Development of Nursing Care and Long Term Care in Estonia

Report to the Estonia Health Project
Ministry of Social Affairs

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Contents

Part 1. Framework for Development of Nursing Care and Long Term Care …..… **1**

Part 2: Needs Based Approaches to Planning and Planning Strategies .…………... **15**
1. Analysis of secondary sources of empirical data on population characteristics and service utilisation
2. Assessment of adequacy of present provision in relation to needs of target population
3. Comparisons to benchmarks of other countries
4. Resource allocation models
5. Planning strategies

Part 3: Service Development Strategies .....…………………………………...… **51**
1. Approaches to service development
2. Development of pilot projects for Geriatric Assessment and Extended Care Centres
3. Service development for nursing homes
4. Service development in social care homes
5. Development strategies for community services
6. Outcomes of service development strategies

Part 4: Funding Strategies ………………..……………………………….. **67**
1. Current funding arrangements
2. Options for restructuring funding for long term nursing care and social care
3. Features of options and four options

Part 5: Proposals for Strategic Projects for World Bank Funding ……………...… **89**

Overview and Budget Summary

Project 1: Pilot Phase of National Geriatric Assessment and Extended Care Program

Project 2: Project Coordination and Development Unit

Project 3: Development of Funding Systems

Project 4: Training Programs

Appendix 1: Criteria and Process for Conversion of Capital Stock of "Excess" Hospital Beds to Nursing Homes and Social Care Homes …**105**

Source Documents and References ………………………………………..….. **113**

Part 1. Framework for Development of Nursing Care and Long Term Care

1.1 Goals

The **overall goal** of this Plan is to provide a framework for the development of services to meet the needs for frail elderly people with chronic health problems and disabilities, and who need continuing nursing care and long term care, in a range of settings including their own home. Achievement of this goal will improve the quality of long term care and raise the profile of nursing care and long term care in policy making in health and social care.

In order to better meet the needs of this target group, the key elements of the Plan are the development of assessment services and a needs based approach to planning and funding services. Sufficient data on population needs is already available for defining initial levels of needed service provision, with refinement and review as the Plan proceeds. A number of recent initiatives also indicate that many providers are ready to adopt new modes of service delivery and this Plan is intended to be a catalyst to these changes. Most of the concepts of long term care are well understood by leaders in the field, and these concepts now need to be translated into practice.

The main **goal for planning and service development** is the conversion of hospital beds that are excess to the need for acute care, as identified in the Hospital Master Plan, into a range of services for nursing care and long term care. As these excess beds are now being identified at the regional level and hospital closures are commencing, the adoption of a strategy for conversion to nursing care and long term care services is a matter of highest priority. The implementation of alternative services for older patients who currently have long stays in acute hospital beds is essential if implementation of the Hospital Master Plan is to proceed effectively.

The **goal for training** is to develop the skilled workforce required for long term care services, including retraining and reorienting of staff from excess acute hospitals. Training strategies are complementary to the planning and service development strategies and conversion of human resources is as critical to the achieving the outcomes of this Plan as the conversion of physical facilities.

The **goal for funding** is to make the most effective use of the total of EEK654m per annum that the 1999 Hospital Master Plan estimated would eventually be released from these hospital beds for funding of long term care, in addition to the current level of funding. Rather than simply converting the excess beds to nursing care beds for long term care, this Plan proposes the development of a range of services to provide integrated

services on a regional basis. To achieve this goal, it is critical that the development of new NCLTC services proceeds in conjunction with implementation of the Hospital Master Plan so that conversion of specific hospitals accords with the overall regional and national framework and that resources are converted to NCLTC services as they are released from the acute care system. Without this close integration, there is a risk that resources will be lost.

The final goal is to ensure that further development and implementation of this Plan and the initiatives proposed for World Bank funding proceed in a coordinated way. To achieve this goal, **responsibility for further development and implementation** of this Plan has to be clearly identified in the Ministry of Social Affairs.

1.2 Terminology

As nursing care and long term care are newly emerging areas of health and social care in Estonia, a standard terminology needs to be developed. As the system develops, it can be expected that terminology will converge with that used in the EU countries and elsewhere, and the adoption of new terminology is an adjunct to establishing new concepts. The key terms noted here extend the definitions developed in a paper on Nursing Care and Long Term Care by Dr Viktor Vassiljev, prepared for the Working Party on Nursing Care.

Pikaravi is the term used to date to describe in-patient care that does not involve active medical treatment. Pikaravi is part of the classification of medical specialities used in Estonia. The term refers to patients who are in hospital for follow up care or who have stays of more than 10 days, but who are not receiving active medical treatment. The term ***hooldusravi*** has also been adopted more recently, apparently to distinguish continuing care of older patients from post acute days in the care of younger patients, but the same time limits and same funding applies to both. As the NCLTC system develops, it can be expected that both the term pikaravi and the form of medical care it describes will disappear. Pikaravi will be replaced by a range of geriatric medical services covering assessment, slow stream rehabilitation, restorative nursing care and community care services provided in residential care settings and community services.

Social care home – hooldekodu. Social care homes are the only widely developed form of long term care in Estonia at present. They are not however licensed to provide nursing care and are not required to employ registered nurses. Many employ staff with two year training for nurse assistants.

Nursing hospital – ***hooldushaigla***. The term nursing hospital was defined by the Nursing Care Working Party as a *hospital* offering 24 hour nursing care for a long term, and/or hospice care, social care services as needed, and possibly offering a base for home care services. It was also envisaged that the nursing hospital would provide assessment and some rehabilitation services. Nursing hospitals were distinguished from acute hospitals by the more limited range of health care services offered and patients' longer

length of stay. Use of the term nursing hospital also appears to reflect the lack of development of nursing care provided in separate institutions, independently of medical care, and the hospital origin of many of the facilities in which long term nursing care will be provided in future. However, four factors mean that the term nursing hospital should not continue to be used:

1. long term nursing care should be separated from medical care provided in hospitals; it is not under the immediate direction of a doctor and does not involve medical treatment aimed at recovery;
2. doctors will not be included in the staff of nursing homes, and care will rather be directed by registered nurses;
3. the duration of care will be indefinite, often until the end of the person's life; this distinction is of particular relevance to funding as funding for hospital care is time limited.
4. the functions of assessment and slow stream rehabilitation should be carried out in Geriatric Assessment and Extended Care Centres that are part of the acute hospital system, *before* the patient is discharged to a nursing home, social care home or home, with community services if required.

The type of long term nursing care that is central to the NCLTC Plan will be equivalent to that provided in nursing homes and through visiting nursing services in EU countries and elsewhere. As Estonian practice becomes established, it is proposed that new terminology be adopted to signify the new approach. The proposed term for nursing home is ***oendushoolduskodu.***

1.3 Context

Demographic trends

Estonia is about to experience pronounced ageing of its population, and the social consequences of these demographic trends. As well as substantial growth in the population aged 65 and over, the aged population will become markedly older. Whereas the size of Estonia's total population will be almost stable for the next 15 years, the population aged 65 and over is projected to increase by 20%. Of most significance for the provision of health and long term care, the population that is 80 and over will increase from just under 40,000 in 1999 to almost 65,000, and increase of over 60%.

Related policy developments

The development and implementation of the NCLTC Plan is closely related to five other developments in health and social care in Estonia:

1. ***The Estonia Policy for the Elderly***, set down in September 1999 makes specific reference to the creation of "an appropriate environment for the elderly who definitely need assistance (demented and disabled persons) and ensure necessary medical rehabilitation opportunities for them". In detailing the health care and welfare services to which older people should have access, specific mention is made of:
   - geriatric medical assistance and interdisciplinary geriatric evaluation
   - open care services (community care)
   - provision of psychological, organisational and legal support to families taking care of an elderly person
   - integration of welfare workers and nurses
   - comprehensive training of doctors and nurses in gerontology and geriatrics.

2. The work of the ***Nursing Care Working Party***, which provided the Terms of Reference for the Estonian Health Project consultancy on Nursing Care and Long Term Care.

3. ***Legislation*** covering health care and social care and family responsibilities for the elderly, especially the new Health Care Services Act.

4. ***Reform of municipal government*** and the redefinition of functions of municipalities which is currently in train.

5. ***The Hospital Master Plan 2015*** which began to be implemented from early 2001.

This Plan takes as its starting point the references to long term care for the aged in the Hospital Master Plan. The HMP stresses the need to strengthen medical care of the elderly. The key points made are:

- There will be increased demand for better secondary medical care for the elderly as well as for long term care.

- A condition of the new hospital structure for secondary care is that patients who need further medical treatment after a short hospital visit can be taken care of somewhere else.

- Long term care must increase its competence and have better physical resources. Clinics for "pikaravi" in the hospitals must be reorganised and very poor facilities in existing long term hospitals must be replaced with new physical facilities.

- As the number of acute hospital beds is reduced from 8,200 to 3,110 beds, there will be 5,090 beds available for conversion to NCLTC and rehabilitation. The HMP estimates that some two thirds of this number of beds will be needed for these alternative functions, 3,343 beds (IHMP, Appendix J p.3).

- The HMP estimates that the number of beds needed for long term care or in nursing homes by 2015 will depend on progress in public health and the on-going development of social care, but a figure of 6,000 to 7,000 nursing home beds is given.

- The HMP estimates that a budget of EEK564m per year will become available for NCLTC and that the conversion from acute to NCLTC and rehabilitation will generate a saving of EEK666m . The HMP also proposes funding of EKK450 per day for NCLTC beds.

- The HMP proposes space standards for physical facilities of all kinds. It recommends 90 sq m for new construction of long term and rehabilitation beds and 80 sq m for reconstruction, and 80 and 70 sq m for nursing home beds.

Without the development of a NCLTC system to provide for the many elderly patients who currently occupy acute beds for very long stays, the implementation of the HMP will not be able to proceed effectively. The development of the NCLTC Plan, identification of priorities for action and early implementation of these priorities is now critical. The implementation of the NCLTC Plan and the development of nursing and other long term care services cannot wait for the implementation of the HMP, but is the key to unlocking the resources currently tied up in excess hospital beds. Implementation of the NCLCT Plan as hospital restructuring proceeds will have the benefits of reducing uncertainty and avoiding stalemates where no decisions are made about the future of facilities.

This Plan sets out a framework for planning the conversion of facilities and resources identified in the HMP as excess to acute care to nursing care and long term care services. The conversion process involves far more than changing excess acute hospital beds into nursing home beds. As the focus of the Plan is on resources and services rather than physical facilities, an early priority is to identify facilities which will definitely not have a future role in the NCLTC system so that these facilities can be phased out and resources released for development of new services. The Plan also calls attention to training strategies to convert the skills of existing staff and recruit new staff to NCLTC services. As the Plan promotes the development of services to provide care in the community, where many older people are currently cared for by their families with little assistance, the roles of informal caregivers needs to be recognised and supported.

The Plan presents four sets of strategies for the conversion process: Part 2 sets out planning approaches, Part 3 covers service development strategies including training strategies, and Part 4 sets out a range of funding strategies. Proposals for funding from the World Bank for strategies that will serve as catalysts in implementation of the NCLTC Plan are set out in Part 5.

Principles

The development of the Nursing Care and Long Term Care Plan has been guided by a number of principles derived from Estonia's stated policy for the elderly and which complement developments in health care and pension policy. These principles are:

1. **Access to NCLCT services is to be based on assessment** of each individual's need for support, taking account of their physical and mental health and social situation. While the majority of those using NCLTC services will be elderly, age is not a criteria for access to services. Assessment is to be carried out by a multidisciplinary team with appropriate training for the tasks of assessment.

2. **Equitable provision of NCLTC services in all counties** is to be achieved by planning and development of services on the basis of the population distribution; the population aged 65 and over provides an appropriate basis for planning.

3. **A range of services is to be developed to meet the diverse needs of the elderly and family members who provide care to frail elderly relatives**. As the majority of elderly people wish to remain at home and can do so with support services, the main emphasis of NCLTC services is on community care, including services to assist family members caring for frail older relatives. Social care homes and nursing homes are provided for those with higher levels of dependency and care needs that cannot be met by community services.

4. **NCLTC services are to be affordable.** Affordability for individual is achieved by setting co-payments for social care homes and nursing homes set in relation to the Age Pension. Affordability for the community as a whole is achieved by ensuring the most cost effective use of the resources made available to NCLTC.

5. **Quality of care** is to be improved by setting and monitoring standards for provision of care and including requirements to meet standards in the licensing of service providers.

1.4 Target population for Nursing Care and Long Term Care

The target population for nursing care and long term care is defined as those who are unable to care for themselves due to the disabling effects of chronic illness and who need continuing nursing and social care. The relationship between age and the prevalence of chronic illness means that the great majority of these individuals are elderly.

Age itself is not however a criteria for access to NCLTC services, and access must be based on assessment of physical, mental and social functioning. Accordingly, individuals under the age of 65 who experience nursing and social care needs similar to older people will be covered by NCLTC services, but the majority of these younger individuals will be in late middle age and will have experienced an early onset of an age related chronic illness.

Separate programs already exist in Estonia for younger people with physical and mental disabilities. These programs offer a wider range of support than NCLTC, including educational and employment support, and will often have to provide support over the individual's lifetime. Younger people with disabilities have the reasonable expectation that they will live normally in the community and do not see themselves as part of the same target population as frail older people. The small number of severely disabled individuals who are in social care homes for the elderly are extremely isolated and unable to maintain the quality of life they expect and alternative forms of residential care are a high priority for this specific target group.

Programs for younger people with mental and physical disabilities have increasingly emphasised open care, and these developments provide models which can be adopted in the development of community care services for NCLTC. Expansion of rehabilitation for those who have experienced injury, or acute episodes requiring rehabilitation such as cardiac illness, will also cater mainly for the younger and middle aged groups. This active rehabilitation with the goal of recovery and return to work can be distinguished from slow stream rehabilitation for older people with chronic illness where the goal is restoration and maintenance of adequate function for daily living.

The population aged 65 and over is commonly used as the target population for planning NCLTC services. It can be expected that between 5 and 10% of the aged population may be using a service at any one time. On the basis of a total target population of 208,546 people aged 65 and over in Estonia in 1999, it can be estimated that NCLCT services will need to serve a client population of approximately 15,000 people. Within the total aged population, the need for NCLTC services rises at older ages; almost 60% of those currently residing in social care homes are over age 75. Population projections for Estonia show that as well as the total aged population increasing in the next 10 to 15 years, there will be pronounced ageing of the aged population, resulting in an increased need for services.

Given the role of family members in caring for frail elderly people, family caregivers should also be recognised as part of the target population. Provision of services such as respite care and day care assist family members in looking after family members.

The target population for NCLTC services is discussed further in Part 2.

1.5 Restructuring Nursing Care and Long Term Care Services

The limited long term care services that exist in Estonia are currently in a state of flux. Without sufficient or systematic attention to assessment of patient needs or the development of other long term care services, there is increasing overlap between the kinds of care being provided in different settings and with different sources of funding. Changes in acute hospitals are leading to beds in many hospitals being used for long term nursing and social care. Under contracts with the Health Insurance Fund (HIF), these beds are reimbursed at EEK203 per day on average. Hospitals cannot redirect resources to other long term care services as no prices for these services have been established by the HIF and so contracts cannot be made for provision of services such as slow stream rehabilitation or visiting nursing. Implementation of these services is however essential if the number of beds in acute hospitals is to be reduced as a high proportion of these beds are occupied by older patients who require other modes of care.

At the same time, municipalities are under increasing pressure to find places in social care homes and are using excess beds in municipal owned hospitals for this purpose. Further, while social care homes provide some nursing care similar to long term nursing care in hospitals, they are not licensed to do so and there is no overall guidance as to staffing levels and care practices. Some municipalities are taking initiatives to establish other services but can only do so to a very limited capacity.

The result is that both large and small hospitals are having to accommodate a mix of patients with widely varying care needs, and that there is overlap with separate social care homes. In larger institutions, separate units can be established to cater for patients with different needs, but this differentiation is not possible in small hospitals. Funding within the same hospital institution is increasingly mixed between the HIF and municipalities. A further problem is that individuals funded by municipalities must contribute 85% of their pension from the time they are admitted to the institution, but individuals funded by the HIF must make a higher contribution, but only after 30 days.

The structure of the present system and the system envisaged in this Plan is set out in Chart 1.1 The present system is relatively undifferentiated, with long stay patients spread across several parts of the hospital system and in social care homes. Rather than converting the excess hospital beds only to long term care and rehabilitation beds as suggested in the HMP, this Plan presents strategies for differentiation of services into four distinct levels:

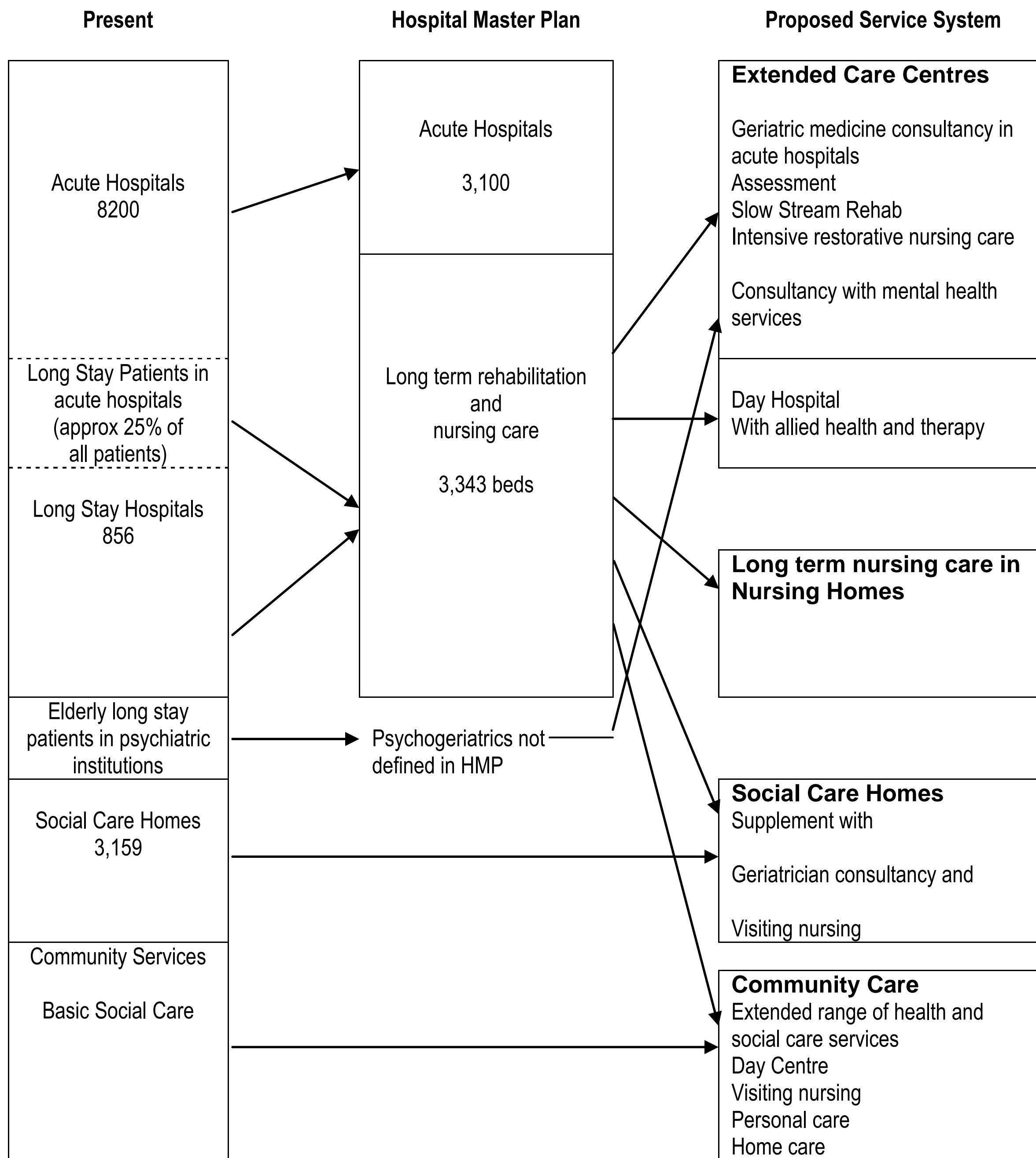
1. Geriatric Assessment and Extended Care Centres (GAECC),
2. Nursing homes providing long term nursing care,
3. Social care homes,
4. Community care services.

The assessment services based in the GAECCs will provide the means of matching services to the needs of frail older people needing long term care.

To date, the closure of some hospital beds and conversion of others to pikaravi, and the use of excess hospital beds as municipal funded social care beds appears to be driven largely by the contracts made by the HIF with individual hospitals. There are no mechanisms or strategies available for planning the conversion process across all hospitals in any area, or for the use of resources for alternative services. Four sets of strategies are required:

Planning and Coordination Strategies involve establishing benchmarks for service provision that can be achieved through the conversion of available resources, to ensure equitable distribution of the resultant services in relation to population need, and to manage the orderly conversion of facilities and capital resources. The Planning Strategy involves a number of activities that span the whole of the NCLTC system and which need to proceed in a coordinated way. Principal among these activities are the development of standards for service provision, operation and outcomes, leading to the production of guidelines and manuals, and monitoring systems. National standards for service provision then need to be applied in developing county level plans to guide the conversion process. The development of standards for service operation is seen as a prime mechanism for improving quality of care, by setting initial requirements for services to be accredited to receive public funding and a program for continuous quality improvement over time. These standards need to cover physical facilities in the first instance and then address care practices, including training of staff. Responsibility for these planning functions, and oversight of implementation, needs to be clearly identified in the Ministry of Social Affairs. As these functions require input from both the Departments of Health and Social Care, a new NCLTC Coordinating Unit is proposed within the Health Project for the next three to five years, with these functions then transferring to the Ministry. A proposal for World Bank Funding for the Coordination Unit is included in Part 5.

Chart 1: Present and Proposed Structure of Nursing Care and Long Term Care System



Service development strategies make up the main part of the conversion process and focus on conversion of facilities and staff resources in four areas:

1. Development of Geriatric Assessment and Extended Care Centres as part of post acute care services provided in hospitals;
2. Development of nursing homes providing 24 hour nursing care for very dependent older people;
3. Enhancing programs in social care homes and expanding community care by building on recent initiatives; and
4. Development of staff skills in long term care through an organised training program.

Needs based approaches to the planning of these services are set out in Part 2 of this report, and Service Development Strategies are outlined in Part 3. This Plan proposes that the World Bank provides funding for the pilot phase of a national Geriatric Assessment and Extended Care Program to be implemented in conjunction with implementation of the Hospital Master Plan. The planning and service development activities required for the conversion of excess hospital beds to long term care nursing homes will be a function of the proposed NCLTC Coordination Unit, also funded by the World Bank. Proposals for both these projects are set out in Part 5.

Training strategies are proposed to build on several initiatives that have been taken in recent years and a proposal for a Training Program is set out in Part 5.

Funding strategies for NCLTC services are required at two levels. First, a dependency based funding system for NCLTC services has to be developed to provide a list of new prices for a range of services. These services and related pricing should be phased in progressively as resources become available from conversion of excess hospital beds. The second level of development is the integration of social care funding from municipalities with HIF funding that currently covers long term nursing care in hospital. Funding strategies are outlined in Part 4 and a proposal for World Bank funding for a project to develop the dependency based funding system is set out in Part 5.

1.6 Funding

Responsibility for **funding** of long term care services is currently divided between health care services delivered in hospitals, funded by the Health Insurance Fund, and social care services, mainly provided in social care homes, funded by municipalities. The major part of the social care services funded by the municipalities is however personal care of a kind similar to the basic nursing care provided in long stay care in hospitals.

Four major problems are identified in current funding arrangements:

1. The level of funding received depends on the patient's location rather than their assessed care needs,
2. Responsibility for funding visiting nursing services remains undefined, posing a major barrier to implementing this service.
3. While the Health Insurance Fund provides funding at the same rate nationally, there are marked variations in the capacity and priorities of municipalities to support long term care services.
4. Quality of care is not related to price, and there a marked variations in the quality of services purchased by both the Health Insurance Fund and municipalities

To address these problems, new funding arrangements are proposed, to be negotiated in four steps:

1. that the Health Insurance Fund define prices for a range of long term care services, including dependency based funding for long term nursing care and social care, and unit prices for visiting nursing care and other community services, and for geriatric medical services of assessment, slow stream rehabilitation and intensive nursing care, in in-patient and day hospital settings. All these direct services are to be purchased with the funds made available from reorganisation of pikaravi units and from conversion of excess acute beds;
2. that access to funded services be conditional on assessment, and benchmarks for total levels of service provision be set on the basis of population needs;
3. that standards of care be defined and that funding contracts require providers to meet these standards, with standards being set to achieve improvements in quality over time; and
4. that consideration be given to options for integrating health insurance and municipal funding for social care, to provide more equitable access to levels of service provision defined on the basis of population needs.

1.7 Responsibility for Nursing Care and Long Term Care

In the short term, 2002-2007

Responsibility for coordination of the development of different long term care services is currently divided between the Health Department and the Social Care Department of the Ministry of Social Affairs, and municipal services are the responsibility of the Ministry of Internal Affairs. To bridge this division of responsibilities, it is proposed that:

- a unit concerned specifically with Nursing Care and Long Term Care be established as part of the Health Project, to coordinate the further development and implementation of the NCLTC Plan over the next three to five years. A statement of the functions of this Unit will be developed in the next stage of the Project. These functions will include the establishment of basic statistical collections appropriate for monitoring the development of NCLTC, in accord with Estonia and WHO statistical conventions.

- When the new NCLTC system is established, the Unit should be transferred to the Ministry of Social Affairs. This new unit will then have responsibility for on-going administration of NCLTC. The exact structure of the Unit and location of the unit with the Ministry will depend on the way in which the NCLTC system develops.

There is also a need for on-going communication with the organizations that are already involved in nursing care and long term care, and with new organizations that can be expected to emerge as the Plan proceeds. To facilitate communication with the field, it is proposed that

- that the present Nursing Care Working Party be reconstituted and convened as four new Working Groups, on Concepts and Standards, Planning, Service Development and Training, and Financing. These Working Groups should advise on further development of the NCLTC Plan and consult on implementation on an ongoing basis. The NCLTC Unit will provide support to these Working Groups.

- That the Estonian Association for Gerontology and Geriatrics be supported to convene an annual conference to promote discussion and development of nursing care and long term care, and that this Conference be funded by the World Bank as part of the Training Strategy.

Longer term developments

The NCLTC plan proposed in this report can be implemented without changes in legislation and within the budget identified for NCLTC in the Hospital Master Plan.

When the new NCLTC services and funding arrangements have been established, and following a full review in five years time, it may be appropriate to consider legislation to

support the continued operation of the NCLTC system. Such legislation would give formal expression to the principles of Estonia's stated policy for the elderly.

Further, the discussion of funding in this report is essentially concerned with expenditure of resources that will be made available from the conversion of excess hospital beds to long term care. In the longer term, it may be appropriate to consider additional revenue measures to ensure the financial sustainability of the NCLTC system in the context of projected increased in the aged population and future economic conditions.

1.8 Proposals for World Bank Funding

Four projects are proposed for funding by the World Bank in the next stage of the NCLTC Project. The proposals outlined in Part 5 are for:

1. Funding for a pilot program to establish the national Geriatric Assessment and Extended Care Program.
2. Development of a Client Care Need Classification and related funding system, and further development of options for integrating HIF and municipal funding.
3. Support for the Nursing Care and Long Term Care Planning and Coordination Unit in the Estonia Health Project, with the work of this unit to include liaison with the various Working Groups and the development of standards for service provision, standards for physical facilities, and standards of care.
4. Support for training programs.

Part 2. Needs Based Approaches to Planning and Planning Strategies

If the conversion of excess acute hospital beds and associated resources is to make the optimal contribution to meeting the needs of older people for long term care, it is necessary to identify the needs that are to be met through the conversion process, and to plan for the allocation of resources and development of services to meet these identified needs. Four approaches to needs based planning are considered here. As no one approach provides a complete account of need or provides a comprehensive basis for planning, all four have to be drawn on in developing strategies to initiate the conversion process.

Taken together, these approaches provide a sound planning strategy as a basis for action to develop nursing care and long term care in an integrated framework. This basic framework can be progressively refined and revised as implementation proceeds and in the light of the outcomes realised. It is critical that implementation of the Nursing Care and Long Term Care Plan commences as soon as possible and proceeds in step with the Hospital Master Plan and that major milestones in both plans are synchronised.

2.1 Analysis of secondary sources of empirical data on population characteristics and service utilisation

The definition of the target population for NCLTC services set out in Part 1 stressed the focus on assessment of dependency related to chronic illness and resultant care need. It also noted that for planning purposes, the target population can be most readily defined as those aged 65 and over. Empirical data on the aged population and need for long term care services is available from several sets of secondary data.

2.1.1 Description of the target population for planning long term care from census data

The size and distribution of the aged population as set out in Table 2.1 provides the basic picture of needs to which services have to respond.

In 2000, there were 208,574 people aged 65 and over in Estonia, accounting for 14.5% of the total population. Of this aged population, almost one in five were aged over 80.

There is relatively little variation in the proportion aged between counties. Compared to the average of 14.5% aged 65 and over, the range is from a low of 13.1% in Hiiumaa to a high of 17% in Vorumaa. The northwest region is relatively young and the southeast region is the oldest.

Of greater relevance to planning services is the concentration of the major part of the aged population in three major centres, with much smaller shares of the aged population in the other counties. In line with the distribution of the total population, one third of the aged population is in Harjumaa, most in Tallinn, and another 10% is in Tartumaa, most in the city of Tartu. Ida-Virumaa contains another 14% of the aged population but divided between the cities of Kohtla-Jarve and Narva.

Table 2.1: Population aged 65 and over, by counties, 2000

County	Total pop.	Pop. 65+	%65+	Share of aged pop.
Northwest				
Harjumaa	532883	72287	13.57	**34.7**
Hiiumaa	11723	1531	**13.06**	**0.7**
Laanemaa	31822	4357	13.69	2.1
Jarvamaa	42970	5990	13.94	2.9
Raplamaa	40086	5543	13.83	2.7
Northeast				
Ida-Virumaa	198610	29233	14.72	14.0
Laane-Virumaa	75421	10794	14.31	5.2
Southwest				
Saareema	39971	5867	14.68	2.8
Parnumaa	99653	15247	15.30	7.3
Southeast				
Jogevamaa	40992	6085	14.84	2.9
Polvamaa	35272	5790	16.42	2.8
Tartumaa	151912	22473	14.79	10.8
Valgamaa	38370	6365	16.59	3.1
Viljandimaa	61933	9757	15.75	4.7
Vorumaa	42579	7255	**17.04**	3.5
Total	1439197	208574	14.49	100.0

These population data provide the starting point for estimating some dimensions of need for services. In order to make a start on planning, it is necessary to adopt some benchmarks for levels of service provision per 1000 population aged 65 and over. While the estimates presented here should be seen as initial indicators only, they do provide some baselines on which future planning can advance as further information becomes available. It is not possible to wait until more data become available to commence the process of conversion of excess hospital beds, and as the process proceeds, it will itself generate quantitative data and qualitative information from experience to guide further planning and the initial estimates set out here can be revised accordingly.

Defining the population size for service catchment areas

The size of the aged populations in the smaller counties averages around 5,000, and this population can thus be taken as a reasonable minimum catchment population for planning and delivery of basic level services. The only county that does not reach this minimum is Hiiuma, with only 1,531 people aged 65 and over on the island.

Catchments of around 5,000 people aged 65 and over can be formed within the counties and cities with larger populations by groupings of municipalities in and around major population centres. Together with the single county catchments, there would be around 40 catchment areas for basic level services, as shown in Table 2.2. Assuming that some 10% of the aged population requires services at any one time, each basic service unit will have to meet the needs of 500 clients.

Table 2.2: Correspondence between Hospital Master Plan Regions and Proposed Catchments for high level services based on Extended Care Centres

County	NCLTC Plan – Proposals for		Hospital Master Plan Region
	40 Catchments Areas for basic level services, @ 5000 people 65 and over	8 Catchment Areas for high level services based on Extended Care Centres	
Harjumaa	14 catchments in Tallinn/Harjumaa	Tallinn (Harjumaa) divided into two catchment areas 1. East Tallinn 2. West Tallinn	))
Hiiumaa	Visiting specialist services only		
Laanemaa	) 3 single county		*) Northwest*
Jarvamaa	) catchments	3. Possible third catchment in southeast of region, focused on Aide in Jarvamma	)
Raplamaa	)		
Ida-Virumaa	6 catchment areas	4. one catchment focused on	) Northeast
Laane-Virumaa	2 catchment areas	Kohtla-Jarve (Puru)	)
Saareema	1 single county catchment	5. one catchment area	) Southwest
Parnumaa	3 catchments	focused on Parnu	)
Jogevamaa	1 single county catchment	Three catchment areas,	
Polvamaa	1 single county catchment	6. focused on Vildandi 7. focused on Tartu	
Tartumaa	4 catchments	8. focused on Voru	)
Valgamaa	1 single county catchment		)) Southeast)
Viljandimaa	2 catchments		)
Vorumaa	2 catchments		)
Total	40 local service areas	8 major catchments	4 regions

Extended Care Centres will require larger catchment populations. Given the distribution of the aged population, eight major service areas might be defined. The size of the population of Tallinn and the geography of the city mean that two catchment areas might be defined for services in the east and western parts of the city, with a possible further centre in Rapla or Paide to serve the southern part of the Northwest region. Other ECCs should be based on Parnu, Tartu, Kohtle-Jarva (at Puru), Viljandi and Voru. Separate concentrations of population in some counties mean that small sub-centres may also be warranted in Haapsalu (under one of the centre serving west Tallinn), Kuressaare (under Parnu) and at Rakvere and Narva (under Kohtle-Jarve/Puru).

In proposing that planning of higher level services provided by Extended Care Centres might initially proceed on the basis of eight major catchment areas, each with a target population of an average 25,000 people aged 65 and over, it is recognised that decision on actual catchment areas will be informed by local circumstances and established patterns of communication between services and between counties. The definition of the major catchments should also take account of the regional basis of the Hospital Master Plan and enable the conversion process to proceed parallel to implementation of the Hospital Master Plan in the same areas. More specific proposals for major Extended Care Centres and sub-centres are presented in the Planning Strategy at the end of this part of the report.

2.1.2 Study of Health and Coping of Older Population of Estonia

Need indicators

This study was conducted by the Estonian Geriatrics and Gerontology Association (EGGA) and the Institute of Mathematical Statistics of the University of Tartu, with support from the Open Estonia Foundation, in 2000. The three part study collected data from a sample of 1000 people aged 65 and over, through a random sample of 200 family doctors. A survey of social workers was also conducted. The data from 811 elderly respondents was weighted to match the age distribution of the population and the results can be taken as representative of the older population of Estonia in cities and the countryside. The report of the study presents a detailed account of the daily living situation of older people and wide range of indicators of need for assistance in activities of daily living, health care and social support, and only selected findings are noted here.

The items detailed in Table 2.3 show that at least 10% of the population aged 65-84 need assistance with some activities and that for the very old population, aged 85 and over, the proportion is over 25%. These figures show that the estimate made above, of 10% using services at any one time, is likely to be a low figure.

Table 2.3: Indicators of need for care in the older population

% reporting	Age 65-84	Age 85+
Need for help in daily life		
Several times a week/every day/ depend on others	15	57
Need nursing help at home	20	26
Need help with		
Shopping	22	62
Housework	20	57
Bath, shower, sauna	10	40
Cooking	10	38
Taking medicine, other therapeutic procedures	7	27

Sources of help

When asked who they would turn to for help, most older respondents nominated a family member: 31% children, 16% grandchildren and other relatives, and 18% neighbours and acquaintances (multiple responses were allowed). Family doctors were mentioned by 25% and family nurse by 9%, but no other services were identified. Social workers reported that 19% of older people they saw needed help from outside their family, but there were few services for older people themselves or their families to turn to.

Service gaps and unmet need

The survey of family doctors and social workers corroborated the picture of need. Further questions were asked on satisfaction with the capacity of institutions and services to meet the needs of older people. Between half and two thirds of the doctors and social workers reported that there were no nursing homes, social care homes or social flats for the elderly in their area, and some two out of three reported a need for improvement in other services or that they were not available. The services that were seen to be most lacking were day centres for elderly people, reported by two thirds of both doctors and social workers. No information was reported on adequacy of visiting nursing services as this service did not exist in most areas.

Both doctors and social workers were asked about the level of training they had received in geriatrics and their need for further training. Other than studying geriatrics and gerontology as part of their basic training, only 15% of the doctors and 25% of the social workers had done a further long course, and the majority relied on studying the literature themselves. Less than 5% reported that they did not want further training, and the majority expressed interest in training ranging from short courses to specialist training, including residency programs for doctors.

The findings of this study not only show the level of need for care services but also that family doctors and social workers are keen to work with each other and with other services to improve the networks in local areas.

Supporting family caregivers

The great majority of older people who need help rely on family members. An important function of community services is to assist family members in their caregiving roles as well as older people themselves. For example, visiting nurses can provide advice and information to family members about how to care for their frail relatives; short stay respite care and use of day centres also assist relatives by giving them a break as well as providing some therapy services to maintain the older persons' capacity to function as independently as possible. The survey findings thus point to the need to recognise the role of family caregivers and to provide services to support them in their caregiving roles.

As family members and older people already have close contacts with family doctors, they will be an important link in referring families and older relatives for assessment for services. The high level of interest of family doctors in gaining further training in geriatrics and gerontology indicates that they are likely to be receptive to initiatives to develop their role as part of the network of NCLTC services

2.1.3 Long stay patients in acute hospitals at present

The publication Estonian Health Statistics, 1992-1999, includes statistics on long stay patients in acute hospitals. This data provides a third source of information on the need for nursing care and long term care as it is this group of patients for whom alternative modes of care will be required as implementation of the HMP proceeds. The available data provide a picture of the number of beds used by long stay patients at any one time and of admissions to and discharges from those beds over time.

1. in designated long term beds

Data presented in the report Estonian Health Statistics show that in 1999:

- 856 hospital beds were designated for long term care, 8.3% of the total 10,358 beds;
- there were 7,341 admissions to these beds, an average of 8.7 admissions per bed.
- the average stay in these beds was 35.4 days compared to 10.3 days for all hospitals.
- bed occupancy for these beds was higher than overall occupancy, 84.1% compared to 73.5%.
- a higher proportion of discharges from these beds were deaths, 14.8% compared to 2.6% of all discharges.

2. total long term patients

Data on long term patients taken from the HIF data base in Table 2.4 shows:

- A total of 65,943 admissions were classified as "pikaravi" or follow-up care in the Health Insurance Fund data base and accounted for 23.3% of the total 282,302 admissions in 1999. Those in designated long term care beds accounted for only 11% of all pikaravi patients.

- Long stay patients aged over 60 accounted for almost twice the proportion of all admissions, 15.3%, compared to younger patients, 8%.

- Of the total pikaravi admissions, 66% were patients aged over 60, and of these 59% had stays of between 10 and 20 days and 36% had stays of more than 20 days.

- The 15,460 patients aged 60 years and over who had stays of more than 20 days accounted for 23.4 % of all pikaravi admissions and would account for a much larger proportion of total bed days.

- The figure of around 15,500 can be taken as a initial indicator of the number of long term hospital patients for whom alternative modes of care will be needed as hospital conversion proceeds.

Table 2.4: Long term patients in hospitals, 1999

Age	No. of long stay patients	% of long stay patients	Long stay patients as % of all patients (282,302)
Under 60	22,671	44.0	8.0
Over 60	43,272	66.0	15.3
Total	65,943	100.0	23.3

The high occupancy rate for designated long term beds, together with reports of delays in discharging patients from these beds, as well as the large proportion of general beds occupied by long stay patients, indicate a need for improved organization of long term care. The high proportion of patients in long stay beds who remain there until their death also indicates a lack of alternative care modes.

Length of stay has been declining in recent years, from 16 days in 1992 to 10 days in 1999. Provision of alternative care for a substantial proportion of long stay patients is a major means of achieving further reductions in average length of stay for the acute hospital sector. This reduction is a major objective of the HMP, but is unlikely to be realised without the kinds of development of long term care services proposed in this Plan.

2.1.4 Tartu University Hospital Feasibility Study

The Tartu University Hospital Feasibility Study, conducted by Scandinavian Care Consultant Services, included consideration of service needs for care of the elderly in South East Estonia. Several aspects of this study are of particular relevance to the development of NCLTC in Estonia more generally.

1. The report presents some concepts based on Swedish experience and outlines the full range of services that make up an aged care system, with a basic division between medical care, provided in hospitals, and social care, provided in other settings, including the individual's own home. While drawing on Swedish experience, the report notes that a service system appropriate to local conditions needs to be developed. (This proviso applies especially to how Estonia is to separate nursing care linked to medical care provided in hospital from nursing care provided in nursing homes and through visiting nursing services, to elderly people who are not receiving medical treatment.)

2. The gap in the level of care equivalent to that provided in nursing homes in Sweden is highlighted, with similar patients occupying long stay hospital beds in Estonia. The development of nursing homes separate from hospitals and providing a distinct level of care between hospital care and social care homes is proposed as the main means of addressing the issue of long stay patients in hospitals.

3. The study conducted a survey of long stay patients in hospitals, in social care homes and special care homes (mental health institutions), using the Resident Assessment Instrument (RAI) that is being used in several countries, but at this stage more in research than in direct service delivery. Only preliminary results are available so far, and it should be noted that references to "nursing homes" in the Swedish report in fact refer to social care homes. The findings indicate the need for more differentiation in types of care and for assessment services that can refer patients to services that are most appropriate to their needs. While the level of handicap of some of those living in social care homes and special care homes may appear low compared to levels of dependency in nursing homes in Sweden, this is not an appropriate comparison and is confounded by inclusion of the much younger population in special care homes. The more appropriate comparison might be with Swedish service houses, and this information also needs to be viewed against the housing conditions in which some older Estonians are living, especially in the countryside. The survey of older people noted above identified many shortcomings in living environments; for example, 46% had a wood oven for heating and cooking, 43% did not have hot and cold water in the house, and 17% did not have an internal toilet, and only 65% had a bathroom.

4. The design of the Study, including the schedules used, are very relevant to the development of a classification of patients needing long term care. Further analysis of the data on diagnoses and dependency for older people who had long stays in hospital and those in social care homes, but excluding those in special care homes,

could make an important contribution to this work, in line with the proposal set out in Part 5.

A comparison of the number of nursing care beds that the feasibility study estimated as being needed in South East Estonia and the number estimated by other means is reported below in 4.2.

2.1.5 Further analysis of Health Insurance Fund data

Further analysis of Health Insurance Fund data is required to differentiate long term patients from acute care patients. These analyses will provide a clearer picture of:

1. the specialities in which older long stay patients are over-represented;
2. differences in the length of stay of older patients compared to younger patients for these specialities;
3. the distribution of these patient in hospitals of different sizes; and
4. trends in use of acute care by older people as implementation of the HMP proceeds, and especially changes in the use of the classification "pikaravi".

A critical indicator of the outcomes of the development of NCLTC should be the impact on length of stay of hospital patients and changes in the mix of hospital patients and bed day use should be systematically monitored.

2.1.6 Data from the Estonian Health Interview Survey 1996

The sample for this survey was stratified by age to ensure sufficient numbers of respondents at older ages, to age 79. The results were then weighted to match the age distribution of the total population. The survey of 4,711 individuals achieved a response rate of 84%. A very wide range of data was collected on health status, health behaviour and health service use.

The items in Table 2.5 show the high levels of health problems and disability among the older population and consistent increases with increasing age. From age 70 onwards, around one in five report a limitation in one or other area, and also reported a need for nursing care.

These data are especially useful in provide an indication of the level of need for assistance among older people living in the community, and show a similar picture to the EGGA survey.

Table 2.5: Health status of older population, Estonian Health Interview Survey 1996

Health indicator	% of Males				% of Females			
	60-64	65-69	70-74	75-79	60-64	65-69	70-74	75-79
Experienced at least one long term health disorder, in last 12m	73	80	83	92	85	87	84	91
Self perceived health bad or very bad	16	26	28	36	22	27	34	36
Mobility limitation	6	10	17	23	3	9	16	23
Communication limitation	1	4	9	18	3	4	8	17
Limitation in doing housework	0	4	12	17	2	4	7	15
Limitation in personal care	0	2	2	4	1	1	2	5
Need for nursing care in household	0	5	13	21	2	5	10	20

Three developments from this survey data should be included in the NCLTC Plan:

1. A report on the health and disability status of the older population using this data needs to be prepared to provide a baseline for planning and for future surveys;
2. The standardised format of the survey questions should be adopted in data collections on use of NCLTC services to enable comparability of service users to the total aged population;
3. Research and evaluation activities in the NCLTC Plan should be carried out in the School of Public Health at the University of Tartu in conjunction with training activities.

2.1.7 Future needs indicated by population projections

The size and age structure of the present and future population of Estonia is shown in Table 2.6. These preliminary projections were provided by the Estonian Interuniversity Population Research Centre.

Table 2.6: Age structure of population, 1999 and projected to 2014.

Age group	No. in 1999	Projected Number in 2014	% increase
Under 40	788,270		
40-44	105,595		
45-49	99,252		
50-54	81,711		
55-59	82,621		
60-64	81,286	89,675	10.3
65-69	72,537	) 130,915	- 1.6
70-74	60,374	) ……...	
75-79	36,412	51,576	41.6
80-84	19,815	) 63,078	70.9
85+	17,677	) ………	
Total all ages	1,445,580	1,446,059	0.0
Total aged 65+	208,574	245,569	17.7

The target population for NCLTC in the future will be shaped by the very uneven sizes of coming cohorts of older people in Estonia. Four factors need to noted:

1. In 1999, life expectancy at birth was 70 overall, but with a marked differential between 65.4 for men and 76.1 for women. While now relatively low compared to EU countries, life expectancy at birth is improving and female life expectancy in 1999 was the highest ever. More immediately, life expectancy at age 65 is already another 12.6 years for men and 17 years for women. So as more of the population reach 65, higher proportions can be expected to survive until advanced ages at which need for support increases substantially.

2. Improvements in morbidity and levels of disability associated with chronic illness can be expected if concerted efforts are made in health promotion programs for adults in late middle age. These programs will be important in adding to gains in life expectancy at earlier ages and to reducing the level of disability in future cohorts of older people and hence limiting the need for long term care services.

3. The most rapid growth in the very old age group who have the highest need for care will occur in the short term, to 2015. The cohorts now aged 65-69 and 70-74 in 1999 are much larger than those aged over 75. The figures in Table 2.6 show that there are currently as many in just the 70-74 year age group as the total population aged 75 and over, and 50% more again in the 65-70 age group. The ageing of these large cohorts of "young-aged", and their increased life expectancy will mean a much increased "old-old" population in the next 10 to 15 years and a commensurate increase in the need for NCLTC services. The projections in Table 2.6 show that while the size of the total Estonian population will be stable over the period to 2015, there will be dramatic increases in the oldest age groups. Within an overall increase of 18% in the population aged 65 and over, the 75-79 age group will increase by 42% and the 80 and over age group will increase will increase by fully 70%.

4. Ageing of the population moderates after 2015 as the relatively smaller cohorts currently aged 45 to 64 reach old age. These late middle aged cohorts reflect the impact of the second world war and its aftermath on the birth rate, survival and immigration. Each of the three five year cohorts is of similar size, and only around 10% larger than the current 65-69 year age group.

2.2 Assessment of adequacy of present provision in relation to needs of target population

A second approach to needs based planning can be made by assessing the adequacy of present provision in relation to need on the basis of:

1. reported adequacy of existing services
2. gaps in the range of services available
3. initiatives taken to fill these gaps
4. equity of provision and access between regions against defined benchmarks.

2.2.1 Reported inadequacies

The Hospital Master Plan states that the number of places in social care homes, 3,195, is seen to be adequate. However, this assessment is subject to some qualification, particularly with regard to the role of social care homes in providing nursing care and the lack of a higher level of nursing care:

- the existence of waiting lists for places together with variability in assessment practices;
- reports of local shortages and having to purchase places outside local areas;
- the lack of a profile of dependency of residents actually receiving care in social care homes;
- the lack of standards and licensing for nursing care provided in social care homes, and
- the increasing provision of long term nursing care in small hospitals and the overlap between this care and basic nursing care in social care homes.
- Funding at flat rates for all long term patients in hospitals and all residents in social care homes may not drive effective resource use; given variations in dependency and care needs, the flat rates of funding may be too high for some patients and too low for others.
- There are wide variations in quality of care, not necessarily related to costs of care.
- Lack of alternative and appropriate accommodation for small numbers of severely disabled younger people; these individuals are extremely isolated in social care homes in which all other residents are very elderly.

2.2.2 Gaps in service provision

A number of gaps in service provision have been identified. These gaps especially hinder discharge of long stay patients from hospital. Service development strategies to address these gaps need to commence as soon as possible if implementation of the HMP is to proceed as planned. A number of initiatives that have been planned and taken by individual agencies provide some directions for development and these initiatives can serve as demonstration projects to promote good practice as the NCLTC Plan is implemented. These innovative services demonstrate the capacity for change within

existing services and the conversion process needs to draw on their experience and promote these care practices.

Assessment

Need indicators

Assessment of long term care needs is currently poorly developed in acute hospitals. Transfers from other hospital departments to pikaravi departments and discharge from long term care in hospital to other modes of care are both problematic.

Assessment for admission to social care homes is managed by the municipalities and there is no formal link between hospitals and the municipal social workers who make these assessments. Informal liaison works well in some areas, but not in all. Difficulties in arranging access to social care homes were reported in areas where there was a shortage of places and resulted in delays in hospital discharges and municipalities having to purchase places from other municipalities.

The establishment of multi-disciplinary assessment teams is seen a priority for improving the match between individual needs and service provision, and to directing individual older people to the level of care most appropriate to their needs. Assessment teams are the cornerstones of the Geriatric Assessment and Extended Care Centres (GAECC), where they have access to inpatient care for assessment and restorative nursing care, and to bed-based slow stream rehabilitation and a day hospital.

Assessment Teams should be responsible for assessment for admission to both nursing homes and social care homes and also to visiting nursing care and other community services.

A critical role of the Assessment Teams will be to sort out the mixed groups of patients currently being cared for in both long term hospital care and in social care homes. Identification of different levels of dependency and care needs and placement of individuals in the most appropriate care setting will lead to a clearer focus on the kinds of services to be provided in different settings and hence an improvement in quality of care and more effective use of resources. Consistency in assessment and care outcomes will be promoted by the use of standard instruments and classification of care needs.

Assessment should particularly identify individuals whose care needs are incompatible with the long term nursing and social care needs of frail older people and for whom alternative services will be required. Three groups of individuals can be identified at the present time:

1 relatively young adults suffering from chronic disease such as multiple sclerosis; visiting nursing services and other home care services can provide more appropriate care for this group;

2 those with TB, who can be managed through day care centres that take responsibility for a list of these patients, along the lines of current open care programs for those with mental health problems;
3 younger people with severe disabilities resulting from trauma, such as spinal injury, whose medical condition is stable and who need care for the rest of their lives, possibly for periods of 30 to 40 years. Neither existing social care homes nor future nursing homes which are focused on caring for older people can provide a satisfactory quality of life and social integration for these younger people.

Recent initiatives

The assessment process developed for the mental health system and associated development of open care services provides an example on which multi-disciplinary assessment teams for long term care can build.

Although no multi-disciplinary assessment teams dealing with elderly people have been established, initiatives for assessment have been taken in the development of training courses by the Estonian Gerontology and Geriatrics Association and the University of Tartu. A guide to geriatric assessment, including a compendium of standard assessment instruments, has been published.

Development strategies for aged care assessment teams are proposed as part of the Geriatric Assessment and Extended Care Program in Part 3, and a proposal for World Bank funding for a pilot program is presented in Part 5. The role of assessment teams needs to include contributing to service development as well as provision of clinical services. There is already some familiarity with international practice in assessment, from individual exchanges and from specialist literature, and short term study tours would provide opportunities for updating and expanding this knowledge.

Long term nursing care

Need indicators

There is a major gap in the availability of long term nursing care. Long term nursing care in hospitals is time-limited and the majority of long term patients in hospital are not in wards specifically organised to provide nursing care. At the same time, social care homes are not formally licensed to provide nursing care and generally do not employ fully trained and registered nurses.

After assessment, the second priority for the NCLTC Plan is the development of long term nursing care as a service that can be provided at different levels of intensity, to individuals with different levels of dependency, across a range of settings. Nursing homes especially have to be established separately from hospitals and social care homes.

The definition of nursing care delivered outside hospitals has been a problematic area and has been addressed in a separate paper prepared by the NCLTC Working Party. Nursing care and social care are at present vertically divided between two separate kinds of institutions. The vertical division in the nature of care services provided, legal requirements, funding arrangements, assessment and other aspects of these two kinds of institutions is seen in Table 2.7. To overcome this vertical division, the three components of care - daily living care, social care and nursing care - need to be reorganised into horizontal layers of care that can be provided at different levels in different settings, with a new setting of nursing homes to be defined as providing high levels of nursing care in conjunction with GAECCs.

Table 2.7: Long term nursing care in hospitals, social care homes and proposed nursing homes

Criteria	Long term nursing care in hospital	Social care in social care home	Proposed long term care in nursing homes and social care homes
Trained Nurses	Legally required	Not legally required	To be legally required in nursing homes. Social care homes not to provide complex nursing care.
Nursing tasks	Medical nursing procedures	No medical nursing procedures	24 hour trained nurses in nursing homes, visiting nurses in social care homes for technical / medical nursing procedures
Training in long term care	Not required	Not required	Require Bachelor degree for Director of Nursing and in-service training to convert skills of nursing to long term care
Role of doctors	Supervision of medical nursing	Family doctor only	No doctors on staff Medical care provided by Consultant Geriatrician and Family Doctor
Assessment	Doctor only	Municipal social worker	Assessment Team
Payment for:			**Propose that**
Nursing care	HIF, EEK203 per day	Not defined	New payment for combined nursing and social care, based on dependency.
Social care	Not defined	Municipality	
Individual payment	Co-payment after 30 days, full payment after 60days	85% of pension	Individual to pay for some part of daily living costs
Change in payment	After 30 days in hospital and after 60 days	Continues indefinitely at same rate	Change on basis of re-assessment
Level of payment	Flat rate, average of EEK203 per day, range EEK198-213,	Flat rate Average funding of EEK3500 a month, plus with pension co-payment of = EEK176 per day	Define levels of care on basis of dependency and set levels of funding according to care needs

Visiting Nursing

Need indicators

The lack of a visiting nursing service was widely identified as a major reason for long stays in hospital and also for some frail older people being admitted to social care homes rather than returning to their own homes.

Planning and development of a network of visiting nursing services is the third priority for this Plan and this development should proceed in conjunction with the development of the GAECCs and assessment services.

A key requirement for converting resources from excess hospital beds into visiting nursing services is that the HIF set a price for this service. In the first instance, this price will have to be set on the basis of the cost of inputs, mainly the salaries of nurses, equipment and vehicles, and negotiation of what is considered to be a fair and reasonable price with contracting agencies. The establishment of a small number of visiting nursing services on a pilot basis would then generate cost data for refinement of prices.

Recent initiatives

The initiative already taken by the Cancer Society in conjunction with the HIF to establish a visiting nursing service for cancer patients can provide a guide for pricing and aspects of service operation. A proposal for a visiting nursing service developed a group of family doctors in Kuressaare provides a further guide to pricing and operation.

Other community care services

The survey conducted by the Estonian Association of Gerontology and Geriatrics found that while there was some variation in the level of development of other community care services, they were generally very limited. Municipal social workers report that services mainly involved social care workers providing direct assistance to elderly people in instrumental activities of daily living, such as shopping and ensuring fuel supplies, rather than more intensive home maker and personal care services.

A number of day centres are also operating and providing social support and sometimes meals to socially isolated people, not only the elderly. The model in mental health services, whereby a day centre service is responsible for support of a designated client load, provides a model that warrant consideration in NCLTC. Day centres could be the focal points in the local catchment areas for basic level services.

A full account of existing community services through investigations at county and municipal level would provide a useful baseline for planning and service development in conjunction with the conversion of resources released from excess hospital beds to a range of basic NCLTC services.

Slow stream rehabilitation

Hospital stays of more than 10 days are funded for long term nursing care only and there is no opportunity for continuing low intensity or slow stream rehabilitation. Many older patients with chronic conditions may thus remain in hospital or be discharged without the full benefits of rehabilitation that could reduce the level of on-going care needed. Provision of slow stream rehabilitation has the capacity to reduce length of stay in inpatient care and to increase turnover, and so make more effective use of available beds. Training of therapists and nurses to staff these services will be required.

Slow stream rehabilitation for restoration of function needs to be developed in the GAECCs and in a network of Day Hospitals, with formal assessment for admission to and discharge from the rehabilitation program. Training of therapists in geriatric rehabilitation will be required.

As a form of post acute care, slow stream rehabilitation needs to be distinguished from both the few days of post-acute care that follow some acute stays, and active rehabilitation which has the goal of full restoration of function and return to home and to work. Slow stream rehabilitation aims to achieve a level of functioning that will enable to individual to function at the optimal level possible given the continuing presence of disabilities associated with chronic conditions. Rather than eliminating disability, slow stream rehabilitation frequently means assisting the individual to manage to live with a degree of disability.

Dementia care

Dementia care was not widely identified as a gap in service provision. However, initiatives have been taken that provide demonstrations of additional services that would enhance the capacity of general services to provide quality care for people with dementia.

The Iru Nursing Home in Tallinn has established a separate dementia care unit in part of an existing building, with an activity program designed for this group of residents. This initiative provides a demonstration of how other residential services can provide more specialised care within their existing buildings.

The Iru program was similar in many ways to a specialised dementia unit provided in the Vaimse Tervise Centre in Tartu. The Vaimse Centre operated a day centre as well as the residential care unit; the day centre catered for around 10 clients and as not all clients attended very day, up to 20 or 30 families a week could be supported in caring for their elderly relatives. Again, these services had been started in an existing building and the focus was on the activity programs rather than the building.

2.2.3 Equity of access between regions

Access to social care homes

Access to social care homes can be readily expressed in terms of beds per 1000 aged 65 years and over. Given the variation between counties in the proportion of the population aged 65 and over, it is more relevant to use the aged population as the base for calculating ratios rather than the total population. Differences in access between counties can then be compared.

Access to social care homes per 1000 aged population aged 65 and over in each county is detailed in Table 2.8.

Table 2.8: Access to social care homes, per 1000 aged 65 and over, by counties

	Current Provision		Benchmark at 15.2/1000			Benchmark at 20/1000		
County	Beds	beds/ 65+	Total beds	Difference		Total beds	Difference	
				Above benchmark	Needed beds		Above benchmark	Needed beds
Northwest								
Harjumaa	639	8.84	1099	-	460	1446	-	807
Hiiumaa	39	25.47	23	16	-	31	8	-
Laanemaa	59	13.54	66	-	7	87	-	28
Jarvamaa	164	27.38	91	73	-	120	44	-
Raplamaa	164	29.59	84	80	-	111	53	-
Northeast								
Ida-Virumaa	534	18.27	444	90	-	585	-	51
Laane-Virumaa	191	17.70	164	27	-	216	-	25
Southwest								
Saareema	75	12.78	89	-	14	117	-	42
Parnumaa	256	16.79	232	24	-	305	-	49
Southeast								
Jogevamaa	136	22.35	92	44	-	122	14	-
Polvamaa	140	24.18	88	52	-	116	24	-
Tartumaa	285	12.68	342	-	57	449	-	164
Valgamaa	143	22.47	97	46	-	127	16	-
Viljandimaa	215	22.04	148	67	-	195	20	-
Vorumaa	119	16.40	110	9	-	145		26
Total	3159	15.15	3170	528	538	4171	179	1192

Compared to an average of 15.2 beds per 1000 aged:

- Harjumaa county stands out as having the lowest level of provision, and in response to this shortage, providers in the City of Tallinn report that it is necessary to purchase beds in surrounding counties. If Harjumaa County is excluded, the average for the remaining counties rises to just over 20 places per 1000.

- Three other counties, Laanemaa (NW), Saarema (SW) and Tartumaa (SE) have below average provision. Shortages of social care places were reported on visits to Saarema and Tartu, with Tartu municipality advising that some 50 places were purchased in surrounding municipalities.

- Four counties have provision only slightly above the average: Ida-Virumaa and Laane-Viruma (NE), Parnumaa (SW) and Vorumaa (SE).

The remaining seven counties have provision above the average; all have at least 22 beds per 1000, and the highest provision is in Raplamaa county, at just on 30 beds per 1000.

Two models of more equitable provision are also presented in Table 2.8:

1. The first model sets the benchmark at the current average of 15.2 beds per 1000 aged. An additional 538 beds would be needed to bring all counties up to this benchmark.

2. The second model sets the benchmark at 20 beds per 1000, in line with the average for all counties when Harjumaa is excluded on account of the low ratio bringing the average down. An additional 1,192 beds are required to bring all counties up to this higher benchmark.

In both cases, most of the needed beds are in Harjumaa, followed by Tartumaa. These models have not taken account of provision above the ratios in some counties. In the first model, the number of additional beds balances the number provided above the ratio, but in the second model, the total number of beds above the ratio is less than 200 out of a total of over 4000. These beds are spread widely across several counties and do not represent significant inequities. The outstanding inequity is the deficit of social care beds in Harjumaa.

Three provisos should be kept in mind in considering these models:

1. The benchmarks selected are presented only to indicate the level of places required to achieve an equitable level of provision in all regions and they do not represent a necessary or preferred level of provision.
2. The models provide a guide for allocation of resource needed to make up for deficits in social care places, but the distribution of excess hospital beds also needs to be taken into account and this issue is taken up below in discussing resource allocation models.

3. Current population figures provide only a starting point for planning and future estimates need to be based on projections of the aged population for 5 year periods to 2015.

Conversion of excess hospital beds to NCLTC services

A similar process for considering equity of access can be applied to the conversion of excess hospital beds to provide long term nursing care beds. The HMP identified a total of 3,434 beds available for conversion, but rather than making a direct 1:1 conversion to nursing home beds, the conversion process needs to take account of the balance to be achieved between the provision of nursing home beds, social care beds, and other NCLTC services, and the potential for redistribution of resources from excess beds between regions and counties.

Balance of social care and long term nursing care places

A benchmark for provision of half as many nursing care beds as social care beds can be proposed. To this end, a benchmark of 10 nursing care beds per 1000 aged balances the benchmark of 20 social care places per 1000, and results in 2080 nursing care beds.

If half of the available excess beds are converted to nursing home beds at a rate of 1.5 nursing home beds for each excess bed, 2,305 beds will be realised. This outcome approximates the number of beds needed at a benchmark of 10 per 1000 aged 65 and over. (The relative cost of nursing care beds compared to the funding of excess beds at EEK450 per day is discussed in the next section).

Excess beds available by regions

The distribution of excess acute beds between regions, set out in Table 2.9, shows that the average ratio of excess beds per 1000 aged population is 16.5. Allowing for conversion of each excess bed to 1.5 nursing home beds and 3.3 social care beds (see discussion in next section for basis of these rates), the available resources are more than sufficient to cover provision of both the additional social care homes and the nursing homes needed to reach the benchmark levels.

Further, there is considerable variation between regions, from only 11.0 per 1000 in the Northeast to 18.6 per 1000 in the Northwest. This variation indicates some possible scope for redistribution of resources between regions.

Table 2.9: Excess acute beds per region

Region	Pop. 65+	Excess acute beds	Ratio of excess beds per 1000 aged 65 and over
Northwest	89,708	1670	18.6
Northeast	40,027	440	11.0
Southwest	21,114	324	15.3
Southeast	57,725	1000	17.3
Total	208,574	3434	16.5

Comparison of estimates

It should be emphasised that the benchmarks of 10 nursing home and 20 social care beds per 1000 population aged 65 and over are very preliminary benchmarks and will need to be revised as benchmarks for other services are developed with further data analysis and discussion with service providers.

To this end, it is useful to compare the benchmark of 10 nursing care beds per 1000 to the estimate based on the survey of dependency of long stay hospital patients and residents of social care homes conducted in the Tartu University Hospital Feasibility Study. On the basis of that data and comparisons with Swedish levels of provision of long term nursing care, it was estimated that between 600 and 650 nursing care beds would be needed for the Southeast region. This number of beds gives a ratio of 11.3 beds per 1000 aged 65 and over, and this estimates can be compared to the outcomes of applying the benchmark and conversion of excess beds:

1. Applying the benchmark of 10 beds per 1000 for the population of 57,725 aged 65 years and over in the South East region would result in 577 nursing home beds. This figure is slightly below the estimate of the Feasibility Study.

2. Conversion of 471 excess beds (half the total 942 available excess beds) to nursing care beds at a rate of 1.5 would result in 706 beds. This result is above the estimate from the Feasibility Study, but as the South East Region has the highest level of excess beds, achieving regional equity would allow conversion of a lower proportion of excess beds and reallocation of some resources to other regions.

The general consistency of the ratios and figures derived from different methods supports the use of a benchmark of 10 nursing home places per 1000 aged 65 and over as a basis for planning at the county level. The strengths of this benchmark as a needs based indicator are that:

- It incorporates the level of need identified in the survey of patient dependency carried out in the Swedish study;
- It is comparable with Swedish experience when allowance is made for differences in age structure;
- It recognises that there will be differences in dependency of patients in nursing homes beds and in social care homes, and differences in funding;
- It is achievable within the resources that will become available from conversion of half the available excess hospital beds to nursing hospital beds.

Provision at benchmark levels

Provision of nursing care and social care beds at the benchmark levels of 10 and 20 beds per 1000 respectively in each county is set out in Table 2.10.

Table 2.10: Provision of social care and nursing home beds at benchmark levels, by counties

County	Social care beds At 20 per 1000 aged 65+	Nursing home beds at 10 per 1000 aged 65 +	Total Beds
Northwest			
Harjumaa	1446	723	2169
Hiiumaa	31	15	46
Laanemaa	87	44	131
Jarvamaa	120	60	180
Raplamaa	111	55	166
Northeast			
Ida-Virumaa	585	292	877
Laane-Virumaa	216	108	324
Southwest			
Saareema	117	59	176
Parnumaa	305	152	457
Southeast			
Jogevamaa	122	61	183
Polvamaa	116	58	174
Tartumaa	449	225	674
Valgamaa	127	64	191
Viljandimaa	195	98	293
Vorumaa	145	73	218
Total	4171	2086	6257
(Rounded)	(4200)	(2100)	(6300)

The outcomes of applying the benchmarks to planning at county level provide a basis for discussion with service providers and planners who have firsthand knowledge of needs and adequacy of existing services at the regional and country level. This step is taken up in the Planning Strategies set out below.

2.3 Comparisons to benchmarks of other countries

Four considerations need to be taken into account in looking to international experience to set benchmarks for service provision.

1. There are differences in population structure, particularly the proportion of the aged population that is aged 80 years and over. As with other countries, the Estonian data presented above show that need for care increases markedly with increasing age. Currently, only 18% of the Estonian population aged 65 and over is aged over 80, a lower proportion than in many EU countries where those aged over 80 account for some 30% of the total aged population.

2. In line with differences in levels of development between countries, there are marked differences in social and economic circumstances of older population, particularly in

housing conditions, that relate to need for long term care. The findings of the Study of Health and Coping of Older People noted above, and the limited provision of social flats, mean that housing related factors may play a bigger part in the reasons for older people seeking care in Estonia than in other EU countries. This situation also highlights the scope for providing simple housing modifications and low technology assistance that can enable older people to remain in their current housing.

3. Differences in the mix of long term care services and related services that older people can be referred to. There are no widely agreed international benchmarks for levels of provision of long term care services. Rather, it is the variation in provision that is more apparent. These variations are related to differences in general standard of living, especially housing, historical development of residential care as compared to community care, stage of development of services and policy initiatives. In looking to set benchmarks for service provision in Estonia, it is important to make comparisons with countries that are at similar levels of social and economic development as well as those with comprehensive aged care systems that have developed over periods of up to 50 years.

4. Differences in definitions need to be taken into account. Standard definitions are only now being developed across the EU countries and in WHO studies, and these definitions can be adopted in Estonia as the NCLTC system emerges.

2.3.1 Comparisons of levels of service provision

Data in Table 2.11 has been taken from a recent comparative report on the 15 European Union countries and Norway, edited by Pacolet (2000). That study attempted to standardise definitions so that service provision could be compared across countries, but in many cases, detailed quantitative data were not available on provision of community care services and services were only reported as available or not available. The difficulty in obtaining these data reflect the relatively low development of administrative systems in long term care services compared to other health services.

Rather than showing any common levels of service provision that could be taken as benchmarks, the authors stress the variability in levels of provision of different kinds of services and also the dynamic state of many national system.

2.3.2 Estonia's starting point

While international experience provides some useful information for planning in Estonia, the main lesson is that Estonia must develop its own benchmarks for services rather than adopting those of any one other country. All countries have placed increasing emphasis on community care services over the last decade, they have done so from very different starting points, and Estonia has its own starting point.

Table 2.11: Levels of service provision in selected EU Countries and Norway

	Provision for population aged 65 and over					
Country	Nursing Homes (including psychogeriatric) per 1000	Social Care Homes per 1000	Service flats and similar per 1000	Home help (full time staff per 1000)	Home nursing (nurses per 1000)	Day care places per 1000
Norway	51	14	46	43 nurses and home help staff combined per 1000		available
Sweden	18	29	40	72	available	available
Denmark	53	11	32	available	available	5
Finland	21	32	20	17	9	1
Germany	12.6	11	32	9	available	available
Netherlands	26	64	23	20	6	6
Austria	25	21	10	10	available	10
Ireland	22	25	4	26	3.4	available
United Kingdom	18	31	50	8% use service	6% use service	50
Portugal	Available, more than 16	available	available	available		available
Spain	28	Very low	available	13 staff per 1000		available
Estonia	4 (in long stay hospitals)	15	Very low	Available but limited	Not available	Available but limited

Compared to Estonia, all the other countries listed in Table 2.11 except Spain have much higher levels of provision of nursing homes, social care or similar homes and service flats or equivalent forms of housing, and well developed community care services.

The low provision of all forms of residential care in Estonia, and the relatively poorer state of housing in which some older people live, especially in rural areas, means that many frail older people who would be living in some form of residential care or supported housing in other countries are living in the community in Estonia. At the same time however, this situation means that unlike these other countries, Estonia does not have a high level of resources tied up in residential care. While there is a need to improve the transition from acute care and long term hospital care to other modes of care, reduction of the use of institutional care is not the primary focus for development in Estonia. Rather, the low level of provision of institutional care means that Estonia is in a very good position to build its long term care services on a strong base of community care from the start.

Given the potential for change in Estonia in the next few years, it will be useful to set preliminary benchmarks, to review outcomes against these benchmarks every few years and adjust benchmarks accordingly.

2.4 Resource allocation models

A key requirement in planning the development of nursing care and long term care is that the options proposed are affordable within the resources that will become available through the conversion of excess acute beds. Two resource allocation models are presented here:

Option 1 is based on the HMP and
Option 2 is labelled a diversification option as it enables the development of a wider range of NCLTC services.

2.4.1 HMP Option

The Hospital Master Plan envisages the development of long term care using the facilities and resources becoming available from the reduction in acute hospital beds from 8,200 to 3,100 over a 10 to 15 year period. It proposed that 2/3 of the beds no longer used for acute care be converted to long term care, and funded at EEK450 per day. The total budget generated for 3,434 beds at EEK450 a day is EEK564m. (HMP Appendix J).

The HMP was not required to develop a detailed budget for converting these resources to long term care, but its outcomes provide some starting points for developing the diversification option:

- Direct conversion of the 3,434 excess hospital beds to nursing home beds, as set out in Table 2.12, would add 16.5 beds per 1000 aged 65 and over and bring the total level of institutional care to 35.6 places per 1000. This conversion would result in a high total ratio of residential care provision and almost equal provision of nursing home and social care places.

Table 2.12: HMP option for conversion of excess hospital beds to long term care places

Type of facility	No. of residents	Ratio per 1000 aged 65+
Existing		208,574
Universal institutions for adults (social care homes)	3,159	15.1
Designated long term beds in hospitals	856	4.0
Excess acute beds for conversion	3,434	16.5
Total	7,449	35.6

- The conversion of all resources to nursing care beds does not free any resources for other services.

- The EEK564m allocated to NCLTC account for 39% of the expenditure of EEK1,444m identified by the HMP as available for hospital and LTC services care,

allowing for a saving of EEK666m out of the present total budget of EEK2,110. This appears to be a very high share of health expenditure to allocate to NCLTC.

- There is no indication of how co-payments are to be dealt with. Although nursing care would not be time limited, the division between health care without co-payments and social care requiring co-payments is not resolved.

- The HMP figure of EEK564 does not include the EEK133m spent on social care by municipalities (estimated on the basis of funding 3159 beds at an average of EEK3500 per month.)

2.4.2 Diversification Option

This option proposes converting the available resources into four sets of services that will achieve the goals of the NCLTC plan to develop a more diversified system, with GAECCs, nursing home beds, social care beds and community care services, and with total levels of nursing home and social care places at the equity benchmark levels.

Funding of EEK450 per day becoming available from conversion of excess acute beds will enable significantly different modes of care to be provided, and as different types of services would achieve higher turnover, this option demonstrates that an increased number of people could be served. Resources would be used more effectively in terms of both costs of care and appropriateness of services.

Municipal funding for social care is included in this option and co-payments are also taken into account. Inclusion of co-payments reduces the total funding required for NCLTC services and so allows an equivalent amount to be redirected back to acute care or to further savings.

The estimates of the cost of the four types of services as summarised in Table 2.13 are based on reasonable relativities compared to a maximum of EEK450 per day for GAECC services, and taking account of current funding for social care homes and pikaravi. A distinction is made between *funding* from government sources, and *co-payments* at 85% of the Age Pension. The purpose of developing these costs and the diversification option is to demonstrate the range of outcomes that might be realised. It must be emphasised that these estimates are presented for illustration and discussion, and should not be taken as indicating recommended funding levels.

Table 2.13: Diversification Option: Funding levels and co-payments

Service Type	Funding EEK per day	Co-payment EEK per day (1)	Total EEK per day	Range for dependency based funding (2)
GAECC	450	0	450	
Nursing care	270	40	310	260, 310, 360
Social Care	100	40	140	90, 140, 190
Community care	100	0	100	

(1) co-payment of EEK40 per day is slightly below 85% of the Age Pension of EEK1500 per month
(2) based on three tiers with difference of EEK50 per day

Post acute services provided by the GAECC

- The cost for assessment, slow stream rehabilitation and intensive nursing care, is set at EEK450 per day, following the rate identified in the HMP for each excess hospital bed. The conversion rate from excess hospital beds to GAECC beds is thus 1:1.

- Four aspects of funding of GAECC services make it similar to HIF funding of acute care: GAECC services will be under medical direction, they will be delivered mainly in hospitals, they will be time limited, and no co-payment will be charged. For these reasons, it is considered that GAECC funding should be returned to the acute care budget.

- The rate of EEK450 per day is more than double the current rate of reimbursement for pikaravi and so will enable provision of significantly higher levels of care, and so achieve increased turnover. A doubling of the current 8.7 admissions a year to pikaravi beds would require some 17 admissions a year for each GAECC bed, or an average stay of three weeks. To achieve this outcome, reasonable limits would be 10 days for in-patient assessment and 30 days for slow stream rehabilitation and intensive nursing care, compared to the current limit of 60 days for pikaravi funding. These are average stays and each GAECC would be set a target number of patients to be treated, allowing some flexibility in actual stays for individual patients. Assessment stays in particular would be reduced through assessments made in the community or in the day hospital. To promote shorter stays, incentive payments could be made for managing more than the target number of patients.

- Provision of a total of 500 beds in eight major GAECCs and four sub-centres, funded at EEK450 per day, generates a budget of EEK82.215m.

Long term nursing home care

- The cost for long term nursing care is proposed at an average of EEK310 per day, made up of funding of EEK270 and a co-payment of EEK40 per day. Funding of EEK450 converts to exactly 1.7 nursing home beds funded at EEK270 a day, but a conversion rate 1.5 has been adopted in the diversification model.

- A co-payment is charged as nursing home care does not involve treatment under direct medical supervision, is not delivered in a hospital, and is not time limited. Nursing home care also includes social care services and daily living costs and charging a co-payment thus achieves consistency with funding of social care homes.

- The total average of EEK310 is 53% higher than the current funding of pikaravi and so enables a substantially better quality of care to be delivered.

- Medical care and prescription medications are not covered in the daily funding. It is proposed that medical care be covered by including nursing home residents on lists of family doctors, and that a safety net be developed as an adjunct to the present funding of prescription medications.

- Rather than funding all long term nursing care at a flat rate of EEK310, it is proposed that a dependency related funding system be developed, as discussed further in Part 4.

- The total budget for 2100 nursing care beds is estimated at EEK237.615m, made up of funding of EEK206.955m and co-payments of EEK30.660m.

Social care homes

- Average municipal funding of EEK3500 per month provides daily funding of EEK117. With a co-payment of EEK40 per day, the total average cost is currently EEK157.

- The current funding of EEK3500 per month is high in relation to the Age Pension of EEK1500 per month on which the majority of older Estonians live. With the establishment of nursing homes, some of the most dependent residents in social care homes could be transferred to nursing homes where higher funding should enable them to receive more appropriate nursing care. The average cost of caring for the population remaining in the social care homes would then be lower.

- Daily funding for social care homes does not cover medical care or prescription medication, and the arrangements proposed for nursing homes should also apply to social care homes.

- To allow for a possible reduction in the average cost of social care, average funding is set at EEK100 a day in the estimates made here. With a co-payment of EEK40, the total cost is EEK140, 12% lower than present funding. The total cost of the existing 3159 and the additional 1200 social care beds required to reach benchmark provision is estimated at EEK222.745m, made up of funding of EEK159.104 and co-payments of EEK63.641. The lower average funding means that the while the number of beds increases by 38%, the total funding of EEK159m is an increase of only some 20% over the current estimated municipal funding of EEK133m.

Community Care Services

- It is difficult to estimate the total level of expenditure that should be allowed for community services. However, if 25% of total funding for NCLTC services (excluding co-payments) is to be allocated to community services, the estimates developed above generate expenditure of some EEK150m.

- As those receiving community services require their pension for daily living expenses, no co-payments are charged.

- The only estimate of the cost of community services that can be developed is based on the rate of EEK100 per visit being paid for the Cancer Society visiting nursing service. Visiting nursing services are the most costly community service and given the prices set for nursing services that are now emerging, a cost of EEK100 per day for all community services should be adequate to cover a mix of nursing and other lower cost services.

2.4.3 Macro-budget estimates

The total budgets for NCLTC services under the HMP Option and Diversification Option can now be compared.

For the HMP Option, the total budget is EEK697m, made up of the EEK564m identified in the HMP together with the estimated EEK133m spent on existing social care beds. The total budget in this option is from government funding, either from the HIF or municipalities, and this option does not provide for raising any revenue from co-payments.

For the Diversification Option, the total budget is EEK692m, made up of government funding of EEK598.3 and co-payments of EEK94.3. The government funding component is 16.5% lower than in the HMP Option.

Table 2.14: Diversification Option, total budget estimates (1)

Service type	Funding EEKm	% of funding	Co-payment EEKm	Total EEKm
GAECC beds	82.125	13.7		82.125
Nursing care	206.955	34.6	30.660	237.615
Social care	159.104	26.6	63.641	222.745
Community care	150.000	25.0		150.000
Total	598.274	100.0	94.301	692.485

(1) annual budget estimated on the basis of the daily funding and levels of provision set out in Table 2.13

Four outcomes of the Diversification Option offer advantages over the HMP option:

1. The funding of EEK82.125 for GAECC services should be returned to the acute care budget as it is funded on the same basis of other health services rather than the other NCLTC services. This reduces the budget for nursing homes, social care homes and community care only to EEK516m.

2. Further exclusion of EEK133m for existing social care homes results in funding required for NCLTC of EEK383; this amount is only 26% of the total HMP estimate of EEK1444 for health and NCLTC compared to 39% in the HMP Option.

3. EEK94m is generated from standard co-payments for both nursing homes and social care homes.

4. The balance between different kinds of services can be established; in this initial estimate, total funding is divided between 14% for GAECC services, 35% for nursing home care, 27% for social care homes and 25% for community care.

2.5 Planning Strategies

2.5.1 Structure and functioning of NCLTC system

The needs based planning approaches are summarised in three charts that set out the framework of the planning strategy.

The overall structure of the proposed NCLTC system is set out in Chart 2.1, which shows four sets of services:

1. 8 major Geriatric Assessment and Extended Care Centres and 4 sub-centres located across the counties;
2. long term nursing care homes, provided at the benchmark of 10 beds per 1000 aged 65 and over;
3. social care homes at the benchmarks of 20 places per 1000 aged 65 and over; and
4. a range of community care services.

The GAECCs and long term nursing care homes are new services, and introduction of these services will have an impact on the way in which existing social care homes and community care services function. Service development strategies to establish the GAECCs and long term nursing care homes, and to promote changes in social care homes and the expansion of community care services are set out in Part 3.

The relationships between the NCLTC services and the acute care system are set out in Chart 2.2 . Three levels of care are defined in this chart:

1. Acute care
2. Post acute care, divided into Active Rehabilitation and the GAECCs and associated services, and
3. Long Term Care, covering long term nursing care homes, social care homes and community care services.

Patients can be admitted to the GAECC from home or from hospital. Transfers from acute care to active rehabilitation or the GAECC will be decided by clinicians, taking account of the patient's condition and expected outcome. GAECC services are part of the health care system as they are under the direction of medical staff, are time limited and no co-payments are required. The funding implications of these three conditions are discussed further in Part 4.

The levels of service provision for each county are set out in Chart 2.3. This chart translates the aggregate benchmarks defined through the needs based approaches to each county and identifies the level of additional services that can be provided through use of the resources that become available from conversion of the excess hospital beds.

Chart 2.1: Structure of Strategy for Nursing Care and Long Term Care

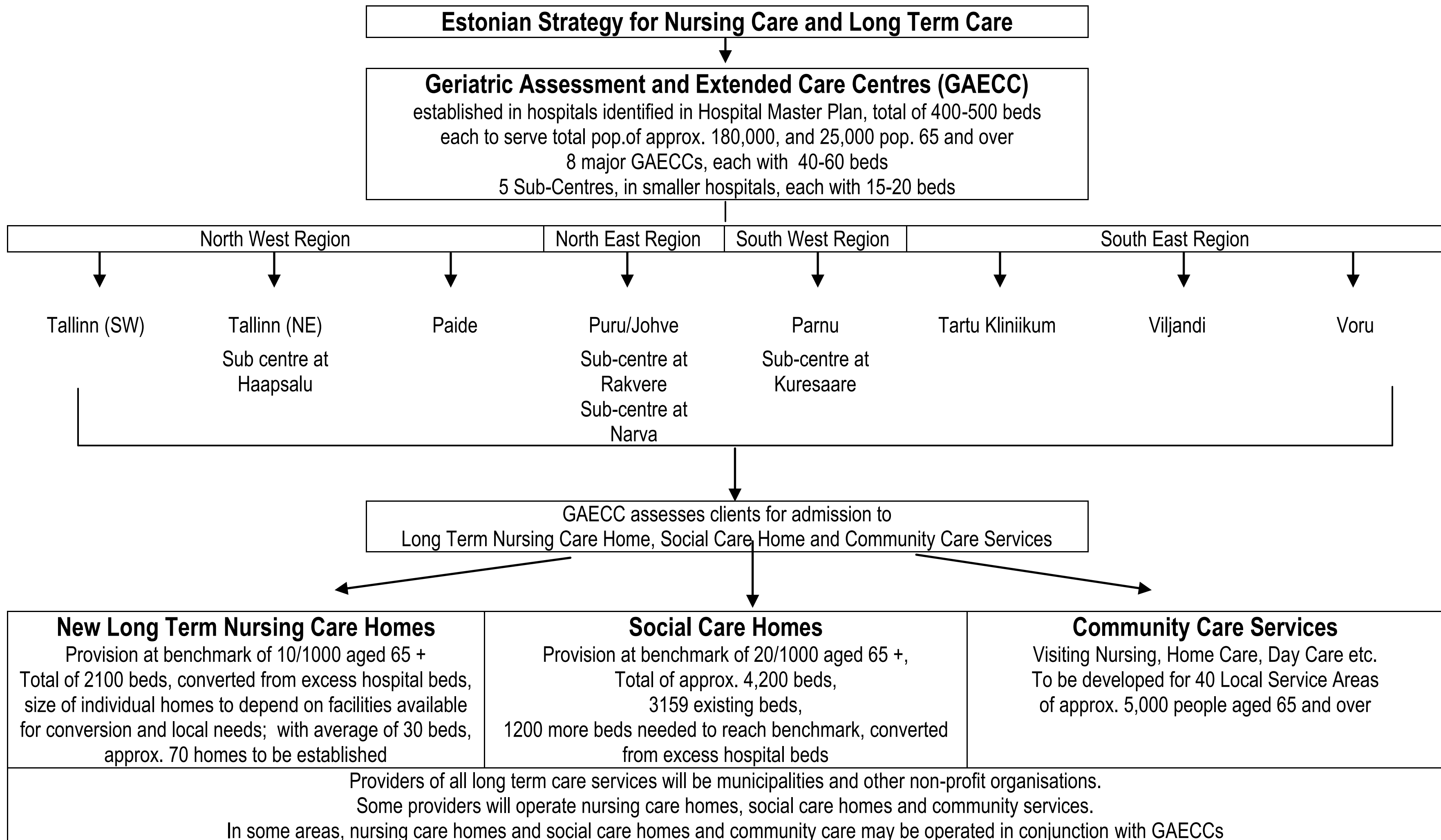


Chart 2.2 Relationships between Acute Care and Geriatric Assessment and Extended Care Centres and Long Term Care Services

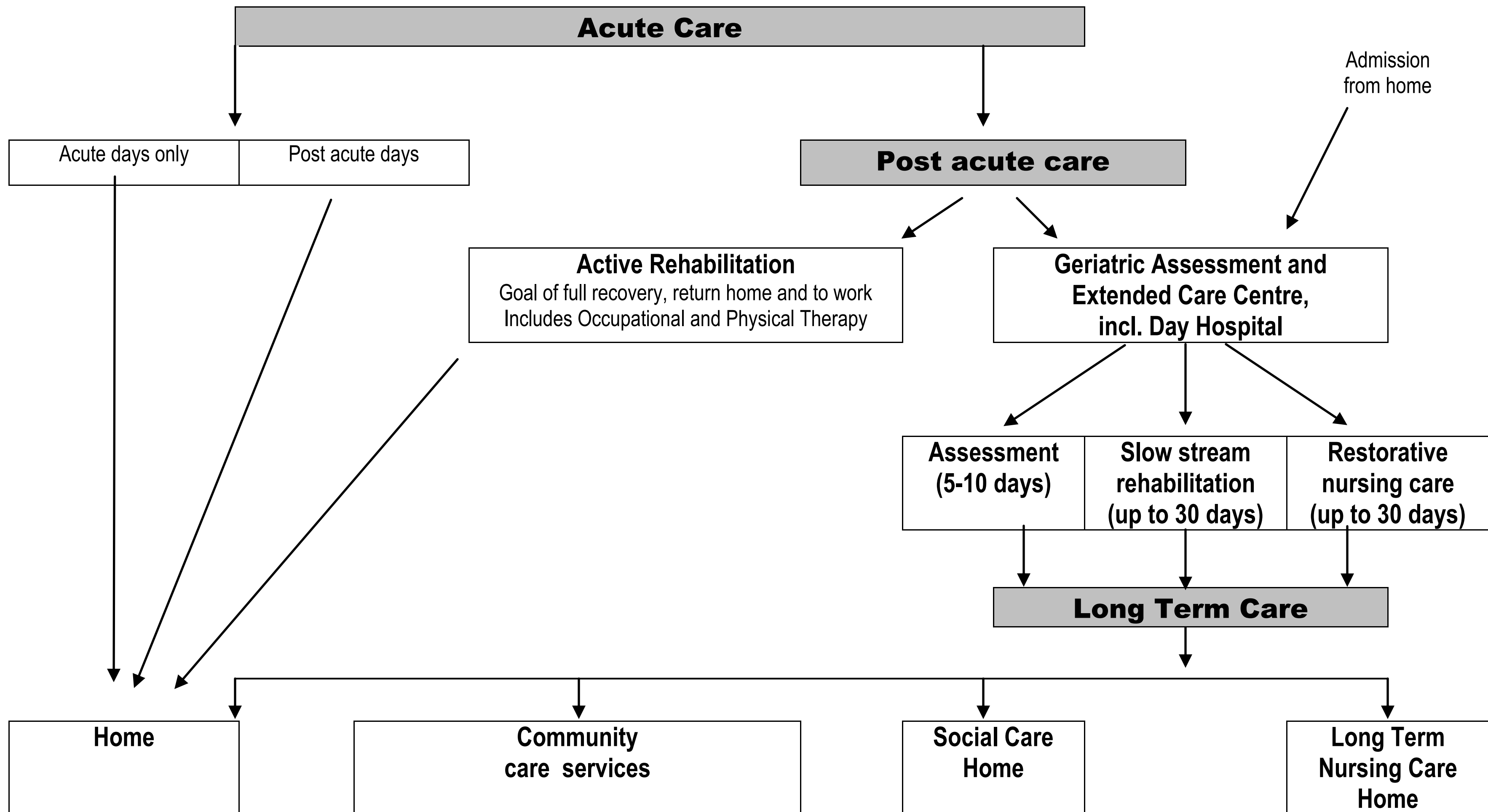


Chart 2.3: Levels of Service Provision for Counties, developed from needs based planning

Demographic Profile					Nursing Care and Long Term Care Services				
County	Total population	Pop. aged 65+	% aged 65 +	Share of total aged pop.	HMP Hospitals to have Geriatric Assessment and Extended Care Centre (8 Major GAECCs with 40 - 60 beds each and Sub-Centres with 15 - 20 beds each	Nursing home beds at benchmark of 10/1000 aged, converted from excess acute beds, size of home depends on local areas served	Social care places: Existing	Social care places: Extra beds needed to reach 20/1000 aged 65 +	Local Service Areas serving 5000 people aged 65+
Northwest									
Harjumaa	532883	72287	13.57	34.7	1. Hospital serving NE Tallinn	361	320	403	7
					2. Hospital serving SW Tallinn	361	320	403	7
Laanemaa	31822	4357	13.69	2.1	2a Sub-centre at Haapsula,	44	59	28	) 1
Hiiumaa	11723	1531	13.06	0.7	also to serve Hiumaa	15	39		) .
Jarvamaa	42970	5990	13.94	2.9	3. Paide	60	164		1
Raplamaa	40086	5543	13.83	2.7	Served by GAECC 1, 2, 3	55	164		1
Northeast									
Ida- Virumaa	198610	29233	14.72	14.0	4. Puru/Johve	292	534	51	6
					4a. Sub-centre in Narva				
Laane-Virumaa	75421	10794	14.31	5.2	4b. Sub-centre in Rakvere	108	191	25	2
Southwest									
Parnumaa	99653	15247	15.30	7.3	5. Parnu	152	256	49	3
Saareema	39971	5867	14.68	2.8	5 a. Sub-centre in Kuressare	59	75	42	1
Southeast									
Tartumaa	151912	22473	14.79	10.8	6. Tartu Kliniikum	224	285	164	4
Jogevamaa	40992	6085	14.84	2.9	To be served by Tartu	61	136		1
Viljandimaa	61933	9757	15.75	4.7	7. Viljandi	98	215		2
Vorumaa	42579	7255	17.04	3.5	8. Voru	73	119	26	2
Polvamaa	35272	5790	16.42	2.8	To be served by Voru	58	140		1
Valgamaa	38370	6365	16.59	3.1	To be served by Voru	64	143		1
Total	1439197	208574	14.49	100.0		2084	3159	1192	40

2.5.2 Implementation of Planning Strategy

Following adoption of the NCLTC Plan, two sets of actions are required to advance the Planning Strategy.

1. Planning Working Group and County Planning Groups

The Planning Working Group established to advise the Estonian Health Project on implementation of the NCLTC Plan will be responsible for the overall planning of services. Decisions at the local level will require input from organizations at local and county level, and the means to achieving this input is to establish County Planning Groups to work in conjunction with each GAECC. Most County Planning Groups will cover only a single county, but where GAECC sub-centres are established or a county is served by a major GAECC in another county, the County Planning Group will involve two or three counties.

The Planning Working Group and County Planning Groups will be responsible for identifying options for service development in each county and local area, and making recommendations for the conversion of excess hospital facilities and resources. These recommendations will be referred to the Coordination Unit to ensure that they conform to the overall planning structure, but at the same time allow the preferred outcome for each county to differ in accord with existing services, the distribution of the population, interests of different providers in developing services and other local factors.

2. Conversion of capital stock of "excess" acute hospital beds to nursing care and social care facilities

The process by which excess hospital beds are converted to nursing homes or social care homes, or closed, must proceed in a coordinated manner to ensure the equitable distribution of services that result from this process and to avoid ad hoc decisions about capital investment. As some of the existing social care homes are in poor standard buildings, the conversion of excess hospital beds may offer improved facilities in some cases and the capital conversion process should thus include social care homes. The balance of existing and bed provision required in the Planning Strategy is shown in table 2.14.

Table 2.14: Existing Beds compared to Provision required in Planning Strategy

Type of beds	Existing Provision	Provision required in Planning Strategy
Excess hospital beds	5,100	
Existing social care beds	3,159	3,159
Additional social care beds	0	1,200
Nursing Home beds	0	2,100
Beds in GAECC	0	500
Total	8,259	6,959

Combining the excess hospital beds and existing social care homes gives a total of 8,259 beds, some 1,300 more than the total planned requirements. There is thus a margin of some 20% or one in five existing beds that can be eliminated in the course of the conversion process.

Given this margin and the constraints on new capital investment, the standard of all facilities should be surveyed and rated so that the poorest standard facilities can be eliminated as nursing homes and social care homes are established in better quality excess hospital buildings. Some of the margin of excess beds may also be eliminated by reducing the number of residents per room in crowded facilities. Taken together, these measures will achieve a improvement in quality of facilities and quality of care without requiring major capital investment.

It is proposed that no major capital investment be made in upgrading existing facilities or building new facilities until all facilities have been surveyed and that only minor capital upgrading be carried out in the first five years of the Plan. Even with minor capital expenditure however, it is important that resources only be invested where they are needed to achieve the optimal outcome. Capital investment decisions thus need to be made through a centralised system based on certificates of need issued in accord with the capital plan.

A two stage process involving the registration and survey of all the facilities and then issuing licences on the basis of the outcome of the survey is required. As the majority of the facilities to be covered are currently hospitals, and there is a need for consistency in licensing for hospitals, nursing homes and social care homes, it is proposed that registration and licensing be undertaken by the single independent licensing body under the Ministry of Social Affairs. A proposal for the process and criteria for licensing is set out in Appendix 1.

Part 3. Service Development Strategies

3.1 Approaches to Service Development

As neither GAECCs nor nursing homes as envisaged in the NCLTC Plan currently exist in Estonia, this Part gives most attention to strategies needed to develop these two services. Development of these new services will bring about changes in the role of social care homes, and there will be an expansion of community services, and the existing services in these two areas provide the basis for further development. An important part of all development strategies is to forge links between the services so that they function as an integrated system and make most effective use of the available resources in meeting the needs of frail older people.

The aims of the service development strategies outlined below are to promote the integrated development of each type of service within the overall framework of the NCLTC Plan, to promote efficient use of available resources and to realise improvements in quality of care, mainly through training of the workforce involved in NCLTC.

3.1.1 Elements of service development

The main elements of all service development strategies are:

1. **Commissioning,** including identification of organisations eligible to tender, specification of tenders, assessing responses to tenders, overseeing agreements and contracts, and providing for on-going support and monitoring of outcomes.
2. **Service development activities** that will establish the range of services to be provided. A prime objective of these activities is to convert the facilities and resources of excess hospital beds to long term nursing care and related services. Training of staff as part of these development activities will be provided through the Training Strategy.
3. **Delivery of direct NCLTC services** in accord with the benchmarks set and to standards defined in the service development strategies, and within contracted budgets.
4. **Monitoring** of outcomes to provide progress reports on implementation of different services and on implementation of the NCLTC plan overall.

The NCLTC Coordination Unit in the Estonian Health Project will have overall responsibility for service development and ensure that development proceeds in accord with the planning processes set out in Part 2. The Concepts and Standards Working Group and the Service Development Working Group will be involved and there will need to be on-going consultation with service providers. A particular role for these groups

will be to work with those involved in education and training to develop manuals and guidelines to establish standards and to improve care practices.

3.1.2 Existing basis for service development

While international experience provides information for service development, it is critical that local experience be taken into account. Local experience not only provides a practical basis for service development but also enables identification of best practices that have been achieved and which are relevant to local needs and which can be further improved over time.

There are a number of initiatives that can be built on to develop care standards. The case studies of NCLTC services presented at the workshop held in Tallinn on August 16th, 2001 showed the foundation that already exists. The service initiatives listed in Table 3.1 can especially serve as demonstration projects. In drawing on international resources, it will be important for the Working Groups to review these materials to make them relevant to the Estonian situation.

Table 3.1: Current initiatives in NCLTC for development as Demonstration Projects

Area of initiative	Activity	Organisation
Assessment	Translation of standard assessment instruments into Estonian	Estonian Geriatrics and Gerontology Association
	Standardised functional assessment of elderly	City of Tallinn
Long term nursing care	Rating of Patient Dependency and Care Planning	Iru Nursing Home
	Rating of Patient Dependency and Care Planning	Parnu Hospital
Open Care Community Care	Visiting Nursing Program in Tallinn	Tallinn City Municipality
	Palliative Care Service	Cancer Society
	Planning of Visiting Nursing Service	Family Doctors Group, Kuressaare
	Home Care Project for elderly people	Pelgulinna Hospital, Tallinn
	Pilot project for home nursing and home care	Puru Hosp[ital
Dementia Care	Day Care Centre and Residential Care for people with dementia	Vaimse Mental Health Centre, Tartu
Education	Curriculum for long term nursing care	Estonian Nurses Association
	Training Programs in Geriatric Medicine	Estonian Geriatrics and Gerontology Association
	Short courses in gerontology	Estonian Geriatrics and Gerontology Association
Research	Survey of health and coping of older people in Estonia	Estonian Geriatrics and Gerontology Association and University of Tartu

3.2 Development of Pilot Program for Geriatric Assessment and Extended Care Centres (GAECC Program)

3.2.1 Commissioning

The mechanism for developing the GAECC Program will be commissioning by the Estonian Health Project and the Ministry of Social Affairs, in conjunction with a financing agreement with the Health Insurance Fund and drawing on the World Bank Loan. The Coordination Unit of the NCLTC Program will be responsible for the commissioning process and will work with the relevant Working Groups at different stages.

The commissioning process will involve issuing an invitation to tender to selected hospitals in appropriate locations to participate in the GAECC Program as ***host hospitals*** for the Program. Each GAECC will be established as a functional department of the host hospital and its primary role will be to manage patients who no longer need acute care but who cannot be discharged home without assessment for support services and who need on-going care in a nursing home or a social care home, or in the community. The GAECC will also progressively assess all patients in ‘excess’ hospitals beds that are to be converted to nursing care beds or social care homes, and will also assess all those in the community who require long term care. All those already in social care homes should be assessed so that the most dependent patients can be transferred to nursing homes and care needs of the remaining residents defined more clearly.

The development of the GAECC should proceed in conjunction with the implementation of the Hospital Master Plan. The host hospitals for the 8 major GAECCs and four sub-centres will be identified among the 12 hospitals defined in the HMP, excluding the large regional hospital in Tallinn. The decision as to whether the GAECC will be located within the host hospital or at a nearby location will be negotiated, taking account of the facilities available to each hospital and redevelopments proposed by the HMP. Decision on the location of GAECCs and sub-centres should be made as soon as possible so that development can proceed in conjunction with the HMP; these decisions cannot be left until after the HMP initiatives are taken.

Tender

Commissioning will proceed by issuing a tender to which the host hospitals will respond. The tender will set out:

1. The range of services to be developed by the hospitals;
2. The target population to be served
3. The funding to be made available from the HIF and the World Bank loan, for a two year period in the first instance.
4. The conditions on which funding is made available; these conditions will include:

- Appointing the core staff of the medical director of the ECC, the service manager and the nurse co-ordinator to the staff of the hospital at appropriate levels, and requiring these staff to undertake relevant specialist training;
- Making suitable accommodation available for the EEC, including reorganisation of pikaravi into in-patient beds managed by the GAECC;
- Facilitating the operation of the assessment process in the host hospital and other hospitals and social care homes, and admitting and discharging patients on the basis of an assessment by the geriatric assessment team;
- Requiring participation in regular program develop meetings with all ECCs and the Estonian Health Program;
- Working with county level NCLTC Planning Groups, with representatives of other agencies, to promote the development of the ECC and other NCLTC services to respond the needs of the target population.
- Maintaining a standard Minimum Data Set on all patients who are referred to and assessed by the GAECC.
- Conditions of the contract to be signed.

Response to tender

The host hospitals will be required to respond to the tender brief by providing a preliminary service development plan which will be revised as the GAECC is implemented. This preliminary plan will set out:

1. The names and qualifications of the key staff who will lead the GACECC

2. The accommodation and facilities to be allocated to the GAECC

3. A list of the nursing homes, social care homes, community service providers and other agencies in the catchment that GAECC will collaborate with to developing nursing care and long term care services, including community care services. These agencies will be represented on county level NCLTC planning groups.

Agreement and Contracting

On agreement of the host hospital to the conditions of the tender, and acceptance of the response to the tender by the Estonian Health Project, Ministry of Social Affairs and HIF, a formal contract will be signed. The contracts will be reviewed at 18m to provide for extension after the first two years.

The contracts that the HIF has with hospitals will provide a model for contracts for the GAECC Program. The contracts should set out separate prices for infrastructure and for services.

It is anticipated that the GAECC pilot program will begin in two rounds, with four major GAECCs established and any associated sub-centres in the first round and another four

major centres and sub-centres in the second round approximately nine months later. While the host hospitals for all GAECCs should be involved in discussions from the beginning, this two stage process will facilitate management of the implementation of the pilot program and enable the second round of GAECCs to build on the experience of the first round.

Funding of pilot projects

To carry out the range of necessary functions of the GAECC Program, services will have to be funded by a mix of World Bank funding and use of resources released as excess hospital beds are converted. Two streams of funding will be identified:

1. establishment funding, with contributions from the World Bank for the pilot phase of the program and a commitment of funds by the host hospitals;
2. payment of standard prices per day for in-patient and outpatient assessment, slow stream rehabilitation and intensive nursing care; these services will involve medical management and as medical services with fixed time limits, prices will not include a co-payment.

To provide the above range of services, each GAECC will require between 40 and 60 in-patient beds and a day hospital, with funding by the HIF as *medical care services*. The in-patient beds should be divided into approximately 15 assessment beds, 20 slow stream rehabilitation beds and 25 intensive nursing care beds, and a day hospital with capacity for 20 to 30 patients a day.

The provision of any nursing home beds and social care beds associated with the GAECC should be decided through the planning process and will depend on the availability of suitable facilities and other local circumstances. The residential care facilities should operate as distinct entities.

Service capacity

On the basis of catchment areas for the 8 major GAECCs defined in Part 2, each Centre would be responsible for a population of around 25,000 people aged 65 and over. Concentration of assessment in a smaller number of teams that carry out a larger number of assessments is an important means to achieving consistency and quality of assessments. A smaller number of teams will also be able to achieve more multi-disciplinary structures and provide a wider range of assessment skills than a larger number of small teams.

At an early stage of their development, assessment teams will have to deal with the large number of older people who are already in hospital and who have had long stays. After this backlog is dealt with, the pattern of referrals to and discharges from GAECCs should stabilise and it will be possible to establish an annual rate of assessment for the aged population. In the pilot stage of operation, each major GAECC might be expected to

assess around 5% of the aged population in its catchment area, with capacity for approximately 1,250 assessments a year. These figures are indicative estimates only and are provided as a basis for discussion; they should not be taken as benchmarks for planning or targets for service provision.

3.2.2 Service Development Activities

Five sets of services will be developed in the GAECC Program. The first three service developments focus on the reorganisation of current pikaravi units to establish Geriatric Medical services in line with the speciality in EU countries, and will also contribute to the conversion of excess hospital beds to NCLTC services. The other service development activities cover slow stream rehabilitation and long term nursing care and referral and liaison with other agencies.

1. ***Multidisciplinary Assessment*** will be developed as a clinical service.

    - The Assessment Team will be made up of a medical director, a nurse co-ordinator and a social worker. The Assessment Team will also have access to therapy staff from the ECC inpatient and day hospital services. Consultancy with psychiatrists will also be needed.

    - The personnel involved and the exact focus of each assessment will differ according to the problems of the individual patient, but a standard set of assessment schedules should be used as appropriate and a standard Minimum Data Set should be compiled as a record of each assessment and to give an account of the overall activity of the GAECC.

    - The outcome of the multidisciplinary assessment will be a recommendation for continuing care with services at home or admission to a social care home or nursing home; for those recommended for admission to a social care home or nursing home, the assessment team will complete the Care Need Rating Scale which will determine the level of funding required for the individual's care needs. While the ECC will have beds for in-patient assessment, assessments will also be carried out on a consultancy basis in other hospitals wards, and on an outpatient basis in the community and in the day hospital. Inpatient assessment should require a maximum admission of 10 days, but will frequently be shorter or completed in the day hospital or through home visits only.

2. ***Slow stream rehabilitation*** will be provided for patients with potential for further recovery following an acute stay, and may be provided as an in-patient service or in a day hospital. Slow stream rehabilitation will be provided only for a limited time only and the patient will only continue to receive rehabilitation if their condition is improving. The level of funding available for slow stream rehabilitation will enable more intensive treatment and therapy than in present pikaravi units and so should

enable a higher level of recovery with shorter stays. A time limit of 30 days on average can be set in the first instance.

3. ***Intensive nursing care*** will be provided for patients whose condition remains unstable after a period of acute care and who can be expected to be discharged home or to a lower level of care when their condition has stabilised. A maximum stay of 30 days should be allowed. ECCs will also provide short stay respite care if such care is recommended as an outcome of the assessment. Nursing homes providing long term nursing care may be operated in some of the excess beds in hospitals in which GAECCs are located, but they will be separate operating units and patients will be discharged from the GAECC and then admitted to the nursing home as a separate admission. Social care homes may also operate in the same way. On-going medical care of patients in nursing homes and social care homes will be undertaken by family doctors, with the GAECC providing consultancy support only as required.

4. ***Referral and cooperation*** arrangements will be developed in conjunction with other agencies. As family doctors will be involved as the main source of referrals to GAECCs and admission to nursing homes and social care homes, and community services will be conditional on acceptance of assessment by the GAECC, these agencies should be involved in developing formal referral arrangements. The referral and liaison role of the GAECC is also critical to the development of an integrated service system rather than just a set of unrelated NCLTC services. Achieving this integration will require participation of the GAECC Service Manager in all planning and service development activities in the ECC catchment area.

5. ***Education and training*** will include

   - specialist training for geriatricians provided through the University of Tartu. This program should proceed as soon as possible and be developed to conform to guidelines for geriatric medical education in the EU so that the issue of recognition as a speciality field in Estonia can be considered at a later date.

   - multi-disciplinary short courses in assessment and other topics in social gerontology for all staff and including personnel from other services which interact with the GAECC. The GAECC Service Manager will be responsible for coordinating this program, in collaboration with the Estonian Geriatrics and Gerontology Association.

   - As family doctors will refer patients to the GAECC and be responsible for on-going medical care of individuals in nursing homes, and social care homes, each GAECC will need to coordinate a training program in their catchment area to ensure that family doctors are equipped to support the NCLTC Program.

3.3 Service Development for Nursing Homes

3.3.1 Commissioning of nursing care services

The conversion of excess hospital beds into nursing homes is central to the NCLTC Plan. It is important to stress that the conversion of staff skills and resources is more important to the development of nursing homes than the conversion of physical facilities. In the short term, there will be relatively little change in the physical condition of the excess hospital beds in which nursing homes will function, but there will be considerable changes in the roles and activities of nurses and other care staff.

This section focuses on the development of care services as the capital conversion process has been outlined in Part 2, and the process and criteria for the capital conversion process are set out in Appendix 1. When the planning process results in agreement that a facility is to have a continuing role as a nursing home (or social care home), each home will have to be established as an entity that can enter into a contract with the HIF. It is expected that all nursing care facilities will operate as not-for-profit entities, managed by municipalities or other agencies, such as foundations. Continuation of contracts will be made dependent on achievement of the specified standards for physical facilities and for care.

As soon as a facility is issued with a conditional licence to operate as a nursing home, the commissioning process will involve three steps:

1. Calling for a tender in the form of a nursing care service plan and each home will have to respond with a preliminary plan for developing these services. The plan will have to set out matters such as the number of patients to be cared for, the number of different kinds of staff, present training and provision of further training, present care programs and programs to be developed to meet care needs, and arrangements for exchange with the GAECC.

2. A contract with the facility will then be made on the basis of the preliminary service development plan and specify the conditions of the contract and outcomes to be achieved in terms of the level of service provision and the standards to be met. As many aspects of the operation of nursing homes are yet to be fully established, conditional licences can be used to facilitate early development and at the same time provide for review and revision of contracts over time.

3. On-going service development and monitoring of standards will be instituted, covering the five areas set out below.

Service capacity

Facilities

The service development strategies will be implemented progressively as the planning process identifies one or two facilities for conversion to a nursing home in each of the 40 local service areas. A total of around 60 homes could be expected, with each nursing home having between 30 and 50 beds, to provide a total of around 2,100 nursing care beds. It could be expected that only 10 – 15 nursing homes might be established in the first year of the NCLTC Plan, followed by 15 to 20 in the next two years and the remainder in the following two years. A staged development will enable the experience of early development to be taken into account in subsequent developments.

Staffing

Conversion of the skills of existing staff is a high priority and a critical element in the conversion of excess hospital beds to NCLTC services and will require a major training program. This training is essential to ensure that nurses, allied health staff and other personal care staff are retained in the NCLTC system rather than being lost to other sectors, possibly outside the health care system.

Workforce planning is also required to address the overall demand for NCLTC staff and the balance between staff with different skill levels. The task of workforce planning should be undertaken by the NCLTC Coordination Unit.

3.3.2 Service development activities

1. Upgrading of physical facilities

Only very limited upgrading of physical facilities will be possible in the short term, that is, three to five years. Priorities for upgrading will be determined through the registration and survey process outlined in Appendix 1, and through conditional licensing. A capital development plan will be developed for each county and each local area, and contracts will require each nursing home to agree to this plan and not initiate their own capital investment without agreement under the plan. Capital investment will need to be managed through a central fund to ensure optimal use of the limited resources available.

Basic capital upgrading will improve the quality of many facilities, but improvements will also be achieved by reducing the number of beds in some facilities and so securing more space, and by re-arranging functions and activity areas in line with care programs, such as provision of day activity areas.

A project should be undertaken in conjunction with the registration survey and licensing process to develop a good practice manual based on examples of upgrading that have already been undertaken in Estonia and which can be replicated in other facilities. This manual should focus on low cost and practical initiatives for improving existing facilities.

2. Assessment and admission

Admission to a nursing home will be conditional on assessment of the patient by the GAECC and acceptance of this arrangement will be a condition of nursing home contracts. The GAECC will also establish a provisional level of care and funding for each patient according to the dependency based system that is to be developed and this provisional classification will be then be confirmed by the nursing home after three weeks.

The dependency based classification and funding scheme will only be developed by the end of the first year of implementation of the NCLTC Plan. Participation in the development of the system will be a condition of the licensing of each nursing home. It is proposed that until the dependency based funding system is implemented, all patients be funded at an average level determined by the HIF.

3. Staff Training and Retraining

Training of existing staff of hospitals who are employed in the new nursing homes is a major activity. Agreement to undertake training should be a condition of employment for individual staff and provision for training will be a condition of contracts between the HIF and the nursing homes.

Admission processes will be developed in conjunction with the GAECC Program, and nursing homes will only be able to admit patients who have been assessed and whose care level has been established by the GAECC.

The Director of Nursing in each nursing home will be required to have completed a recognised training course as a condition of accreditation of the facility.

The Estonian Nurses Association has already developed short courses for training in long term care nursing and the Training Strategy will provide for delivery of these courses in all areas. Long term care nursing should also be included in the curriculum of undergraduate nursing training and again, the Estonian Nurses Association has developed a curriculum for this purpose.

4. Development of Care Programs

Care planning

A major part of service development will focus on standardised care planning for each patient and organising structured care programs for patients requiring similar kinds of care. Dependency based funding will operate in conjunction with these care programs.

The nursing homes will work closely with the GAECC Program in referral and admission processes and the GAECC will assess the level of care needed by each patient. The nursing home will then draw up a care plan for the patient and provide the appropriate care program.

The goals of care planning and care programs in nursing homes are focused on maintaining each resident's physical, mental and social function to the optimal level possible, in a home like environment. This focus of nursing care programs is thus quite distinct from treatment in a clinical medical environment.

Demonstration projects

While long term nursing care outside hospitals is a new concept in Estonia, a number of better pikaravi units have already taken initiatives to develop dependency based care plans for patients and different care programs for groups of patients with different care needs, such as dementia care. These initiatives can serve as demonstration projects by providing guidelines for other facilities and sites for in-service training. The training strategy will provide funding for these demonstration projects.

A particular function of the demonstration projects should be to develop the basic documentation needed for care planning in each facility and for each resident. This activity should be carried out in conjunction with the Concepts and Standards Working Party and result in a manual for use by all facilities. This documentation can in turn provide a basis for monitoring standards.

Training

The Estonian Nurses Association has already developed a curriculum for long term nursing care and training programs using this curriculum should be implemented from the start of the NCLTC Plan.

Intensive short term training programs will also be needed to upgrade the skills of staff in facilities that are to be converted to nursing homes and this training should be made a condition of licensing. Much of this training will be provided on an in-service basis and in conjunction with the demonstration projects.

5. Service Management

As the nursing homes will be new financial entities, management systems will need to be developed and management staff trained in using these systems. The management systems should cover finances, services and staffing.

6. Standards for Care

The initial conversion of a former hospital to a nursing home will be marked by conditional licensing of the physical facility and conditional accreditation of the care programs. Confirmation of accreditation will depend on achievement of the care standards set for all nursing homes.

Standards of care will be developed by the Concepts and Standards Working Group and the Training Working Group, with input from the demonstration projects and staff in nursing homes. While international experience can be drawn on in developing standards and especially for identifying the areas in which standards should be set, the care standards must be based on recognition of the best care practices that already exist in Estonia. As these best practice standards can be documented and demonstrated, it can be expected that all nursing homes will be able to achieve these standards. The standards should also cover management standards.

It should be emphasised that the aim of setting and monitoring care standards is to promote good practices and continuous improvement in quality of care and not simply to check detailed compliance. It is generally recognised that standards should provide broad guidelines that set out the outcomes to be achieved and that will enable staff to work towards improving quality of care rather than prescribing inputs to care or specifying detailed care practices. A manual will be needed to set out the care standards, including practical examples of how the standards can be achieved, and provide a guide for training. The manual should include copies of pro-formas to be used for care planning and other individual patient records. It is proposed that draft standards be developed in the first instance and reviewed as part of the two year review of the NCLTC Plan.

Standards will be monitored by panels made up of members of the two Working Groups and another expert nurse, such as the nursing coordinator of the relevant ECC or the Director of Nursing of a demonstration nursing home. The monitoring process standards should involve assessment of each standard and a summary rating for the nursing home as a whole. The assessment should provide a score on the individual standards and the summary rating that indicates the extent to which the standards are met as:

- Met fully and care is of a high quality,
- Met adequately and care is of an adequate standard, but with scope for improvement;
- Not met and care is not of an adequate standard.

This monitoring system can thus provide incentives and motivation to achieve the highest quality ratings as well as addressing poor standards. Where individual standards are not met, advice should be provided for remedial action. In the event that the overall summary score indicates that the home has failed to meet most of the standards, the licensing agency will be able to suspend the licence or not renew it until the standards are met.

3.4 Service Development in Social Care Homes

The service development activities in social care homes will be concerned with improving quality of care and differentiating the roles of social care homes from the roles of nursing homes. A second objective will be to address the wide variations in quality of care that currently exists in social care homes.

Key service developments that will contributing to achieving these objectives include:

- Assessment of residents by the GAECC prior to admission, with reassessment in the event of marked changes in the resident's functional status;
- Dependency based funding;
- Development of individual care plans for each resident;
- Development of structured care programs to meet resident needs;
- Staff training; and
- Setting and monitoring of standards for social care homes that specify the range of care to be provided in social care homes and the range of additional services that are provided in nursing homes.

The Content and Standards Working Group and the Service Development Working Group will oversee service development strategies for social care homes and the integration of these strategies with other service development activities.

The Association of Social Care Home Providers will also have a key role to play.

3.5 Development Strategies for Community Services

A very substantial increase in funds will become available for the expansion of community care services as the conversion of excess hospital beds proceeds. Development strategies are focused on enhancing the capacity of existing agencies to provide community services, and extending the range of service available.

3.5.1 Commissioning of organisations to provide community services

The commissioning process for community care can build on the experience gained in the development of open care for mental health and disability services. It can again be expected that many existing organisations including municipalities, not for profit bodies, existing social care homes and newly established nursing homes will be interested in providing these services. Each type of service should be covered by a separate contract, or specifically identified in a single contract that covers a bundle of services.

Commissioning should take particular account of the viability of the organisation. Adding community service provision to the functions of existing agencies may in many cases be preferable to setting up new entities and achieve efficiencies in administration and overheads.

As different agencies will have to collaborate with each other in service delivery, the commissioning process should seek to fosters cooperation by requiring tendering agencies to indicate their links to other agencies. Competitive processes that lead to fragmentation of services between different providers should be avoided.

It has not been possible to develop any estimates of service capacity and rates of take up of services and coverage of the client population should be closely monitored. Allocation of funding on a per capita basis between the counties provides one means of promoting equitable outcomes, and service benchmarks can be developed over time.

3.5.2 Service development activities

1. Training

Training of the workforce to provide community services will lay the foundation for the new types of services that have to be built into a system of community care. Visiting nursing, home care and day care are the main types of services to be developed. As these services are very limited at present, there will be considerable demands on those who can provide training and other support for new organisations and their staff. Particular attention should be given to the retraining of staff from the hospital with “excess” beds.

The Service Development and Training Working Group will need to devise a national training strategy in which each provider organisation can participate. This strategy should offer a wide variety of training methods and especially include options such as:

- a consultant trainer who can visit individual organisations and work with staff;
- placements with existing services to give experience to those who are initiating new services;
- self directed learning materials, such as video material that can be used in short in-service sessions in local organisations;
- more structured in-service training that contributes to certification;
- formal training modules that also contribute to certification; and
- use of demonstration projects

Each provider organisation should then develop a training plan drawing on the options offered in the national strategy.

2. Demonstration Projects

Existing community services will provide a very important base for staff training and other aspects of service development. Given the expected growth in community care services, demonstration projects could be identified as leaders in partnership with a number of new organisations. Demonstration projects should be funded to enable them to take on this role.

3. Service management

Training should cover management of organisations as well as direct delivery of care services. Simple and standard management system that are compatible with those in nursing homes and social care homes should be developed to achieve administrative efficiencies.

4. Transport

Transport for both clients and staff is an integral part of community care. The planning and development of transport infrastructure for visiting nursing and home care will require purchase and maintenance of vehicles for use by staff, and ensuring that staff competent drivers.

Client transport should be based on purchase of standard station wagons, larger four door sedans and mini-buses. Where clients require special transport, there should be close liaison with ambulance services that are commonly based at the hospitals from which GAECCs will operate.

5. Service Standards

A system of standards for community care service will need to be developed, through consultation between service providers and the Content and Standards Working Party. In the first instance, it may be appropriate to modify standards applied in other areas of open care and to review the standards after two years.

As with residential care, the standards should aim at improvements in quality of care rather than just regulation of providers.

3.6 Outcomes of Service Development Strategies

Outcomes of service development strategies need to be monitored at the level of each client, each service provider, and the long term care system overall. Four aspects of monitoring and evaluation warrant note:

1. A formal but simple evaluation strategy should be established as a means of linking outcomes of assessment and classification of individual clients to the funding provided to agencies and the quality of care delivered by these organisations, and the performance of the NCLTC system overall. This strategy should identify major milestones and report on progress towards them for the NCLTC system overall by aggregating information from individual providers. For example, the monitoring and evaluation strategy should report on progress with licensing of facilities across the country, and the extent to which standards are met across all providers. As well as reporting quantitative data in standard Minimum Data Sets, it is important for qualitative narratives of development processes to be recorded so that the experiences of early service development can inform later developments.
2. Regular feedback on outcomes should be provided to the Ministry, the HIF and all organisations involved in NCLTC. A regular newsletter would be a useful means of disseminating this information.
3. Evaluation should be carried out by an agency with a degree of independence from the Ministry and from providers. This evaluation strategy can be combined with research into questions identified by the Working Groups and others.
4. Most importantly, the monitoring of outcomes of service development will give an account of progress in converting resources from excess hospital beds into NCLTC services and evaluation will provide an assessment of the effectiveness of the use of those resources.

Part 4. Funding Strategies

Current funding arrangements reflect the vertical structure of HIF funding of pikaravi and municipal funding of social care homes. This division poses a number of obstacles to introducing new NCLTC services, and changes to funding arrangements are needed to facilitate the development of an expanded range of nursing care and long term care services based on assessed level of care needs. New funding arrangements will provide powerful incentives for consistency in prices and quality of care.

This section builds on the resource allocation models presented in Section 2. It begins with an analysis of current arrangements, including the role of municipalities, and identifies five main areas in which changes in funding are needed to stimulate service development. Options to address each of these problems areas are then proposed.

4.1 Current funding arrangements

4.1.1 "Vertical" funding by Health Insurance Funds and Municipalities

At present, funding for long term care depends on whether the individual is receiving care in hospital or in a social care home, and the source of funding for each of these kinds of facilities, rather than the type of care and level of service that is needed. The present funding arrangements are thus structured "vertically", as shown in Table 4.1.

Table 4.1: Sources of funding in different care settings: Present arrangements

Care component	Long term hospital	Social Care Home	Community
1. Skilled Nursing Care	**Skilled nursing and social care not separated in funding Paid for by HIF at between EEK185 and 213 per day, average of EEK203, after stay of 10 days**	Not recognised	**Not provided**
2. Social care (assistance with bathing, dressing etc)		Paid by municipality, between EEK2500 and EEK4000 per month, average of EEK100 per day	**Limited social care funded by municipalities**
3. Daily living needs (food, heating etc)	**Co-payment from Pension only after 60 days**	Co-payment of 85% of Age Pension	**Individual pays from Pension**
4. Medication	**Paid for by hospital**	Home pays for basic medication Individual pays co-payment for prescription	**Individual pays for basic medication Individual pays co-payment for prescriptions**

These arrangements reflect the historical division between HIF funding for long term care "medical" nursing care in hospitals and funding of social care in social care homes by municipalities, with a contribution by the individual from their pension or from relatives.

In hospitals, patients may be classified as a pikaravi patient on admission or at any point following acute care. The HIF pays the full pikaravi rate of EEK 203 per day for 30 days, with only a limited range from EEK185 to EEK203 depending on the hospital agreement with the HIF. In common with other hospital care, no co-payment is required for this period. However, this general rule changes for patients who have stays in excess of 30 days, when the individual has to pay 50% of the pikaravi rate, and after 60 days, the HIF funding ceases altogether. These arrangements present several difficulties:

- While providing hospitals with a strong incentive to discharge patients, there is no coordinated means of transfer from hospital to social care homes as admission to social care homes is controlled by the municipalities.
- The co-payment of some EEK100 per day that the patient must pay between 30 and 60 days, and full payment of over EEK200 after 60 days, is considerably more than the Age Pension which is only some EEK50 per day. Very few older people themselves have any capacity to met this cost, and where no family members can contribute and the patient cannot be discharged, the hospital incurs a debt.
- While there is a expectation that family members will contribute to the cost of long term care of elderly relatives, this is not a legal requirement and cannot be enforced. It is not known how often or how much family members actually contribute. There is also a major inequity in that the burden falls unevenly on family members whose elderly relatives require one type of care, namely long term nursing care, but not on those whose elderly relative requires another and more costly type of care, namely acute care.

In social care homes, payment is also at a flat rate, with the amount being determined by the municipality. The highest rate paid is EEK4000 a month but the average is around EEK3500, but may be as low as EEK2500. Individuals contribute 85% of their Age Pension, EEK1275 out of the pension of EEK1500 per month. The average cost for care in a social care home is thus EEK4775 per month or EEK157 per day; the individual's co-payment of EEK42 per day accounts for 24% of this sum.

These funding arrangements present five main problems:

1. The flat rates of payment are not related to dependency and may be too high for some patients and too low for others;
2. There are inconsistencies in co-payments, and the level of some co-payments is unaffordable;

3. The level of pikaravi payment is too low for slow stream rehabilitation or intensive restorative nursing care, and there is no defined payment for assessment, including arranging transfer to other levels of care;

4. There are no standard prices for community services other than the HIF payment for the visiting nursing service provided by the Cancer Society to cancer patients.

5. Care in both pikaravi and social care homes combines different levels of nursing and social care, but different payment sources cover the same type of care in the two kinds of facilities.

The Hospital Master Plan estimates funding for nursing care at EEK450 per day and a total budget of EEK564. This amount is considerably above the current rates for pikaravi and the total budget presents the opportunity for developing a more differentiated system of funding based on patient dependency and care needs, and covering a wider range of services. Before considering these options, the role of municipalities in funding, and related funding systems for medications and mental health care are reviewed.

4.1.2 Role of Municipalities

Provision of social care homes

At the end of 2000, there were 94 social care homes, with 3,195 beds. As there are over 200 municipalities, most are not direct providers of social care. The distribution of homes and beds by ownership type is shown in Table 4.2.

Table 4.2: Provision of social care homes

Size	Municipal	State	Private	Total
Under 15	21			21
15-29	32	3	2	37
30-59	19	3	3	25
60-119	3	4		7
120+	4			4
	79	10	5	94

Municipalities are the main owners of social care homes, with 79 of the total of 94 homes. The municipal homes are also the most varied in size, from as small as 7 to as large as 337.

The 10 state owned homes are larger on average, with 7 having 30 or more beds. It appears that these state owned homes are associated with special care homes and new management structures for these homes are likely to be developed as the mental health reforms proceed. There are five homes operated by private companies.

Information on use of social care homes shows:

- In 1999, there were 3,013 residents and 1,224 discharges, giving a turnover of 40%. The number of individuals who received long term care in social care homes over the year was thus 4,218.
- 75% of the turnover was due to deaths, 16% due to discharges to the community, 5% due to transfers to other nursing homes and 4% due to other outcomes.
- Some social care homes provide respite care and respite admissions are likely to account for most of those who were discharged to the community.

Total funding

Funding of social care homes was estimated at EEK133m in the resource allocation models developed in Part 2, based on 3,159 beds funded at an average of EEK3,500 per month, *excluding* co-payments.

This figure accords with a total cost for general institutions of EEK165m reported by the MSA, *including* contributions from residents' pensions and payments by relatives. The average total cost per resident was EEK4475, indicating the average municipal contribution is closer to EEK3000 than EEK4000. Municipal funding accounted for only 57% of total funding, resident and relative contributions about 25% and state budget inputs about 16%. This average cost in general institutions is higher than in special mental health institutions, EEK3,649.

Issues

Municipal budgets are allocated from the central government budget on the basis of a 60% share of the 26% payroll tax. Payments to municipalities are made on a per capita basis, with some further equalisation adjustment for disadvantaged areas. Municipalities also raise local taxes and charges; the revenue from these source varies greatly between large cities and small rural municipalities.

Four major issues are identified in analysing the role of municipalities in funding social care services.

1. While all municipalities have a legal responsibility to pay for social care, the amount of funding allocated to this purpose is at the discretion of each municipality. In the absence of an obligation to allocate a given proportion of the municipal budget to social care, there is potential for considerable variations in access and the level of funding available to individuals who live in different municipalities. In recognition of the differences in financial capacity of municipalities, the Ministry of Finance provides a pool of funding to equalise these differences.

2. Municipalities are both purchasers and providers of places in social care homes, but the wide range in the size of municipalities means that there is great variation in their capacity to fund and provide services. The range and quality of services is thus

subject to considerable variation between municipalities. The analysis of provision of social care homes above shows the majority of the municipalities are not direct providers, but rather have to purchase places in homes operated by other municipalities. Prices paid do not appear to be systematically related to resident dependency or income, or to quality of care, but rather to municipal practices, with variations evident in both provider and purchaser practices.

3. Services provided in social care homes include support for daily living and social care similar to the care of long stay patients in hospitals. Social care homes are not licensed to provide skilled nursing care.

Municipal reform that is currently under consideration will see an amalgamation of smaller municipalities into larger units and there will also be changes to the functions of municipalities. The current variation between municipalities in capacity and interest in supporting NCLTC should be reduced, but not eliminated, as municipal reorganisation leads to larger administrative units. This reorganisation presents an opportunity for restructuring the purchaser and provider roles and reaching a clear definition of municipal roles in long term care.

Provider roles

Municipalities have a number of advantages as providers of social care services, and this role could be strengthened in future. These include:

- No other provider agencies have the potential to cover of all areas of the country.
- There is an established basis of co-operation between some municipalities.
- Municipalities are the foundation for a network of community care providers.
- Facilities and service agencies could be established as not-for-profit business units under municipal administration.

Purchaser roles

In contrast to the positive prospects for provider roles, the continued role of municipalities as purchasers or funders of social care services presents a number of difficulties. Principal among these are:

- There is a disproportionate administrative burden on small municipalities which are unable to provide services locally and have to purchase from other municipalities.

- A decision to allocate very limited resources to social care on the part of one municipality will have adverse impacts on other services and other municipalities, for example, the capacity of hospitals to discharge patients will be affected by the

willingness of municipalities to purchase places in social care homes for local residents.

- Ensuring equitable access to the same level of services could impose undue cost burdens on municipalities with higher proportions of older population.
- Some municipalities are purchasers of services which they also provide.
- The development of dependency based funding for nursing care and social care, to be administered by municipalities, would result in multiple, complex transactions, but these could be avoided in a centrally administered funding system.

4.1.3 Related funding systems

Development of funding arrangements for NCLTC needs to take account of arrangements for pharmaceutics and mental health services. As well as ensuring consistency, review of these arrangements may provide models for procedures in the NCLTC system for setting prices, defining standards and approving providers to deliver NCLTC services.

Payment for medication

As older people are major users of both prescription and "over the counter" medications, it is important to provide consistent access to pharmaceutics for patients of all NCLTC services. There are some inconsistencies at present.

Prescription medication is funded through the pharmaceutics scheme and a co-payment is made by the patient living in the community or in a social care home. Most medication used by elderly has a 90% subsidy.

Non-prescription medication is paid for by the individual in the community but covered by municipal funding in social care homes and by HIF funding for hospital patients.

The main difficulty in meeting the cost of prescription medication is reported for residents of social care homes who are left with only 15% of their Pension and who may not be able to afford the co-payments for the level of prescription medication that they require.

It is likely that increased use of pharmaceutics will play a part in improving quality of care as the NCLTC system develops. Attention should be given to three areas:

- Defining a list of essential drugs specifically for long term care
- Developing a purchasing system for long term care services and for family doctors prescribing to pensioner patients to achieve economies of scale in purchasing these essential drugs;

- Fixing a reduced co-payment for these essential drugs for pensioners, with a safety net once individuals had spent a defined amount on co-payments in a year.

Mental Health Services

Older people account for a sizeable minority of the individuals living in mental health institutions. At the end of 1999, the 675 residents aged 65 years and over accounted for 26% of the total of 2,635 residents. These older residents are mostly individuals with long standing mental health problems who were admitted at younger ages and who have grown old in the institution. The profile of older people in mental health institutions will change in future as a consequence of the reforms of mental health services which began in 1998.

The co-ordination and on-going administration of the reform process in the Social Welfare Department of the Ministry suggests some models of particular relevance to the NCLCT Plan and for the Unit proposed in the Health Project. Many of the directions of these reforms are along similar lines to those proposed for NCLTC, for example:

- The Ministry of Social Affairs estimates that there are around 7,000 people with mental health problems who need continuing care. Changes to the service system have seen a 30% increase in coverage of clients in open care and a decrease in the number of institutional places by some 17% in the last year. This decrease will continue as new admissions have been curtailed.

- The mental health service is now based on multidisciplinary assessment teams working from four institutions. The assessment team recommends services and makes a rehabilitation care plan for each individual. A major shift has been to move from a narrow medical model of rehabilitation to a wider occupational view.

- There are now nine funded service types. Services were identified as funds became available and agencies came forward to be providers. Non-government providers include self help groups and not for profit organisations that operate supported work environments, days centres and social care homes. Standards are set in accord with community norms.

- Payment is made directly from the social care budget, to agencies that are contracted to provide services. Resources were freed by stopping new admissions to special care homes. 80% of the budget still goes to institutions and 20% to open care services which serve half the clients. Prices were based on discussions with providers, and the Ministry pays only salary costs, with the balance of costs paid by municipalities.

- As day centres have responsibility for all clients on their list, the service has been renamed "supported every-day life services". In areas with smaller populations, there are multi-service centres.

- A major role of open services is to promote access to general services, so that special mental services are called on only when general services cannot meet needs. A social assistance benefit of last resort is available for individuals who have a monthly income of less than EEK500.

- Having a Psychiatric Care Plan is the basis of receiving a social care benefit for a child with a mental handicap. The care plan has to be action oriented with achievable outcomes, and has to state who is responsible for implementing the Plan. There is a set format for the Plan, and this will be revised in due course.

4.2 Options for Restructuring Funding for Long Term Nursing Care and Social Care

Analysis of the present funding arrangements pointed to five problem areas that need attention in the design of alternative arrangements.

4.2.1 Replacing flat rate payments for pikaravi and social care with dependency based payments

Problems of current arrangements

While the pikaravi rate is about 30% higher than the daily cost of social care homes, this range and the payment of both levels of care at a flat rate does not reflect the range of dependency of patients and limits the provision of different levels of care on the basis of patient dependency. The hospital payment is seen to be too low to provide care that promotes restoration of function and discharge to settings where the patient can function more independently, and is inadequate for those with a high level of dependency needing long term nursing care.

The flat rate payment in the social care homes is relatively high compared to the Age Pension on which older people in the community live, and so appears too high for some residents with low levels of dependency. At the same time, the flat rate of payment acts as a disincentive to admitting individuals with relatively high care needs.

The limitations of flat rate funding can be addressed by developing a payment system based on assessment of care needs and classification of patients on the basis of dependency. Assessment provides the means for matching services to individual care needs, but at present there is no single method of assessment followed by referral to the most appropriate level of care. Decisions on admission to a social care home currently rests with the municipalities and there is likely to be considerable variation in practice due to differences in qualifications and experience of personnel involved.

Options for resolution: Dependency based funding based on classification of client needs

The needs based approaches to resource allocation at the population level discussed in Section 2 need to be complemented by a system for allocating services in relation to the level of dependency of individual patients or clients who are using services.

Doctors and other care staff in existing institutions recognise the range of patient care needs and in some cases have structured care programs accordingly. In some long term hospital wards, patients were divided into organised programs for slow stream rehabilitation distinct from others receiving continuing nursing care, either indefinitely or in expectation of discharge home or to a social care home. In social care homes, the main separate program was for dementia care.

Recognition of differences in care needs

While there is no system of classifying the care needs of those in long term hospitals or social care homes at present, five developments indicate a readiness to adopt this approach.

1. Staff in several institutions have developed schedules for rating patient dependency that are used in care planning and for monitoring patient dependency in response to that care that is provided. The Iru Nursing Home, the long term care section of Parnu Hospital and Vaimse Mental Health Care Centre all provided examples of these schedules and other institutions are likely to have developed similar forms for their own use. These initiatives provide the basis for developing an Estonia-wide scheme.

2. The Estonian Association of Gerontology and Geriatrics has compiled a comprehensive set of the schedules commonly used in geriatric assessment and translated them into Estonia, with a view to promoting more standardised approaches to assessment of patient dependency and care planning.

3. The experience of survey conducted in the Tartu University Hospital Feasibility Study which used a version of the international Resident Assessment Instrument (RAI). The RAI is a very lengthy and detailed form and further analysis of the data from this survey could usefully be carried out to identify a smaller number of variables that were the best predictors of care need.

4. Interest in other international experience with dependency based funding systems such as the Australian Resident Classification Scale and associated eight level funding arrangements.

5. The development of case mix funding for acute care is stimulating interest in the extension of this approach to NCLTC and the growing expertise in this area is the HIF should be drawn on in developing a classification for NCLTC.

Among the considerations that need to be taken into account in developing a classification system that will suit Estonia's situation are:

1. Compared to many other countries where classification systems have been developed, the total population in future nursing homes and social care homes will be small, around 6000 on the basis of a total of 30 residential care places per 1000. While the modes of care delivered in these settings will become more varied that at present, they are likely to be covered in a classification system with fewer categories than are required for systems where the functions of institutional LTC are very diverse. By way of example, the development of Resource Utilisation Groups from data collected using the RAI in the US and Canada resulted in 16 categories, but just two categories accounted for 50% of the patients and another two categories for another 20%. The Resident Classification Scale used in Australia has only eight categories for a residential care population of some 150,000.

2. A large number of categories with a small number of patients in each, and small differences between categories, would be cumbersome to administer and could require frequent reclassification of patients with changes in care needs. These practical considerations and other technical constraints may also make it preferable to develop a classification with a smaller number of categories, a larger number of patients in each, and clearer distinctions between categories.

3. The categories should be meaningful in terms of care practices as well as being based on measurement of resident dependency. The different care programs that have already been developed by staff in some institutions point to some of the categories of care that might be expected to emerge in a formal patient classification scheme. Development of a classification system will thus require input from nursing and other care staff so that assessment and care planning can be readily related to the classification process.

4. Consistency in assessment would be greatly enhanced by concentrating this function in a small number of teams with skilled, multidisciplinary staff, and developing a standardised approach and documentation. Payment of benefits for provision of NCLTC services to any individual, whether in residential care facilities or community services, can then be made conditional on assessment and recommendations of the assessment team. To receive these payments, service providers must then accept referrals from the assessment team and only admit patients assessed by the team. Effective referral and transfer between services is promoted.

5. Finally, a classification system that underpins funding on the basis of patient dependency can also be linked to monitoring of quality of care. A proposal for developing a classification and funding scheme is set out in Part 5.

Setting funding levels

The number of levels in any classification of care needs will be related to the range in levels of funding. The average funding for nursing home care proposed in Part 2 is EEK310 per day, including the co-payment. This funding is 50% more than the present EEK203 for long term care in hospital, and will enable a range of funding levels. While the decision on the number of levels in the classification and the funding for each level has to be based on analysis of empirical data on dependency and care needs, a number of considerations need to be taken into account in designing the system.

- The classification needs to have a sufficient number of levels to moderate the differences in funding between each level. Large or uneven increases between levels create incentives for gaming, that is, to classify patients at higher levels in order to attract significant increases in funding. This problem can be managed by a combination of design features and operational measures, including:
  - having even increases in funding between each level;
  - defining the proportion of the total population to receive care at each level;
  - managing the distribution of funds between levels within the total available budget;
  - monitoring the classification process.

- At the same time, the classification system should not have so many levels that it becomes too complex to manage and it is difficult to define the boundaries between each level. For example, rather than having to adjust the patient's classification if there are small changes in care needs, each level of the classification should allow for some fluctuation in care need, so that re-classification is required only when major changes in care needs occur.

4.2.2 Resolving inconsistencies in co-payments

Problems with present co-payments

There are several inconsistencies in the requirements for co-payments:

1. Within hospitals, there is a conflict between HIF funding that does not require co-payments and the arbitrary imposition of a co-payment for one group of patients after a 30 day stay, then full payment after 60 days.
2. The amount of the co-payment required for pikaravi patients is more than double that paid by individuals in social care homes, and this amount is effectively unaffordable for many older people.
3. The point at which the co-payment commences depends on where the patient is receiving care; provision of 30 days care in hospital without requiring a co-payment may encourage patients to remain there rather than move to a social care home where

they must pay a co-payment from the first day. After 30 days, and especially after 60 days, the patient has to meet a much higher cost if they cannot be transferred to a social care home, either because of the level of care needed or because no place is available. Instead of an arbitrary time limit, the decision on transfers should be made on the basis of assessment of the kind of care the individual requires.

4. While co-payments based on the Age Pension can be taken as covering food and other daily living costs in social care homes, the higher co-payments for long term care in hospitals also cover a part of the cost of social and nursing care.
5. If the co-payment is seen as covering daily living costs, the individual can be expected to meet these costs as soon as long term care commences as those assessed as needing long term care will no longer have to maintain the cost of their dwelling in the community as they will not return home.

Option for resolution: Standardise co-payments

The inconsistencies in present co-payments could be resolved in two steps.

1. A stay of up to 30 days in the GAECC should be allowed without a co-payment, in line with HIF funding. The current 30 days pikaravi care without a co-payment provides a time limit for stays in GAECC beds. There will however be far fewer GAECC beds than pikaravi beds, and with a higher level of care services, they will have higher turnover and most stays will be shorter than 30 days.

2. A standard co-payment should then apply for both long term nursing care in nursing homes and care in social care homes. The standard co-payment only applies once the decision is made that a patient will not return home but will be admitted to a nursing home or social care home, and that their stay will be indefinite, usually to the end of the individual's life. Introducing a standard co-payment for long term nursing care, from the beginning of the stay in the nursing home, would eliminate the inconsistency of charging patients or their families for the part of the cost of their care for stays of between 30 and 60 days, and for the full cost after stays of 60 days. Inclusion of a standard co-payment for nursing care beds will mean that a proportion of total funding for long term care approximating the proportion that previously came from co-payments for pikaravi will be maintained.

The level of the co-payment should remain at 85% of the Age Pension. Those whose income exceeds the pension means test should be required to make an equivalent co-payment from their own income. In considering further means testing for higher co-payments, three factors need to be taken into account:

1. The great majority of older Estonians, especially the very elderly who are most likely to need long term care, rely on the Age Pension and very few have a higher income.

2. The total amount of revenue to be obtained from further means testing is likely to be very small; the administrative cost of developing and applying further means testing is likely to be high.

3. The imposition of any further means testing on elderly people is potentially very inequitable given the relative disadvantage of the older age group compared to younger age groups, and could meet with considerable resistance from older people and their families. It is especially inequitable to impose further means testing on this group for relatively low cost services when other groups in the population have access to a wide range of higher cost services, including acute health care, education and other services, without means testing.

4.2.3 Payments for Geriatric Assessment and Extended Care Centres

Problems with present arrangements

Three problems are evident in the present payments for pikaravi:

1. The level of payment is inadequate for providing a level of slow stream rehabilitation or restorative nursing care that could result in discharge of the patient to a lower level of care.

2. The flat rate of payment means there is little differentiation of care provided to patients who may have different care needs and potentially different outcomes.

3. There is no funding for assessment or to cover making arrangements for transfer to other levels of care.

Options for resolution: Coverage as Post-Acute Care by HIF

The HIF is proposing to fund a set of post acute services on a per day basis, for time limited stays. Attention has focused on rehabilitation, but this method of payment is also appropriate for the range of services to be provided by the GAECC. The daily rate of EEK450 as proposed by the HMP would cover assessment, slow stream rehabilitation and restorative nursing care. This funding does not include a co-payment.

The time limit for in-patient assessment might be set at 10 days, but may patients would be seen at home or in the day hospitals, and a pro-rata payment made for these assessment. Limits of 30 days could be set for slow stream rehabilitation and for restorative nursing care, and given the higher intensity of care services, higher turnover and shorter stays would be expected compared to pikaravi.

The number of GAECC beds for which there was no co-payment would be much lower than the number of pikaravi patients, and long term care in both nursing care homes and social care homes would include a co-payment. The contribution of co-payments to the total long term care budget would be at least maintained and possibly increased.

4.2.4 Setting prices for NCLTC community services

Problems with present arrangements

A number of municipalities and some other agencies have initiated community care services and have covered the costs from a range of sources. Some of these initiatives have had only short term funding, such as grants from foundations. While providing useful funding for pilot projects, these source cannot support on-going services. The lack of an identified source of funding and standard prices for community care services is a major factor inhibiting their development.

To date, the HIF has set a standard price only for the visiting nursing service provided by the Cancer Society. The Ministry of Social Affairs also sets prices for contracts for social care provided in open care for people with disabilities and for mental health services, and in special institutions.

Options for resolution: Approaches to setting standard prices

Although no investigations have been made into the cost of providing NCLTC community services, there are a number of possible approaches to setting prices. These methods include:

- Setting prices relative to known prices of related services, such as existing open care services;
- Making comparisons of costs of different agencies providing the same services;
- Calculating prices on the basis of inputs such as salaries for which prices are known;
- Discussion and negotiation with providers on the basis of current costs and expected costs to establish benchmarks that are “fair and reasonable”;
- Conducting pricing studies to establish actual costs once services have been established, with allowance made for new services having somewhat higher establishment costs.

By way of example, factors that could be taken into account in setting a price for visiting nursing services are:

- The cost of the nursing service operated by the Cancer Society, EEK120 per patient per day.
- The cost of nurses working with family doctors, noting that there is no transport cost for these nurses and the procedures carried out may take less time per patient;

- Costs cited by agencies considering new services, such as the initiative proposed by Tallinn Municipality to establish a visiting nursing service to operate in conjunction with the Tallinn Long Term Hospital and the group of family doctors in Kuressaare; the latter proposal estimated that around EEK5,000 would be required per month to cover the salary for a nurse, transport and equipment and that one nurse would manage 10 patients, at a cost of EEK300 and 600 per patient per month, depending on patient dependency, frequency of visits and so on.

Setting of prices also requires standards to be set for the quality of the services that are being purchased. Four sets of standards can be specified:

- Input standards that providers must meet as a basis for entering into contracts, so that services which are unable to meet these standards are excluded from the NCLTC system;
- Process standards for practices in the delivery of care, including staff training;
- Quantity standards by way of the volume of service to be provided for the available resources; and
- Quality standards by way of outcomes to be achieved as a result of the delivery of care to patients.

Taken together, these four sets of standards can act to restructure the nature of organizations involved in provision of long term care, and improve quality of care.

4.2.5 Division of funding for "medical" nursing care and social care

Problems with present arrangements

The division of long term care between pikaravi funded by the HIF, and social care homes funded by municipalities poses a number of problems for providing long term nursing care outside hospitals, whether in nursing homes or by community nursing services. At present, the HIF covers only nursing care that is associated with medical care provided in hospitals, while social care homes are not licensed to provide nursing care.

The long term nursing care currently provided in hospitals has some activities in common with care provided in social care homes. Both care settings involve provision of meals, laundry, assistance with bathing and dressing, with mobility and personal hygiene, and supervision of medication, and it is only the level of technical nursing care that is marginally greater in hospital. However, funding for essentially the same activities is covered by different sources: while the HIF covers the total bundle of care activities in hospital, funding in social care homes can be seen as being divided between co-payments that cover daily living such as meals, and municipal funding for care activities.

The question that then arises is how each type of care should be funded. Greater consistency would be achieved by funding of NCLTC services in all settings through a

mix of (1) individuals paying for daily living costs from their pension, (2) municipalities paying for social care, and (3) HIF funding for nursing care and slow stream rehabilitation. While achieving consistency between funding source and type of care activity, such a mixed system has two major disadvantages:

1. It perpetuates the division between medical or health funding for some services and social care funding for others when long term care requires a mix of both kinds of services, and

2. It requires multiple transactions for different levels of different types of care at the individual patient level. For example, funding for two individuals receiving different levels of dependency based funding in a nursing home would involve six different calculations and transactions.

The division between "medical" nursing care covered by health funding and social care covered by social care funding is a common problem in international long term care systems. Attempts to determine which services are to be funded in different settings from each source have generally resulted in continuing disputes and cost shifting, and the best resolution has been achieved where a combined source of funding has been established to cover the bundle of nursing and social care services that make up long term care. The situation in Estonia presents a number of options for developing a new Nursing and Social Care Fund that combines HIF and municipal sources of funding to cover a range of long term care services, and to include a co-payment set on the basis of the Age Pension to cover daily living costs.

Should the HIF or municipalities be the purchaser of NCLTC services?

The first question to be addressed in considering funding options is the responsibilities of the HIF and municipalities as purchasers and providers of NCLTC services. The HIF is only responsible for purchasing services, but municipalities have both purchaser and provider roles. The potential conflicts that municipalities face in having both responsibilities could be resolved by municipalities continuing to purchases services but handing over their provider role to other agencies, or retaining and strengthening their provider role and assigning all purchaser roles to the HIF or Ministry of Social Affairs. There are several considerations that favour the second option:

1. The budget that will be available for NCLTC services from conversion of excess acute hospital places is estimated at a total of EEK564 at the end of the process. Inclusion of the estimated EEK133 from municipalities brings the total to EEK697. The municipal share will account for only some 20% of the total and the share controlled by the HIF is likely to exceed 80%.

2. Municipalities have established roles as providers which could not readily be taken on by other agencies, and ways of strengthening the provider role of municipalities have been noted above.

3. Assigning all purchasing roles to one agency eliminates the potential for cost shifting between different payers. At present, there is no organised mechanism for transfer of long term hospital patients waiting discharge to a social care home, and municipalities homes may see such transfers as shifting costs from the HIF to the municipality and may prefer to pay for individuals admitted directly from the local community.

4. The HIF has experience in the design and administration of standard payments. Use of standardised administrative tools, such as assessment and classification systems, will be facilitated and there will be more consistency if there are fewer, larger agencies acting as purchasers of services rather than multiple agencies of widely differing sizes. There would also be efficiencies of scale for purchasers in negotiating fewer, larger contracts rather than multiple, smaller ones.

5. The range of services to be provided by the proposed GAECCs, and the kinds of staff working in these services, and their role in managing discharges from acute hospitals, mean that GAECCs will have closer affiliations with hospitals and health services than with municipalities. Continuation of the present funding arrangements would mean that GAECCs would have to negotiate contracts with the HIF for services defined as health services and with municipalities for services defined as social care. Further, whereas the HIF sets standard prices for health care services for all providers, municipalities may want to purchase social care services at different prices. A single contract for a single bundle of services is preferable.

6. There is a need for the central government to equalise funding of services by municipalities to overcome the variations in municipal funding capacity. This need for re-insurance would be overcome in a system of national funding for NCLTC through the HIF.

At the same time, there are several factors that favour the HIF managing the new Nursing and Social Care Fund and developing the role of funder or purchaser of NCLTC services.

1. Its experience in developing complex prices for health care services is very relevant to developing dependency based funding for NCLTC services;

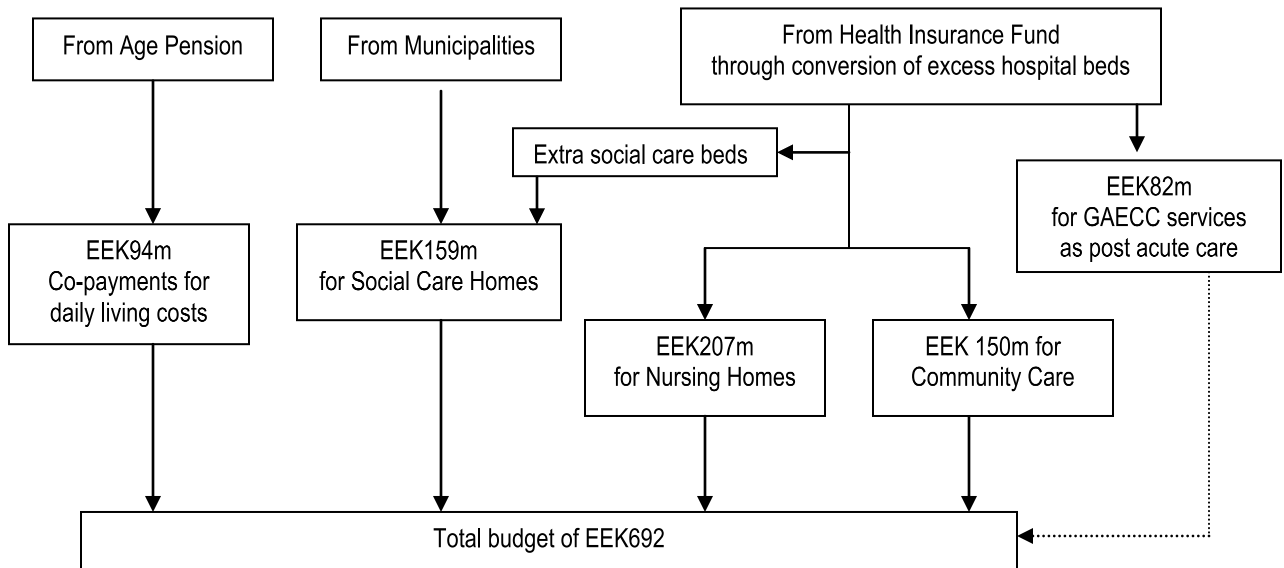
2. It has experience in setting standard prices that apply to all providers, and contracting at those prices

3. The excess hospital beds and associated resources that are available for conversion to NCLTC services account for the great majority of NCLTC funding and are currently in the HIF budget;

4. There would be considerable efficiencies in having a single funder rather than a large number of municipalities.

4.3 Features of options for funding arrangements

Under the current funding arrangements, the total budget for NCLTC services as developed in the Diversification Option of the resource allocation models in Part 2 would be contributed from three different sources of funding as set out below.



The complexity of these arrangements is apparent and four options are set out for ways of restructuring the contribution that municipalities currently make to purchasing places in social care homes. The main features of these options are:

1. Daily living costs are covered by a contribution for the individual's pension, with the payment commencing once assessment has established the need for long term residential care and that the individual would not be able to return to their own home.

2. All options include dependency based payments for nursing care and social care, and set prices for community care services.

3. Further, to avoid the division between separate payments for "medical" nursing care and social care, three options include a new Nursing and Social Care Fund to pay for combinations of nursing care and social care in long term are nursing homes and social care homes and community care services.

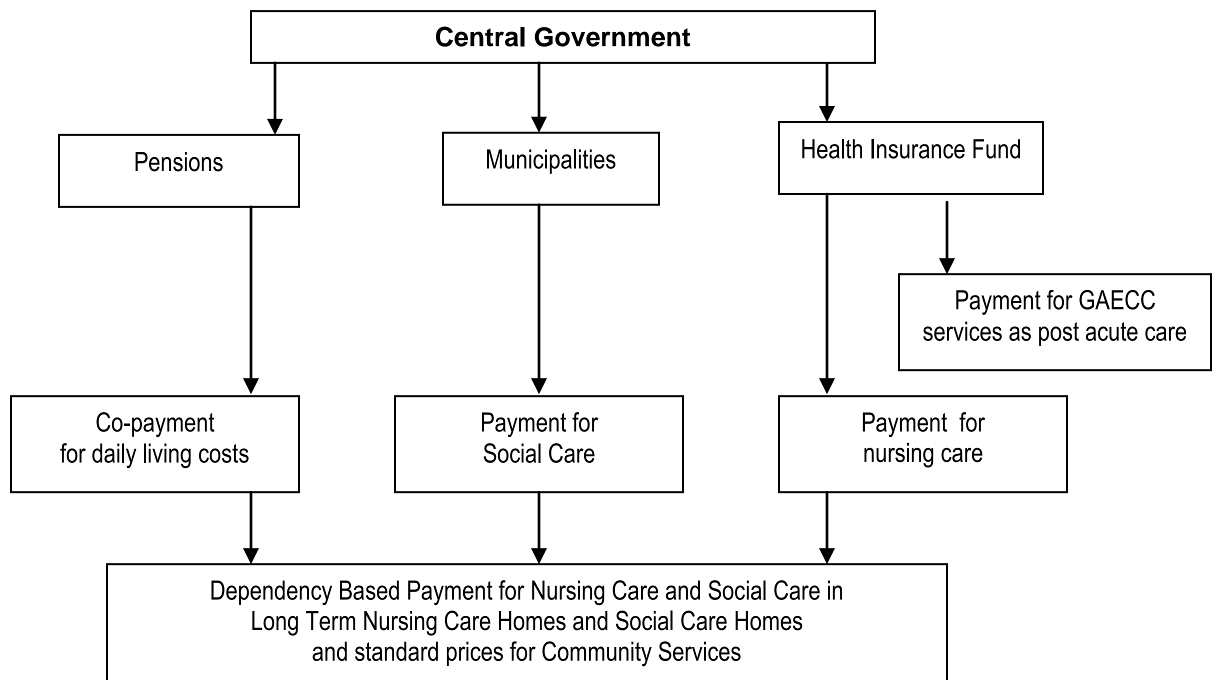
Option 1: Standard contribution for social care

This option proposes replacing the current flat rate payment made by municipalities for social care in social care homes only with a variable rate payment that varies in accord with the level of social care that the individual receives in both social care homes and long term nursing care homes. Compared to the current flat rate, some individuals would receive a lower level of funding and others a higher level, but the total cost to municipalities would remain the same. This option would have the advantage of standardising the level of payments made by all municipalities.

Nursing care costs would be covered by the HIF, with the level of payment again varying in accord with the dependency and care needs of patients in long term nursing care homes.

The main disadvantages of this option are:

- the complexity of transactions required for municipalities,
- the cost burden would fall most heavily on municipalities that had a high proportion of older people in their populations; this latter problem could be reduced by a funding equalisation mechanism operated by the central government, but this would again add to complexity.
- the division between social care and nursing care remains.

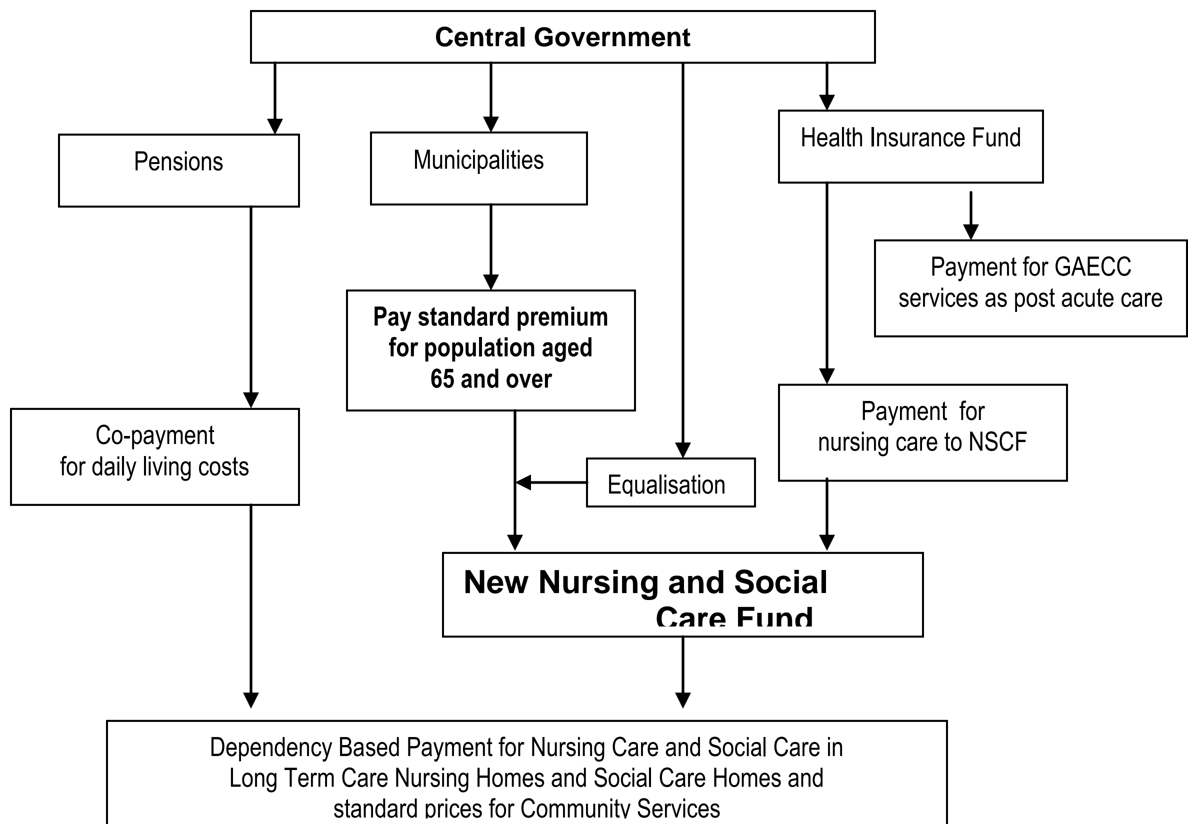


Option 2: Direct payment by Municipalities for Social Care replaced by Standard Premium Paid into Nursing and Social Care Fund

In this option, it is proposed that instead of paying for social care directly, and only for patients actually receiving care, all municipalities would make a per capita payment based on the aged population in their area. This levy would be paid to the new Nursing and Social Care Fund and used to cover the social care component of all NCLTC services.

A per capita levy is equivalent to an insurance premium and is thus consistent with the insurance approach to health care funding. The limitation is that such a levy would fall most heavily on municipalities with high proportions of older people, and central government equalisation would again be required.

The HIF would then set prices to cover bundles of services that combined different levels of social care and nursing care, and based on dependency.

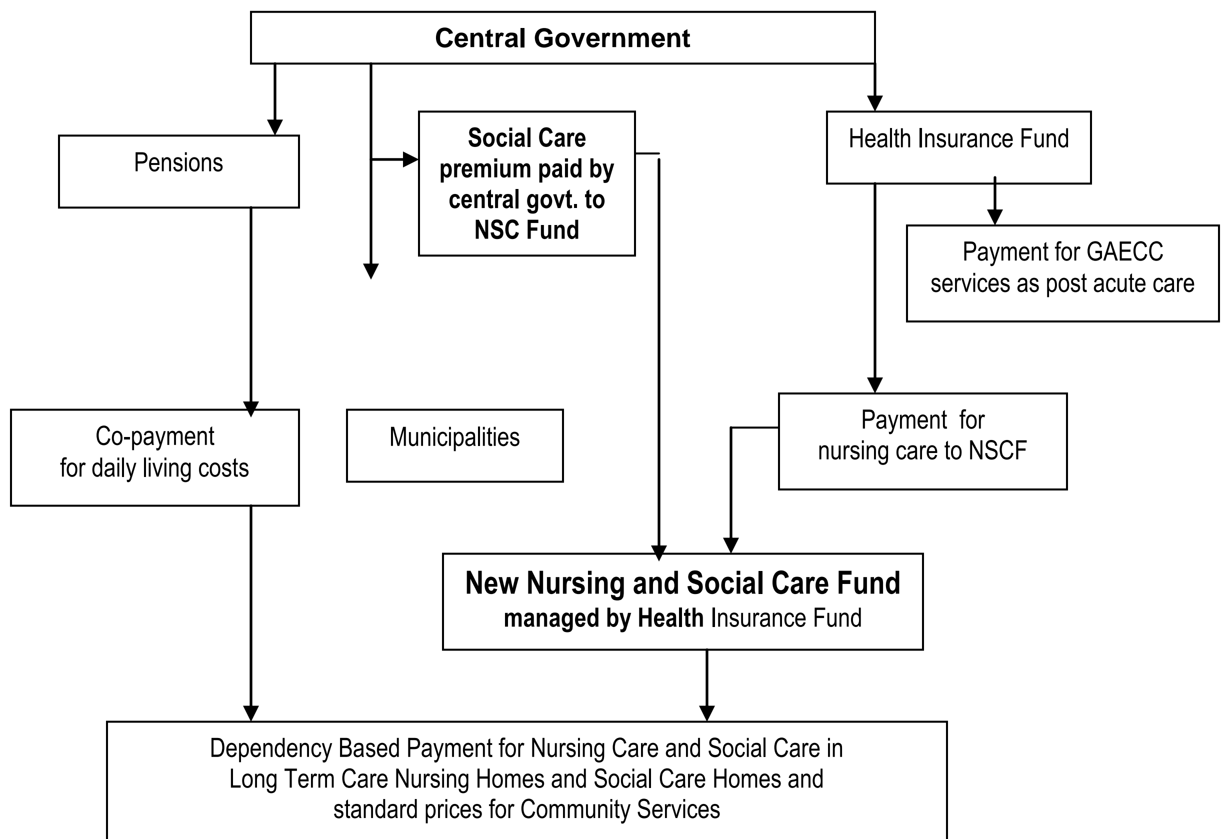


Option 3: Funds directed to Nursing and Social Care Fund directly from central budget

In this third option, the allocation to the Nursing and Social Care Fund for social care is made directly from the central budget rather than by municipalities. To preserve the premium-based insurance approach, the allocation would be calculated on the basis of a per capita allocation. Similarly, funds for nursing care are set aside from the HIF and added directly to the Nursing and Social Care Fund.

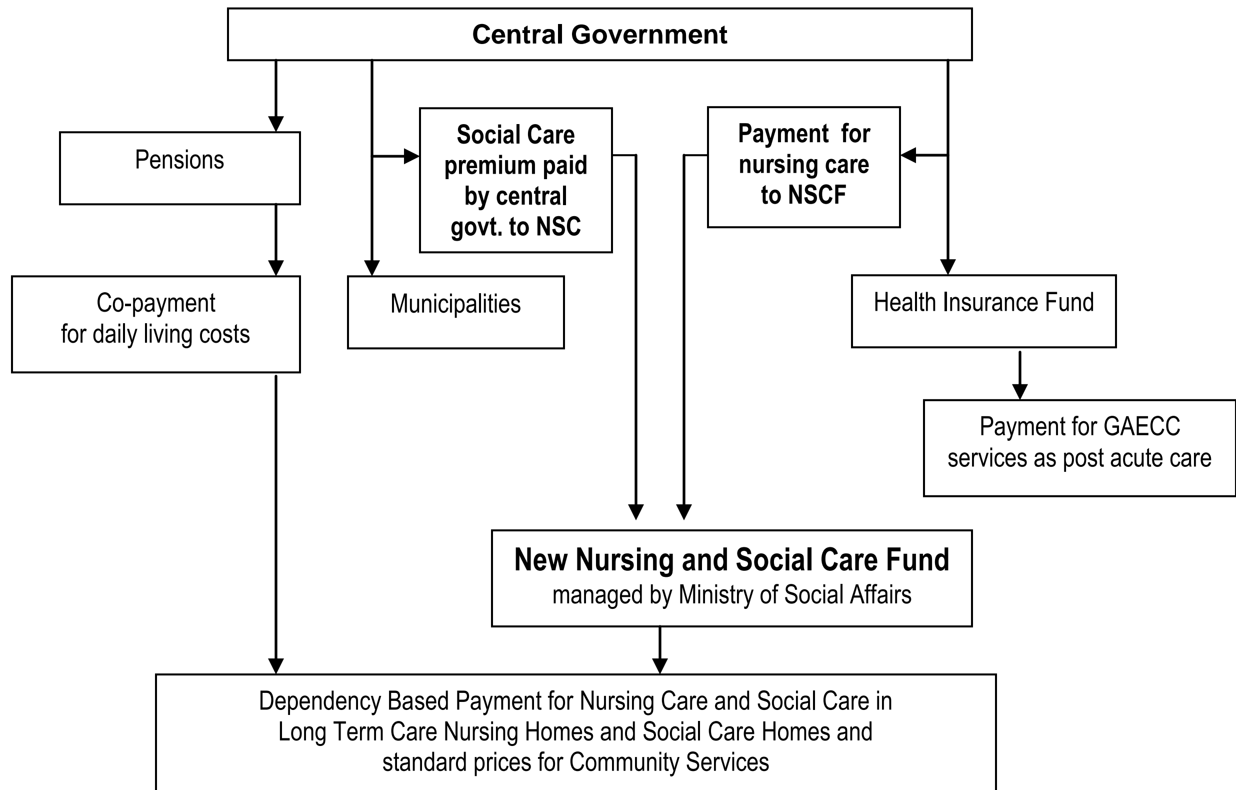
The advantage of this direct allocation is that it avoid the needs for an equalisation mechanism between municipalities; the direct per capita payment funds achieves equalisation directly.

Payment for services would proceed on the basis of prices set by the HIF, as in Option 2.



Option 4: Transfer all funding for NCLTC to the Ministry of Social Affairs

In contrast to Options 2 and 3 that place responsibility for the Nursing and Social Care Funding under the HIF, this option proposes that the Ministry of Social Affairs administers NCLTC funding along the lines of funding of mental health services. To establish this scheme, funds would be diverted to the NSCF from the HIF to cover nursing care. Social care would be covered through the per capita method proposed in Option 3. The Ministry would then be responsible for setting prices and standards and making payments to providers on the basis of care provided to assessed patients.



Further development

These four options are presented to show some possible alternatives to the present arrangements and as a basis for discussion. The advantages and disadvantages of each option need to be fully explored. Financial modelling also has to be carried out, and when a preferred option is identified, a trial in one region should proceed national adoption. It is likely that further modifications and options will emerge as these issues are debated by the parties involved in the development of NCLTC.

A proposal for World Bank funding for this developmental work is presented in Section 5.

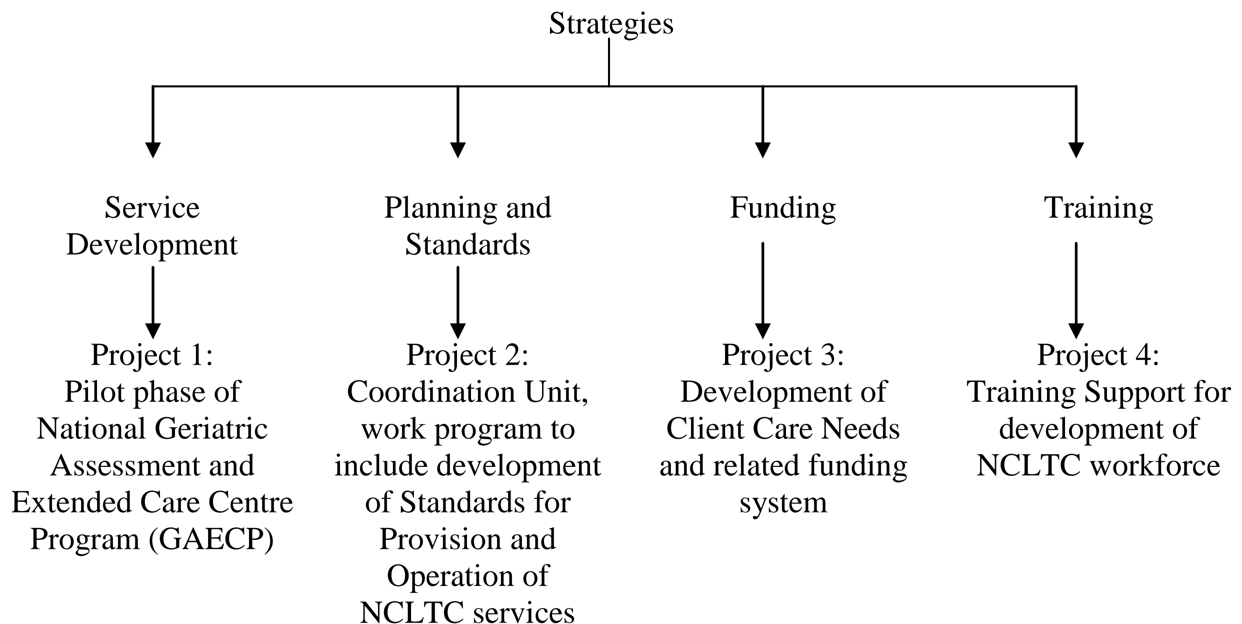
Part 5. Proposals for Strategic Projects for World Bank Funding

5.1 Overview and Budget Summary

5.1.1 Four strategic projects

Four interrelated projects are proposed for the Nursing Care and Long Term Care Plan, in line with the four strategies developed in this report. The proposals have been developed with a view to implementation from early 2002 and to run for five years in the first instance.

These four projects address major areas of strategic development and it is expected that they would generate a variety of complementary activities on the part of other agencies. The role of World Bank support is thus to be a catalyst to change and is not intended to fund NCLTC services per se. The cost of direct delivery of services will be met from resources realised from the conversion of excess acute beds.



While the major part of the NCLTC program will be conducted within Estonia, provision is made for continuing expert consultant support. A key role of the consultants will be to participate in major reviews and report on progress to the Ministry of Social Affairs and the World Bank. The consultants will also contribute to specific activities in each projects and will be responsible for identifying needs for further expert input.

Each project proposal includes a detailed timetable and a summary timetable for the four projects is set out at the end of this part of the report. The summary timetable identifies critical stages for the NCLTC Plan overall and major review points at which progress on all four projects will be reviewed. The need for revision of the individual projects and the Plan overall will be considered at these points.

5.1.2 5 year budget estimates for funding of NCLTC Program

Budget estimates have been prepared on the basis of a total of EEK120 being available from the World Bank loan over five years. As a major purpose of the loan funding is to act as a catalyst to conversion of resources tied up in excess hospital beds, funding is allocated on a sliding scale over this period. Resources from excess hospital beds are expected to be realised cumulatively over the five years, and the ratio of these resources relative to the World Bank loan funding increases so that by 2006 all excess hospital bed resources are realised. This rate of conversion is very rapid, but it expected that considerable momentum will be generated once the pilot program for Geriatric Assessment and Extended Care Centres begins.

A start-up period of lower World Bank loan funding is allowed in 2002, with an increase to maximum funding in 2003, then reducing in subsequent years to phase out at the end of 2006. Adjustments for any slippage in expenditure will need to be made, either by carry over to the next year or extension beyond the five year time frame.

Source of funds	2002	2003	2004	2005	2006	5 year total
World Bank EEKm	30	40	30	15	5	120
Conversion of excess hospital beds:						
Realised EEKm	100	200	300	400	564	1,564
Balance of funds to be converted EEKm	464	364	264	164	0	1,256
Total EEKm	564	564	564	564	564	2,820
Municipalities for Social Care Homes EEKm	133	133	133	133	133	665

5.1.3 Five Year Funding Plan for Strategic Projects

Allocation of loan funds between the four strategies is set out below. The GAECC pilot program accounts for 75% of the total loan funds.

Year/ Total funding	Project 1 Pilot GAECC Program	Project 2 Planning and Coordination Unit in Estonian Health Project	Project 3 Development of Patient Classification	Project 4 Training
1 EEK25	EEK18m	Project to continue for duration of Program EEK 5m	Short term project, completed end year 2 EEK 1m	Initial intensive Training Program EEK1m
2 EEK45	EEK38m	EEK 5m	EEK 1m	EEK1m
2 year Progress Review				
3 EEK28.5	EEK23m	EEK 5m		Continuing Training Activities EEK0.5m
4 EEK17	EEK11.5m	EEK 5m	0	EEK0.5m
5 EEK4.5	0	EEK 4m	0	EEK0.5m
Total EEK120m	EEK90.5m	EEK24m	EEK2.0m	EEK3.5m
Share	75%	20%	2%.	3%
Full Review of Implementation of NCLTC Plan				

Project 1: Pilot phase of National Geriatric Assessment and Extended Care Program (GAECP)

Objectives

The objectives of funding the pilot phase of this Program are to:

1. provide a catalyst to the orderly reorganisation of the existing pikaravi units in acute hospitals and management of long term care patients in general into eight major Extended Care Centres that will provide multi-disciplinary assessment teams with associated in-patient beds for assessment, slow stream rehabilitation, and intensive nursing care, a day hospital and possibly a base for visiting nursing services and other community services.

2. stimulate the development of networks of nursing care and long term care services, linked to the eight major ECCs, through using the resources and facilities becoming available from the conversion of beds excess to acute care needs. Standards for the provision and operation of these services are to be developed in Project 2.

3. the reorganisation of the present two tiers of long term nursing care in hospitals and social care homes into levels of care based on assessment of patient dependency, with the levels of care to be funded according to the Patient Classification Scheme to be developed in Project 3.

4. improvements in quality of care at all levels of care through support of demonstration projects to promote changes in care practices, with further training initiatives funded through Project 4.

Development Process and Activities

- **Scope:** It is proposed that pilot phase should establish eight Geriatric Assessment and Extended Care Centres and the four sub-centres. The GAECCs should be established functionally within hospitals although they may be located in physically separate buildings. The prime reason for functional location within hospitals is the major role that the GAECCs will take in the management of hospital patients needing long term care after acute care, whether in residential care of some form or in the community.

- **Submissions:** Candidate hospitals for Extended Care Centres will be invited to submit proposals to participate in the pilot program. These proposals will follow general specifications set out by the Estonian Health Project and each candidate hospitals will be required to develop a specific plan for the services it is to provide, to identify priorities and milestones to be achieved in the first two years. Each

GAECC will then have to commence service provision within an agreed timeline, and achieve defined outcomes.

- The focus of the pilot projects will be on development of geriatric medical services, including negotiation with other service providers to establish arrangements for referral of patients and transfer to care services following assessment, bringing about the reorganisation of nursing care and social care services to meet the assessed needs of clients, and planning and promoting the development of community services. The GAECCs will be expected to develop three broad sets of activities:

  - Clinical services
  - Planning and development of residential and community services in conjunction with other agencies in region
  - Management of the GAECC.

- The development of the pilot program will be supported by the four Working Groups and will involve extensive consultation with other service providers in each catchment area. The GAECC participants will be expected to meet monthly and to present progress reports every three months. A major workshop should be convened as part of the review at 2 years.

Funding

Allocation: The GAECC Pilot Program accounts for EEK90.5m over five years.

Core funding: Hospitals that are invited to submit proposals to provide ECCs will be expected to contribute to core funding according to the proposal specifications which will include:

- A commitment by the hospital to core funding to cover:
  1. 50% of the salary of two internal medicine specialists who will undertake specialist training in geriatric medicine, and one of whom will be the Director of the GAECC;
  2. 50% of the salary of the GAECC Service Manager; the service manager may be medically qualified;
  3. 50% of the salary of a nurse co-ordinator and
  4. a share of infrastructure costs, including vehicles.

- A preliminary indication of how the establishment of the ECC will contribute to the implementation of the Hospital Master Plan in the region
- Identification of other services to be involved in development of residential and community care services in the region; and
- An agreement to compile a Minimum Data Set on clients seen by the Assessment Team and other services, and to submit regular reports.

World Bank funding will cover the 50% of the core costs for each GAECC for two years and then decline on a sliding scale over subsequent years as funds are released through the conversion of excess acute beds. The cost of direct services will be met by the release of resources as pikaravi units are reorganised and excess hospital beds are converted to NCLTC services.

Expert advice will be required to support the project. This advice should be from Finnish, other Scandinavian or possibly UK experts and aim to achieve service outcomes in line with EU standards. These expert advisors should have experience in service organization and development as well as clinical geriatric medicine. They should be able to make more frequent, short visits as required, and contribute to the training and education strategy set out in Proposal 4, and to organise short visits for the Estonian project participants to overseas services.

Operating funding for care services will be generated through the redirection of HIF funding as conversion of excess hospital beds proceeds. It is proposed that the level and range of services to be provided will be specified in contacts negotiated between the GAECCs and the HIF, with access to NCLTC services conditional upon assessment by the GAECC assessment team.

Capital funding: The pilot GAECCs will be established in existing facilities and the pilot program funding does not include provision for capital facilities which will have to be covered in hospital capital plans. Any capital works for GAECCs, nursing homes and day hospitals will be planned and undertaken as part of the Hospital Master Plan. A draft set of criteria have been developed to identify hospitals that are suitable for conversion and reprofiling to nursing care and long term care services and elimination for those which are not suitable for conversion to long term care. This document is at Appendix 1. The Geriatric Assessment and Extended Care Program will not provide funding for capital works. Capital funding will have to be planned in conjunction with the Hospital Master Plan.

Timetable

<table>
<tr><th>Year</th><th>World Bank Funding</th><th colspan="2">Health Insurance Funding</th></tr>
<tr><td rowspan="3">1</td><td rowspan="3">50% of key staff and program support services

staged implementation
• 3 or 4 pilot GAECCs in first 6 m
• further 3 or 4 after 9 months
• remaining GAECCs as ready</td><td rowspan="3">Existing hospital resources, with special contracts with HIF for Pilot Program
50% of positions for medical director and deputy director
50% of nurse co-ordinator salary</td><td>Conversion to new services funded at new prices</td></tr>
<tr><td>Prices established for care services, as per Project 2</td></tr>
<tr><td rowspan="2">Commence conversion of resources from excess acute beds to trial of payment for services at new prices</td></tr>
<tr><td rowspan="2">2</td><td rowspan="2">50%</td><td rowspan="2">Hospital commitment continues at 50% of enlarged budget</td></tr>
<tr><td>Review and revision of classification and funding scheme</td></tr>
<tr><td></td><td colspan="3">Review of GAECC Program at end of 2 years,
including consideration of outcomes of review and revision of Care Need Classification and Pricing</td></tr>
<tr><td>3</td><td>20%</td><td colspan="2">Hospital contracts continue and
progressive increases in proportion of funding of care services from HIF under contracts for ECCs and associated network of care services at new prices</td></tr>
<tr><td>4</td><td>5-10%</td><td colspan="2">70% of Program funded by HIF</td></tr>
<tr><td>5</td><td>Phased out</td><td colspan="2">Program effectively fully funded by HIF</td></tr>
</table>

Project 2: Project Coordination and Development Unit

Objectives

1. To co-ordinate the overall implementation of the NCLTC Project, through liaison with the Ministry and the Working Groups;
2. To develop the planning framework and standards for service provision and operation;
3. To develop the structure and functions of a NCLTC Unit to be established in the Ministry of Social Affairs;
4. To liaise with expert consultants and the World Bank.

Activities

This unit will be located in the Health Project and have responsibility for two sets of activities

1. Coordination of implementation of the NCLTC Plan generally in the Health Project.

2. Undertaking the developmental activities associated specifically with the World Bank funded projects.

The activities to be undertaken by the Unit focus on the development of standards for the provision and operation of services and will proceed as the NCLTC Plan is implemented. The main tasks to be carried out are:

- identifying benchmarks for planning levels of service delivery

- defining quality of care standards that providers will be required to meet in order to receive funding, with an initial priority being to define standards that can be used to determine whether existing facilities are appropriate for conversion to nursing hospitals, day hospitals etc.

- development of monitoring systems, including establishing and maintaining a minimum data base on NCLTC services which will generate data for future planning, in conjunction with the Ministry of Social Affairs Statistical Division.

These developmental tasks will produce guidelines and manuals to ensure consistency in service provision as the NCLTC emerges.

The Coordination Unit will also provide secretariat support to the various Working Groups and arrange the major program reviews and other workshops as required for the GAECC Program.

Funding

Allocation: Funding of EEK24m is allocated over five years.

World Bank Funding: The Unit will be fully support by loan funding which will be used to cover three main components:

- a Project Manager and three other full time staff
- Expert consultancy
- Associated support costs.

Other funding: The Unit may attract other external funding as appropriate for additional activities.

Timetable

It is anticipated that the Unit will operate for the first five years of the Project and that following the review of progress at the time, its functions will be transferred to a NCLTC unit in the Ministry of Social Affairs.

Project 3: Development of Funding Systems

Objectives

1. To develop a dependency based funding scheme. This activity requires development of
   (a) Client Care Needs Classification based on a survey of dependency of patients of nursing care and long term care services, including residents of social care homes, and
   (b) a funding system based on levels of client dependency so that the available budget for NCLTC services is allocated on the basis of need for care to replace the existing flat rates of funding of long term care in hospitals and social care homes, and to extend to home nursing services.

2. To develop options for integration of HIF and municipal funding, including financial modelling at the national and local level.

3. To enhance the capacity of health economists in Estonia in financial analysis and management of the NCLTC system.

Activities

Dependency based funding

The foundation for the activities required to develop a Care Need Classification and funding system have been laid in the surveys conducted by the Estonian Association for Gerontology and Geriatrics and the Southwest Estonian Strategy Study, and in the patient rating schedules developed in a number of pikaravi and other long term care units, as noted in the Report. The Project requires the following activities:

1. Review the available Estonia material in the context of international experience, including the Resident Assessment Instrument (RAI) that has been developed in the US and adopted in several European countries and classification and funding systems in operation in other countries, such as the Australian Resident Classification Scale. This review should include a workshop with key individuals who will be involved in the further steps of the project.

2. Conduct of a pilot survey and full survey to collect dependency data

3. Collection of information on staffing and other inputs to care.

4. Analysis of data.

5. Development of integrated system of assessment, care planning, and dependency related funding.

6. Trial implementation

7. Review

These activities should be carried out in the first 2 years of the NCLTC Program. As timing of this activity is critical to overall progress of the Program, a detailed timetable is set out below.

This strategy will need support from an international consultant with expertise in the development of care classification and funding systems, including data analysis and computing systems.

The strategy will be supported by the Working Group on Financing.

Options for integrating HIF and Municipal Funding

This project will be carried out in conjunction with the Financing Working Group and will involve the following steps:

1. Review of options set out in this Plan, assess responses of various parties and identify any further options;

2. Undertake financial analysis of current expenditures by HIF and municipalities in all relevant areas and revise estimates of resources associated with excess hospital beds; these analyses should be made at national level and also at the level of the major catchment areas, with HIF and municipal funding aggregated at this regional level.

3. Investigate relativities of costs of NCLTC services relative to acute care services funded by the HIF and social care services funded by municipalities.

4. Refine timetable for realisation of excess in conjunction with conversion of excess hospital beds and assess extent of redistribution of resources required to achieve equitable levels of service provision at proposed benchmarks.

5. Investigate methods of piloting alternative funding arrangements, in particular with the City of Tallinn and City of Tartu, and with municipalities on at least one county that includes an urban centre with a GAECC and surrounding rural municipalities.

6. Contribute to related policy development regarding functions of municipalities.

7. Present preferred options and financial plans at the time of the 2 year review.

Funding

Allocation: Funding of EEK2m is allocated at EEK1m for two years.

World Bank Funding: Loan funds will fully cover this one-off project. A local health economist and a project officer should be engaged to work on these tasks with the Estonian Health Project, possibly through shared university research appointment. World Bank funding should cover the salaries of Estonian staff seconded to the project, and expert consultancy and data analysis.

Timetable

Month	Activity	Outcome
1	Workshop to review of current assessment schedules, the international Resident Assessment Instrument and other schemes, including the Australian Resident Classification Scale.	Development of a draft Estonian Care Need Schedule
2	Pilot survey of draft Care Needs Schedule in a small stratified sample of social care homes, hospitals (long stay aged patients only) and aged residents in special care homes (psychogeriatric patients).	Pilot survey data for analysis
3	Analysis of pilot data	Report on preliminary classification
4	Review of draft schedule	Revised Care Need Schedule
5	National survey of social care homes, elderly long stay patient in hospitals, and aged patients in special care homes (aged 65 and over) (facilities in pilot study will not be required to participation again). Sample of clients receiving care at home to be included if possible	National data base
6	Analysis of data on resident care needs to develop classification, expected to have between four and six levels of care.	Full data analysis and computer program for classification system
7	Survey of costs of care, through collection of data on care services provided in facilities in pilot survey, covering types of staffing, hours of nursing and social care provided etc.	Data on costs, care services and practices
8	Development of assessment and funding system integrating classification of client care needs and levels of funding , to establish distribution of client population across categories, mix of care needs in ECCs, and in nursing and social care homes. Analysis of costing data in relation to client categories. Development of funding levels within total available budget	Presentation of final report, including • final schedule and guide for completion • guidelines for care practices for each level of care • program for data analysis • definition of funding levels and distribution of clients between levels
9	Workshop for trial implementation of new scheme, including training of staff in facilities	Staff prepared for trial implementation of new classification and care practices
10-21	Trial implementation for one year	Reports to be provided at 3, 6 and 9 months.
22-24	Review and revision	

Project 4: Training Programs

Objectives

1. To develop a skilled workforce for nursing care and long term care services, at all levels of qualification.

2. To build the capacity of health education institutions in providing a range of education and training activities for nursing care and long term care

3. To provide opportunities for conversion of skills of staff in facilities that are to be converted to nursing care and long term care services.

4. To strengthen the role of professional associations in nursing care and long term care, and to achieve standards in line EU guidelines.

Activities

An immediate priority is to train a small number of physicians as specialist geriatricians. It is proposed that agreement to undertake this specialist training be made a condition of appointments to the position of Medical Director of the Extended Care Centres, and these appointees work under the supervision of three experts appointed by the Ministry of Social Affairs and the body responsible for recognising medical specialisations. One of the experts should be an overseas geriatrician who should spend some time in Estonia and who can accept Estonian personnel for short training programs. The positions with the ECCs should function as residencies in Geriatric Medicine, so that the specialist geriatrician training developed in this way can be granted formal recognition as a specialist field within internal medicine.

More generally, the basis of training programs in geriatric medicine and long term nursing care already exist. The immediate priority for the project is on implementation of an intensive training program to complement the establishment of the Geriatric Assessment and Extended Care Program and to ensure skills of nursing and other staff in excess hospitals are converted to nursing care and long term care services, and including provision for upgrading of skills of staff in social care homes. A major effort will be required to generate the workforce required for expansion of community care services.

The Working Group on Service Development and Training will guide the Training Strategy. Given its established role in training, the Estonian Association for Gerontology and Geriatrics should be given responsibility for implementation, and for liaising with representatives from the Estonian Nurses Association, the relevant departments of the University of Tartu and the University of Tallinn, the City of Tallinn Centre for

Development of Social Care, the organization of managers of social care homes and other relevant bodies.

Training should be offered in a mix of in-service and short term courses, with the immediate priorities being coverage of :

For ECC Staff:

- Residency for Specialist Geriatrician Training, with international expert support and short courses overseas;
- Development of Team work as well as enhancing skills of individual specialists;
- Nurse co-ordinators.

For staff of new nursing and long term care services:

- Short term training for staff for visiting nursing services
- Short term courses to train therapy staff for slow stream rehabilitation and day hospitals
- In-service conversion courses for staff in nursing hospitals and social care homes

For family doctors

- In-service courses for familiarisation with the role of ECCs and related nursing and long term care services

For social workers and others:

- Short courses and development of units in formal curricula.

Outcomes

Formal training courses should lead to qualifications recognised by the Ministry of Social Affairs and these qualifications should become requirements for staff holding designated positions in nursing care and long term care services.

Capacity established for on-going training programs

Funding

Allocation: A total of EEK3.5m is allocated to the training strategy, with EEK2m in the first two years and EEK.5m per year for the next three years.

World Bank Funding: Loan funding will fully cover the training strategy for five years. Four components of funding are required

1. support for a secretariat to the Coordinating Committee
2. places in a range of training programs, with numbers agree for an overall program.
3. provision for an annual conference, with subsidies for attendance
4. international expert input and overseas short courses, organised in conjunction with the European Union for Geriatric Medicine Society and the European Region of the International Association of Gerontology.

Timetable

A timetable will be developed by the Working Group to provide intensive training in the first two years, followed by a continuing program.

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APPENDIX 1

Process and Criteria for Conversion of Capital Stock of "excess" Acute Hospital Beds to Nursing Homes and Social Care Homes

1. Scale of conversion

The number of "excess" acute beds is approximately 5,100.

The NCLTC Plan estimates that 3,450 long term care beds are needed (note that while this number closely approximated the estimate in the Hospital Master Plan, the basis of the estimate differs). The needed beds are divided into:

- 2,250 nursing care beds, for provision at 10 beds per 1000 aged 65 and over, funded at an average of EEK350 per day, maximum EEK450.
- 1,200 social care beds additional to the existing 3,159 beds, to bring provision in all counties up to 20 beds per 1000 aged 65 and over. Some of the existing social care homes are in poor standard buildings and conversion of excess hospital beds may offer improved facilities in some case. The capital conversion process should thus include social care homes.

Combining the excess hospital beds and existing social care homes gives a total of 8,259 beds, some 1,650 more than the total needed nursing care and social care beds and existing social care beds. There is thus a margin of some 20% of beds that can be eliminated in the course of the conversion process.

The nature of conversion of the excess beds will depend on rating their future as suitable for continued use as a nursing care facility or a social care home:

1. in their present state with no capital upgrading;
2. with only minor capital upgrading;
3. with more substantial upgrading;
4. only for a limited period and then to be rebuilt; and
5. facilities that are not suitable for continued use and not to be considered for upgrading, and hence eliminated from the stock.

Identification of the category 5 facilities is a high priority so that these facilities can be eliminated from future planning and their operations brought to an end in an orderly manner. In particular, these facilities should be prevented from undertaking ad hoc capital improvements that would be wasteful of resources that could be better used elsewhere.

Several factors will affect the scale of the conversion process and the outcomes. They include:

1. Some bed closures may be achieved by reducing the number of beds in facilities that meet the physical standards but which are overcrowded. Reducing the number of beds would enable these facilities to meet higher standards of space per resident.

2. The excess hospital beds are unevenly distributed across counties. By far the greatest number are in the North West Region, mainly in Tallinn, where there is also the greatest shortfall in provision of social care homes. Some of the excess hospital beds in Tallinn can be expected to be converted to social care homes as well as nursing homes for at least for a period of 3 to 5 years.

3. It is likely that bed closures will be concentrated among very small homes which are not viable and very large homes where bed numbers need to be reduced to provide more space, better quality care and less institutional care practices.

4. Beyond the closure of the poorest standard buildings, there needs to be a program of upgrading and replacement of other facilities to meet contemporary standards. As a starting point, allowing for elimination of 20% of beds, the remaining beds can be divided into four categories of relative quality: 20% of beds will meet accepted standards, 20% will require minor upgrading, 20% will require more substantial upgrading and 20% of lowest quality will need to be replaced in a relatively short time, say within 5 years.

2. Timetable

The capital conversion process should be planned in two stages:

1. Over the next five years, the priorities are to eliminate the poorest quality facilities and upgrade and rebuild the facilities remaining in the next lowest quality category. On the estimates given above, there will be around 500-600 beds in each of the quality categories, and a building program of around 100-125 beds a year would be required to achieve this replacement of the lowest quality homes in five years.

2. Over the further 10 to 15 years to coincide with capital investments made in accord implementation of the Hospital Master Plan. A lower level of new construction will be required over this time, and a capital replacement plan should be developed to ensure that all facilities will be able to continue to meet the standards that will be expected by 2015.

Decisions on the future of particular facilities have to be made at a county level and take account of local circumstances, but some overall guiding criteria need to be applied to achieve a consistent outcome nationally.

A three stage process is proposed for setting standards for facilities for long term care.

Stage 1: Registration

In the first instance, all buildings that are candidates for nursing care facilities or social care homes need to be registered as actual or potential long term care services. This register should be developed on a county basis and a Registration Survey conducted to compile information that will enable an initial assessment of capital standards to be made. The Registration Survey should include:

- basic data on each facility (no. of beds at present, total floor space and space per bed, number of shared rooms, equipment, etc)
- a rating on the essential criteria set out below; and
- an overall summary assessment of the likely future of the facility and classification into one of the five categories noted above, to indicate the likely outcome in the short term (next 3-5 years), medium term (5-10 years) and longer term (10-15 years).

Stage 2: Conditional Licensing

The second stage of conditional licensing is intended to separate facilities which meet essential standards from those which do not. Conditional licences should be granted on the basis of the results of the Registration Survey.

Facilities which meet the essential standards can then operate with a conditional licence for either a nursing care facility or a social care. Licenses should set out the conditions of operation, such as the nature of any upgrading required and the time by which each facility is to meet further standards to become a certified facility. The conditional licences should distinguish between Categories 1,2, 3 and 4 as noted above, with the proportion of facilities in each category determined on the basis of the results of the Registration Survey. For inclusion in Category 1, facilities could be expected to meet all the essential standards fully. The level to which the essential standards have to be met for inclusion in the other categories will be a matter for assessment by the surveyors and these decisions can only be made when the information from the Registration Survey is to hand. The levels should be set to take account of the scale of upgrading that can realistically be expected in a given time frame; they should not be set so low that very few facilities need to be rebuilt or upgraded, or so high that a very large number will need to be rebuilt or upgraded.

The remaining facilities that do not meet the essential standards and which do not warrant upgrading are the category 5 facilities noted above. These facilities should be phased out as soon as possible by halting any further admissions, and by assessment of all residents with a view to transfer to alternative care arrangements wherever possible.

Stage 3: Certified Licensing

Licensed facilities which meet the conditions of their initial licence will be certified for a given period of one year, three years or five years, and will be required to maintain and improve standards for continued certification.

The level of standards to be met can then be revised in subsequent surveys for continued certification.

3. Criteria for standards of facilities

Criteria for standards of facilities need to take account of some absolute requirements and relative standards. Relative standards can be set with reference to existing facilities that are considered to offer good quality care by contemporary standards. These relative standards should therefore be achievable by all facilities by a specified time, and so provide for continuous quality improvement. All facilities can then required to meet all the standards by a given date as a condition for continued licensing and receipt of funding under contracts with the Health Insurance Fund.

Essential criteria for continued operation

The essential criteria for consideration for continued operation of social care homes or conversion of excess hospital beds to nursing care facilities or social care homes are proposed as follows.

1. Structural soundness

Structural soundness should take account of the age of the building, its layout, the standard of original construction and the level of maintenance to date and cost of continuing maintenance.

2. Adequate access for frail elderly people and for care staff assisting residents.

A lift is essential for buildings of more than one floor to be used for nursing care facilities. Installation of lifts is costly and may not always achieve a satisfactory result. Buildings which do not have currently a lift but which are otherwise suitable should be

very carefully assessed before a commitment to capital upgrading is made. Buildings of only two floors without lifts may in some circumstances be adequate for social care homes but not for nursing care facilities.

3. Cost effective heating

Many older buildings have poor quality and costly heating, including some that still rely on firewood. Cost effective heating and energy efficient building design will contribute to lower operating cost as well as enhancing the quality of the living environment. Installation of new heating systems should only be considered when other aspects of building design are suitable.

4. Space requirements

The Hospital Master Plan recommended a space standard of 70 sq m per bed for existing facilities to be used as nursing care facilities, and 80 sq m for newly constructed facilities. An equal standard could be adopted for social care homes.

As well as setting exact space requirements, building configuration should be taken into account to allow for single rooms for residents in social care homes and a maximum of rooms shared between two patients in nursing care facilities.

Appropriate levels of provision of bathrooms and toilets also need to be set for nursing care facilities and for social care homes. Space in bathrooms and toilets also needs to take account of staff assistance to residents, especially in nursing care facilities.

Allowance has to be made for day activity areas, dining rooms and kitchens, in both social care homes and nursing care homes, with nursing care homes also requiring therapy areas.

As nursing care facilities will have higher staffing levels, more staff areas will be required. Both kinds of facilities should provide areas for staff to sleep overnight.

5. Location and site

Facilities must be where they are needed and locally accessible. Rating of the location of facilities should take account of:

- the overall distribution of facilities in the local area and wider region,
- the specific location of each facility in relation to public transport and other local services for access by visitors, visiting staff and delivery of supplies,
- other particular features of the site that make it appropriate, such as sloping, aspect, landscaping etc.
- potential for redevelopment and expansion.

6. Viable size

Very small homes are unlikely to be viable in terms of staffing and services and so should be phased out. While some local areas with only a small aged population may require only a small facility, existing homes with fewer than 20 residents should be very carefully considered and no facilities that can offer less than 20 places should be considered for conversion.

Very large facilities should also be considered. Where large institutions already exist, or facilities for conversion offer large numbers of beds, consideration should be given to reducing the total number of places and to configuration into separate operating units at a smaller scale of 50 to 60 beds.

The Registration Survey should report a rating on each of these criteria as not met, met in part or fully met. Given the lack of systematic information on the standard of the excess hospital facilities and existing social care homes, and what might be considered to be acceptable standards, it is proposed that a panel of three surveyors be formed to conduct a pilot survey of a selection of facilities known to range from very low to very high standards. This pilot survey can then be used to refine the standards and to provide a guide for rating.

Summary of Criteria for Physical Standards for Nursing Care Facilities and Social Care Homes

Criteria	For nursing care facility	For social care home
1. Structural soundness	Essential	Essential
2. Access- Lift access for multi-storey buildings	Essential	Desirable
3. Cost effective heating	Essential	Essential
4. Space requirements:		
Bedrooms	Shared by a maximum of 4 patients, to be reduced over time to 2.	Shared rooms to be progressively reduced to single rooms over time
Bathrooms and toilets	Capable of cost effective upgrading	Capable of cost effective upgrading
Day, dining, therapy areas	Adequate space essential	Adequate space essential
Staff accommodation	Essential	Essential
5. Location	Essential	Essential
6. Viable size	Essential	To be achieved over time

4. Source and management of capital funds

On the basis of the proposals made in the Hospital Master Plan, it is taken that the recommended funding of EEK450 per day, and the total budget of EEK564, for nursing care beds is for operating costs only, and that capital costs will be met from the identified savings of EEK666m for all hospital services. If these total savings are to be made available for capital works, and allocated in proportion to operating costs, just on 40% or EEK266m would be available for capital expenditure for long term care facilities each year.

The NCLTC Plan proposes that only around half the budget of EEK564 would be required for nursing care beds. A capital fund of EEK266would provide a very high ratio of capital investment to operating costs. While no estimates of capital costs have been prepared, this amount would appear to be more than adequate for likely requirements and construction capacity.

In considering options for managing capital investment in long term care, some marked differences with the acute sector warrant note. Whereas acute sector investment in Estonia is focused around 13 major hospitals in a small number of centres, investment in long term care facilities will be spread across a larger number of smaller facilities, in all counties. Many of these small facilities will have limited financial management capacity.

Three options are available for management of capital funds.

1. Inclusion of a capital component in case payments made by the Health Insurance Fund for purchase of care services.
2. A centrally managed capital fund.
3. A combination of 1 and 2.

Option 1 faces a number of limitations as a mechanism for allocating major capital resources for long term care services. While regular payment of component for capital financing may be appropriate in a well established system in which capital requirements are evenly spread across all facilities, this is not the case in long term care. Rather than all facilities having similar levels of capital requirements, some newer facilities will have very limited immediate capital needs and some will have modest needs for upgrading, others will face substantial investment needs and there are also requirements for new capital development to replace obsolete facilities in the next five to ten years. In this context, the limitations of including a capital component in case payments are identified as:

1. The major limitation is that the distribution of payments made to individual facilities that are currently operating services will not match the overall priorities for the distribution of needed capital investments. This method of allocation cannot thus bring about the conversion of facilities in line with planning processes. In particular, it may prove difficult to attract new providers to areas where there is a deficit of

provision and new facilities are required, as these providers would have to take on a large capital commitments and the capital payments may be insufficient to meet these commitments. In contrast, in areas where there are adequate facilities and a lower level of capital investment is needed for upgrading, capital payment to operating services could be in excess of capital requirements. Whereas the former providers would have a debt burden to service, the latter providers who received the excess capital payments would have a source of income from investing those funds. Differences in the financial position of different facilities would be increased by factors unrelated to their operating performance.

2. There is a risk that if a capital component is included in case payments to facilities that do not have an immediate capital need or which do not have loan repayments for capital commitments, the capital funds may be spent on recurrent costs instead of managed for future capital outlays. By making more funds available, expenditure of capital payments on recurrent costs would have an inflationary effect on prices paid for these inputs.

3. Many providers of nursing care and social care facilities will be operating on a small scale and will not have experience in assessing future capital needs or in managing capital investment funds over an extended time scale. The risk is that the availability of capital funding could lead to unwise investment decisions being made at an early stage, and capital funds then committed, with the result that funds were not available to meet future needs. Alternatively, if facilities are required to invest capital payments to meet future needs, there is a risk of unwise investments that may not provide adequate returns. Certificate of need processes could be used to control investment decisions but would still not fully manage the use of capital funds paid as a component of routine payments.

4. In a situation of a likely shortage of capital funds, all available capital should be allocated to priority needs rather than making some capital payments to providers to invest to cover future needs.

5. The only capital payment that should be included in routine payments is a small allocation for maintenance and minor capital items.

Option 2 offers far more control in the allocation of available funds to meet priority capital needs between areas and over time. Under this option, capital funds would be allocated through grants to providers, and using certificate of need processes. In kind contributions could be required from providers by way of land or existing buildings in the case of upgrading.

Option 3 combines elements of Options 1 and 2, with allocations from the central fund to be made as loans that are repaid from the capital payments made to facilities. Many of the limitations of Option 1 however remain.

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