	Other
Care home	41	58	1
Home-service	98	1	1
Day care centre	86	8	6

Source: Grünvald, 2009

2.4. Informal care

Informal care is mainly funded by local governments and is closely related to the economic possibilities of local governments. It is up to the local government whether to pay caregiver's benefit or not. Local governments fund supporting services offered to people taking care of their relatives.

Graph 1. Main funding of LTC services



Source: Integrated long-term care in Estonia

3. Demand and supply of LTC

3.1. The need for LTC

Estonia has a population of 1,340,602 (as of 1 January 2008), approximately one-third of whom live in rural areas. Since 1990, the population has decreased by approximately 200,000, as a result of migration to the east and west, as well as natural negative growth. Although the crude birth rate has increased continuously since 1998 (a low of 8.8 live births per 1,000) and despite the death rate falling steadily since 1994, the combined effect has not been sufficient to result in positive population growth. In terms of the population's age structure, fewer than 15% are aged between 0 and 14 years and the share of the population of 65 years and older (17.1%) and 80 years and older (3.5%) is increasing (2007). These trends are not reflected yet by the age-dependency ratio, which has slightly decreased from 49% in 2000 to 47% in 2007, but the burden of an ageing population is expected to increase in coming years, as the working-age population will decline.

Total expenditure on care services is relatively low in Estonia. According to the OECD, total expenditure on public sector care services in 2008 was 0.28% of GDP. In 2009 PricewaterhouseCoopers (PwC) made an analysis of the LTC system in Estonia. The main aim of their report was to evaluate the sustainability of LTC. In order to evaluate the sustainability of LTC financing, the amounts of financing from current sources were projected until 2030 and compared to the estimated total costs. The demographic trends and changes in the health status were also taken into account in their analysis. Two projections were prepared, both demand and the actual need for such services. The demand projections assumed that the coverage and provision of formal care services remains at the current level, e.g. the share of formal care recipients from the total 65+ population remains constant. The projections for the need of formal services dismissed such assumption.

The results revealed that with respect to the projected need, total expenditures on LTC services should be about 5 times higher (1.06% of GDP) compared to the current level.
According to estimations by the Institute of Estonian Demography, 37.8% of the 65+ population have a need for LTC. Only 5.6% of the 65+ population are recipients of formal care services, but the need for formal care is estimated at 24.7% (see Table 4).

Table 4. The estimated need for total LTC, formal care and informal care

	Actual 2007	**Proportion 65+**	**Needs 2008**	**Proportion 65+**
Formal care	12,746	5.6%	56,561	24.7%
Informal care	73,810	32.2%	29,996	13.1%
Total	86,556	37.8%	86,556	37.8%

Source: PwC 2009

In Estonia the planning of nursing care is based on the number, and other indicators, of 65 and older (elderly) people. According to the Nursing Care System Strategy of Estonia for 2004-2015 the need for nursing care beds for 2015 based on calculations of 10 beds per 1,000 aged 65 and older persons, is 1.4 per total population. For care homes (20 beds per 1,000 aged 65 and older persons), the figure is 2.9 per total population. At the end of 2007 there were 1,348 nursing care beds (the need according to calculations was 2,305) and 5,128 (welfare) care beds (the need according to calculations was 4,610). Therefore, according to need, the number of care beds in welfare is optimal, but there must be more nursing care beds to fit the need.

The problems in determining the need for LTC in Estonia include:

- The real need for care is not sufficiently analyzed;
- The number of clients able to pay their own share of financing is difficult to determine;
- Awareness of services (cancer supportive therapy, geriatric assessment);
- Changing the proportion of family care;
- A prospective increase in morbidity (CVD, cancer);
- Acute care quality improvement;
- Increased availability may bring along growth in demand for care.

Problems in determining the need for welfare services are:

- The real need is not thoroughly analysed;
- Prospective change in the volume of family care services and change in its proportion compared to institutional care;
- The change in expected healthy years of life due to the increase in overall life expectancy;
- The increase in the image of care homes may increase the demand for such care;
- The improvement in the standard of living increases the capacity of clients to pay their own share of financing the care.

3.2. The role of informal and formal care in the LTC system

While supplying people with LTC services, the emphasis is on helping people in their home as long as possible. According to that goal, the amount of non-institutional services has increased especially day care and other supporting services. The selection of different forms of care services is however limited.
According to NOSOSCO, about 0.4% of under 65 and 2% of over 65 year old people are in care institutions. About 0.1% of under 65 and 2.2% of over 65 year old people receive home help.

3.3. Demand and supply of informal care

The Family Law Act provides the description of responsibilities children have over their elderly parents. Since informal care is not regulated by law in Estonia there may occur situations where caregivers have too much workload or they simply cannot handle it. In general informal care is provided at home by the family and free of charge.

There is no data about any kind of informal care in Estonia.

3.4. Demand and supply of formal care

The accessibility of home care and day care services is inconsistent. The accessibility of nursing and health care services in care homes is low.

Table 5. Demand for LTC services in 2007

	Service	**Number of cases (% of total LTC)**
Nursing care	Institutional nursing care	12,815
	Home nursing	13,627
	Geriatric assessment	1,149
	TOTAL	**27,591* (29%)**
Care (welfare)	Care home	7,016
	Home services	6,428
	Day care centres	54,211**
	TOTAL	**67,655 (71%)**
LTC (nursing + welfare)	**TOTAL**	**95 246 (100%)**

Source: Grünvald, 2009

**Tallinn (the capital of Estonia) provides about 1,000 extra cases every year. According to that, the total number of cases in nursing care is about 28,591.*

***The number of clients. The number of clients in day care centres is approximate.*

Table 6. Supply of LTC services

	Service	**Number of providers (year)**
Nursing care	Institutional nursing care	47 (2007)
	Nursing care	44 (2007)
	Geriatric assessment	7 (2007)
	TOTAL	**98**
Care (welfare)	Care home	118 (2007)
	Day care centres	82* (2005)
	Home services	682 (2005)
	TOTAL	**882**
LTC (nursing + welfare)	**TOTAL**	**980**

Source: Grünvald, 2009

**For the elderly*

3.4.1. Institutional care

According to MoSA, in 2006 there were 4,737 persons in welfare institutions for adults (62% women and 40% over 80 years old) staying on average in the institution for 8.3 months. Compared to 2000, the number of persons in these institutions had increased 45%. The fastest increase was among persons 80 years and older, making up 40% of persons in social care institutions in 2006 (compared to 34% in 2000). A total of 118 social welfare institutions offered care services to the elderly in 2007 (excluding those designed for people with special psychiatric needs), providing 24-hour care to 4,970 people, 80% of whom were above the age of 65. In 2008, there were already 2,008 institutions.

In 2007, 58% of expenses were paid by the service receiver or their family, 40% of costs were covered from the budget of local government. Total costs were 360,120 kroons. The private expenses for institutions have increased over the years as in 1998 only 23% of care in institutions had to be covered by a person, 54% was covered by local government and 17% by state budget. Now, only 1% comes out of the state budget.

The demand for institutional care has increased about 28% in the past 5 years mainly because of the increase in the share of the elderly. The average waiting time for institutional care is 0.5-2 months. Waiting times differ between different providers. The average waiting time for public institutional care is longer than private-for-profit institutional care. Waiting times have remained constant during the past five years.

The number of service providers and beds in institutional care (24-hour service every day) has increased. From 1998-2006, 25 new institutions and 1,500 service users were added. There are round-the-clock care service providers in every county offering the main service, but not in every local government.

In 2007, 9,580 persons (over 12,000 cases) used institutional nursing care services (PwC 2009). The average length of stay in institutional care was 27.6 months. The length of stay has increased in the past five years about 4% (TAI www.tai.ee). The average cost of one nursing care case was 13,179 kroons (842.6 euros) (PwC 2009). The average daily fee for institutional nursing care per recipient is about 640 kroons (40.9 euros) (http://www.haigekassa.ee/kindlustatule/tervishoid/taastus). Fees are different among providers and according to the intensity of care need. Care recipients can choose the provider freely.

According to the Development Plan of Nursing Care for 2004-2015, there must be 4 helpers at night and 8 in daytime per 30 clients in nursing care homes. There also has to be at least 1 social worker per 30 clients (PwC 2009). At the end of 2005 the number of full-time employees in adult care institutions was 1,081. For one full-time worker, there were about 4 service users. In 2007 there were 1,173 workers in care homes, including 7 physicians and 174 nurses. That equalled 4.2 clients per care-worker. In smaller areas, the number of clients per care-worker is much bigger (PwC 2009). Institutional care providers cannot expand their

capacity freely because of the limitation of resources (workforce, number of beds, etc.). There is no remarkable competition between public and private sector institutional care providers.

3.4.2. Home care

Home services were provided to 6,428 persons, including 3,960 with special needs (i.e. disabled) in 2007. Of all service receivers, 76% were female (74% of persons with disability). Out of all recipients of home services, 82% are older than 65 years (44% over 80 years). Of all receivers, 40% are women over 80 years old. When separately analysing receivers who are disabled we can see that 75% are over 65 years old. A high proportion of disabled people who received home services were older than 65 years old – 87% of women and 62% of men. The proportion of disabled and elderly among home services receivers has been increasing over the years. Although home services are the responsibility of local government, not all of them are providing this kind of service (30% of them do not). In 2006, there were 667 social workers providing home services. On average, this service was provided to 45 persons per 10,000 (576 per 10,000 in the case of persons over 80+).

In recent years, the amount of home-care services has been stable – about 70% of local governments approve home-care services.

In 2007, 4,200 persons (over 13,000 cases) used nursing home care services (including nursing care for people with cancer). The average cost of one case was 2,239 kroons (the cost of one case of nursing care for people with cancer was 1,343) (PwC 2009). According to the Development Plan of Nursing Care for 2004-2015, the optimal number of clients per nurse is 8-10. In 2007, the average number of visits per month per nurse was 132. At the same time, 17 doctors and 24 nurses were engaged in home care for people with cancer (PwC 2009).

The number of clients per care-worker in Tallinn (the capital of Estonia) in 2007 was 6.6 (PwC 2009).

3.4.3. Semi-institutional care

In 2007, 1,100 persons (1,149 cases) used geriatric assessment service. The average cost of one case was 800 kroons (PwC 2009).

In 2007, over 54,000 clients visited day care centres. There were 1,001 workers, equalling about 54 clients per worker (PwC 2009).

4. LTC policy

4.1. Policy goals

Major LTC reforms are in process and will take effect in 2013. Official LTC goals refer to costs of formal care in general (19,423,120 euros), institutional care (192,862 euros) and home care (316,613 euros) (http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalvaldkond/kogumik/sotsiaalminist_eetik_trykki_1_.pdf).
Current LTC goals refer to different groups of recipients, e.g. people with dementia or disability.

The overall goal is to ensure access to services to all people and ensure that the need for care does not cause poverty or economic addiction. In addition, the aim is to pay more attention to the inadequacy of accessibility of services. The emphasis is on helping people in their home as long as possible.

According to the Social Welfare Act, the main goals in welfare (care) are:

- less state, and more contribution by individuals and local governments;
- the development of case-management methodology;
- the development of housing services.

According to the Nursing Care System Strategy of Estonia for 2004-2015, the main goals in nursing care are:

- to reach the following proportions for total nursing care expenditure by 2015: health insurance 56%, local government 31% and service users 13%. The aim is to provide all services free of charge for service users, except care home and nursing care home;
- Increasing the number of nursing care beds in nursing care up to 2010 to meet the need (based on calculations of 10 beds for 1,000 65 and older persons);
- All nursing care beds should be without time limitation of occupancy (now the maximum time of occupancy is 120 days), so that the nursing care time will be dependent on the need;
- Improvement of quality and accessibility of nursing care services. Properly assessed needs should be considered while supplying of services. More various and need-based services should be offered;
- Service users move between different services according to different care needs;
- Home nursing care will be the base and active nursing care the top of nursing care, indicating the change in the focus of development planned for 2004-2015;
- To create an effective network of nursing care by 2015 according to the objectives set in the national strategy. Also the aim is to uniformly cover the need for services everywhere in Estonia;
- To decrease the institutional services, focus on an individual and provide flexible integrated community-based care services.

4.2. Integration policy

The development and sustainability of the nursing care and social welfare system is significantly influenced by the ageing population. It is evident that a decrease of the working age (15-64 years old) population from 2015 will result in the pressure to fund health care through taxation of the working age population or the increase of their own contribution. To facilitate the development of in-patient nursing care to the desired level there is a need to find new funding schemes, where health insurance would be assisted by the contribution of the local government and even people themselves, similar to the funding of care beds. Furthermore, along with growing revenues from the collection of health insurance, the private sector, central government and local municipalities should increase their expenditure on health care in pace with the growth in GDP in the future. The Local Governments' Act, however, does not set the requirement to the latter to finance health care.

The key values and principles now underpinning social services policy have a clear focus on the individual's needs rather than provision of the services available, supporting the maintenance of the greatest possible degree of independence and integration in local communities. For focusing individual needs, in recent years there has been more emphasis on assessing needs and the instruments of assessing needs. Local government's social workers have been educated on that theme. While developing the integrated system of care, regionally responsible centres will be developed to improve fitting services to people and movement between different services.

In practice, integration between health, nursing and welfare services is very low and insufficient now. As a result, for example, accessibility of nursing and health services is insufficient and limited for the elderly in care centres. To solve this problem, care and health specialists have united to develop the Conception of Integrated Care Services for Elderly. Nursing and welfare services will be provided in the same institutions. The practical outcome of an integrated system of providing care services will be regionally located multifunctional institutions with stable and long-term (at least 3 years) primary funding.

The integrated system is funded by three main sources. First, service users pay for housing, food and necessaries. Second, medical personnel costs and nursing care given is funded by the EHIF (health insurance). Third, welfare services and equipment needed is funded by local government (in case of need). More clear-cut funding helps to use the money more effectively and makes clear the part of payment by each participant.

4.3. Recent reforms and the current policy debate

Keeping health expenditure under public control has forced the health sector to increase their internal efficiency (e.g. the reform of family physicians, reform of hospitals). Since 2003, year-to-year the number of beds in institutional care has grown. In 2003, there were 976 and in 2007 1,348 beds. (http://www.tai.ee/?id=5841).

The problem related to persons without health insurance must be solved to ensure the possibility of access to LTC services for all people living in Estonia. The first steps have been done already, e.g. giving health insurance to jobless people who are actively finding a job or attending refresher courses. Nevertheless, a lot of work has to be done in the short-run.
In order to improve nursing care quality geriatric experts are formatting regulations for services. The EHIF supports that with funding and monitoring services provided according to the regulations of services in future. Digital solutions are being developed to aggregate all cases into one digital system. The so-called e-Health project (*e-Tervise projekt)* makes it easier for different specialists to work with cases. It also improves providing person-centred care services.

In 2005, the state gave resources to local governments to pay a caregivers allowance. After that change, all care organisation instruments were in one place – in local governments. Assessing the needs of all clients was done with that change. As a result, local governments have a better overview of the needs of their residents and it is easier to develop services and plan resources. Moreover, as 2/3 of disabled persons are pensioners, the allowance is one way to support informal care.

The supply and volume of welfare services provided have grown from year to year. A future challenge is to encourage service providers to implement new, more economical and increasingly effective services.

One of the goals is to maintain the sustainability of the LTC system. Hence it is important to have enough qualified personnel. A large problem is the low salaries in the care sector. However in recent years the number of specialized personnel has increased. Care workers' (in the public service) salary is one theme that is currently being discussed at state level in the Government. To assess and develop the quality of labour, refresher courses and an employee registration system are being developed.

4.4. Critical appraisal of the LTC system

The main problems with LTC are the lack of provision and high expense of services. For instance, the cost of care home (i.e. long-term care in institution) varies according to the institution from around 5,000-7,000 kroons (319.4–447.1 euros) per month, but reaching up to 12,000-17,000 kroons (766.5–1085.8 euros) in some cases. The average wage in Estonia in 2007 was 11,336 kroons (724.1 euros) (13,117 kroons – 838.8 euros, fourth quarter of 2008). The average old-age pension was 4,356 kroons (278.4 euros) in 2008. Thus, in general care homes are really expensive and not widely available.

Main problems in the LTC system:

- The system of LTC according to the need of services is not sustainable in the long-term outlook. More emphasis should be paid on developing home services and

supporting more informal care services. As the demand for LTC services grows year-to-year, because of the ageing population, provision has to increase too;

- Less attention has been paid to informal care: financial support is insufficient;
- Accessibility and quality of services is uneven in different counties;
- Integration between the health care and welfare systems is low and random. Consistent and need-based service providing is not ensured;
- Salaries and the number of (qualified) personnel have to increase to increase the quality and provision of care services.

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ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (http://www.ancien-longtermcare.eu).