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SOCIAL INNOVATION IN THE PROVISION
OF SERVICES IN LONG-TERM CARE**

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The present study focuses on the potential of extension of social innovation in social services in long-term care. The aim of the paper is to analyse barriers and drivers according to different care regimes: 1. standard care-mix regimes; 2. universal-Nordic; 3. family-based; 4. Central and Eastern European. Applying different qualitative methods (mapping of initiatives, 62 good examples of which 18 were in-depth, expert interviews, focus groups), the paper is going to explore similarities and differences between care regimes with a special focus on Central and Eastern Europe to see whether the Central and Eastern European care regime can be considered as a special one or not. It becomes clear from the analysis that there are similarities and differences between the individual care regimes and it is of fundamental importance that these as well as the good practices should be widely known and transferred or adapted to the given care structure. This requires continuous mapping and research.

Keywords: long-term care, provision of services, social innovation

Soziale Innovation bei der Leistungserbringung in der Langzeitpflege: Der Schwerpunkt dieser Studie liegt auf dem Potenzial der Anwendung sozialer Innovation bei der Leistungserbringung in der Langzeitpflege. Ziel ist die Analyse der Barrieren und der Motivationen in den verschiedenen Pflegeregimen: 1. Standardregime mit einem Pflegemix, 2. universell-nordisch, 3. familienbasiert, 4. mittel- und osteuropäisch. Es werden verschiedene qualitative Methoden (Erfassung der Initiativen, 62 gute Beispiele, von denen 18 eingehend behandelt werden, Befragungen von Fachleuten, Fokusgruppen) angewandt, um Ähnlichkeiten und Unterschiede zwischen den Pflegeregimen festzustellen. Besonderes Augenmerk liegt auf Mittel- und Osteuropa, um festzustellen, ob das mittel- und osteuropäische Pflegeregime als besonderes zu betrachten ist oder nicht. Die Analyse zeigt, dass es Ähnlichkeiten und Unterschiede zwischen den Pflegeregimen gibt und es von grundlegender Wichtigkeit ist, dass diese Regime und auch die bewährten Initiativen weit hin bekannt sind (werden) oder an die jeweilige Struktur angepasst werden. Das erfordert kontinuierliche Erhebungen und Forschungen.

Schlüsselbegriffe: Langzeitpflege, Leistungserbringung, soziale Innovation

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1. Background

According to the European Commission, in 2060 the number of people over 80 is expected to be 62.2 million, almost triple compared to 2013 and this age group is most likely to need care. Life expectancy is increasing, however healthy life years (HLY) are not following that increase. An average increase of two years among persons over 65 between 2010 and 2020 was a goal of the EU (JAGGER et al. 2013). However, there are substantial differences between the different countries and in a number of countries even a significant deterioration was experienced in the HLY indicator between 2012 and 2014. The indicator showed a decline compared to the average growth of 0.1% measured in the EU (for both men and women). In Croatia, Latvia, Austria, Switzerland, Luxembourg and Portugal this ranged between 1.1 and 4.6 years for women. The negative values for men were between 0.5 and 3 years in Croatia, Greece, Latvia, Portugal, the United Kingdom and Switzerland (Eurostat 2016).¹ What does this mean for care? According to LOPES and colleagues (2013) a substantial proportion of Portuguese men over the age of 65 are in relatively good health up to around the age of 75, but after that they are in need of some degree of help. When analysing the challenges facing long-term care the EU found that there is an increase with age in the prevalence of illnesses restricting daily activity (European Commission 2012), particularly osteoporosis, cardiovascular diseases, ischaemia, stroke, tumours, impaired sight, impaired hearing and people living with dementia. In 2010, 35.6 million people lived in the world with dementia and this number is projected to increase to 65.7 million in 2030 and 115.4 million in 2050 (WHO-Alzheimer Disease International 2012), its prevalence growing with age (almost one quarter of those over 85 suffer from dementia, FERRI et al. 2005). The numbers of people living with dementia point to a critical situation in Germany (1.572 million²), Italy (1.272 million), France (1.174 million) (Alzheimer Europe 2013), and the UK (approximately 1 million, Department of Health 2015).

To sustain the long-term care system (see European Commission 2007, European Commission 2012) social innovation is needed. Social innovation has been in the focus of scholars in many areas such as city development, elaboration of elder-friendly cities, places, new technologies for older people (e.g. projects such as Happy Ageing 2009–2011³), but long-term care and social innovation have hardly been linked at all (although there were projects clearly with such a goal financed by the

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¹ Based on Eurostat data <http://ec.europa.eu/eurostat/tgm/refreshTableAction.do?tab=table&plugin=1&pcode=tsdph220&language=en>.

² See also <http://www.alz.org/de/dementia-alzheimers-germany.asp>.

³ Happy Ageing Project (2009–2011) retrieved 19 Oct 2016 from <http://www.aal-europe.eu/projects/happy-ageing/>

EU). For a long time a variety of concepts were applied (e.g. RUPPE 2011; MOULAERT et al, 2013). Social innovation applied by the European Commission (2011) can be defined as ‘new ideas (products, services and models) that simultaneously meet social needs (more effectively than alternatives) and create new social relationships or collaborations. They are innovations that are not only good for societies but also enhance societies’ capacity to act’. However, bridging long-term care and social innovation was a grey area.

To explore social innovation in long-term care was therefore one of the eight key scientific themes of the ‘Mobilizing the Potential of Active Ageing in Europe’ (MoPAct 2013–2016)⁴ project. A working group (WP8) aimed to map new roads in ‘Social support and long-term care: matching sustainable supply and demand for long-term care (LTC) and ageing-related social support’. The present study focuses on one segment of this research and it is going to explore the potential of extension of social innovation in social services in long-term care.

2. Methods

The working group consisted of Austria, Estonia, Finland, Germany, Hungary, Italy, Portugal and Romania. In addition Greece, UK, the Netherlands, Denmark, the Czech Republic, Bulgaria, Lithuania, and Latvia were represented by the core members. The first research phase aimed to acquire good examples in each country. Following the definition of the European Commission (2011) it seemed obvious that new roads of long-term care initiatives should be linked with long-term care. However, after presentations of the first mapping it emerged that obtaining initiatives in social innovation in long-term care was not an easy task or at least that it would be difficult to reach the original aim of obtaining five good practices per country. Although some of the initiatives indicated innovation they were not directly linked with long-term care but other areas of ageing. Substitute examples were therefore needed; finally a sample of 62 initiatives (mostly between 3–5 examples per country) was assembled.

From the above sample through voting by members of the working group 18 were selected for an in-depth analysis along drivers and barriers in social innovation in long-term care in the following categories: *social innovation; integration of long-term care status, impact; transferability; sustainability*. For each category partners gave a score from 1 (not relevant) to 5 (most pertinent) or ‘not applicable’ if there was not enough information or the category was not applicable. The order of the scores – ranged between 83 and 174 – was only one aspect of the selection; an effort was also made to keep a balance between countries and to ensure a proper representation of care regimes. In some cases ranking was altered by advancing countries with a less favourable ranking. 15 focus groups (with different stakeholders: representatives of long-term care: carers’ associations, local/regional administration, relevant NGOs/local associations and service providers, hospitals, researchers, nursing

⁴ See the website: <http://mopact.group.shef.ac.uk>.

schools and health insurance companies) and 20 expert interviews were carried out (2–5 per country) to explore barriers and drivers of social innovation in long-term care.

The paper analyses initiatives in the context of care regimes and focuses on the following elements: exploring barriers, presenting suggestions mentioned by experts and member focus groups to see whether there are useful innovations among the good examples.

3. Results

3.1. Care regimes applied in the project

The comparison of the drivers and barriers of social innovation in long-term care was first based on the typology of four care regimes.

Table 1
Care regimes as a context for social innovation and active ageing policies

	<i>Demand for care</i>	<i>Provision of informal care</i>	<i>Provision of formal care</i>	<i>Acknowledgement of LTC as a social risk</i>	<i>Countries</i>
<i>Standard-care-mix</i>	Medium-high	Medium	Medium	Early movers	Germany, Austria, France, UK
<i>Universal-Nordic</i>	Medium	Low	High	First movers	Denmark, Finland, the Netherlands, Sweden
<i>Family based</i>	High	High	Low	Late movers	Spain, Italy, Portugal, Ireland, Greece
<i>Transition</i>	Low	High	Low	Starters	Hungary, Poland, Czech Republic, Slovakia, Romania, Bulgaria, Estonia, Latvia, Lithuania

Source: Lamura 2007⁵; NIES et al. 2013.

According to this categorisation all former socialist countries were classified as ‘transition care regime’, still applied in the ‘Overview Report’ in 2013 (SCHULMANN et. al. 2014). However, Central and Eastern European researchers of ‘transition’

⁵ Lamura, G. (2007) *Dimensions of Future Social Service Provision in the Ageing Societies of Europe*, Paper presented at the VI. European Congress of International Association of Gerontology and Geriatrics, St. Petersburg, Russia, July 5–8, 2007.

countries⁶ of the working group strongly argued for a new label. Their argument was that 26 years after systemic change can hardly be considered any longer as a ‘transition’. And a remark was also made. Slovenia was missing in the fourth category. The Baltic countries have a population size and territory similar to Slovenia, and Slovenia is a former socialist country too, but nevertheless it does not appear in this care regime type. A new label was therefore proposed and accepted: ‘Central and Eastern European countries.’⁷

3.2. Mapping of good examples

3.2.1. Standard care-mix regime

The challenges mentioned earlier in connection with dementia, also appear in initiatives of the standard care-mix regime. The Austrian ‘*Action Dementia – Dementia Friendly Communities in Vorarlberg*’ (Aktion Demenz, Austria), targeted family members caring for persons with dementia by providing services that were difficult to access in small settlements (transport, shops, hairdresser, medical doctors in the community). A similar initiative has been launched in the Salzburg region. One of the four UK examples, the ‘*Dementia Recovery Model*’ aimed to create a new model in an acute mental health ward, involving them in the decision-making process in care providing meaningful activities. Two of the eight German initiatives involved receivers of care and/or the family members caring for them: support for persons living with *dementia* and their *carers* through a specially-equipped mobile service (*Mobile Demenzberatung/Mobile advice service*, Germany); involving volunteers to ease the burden of family members caring for persons with *dementia* (*Zeit für dich/time for yourself*). In Germany demented older people with a migrant background represent a special problem due to the special needs of different cultures (*Demenzservicezentrum für Menschen mit Zuwanderungsgeschichte*, Germany).

Technology and ICT-based innovation played a major role in help for informal carers or the receivers of care (*TOPIC-The Online Platform for Informal Caregivers; Vera/Projekt Vernetzt and Aktiv*, Germany). Also of special note were the various initiatives based on *networking* (in-patient and out-patient care sectors, *LoVe*, Germany), citizen companions (*Bocholter Bürgergenossenschaften – Dienstleistungen für das Alter gemeinsam und nachhaltig gestalten*, Germany), local network (*CarePortfolio Germany; Village Service* (Association of Services for Households, Families and Companies-Village Service, Austria, analysed in depth later). There were also network initiatives based on the Internet (*Tyze-Social Network for Care, Online personal network*, UK). One special form of this, the mutual exchange of ‘*Support provided*

⁶ Mihaela Ghența, Aniela Matei, Gerli Paat, Anett Maria Tróbert, Zsuzsa Széman.

⁷ See: <http://mopact.group.shef.ac.uk/wp-content/uploads/2013/10/MoPAct-Policy-Brief-7-Potentials-for-active-ageing-by-social-innovation-in-long-term-care-and-social-support.pdf>.

by me now in return for support for me later' (UK) was also included among the good examples.

Compared to the above, there were fewer cases of good examples based on the employment, labour market pillar (*Care as a future labour market – Developing care competences in rural areas*, Austria; *Trading Times*, linking labour market, social enterprise, UK).

Although there was only one initiative that can be linked to the environment among the many examples, it deserves special attention and was included in the sub-sample because it is associated with a comprehensive concept (*Bielefelder Model*, Germany).

3.2.2. Family-based care regime

Among the many good examples belonging in this care regime we also find *dementia* (*Care for carers*, Portugal, *Up-TECH*, Italy, both will be analysed in depth), and initiatives based on ICT and technology (*Batta-Pool of technical and technological support*, Portugal, *E-health Unit*, Greece, *Amica*, Spain, *VALCRONIC-CARS*, Spain). One example designed to overcome some basic needs, especially loneliness, isolation of elderly or dependent people by volunteer activities of young people ('*Old friends, new smiles*', Portugal) deserves special attention. Like the standard care-mix regime, here too the repertoire includes networking, mutual help (*Mutual Aid Association*, Portugal), utilisation of local resources (*Welfare in the community to care for severely disabled people - Rome*, Italy), involvement of older volunteers (*Senior Health Mentoring*, Greece), an opportunity created by involving multiple actors (*Friendship Clubs*, Portugal). There are also initiatives aimed at the environment, at creating suitable housing ('*Tiedoli houses*', Italy). The *Leonardo da Vinci e-learning* programme supported by the EU, designed to ease the care burdens of formal, informal and migrant care workers with new knowledge is interesting for the fact that the participants included as well as three countries belonging to the family-care regime – Greece, Spain and Cyprus – are also partners belonging to the Central and Eastern European model – Hungary and Lithuania ('*ECV Certificate*'). The attention paid to informal carers once again confirms the need of this target group of help (*Recognition of informal skills – Piemonte Region*, Italy).

3.2.3. Nordic-Universal

The Dutch *Buurtzorg: Care in the neighbourhood*, with a holistic concept of medical, personal and social needs in long-term care belongs in this care regime. The shift in providing LTC from home help to self-care can be seen in The *Fredericia* experience from Denmark. There is a mixed Nordic-Baltic initiative (*VIRTU*), we classify it under the Central and Eastern European pattern as the elaboration and set up of the program was carried out by Estonia. We classify other examples created with material support provided to the Baltic countries under the Central and Eastern European pattern as well.

3.2.4. Central and Eastern Europe care regime

In contrast with the care-mix care regime and the family-based care regime, the question of dementia did not appear in the Central-Eastern European care regime type; this can be explained by the difference among countries in life expectancy at birth. Because of the poorer indicators (Eurostat 2016) the latter countries have not yet paid adequate attention to this challenge. At the same time the appearance of ICT initiatives here is striking. Four of the five Estonian initiatives have technology in their name: the *Alarm button service*, the *My locator* developed by a market actor, *ELIKO* specialising in innovative technologies and products developed by eight companies and *Elder-friendly alarm handling monitoring*, *DREAMING* supported by the EU. Two of the three Hungarian initiatives are based on the possibilities offered by the Internet: *Skype Care* for the elderly, the *Webnurse* that regarded informal carers as its target group, and both initiatives had an NGO in the background. The Czech *AREION* emergency button was also developed through a non-profit actor to enable people living with chronic illness to continue living safely at home. The ICT-based good examples belonging to the Central and Eastern European care-regime are characterised by the combination of market R&D activity, technical innovation in response to a social and/or medical problem, and also by the strong presence of the non-profit sector in the initiatives.

An examination of the good examples from Central and Eastern Europe shows that countries belonging in other care regimes also participated in some of the initiatives. The explanation for this lies in the material support provided by the EU or other international organisations. The Latvian *INNOCARE* realised with financing from the Central Baltic INTERRG IV programme, coordinated by an Estonian university and with the participation of a Swedish partner clearly shows the connection between the Central and Eastern European and the Nordic-Universal care regime. The Estonian *VIRTU* produced its good example jointly with a Nordic, Finnish partner. It can also be regarded as an agreement between two care regimes, in which the Nordic Universal care regime supports the Baltic states in its neighbourhood.

The initiatives supported by the EU have a far greater scope, involving several care regimes. In the *CARE+* project that is part of the ICT Policy Support Programme all four care regimes can be found (France, Austria, Belgium, Italy Sweden, Latvia, the United Kingdom Hungary, Romania). *CareIn*⁸ in the Leonardo da Vinci Transfer of Innovation project brings together ‘only’ three regimes: family-based, Nordic-Universal, Central-Eastern Europe (Spain, Italy, Denmark, Bulgaria, the Czech Republic, Poland). Three care regimes Nordic-Universal, family based, Central-Eastern Europe – are also found in *FOOD* (Italy, the Netherlands, Denmark, Romania, Sweden, AAL European program). All three projects supported a technology-based initiative.

⁸ To help care assistance workers to acquire competences in Emotional intelligence by elaborating a learning environment based on Web 2.0.

The Central and Eastern European care regime and the family-based care regime are similar in that in both a new carer resource, voluntary activity by young volunteers, helps persons in need: lonely elderly persons (Portugal *Old friends, new smiles*), while in Hungary young people teach elderly receivers of care how to use Skype and the internet (*SkypeCare*).

Among the Central-Eastern European examples as well as in the *Bielefelder model* that belongs in the standard care-mix regime the question of the environment comes to the fore in the *Elder-friendly House* (one of the 18 examples).

It can be seen from the above that there are both common features and considerable differences between the types of initiatives in the different care regimes. Networking is strongest in the standard care-mix, while, although there are many good examples related to technology and ICT in all care regimes, ICT occupies a very prominent position in the Central and Eastern European examples, and there are many initiatives launched by NGOs, the market or the EU.

3.3. Potential of social innovations for the expansion of long-term care services

The analysis below is based on those expert interviews and focus groups which were conducted by researchers of Central and Eastern Europe and the German team.⁹ It indicates, in comparison with other care regimes, what factors could be taken into consideration for the potential of social innovation for the expansion of long-term care services. We should emphasise that the good examples were the result of attempts to solve earlier existing problems, giving an innovative answer to a concrete need. They are connected both to the present barriers and to the suggestions; particular segments of the given barrier can also be found in other countries.

The following types of *barriers* were found:

1. Lack of *Prevention*
2. Lack of *Professionalism*
3. Lack of *Support for Carers*
4. Lack of *Funding*
5. Lack of *Concepts for Special Needs*
6. Lack of *Access*
7. Lack of *Information and Communication Technology Dealing with Older Persons*
8. *People with Migrant background*

Among the barriers listed by *all the participants of focus groups and experts*, the most frequently mentioned barriers were lack of *Access* and lack of *Professionalism* (7–7), but there were almost the same number of mentions for lack of *Prevention* (6)

⁹ Team members of WP8: Michaela Ghenta, Aniela Matei, Gerli Paat-Ahi, Monika Reichert, Sandra Schulze, Zsuzsa Széman, Anett Mária Tróbert.

and lack of *Support for carers* (6). This indicates that these barriers appeared with roughly the same weight. These were followed with slightly fewer mentions by dealing with *People with Migrant background* (4), *Lack of Funding* (3), *lack of Information and communication technology* (3) and finally, *lack of Concept for Special Needs* (1).

A pattern containing exclusively *Central and Eastern European* good initiatives can be observed: in four cases regarding suggestions for lack of *Prevention*, two for lack of *Professionalism*, one for lack of *Support for carers*, and one for lack of *Funding*.

In the case of lack of *Prevention* the initiatives indicate that in the *Central and Eastern European* region, the environment, technology and in particular ICT currently play a strong role. This is a possible direction for catching up by the region. In other regions this range of tools has long been included among the possible means for solutions.

Lack of prevention (barrier)

- *Reinforcing public safety* (suggestion)
 - Isolated farm service (HU) (good example)
- *Development of alarm systems* (suggestion)
 - AREION Emergency care (CZ) (good example)
- *Suitable environment, infrastructure for transport, organisation of transport* (suggestion)
 - Isolated farm service (HU) good example
- *Developing ICT skills among the elderly* (suggestion)
 - Skype Care Program (HU)

The lack of *Professionalism* especially in Hungary makes it difficult to provide and control quality assurance and it is impossible to provide complex and cost-efficient care. The complete separation of the health and social spheres, as well as the excessive burden on service providers and their rising costs, also make cooperation between the spheres impossible. Due to the fragmentation of the system certain professions important in services can fall between the two systems although they could play an important role in ensuring that the systems function in harmony, or in providing a link between the systems. In Romania the lack of coordination between the two systems has a negative impact both on the case process and on professional work. In Estonia there is a lack of appropriate training provided for professionals or information for lay persons (e.g. the elderly). Key problems were found in *all* Central and Eastern European countries in the sample: the lack of cooperation among professionals (general practitioners, social and health care professionals), the different service providers, and other participants in the care process. The lack of possibility for consultation between service providers and the carers leads to gaps in professionalism (e.g. general practitioners do not have enough experience in topics regarding LTC).

Lack of professionalism (barrier)

- *Integrated LTC* (suggestion)
 - Integrated Help-at-Home Development Programme (LT) (good example),
 - Home Care and Assistive Services for an Independent and Dignified Life (BG) (good example)
- *Qualified care; uniform control criteria – quality control* (suggestion)
 - Home Care and Assistive Services for an Independent and Dignified Life (BG) (good example)
- *Case management with a skilled team at the interface of the health and social areas* (suggestion)
 - Family Nurse Programme (IT) UP-TECH project (IT) (good example)

At the same time we found good examples from the standard care regime from two countries only for a single suggestion regarding the lack of *Access* barrier. The *New financing* form appears to be a suggestion to which the initiatives of two countries in the standard care regime, Austria and the Netherlands, offer a solution.

Lack of support for carers (barrier)

- *Expansion of home nursing and day services with new functions* (suggestion)
 - Integrated Help-at-Home Development Programme (LT) (good example)
 - VIRTU (EE/FIN) (good example)
- *Expansion of employment opportunities* (suggestion)
 - Recognition of informal skills (IT) (good example)

Lack of funding (barrier)

- *Integrated LTC system for cost efficiency* (suggestion)
 - Home Care and Assistive services for an Independent and Dignified Life (BG) (good example)

The lack of *Support* and lack of *Funding* occurred in only one suggestion their significance should not be neglected since both arise from the lack of an integrated system.

The good examples are responses to a challenge, a more thorough examination of them in the Eastern European region is enlightening. The situation is especially difficult for persons in a financially disadvantaged situation living in rural areas on isolated farms in Hungary and Romania.¹⁰ The situation is further aggravated by the lack of mobile services in rural areas, and the inadequate infrastructure. Laws and standards guaranteeing uniform services are lacking at local and European levels. The lack of suitable care for groups with special needs is also an aspect of the inequality concerning

¹⁰ We analysed the situation in Romania on the basis of data in the working material of Michaela Gentha and Aniela Matei.

access to services. It was noted in the interviews that this can be attributed, among others, to the lack of a conception regarding special needs, the lack of complex thinking, inadequate communication found in the area of care needs, and the lack of homes adapted to special care needs. The need for an expansion of existing LTC services and the establishment of new services represent therefore a priority, particularly in rural areas, even in countries with well-developed LTC infrastructures. As services for people living in rural areas, technical support and training for older people, day care services, personal and mental support services for informal carers, preventive services, and services for low-income older persons are lacking, the coverage of LTC services and the reduction of regional variation in access need to be considered in these countries. The potential for using ICT in long-term care can be harnessed and a stronger partnership among public and private service providers is needed.

There are *suggestions* for which good examples can only be found from the *family care regime*. This arose in the lack of *Support for Carers* problem and the Italian good example of the *expansion of employment*, ‘*Recognition of informal skills*’. The suitable involvement of informal carers and migrant carers in elder care has long been a challenge in Italy. We found two initiatives from Italy for the other suggestion raised regarding the lack of ‘*Professionalism*’ barrier, namely ‘*Case management with a skilled team at the interface of the health and social areas*’; the other is also related to a technology (*Family Nurse Programme (IT) UP-TECH project (IT)*). Both can be adapted and linked to technology in line with one of the directions considered desirable in Central and Eastern Europe, involving technology in care.

Lack of concepts for special needs (barrier)

- *Dementia patients in hospitals, increase offers of palliative care / hospice services* (suggestion)
- Active Ageing with Dementia (PT) (good example)

Lack of access (barrier)

- *New financing form* (suggestion)
- Buurtzorg (NL) (good example)
- Village services (AT) (good example)

One of the characteristics of the lack of *Access* challenge is that the problem appears in *all care regimes*. We can conclude from this that this barrier to social innovation is one of the most fundamental in all regions. Several care regimes can be associated with the individual suggestions.

The situation is the same for certain suggestions regarding lack of *Professionalism*: e.g. ‘*utilisation of resources of volunteers*’ appeared in both a Hungarian and a Dutch initiative.

There was a segment where, among the countries analysed by the Central and Eastern European and the German team, it was only in Germany that the combined appearance of *long-term care and migration* represented a serious problem. All German

experts stressed the difficulties arising in connection with older people with migrant background. This was not only a matter of language difficulties, they used numerous tools to bridge those and also made efforts to adapt services to the needs of persons with differing cultures. The real challenge appears when the cultural differences are extremely deep and they can only be handled with great efforts or not at all. In place of the available and well functioning home care services an elderly woman wanted a larger apartment so that her daughter could care for her. The existing and efficient formal care system came up against the cultural expectation that regards care as the task of the family and in particular of the daughter, and refuses to consider any other solutions. In view of the present migration processes this challenge will only increase in Europe in countries where there are older people with migrant backgrounds, different languages and cultures. This problem seems to be acute especially in Germany. The German society and the formal long-term care system have not been able to cope with this challenge despite some attempts. Therefore great attention should be paid to this.

However, there are other barriers which seem to be serious challenges in Central and Eastern Europe. In Hungary the growing care needs go together with declining service capacity and low service quality. In Romania the financing does not take the target groups into account, and the needs of different entities are not sufficiently involved. The social innovation potential of expanding formal LTC services can in the first place only be realised by means of significant short-term social investment that could be legitimised by an important mid- or long-term social return on investment. The lack of *Support for informal carers* and the *formal workforce* in LTC, particularly informal carers, is also a crucial barrier of social innovation in long-term care in all of the Central and Eastern European countries. The lack of *Information, of awareness, and of communication* (e.g. Estonia) also has a negative impact on the quality of life of care receivers, makes the work of carers more difficult, and impedes prevention.

3.4. Potential for the expansion of services: for whom?

Involvement of older people with a very high risk of social exclusion: e.g. persons with dementia can be classified in this group as well as certain old cohorts or/and their carers. Expansion of LTC services however is not always directly related to the person with special care needs, (e.g. other forms of information, special training for carers). Expansion of services can be considered in a wider context. According to the analysis of experts, participants of focus groups and 18 case studies, expansion of service in long-term care could be achieved by making services available for *all people in the same age group* or all carers or all family carers. Shifting of services towards a *younger generation* is another important possibility, e.g. by 10 years from 75 to 65 as was mentioned in Hungary. In Germany there are different approaches such as *citizens of district towns/regions*, where there is also a comprehensive solution, by combining the regional expansion with expansion to all age groups living in rural areas. Service not only for a certain age group but for all citizens of an *ageing community* can be considered as prevention. If a younger citizen has access to suitable services

they might not need services in old age at all or only in a later period of life. While in the case of Germany, Austria, Portugal or Hungary this is linked only to the given country, there were also good examples where countries belonging to all care regime types participated, so that the efforts were also uniform. It is interesting in this approach that the potential of expansion of service includes all members of the given community discussed above but this approach is irrespective of the care regime. This clearly reflects the concept of ageing, a process that also includes prevention, and interprets the challenge of LTC in a wider context. Instead of focusing only on older people the appearance of younger generations among the target groups indicates a wider concept of *ageing* persons on the one hand and that of *ageing communities* on the other hand. The latter covers citizens of an ageing space and allows social participation. A regional approach is also an important consideration in expansion. Reflecting the situation of older people with migrant backgrounds, a *seemingly contrary trend* appears: the forming of a *subgroup* from a wider target group. Due to their different culture and language they are excluded from existing formal services for the majority.

4. Conclusion

The prevention and early intervention actions should become important components of the expansion of the long-term care system, particularly if they are part of a holistic long-term care system that includes access, information and communication, funding, professionalism and support of carers (formal and informal). There are a great variety of possibilities for the expansion of services in long-term care. However there are ways of service expansion which can and/or should be considered as general ones and independent of care regimes, e.g. financing, cooperation, suitable legislation, and involvement of stakeholders.

Ways to achieve expansion of services and to facilitate integration and coordination often overlap each other or run parallel, such as: partnership of stakeholders, information, consultation, civil society, and new or other forms of employment.

It became clear from the analysis that there are similarities and differences between the care regimes. At the same time there are also common points, both in the barriers and the drivers. The implementation of national legislation concerning granting a right to minimum social care could be envisaged. It is of fundamental importance that these and the good practices as well should be widely known and transferred or adapted to the given care structure. This requires continuous mapping and search for further good examples and policy in practice.

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