

Freedom of choice and dignity for the elderly

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This paper briefly analyses the relevance and transferability of the Swedish policy for the elderly to the Czech Republic. It was prepared in cooperation between the peer country official delegate and the non-governmental expert.

1. Relevance of the policy to the Czech Republic

The Swedish policy represents a very comprehensive, balanced and practical approach to the ultimate goal of greater freedom of choice and dignity for the elderly. The Swedish government shows the strong commitment to the development of a modern system of services for the elderly and to the enhancement of independence, dignity, and quality of life of elderly people in need of care. The authors of this paper would like to express their appreciation of the commitment and effort of the Swedish government in the area of care for elderly persons.

The policy under review is very important and topical for the Czech Republic for several reasons:

First, the population of the Czech Republic is, similar to the population of other European countries, ageing at a quite rapid pace. As of 1 January 2006, there were 1,456,391 (14.2%) people aged 65 and over. According to the middle projection of the Czech Statistical Office, persons over the age of 65 years will account for 22.8% of the Czech population in 2030, and 31.3% in 2050 (equivalent to roughly three million people). The share of persons in the highest age groups will rise the fastest. In 2050, there should be about half a million inhabitants aged 85 or over in the Czech Republic (compared to 101,718 as at 1 January 2006).

Second, the Czech Republic is reviewing and updating its policy on population ageing and older persons at these days. The Minister of Labour and Social Affairs will submit to the Government a new strategy and action plan on ageing by the end of October 2007 called „Quality of life in old-age“. The strategy will set priorities and measures in the area of ageing for the period of 2008 and 2012 and is being developed in close cooperation with the Government Council on Ageing and Older Persons established in March 2006¹. The strategy builds on the experience with the implementation of the National Programme of Preparation for Ageing for the period from 2003 to 2007. The overarching goal of the strategy is to increase quality of life in old age. Achieving greater freedom of choice and dignity for the elderly is a leading priority in the strategy.

¹ The Council is a permanent advisory body to the Government of the Czech Republic on issues related to ageing and older persons. The Council consists of representatives from various sectors of society, including ministries, social partners, civil society and organisations of seniors, and health insurance companies. See more details on the Council's web site at <http://www.mpsv.cz/en/4538>

Third, the Czech Republic is continuing in the process of transformation of the system of social services introduced by the Social Services Act, which has come into force on 1 January 2007. It introduced a system of authorization of social services provision and a system of quality control of social services. The Act also introduced the new social benefit „care allowance“, which is granted based on an assessment of the health and care needs of the person. Strategic priority of the process of transformation of the system of social services is to develop accessible social services of high quality at local (community) level, which support independence and increase the quality of life of the elderly persons, especially those in need of care. At the same time a top priority of the transformation process is to support the development of special housing for older persons and to increase its quality.

2. Similarities and differences of the policy

Priorities and measures of the Czech government in the area of care and quality of life of elderly persons are set in several policy documents. The above-mentioned National Programme of Preparation for Ageing for the years 2003 – 2007 is a very broad strategy covering many areas of life. It focuses inter alia on the development of primary integrated community care and close cooperation between medical services and social services, qualified nursing and rehabilitation, and home care services.

The „Health 21 Programme“, which is the Czech version of the WHO „Health for All in the 21st Century Programme“, sets two specific targets under „Healthy Ageing“, which read as follows: „There should be an increase of at least 20% in life expectancy and in disability-free life expectancy at age 65 years“ and „Increasing by at least 50% the proportion of people over 80 years of age who enjoy a level of health in a home environment that permits them to preserve their autonomy, self-esteem and their place in the society“. Health 21 Programme includes important measures promoting independence of elderly persons.

The National Report on Strategies for Social Protection and Social Inclusion for 2006-2008 reflects new trends in institutional settings and capabilities, including problems of research and monitoring of social inclusion, and sets priorities in the area of health and long term care.

There are lots of both similarities and differences between the Czech and the Swedish system of care provision for elderly people. In general, local municipalities are responsible for provision of social services in the Czech Republic. Local and regional authorities prepare plans of social services development to ensure the availability of various social services. Social home care (domiciliary social care) is provided mostly by the municipalities. In 2006, social home care was provided to 23,963 elderly persons (of which 8,509 men and 5,454 women). Residential social care facilities („homes for seniors“) are established and co-financed by local and regional authorities. There were 532 special housing establishments for the elderly in 2006, of which 390 „homes for seniors“ and 142 „pensioners‘ lodging homes with 38,672 beds in „homes for seniors“ (of which 15,265 in nursing wards), and 11,428 beds in pensioners‘ lodging homes (of which 564 in nursing wards).

Besides, the system of social services long-term care is provided in health care facilities. By the end of 2006 there were 14,597 beds for nursing after-care in the Czech Republic, of which 6,072 beds in hospitals, 7,462 beds in long-term care facilities, 335 beds in hospices and 98 beds in

other specialised therapeutic facilities. The total number represents almost 10 nursing after-care beds per 1,000 persons 65 years old and older. The regional distribution of beds is unequal.

Home health care is provided mainly by home health care agencies. There were 494 agencies with approximately 3,500 workers (of which 73% nurses), most of them (88%) have services available round-the-clock (24-hour). In 2005, home healthcare services were used by 142,500 clients, of which 77% were aged 65 or older. Home health care is prescribed by general practitioners (90%) or by the doctor at the end of hospitalisation (10%). On average, each healthcare worker (non-doctor) makes 7-8 visits per day, and 43 visits per client over the year. Of the total number of nursing tasks, 60% were provided to mobile patients and 40% to immobile patients.

Generally, there is low availability of short stay accommodation or short-term health and respite care in special housing facilities as homes for seniors and other facilities. Respite services are provided rarely, mostly by NGOs and charities and some municipal residential social services. NGOs play an important role in modernizing social services for the elderly, especially by introducing new services and activities important for quality of life and independence of the elderly such as emergency assistance using assistive technology and ICT, educational and cultural activities, transport services, social events etc.

3. Potential transferability of the policy

We are convinced that the policy of the Swedish government offers many inspiring examples and innovative approaches, which could be successfully introduced and implemented in the Czech Republic. The Swedish policy and experience raises many questions and issues, which have to be addresses in order to develop broader and comprehensive policy leading to greater dignity, independence and satisfaction of frail elderly persons in the Czech Republic.

One of the biggest challenges is the integration of social and health services. Nevertheless, ensuring seamless provision of „one care“ may be a very challenging task in situations of two separate health and social services budgets. Moreover there is a tendency to consider the needs of frail elderly persons as social („social cases“) and thus being out of the competence of the health care system. The existing division between health and social budgets poses a serious barrier to the integration of services and increases the risk of poorly coordinated care for the elderly. Nevertheless, strong commitment and partnership between the central government and local authorities and the creation of a single point of entry to the care system may help to solve this problem.

To move forward in the process of the transformation of social services and to promote independence and living in own homes it is necessary to encourage local authorities and providers to reshape their services and focus on providing care and support to the elderly living at home. Nevertheless, it seems that there is still strong preference for institutional care rather than care and support provided at home. Thus it is particularly helpful for us to learn more about the experience of the Swedish government with introducing measures and incentives encouraging overtaking greater responsibility and initiative of regional and local authorities in developing social and health services to promote independence, living at home, dignity, and services for families. We especially need to promote development of home care services, which is the prerequisite for a life in the own home for people with more extensive care needs.

We hope that the new Social Services Act will serve older people like the Social Services Act in Sweden, and that it will encourage the development of more services provided in home of older persons instead of institutional setting. At the same time we need to transform and develop special housing for the elderly persons and develop modern facilities with one-bed rooms equipped with toilet, bath, and kitchen. Special support services and special housing for persons with dementia are also among the areas where learning more from the Swedish approach and experience would be very fruitful.

Regarding the transferability of the Swedish experiences we are particularly interested in two issues:

- a) Good accessibility of home care services and their financial sustainability on the basis of the client choice model
- b) Stimulation of the development of new assistive devices (technologies) wanted by older people or/and their families.

The Czech NGO ZIVOT 90 has this kind of assistive device - AREION distress care unit, which cares about 1000 older people living at home through telephone lines – since 1992. We have had a possibility to see in Malmö a Swedish model of the company Svenska Trygghetsjouren AB (serves 14000 clients for 15 municipalities) using more advanced ICT technologies.

4. Important questions about the policy that are being raised and debated in the Czech Republic

There are some questions about what is not working and what is needed in the field of long term care and care for the elderly generally. What works are the minimum standards, which help set benchmarks for what is needed and expected in care provision. What is not working is that there are not enough homes for people with specific needs. Nurses are often overworked, which can reduce the quality of provided care and lead to overuse and misuse of drugs to ease care. Nurses are often pushed for time, which means that the individual ends up with no choice on such matters as to when they go to the toilet and to bed. Provision of care is not individualised enough and residents in special housing have often little choice of activity.

We feel that there are measures, which can improve the care for older people and contribute to a better quality of care:

- Families of older people need to be able to complain to local authorities, which should then go into homes to ensure that standards are being met.
- An independent body should have the authority to visit homes to monitor standards and check for signs of abuse and neglect.
- More residential services are needed which fall in between hospitals and homes, which are able to deal with long-term care needs.
- More geriatricians are needed and greater training opportunities for doctors and nurses in care for older people.

- More research is needed too on the effect of medication on older people (with the attention to the effects of combining different types of medication).

Monitoring and the measurement of such processes require much more activities. On the one hand there are already statistical and other official data available, which should be harmonized and better used, on the other hand a substantial completion of information sources is needed. There are several governmental, social partners, research and information bodies in the Czech Republic that produce data and can feed the debate on social policies, among them in particular the Ministry of Labour and Social Affairs (MoLSA), Trade Unions, National Training Fund, Civil Society Development Foundation, Older People's Council etc. Unfortunately there is still no extensive public debate in these processes.

5. Key issues and main questions proposed for debate at the review meeting.

There are some issues of interest for discussion:

- Client choice model in elderly care, certification procedure, „the same payment“ for providers, financial sustainability of clients choice model.
- Incentives for municipalities and providers to develop services necessary for living in own home, including support for families and adaptation of accommodation.
- Cooperation between municipalities, county councils and the government, division of responsibilities for quality of care for elderly, organizational and management issues.
- Quality control, open comparisons, dignity guarantee, monitoring of the care system.
- Measures to improve access to doctors, experience with home visits and preventive work.