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MORE HOME CARE
AT PRIMARY HEALTH LEVEL

MORE COMMUNITY
HOME CARE CENTRES

Policy Brief
No. 18

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More care in primary health!

More community care centers!

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More care in primary health!

More care centers in the municipalities!

In the period 2007-2008, the Centre for Research and Policy and Making (CRPM), with technical support from United Nations Development Fund for Women (UNIFEM) and financial support from Austrian Development Agency (ADA) researched the implications of Diagnosis Related Groups (DRG), a new payment system of hospital services, on women. The research results revealed that the DRG introduction decreases the average length of stay in hospitals. The analysis further identifies that after hospital discharge, there is a transfer of care from the hospital to the patient's home (and the primary health care, patronage service as well as home treatment insufficiently replace the care work of family members). Using a time-use survey, CRPM research team that the burden of care is undertaken by manly female family members (they spend 5 hours a day compared to men who take care of the ill family member only two and a half hours a day). CRPM assessed that this care work provided by the family members has a value of 10,000 denars a month.

The analysis used gender responsive budgeting as a tool to assess the budgetary implications of the reform. It was noticed that the introduction of DRGs will generate savings in the health care system (34% of Ministry of Health budget), funds that will remain in secondary health care to allow for the system to accept larger number of patients.

Recognizing such implications, the CRPM started implementing another project in 2009 (Responding to Diagnosis Related Groups - Advocacy for reform of the health and community based services to substitute unpaid carework of women in Macedonia") which aimed at identifying policy measure which would substitute the unpaid care work of women. Within this Project, CRPM team visited Slovenia and Croatia, where certain mechanisms that cease transfer of care from the hospital to patient's home have been applied. These lessons could be learned in Macedonia too.

The mechanisms identified could be divided in two groups:

A) Institutional measures in health care system

- Departments of post-acute care in hospitals (extended treatment),
- Daily hospitals,
- Hospices,
- Reorganized patronage service and home treatment

B) Non-institutional measures at municipality level

- Community care centers
- Daily clubs,
- Hospice service organized by non-government organizations
- Telemedicine

In the period April – November 2009, the CRPM project team organized 7 round tables: First was dedicated to discuss the measures that can help increasing the care in the primary health sector. It was attended by all stakeholders in the policy making process in the health and social protection sectors. Other six round tables were organized in the regional centers: Skopje, Tetovo, Veles, Stip, Strumica and Ohrid. These were attended by representatives from the municipalities and non-governmental sector. They discussed the measures that municipalities should take in order to provide home care services on their territory. The conclusions from those meetings are presented in this document.

A) INSTITUTIONAL MEASURES IN THE HEALTH CARE SYSTEM

After hospital discharge, patients are in need of care that includes health and social services. Public health should offer the health related services.

Post-acute care in the hospitals

In Macedonia, under the DRG reform hospitals provide only the regulated treatment for the diagnosis (the intervention). Longer-term, extended post-acute care is not offered in the hospitals. Hospitals that treat chronic diseases do not exist, except the special psychiatric hospital in Bardovci and the special hospital for lung diseases in Jasenovo.

In many countries this situation is solved by passing a law on long-term health care. In Slovenia, although there is no Law for long-term care, institutionally non-acute care in the hospitals is offered. This care is available for 30 days in the so called care departments of the hospitals. Most often this care is given to the patients that have received intervention, who cannot go home, but still need care and help with clothing, washing, moving, and eating. Patients who live alone also are beneficiary of these departments. Services in non-acute nursing departments are not paid according to the DRG system, but patients are charged by hospital day. In 2008, the health system in Slovenia allocated 2 million Euros to support non-acute care in the hospitals.

In Croatia, there are post-acute care hospitals and hospitals for chronic patients. In this way, everyone who needs extended health care can receive it at hospital level.

The Ministry of Health of Republic of Macedonia is planning to invest in nursing homes which would provide necessary care. The plan predicts opening of the first nursing home in 2009. However it seems that the realization of this plan is staggering and one of the reasons could be the size of the investment for such homes. At the national round table, that was attended by representatives from the Ministry of Health, Ministry of Labor and Social Policy, and other relevant stakeholders

from this sector, as well as representatives from Health Insurance Fund of Slovenia, the recommendation was not to invest in new objects and new capacities, but to reorganize the existing ones (nursing staff to work in the nursing department in the current hospital and to charge services per day, and not per DRG).

Daily hospitals

Mechanism that could be efficient response to the need of extended health care is daily hospitals. Daily hospitals receive patients that would be treated during the day and discharged in the evenings. They sleep at their homes, but if they need care they come back to the daily department in the hospital the next day.

In Slovenia there is short-term and long-term day care. While short-term care lasts less than 24 hours and does not include overnight stay, long-term care lasts longer periods of time, with interruptions, but also includes hospital stay not longer than 24 hours. Patients stay overnight in their homes, but receive necessary care during the day in the hospital.

In Croatia, from 1 January 2009 the family doctor can perform minimal invasive operations (taking out objects from the eye, from mucosa membrane of the ear and nose, etc.) and in this way earn up to 10% of the capitation (the method of financing primary health care services) through implementing procedures regulated by DRG (up to 500 euro).

In Macedonia the hospitals should be encouraged to establish daily hospitals, thus increasing their efficiency. Current health sector reforms (DRG, hospital autonomy, independent management of hospitals) provide all conditions to the hospitals to make a decision to establish daily departments for minimal invasive interventions.

Hospices

Hospices are institutions that provide services to terminally ill patients. Most often those are patients with cancer. The hospices provide health care, and their families receive psycho-social support when losing ill family member. Hospices are expensive investments and could be established as part of health care system (independent institutions or parts of hospitals where services would not be charged per DRG) or as service at municipality level organized by the community.

Slovenian Hospice Association functions as non-government organization, and is active in Ljubljana, Celje and Maribor. This organization gives palliative care, i.e. helps people in terminal life phase. They have signed contract with the Ministry of Health providing them with paid nurses that offer health care to the patients, and besides that there are also support groups with volunteers who help the families, mostly psychologically.

In Macedonia and Croatia there are no hospices. At the national round table which was attended by representatives from the Ministry of Health, Ministry of Labor and Social Policy, and other relevant stakeholders from this sector, representatives from international organizations as well as representatives from the Health Insurance Fund of Slovenia, it was recommended not to invest in expensive hospices, but to stimulate non-government organizations, the communities and municipalities to provide these services through covering the health care expenses from the health budget, and social services through municipality budget.

Primary Health Care: Patronage Services and Home Treatment

After hospital discharge, nursing should be taken over by primary health care. In Macedonia it is the chosen (personal) doctor. Unfortunately, contracts that chosen doctors sign with the Health Insurance Fund, so far do not include nursing services, and personal doctors do not provide them since they cannot charge for them. This gap of care on primary health care level is bridged by the patronage nursing service (which is polyvalent, the teams are not as many as needed and their role is mainly advisory/counseling) and home treatment (the number of teams is little and cannot serve the whole population).

Patronage service in Slovenia and Croatia is highly developed. Number of patronage teams is high and thus can serve larger number of users. In Slovenia, patronage service has been reformed. It does not have only prevention and advisory role, but also a lot of treatment (curative function). One patronage team provides care for about 2,300 people.

If the patient is discharged from hospital in Croatia, his nursing is taken over by the family doctor. Family doctor collaborates with home treatment (nurse that spends certain time in the patients home every day and nurses him in home environment) and patronage service (nurse that visits the patient, advises him and does some monitoring of the home treatment team work and implementation of the home treatment activities; patronage nurse informs the family doctor of the patient's condition, and the decision to continue with the home treatment is made by him/her) Patronage service in Croatia is part of primary health care, and the number of population per one patronage nurse is 2100.

At the national round table attended by representatives from the Ministry of Health, Ministry of Labor and Social Policy, and other relevant stakeholders from this sectors, representatives from Health Insurance Fund of Slovenia and international organization, the recommendation was to re-organize the patronage service, which is necessary to undertake more curative function, which also withdraws changes in the financing of their work of this service, since materials they would use by providing curative services (bandaging, drug/injection application, etc.) currently are not foreseen in the contract signed between Ministry of Health or Health / Health Insurance Fund and the Health Homes within which the patronage services are organized. Increasing the number of home treatment teams was the other recommendation that resulted from this meeting.

B) NON-INSTITUTIONAL MEASURES AT MUNICIPALITY LEVEL

When the new Law on Local Self-Government entered into force, in 2005, large part of the central government obligations were transferred to local level. CRPM Research indicates that patients are in need of social care after being discharged from hospital: cleaning, washing, feeding, walking, clothing, etc. Such care could be enabled in nursing centers in home environment. Thus, we looked at what are the municipalities' obligations in social protection sector.

In social protection sector, legislation does not impose on and oblige the municipalities to provide forms of social care, nor guarantees funding to the municipalities to cover the expenses for such social care services. Regional discussions within the project implied to the dysfunctional decentralization in this area. Namely, if in the municipality there is social institution, with the decentralization the central government would transfer to the municipality the functions and the finances, but if there is not one (for example nursing home or kindergarten) the functions are transferred, but not the finances. Thus, it was concluded that with the decentralization in Macedonia, finances follow the institutions, and not the functions that are transferred, especially in the social protection sector.

In this sector, the legal framework defines that municipalities could provide social care to:

- People with physical disability,
- Children without parents and parental care,
- Children with special needs,
- Street children,
- Children with educational and social problems,
- Children with single parents,
- Persons exposed to social risk,
- Persons, drugs and alcohol addicts,
- Older people without family care.

There are a few forms and types of social services municipalities can organize within their obligations:

1. **Day care centers for taking care of homeless children, children with mental handicap, adult invalids, drug addicts, persons victims of family violence, etc.**
2. **Community care centers for old and invalid persons.**

Community Care Centers

The Community Care Centre of Ljubljana functions at municipality level, and is financed by the municipality, as well as patients themselves. In Ljubljana, the municipality participates with 80%, while the patient with 20%, although there are differences from one municipality to another. Home care services cost about 3-4 euro per patient per day. As part of the services, chronic patients and elderly people are visited by trained nurses who help them in everyday activities such as moving, washing, eating, cleaning, socializing, etc., for a few hours a day, and all in order the patient's family to be relieved from the burden of nursing.

In the small Croatian municipality of Zupanja, the Red Cross signs a contract with the Ministry of Health and Social Care to provide home treatment services. According to this project, one visits old and decrepit persons to help them in the basic household duties - hygiene, care and socializing. Social worker from the Social Care Centre decides who will get this help, and trained nurses from the Red Cross provide the service. Ministry of Health and Social Care determines the prices of these services, and the Red Cross delivers (provides) them.

In Macedonia there are several voluntary home care services, organized mainly in non-government organizations using mainly volunteers to provide the services: Humanity in the Municipality of Aerodrom, Esma and Sumnal in Suto Orizari, Kitka in Prilep, OFO St. Nikole in St. Nikole, Multiculture in Tetovo, Prodolzen Zivot in Strumica and Nov Zivot in Stip. They all have problems with sustainability of the service. Also they would need for the scope and number of services to be determined, as well as the price of services. Hence, the discussion conclusions from the six regional round tables are:

1. There is need for assessment of the needs for establishment of community home care centres/services in every municipality separately. This issue is already at the political agenda of several municipalities (Karpos, Gazi Baba, Cair, the city of Skopje, Veles and Tetovo) that have Program and Strategy on Social Care and can allocate part of their budget for 2010 to finance home care services. In this way they will become more human. However, assessing the needs is especially significant to these municipalities, as it will reveal the potential beneficiaries, where they live, what services they need, how many teams are needed to provide the services, how much these services would cost. This assessment is crucial for the municipalities which borders have been changed with the new Law on territorial boundaries, since the official statistics still fail to reflect the real situation on their territory. Thus, additional profound field research and analysis should precede the initiation of municipal home care services.

2. How to find beneficiaries? Assessing the needs and conditions should imply methods to bring the potential home care services to the beneficiaries. Experience from several organizations that tried to organize such services is that pensioners and veterans associations along with the social care centers could help to identify the potential beneficiaries of these services (through databases of the registered beneficiaries for outer care and long-term financial help). In certain areas populated by Roma population, it was concluded that it is necessary to use the experience and the trust they have in the non-government sector. In urban areas the existing mechanisms should be used, such as municipality information services, local communities (especially in the Tetovo region), as well as the network of primary care physicians who could suggest which of their patients should receive home care. In traditional communities where religious leaders have large authority, they should also be included in the service promotion and identification of their beneficiaries.

3. Combined financing system. Financing the services is the biggest challenge for the realization of this initiative and fulfilling the needs of more home care that would replace non-paid care women provide at home. In order to develop adequate financing system, initially there should be defined service price. Some experience from the non-government sector, especially the recent project of NGO Humanity (that used professional labor to provide the services), can serve in the identification of realistic price of home care service for about 30 beneficiaries. Municipalities interested in establishing such services are willing to finance a part of it, but consider that they would not be able to finance the complete service (without previous calculation of its cost), which suggests co-financing by the central government (possibilities to re-allocate funds now used for extra care and long-term financial help should be considered), as well as co-payment by the beneficiaries themselves (according to their income to define the beneficiary' co-payment percent, if they could pay the market price of services). Those municipalities that are financially unable to establish community home care centre, and the needs for such centre exist, should consider the possibilities of inter-municipality collaboration, enabled by the new Law on Inter-Municipality Collaboration.

In order to form the community home care services, one should bare in mind the possibility of using IPA funds for social inclusion, for which the Macedonian Government and the European Commission signed a contract. Highly significant segment regarding the obligations and institutional capacity to form the services is the initial principle of pluralism in the field of social care that refers to the possibility that citizens' associations and physical entities to be able to provide certain social care services and appear as founders of social care institutions. Changes and amendments of the Law on Social Care provide physical entities with the possibility of providing advisory services, home care and help to individuals and families, as well as accommodating a person in a nursing family.

These persons receive license to provide certain social care services as professional engagement approved by Decision by the Ministry of Labor and Social Policy, thus getting the opportunity of self-employment and engaging in providing services and other activities within their living environment.

Regarding the citizens' associations, there is defined procedure to award funds to citizens' organizations to provide certain social care services. Ministry of Labor and Social policy will award part of the necessary funds to citizens' associations to provide certain cervices according to the defined procedure and developed criteria. Entitled to receive the funds are the registered associations. Funds are awarded through advertising public competition. It should motivate citizens' associations to involve in the system of social care service providers, and the additional funds for functioning of the association should be provided on other different bases (municipality enters through its programs).

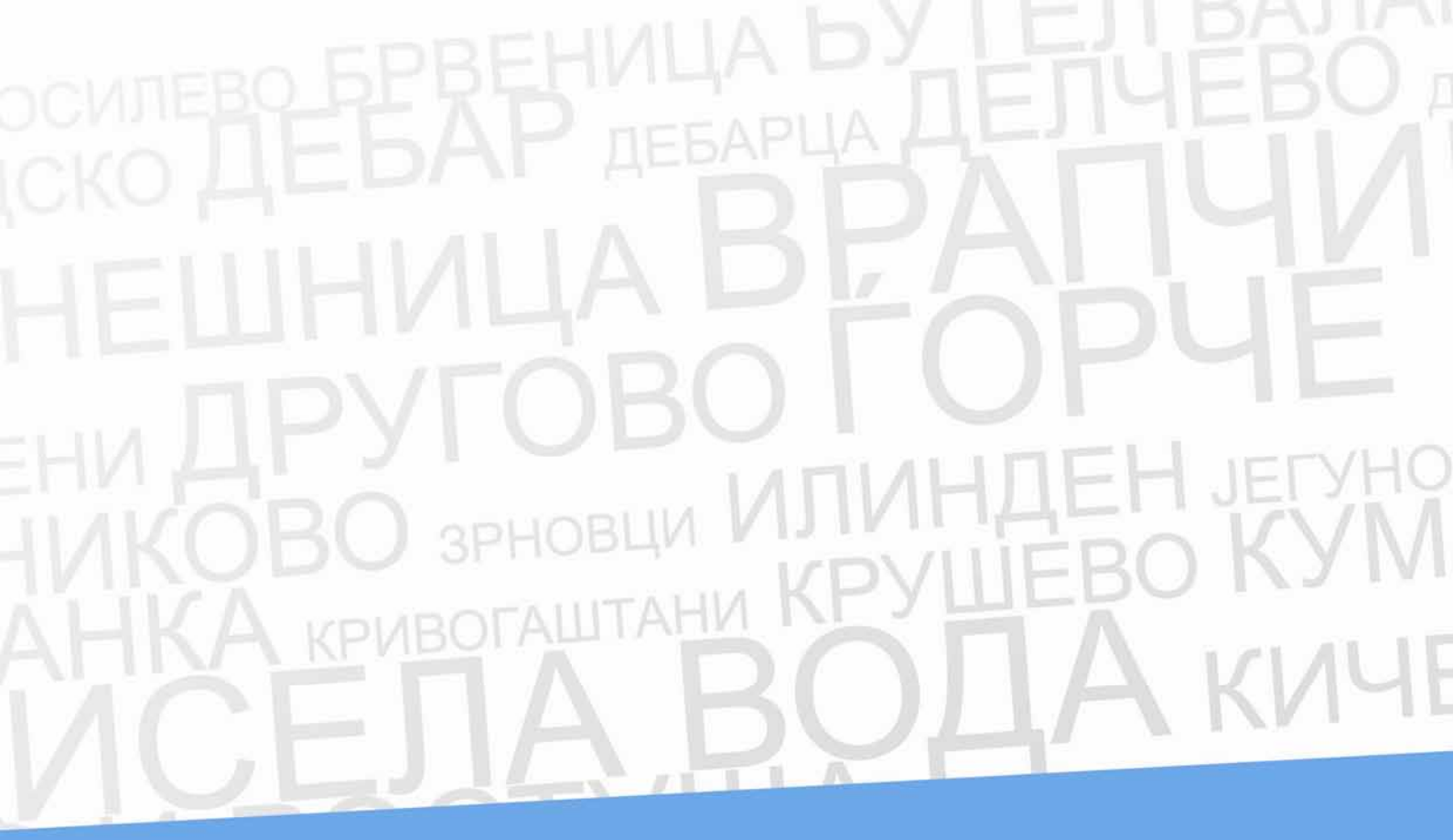
4. Limits to the success exist. Number of customs, patriarchal lifestyle, prejudice, lack of information and the mentality of the population could become an obstacle for organization and successful introduction of community home care services, especially in the conservative and underdeveloped areas (although such challenges were pointed out by representative of the municipalities and the non governmental sector in urban' and relatively developed regions such as Strumica and Tetovo). In certain municipalities where there is large politization of the population and local government is not supported by the majority (such as Tetovo) it is possible to come to distrust in every initiative promoted by the local government.

Telemedicine

To those who live alone and need communication, monitoring and counseling from a distance by a health care provider or social worker, telephone assistance service or telemedicine should be provided.

In Ljubljana, Home Care Institute incorporates 'distant care' service. This service provides the patients with special telephone apparatus, which is very sensitive to voice and touch, and signals immediately to the trained nurses or social workers that work as operators. In certain moments when the patients have problems at home, the operators try to calm them, diagnose them, give them instructions how to help themselves and call an ambulance if needed, and all is done on the phone.

In Macedonia this service does not exist and during the discussions there was no interest noted from neither municipality to establish a department within the municipality that would provide such phone assistance service.



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