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Implementation of the *Long Live The Elderly!* in the territory of Prague 7

Feasibility study

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Introduction

The chances of seniors staying in their home environment until the highest age, ideally throughout their lives, depend on a number of factors. It is primarily about the availability of health and social services at home and the possibilities of their interdependence. The more varied and complex the system is, the more difficult it is for the end user to orientate in its offer. The level of information on the supply of services therefore also plays a role in the accessibility of services. An important place is occupied, for example, by a case manager (care coordinator, care guide) who plans and coordinates different types of services. Natural social networks also play a crucial role in these chances, i.e. people who are able and want to offer informal assistance. These are caregiving family members/communal households, but also volunteers, neighbours, members of associations or self-help groups, i. e. the whole community. The quality of economic security of both the elderly and the caregiver also has a significant impact.

In the text below we will get acquainted with the general conditions for the provision of social and health services in the home environment in the Czech Republic. We will provide a brief assessment of this system and describe the possibilities of securing the citizen in the need for long-term care in natural conditions. In the special part of this report, we will focus on availability of the above-mentioned services in the territory of Prague 7. We will be interested in the availability of the social and health services in the territory, taking into account the number of their potential beneficiaries, as well as the opportunities for their interconnection. We will try to describe the barriers in access to these services and we will address the conditions in the natural environment. Finally, we will present the prospects for further development in this area.

I. GENERAL PART — Available health and social services in natural social environment

1. Terminology

The concept of home care does not exist in Czech legislation and as such is ambiguous in the Czech environment.

A. Home care in health care services

The concept of home care with its importance in our country is mainly related to **home health care**, which corresponds to the original English term 'home care'. Then there are home (health) care agencies, the Home Care Association, the home care segment (in health services) and a nurse specialization in home and hospice care.

Home care in health services differs from the care provided in the patient's own social environment, which is both the patient's home environment and also the environment replacing this home environment, such as social beds in the hospital or inpatient social services facilities, etc. (Act 372/2011 Coll. on Health Services § 4)

Health care in the patient's own social environment takes the form of a **visit** of the general practitioner and/or nurse and also home care, which is rather **nursing care**, therapeutic rehabilitation care or palliative care. (Act 372/2011 Coll. on Health Services § 7 and § 10)

Special outpatient care can also be provided in the **natural social environment**. This care is provided mainly to persons with acute or chronic illnesses, persons who are physically, sensory or mentally

handicapped and aids-dependent or to persons in the terminal state of a disease (palliative care mainly). It is provided on the basis of a prescription by the general practitioner or by visits of the physician during hospitalization.

B. Home care in social services

The term 'home care' is not used in social services. Since the term is used in the health sector, it won't even be effective. English in this case uses the expression 'home help' or help in household. The Social Services Act refers to **field services**, which means services provided to a person in the **natural social environment** (Section 33, paragraph 4). More information about the different types of services provided in the **household** can be found in the following chapter.

In the Czech environment, it is not advisable to speak about a system of home care and services, because it is not clearly defined what it is. So, we will speak about the system of care in the natural social **environment, a person's home environment** or in a **person's home** (not in a substitute home environment, i.e. in institutions).

2. Description of available social services

Social services that allow seniors with limited self-sufficiency to stay in their natural, home environment are regulated by Act No. 108/2006 Coll., on Social Services. The law divides social services into social counselling services, social care services and social prevention services. As regards the form of provision, social services are divided into inpatient, outpatient and field services.

In the text below, we will focus mainly on field and outpatient services, which allow the senior to stay in his/her home environment for as long as possible. The provision of these services assumes that the senior has a functional social background, which supports him/her according to its capabilities. Social services work hand in hand with informal care. It usually starts where informal care is no longer enough, offers sharing of care and relieving care for caregivers. Informal caregivers are as important as quality social services.

A. Social counselling

Basic social counselling is offered by municipalities with extended powers and all providers of social services. This service helps to find and mediate ways to deal with an unfavourable situation with regard to the needs of the person. It is available to all citizens in full free of charge, as it has a preventive-information character.

Special social counselling is provided with a focus on the needs of various social groups**,** e.g. in civic counselling, marriage and family counselling, counselling for the elderly and people with dementia, counselling for persons with disabilities, counselling for victims of crime and domestic violence, mobile and inpatient hospices, etc.

B. Field and outpatient social care services

Domiciliary care – is a field or outpatient service provided to persons who have reduced self-sufficiency due to age, chronic illness or disability, and to families with children whose situation requires assistance of another person. It includes the following activities: assistance in caregiving for one's own person, assistance in personal hygiene or provision of conditions for personal hygiene,

provision of food or assistance in providing food, assistance in ensuring the running of the household, mediation of contact with the social environment.

Personal assistance – is a field service provided to persons who have reduced self-sufficiency due to age, chronic illness or disability, whose situation requires assistance of another person. The service is provided without time limit, in the natural social environment and in the activities that the person needs. It includes activities such as assistance in managing caregiving for one's own person, assistance in personal hygiene, assistance in providing meals, assistance in ensuring the running of the household, educational and activation activities, mediation of contact with the social environment, assistance in the exercise of rights, legitimate interests and in the provision of personal matters.

Emergency care – is a field service that provides 24/7 distance voice and electronic communication with people in their household. These are persons at constant risk of endangering their health or life in the event of a sudden deterioration in their state of health or abilities. It includes the provision or mediation of urgent assistance in a crisis situation, socio-therapeutic activities, mediation of contact with the social environment, assistance in the exercise of rights, legitimate interests and in the provision of personal matters.

Guide and reading services – are field or outpatient services provided to persons whose abilities are impaired due to age or disability in the field of orientation or communication and they help them to deal with their own affairs.

Day services centres – provide outpatient services to persons who have reduced self-sufficiency due to age, chronic illness or disability, whose situation requires the help from another person.

Day care centers – provide inpatient services to persons who have reduced self-sufficiency due to age or disability, and to persons with chronic mental illness whose situation requires regular assistance from another person.

Weekly care centers – provide inpatient services to persons who have reduced self-sufficiency due to age or disability, and to persons with chronic mental illness whose situation requires regular assistance from another person.

Respite services – are field, outpatient or inpatient services provided to persons who have reduced self-sufficiency due to age, chronic illness or disability that is otherwise cared for in their natural social environment; the aim of these services is to enable the caregiver to rest.

To allow care recipients to pay for social care services according to their needs, people with disabilities are entitled to the so-called **care allowance**. This is a benefit that the state contributes to persons dependent on the assistance of another person to cover the cost of care. The amount of the benefit is determined by the age of the benefit claimant and the degree of his/her dependency. The degree of dependence is then defined by a number of basic necessities of life that the claimant of the benefit is unable to cope with due to a long-term unfavourable state of health. It concerns mobility, orientation, communication, eating, dressing and dressing, physical hygiene, physiological needs, health care, personal activities and home care. The amount of the contribution ranges from CZK 880 to CZK 19,200. The allowance is requested and decided by the Labour Office.

C. Field and outpatient social prevention services

Telephone crisis assistance – is a field service provided temporarily to persons who are in a life/health risk situation, which they cannot temporarily deal with on their own.

Interpreting services – are field or outpatient services provided to persons with communication disorders caused mainly by sensory impairment, which prevents normal communication with the environment without the help of another person.

Social activation services for the elderly and persons with disabilities – are outpatient or field services provided to persons of retirement age or persons with disabilities at risk of social exclusion.

Crisis assistance – field, outpatient or temporary inpatient service provided to persons who are in a life/health risk situation**,** which they cannot temporarily deal on their own.

Intervention centers — provide field, outpatient or inpatient services for persons at risk of other person's violent behaviour.

2.1 Social service providers

The basic legislative framework, as well as setting of funding flows, is created by the state and its entities. The provider of social services may be a public body, but more often private. A public service provider of social services is set up by the state or local authority (municipality or region) as its contributory organisations. The private sector consists of social service providers from non-profit and for-profit organizations, as well as organizations established by churches.

Providers must register with the competent regional authority every service they provide. Registration serves as a verification of the provider's ability to provide a specific social service. Information about providers of registered social services is available in the register, which is publicly available on the website of the Ministry of Labour and Social Affairs (iregistr.mpsv.cz).

Regions are responsible for ensuring the availability of social services in its territory. The region cooperates with municipalities, other regions and social service providers and determines the network of social services in its territory. To do this, it uses various community planning tools. In practice, it explores the provision of social services as well as the needs of the potential service users. Community planning involves mainly representatives of users, providers and sponsors of social services, as well as other public engaged in the topic of social services.

2.2 Financing of social services

Sources of funding for social services are diversified. The cost of social services is covered by the state, local authorities (in the form of budgets, subsidies and grants), users of social services (from care contributions and private income), the resources of foundations, sponsors and donors. The reimbursement of health insurance companies plays a role in social care services. Typically, multiple resources are used at one time for the purpose of covering the cost of a single type of service.

2.3 Promoting the role of a caregiver

For this purpose, a social benefit, the so-called **long-term attendance pay**, has been introduced. The caregiver is entitled to the benefit in agreement with the employer after the prior release of a person from hospital. Entitlement to the benefit can last up to 3 months and its amount is derived from wage. The benefit is paid to a person who lives in a common household for at least 3 months with the person he/she will care for.

3. Description of available health services

In the patient's natural environment, only a limited range of medical procedures can be performed. The provision of health services is regulated by Act No. 372/2011 Coll. on Health Services and Act No. 48/1997 on Public Health Insurance.

In the patient's social environment, only such medical procedures may be performed, the provision of which is not conditional on the technical and factual equipment. This is one form of healthcare provision.

Healthcare provided in the patient's social environment includes visitor service, home care, nursing care, therapeutic rehabilitation or palliative care, and hospice care.

A. Visitation service

Visitor service means the provision of healthcare in the patient's social environment, especially in cases when the patient is not able to come to the provider's medical facility due to his/her state of health and the provision of healthcare in this way is possible due to its nature.

The visitor service is always a part of the primary outpatient care provided by registered providers in the field of general practical medicine and practical medicine for children and teenagers. It is therefore carried out by private general practitioners or their nurses, and the care is fully covered by public health insurance.

B. Home health care

Home healthcare includes nursing care, rehabilitation or palliative care. The most frequent clients are patients discharged from inpatient facilities who need follow-up care at home. Care is also provided to people who are chronically ill, as well as to patients after injuries and operations who need systematic nursing care, rehabilitation, re-bandaging, etc. Home health care is also provided to clients in the terminal stage of a disease who wish to die in a home environment in the circle of their loved ones.

The home health care service can be prescribed by a general practitioner or attending physician of the hospital's inpatient department on the basis of an examination. The doctor will recommend the frequency and length of visits to the patient, the goals and actions of home health care. On the basis of these documents, the nurse enters the patient's household and performs individual nursing operations (administers medications, injects and infusions, treats open wounds, takes biological material, treats stomous and permanent urinary catheters, checks the general state of health, etc.) , records all objective findings, changes and biological values, of which he/she regularly informs the general practitioner, who may, on the basis of an evaluation of the patient's state of health, extend or change the scope of the home healthcare and the procedures provided. Home nursing care is ended up upon the decision of the general practitioner.

If home care is prescribed by a doctor, it is fully covered by the health insurance company. Home health care is provided by some agencies even for direct payment by the patient.

C. Home hospice care

This form of care is intended for terminally ill patients. General palliative care can be provided by a general practitioner. If he/she wants to indicate homely palliative care, he/she prescribes a so-called signal code. In such a case, nursing care and material costs may be provided and reported in unlimited amounts.

Optimally, home hospice care is provided by an interdisciplinary team, which also includes a doctor specializing in palliative medicine. It is a so-called specialized hospice care, which can be provided in the form of mobile home care, in an inpatient hospice or in a hospital.

The costs of hospice care are usually covered from several sources – from the patient's funds and public health insurance, from donations and sometimes from contributions from municipalities. More stable funding of palliative care providers in terms of adjusting subsidy programs would contribute to the development of palliative and hospice care.

3.1 Health service providers in the patient's natural environment

The provider of the above-mentioned health services may be a medical facility in the category of special outpatient or special inpatient care (in case of palliative care in an inpatient hospice facility) (pursuant to the Act on Public Health Insurance No. 48/1997 Coll., Sections 22 and 22 a). Non-state providers usually provide home healthcare. The authorisation to operate a non-state health facility is created by a registration decision made by the regional authority according to the place of operation of the non-state facility. Registration is used to verify eligibility to provide health services.

3.2 Funding of the health services in the patient's natural social environment

As mentioned above, health services provided in the patient's natural social environment are in most cases covered by public health insurance as special outpatient care, on condition it is indicated by a doctor. If this is not the case, the costs of home healthcare are borne by the patient him/herself. [1]

Medicinal products and food stuffs for medicinal purposes are covered, in whole or in part, by a prescription. Sometimes additional costs are covered by the patient. In case these costs exceed CZK 500 per year in patients aged 70+, the extra cost is covered by the health insurance companies.[2]

4. Strengths of the system of care in the natural social environment

In the Czech Republic, primary **health care has traditionally been at a high level**. All citizens of the Czech Republic are registered at their general practitioner for adults, who regularly perform preventive examinations reimbursed by the health insurance company every second year. General practitioners are to perform a visitation service with their fragile immobile patients. Those are also covered by the public health insurance. They can also prescribe visits of the home care agencies or home hospice care through the so-called signal code. They send their patients for specialized examinations and to hospitalization. General practitioners take on the role of the gate keepers, who regulate the patients' access to the health services and take care of their long-term sick patients. Health insurance companies

[1] Pursuant to the Public Health Insurance Act No. 48/1997 Coll., § 22a
[2] Ibid, § 16a

reward general practitioners according to the number of registered patients, i.e. by capitation payment (the basic rate is CZK 56 per patient per month). Its height takes the age of patients into account. In patients aged 85+ the coefficient reaches 3.40.

Home healthcare (home care) is well developed in the Czech Republic. It is provided by qualified general nurses with specialization in home and hospice care. There is a large number of providers of all forms of home care like home preventive care, home short-term care (so-called home hospitalization or follow-up care after discharge from the hospital), home long-term nursing care (for patients with long-term illness and disability), as well as home hospice and palliative care. As hospice and palliative care analyses show[3], its development is rather slower than in other forms of home care, however, there are great pioneering organizations such as Cesta domů, or Most k domovu, or Péče doma in Prague, Mobile hospice Ondrášek in Ostrava, etc. Some providers are able to combine health and social care in patients' home environments and provide so-called comprehensive home health and social care (Charita of the Czech Republic, Diakonie ECCB, etc.). The funding is from more resources. Artificial pulmonary ventilation and dialysis can also be provided in the form of home care. Physiotherapy can be provided in the home environment, too, on the doctor´s prescription, but the health insurance reimburses it less frequently. Mostly it has just the form of nursing rehabilitation. However, physiotherapy is also available as a service of private providers paid by the patient.[4]

The **idea of the integrated health and social care in the community** is enshrined in Section 59 of the Decree No. 55/2011 Coll. on specializations of non-medical healthcare professionals, where the specialization of **community nurse** is described. He/She should know all health and social care facilities in the given region and coordinate their care services, monitor the situation of at-risk persons in terms of the complexity of support and nursing care, and provide advice to caregivers. It should therefore comprehensively ensure integrated health and social care for individuals in their own social environment (Kalvach, 2014). In practice, however, this profession does not exist, instead of it there is a non-medically defined position of **support and care coordinators** or the role of support provider, a guide or an advisor for caregiving families. The research carried out by the Long-life Education Fund (2014-2019) provided deep description of the positions of a care coordinator. There is also experience with the application of this position on regional level especially as an outcome of the project Pečuj doma of Diakonie ECCB.

Social care is offered by quite a **wide range of social service providers** established by regions or municipalities, but more often by non-governmental organizations (NGOs), especially by church-based organizations (Charita CR, Diakonie ECCB). For seniors social counselling services (e.g. Civic advisory centres, counselling of Elpida or Život 90), social prevention services (crisis centers, crisis call centers, centers of social activization) are available. Social care services (domiciliary services, nursing homes, homes for the elderly and homes with a special regime) are especially important for old people. In the the sector of residential services big commercial providers, e.g. the entire chain of seniors homes – have been emerging in recent years. Personal assistance or respite care services are less available. There are also many non-profit pro-senior organizations focused on promoting social inclusion and activization of the elderly (Život 90, Elpida), raising awareness of the problems of old people living with serious diseases (Czech Alzheimer's Society, Dementia.cz, Parkinson's Society, etc.) as well as providing interdisciplinary counselling and care for old people and their families (A Doma, Alzheimer Point, Reminiscence Centre, Señorina, Alzheimer's Café, Pečuj doma of Diakonie ECCB). Self-help support groups for informal caregivers and various forms of their education (e.g. in nursing skills and communication) are on the increase. Mutual assistance services have been emerging, such as friendly

[3] Palliative Care Centre (2018): Palliative care in the capital city of Prague. Analysis. Online. Available from: https://cdn.paliativnicentrum.cz/sites/default/files/soubory/2019-06/CPP_Praha-2019_brozuraA5_WEB_logoPraha_jednostrany.pdf

[4] Ibid

visits and calls to support lonely and immobile older people through the involvement of younger seniors as volunteers. (Život 90)

Community planning at the level of regions and municipalities is an important tool for meeting the needs of long-term care for older people within their natural environment. In community planning there are working groups on senior issues responsible for the development of services in the area. Their members are representatives of the municipality, the service providers and the seniors themselves.

5. Weaknesses of the care system in the natural social environment

Lack of support for informal caregivers. Informal caregivers are not a defined target group for social services at this time. (Hubíková, 2017) It means that there are no registered social services intended specifically for family caregivers. Activities for family caregivers take place only within the framework of NGOs projects or on a voluntary basis (Pečuj doma, etc.). Research shows that informal caregivers, especially those caring for people with dementia, lack the governmental assistance in the provision of information about the sources of help and support. They also miss the system of coordinated aid (Dragomirecká 2021, Long-life Education Fund 2019). They experience doctors who trivialize their problems and do not send them to specialists. Doctors also fail to provide their patients with information on available services or the patient's entitlement to the care allowance and to sanitary and medical aids. The opportunities of psychotherapeutic support for caregivers are insufficient.

Research and practical experience suggest that among the most important unfulfilled needs of caregivers, is the availability of social services, their mutual coordination, continuity, connectivity with health and other services in the community. This is the most serious limit for the development of care at home**.** Kalvach (2014) highlights the importance of the Integrated Support Services System (SIPS) provided in the community, which includes field and outpatient social and health services, transport and informal resources (volunteers, neighbours, caregiving families). In fact, it is the lack of orderliness, coherence, continuity and integration of social and health services that are among the weakest aspects of the care system in the Czech Republic. It means that services provision is not coordinated enough with regard to the needs of the long-term ill people and their caregiving families.

It seems that, in particular**, domiciliary and assistance services are still in short supply.** A pretty low number of service providers can operate 24 hours a day, 7 days a week. The activities of the domiciliary service set up by the law do not allow sufficient flexibility. For example, they include delivery of meals for old people, which is not very efficient and can be provided by commercial delivery companies which are very responsive especially in this covid times. Instead of this "meals on wheals" domiciliary service should include more activization and social inclusion services (e.g. just walks) or the basics of palliative care. Personal assistance is too costly for many seniors, especially for those who are lonely and endangered by poverty.

Respite home service (e.g. looking after an old person) is rarely provided, yet it is required by caregiving families. Similarly, there is a lack of places in respite facilities that could bring the necessary relief and rest to the caregiving families.

There is also a lack of active or assertive approach to **dépistage**, i.e. a lack of active screening for high-risk, fragile individuals dependent on the help of other people, especially for seniors 80+, those living alone, in unsatisfactory and undignified conditions, in poverty, with unsatisfactory social support and unsafe social network. Research of Hubíková (2020) showed the importance of the dépistage in the CR

and its weaknesses. Its importance is increasing as a result of high numbers of lonely seniors, seniors living in isolation or seniors endangered by domestic violence.

Long waiting periods for **granting the allowance to care** by the Labour Office seem also to be a problem**.** Screenings of the Labour Office´s social workers in applicants' households are done inefficiently, are narrowly focused on the assessment of the basic needs and self-suffiency in activities of daily living and are not linked to social work, i.e. to the recommendation of the necessary services, providing information and mapping natural sources of support in community.

Emergency long-distance services have become commercialized. The offer is quite large but introducing this service and monitoring systems into the apartments of old people is rather expensive. Moreover, the service is rejected by many seniors – they do not feel comfortable knowing that they are constantly watched by someone. It also seems to be risky that the introduction of this service does not take place in cooperation with doctors and that the providers of this service do not require a medical report or recommendations.

Housing in elderly people is regarded as weak point too. The availability of various forms of flexible housing for seniors with reduced mobility and increased demands on support and care is absolutely insufficient. It is mainly about accessible apartments, sheltered housing, small housing units for groups of seniors, which provides them with sufficient degree of autonomy and intimacy, as well as with necessary participation in the community life according to their wish. It is also about the absence of an offer of apartments integrated into ordinary public housing, which would allow the seniors to participate in the public life of the local community, while ensuring them with necessary support and assistance in the form of available services. The overall environment of public life is not yet very accommodated to the limits of living in old age. The "caring community" or "dementia friendly community" model is not yet part of the public consciousness.

6. Cooperation between health and social sectors

This cooperation has several levels and represents the most critical point in the long-term care for old people in their natural environment.

A. Discharge of endangered patients from hospitals

Discharge should always be well prepared, planned, safe and should include:

- timely monitoring of the degree of dependence and the need of support for the patient, i.e. fragility, orientation, presence of physical and cognitive impairment (the so-called comprehensive functional assessment), and assessment of the overall social and housing background of such an endangered old patient;
- equipment of the discharged patient with medication and medical aids, and with information regarding the opportunities of follow-up care;
- encouraging the family to care;
- informing, educating, assessing the patient from the very beginning of hospitalization, as well as continual cooperating with the family in discharge planning, support and education of the family;
- interdisciplinary team cooperation of doctors, nurses, physiotherapists, occupational therapist, rehabilitation workers and medical social workers, etc. in dealing with complicated discharge;

- cooperation of medical social workers with the social and health services in the community, with municipality social workers, with Labour Office as for the care allowance for the disabled patients and with the family caregivers´ employers in terms of the long-term attendance allowance.

In most cases, hospitals employ **medical social workers**. Less often they have adequate partners in the natural environment of the patients – community or municipal **social workers and care coordinators**. There is a lack of interdependence and continuity of care, hospital social work and social work in community.

Discharge of patients from a hospital sometimes fails to perform evaluation of the patients´ social and physical environment in connection to their health status, self-sufficiency and their needs. There are not enough **field occupational therapists** working directly in the households of the discharged old people. In collaboration with the family, they could assess the conditions at the households, and suggest suitable modifications, equipment and medical aids for the patients. The same applies to physiotherapists and masseurs.

B. The role of general practitioners (GPs) in follow-up care after the discharge and informing the patients on further service

Information about the available services is either not shared or the services are not at the disposal (e.g. dementia support centers). In this sense there are great shortcomings in this area, doctors do not dispose of up-to-date information. Sometimes they seem to be unwilling to assist in the particular matter and claim that they are not paid for this activity. They do not consider it to be a part of their role.

C. Visitation service

The same unfavourable attitude can be encountered in some GPs in relation to the visitation services or to prescribing of home care. The GP´s visitation service is described in the health legislation[5] as a part of primary care and doctors are obliged to perform it for at least 12 hours a week. In fact, this activity is underestimated in the health insurance points system and for the doctors it is not worth their initiative.

D. Outpatient specialized care in the home environment of patients

This form of health care is not available. Specialists and dentists are not paid for the visitation service and cannot report it to the insurance companies. In many cases, this form of health care would prevent the deterioration of the patients´ health status if they refuse to see a doctor or if their condition is so severe that transport to the doctor would significantly worsen their condition.

Overall, the biggest long-term weak point is the lack of connectivity between the two sectors at all levels. An community level, there is a lack of information towards the public, especially to patients and caregiving families. Sharing information between the providers of health and social care services is also unsatisfactory as well as between the providers of various social services themselves. We can speak about the absence of both internal and external information flow. There is also a lack of interdisciplinary teamwork that can solve health and social problems of old people comprehensively and effectively. The idea of community geriatric teams is still in its infancy.

[5] Act No. 48/1997 Coll., on Public Health Insurance

7. Options for long-term care and security of the oldest people in community

A. Information area

It is necessary to search for different ways of transmitting information about services as well as about available financial assistance, i.e. care allowance, long-term attendance allowance for family caregivers, housing benefit or contribution to sanitary and medical aids is necessary. The examples might be leaflets put directly to the mailboxes of seniors over 80, hanged out in shopping centers and municipal offices, posted up via the Internet. The use of the employers, clubs, community centers might be effective, too. It is very important to strengthen information flows and bring information closer to individual health and social care providers in a way that is friendly to their nature and location (e.g. doctors cannot be expected to search for information themselves). Data sharing between Labour Offices, social security administration and social departments of municipalities would also be helpful. Community planning processes should make use of available statistics on health status of the oldest population.

The prerequisite is the initiative of municipalities, the search for ways of transmitting information, the preparation of information materials and their distribution. This is an area that should be dealt with separately within the framework of community planning. Creation of platforms for interdisciplinary meetings and interdisciplinary dialogue can serve as a precious opportunity for further development in this field (e.g. Dementia.cz in the Central Bohemian Region).

B. Area of coordination of services

Introducing of the position of **care coordinator** at the municipality or even at the regional level appears to be very beneficial. They use case management methods in the discharge of endangered old people from hospitals and in seniors with high need of support and care. It is also about support provided to caregiving families and their involvement in person centered individual planning of care.

The flexibility and interdependence among health and social services as well as among social services themselves is very important. There is also a chance for involvement of services that have not been registered yet or for the activities of the volunteers, clubs, associations and neighbors (e.g. the so called shared care for people with dementia involving family caregivers[6], friendly visits[7], time accounts[8], etc.). Some of these self-help and volunteering activities based on the idea of a caregiving community do not need large financial resources and can also be financially self-standing.

The prerequisite is the development of social work in the municipality, creation of positions of care coordinators, implementation of dépistage and founding of integrated care and support centers, e.g. dementia support centres, etc.

C. Field of education

It includes training of family caregivers in nursing and communication skills and in the self-care to cope the care burden. The education can be provided by educational agencies and by volunteers within the self-help groups. In addition to medical professionals and social services staff, also the shop assistants,

[6] Dementia.cz

[7] www.zivot90.cz/cs/asistence/pratelske-navstevy

[8] https://www.totemplzen.cz/regionalni-dobrovolnicke-centrum/totemove-dobrovolnicke-projekty/sousede-plus/

police, firefighters, drivers and public transport workers, post office staff, the staff of libraries, museums and other cultural institutions should also be educated. Their friendly and helpful approach and their communication skills can be useful in integration of very old people and people with dementia into the everyday life of communities.

D. Area of architecture and urbanism

There are significant reserves in the involvement of architects and developers in designing the age-friendly community. They should create accessible housing for older people with disabilities and design such environment that meets the needs of very old seniors. It should also include old people endangered by loneliness and dementia and create an environment that can integrate even the most fragile seniors into society.

E. Area of legislative, conceptual and policy measures

It is important to establish ways of funding the medical specialists´ visitation service. The extension of the competences of general nurses and other specialized professions with university degree e.g. occupational therapists and physiotherapists, within the framework of the home care is also necessary. This measure should include the reimbursement of their services by the health insurance companies. Furthermore, opportunities for new social services and technologies such as distance supervision, assistive technologies, telecare and social robots should be created. At the same time innovations of existing services, especially care services, should be supported. It is also desirable to support various forms of shared care (i.e. the involvement of family caregivers in individual care planning). Family caregivers should also be defined as a target group for social services. Government-approved programs such as the Strategy of Preparation for Ageing for the years 2019-2025 or the National Action Plan on Alzheimer's Disease and other strategic documents should play a crucial role.

II. SPECIAL PART — Health and Social Services in the territory of Prague 7

8. Description of the target population

According to the Statistical Yearbook (CSU, 2020), there were **46,652 inhabitants in the Prague 7 district in 2019**. Of these, almost **16 %** (7 467 persons) were over the age of 65 (of which women: 59%, men: 41%). The average age was **40.3 years**. The age index (the proportion of persons over 65 years of age and those in the 0-14 category) was 97.5. It is therefore a population which is rather younger.

According to the SILC 2019 Survey (in CSU, 2020), **20.3%** of Pragueers report long-term restrictions in normal activities. Their representation increases significantly in the 55-64 (25.2%), 65-74 (33.9%) and 75+ age categories (57.8%). The number of holders of disability cards in Prague in 2019 was 37,816 persons. If we apply this data to Prague 7, approximately 3 600 people at the age of 65+ would be subject to restrictions in daily activities.

Generational renewal is taking place in the territory of Prague 7. Young families with children are moving in. On the contrary, older residents leave Prague 7 to join their family members or seek out houses for seniors which are not in the area of Prague 7. The increasing migration of elderly citizens is also due to rising housing costs, which are unbearable for often lonely citizens.

According to the Smart Home Care survey (2017)[9], it is necessary to count on an increasing absolute number of people aged 65+, i. e. an increase in potential users of various social and support services, i. e. including care services in the home environment'.

Almost a **half of the households of senior citizens** in Prague **live** and **farm as individuals,** most often after the death of a partner or after a divorce. Prague 7 is no exception, and the proportion of households of independent seniors is even higher than the Prague average (CSU, 2015). **36.7 %,** i. e. about 2 740 seniors from Prague 7 live in an apartment **completely alone**.

The survey[10] shows that the vast majority of senior households live in **apartment buildings** (the average number in Prague is around 83 %). Exact data on the number of accessible apartments in Prague 7 are unknown. However, due to the nature of the buildings in Prague 7, it can be expected that most apartments are inaccessible. This poses **considerable barriers** in access to the external environment for seniors, especially those with reduced mobility. This further increases their **isolation**.

Physical barriers in the apartment or in its immediate surroundings (e. g. absence of lifts) are considered to be one of the factors of **overuse** of inpatient social services and an obstacle to staying in the home environment even for those seniors who would prefer field services in their home environment to inpatient services. The aforementioned **rising housing costs** are another obstacle to staying at home.

1.1 **Persons dependent on care**

The number of seniors requiring regular care of the other person can be partly derived from the data on the recipients of the care allowance. In 2016, 750 beneficiaries received a care allowance in Prague 7 (550 persons are 80+). **Seniors aged 65+ make up 75 %** of all beneficiaries. At the age of 80+, they make up about 55 % of all beneficiaries[11]. In beneficiaries of the care allowance in the 3rd and 4th degrees, we may expect needs for long-term and intensive social or health care in the form of either inpatient or outpatient services.

However, the number of citizens in need derived from the number of beneficiaries of the care allowance is only indicative. Not all citizens who receive a form of care are granted this allowance (e.g. they do not know about their entitlement or do not ask for it, or are not granted it). According to the feasibility study (2017) [12], there is also a certain group of citizens who do not need long-term care but use certain ad hoc social services (e. g. cleaning, lunch delivery, etc.).

According to qualified estimates[13], the number of recipients of the care allowance is expected to increase by **35 - 40% by 2030.** At the same time, it appears that the number of people receiving care services has been stagnating for a long time, while the number of **unsatisfied applications for placement** in social services regularly increases.

[9] Smart Home Care – feasibility study in Prague 7 (CTU UCEEB, 2017)
[10] Survey carried out by the Institute of Planning and Development of the Capital City of Prague in 2015
[11] Strategic plan for the development of the Prague 7 district for the period 2016-2022 – analytical part
[12] Smart Home Care – feasibility study in Prague 7 (CTU UCEEB, 2017)
[13] Průša, L.: New projection of the development of the number of recipients of care allowances in the Czech Republic by 2030. Demographics, 2018, 60: 49-60

9. Offer of health and social services

Prague 7 has the status of a municipality with extended powers. It thus ensures the performance of state administration and self-government in the social field. As a result, it has a relatively large influence on the provision of care to the elderly on its territory. It uses the following entities and procedures:

1. Department of Social Work at the Department of Social Affairs and Health,
2. its own contributory organizations (partly funded by the municipality),
3. community planning of social services,
4. cooperation with local providers of social and health services.

The Social Work Department[14] provides citizens with counselling to address their social problems. It provides necessary social and follow-up services and helps people at risk of social exclusion to participate in everyday life. It ensures the issue of parking passes for vehicles carrying persons with severe disabilities. Within the department there are social curators for adults who provide assistance to persons at risk of social exclusion. Around 75 % of the department's activities relate to support for people aged **65+.**

Contributory organizations of Prague 7 are: Care Center Prague 7 and The Associated Outpatient Facility, also known as a Health Center.

The Prague 7 Care Centre operates care service, a day care center, special purpose flats in nursing homes, a respite service center, a day nursery, canteens, 2 senior clubs, 2 personal hygiene centres, laundry and social counselling.

The Associated Outpatient Facility – The Prague 7 Health Center provides outpatient healthcare in various specializations. If necessary, doctors go to patients' homes or to the care center.

At present, the intention is to **deepen the cooperation** of the Prague 7 Health Center and the Care Centre in the field of care for the elderly. The potential of cooperation is, for example, in providing field care by general practitioners and specialists, cooperation in the field of care integration and in the field of effective information sharing as well as in the creation of a common IT center.

In the Prague 7 district there is also a **wide range of providers of social, health and follow-up services**[15], or leisure activities for different groups of inhabitants. Among those that can be used in life support in natural conditions are: palliative care facilities, home health care, rehabilitation, other care and nursing services, personal assistance, emergency care, lending of compensatory equipment, voluntary programes, programes to promote intergenerational cooperation, education services and legal aid. Emphasis is placed on the interdependence of both health care and social services. In addition to these services, seniors have access to a wide range of cultural, sports and leisure activities.

One of the most widely used social services all over Prague, which belongs to our circle of interest, is the **care service**. According to the Statistical Yearbook (CSU, 2020), 12 948 clients used it in Prague in 2019. Respite services were used by about six times fewer clients. Slightly more personal assistance was used.

[14] Medium-term concept of development of social policy, social and health services 2018-2022, website of the Prague 7 City Government

[15] Medium-term concept of development of social policy, social and health services 2018-2022

In order to ensure adequate coverage with social (and health) services on its territory, Prague 7 participates in the **community planning of social services** in cooperation with the municipality of Prague. It is a coordinated process, the result of which is the preparation of a medium-term plan for the development of social services in Prague 7 in cooperation with the municipality of Prague, providers of social services in its territory and with the participation of the service users.[16]

Volunteering is a living concept in Prague 7. The city district itself is not an organizer of any volunteering activities. However, it supports and encourages its citizens to volunteer. It does so through projects by non-state organizations. It publishes information about various programes on its website. More about the possibilities of using volunteering in the support of the elderly can be found in chapter 13.

The offer of services for the elderly is **constantly expanding** as a result of cooperation between Prague 7 and local non-state organizations. New counselling services are being created, a contribution to emergency care facilities has been introduced, opportunities for informal volunteering within neighbouring associations are being extended, educational courses for the elderly are being held, etc. The Police of Prague 7 and the Town Hall have been relocated to new accessible buildings.

However, despite plans working positions of community nurses and psychiatrists that would be able to enter households, were not created. The project to create a multidisciplinary team was postponed due to insufficient staffing capacity. There was also no increase in the capacity of inpatient care in the territory of Prague 7 and neither a facility for elderly people with dementia was founded.

9.1 Weaknesses in provision of services for the elderly[17]

Interest in services for elderly citizens is **high**. Providers must **reject clients** and connect them to other services. The expansion of services faces difficulties in **providing suitable staff**.

The **overall arrangement** of the social and health services system**,** both for clients and providers, appears to be a key theme. Citizens are not well aware of the range of services offered and often confuse different types of services. There is a lack of general awareness of the services available even in groups that do not use the services.

In the support of the elderly and the system of services, the role of **prevention** and **screening** should be promoted**.** Providers also mention the need to support informal caregivers. They themselves often lack the necessary information, do not know how to coordinate different types of care. Similarly, service staff should be informed of ways to assist informal caregivers with a combination of informal and formal care.

The mutually **low awareness of providers about the services** they offer seems to be an issue as well. Providers propose that Prague 7 should initiate regular meetings of providers as part of the community planning process in order to increase their mutual awareness. The lack of cooperation is being developed by the **Labour Office**. **General practitioners** also have insufficient insight into the available services.

[16] These obligations arise from Act No. 107/2006 Coll., on Social Services as amended

[17] Adjusted according to findings from Smart Home Care – feasibility study in Prague 7 (CTU UCEEB, 2017)

According to service providers, the city district should **map the availability of services** on its territory and be able to offer a package of eligible services to a specific senior – serving as a so-called case manager. It should perform screening of people in need and serve as a kind of "socio-infocentre".

There are some other weak points of seniors' security in Prague 7: [18]

- absence of social care housing for the elderly with significantly reduced self-sufficiency;
- absence of field psychiatric services (seniors with cognitive impairments);
- provision of health and social care separately by different providers;
- low awareness of many seniors about the possibilities of help – they then stay at home without any assistance, have a low quality of life;
- absence of a coordinator of social and health services;[19]
- lack of cooperation between health and social service providers;
- the absence of inpatient facility offering follow-up or long-term nursing care to seniors with complex health problems;
- limited availability of services, in particular health and rehabilitation (excluding care services) at home/outpatient;
- seniors are still viewed negatively by a vast majority of population;
- a proportion of the elderly are at risk of poverty;
- the majority of buildings in Prague 7 is inaccessible;
- low number of social housing or small-town apartments intended for seniors wishing to move in.

10. Coordination of services

Coordination of services has long been considered one of the weaknesses in the system of social and health services in Prague 7. However, in recent years, this topic has received a lot of attention. The role of coordinator of social and health services was created by the Social Work Department of the Department of Social Affairs and Health.

Its agenda includes the following activities:

- continuous provision of social counselling and regular information to persons on all social assistance and health services possibilities in the form of leaflets, brochures, periodic printing;
- comprehensive social work for persons in unfavourable social situations;
- assistance in providing follow-up care after discharge from hospital (cooperation with hospital staff and other organizations providing care services, especially with the Prague 7 Care Centre);
- assistance in submitting applications for benefits;
- assistance in crisis situations of different kinds;
- financing and commissioning of emergency calls and pager distribution in Prague 7.

At present, the city district is implementing a project focused on the **development of case management**, the output of which is to be a functional interconnection of health and social services

[18] Ibid

[19] At present, the city district is implementing a project focused on the development of case management, the output of which is to functionally connect the two types of services with regard to the needs of a particular client.

with regard to the needs of a particular client. It is based on regular meetings between the city district workers and the care center.

Cooperation relationships logically arise and are developed among other service providers. For example, doctors cooperate with care coordinators. At the same time, doctors point to a lack of support provided to informal caregivers, a lack of capacity for respite services, long-term sick people's hospitals, and nursing homes. Doctors are encountering problems with their visits in their patients' homes. The problem mainly lies in the availability of parking.

11. Support for informal caregivers[20]

Based on data on the care allowance and the volume of senior population, it is estimated that there are between **570 and 730** informal caregivers in Prague.

A survey (2012) carried out in Prague 7 and 8 states that the typical family caregiver is most often a **child** (61 %, mostly a daughter**),** or a **life partner** (14%). Caregivers spend an average of **34 hours** a week on caregiving for their loved ones, and most often it is assistance in the home (86 %), as well as nursing care (65 %) or accompaniment (68 %). Only 40 % of caregivers live with a person in the same household. It is estimated that almost half of caregivers are **economically active**. About 75 % of caregivers surveyed used a kind of health/social service at the same time.

The conclusions of the above-mentioned survey and the focus groups with caregivers (2016-2017) result in the following frequently occurring problems:

- transport (commuting to the patient's home, transport to services);
- availability of compensatory and medical services;
- availability of more flexible personal assistance, respite and nursing services;
- availability of residence services;
- quality information on the offer of services;
- lack of time for themselves, mental fatigue;
- chronic health problems and fear for the future;
- feelings of exhaustion from care.

Other weaknesses in the support of caregivers include the following:

- insufficient financial security for caregivers;
- lack of opportunities for sharing/combining formal and informal care;
- the minimum direct support for caregivers, it is not well-coordinated, comprehensive and is predominantly random;
- the absence of opportunities for education of informal caregivers;
- lack of psychological counselling or care.

The city district responds to many of the above-mentioned problems. In cooperation with non-profit organizations, it operates counselling centers for clients and caregivers, offers a service of home environment evaluation and consultation of the selection of compensatory products. Free rental of

[20] Adapted according to the Medium-term concept of development of social policy, social and health services 2018-2022, as well as in the Analysis of The Needs of Caregivers (Evetdata, 2017)

compensatory equipment is used, and it serves as a source of contact with caregivers. Self-help groups for caregivers began to take place. The city district has prepared information material for caregivers, in which it represents an offer of usable services. General practitioners' waiting rooms have been provided with bulletin boards with information for potential servicers and caregivers.

12. Barriers in access to services

Generally speaking, barriers to access to services can be of a **dual nature**. The first one relates to the recipient of the service (e. g. his/her willingness to accept, use the service) or to the level of awareness of the recipients about the service itself. The other category of barriers relates to the services themselves. These include, for example, capacities for services, presentation of services, design of services, their physical, time or economic availability in the locality, etc. A number of these obstacles are discussed in chapter 9.1

Seniors make up a relatively large group of inhabitants of Prague 7. Most of them have been living here for a long time. In terms of the situation of seniors, information about social services and access to them, seniors can be divided into approximately **4 groups**[21]:

1. Active seniors who are informed and interested in the services. These are services/activities organized by Prague 7 or other organizations intended for active seniors (education, cultural and sports, leisure events).
2. Seniors living at home who mainly benefit from the services of field care workers and several other services.
3. Seniors fixated only on their apartment who are not informed about possible benefits and services offered and therefore do not more or less use them.
4. Seniors who stay in inpatient facilities (social or health services) in the territory of Prague 7 (Social Respite Centre) or outside the territory of Prague 7 (hospitals for long-term sick people, inpatient services for people with dementia, inpatient hospice care).

13. Barriers in access to the natural environment

The natural environment in relation to the elderly population is described in the Smart home care feasibility study.[22] It states that Prague 7 is a lively part of the city, where many activities take place, and at the same time it operates in a community way – there are many **neighborhood events** for locals. Prague 7, in cooperation with non-profit organizations, also organizes many activities especially for seniors. Seniors are encouraged to volunteer within neighborhood associations. However, seniors lack a **community center** where they can meet.

Volunteering seems to be an effective tool for supporting the elderly. Seniors who live alone often lack social contact. Therefore, they appreciate being in contact with volunteers, being accompanied for a walk or talking to volunteers.

[21] Medium-term concept of development of social policy, social and health services 2018-2022, website of the Prague 7 City Government

[22] Smart Home Care – feasibility study in Prague 7 (CTU UCEEB, 2017)

A fundamental problem in the accessibility of the natural environment is the **limited mobility** of the elderly in combination with **inaccessible housing**, or the environment in general. This problem may be partially solvable with the support of volunteers and neighbourly assistance. The availability of information on accessible transport or affordable taxi services can also help. Service providers could organize transport themselves for their events. It is also important to ensure the availability of information on subsidies for the construction of lifts, etc.

14. Cost of providing services[23]

The most significant expenditure of the budget of Prague 7 is the contribution of the founder to the operation of the **contributory organization** (Care Centre of Prague 7). The activities of this largest provider of social welfare services in Prague 7 are financed by the contribution of the founder, from the contribution of the municipality of Prague, from the subsidy of the Ministry of Labour and Social Affairs and from the payments of individual clients.

The Prague 7 also supports other organizations through its **grant program**. However, the aid is rather symbolic and covers only a small part of the total costs for professional social service providers.

Prague 7 actively strives to use projects for implementation of activities for which Prague 7 does not have funds in the current budget. Currently Prague 7 implements two projects focused on case management development, in other projects it is in the role of a partner.

Other information on the economic aspects of the provision of services will be elaborated by a local working group.

15. Vision for the near future

Support for people of senior age is a priority that finds its anchorage in a number of strategic documents of the city district.[24]

For the period 2016-2022, the city district committed to the area to:

- promote active and dignified ageing;
- improve health care through better information, availability and interdependence of services so that people with health restrictions can stay at home for as long as possible;
- to support the idea of neighbourly assistance;
- support procedural measures, cooperation of organizations and planning for the development of social services.

These objectives correspond to the thematic focus of individual projects (specific activities) formulated in the 2020 and 2021 action plans. These are:

- introduction of case management and creation of a case management platform;
- support for self-help activities aimed at supporting informal caregivers;
- promoting the provision of palliative and specific healthcare;
- promoting volunteering;
- activities including counselling for the elderly, counselling for caregivers, ergo counselling and home environment adjustment, legal counselling for the elderly;
- the establishment of a multidisciplinary rehabilitation team ensuring continuity with hospital discharge and prevention of long-term stays in hospitals for long-term patients;

[23] The information was provided by members of the local group.

[24] Medium-term concept of development of social policy, social and health services 2018-2022, Strategic plan for the development of the Prague 7 district for the period 2016-2022 – analytical part

- the introduction and pilot verification of modern technologies in social and health services — support for emergency care;
- transformation of care services;
- processing and publication of a catalogue of services for the elderly;
- development of a community garden within a nursing home.

Conclusion

The report provides an overview of possible sources of support that can be used by seniors and their families in their joint efforts to stay in the natural environment, even in situations where health and self-sufficiency are impaired. Although the offer of these services is rather varied and complete, it offers a number of issues and challenges that must necessarily be addressed in the near future. In particular, it is necessary to coordinate health and social services at a professional level in accordance with the needs of a particular client. Attention has to be drawn to maximizing support for informal caregivers. On the other hand, the system of service itself offers a wide range of opportunities for future development. One of them is the promotion of volunteering, in which active, healthy seniors can play the role of providers and the fragile seniors can be in the role of beneficiaries.

Resources

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