



# **ILC Global Alliance papers on integrated health and social care for frail older people**

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# Table of Contents

**Argentina .....3**

**Czech Republic .....6**

**Dominican Republic .....11**

**France .....13**

**India.....16**

**Israel.....21**

**Japan.....24**

**South Africa.....29**

**United Kingdom .....32**

## ***Trends and development in integrated care for frail older people***

### ***ILC- Argentina***

#### ***Argentina - Socio demographic situation***

The last census in Argentina was held in 2010. First results show that the total population is approximately 40,100,000 inhabitants, with 100 women for every 95 men, 70% of the population living in or near six major cities. Over the last three decades, Argentina has witnessed a growth in its older population (aged more than 65yrs.) from less than 7% to more than 10%. Nowadays, elderly people account 10, 2%, with a maximum of 16.4% in the city of Buenos Aires. There are 3500 people over 100 years<sup>1</sup>.

The main source of income in the population over 65 is their pension; 61.2% of their perceived income comes this way. The proportion of poor older people decreases with age. An estimated 12% of those over 65 are considered poor and only 4% are in *extreme poverty*. People aged 80 years and percentage of poverty has been reduced to 8.4%<sup>2</sup>.

According to data, from the “*Comisión Nacional de Pensiones Asistenciales*” in 2007, the number of people 60 and over who receive non-contributory pension, were more than 250,000 people, more than a half being females. According to the 2001 census, 73% of older men had a retirement or pension, the percentage was 60% for women. As age advances, the proportion of seniors with retirement income increases, exceeding 85% in males, reaching 77% in women aged 75 years.

#### ***Health services for older people in Argentina***

Argentina still lacks a nationwide health care system specifically for the elderly, and proper health care coverage is not guaranteed to everyone's in the country.

Overall, health care in Argentina is based on three systems: the public, social security (union's health and PAMI), and the private health care system. The PAMI – *Programa de Atención Médica Integral* – is a separate health insurance fund for pensioners, broadly comparable to Medicare in the USA.

Each of the three sub-sectors suffered from fragmentation and lack of regulation (3). Almost all parts of the health system suffered from a heavy bias towards expensive specialist curative services, and overlooked more basic intervention and therapies.

Despite this situation through the PAMI or Union Health care system and / or by private health care system are covered almost 80% of senior's citizens, based on 2005 data. 84% of elders are affiliated to a health care system; again the percentage rising up with age. The PAMI cover approximately more than 3, 6 million elders.

The percentage of seniors, who go to a health center, primary health care or a public hospital, is rather low because in Argentina the public sector is frequented by those who don't have any protection at all,

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<sup>1</sup> Census 2010 – Personal communication.

<sup>2</sup> Seguridad económica, Salud y Atención a la Dependencia y Participación de los Adultos Mayores en el Cono Sur. Organización Iberoamericana de Seguridad Social, IMSERSO, 2008. Accesible: [http://www.oiss.org/IMG/pdf/web-Seguridad\\_economica\\_salud\\_dependencia-Cono\\_Sur\\_junio\\_08.pdf](http://www.oiss.org/IMG/pdf/web-Seguridad_economica_salud_dependencia-Cono_Sur_junio_08.pdf)

but the situation is nevertheless changing due to the present economical situation for an important part of the Argentinean middle a lower class population.

While 38% of the population goes to primary care centers, only 14% of older people do it. The categories where the difference in spending is highest among the general population elders are laboratory analysis, treatment and hospital care where the difference is 6 times, follow by prescriptions.

In 2004 the *Plan Medico Obligatorio* (PMO) has regulated the basic essential services designed to ensure and to guarantee services provided trough the sub-sector of *Obras Sociales* and private sector. The PMO cover 95% of cases of primary care, surgical and hospitalization, dental care and mental health services, rehabilitation and palliative care<sup>3</sup>.

Argentina has the “*Programa Remediar*” aimed to strengthening the primary care model, ensuring access to essential medicines. Of the more than 13 million beneficiaries of this program, 11% are over 60 years, representing 30% of the largest group, with around 1.5 million people.

Home care is still in a developing stage, and most of the medical doctors practicing home care medicine do so as a second job. Only 2% of the senior’s citizens live in adapted housing, residential homes or nursing homes<sup>4</sup>.

Division, decentralization and specialization in health care introduce risks of fragmentation and loss of coherence regardless of whether the provider is public or private. So, an integrative care health system is a response to this phenomenon.

Health services in Argentina are still organized in a hospital centered and acute conditions and short terms interventions model of provision.

## **Conclusions**

Integrated care for the elderly has become a major theme in health reform because of well documented issues surrounding the poor quality of care being delivered to those with chronic conditions. An effective health care of the elderly is crucial and a paradigm change is required. Recent years have seen increased debate about public policies for elders, especially in developing countries. Much of this has focused on the different characteristics of the privatization processes<sup>5</sup> Less attention has been given to the different challenges on epidemiological or demographic transitions, putting great focus in the expenditure related with the ageing process. In fact, a comparative research shows that the impact of ageing on health expenditure is not particularly significant and that it is strongly mediated by other effects such as how services are organized and financed<sup>6</sup>.

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<sup>3</sup> Organización Panamericana de la Salud, Programa de Organización y Gestión de Sistemas y Servicios de Salud. Perfil del sistema de servicios de salud. Republica Argentina. Washington DC. OPS, 2001.

<sup>4</sup> Montero Odasso M., Przygoda P., Redondo N., Adamson J., Kaplan R., Health care for older persons in Argentina: A country profile. JAGS 2004, 52:1761-1765.

<sup>5</sup> Lloyd Sherlock P., Health sector reform in Argentina: a cautionary tale. Soc & Science Med 2005, 60:1893-1903.

<sup>6</sup> Gentzen T., Population aging and the growth of health expenditures. Journal of Gerontology 1992, 47:98-104.

Numerous analyses in past years have been drawn attention to the range and severity of problems affecting Argentina health sector, so the problem is not new. Argentina is at an advanced stage of demographic transition, so that changes and adaptation mechanism should be quick. The current situation in Argentina is that the reality outside the health system is faster than the changes that are internally. In a nutshell, it is organized in the same way for decades regardless of the demographic and epidemiological changes in recent years. The organizational culture is based on an older model; resources are limited and are not effective and efficient as they should be.

Argentina spends 9.6% of its GDP, on health is the largest Latin American country in investment and its results are worse than other countries with less expense and doesn't reflected in health indicators <sup>7</sup>. The Argentine model is a particular case based in the high fragmentation. Health coverage is organized in three sub-sectors, which represents social sectors if we take in consideration social class of the users; that lack of proper coordination and health care provision is very heterogeneous. The incentive system is not adequate so different sources of income in health professionals is quite common.

Scientific evidence shows that care continuity, integration of processes with a patient in an active role, make better results. Today in Argentina, health systems based on integrated care are an unmet need.

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**Competing interests:** Opinions or points of view expressed are those of the author and do not necessarily reflect the official position or policies of the any institution or organization works.

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<sup>7</sup> Bello M., Becerril Montekio VM. Sistema de salud en Argentina. Rev. Mex Salud Publica 2011;53Supp2:S96-S108.

# **Integrated Care in the Czech Republic**

## **Care for Older People and Long-Term Care in the Czech Republic**

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In this article, we will deal with integrated care for older persons in the Czech Republic, especially focusing on the care provision on the community level. Based on our experience, we explain both difficulties and problems and also opportunities in this area. By the term „integrated care“ for older people, we understand continuum of services for older persons and older patients (e.g. these who live with or are at risk of reduced self-sufficiency mainly due to a chronic disease).

Czech Republic has undergone important changes in its health and social care systems since the change of political situation in 1989 and the dissolution of Czechoslovakia into the Czech and Slovak Republics in 1993. It is difficult to describe all developments affecting these systems. Therefore, we will focus on the present state of care for older people and persons in need of a long-term care.

Arguably, the split of responsibilities for care provision between the Ministry of Social Affairs and Ministry of Health remains the main obstacle to integrated care provision. For instance, long-term care is provided both by health care and by social care providers, however, this happens under very different conditions. Even within both systems exist some obstacles to integrated care provision. On the other hand, there are also some examples of functional integration of services showing that despite these problems, the integrated care provision is possible. Functioning of this care model highly depends on local conditions and support from local (municipal) authorities. We explain briefly main principles of health and social care provision in this country and thereafter, we focus on long-term care as an example of care integration.

Health care in the Czech Republic is provided by general practitioners (and other primary health care physicians – stomatologists, gynaecologists and home care nursing agencies) and specialists in the ambulatory sector. In the institutional sector, there are hospitals and therapeutic institutes (e.g. therapeutic institutes for long-term sick patients), psychiatric and rehabilitation hospitals. Health care is covered by general health care insurance (through 12 insurance companies operating according to the law under very similar conditions, one of them being public and others private).

There is a new law on social services in the social care sector, , 108/2006, Collection of Laws and Regulations. This law stipulates different types of social services and care allowance provided to persons with disability and limited self-sufficiency. There are 4 grades of care allowance (800 CZK, 4000, 8000 and 11 000, 1 euro- cca 24.5 CZK). Persons with limited self-sufficiency and disability are supposed to purchase services from registered social care providers and they may also be cared for by their family caregivers and other persons. Despite the fact that this law has brought some important changes into the social care provision in the Czech Republic, there are still many gaps and problems especially in the care provision for chronically sick persons with long-term care needs, most of them being older people.

Persons who need integrated care are entitled to an evaluation of their status and also to receive care allowance from the state. They may purchase care either from their family caregivers or from registered social services (these services are registered with the regional authority according to the law on social services ).

The General Practitioner as a primary care physician is authorised to prescribe home nursing care according to the patients' needs, and also drugs. Medical aid including incontinence pads and other so-called induced services (specialist consultations, other auxiliary, laboratory and imaging medical examinations) are also supposed to be prescribed and indicated by GP and these are included in GP's hypothetical budget that is regulated by the insurance company. General Practitioner's care is funded on the per capita basis which means that he/she receives regular payment according to the number of registered patients and their age. GP is also supposed to visit their patients in their homes. In case of special care needs, patients are referred to specialists. In case a hospital care is needed, they are referred to acute care hospitals or long-term care hospitals.

The above description of care applies only to "ideal" situation. As we already mentioned above, there are many practical and systemic obstacles to the care provision. People with long-term care needs might stay in a health care or social care institution or in their home. Persons with long-term care needs are referred to long-term care hospitals within the health care system (then the care is fully covered by the general health care insurance, even if they stay there for several months or even years). Long-term care or so called „aftercare“ departments in the Czech Republic are parts of hospitals or therapeutic institutes (long-term care hospitals or psychiatric hospitals etc.). Despite the fact that they constitute a part of a health care system which is relatively well developed and which has undergone important changes and quality improvement, received major investments etc., in recent years, the positive changes do not apply to many of these departments. Very often they are insufficiently equipped, located in decrepit hospital buildings, sometimes also with significant architectonic barriers. Very often the staff numbers and qualification are lower than necessary and the quality of care is insufficient and these departments are too „hospital-like“ for long stays of persons with disabilities. Typically, people are required to stay in their beds even when it is not necessary and different restraints (bed-rails, permanent catheters etc.) are overused. Family members are not generally satisfied with the level of care, however, it is very comfortable for them to abide as it is completely free (except for the regulation fee 60 CZK- 2 euros per day). This might be one of the reasons why this inefficient and ineffective system has persisted for such a long time even after the change of political system and thorough changes in health and social care legislation.

Persons with very similar health conditions and with long-term care needs can also stay in homes for seniors - retirement homes or so called homes with specific regime (within the social care sector). Homes for seniors are defined as social care institutions that provide care for seniors who need „social care“, whereas homes with specific regime are defined as social care institutions that provide care to persons with „specific needs“, among these needs is also included the Alzheimer's disease. Both retirement homes and homes with specific regime have obligation (according to the law) to assure also the health care provision either by their own staff or by staff of health care institutions. This applies both

to physicians and to nurses. Compared to long-term care hospitals, there is even less staff available in general and also considerably less nursing staff. It is difficult to find general practitioners and specialists for these nursing homes as the care there is expensive and consumes much of their allocated budgets. Due to restrictions set by insurance companies (and sometimes necessary co-payments), difficulties may occur also in drug prescription which is sometimes very limited and does not respond to the needs of these patients (e.g. very low prescription rate of cholinesterase inhibitors, antidepressants and also modern and effective analgesics etc.). In general, we can draw a conclusion that people who live in social institutions are disadvantaged in their health care provision.

Care allowance forms a base for funding care, both at home and in institutions. Persons with limited self-sufficiency and in need of long-term care can apply for care allowance according to the above mentioned law on social services. As a mandatory attachment to their application, a General Practitioner must provide a report on their health status (which usually summarises diagnoses), and a report by social worker. Social worker must visit patient in his/her home, not in a health care institution. Report by social worker includes a check-list monitoring which activities of daily living are impaired. However, social workers do not have sufficient skills in self-sufficiency evaluation. Therefore, they often only fill in the check-list as a questionnaire, asking patient questions about their self-sufficiency. Sometimes the responses are relevant, sometimes not. Especially persons with dementia overestimate their capacity (e.g. 87 years old woman with dementia who lives in a residential home answered that she is capable of managing all activities of daily living and she also takes care of her mother) – this opinion is documented in the check-list of ADLs and IADLs. Based on this, often biased information, the physician of social department (who does not meet the patient in person) decides which care allowance degree will be allocated.

People who stay at home are cared for by their family caregivers or other informal caregivers, alternatively they can purchase registered social services. Older people very often do not know (and they are not properly informed) what is the purpose of the money they receive as their care allowance and they tend to put it aside themselves or for their families without having received necessary services.

Apart from that, another major problem presents the accessibility of services. It is generally known that especially small communities do not have access to sufficient (or any) social services. Authors of the legislation on social services expected that the law would bring about a spontaneous creation of market with social services. However, these expectations were not met, a boom did not happen. Social services remained underdeveloped as people did not purchase services they were offered and these services started to wear off.

Obviously, there are also many other factors necessary for care provision in the home environment - different types of support, education and respite care for family caregivers. These services are extremely rare and not accessible. Despite the fact that most persons with long-term care needs (cca 80%) stay in their home environment and are cared for by their family caregivers, the care situation remains very difficult.



Despite above mentioned obstacles within the system of health and social care provision (especially in the field of long-term care where both components should be coordinated), some examples of integrated care provision already exist. Most of them have been made possible thanks to the local authorities, their interest in this kind of care and their support.

Centre of Gerontology in Prague 8 started its activity 20 years ago in 1992. The project of the Centre was designed in 1991 in close collaboration with the local authority Praha 8 (a major district of Prague with 106 thousands inhabitants). At the beginning of the last decade of the 20th century, it became clear that there is an increasing demand for services for older people. In Prague 8 there was already a developed network of existing health and social services. However, it was clear that some services for older persons were still missing. After consultations with other care providers and local authority representatives, it was decided that the project should cover especially problematic and neglected areas - rehabilitation of older persons after their stay in hospital, and also situations when older persons are not able to stay in their homes because of their deteriorated health conditions but at the same time, their state is not indicated for acute care either. It was decided that „semi-mural“ services (day care unit) and domiciliary services would be also useful components of the whole spectrum of care for older persons in the community. For the last two decades, the Centre of Gerontology has been developing services in close collaboration with the municipal authority in Prague 8. Gradually, different types of services were established: geriatric rehabilitation unit for 32 patients, palliative care unit for persons with dementia for 12 patients, day care unit for persons with dementia (capacity 15 persons), home nursing care (60 clients), geriatric clinic, geriatric team visits and also auxiliary services as meals on wheels, emergency button service for persons who stay at home and home assistance. Collaboration with 3 neighbouring residential homes was established, in the framework of which we provide the service of general practitioner. Above mentioned professional health and social care services are complemented by the services of Czech Alzheimer Society (founded in 1996 in the same premises and working in conjunction with the Centre). The services of the Czech Alzheimer Association include respite service at home, consultations, counselling, providing written information materials etc. Another NGO under the roof of the Centre is GEMA which organises leisure activities for seniors: dance courses (well-established and popular for more than one decade), internet café for seniors, various meetings, trips, teaching activities, petanque, nordic walking, voluntary activities „for seniors and others“ etc. The strategy is based on proactive and preventive measures rather than just easing the symptoms. Older persons are encouraged to be part of activities which promote health and mental well-being, we aim to maintain their participation by building a community of interested individuals. In case of illness, interventions are designed to help the clients regain their self-sufficiency through a short-term stay in the department and case management approach enables them to come back to their home environment with the option of using a variety of our services.

Conclusion: We have shown that the situation in the health and social care provision in the Czech Republic does not yet facilitate an integrated care provision. However, this might change if communities and municipalities acknowledge the importance of it and take appropriate measures to assure integrated services for their citizens. The feasibility of this prospect was clearly demonstrated by the example of the Centre of Gerontology and the local authority of Praha 8. New legislation on long-

term (which is now being prepared by the Ministry of Health and Ministry of Labour and Social Affairs) care will hopefully bring about substantial changes in the long-term care provision and also changes in coordination of services on the community level (multidisciplinary teams, community nurses, comprehensive evaluation etc. are declared to be the main principles of this legislation). In our view, especially municipalities should play a crucial role in these developments, as their participation is indispensable in establishing a functioning system of integrated care (not only for older persons).

# **Integrated Care for Older People**

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President ILC-DR

## **Introduction:**

The population of the Dominican Republic is ageing and although many older people live well for longer with good health, there is a steady increase in the number of people with acute and chronic health conditions and consequent pressures on health and social services.

## **Actual situation in the Dominican Republic**

Right up till ten years ago the health system in our country had four different providers:

- The Ministry of Health and Social Assistance that provided services for poor people. Most older people had to seek health care in the public hospitals because the majority of those in the seventh and eight decades never had a formal employment, therefore had no insurance or money to pay for their health.
- The private sector that provided for those that had insurance and those who could afford to pay.
- The Dominican Institute of Social Security that serviced those private employees with minimum wages.
- And the military that had their own hospitals

After the law that created the Dominican System of Social Security was passed, the whole scheme has been modified but we are still in the process of implementation. It has 3 different regimes and they are:

1. The contributory regime that caters for people with formal employment and once they have the health insurance, their families are also covered
2. The contributory/subsidized regime catering for the independent professionals and small business owners whose income is variable. Here, a percentage of the health cost is paid by the government and the other by the person in question.
3. Finally, we have the subsidized regime catering for poor, indigent and most older people for the reason expressed above.

According to our last census, 7.6% of our population is over 65 which mean that the implementation of the subsidized regime has been rather difficult for the financial burden it represents for the government. So far, less than 1% of the older population has been affiliated to any health insurance provider therefore, they still have to go to public hospitals to seek for health care.

Being that so, we see very often people without proper medical attention whose medical conditions become chronic and complicated making their admission to hospitals more frequent and the demands for permanent care placements in a constant increase with all the inconveniences that those situations represent.

For all those reasons it is very important for us develop a system that can revert that status quo and improve health provision and access as well as diminish costs.

## **Why is it necessary to create a system of integrated health and social care?**

We know that older people often require a range of services from different sources. Integrated care offers a coordinated approach to meet their often complex needs. Old people's services must work together if they are to meet people's needs and aspirations effectively. Many different agencies work

with older people including many non-specialist services, such as transport, education and housing as well as services that provide care. Very often older people receive a disjointed, confused response when they need help or information. Frequently the responses that they receive meet their needs only in part.

Consultation with older people highlights the fact that they would like public services to be more flexible, better coordinated and more focused in helping them to remain independent for as long as possible. This aspirations that are shared by the relatives as well because Dominicans want to keep their old people with them as long as possible, can only be achieved if the full range of services that have a contribution to make work together in order to deliver better outcomes for older people.

A whole system approach that places the older person in the center will benefit older people by providing the right support, at the right time and by addressing the entire range of needs. A whole system approach will also involve older people as partners, both as individuals who express their needs and help to define the results they would like to see and as a group of citizens and users of public services who have a voice in the way that services are shaped and delivered. For those who provide services to older people, a whole system approach encourages better management of the system and clarifies the roles and responsibilities of each agency.

In that order, in the Dominican Republic, there are two pilot projects being carried out by two different geriatric services one located in Santo Domingo and the other in Santiago with the objective of showing the government that coordinating services and providing home visits can diminish hospital admissions and costs as well as providing greater satisfaction to patients and relatives. Those projects involve geriatricians, nurses, social workers and occupational therapists as well as provision the of medicines.

Despite the fact that as today more than 35% of acute hospital beds are occupied by older people and that their stay is more prolonged representing greater costs for the health service, the teams conducting those pilot projects have received very little support from the Ministry of Health.

Much work is needed to make governments understand that this is a win/ win situation and we will have to continue promoting the system for the benefit of the population we advocate.

## Trends and developments on integrated care for frail older people in France

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In France as well as in other countries it is possible to identify 3 categories of elderly :

- Elderly needing long term care (“dependant people”) : 7 to 9%.
- Frail Elderly : 10%
- Healthy independent elderly : 81 to 83%

The structure of care is necessarily different for each population.

Frailty is a complex vulnerability syndrome described by Fried in 2004 as a physiologic state of increased vulnerability to stressors that results from decreased physiological reserves and deregulation of multiple systems.

The Fried description includes underlying modifications : inflammation, endocrine dys-regulations, nutritional modifications leading to a decrease in physiological reserves. The phenotype encompasses various symptoms : anorexia, weight loss, muscle weakness, fatigue, fear of falling, low physical activity, gait instability, slow gait speed.

The risk is the difficulty in maintaining homeostasis when a stressor occurs.

The consequences may be the occurrence of falls, adverse health outcomes, acute conditions, hospitalisations, disability, dependency, placement in institutions and death.

The total prevalence of frailty in people over 65 years is around 10%. From 4% from 65 to 74 years, 11.6% from 75 to 84 years and 25% at 85 years and more.

The structure of care must allow, thanks to systematic geriatric consultations, the prevention or treatment of the various risk factor : sarcopenia, osteopenia/osteoporosis, gait impairment and instability, nutrition problems.

**A free geriatric consultation at 70 years** and or at the age of retirement is experimented in France in the framework of the “Plan Solidarité Grand Age”.

**The structure of care must not only prevent the conversion of frailty to dependency but also allow the frail elderly to get help to keep their daily life autonomy at home or in institutions.**

In 2002 was created an allowance for the elderly needing care called APA (Allocation Personnalisée à l’Autonomie). It is financed by the local councils and a new agency called CNSA (Caisse Nationale de Solidarité pour l’autonomie).

The CNSA is not financed by general taxation but by an extra work day for all employees, a 0.3% tax for the employers and the health system for the medical expenditures.

This allowance is mainly given to dependant elderly but its objective is also to prevent the loss of autonomy of frail elderly.

More than one million dependant people receive this allowance, mainly mildly impaired elderly and 61% of the beneficiaries live at home. A scale called GIR defines the degree of loss of autonomy. Frailty corresponds to the GIR 4 (very mildly impaired). The “GIR 4” frail elderly represent 44% of the beneficiaries and 80% live at home.

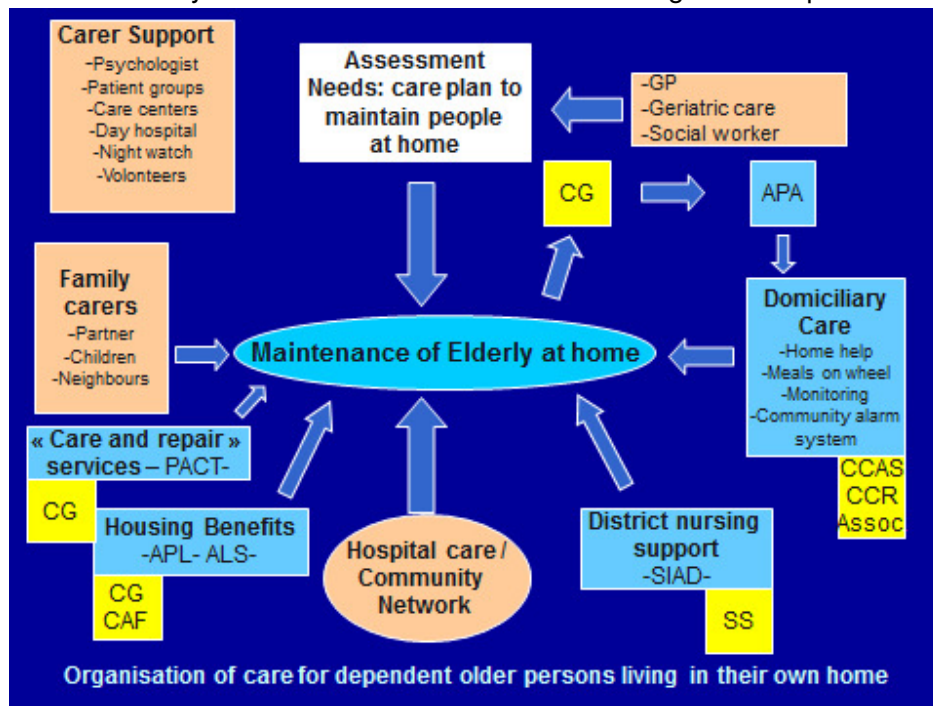
There are many key players for frail older persons living at home :

Family care givers or friends, family practitioners, homes services, meals on wheels alarm system, “clubs” for the elderly, day centres, volunteer associations.

According to the needs of the person, home services may integrate nurses, physiotherapists,

psychologists etc...

The frail elderly is at the centre of a network including all these professionals and structures.



Most frail elderly want to live at home with the aid of their families and/or the home services. A placement in institution becomes necessary when an important loss of autonomy occurs most often linked to acute conditions or worsening of chronic diseases.

There are more than 680.000 places in institutions, including assisted living facilities, nursing homes, long-term care hospitals.

The institution fees are divided in 3 parts : the dependency costs taken in charge by the APA, the medical costs paid by the health system, the food and accommodation costs(1500 to 4000 € per month) ensured by the person and/or his/her family .

This last part poses difficult problems to patients and family because this amount is higher than the average retirement pension in France (1200€ per month). A law is in preparation to address this issue.

There have been several governmental plans since 2001:

1. Plan « **Vieillesse et solidarités** » 2003-2006
2. Plan « **Solidarité-Grand Age** », voted in 2006, confirmed in 2007 until 2012 : the annual number of new institution beds progressively increases in order to maintain the objective of 467 places/1000 inhabitants of 85 +.
3. Three « **Alzheimer** » plans : in 2001, 2004 and 2008, the last one covers the period until 2012.
4. Law « Handicap » 11/02/2005 : a tool for a decentralized management at the departement level - (**Priac**) : « *programmes interdépartementaux d'accompagnement des handicaps et de la perte d'autonomie* »

All these plans were important tools to improve the integrated care for the elderly in France. They allowed an important development of geriatrics, and in particular of academic geriatrics. The number of professors of geriatrics was doubled.

**The issue of frailty is different if the definition includes cognitive impairment.** Indeed, the Rockwood criteria add incontinence and cognitive impairment to the phenotype.

The most important problem would therefore be the number of Alzheimer's victims which increases with the aging of the population. They are 20 million in the world, 4.6 million new cases per year, one case every 7 seconds. In France, 850 000 persons are victims of Alzheimer's diseases or apparented disorders, 225 000 new cases each year, 50% are not diagnosed, 17% are treated. These diseases are responsible for 70% of the institutionalisations and 72% of APA requirements.

The governmental Alzheimer plans are necessarily of the utmost importance, particularly to help the care givers. Indeed, a majority of care-givers are women, spouse, daughter, grand-daughter (58%); 72% are the partner, mean age of 71, retired in 2/3 of cases; 20% are a child : 81% a daughter (of which 70% are living with, mean age of 52). The objective of the 3<sup>rd</sup> Alzheimer plan 2008-2012 were: 1- Improve quality of life for patients and caregivers, 2- Advance research efforts and knowledge, 3-Increase social awareness of AD. It has demonstrated its efficacy and has taken an important place in the integrated care of the elderly. The issue of frailty may include cognitive impairment but does not include dementia. Nevertheless, the notion of integrated care must comprise a continuum of care to take into account the possible worsening of the "frail" elderly conditions.

**One of the major objectives of the care for the frail elderly is to prevent the conversion of frailty to an advanced stage of loss of autonomy.** The structure of care must face this challenge with two key objectives: the promotion of health as a state of physical, social and mental well-being and the promotion of activity. The health and care system must first promote healthy life style :

- Education throughout life and health literacy
- Healthy nutrition
- Moderate and prolonged physical activity
- Intellectual activity and social interactions
- Prolonged professional activity and leisure activity
- Personal commitment and responsibility

The key players for prevention as a lifelong perspective are: GPs and paediatricians, Hospitals clinics, Schools, Universities, Mass media and the Work places.

Ilc- France is convinced that the companies, the administrations, the working sector are the best place to promote prevention because most people are too tired or busy with children to be interested in prevention after a work day. The "Healthy company" project aims at demonstrating the efficacy of a prevention programme promoted by a company at the workplace.

**The second objective of the challenge of longevity is to promote activity.** A number of studies have demonstrated that, the level of education, the intellectual and physical activity, the social engagement and the prolonged professional activity could postpone the occurrence of the Alzheimer' symptoms.

**Integrated care, promotion of health and activity are the best tools to, not only prevent the conversion of frailty to dependency but also reverse the frailty syndrome to the normal healthy status accessible to most elderly.**



## **Trends & Developments on Integrated Care for Frail Older People in India.**

### **The Importance of being a senior citizen in India:**

While approximately 70 to 75 percent of the elderly population lives in developing countries, a considerable portion of it lives in India at any given time. India being the second most populated country in the world, it has experienced probably the most dramatic & rapid demographic changes in known history of about 5000 years. Owing to a noteworthy increase in the average life span in the last one hundred years; { from about 45 years in 1900 AD to about 64 years in 2000 AD}; India as on today, has the second largest population of elderly people in the world. {More than about 81million older people}

According to recent statistics related to elderly people in India, (according to census 2001), it was observed that as many as 75% of elderly persons were living in rural areas. About 48.2% of elderly persons were women, out of whom 55% were widows. A total of 73% of elderly persons were illiterate and dependent on physical labor. One-third was reported to be living below the poverty line. 66% of older persons were in a vulnerable situation without adequate food, clothing, or shelter. About 90% of the elderly were from the unorganized sector, i.e., they have no regular source of income. India is one of the few countries in the world in which the sex ratio of the aged favors males. This could be attributed to various reasons such as under-reporting of females, especially widows and higher female mortality in different age groups.

### **Defining Ageing in the Indian Perspective:**

In ancient India, life span of one hundred years was divided into four stages:

1. 'Bramhacharya' ashram (life of a student) – This phase was to be spent at the teacher's (guru) house. This is the life of a celibate, to be spent

in education and training. Once education was complete, the boy (grown into adulthood by now) would be ready to enter the second phase

2. 'Grihasta' ashram (the life of a householder) – This second phase was meant for man( & of course for a woman) to get married, have children, shoulder various responsibilities of an average citizen in the society. He/ she was to discharge the debts he owed to the parents (pitru rina) by begetting sons and to the gods (deva rina) by performing Yajnas (rituals). This was the phase when a man(or woman) would fulfill his / her basic desires, for love, marriage, for parenthood, for status, for wealth, for prestige and other such physical and social needs. When the head turned grey and wrinkles appeared, he / she was to give up this life of householder and turn to the third phase.

3. 'Vanaprastha'ashram – This third phase means 'moving to the forest'. A mature and ageing person would gradually give up his / her worldly pursuits, move away from the routine of householder/ housewife and would set out in search of spiritual growth. Finally, when he / she was spiritually ready, he / she would renounce the world completely and enter the fourth phase.

4. 'Sanyasa'ashrama – This phase, which can be considered 'unique' to the then Indian subcontinent, may be understood as 'asceticism' or thorough sacrifice.



### **The term ‘Integrated Care’ in the Indian perspective:**

The traditional division between health and social care as observed in many parts of the globe is not necessarily followed in India. The ‘Indian’ culture enables a flexible health and social care provision that may be personalized as & when needed.

‘Integrated care’ concepts used to be notable components of health and socio-cultural policies across the then Indian subcontinent. For example; the present (western) concept of integrated care may be related to the then Indian practices as shown below.

<b>Component of integrated care according to present western terminology</b>	<b>How it used to be implemented in the then Indian subcontinent</b>	<b>Remark (if any)</b>
Inputs	By the way of listening to their views in cases of disasters & / emergencies	Quotations suggest that the elderly were to be consulted before important decisions
Delivery	By the way of various offerings to the elderly	In almost all Indian celebrations, something is traditionally offered to the elderly.
Management	By prefixing a role for elderly in some of the rituals	In many religious, & / family functions, the elderly were expected to say ‘good words’ in return to the prayers done by the younger ones.
Organization	An unofficial consortium of elderly used to give advice to the rulers @local level	

It may be easily inferred that within the Indian contexts, integrated care pathways referred above (in first column) have long been advocated as a means of respecting the elderly & involving them in many socio-cultural happenings.

Integrated care in ancient India was a blend of cure & care.

Medical Treatment aimed at the cure part while behavioral patterns & respectful approach constituted the care part of it.

Just to mention briefly, the following are the salient features of the ancient Indian culture which directly / indirectly influence the concept of ‘Integrated Care’

- a) Blend of spirituality & religion

- b) Respectful inclusion of elderly in social gatherings
- c) Strong ethical values influencing general decision-making about elderly
- d) Joint & / extended families

### **Types of care offered to the elderly in India –**

**Emotional:** Generally, the elderly people stay within joint or extended families which ensures less loneliness resulting into better emotional support.

**Physical:** Ayurveda, the traditional Indian Medicine is practiced @ different levels to give comfort from some of the expected physical ailments. For example, oil massage after regular intervals, putting drops of medicated oil into nose ...etc.

**Financial:** 1) Everyone who is 60+ & has retired from a government job receives a monthly pension (except in the province Arunachal Pradesh) sufficient to provide for his / her basic needs.

2) Concession is made available to all the elderly for travelling by government owned vehicles.

3) Higher interest rate is offered by the Banks for elderly depositors.

4) Rebate on the income tax paid by senior citizens (introduced in 1992)

**Social:** 'Maintenance & Welfare of Parents & Senior Citizens' act has been passed

### **Strategies to Improve the Role of the Geriatric Health Care System**

At present, most of the geriatric outpatient department services are available only at tertiary care hospitals. Most of the government facilities such as day care centers, old age residential homes, and counseling and recreational facilities are available in urban & / semi-urban areas only. Since 75% of the elderly reside in rural areas, it is mandatory that geriatric health care services be made a part of the primary health care services. This calls for specialized training of Medical Officers in geriatric medicine. Among the secondary level health facilities, which mainly include the district hospitals, sub-district, and medium sized private hospitals, mostly under the public sector, it is seen that India has about 12,000 hospitals with 7 lakh beds with facilities for the elderly people. The need of the hour is to set up geriatric wards that would fulfill the specific needs of the geriatric population. At the tertiary care level a multi-disciplinary team, specifically trained to meet the needs of the geriatric population needs to be created. This team would comprise a physician, psychiatrist, orthopaedician, diabetologist, gynaecologist, cardiologist, urologist, eye surgeon, psychologist, physiotherapist, dietician, dentist, and nurses trained in geriatric medicine.

Capacity building of the community leaders is essential for the success of community-based geriatric and rehabilitative health services. Community leaders can play an important role in identifying the felt needs of the elderly and also in resource generation.

### **Existing Programmes**

The Constitution of India encourages the State to shield older people from potential risks & exploitation. An Old Age Pension (OAP) scheme has been introduced to meet the needs of people who have no means to support themselves. But OAP is at a low priority in many states and the amount given sometimes can be as low as Rs 50 per month (roughly US\$1.25). The Ministry of Social Welfare makes financial assistance available to voluntary agencies to run day care centers for the elderly. Often called 'activity centre', 'hobby club' or 'golden age centers', these centers are

managed by voluntary agencies. In 1993, there were 73 such centers in seven states supported by the Ministry of Social Welfare (now known as the Ministry of Social Justice & Empowerment).

There is a need for these centers to expand both quantitatively and qualitatively in order for their impact to be felt. Even in urban areas many older people do not have any idea of the relevance of such centers.

The Constitution of India contains some provisions for the welfare of older people.

The Law also helps retired citizens in evicting tenants who occupy their houses and refuse to vacate them. Voluntary organizations are given grant-in-aid to start old age homes, day care centers & mobile medical units.

In 1995, National Social Assistance programme was launched that costs over Rs 4,000 million.

Government's financial assistance is also available for the destitute.

Geriatric medicine has not yet developed strong roots within Indian medical

Schools. ILC India has designed courses to mainstream 'Ageing'. ILC India aims at running these courses at various levels in collaboration with different educational institutes.

### **Concluding note:**

The problem of the elderly in India was not serious in the past because the numbers were small and the elderly were provided with social protection by the family network. But owing to relatively recent socio-economic changes, ageing of the population is emerging as a problem that requires consideration before it becomes critical. Indian culture has inherently several elder friendly values and practices which need to be reinforced. Importing a western model of care for elderly people is likely to be costly in a country that can ill afford such initiatives. Working in close collaboration with international agencies is one way of learning from models that have been used in other countries and adapting those best suited to the socio-cultural environment of India.

ILC India would like to appeal for any such collaborative work in future where ILC India will provide technical expertise for dealing with ageing ( with the help of Yoga & Ayurveda, the two world renowned Indian sciences for grooming body & mind respectively)

Presented by : International Longevity Centre – India

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## **State of Israel**

### **The Ministry of Social Affairs and Social Services' Treatment of the Elderly**

#### **1. Target Population:**

There are about 700,000 elderly people living in Israel today, which is about 10% of the country's population. The elderly population continues to increase in Israel each year. 10% out of that population are not Jewish and 25% are immigrants who arrived in Israel in the 1990s.

#### **The Main characteristics of this Population:**

About 20% are limited in their function, about 25% live alone without a family, 26% live off a social security stipend+ income supplement, and about 20% live below the poverty line.

#### **The population most in need of social services is the population of frailty, lonely and disadvantaged elderly people.**

**Today, 250,000 elderly people are being treated by the social services,** as they constitute over a third of the country's elderly.

#### **2. Our Ministry's Principals for Caring for the Elderly**

A. **Helping the elderly person remain in their home and their community-** For that purpose, we are developing a network of community services, which provides widespread solutions for elderly people who do not wish to move to a retirement home but require the care.

B. **The family is the main supporter for the elderly-** Social services aids the families who care for elderly relatives, and focuses mainly on caring for elderly people who have no families. Families, whose elderly parents enter retirement homes, must participate in the expenses of their lodging, to the best of their abilities and according to the alimony law.

C. **Maintaining the elderly person's dignity, privacy and their right to choose-** Adapting the services package for elderly people who wish to continue living in their homes as well as for those who wish to move into a home, through consulting with the elderly person himself and in accordance with his choice.

D. **Empowering the elderly and incorporating them in the policy design-** There are about 150 local non-profit organizations for the elderly, operating in Israel today with the goal of developing local services for the elderly.

Furthermore, the Service for the Elderly operates two "Round Tables" within the community and the institutional field. Representatives of both private and public organizations participate at each table, as well as organizations for the elderly. The tables are meant for raising and discussing such issues as: bill propositions, regulations, service development and more.

E. **Raising the treatment quality within the community framework and the retirement homes-** This is done by appropriate legislation, by raising the bar of required services, by inspecting and monitoring the provided services, and by training the appropriate employees to care for elderly people within the various frameworks.

F. **Subsidizing Services-** For disadvantaged elderly people, according to income inspections.

### **3. The Services Available for the Elderly**

#### **A. Direct Treatment**

A1. **Individual and Group Treatment** which includes: consultation and mediation to services. The treatment is done by social workers at the local authorities, who specialize in treating the elderly, and under the professional supervision of the “Service for the Elderly” superintendents.

A2. The treatment also includes **treatment of elderly people who suffer from neglect, abuse and financial exploitation**. It is done by almoners who were trained for this job, and within the framework of the elderly protection laws.

A3. **The Nursing Insurance Law-** allows elderly people, who are dependent, on others on a daily basis, the option to choose in-house treatment, emergency buttons, and treatment at daily centers. The treatment is given at the extent to 22 hours per week.

A4. **Personal treatment and management of the elderly person’s home-** This is done through the elderly service budgets, for elderly people who are in need of this treatment and are not entitled to it according to the nursing insurance law.

A5. **Completing home equipment and basic furniture-** It is provided by the service budgets for the elderly who are in need of it according to the attending social worker’s examination.

A6. **Driving services for life saving medical treatment, dental treatment, glasses and hearing aid fittings-** Provided for disadvantaged elderly people and for those in need.

#### **B. Community Services**

Community Services include:

B1. **Social Clubs** that provide social and cultural activities. They are meant for elderly people who are still able to properly function, for the purpose of diminishing their sense of loneliness.

B2. **Employment Clubs for a Fee-** There the elderly are being paid for the work that they do, in addition to enjoying the company of others and having a group to belong to.

B3. **Social Clubs with Additional Services-** These are social clubs, enriched with vast social activity, which also provide rides to the clubs and a light meal.

B4. **Daily care Centers**, providing: meals, rides, individual treatment and social activity. These clubs are meant for elderly people whose level of function has diminished and therefore require care.

B5. **Respite care for the Elderly-** That are meant for providing short-term treatment for elderly people who are frailty and mentally unwell, and who are released from the hospital but are in need of nursing and have no one to care for them during the transfer. These retreats also serve as an aid for the families who are caring for elderly relatives.

B6. **Supportive Communities**, proving the elderly with emergency buttons for their homes at all hours of the day, all year long: to be used for calling a doctor or an ambulance whenever they need to. The communities also provide social activity, and are aimed at elderly people who continue living in their own homes.

#### **C. Protection Accommodations**

C1. **A law of protected accommodation** is currently in process. Such a law will allow monitoring of the homes where elderly people live in individual accommodation units, and receive only part of the

services offered as part of the retirement home (usually including: guarding, first aid, social activity, maintenance and cleaning).

C2. **Public Housing** for homeless and disadvantaged elderly people, and particularly- new immigrants. Such public housing will include basic supporting services.

**D. Old Aged Homes**

D1. About 180 homes for elderly people, who are independent but who suffer from diminished functioning, **are currently operating under the supervision of the ministry**. The task of supervision is fulfilled by social workers and nurses. It is done according to the standards method and is implemented on all elements of daily life according to the law of monitoring the lodgings, and its regulations. Only a lodging institution that has successfully passed the supervision can receive operating license according to the law.

D2. The ministry works towards **shutting down lodgings** that do not measure up according to the standards determined by law in cooperation with the Ministry of Health.

D3. **Referring the elderly to homes**- About a third of the elderly people living in ministry supervised home are referred by the welfare services, and are enjoying funding from the ministry and the local authorities; all according to the income examinations of the elderly and their family members.

E. **Holocaust Survivors**- about 220,000 holocaust survivors are living in Israel today. IN the past two years the ministry has been preparing to provide particular care for this population, which includes: center for general information and information about taking full advantage of their rights; particular therapeutic social activity; increasing income and providing discounts for necessary services.

Prepared by: Miriam Bar-Giora. Director, Service for the Elderly.

The treatment of elderly is done by the Ministry of Social Affairs.



## **"Integrated care" - the case of Japan**

### **Issues in medical care and welfare –before 1990's and in 1990's**

Since its enactment in April 2000, Long-Term Care Insurance (LTCI) system of Japan has oriented itself to the achievement of the "integrated care".

As is the same with other countries, prior to the 1990s, elderly care services were provided under either "welfare system for the elderly" as one of the social welfare system, or health care system (health insurance system in the case of Japan). The "welfare system for the elderly" under social welfare system, the services were scarce, the process to use the services was cumbersome, and there existed a stigma to use. On the contrary, people rushed to the medical services under universally-covered health insurance, because the health insurance system employs the system of "free access (people can use any medical institution by showing their health insurance policy card)", and there was no stigma to use. However, there existed inefficiency that the per-person-per-night cost of hospital beds was higher than that of nursing home beds, lower-quality-of-care as the elderly were treated as "inpatients" rather than "residents", and lower-quality of living environment. Such condition was criticized as "social hospitalization". On the other hand, the elderly who were "bedridden" at home without proper rehabilitation and care was another concern. Moreover, increase of the senile elderly was also recognized; it was evident that Japan needed a system to provide health care and welfare in an integrated manner.

To correct such situation, the establishment of a new long-term care system was considered in the 1990s. Discussion had been made within the government initially, then the governing Political Parties took the lead for discussion. Throughout the course of discussion, to establish the consensus to the new system, the Government and the Parties exchanged opinions closely with interested groups, such as elderly groups who were "the central players", women's groups who were the domestic caretakers, employers' association, labor unions, and the Japan Medical Association, among others. In parallel, under the governmental "Gold-Plan" to promote the health and welfare services for the elderly, long-term care facilities and services were rapidly established throughout the country. In Japan, "consumption tax" of 3% (broad-based indirect tax) was introduced in April, 1989, and the rate was raised to 5% in April, 1997. Establishing elderly care infrastructure was used as a cause for such tax burden. "Hybrid" services between medical care and welfare services in its nature such as "Intermediate Care Facilities for the Elderly" to provide rehabilitation and "Visiting Nurse Stations" to provide nursing services at home (both of those have been financed by health insurance system) were also promoted under the "Gold-Plan".

### **Enforcement of LTCI – 2000**

Under the LTCI system (started in April, 2000), elderly welfare services and those "hybrid" services provided under health insurance were consolidated under a single system by cities and towns, which is financed 50/50 by social insurance premiums and tax-funded subsidies. Upon the use of the services, "certification of long-term care need" is conducted to individual applicants; the maximum amount of



insured services is fixed according to the certified "care need level". The "care need level" is determined by cities and towns based upon physician's opinion and the examination of ADL by the "care manager" so as to take into account both the medical aspect and mental and physical status.

In addition, it was standardized that the user of services go through the care management by the "care managers" in principle. To become a "care manager" one has to have an experience to work in the field of public health, medical care or social welfare, pass the examination to receive the "practical course" for long-term care, and complete the "practical course". At the "practical course", basic knowledge and techniques applied to elderly care are taught at any class, regardless of the former occupational experience of the individuals. Such curriculum reflects the notion that the usage of services under the LTCI should be based on the perspective of the professional "care manager", who assesses and evaluates the various medical and welfare needs of the elderly.

### **Introduction of Comprehensive Community Center –2006**

By the sharp increase in the use of services by the elderly with lower "care need level" within a few years after the introduction of LTCI, the continuity of the system came to be questioned. Besides, it was obvious that in near future the "first baby-boomers" who were born after the WWII, raised in relatively affluent society and whose value of family or lifestyle differ from the elderly imagined at the discussion in 1990s, would become "the elderly. Moreover, as the LTCI system was widely recognized and many people have come to pay insurance premium to the certain amount in a number of years, people's expectation to the quality of service would be heightened. To meet those challenges, the LTCI law was reformed, including the reform of the services for lower "care need" elderly to be more emphasized on preventive services. The reform bill was enacted in April, 2006. In addition to the reform of the services to the lower "care need" elderly, small-sized, neighborhood-type services for the demented elderly and elderly living alone were introduced. Furthermore, "Comprehensive Community Centers", which assume the role of counseling and advocacy for the elderly, "care management" for the elderly with lower "care need", and support services for "care managers" in the community were established in all municipalities. It is evaluated that this reform has made it clear and strengthened that the "prevention" and "life support" are included in the scope of LTCI.

It is noted that the aforementioned support services for the "care managers" by the Comprehensive Community Center include the networking with regional medical institutions, LTCI services, local government offices, and volunteers and regional civic groups. Also, inclusion of not only statutory services by service corporations but various informal activities offered by volunteers and civic groups has been expected for the "care plan" of the elderly with less care need. To collaborate with independent activities of the citizens, both administration and "care managers" need flexibility as well as the viewpoint not of a service provider but of an ordinary citizen living in a town or village. In this way the integrated view among the concerned bodies has been nurtured at the forefront.

### **Progress of the integration of care –2011**

In June 2011, second amendment bill of the LTCI system has passed the Diet. It is evaluated as another progress in terms of pursuing integrated care, although most of the measures on the financial side was postponed. For example, a new "24-Hour Periodical Round plus On Demand Service" at

home was introduced. This is a service type with periodical checks and on-call visit by home helpers through all day, which has not been provided formerly. Under new service type, with the continuous assessment of physical and mental condition of the elderly, service will be provided in a consecutive manner, and the nurses will accompany the home helpers and provide care together when necessary; integration of care by nurses and (non-nurse) helpers is the significant character of the new service.

At the same time, another Bill to facilitate the supply of elderly apartments with services has passed. By the Bill, various incentives such as subsidy, loan, tax break are provided to the developers of the elderly apartments when the apartments meet certain quality standards about the size of the room, assistance provided, etc.. This Bill is aimed for increasing alternatives to the elderly, especially single or husband-and-wife-only elderly, to continue to live in their community. It can be evaluated that the bill would enable the rich and peaceful retirement life in near future when the "first baby boomers" will become the majority of the elderly by utilizing the market mechanism in the real estate market with public long-term care services as the basis.

The realization of "Comprehensive Community Care" has been raised as the purpose of the reform (see Figure). This concept of "Comprehensive Community Care" includes "LTC (long-term care) ", "medical (health) care", "prevention", "life support", and "housing", and could be evaluated as the evolution of the "integrated care" in Japanese way.

The progress of the notion of "integrated care" is also seen in the field of medical care, in addition to the long-term care as described. In Japan, although the insurer is fragmented, the fee schedule is universally fixed, therefore people could use a certain level of services anywhere around the country. Under the Japanese health care system where the private (non-public) hospitals and clinics play a vital role, by preparing various policy incentives upon the designing of the fee schedule (reform), the governments leads those private health service providers to shift their practice to the desirable ones. What was significant in recent fee schedule reform was the introduction of "In-home treatment support clinics system" in 2006 (now extended to hospitals). The system is to pay more favorable reimbursement to the in home treatment by the clinic if the clinic situates certain conditions such as the method of communication in case of emergency, 24-hours availability for visiting, as well as the cooperation with Visiting Nurse Station(s). The "in-home treatment support clinics" have been proliferated nationwide, with regional gap to some degree. Together with the LTCI system, those clinics support the daily life at home of the elderly with high "care need" such as in severe chronic condition after the stroke or with terminal-stage cancer. Moreover, the proliferation of integrated system of the medical services by "support clinics" and visiting nurse stations, and the life-support services by LTCI service providers will enable the "terminal care at home" that many people wish to receive(\*). In Japan where the annual number of deaths is expected to exceed 1.5 million due to the aged population soon, such integrated system - a social infrastructure that supports the dignity of people - should be made available nationwide .

(\*) According to a survey in 2007 by Cabinet Office, 56.7% of 75 years and older surveyed choose “own home” as “the place that you like to be at your final moment”. However, a 2008 statistics shows that 82.4% of 70 years and older dies at the hospital.

### **Great East Japan Earthquake and “Integrated Care”**

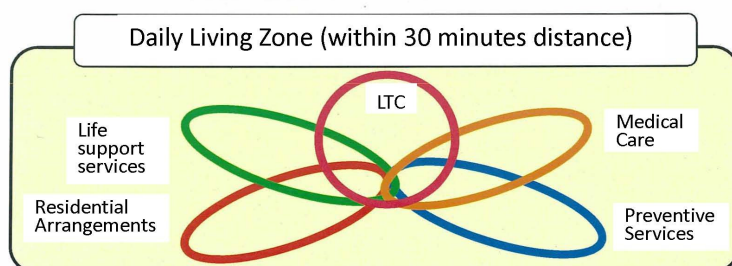
About half year has passed since the Great East Japan Earthquake on 11<sup>th</sup> of March, 2011. Refugees, many of them are elderly, are living in provisional houses in very inconvenient way. To support the life of those victims of the disaster who are in deprivation and distress, the Government is settling the “Support Station” in the neighborhood of those provisionary houses. There, various services - consultation about the life in general by the professionals, LTCI services such as “Day Care”, distribution of meals, “salon” for socializing, and specialized consultation about mental health problems, among others – are provided comprehensively according to the needs within the community. It is expected that the activities by the “Support Stations” would realize the effectiveness of “integrated care” in a progressive yet concrete manner, since the provisional houses communities could be regarded as the epitomes of the aged Japanese communities nationwide in near future.

### **Toward the realization of Integrated Care nationwide - 2025**

Government wishes to proliferate the “Comprehensive Community Care” to every “daily living zones” - equivalent to a junior-high school district that is about half an hour walking-distance range for adults in urban settings - by 2025. Currently, it is only in its infancy. We can find, however, many local governments that actively engage in preventive services and networking of community resources, and have proven effective in reducing the rate of certification for LTCI services. Also, various medical corporations or social welfare corporations now provide integrated medical and welfare services by utilizing its own service network in a comprehensive manner within a community. It is expected that these model will spread nationwide.

Without financial resources, the system will not become sustainable, no matter how the model is perfect. Regrettably in 2011 reform the debate on financial sustainability was postponed. We believe that the biggest challenge to realize “Comprehensive Community Care” - the Japanese way of “Integrated Care” - is whether not only the government and the Political Parties in power but any citizens including the elderly themselves could face the realities of financial condition of LTCI faithfully, and secure the necessary funding for that.

## “Comprehensive Community Care System”



### Five viewpoints that realizes “Comprehensive Community Care”

It is necessary for the realization of “Comprehensive Community Care” to enforce the necessary measures with five viewpoints below in a comprehensive (appropriate mixture of services from 1. to 5. to meet the needs of the users) and continuous (seamless provision of services throughout hospitalization, discharge and return to home) manner.

1. **Strengthened cooperation with medical care services**
  - Enrichment of 24-hour home medicine, visiting nurse and rehabilitation.
  - Allowing several medical practices (such as sputum vacuuming) to care workers
2. **Enriched and strengthened long-term care services**
  - Enhanced promotion of long-term care infrastructure (such as Special Nursing Homes) (FY 2009 Supplementary Budget: 160 thousands beds for 3 years)
  - Strengthening in-home services such as the establishment of “Periodical Round plus On Demand Service”
3. **Promotion of preventive services**
  - Promotion of preventive services so as not to become in need of care, as well as care services that enhance the independence of the elderly
4. **Securing various life-support services (guardianship, meal delivery, shopping, etc.) and rights advocacy**
  - Promoting various life-support services (life support such as guardianship or meal delivery, rights advocacy services such as property management) that accommodate the increase of elderly living alone or with spouse only or demented elderly
5. **Enhancing the provision of residents for continuous living of the elderly (Collaboration with the Ministry of Land and Transport)**
  - Amending the Elderly Residence Law to include the for-profit nursing homes etc. that meet the standard for proper regulation

## **Integration of care for frail older people**

### **Contribution of ILC South Africa to discourse in the ILC Global Alliance Conference, Leiden, September 29, 2011**

ILC South Africa is unable to contribute substantively to discourse in the ILC Global Alliance symposium on "Integrated care for frail older people" as such. Formal health and social care services for older people in the country, let alone care for frail older people, let alone integrated care, are themselves seriously wanting. No policies or programmes on frail care exist, apart from single guidelines, regulations, standards and norms for public sector facilities. Frail care in the South African context typically denotes custodial type care provided in a frail care wing of a residential care facility – or in the case of social pensioners, in a state subsidised old age home accessible only to individuals in need of "24-hour nursing care." No policy effort has been made to otherwise plan or integrate care services for frail older people. Nonetheless, an explication of the care situation in our country may offer a counter position to the situation in more developed countries, which may be peripherally instructive.

### **Dual economies and healthcare systems**

Although classified as an upper middle income country, the majority of South Africa's population survives within a third world economy – and is dependent on public services. The country has one of the highest Gini coefficients (a measure of inequality in the national distribution of income) in the world, and a clear distinction may be made between "haves" and "have-nots." Accordingly, two healthcare systems are operated: The minority population with economic means is likely to have health insurance cover (16 % of the total population) and to access private healthcare – the quality of which is comparable with the best in the world. The very large poor population on the other hand largely depends on social grants and other entitlements, has no health insurance (84 %) and has little alternative than to access healthcare in the public sector. Healthcare in this sector is delivered on three levels: primary (92 % of clients are served at this level), secondary (6 % of clients) and tertiary (only 2 %); referral from primary care level, through secondary to tertiary levels is far from seamless. The majority of South Africa's older people are poor and receive a social old age grant which conjointly entitles them to free public healthcare. When frail and without family to care for them, they may be eligible, if assessed to be in need of 24-hour nursing care, for admission to a state subsidised residential care facility. However, the standards and quality of care provided in these facilities are invariably problematic.

### **Care for frail older people in the private sector**

Frail older people able to pay for private healthcare (or who have health insurance cover) are largely dependent on their general practitioner (GP). Ageism in the medical fraternity often translates into GPs not referring older patients for specialist investigation or other therapeutic services, if indicated – stemming from an attitude that little can be done for them as they are "old." When in need of 24-hour

care, some of these individuals may relocate to a frail care wing of a private residential care facility, but where they remain reliant on their private GP for clinical care. Others may remain living at home and, funds permitting, source private home care and home nursing services arranged by their family. Only within these parameters may care services for frail older persons who are not eligible for care in the public sector be seen to be “integrated.”

### **Care for frail older people in the public sector**

Frail older people who are beneficiaries of a social pension are likely to remain living in a multigenerational household and to be cared for, variably, by family members, as available. (Often, a family benefits from shared pension income this way.) The relatively small number of state subsidised “old age homes” (mainly located in urban areas), are largely operated by non-governmental (NGO) or faith based (FBO) organisations, partially subsidised by the state. However, few older persons relocate to these facilities, as the facilities may be distant from where family resides and a cultural expectation that elders will be cared for by family at home remains strong. The majority of the residents of these old age homes are indeed bereft of family. When residents need medical treatment, they will be transported to a public clinic or hospital, in a wheelchair or on a stretcher, to consult a doctor, but which typically involves a waiting time of several hours. Previously, district surgeons visited old age homes monthly to monitor residents’ health, but this service was withdrawn by the ANC government in 1994 in favour of augmented services for children.

### **Other barriers to integrated care for frail older people**

Several other barriers militate against frail older persons’ access to care services and integrated care:

1) The national government’s Guidelines for Frail Care, and Regulations on the National Norms and Standards for Acceptable Levels of Services for Older Persons, in line with the Older Persons Act, are mainly aimed at ensuring the “protection” or safety of older people in facilities funded or subsidised by the state. Underscoring the regulations are preventive and punitive measures for elder abuse in the facilities. In practice, the legislation and regulations, which provide for regular monitoring of standards of care and safety – and hence imply compliance and accountability, are largely lost in interpretation. In 2011, fires at two large old age homes in Gauteng Province claimed the lives of a total of 32 frail residents and injured dozens more. Investigations confirmed that safety measures at the homes had not been inspected and were neither applied.

2) Schisms between the ministries of Health and Social Development result in fragmentation of health and care services for older people. While the latter ministry is responsible for the subsidisation of old age homes – and other social care services, nursing care within the homes is the responsibility of the health ministry. Yet the health ministry does not remunerate nursing staff, which is the internal responsibility of the facility. Through inability to pay competitive salaries, the facilities have great difficulty attracting suitable nursing staff. 3) The government has made it clear that family is the preferred care provider to older persons in need of care, yet it funds no home care programmes nor provides any support to family caregivers. 4) Old age homes are not suitably equipped to care for

residents with dementia (an estimated 88 % of resident populations); they have neither a separate section for demented residents nor appropriately trained staff. 5) State subsidies of the homes are declining and many homes are privatising, translating into ability to pay as a criterion for admission. An imbalance in a need for and availability of such care is increasing. 6) The country lacks a policy dialogue on (integrated) frail care; the government prioritises the needs of the young and deprioritises those of the old (and very old).

## **Conclusions**

Health and social care services for older people in South Africa in the private and public sectors lack co-ordination, and standards of care in public care facilities need improvement. No policy environment exists within which to foster the integration of frail care; the government largely views frail care as the responsibility of family. Resources and the capacity of service providers to care for frail older people are limited. Non-compliance of care institutions with national norms and standards for acceptable levels of service is a key concern. Increased longevity along with other demographic trends such as youth migration and AIDS associated mortality are rapidly leading to a growing number of older people in need of care but lacking family to care for them. Increased state subsidies, expanded training of care workers, and regular, effective monitoring of facilities and residents – to meet and adhere to established norms and regulations, as well as policy dialogue and action on integrated frail care among policy makers and practitioners are indicated.

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12 September 2011



## **Integrated care for frail older people in the UK**

### ***Demography.***

The world's population is ageing. By 2050, the number of people aged 60 and over will reach 2 billion; comprising 22% of the world's population. By 2030, 55 countries are expected to see their populations over 65 comprise at least 20 percent of their total.

In the UK the fastest population increase has been in the number of those aged 85 and over, the “oldest old” who have more than doubled in number between 1985 and 2010 to reach 1.4 million. Projections indicate that by 2035 there will be more than 3.6 million people aged 85 and over in the UK alone; accounting for 5 per cent of the total population. (ONS, 2011)

### ***Frailty***

It is anticipated that the number of frail older people living in the world will continue to increase in line with the ageing population. Frailty can cause an older person to lose their ability to function independently, experiencing a general feeling of exhaustion with low levels of physical activity. It is often associated with weight loss and or cognitive impairment, depression and or dementia as well as with multiple co-morbidities. (Fried et al, 2001). Older people with this condition have an increased likelihood of falling over, admission to a care home or hospital and mortality.

### ***What is needed to look after frail older people?***

Coordinated, integrated, skilled, educated and compassionate, empathic and cost effective workforces are required to support these people. The workforce must have knowledge about what is effective in enabling older people to remain in control and to maintain their autonomy and independence. Complementary to these principles will be the recognition that models of care must be found to halt the increasing numbers of emergency admissions to hospital and to care homes.

Grone & Garcia-Barbero (2001) stated that “Integrated care has become an integral part of health policy reform across Europe. Every organizational activity – from the making of pots to placing man on the moon – gives rise to two fundamental and opposing requirements: the division of labour into various tasks to be performed, and the coordination of these tasks to accomplish the activity. The structure of an organization [or a system] can be defined simply as the sum total of the ways in which it divides labour into distinct tasks and then achieves coordination among them.”

Countries should have comprehensive primary health care services, ensuring continuity of care through efficient and cost-effective systems of referral to, and feedback from, secondary and tertiary hospital services.

### ***The current barriers to the delivery of seamless care.***

It is not easy for an individual with this condition; both Dementia and frailty are increasingly recognised as terminal conditions (Mitchell, 2009). Dementia itself commonly causes or occurs with Frailty. Navigating the complex systems of domiciliary care services aiming to assist the older person to live independently can be extremely problematic. A transfer of expertise and professional support has not accompanied the welcome shift in the UK from long-term institutional care to multiple providers and the independent sector. In the UK long-term care in care homes has been outsourced to the independent sector and healthcare to primary



care without transfer of skills, training, resources or expertise. Home and community services have been described as fragmented with poor outcomes and wasted resources. (Low et al, 2011)

Services are traditionally arranged to suit the staff and the needs of the individual and their family can get forgotten or ignored. These attitudes have been increasingly challenged in the UK and there is growing awareness that greater sensitivity in this area could prevent untoward outcomes. Publications identifying a lack of attention to human rights and dignity in care homes, the domiciliary sector and hospital have demonstrated disastrous consequences for individuals receiving care. (Joint Committee on Human Rights, 2007)

### ***The situation in the UK.***

Integrated care is a term that reflects a concern to improve patient experience and achieve greater efficiency and value from health delivery systems. The new English Commissioning consortia will take over £60 billion of the NHS budget. It is suggested that integration of primary and secondary care with social care will deliver more efficient and effective services. (Nuffield Trust, 2011)

A recent systematic international review of different models of non-medical and community service for older people looked at case managed, integrated or consumer care led services (*ref*). The review showed that combining key elements of all three models might maximize outcomes. More evidence is required to inform decisions about how to develop integrated care. There is no single model of care which fits all.

The European survey of integrated care approaches outlined a list of strategies to facilitate integrated care:

- Case and care management
- Intermediate care strategies to improve the hospital/community care interface
- Multi-professional needs assessment and joint planning
- Personal budgets and long term care allowances
- Joint working among health and social care sectors
- Admission prevention and guidance
- Moving towards the integration of housing, welfare and care
- Supporting family care
- Independent counseling
- Coordinated care conferences
- Quality management as an instrument of agreed outcomes

MacAdam (2008) in her systematic review of integrated care argues that the key elements for effective integrated care are:

- Umbrella organisation structures to guide integration of strategic, managerial and service delivery levels
- Multi-disciplinary and case management for effective evaluation and planning of client needs with one point of access
- Provider networks with standardised procedures, joint training, shared information systems and common ownership of resources.
- Financial incentives to promote prevention and rehabilitation

No single element by itself has been shown to be effective, but the strongest predictors of success have been the active involvement of physicians, the use of multi-disciplinary care and case management with access to a range of health and social care.

The balance of care between total hospital inpatient costs and social care costs shifts dramatically with increasing age and it appears that a crossover occurs in people aged 90 and over when estimated social care costs which, in the last year, exceed the hospital inpatient costs. Marked differences between English Primary Care Trusts and Local Authority areas in terms of balances between health and social care costs were found in a recent study of three areas (Bardsley et al, Nuffield Trust, 2010).

One of the most successful examples of integrated health and social care in the UK has been developed in Torbay in the South West of England. The establishment of health and social care integration initially helped to develop a wider range of responsive services, which worked closely with primary care and general practice. The results included a reduced use of hospital beds, low rates of hospital admissions and minimal delayed transfers of care. The root of success appeared to be keeping patients and service users at the heart of the development. (Thistlewaite, 2011)

Linked to these key factors, the Nuffield Trust recently published a report on Four International Case Studies on Integration in Action (Rosen et al, 2011). They cited the critical importance of leadership, and effective governance structures to the development of shared objectives and interactions between clinical tools, as well as the use of data and information systems. Other important determinants of integrated care were national policy, regulation and payment systems.

On a policy level, the current system for funding the social care system in the UK has been recognised by the recent Dilnot report (2011) as both unfair and unsustainable. At present anyone with assets of more than £23,250 must pay the full cost of their care. Dilnot stated that "The contribution any individual makes towards the costs of their care, excluding general living costs, should be capped at between £25,000 and £50,000, with the Commission recommending the cap should be set at £35,000."

In the case of Frailty and or Dementia these conditions are key indicators or predictors of the need for integrated care and services must focus fully on their clients' complex needs. There is a need for services to work together in a systematic, joined up and cost effective way to identify older people with Dementia and or frailty, or people at risk for developing these conditions. A holistic approach to care underpinned by effective shared assessment, communication, education, training and close collaboration will ensure more effective care delivery to prevent crises and promote early review and intervention.

Staff looking after the needs of this challenging and complex group of people need to be supported, understood and trained alongside one another. Professional carers in the community and hospital often feel that they take the blame for any misadventure. They can then appear defensive and or uncaring. They too need to be treated with dignity, supported and listened to and be allowed to deliver care to an individual in a timely, humane and supportive fashion. Torbay (UK) brought together front line teams and aligned these teams with general practice. They had a clear vision to make a difference to the individual.

The NHS Future Forum's recommendation, in response to the NHS Health and Social Care Bill is that there should be "multi - professional involvement in commissioning; clinical leadership at all levels and leadership development; and, information and evidence to support high quality integrated care" is welcome and should ensure that care homes are included. The creation of "Local NHS Education and Training Boards" must ensure that the training needs of all nursing and care staff in care homes and the primary and domiciliary sector are considered. (DoH, 2011)

In addition commissioning must pay more attention to the voice of the consumer and or their next of kin. Services developed without their voice will lack compassion and sensitivity. Models of care for older people with frailty and or dementia needs to be holistic, person and family focused giving an individual an opportunity to receive treatment while ensuring their physical, functional, emotional and psychological needs are met and that they can be in control. Discussions or conversations about end of life care should be included in any care planning.

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