

**CASE-STUDY
UKRAINE**

Vladislav V. Bezrukov

Ukraine

11

CASE-STUDY: UKRAINE

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1 General background data

1.1 Preamble

Ukraine belongs to the cluster of countries currently having a large elderly population. Therefore, it is essential to the process of reforming the health care and social service systems in the country that current demographic changes are taken into account. Population ageing will have a direct impact on the country's socioeconomic status. In 1939, the number of persons 60 and over in the total population was 6.2%. In 2000, this figure reached 20.5%. It is predicted that it will grow to more than 25% by 2025. With these increases in both the relative and absolute numbers of elderly people, the morbidity level has also risen. The main incapacitating diseases in Ukraine include those of the circulatory system, nervous system, sensory organs, bones and joints, as well as cancer and psychiatric disorders. For these reasons, the greatest proportion of the population in need of long-term care is the elderly (who comprise two-thirds of the total number of those in need).

The capacity of the informal care system is already very limited. The country displays a clear process of reduction in its population (the natural population loss coefficient is approximately seven (the birth rate is 7.8, and the death rate 14.8, per 1000). The demographic burden per 1000 people of working age is 896 children and persons of the retirement age. In rural areas, the number of persons who are not able to work exceeds the number of those who are able to work. In this context, the role of the family in caring for those with long-term illnesses - primarily the elderly – will not become the dominant mode in LTC. The key role in the organization of long-term care should therefore be shifted to the State.

Presented on the following pages are background data concerning Ukraine, derived from international data bases.¹ These data include demography, vital statistics and epidemiology, economic data, and health expenditure.

¹ For consistency reasons data used in this section are taken from international data sources: UN, World Population Prospect, the 2000 revision (median variant); UNDP, Human Development Report 2001; US Government. The World Factbook 2002; WHO, World Health Report 2002; World Bank, World Development Indicators Data Base; ILO, Yearbook of Labour Statistics, 2000; UNAIDS/WHO Working Group on HIV/AIDS, 2002.

1.2 Background data from international data bases

Demography (year 2000)	
Population (thousands)	49 568
Land area (sq km)	603 700
Population density (per sq km)	82
Population growth rate (% 2000–2005)	-0.94
Urban population (%)	68
Ethnic groups (%)	
Ukrainian	73
Russian	22
Jewish	1
Other	4
Religions (%)	
Ukrainian Orthodox, Ukrainian Catholic Protestant, Jewish	
Total adult literacy rate (% in 1997)	100
Age Structure (%):	
0–14	17.8
15–24	14.9
60+	20.5
65+	13.8
80+	2.2
Projections 65+ (%)	
2025	19
2050	28.7

Demography (continued)

Sex ratio (males per female):

Total population	0.86
15–64	0.91
65+	0.49

Dependency Ratio:

Elderly dependency ratio in 2000 ²	22.7
Elderly dependency ratio in 2025	29.9
Parent support ratio in 2000 ³	12.9
Parent support ratio in 2025	18.7

Vital statistics and epidemiology (year 2000)

Crude birth rate (per 1000 population) (2000) 8.1

Crude death rate (per 1000 population) (2000) 15.4

Mortality under age 5 (per 1000 births) (2001)

males	18
females	13

Probability of dying between 15–59 (per 1000) (2001)

males	376
females	140

Maternal mortality rate (per 100 000 live births) (1995) 45

Total fertility rate (children born/woman) (2001) 1.1

² Elderly dependency ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.

³ Parent support ratio: the ratio of those aged 80 and over per 100 persons aged 50–64.

LONG-TERM CARE

Vital statistics and epidemiology (continued)

<i>Estimated number of adults living with HIV/AIDS</i> (2001)	250 000
<i>HIV/AIDS adult prevalence rate</i>	1
<i>Estimated number of children living with HIV/AIDS</i> (2001)	–
<i>Estimated number of deaths due to AIDS</i> (2001)	11 000
<i>Life expectancy at birth</i> (years) (2001)	
Total Population	67.7
Male	62.2
Female	73.3
<i>Life expectancy at age 60</i> (2001)	
Total Population	17.0
Male	14.0
Female	19.0
<i>Healthy life expectancy (HALE) at birth</i> (years) (2001)	
Total Population	57.4
Male	52.9
Female	61.8
<i>Healthy life expectancy (HALE) at age 60</i> (2001)	
Total Population	10.5
Male	8.8
Female	12.2

Economic data (year 2000)

<i>GDP – composition by sector (%)</i>	
Agriculture	12
Industry	26
Services	62
<i>Gross national income (GNI) (\$PPP)⁴</i>	183 billion
<i>GNI – per capita (\$PPP)</i>	3700
<i>GDP – per capita (US\$)</i>	700
<i>GDP growth (annual %)</i>	5.8
<i>Labour force participation (%)</i> :	
male	55.8
female	46.3

Health expenditure (year 2000)

<i>% of GDP</i>	4.1
<i>Health expenditure per capita (\$PPP⁴)</i>	146
<i>Health expenditure per capita (US\$)</i>	26

⁴PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries

LONG-TERM CARE

2 General health, social and LTC system

2.1 Basic income maintenance programmes

The sources of income support for disabled and elderly persons include:

- monthly pension payments for all State pensions (labour pensions, old age pensions, and incapacitation and loss of breadwinner pensions) and social pensions;
- allowances for services to low-income families, e.g. drug provision, sanatorium-and-spa treatment, and prostheses;
- one-time payment to pensioners; and
- free meals for low-income, single disabled persons.

Also, in the majority of towns in Ukraine, certain national committees release funds for the financing of home-based medico-social services for the needy.

2.2 Organizational structure of decision-making

2.2.1 Major stakeholders

The State plays a principle role in the planning, financing and development of health care services through two separate ministries that function within the Cabinet of Ministers of Ukraine: the Ministry for Public Health and the Ministry for Labour and Social Policy.

The Ministry for Public Health is composed of a number of departments, each dealing with a particular sphere of management: organization of medical care for the adult population, sanitary and epidemiological management, science and international relations, personnel, educational institutions management, social development, etc. Likewise, public health care departments exist at the regional and local levels, functioning within the regional ('oblast'), municipal and district state administrations.

CASE-STUDY: UKRAINE

The Ministry for Labour and Social Policy has a number of departments, such as social services for the elderly, legal control, employment, etc. Respective departments also exist at the regional and local levels for the social protection of the population that function within the regional ('oblast'), municipal and district state administrations.

Overall coordination of the activities of the two Ministries is accomplished at the levels of the Prime Minister and the Cabinet of Ministers. Coordination is conducted in localities by the first deputy chief of local administration or by special coordination commissions dealing with care provision for those who are in need. Despite the fragmentation of health and social services at the local level, the district doctor plays an important role in determining care plans for home care services provided by the department of social services.

The NGOs involved in health care provision are relatively new associations that deal with Parkinsons disease, Alzheimers disease, diabetes mellitus, cerebral paralysis, and the Red Cross, that provide education and training for families of long-term care patients. There are also NGOs (religious and charitable organizations) that operate at the local level and provide additional funding for LTC provision. For example, geriatric hospitals have opened in several regions under the auspices of local NGOs. NGOs are also involved in the provision of home care for the frail elderly and the disabled.

LTC services, mainly for the single elderly and disabled, are provided by special divisions in both the Ministry of Public Health and the Ministry for Labour and Social Policy and are financed from the State budget. A special department of social services for the elderly at the Ministry for Labour and Social Policy provides care mainly to these single elderly and disabled.

Services are provided in various housing facilities and at home. A special subdivision for long-term health care within the Ministry of Public Health provides:

- care in geriatric hospitals and units for long-term care of chronically-ill patients;
- nursing care units in multi-profile hospitals;
- hospices; and
- home assistance for the disabled in district outpatient facilities.

LONG-TERM CARE

2.2.2 Decision-making

In a general sense, it can be said that the health and social service systems in Ukraine are fairly centralized. For many years, there existed a State-controlled, centralized system of medical and social services, funded predominantly by the State budget.

As a result of the complex socioeconomic and demographic situation in the last few years, there is now an urgent need to change the policy of the national and regional administrations. This change in policy is needed with regard to health care and social protection in the country.

Currently, Ukraine is undergoing a process of decentralization, financial restructuring, restructuring of medical and social services, and expansion of services. The concept of health care and social welfare reform envisages an improvement of the forms and methods of managing these branches at the national, regional and local levels through:

- decentralization of institutions – transfer of a number of institutions to local administrations;
- financial restructuring – increasing local budget expenditures;
- restructuring of medical, social and daily living service – changing the internal structure of practical health care institutions and services;
- changing the forms of their interaction and subordination;
- creating new types of services that would more adequately meet the needs of the people; and expanding the infrastructure of services.

The bases of the reform measures include:

- adequate financing;
- reorientation of priority development of primary medical care (introduction of family medicine, strengthening of the rehabilitative and geriatric fields).

- standardization of services and introduction of estimated rates for different kinds of medical, social and daily living services, and organization of a system of quality control of these services;
- creation of an up-to-date information base; and
- enhancing continuity and an interaction between the medical, social and public structures in addressing the issues of support for patients in need of long-term care.

3 Financing of health services

Public health care and social protection services in Ukraine are funded through the national budget. Allocated from the total 1999 budget of Hr 32 876.4 billion (about US\$6 billion) was:

- Hr 3808.7 million (approximately US\$700 million, or 11.5% of the total budget) for public health care; and
- Hr 4147.1 million (approximately US\$755 million, or 12.6% of the total budget) for social protection and social welfare.

Also, in the majority of towns, certain national committees release funds for the financing of home-based socio-medical services for the needy. Other sources of funding are the local municipalities, private donations, and out-of-pocket payments.

In accordance with the main law of Ukraine (the Constitution adopted in 1996), each citizen has the right to health care and medical aid, provided through State financial support and available free of charge at State and communal institutions (Article 49).

LONG-TERM CARE

However, because of the gap between budgetary allocations and the real cost of medical services, some of the services that require technical or material means (including dental care, laboratory diagnostic analyses, highly specialized consultations, tomography (CT), x-rays, and dressing materials) as well as drug provision, are partially or fully paid by the patients themselves. Subsidized coverage (free or at reduced prices) is provided for specified medical care and drug provision for specific population groups, such as those suffering from diabetes, tuberculosis, AIDS, etc.; the disabled of all categories and ages; and low-income citizens. Also, disabled war veterans are given privileges to buy drugs within the system of specialized (e.g. veterans) pharmacies.

In addition, disabled persons of all categories, victims of the Chernobyl disaster, low-income pensioners and families, all have privileges to pay reduced housing-communal payments. The State pays part of the cost of the sum exceeding 20% of total family income. Furthermore, local administrations provide material aid for persons in need (in cases of childbirth, illness, death of a spouse, extraordinary situations, natural or man-made disasters, etc.). The amount of aid varies.

4 Services delivery system

Medical care is provided by a network of general and specialized health care services in the following types of facilities.

- Treatment institutions. These include district, central district, central town and regional hospitals; hospitals for World War II disabled veterans; and emergency aid hospitals.
- Specialized hospitals. These include psychiatric, psycho-neurological, physiotherapeutic, and geriatric clinics at research institutes
- Dispensaries. These include oncological, cardiological, anti-tuberculosis, endocrinological, and psycho-neurological dispensaries.
- Ambulatory-polyclinic institutions. These include medical-obstetric stations, village medical ambulatory centres, town, central district and district polyclinics, stomatological, and physiotherapeutic polyclinics.

- First aid and emergency medical stations.
- Resort houses, sanatoriums, rest homes, prophylactic centres, medicinal baths/springs.

The system of social protection of the population includes various kinds of assistance as follows:

- pension provision;
- material (pecuniary) aid;
- privileges;
- full board plus socio-medical service at stationary institutions; and
- various kinds of domestic social and daily living services.

The social (medico-social and social/daily living) assistance for the population is provided through the following institutions:

- Homes for the aged and disabled, including nursing homes for elderly and disabled persons; geriatric nursing homes; special boarding houses for elderly and disabled persons who have been released from prisons.
- Homes for mentally ill persons.
- Boarding houses for agricultural workers.

LONG-TERM CARE

- Territorial social service centres for pensioners and single disabled citizens, including informal care units; social and daily living rehabilitation units; socio-medical rehabilitation units; stationary units for temporary/permanent residence; units providing material aid/assistance in kind to low-income disabled persons; domestic social care units within district departments for social protection; and special residential houses for single pensioners (sheltered housing).

As of 1 January 2000, there were a total of 3300 medical institutions in Ukraine. The number of beds was 96.1 per 10 000 population. The number of medical ambulatory-outpatient institutions was 7200. The number of visits per one working shift was 195.5 per 10 000.

Primary ambulatory medical care is provided by a network of ambulatory polyclinic institutions at municipal and district medical centres, trauma centres, rural medical ambulatory and medical-obstetric services, and through private clinics. Primary medical care is delivered by a district physician and a medical nurse. Currently, emphasis in health care is being placed on the development of family medicine. In the case of home care, the district doctor, or other specialist from a polyclinic or the first-aid team, is called on to conduct home visits. All equipment/supplies to care for a chronically ill person in her/his home environment are procured at the patient's expense, from the hiring stations at territorial social service centres for pensioners, pharmacies, special community funds, etc.

For the treatment of acute diseases and depending on severity, the patient can visit a district doctor at an outpatient department or call a first-aid medical team to visit him/her at home. If need be, the patient will be admitted to a profile hospital division. All the listed services are provided free of charge.

In a number of towns there exists an informal sector offering alternatives to formal sector services, such as emergency medical aid, inpatient and outpatient treatment, including stomatological and rehabilitative services. However, these services do not meet the health care needs, either in volume or in quality, of chronically ill patients (such as those with cancer, diabetes, or emphysema).

CASE-STUDY: UKRAINE

Inpatient care is provided at multi-profile or specialized (cardiological, geriatric, psychiatric, etc.) hospitals and dispensaries. Rehabilitation units have been opened at some hospitals.

Drug provision within the primary care system is at the expense of patients themselves. At the same time, invalid patients and war veterans are given privileges to buy drugs within the system of general or specialized pharmacies (e.g. those for veterans). There are also privileges for patients suffering from illnesses specially listed (diabetes, tuberculosis, etc.), to buy drugs free of charge or at reduced prices.

There are regional differences in the provision of health care and social protection services in the Ukraine. Some regions and localities have more developed infrastructures of these services owing to additional financing by local administrations, public funds and religious bodies.

The present-day health care reform is focused on improving primary medical care and long-term care, with a strong emphasis being placed on strengthening secondary prevention. Further reform envisages the replacement of district therapists by family doctors and general practitioners. In the health care institutions, the quality of care is evaluated on the basis of selective check-ups by the respective administrative bodies. One of the main directions of health system reform is the development of quality standards for health services.

4.1 Auspices of health service providers

The provision of health and social care is through a system of state-owned institutions affiliated with the Ministry of Public Health and the Ministry of Labour and Social Policy at regional, district and municipal levels. The work of all medical institutions is controlled by the State, by special departments within the *oblast*, municipal and district administrations.

The majority of medical institutions are State-owned and financed from national and local budgets. In addition, there are private clinics such as, for example, stoma clinics.

The Red Cross, other public organizations, and charitable funds (both religious and secular) also play an important role in the provision of care.

LONG-TERM CARE

5 Human resources and training

Medical professionals are trained within the system of State-owned and private secondary and higher educational institutions. Ongoing improvement of professional knowledge and skills is conducted within the system of advanced postgraduate education, at special schools on a local basis and at work sites in leading clinics. All State-owned and private medical institutions are subject to licensing and accreditation.

5.1 Physicians

After receiving a medical degree (six years of study), all medical doctors undertake a specialized intern course (one year). In addition, physicians in polyclinics pass an advanced training study course at the Chair of Gerontology and Geriatrics of the Institute for Postgraduate Education (three months study). Every fifth year, physicians in all specialties must take a three-month continuing education course.

The role of the physician includes assessing diseases, deciding on treatment, and coordinating the work of medical personnel, social workers, and other personnel involved in care for patients. Despite the fragmentation of health and social services at the local level, the District Doctor plays an especially important role in determining care plans for home care services provided by social services.

5.2 Nurses

Medical nurses and Red Cross nurses must have earned diplomas from secondary medical education (3 years). They improve their qualifications at special courses (1–4 weeks) and schools (ongoing courses, each with one lecture per month).

Medical nurses fill doctors' prescriptions, monitor patients' health, conduct rehabilitative measures, and instruct/educate the patient's relatives/carers.

5.3 Other health/social care providers

Junior Red Cross nurses, social workers, and alternative servicemen have various terms of educational and training requirements for specific positions.

CASE-STUDY: UKRAINE

Social workers receive short-term training courses in management and care of chronically ill persons, held on a local basis. As an element of their training, social workers receive weekly courses for familiarization with the specifics of care for frail patients, their psychology, and issues pertaining to their legal protection. In the course of their working life, they receive necessary in-service training at special training centres (once a month).

An important role of the junior Red Cross nurse, the social worker and the alternative servicemen is to help the doctor/ nurse in providing various kinds of services for chronically ill patients.

For example, social workers can provide the following kinds of services:

- purchase and delivery at home of supplies and food;
- cooking meals;
- delivery of prepared meals, medications, newspapers;
- calling a doctor at home;
- rendering assistance with periodical medical examinations, hospitalization;
- help with house cleaning, laundry, all kinds of repair work, fuel provision;
- preparation of documents in order to receive pensions, subsidies, and other kinds of payments;
- preparation of documents in connection with sanatorium–spa treatment, move to a boarding home, or admission to an inpatient unit of the territorial social service centre;
- writing applications to receive services from food/daily living/ telephone/housing organizations and agrarian enterprises;
- establishing and maintaining linkages with former employers in order to receive moral and material support;
- creating conditions for doing a job; and
- solving other problems for persons living alone, when asked to do so.

LONG-TERM CARE

The volume of services provided to persons with disabilities living alone varies depending upon the severity of the condition. For those who never leave their home, the above-listed services are provided in full. Among those living alone, full care is required by 12.5% of the urban and 1.1% of the rural population. Those who need partial assistance to perform daily living activities comprise 10.4% of the urban and 4.6% of the rural population.

5.4 The role of the volunteer

There has been a long-standing tradition in Ukraine to render assistance to disabled, frail old people on a voluntary basis. In recent years, this type of public activity has grown into a voluntary movement among all layers of society. In different regions of the country there are centres, where the training of volunteers to perform various kinds of activity is carried out. The volunteers work in social service centres, in the medical-sanitary centres and Red Cross rooms, at inpatient institutions of the public health service, and in the welfare service system.

6 Summary of LTC provision

A unified, single LTC system does not exist in Ukraine. LTC-type services do exist in the systems of the Ministry of Public Health and Ministry of Labour and Social Policy. Within the system of social protection for the population, LTC is one of the most significant points of focus. This focus is expressed in financing services and in planning and allocating budget resources at both the national and local levels.

At the same time, the practical health care network, which provides long-term care for specific population groups, is developing at a slower rate, and financing at national/local levels is not a priority. The long-term treatment of patients suffering from tuberculosis, diabetes, bronchial asthma, cancer (certain groups) and AIDS, as well as Chernobyl victims, is provided by national and local budgets. However, financing of long-term health and social care for old chronically ill persons is mainly at the expense of local budgets and on the initiative of local administrations.

The main set of services is regulated by Ukrainian laws and by the respective documents (such as orders, resolutions, decrees, recommendations) of the Ministry of Public Health and the Ministry of Labour and Social Protection. Fulfilment of legislation is regulated by relevant documents issued by local state administrations in consideration of local conditions, followed by a control of the respective administration commissions at the town and district levels.

These commissions are composed of public officials, representatives of the industrial sector, businessmen, and heads of public organizations and foundations. They participate in discussions concerning the fulfilment of the regional social programme and may even release additional funds to finance elements of the programme, and not infrequently, long-term care.

Overall, long-term care services are paid by the State. In the case of those who are not eligible to receive social care free-of-charge (e.g. those living in a family with a total average income higher than a subsistence level defined by the Government) may, under existing legislation, receive services upon partial or full payment of their costs. Many of those receiving public services also need to supplement them with out-of-pocket payments.

The district physician–therapist plays a key role in the organization of long-term health and social care for chronically ill persons in their homes. He/she determines the whole complex of measures, including the volume of required services to be delivered by social services. With further development of long-term care, the role of paramedical personnel with special training in rehabilitation and geriatrics will be enhanced.

This chapter will first consider LTC services according to whether they are provided in the health or the social system, with additional information about the participation of religious groups. Next, this discussion will examine target populations receiving various types of services (e.g. institutional, home-based) together with exceptional programmes in various regions. Finally, LTC services in a specific region, the Ternopil *oblast*, will be described.

6.1 Care provided in health and social care systems

Within the **health care system**, separate structural subdivisions, fully financed from the budget, provide long-term health care, including:

- Geriatric hospitals and units (based on multi-profile hospitals) for long-term treatment of chronically ill patients.
- Nursing care units as part of multi-profile hospitals.
- Hospices.
- Medico-social divisions providing home assistance for disabled individuals living alone (district territorial outpatient facilities).

LONG-TERM CARE

Within the **social system** of care, priority is given to long-term care of elderly citizens living alone and to disabled persons. This is a budget-restricted form of care, which is provided at:

- boarding homes of various types;
- inpatient care units of the territorial social service centres for pensioners; and
- domestic service units.

To provide long-term care for disabled citizens living alone, special geriatric hospitals were opened under the auspices of religious bodies in several regions (L'viv, Ternopol, etc.). The parishioners of different religious groups also provide home care for fragile elderly and disabled individuals. In the majority of towns, ethnic communities release funds for financing home-based medico-social services for the needy.

6.2 Target populations for LTC provision

LTC targets:

Chronically ill persons, including **persons with disabilities and elderly citizens living alone**, who are receiving care in nursing and LTC multi-profile hospitals, at hospices and in their homes.

Chronically ill persons with infectious diseases, who are being cared for in the infectious disease hospitals and in specialized inpatient dispensaries.

HIV-infected persons and patients with AIDS who are registered and undergo treatment in specialized medical institutions at the regional and national levels (mainly in general wards of infectious disease hospitals).

Persons disabled as a result of injuries who are placed initially in the specialized traumatology units of multi-profile hospitals or emergency aid hospitals. Rehabilitation of such patients is carried out under ambulatory conditions in rehabilitative units of the territorial polyclinics. Patients with complicated traumas and their consequences are sent to specialized clinics at the research centres.

To date, there has been no decision as to the organization of care for elderly persons with hip fractures and other complicated injuries who become functionally disabled as a result. In recent years, the Government has allocated funds for the development of national production of prostheses and other necessary equipment and devices for rehabilitation of disabled persons. However, these funds do not fully meet existing needs. Many patients who are in need of prostheses have to pay, partially or fully, their costs.

Persons with sensory limitations generally belong to community associations, which are responsible for arranging their social rehabilitation. Medical care for these persons is provided within the ambulatory-polyclinic network or by physicians within specialized inpatient divisions.

Mentally ill persons are treated by physicians—psychiatrists at polyclinics, specialized hospitals, units, and dispensaries. There are nursing homes for the psychically chronically ill within the welfare system, and inpatient specialized geriatric units for **persons with dementia**. There are no arrangements for long-term home care for those with severe psychiatric disorders.

Persons with substance (alcohol, narcotics) dependence are registered and undergo courses of treatment with narcologists at polyclinics and specialized dispensaries.

Aid for victims of man-made and natural disasters is provided within the general health care system network and in specialized ambulatory and inpatient institutions funded by the Cabinet of Ministers, the Ministry for Extraordinary Situations, international funds, and the Red Cross. Informal care for these population groups is provided by family members, neighbours, and volunteers. The significant role of volunteers in LT for patients in rural areas must be stressed.

6.3 Types of long-term care services

Disability prevention occurs at all stages of primary and secondary health care provision. The central figure in this work is the district physician—therapist of the polyclinic. He/she arranges for observation of those patients who are in need of long-term follow-up and rehabilitation. The district physician is obliged to conduct a medical examination of every elderly person at least once a year. However, only a few elderly persons actually receive such examinations.

Disability and chronic disease prevention are handled in the rehabilitative units (rooms) in polyclinics, inpatient institutions, and territorial social service centres. However, only 30% of the need for well-elaborated programmes of socio-medical and preventive rehabilitation for different groups of people are being met, and such structures are developing slowly.

LONG-TERM CARE

In Ukraine, there is no **education/training for families of patients** who require long-term treatment and care. However, the appearance of new associations (such as Parkinsons disease, Alzheimer disease, diabetes mellitus, cerebral paralysis), is bringing together patients, their relatives and carers, and other personnel. The activities of these associations focus on education and training of patients' relatives/carers.

Programmes for education of pensioners at 'third age' universities include special classes on issues of care for chronically ill persons in home conditions. In addition, Red Cross activists and district physician nurses educate family members in specific diseases, and how they should take care of the particular patient. The municipal and district Centres of Health regularly publish booklets on the concerned topics, which are also dealt with in special television and radio programmes.

Inpatient facilities include

- hospitals and nursing care units for long-term chronically ill persons,
- hospices,
- social inpatient facilities attached to district village hospitals,
- religious community-based long-term care hospitals,
- boarding homes for the elderly and invalid persons,
- geriatric nursing homes;
- nursing homes for mentally ill persons;
- inpatient units for temporary (up to six months) and permanent residence of disabled citizens living alone at social service centres, boarding homes for collective agricultural enterprises; and
- specialized dwelling houses with medico-social services (sheltered housing).

In many regions, such structures as hospices, long-term and nursing care hospitals are only now coming into existence and have not been widely used. Over 15 000 elderly patients were treated at day inpatient facilities in hospitals and polyclinics in 2000.

Home-based services are provided by polyclinics (not universally) and social service units. In the case of home care, the district doctor/other specialist from a polyclinic or the first-aid team may be called to visit a patient at home. The principal health professional teams who organize home-based LTC are:

- a district physician – therapist;
- a district physician – nurse assistant;
- a nurse – physiotherapist;
- a Red Cross nurse – nurse assistant.

Home care is provided by social workers of the 19 territorial social service centres and domestic social service units, as well as by those performing alternative (i.e. non-military) national service and volunteers. In 2000, the total number of single non-working citizens in need of home social care was 266 000. This service was delivered to 215 000 people (77%), while 51 000 people (mainly in rural areas) received home care from their neighbours or volunteers.

The work load (i.e. the number of individuals served) of social workers in the staff structure of home-based service units is from four to twelve persons. The number served depends upon the severity of the patient's condition (as for example in the case of a person living alone who has lost self-care abilities) and on the location of his residence (in a town or village). The number of visits by a social worker to an individual living alone (at least twice a week) is determined by the chief of the home-based service unit. These social workers are assisted by nurses of the Red Cross and volunteers.

A specific form of home care involves an 'in-home hospital' for a long-term stay. Medical care for in-home hospital patients is delivered by physicians and nurses of the polyclinic and by Red Cross nurses. Social care and assistance in daily living activities are provided by social workers of social domestic service divisions and by volunteers. A patient living in the family is cared for by members of the family. In 2000, there were about two thousand pensioners in such in-home hospitals.

LONG-TERM CARE

Formal care (including that in the structures listed above) is funded through budgets at the national and local levels. In addition to this formal care should be added LTC activities of the Red Cross organization and ethnic communities (Joint-Hessed, etc.). Formal care is delivered generally by qualified medical professionals (physicians, nurses and social workers) and their assistants.

Informal care is delivered by family members, neighbours, friends, and religious community volunteers, etc.

In organizing LTC services, **assessments of need and monitoring of the quality of service provision** are made by health care services – namely, the district doctor (physician’s assistant in rural area) – and by social welfare services – namely, the employees of domestic and social protection service divisions of local administrations. Public organizations, such as councils of veterans, also have some control over the quality of services.

A number of State-owned and cooperative enterprises throughout the country manufacture approximately a hundred products for invalid persons, in order to facilitate their motor abilities and **self-care**. However, the volume of this production, its cost and sometimes its quality, do not meet their needs.

6.4 Exceptional LTC-type programmes directed to specific target populations in specific regions of Ukraine

These programmes include populations in:

■ **Kiev**

An International Medical Rehabilitation Centre for the victims of wars and totalitarian regimes has been established, which provides long-term medical, psychological and social-daily living assistance for sufferers and their family members in their homes.

If necessary, the Centre refers patients for long-term inpatient treatment. The Centre is financed from the funds of local administrations and international foundations (grant-supported projects).

■ *The Ternopil Oblast*

Under the auspices of a men's orthodox monastery, a hospice with a capacity of 50 places for frail old persons needing LTC and treatment was opened. In the Zolotnik District of the same oblast, a social care inpatient institution with 30 beds and elements of medical rehabilitation was organized using as a base the village district hospital at the expense of private donations.

■ *In a residential district of Kharkov*

Using as a the base the Territorial Centre for social services for pensioners, an information-consultative centre was opened. In this establishment, any citizen can obtain consultative assistance on all questions of medical and social care, and receive substantive LTC support.

■ *In a number of villages of the Kupiansk district (Kharkov Oblast)*

Social care and assistance with activities of daily living for elderly people living alone and who are in need of long-term care has been organized. This work has been undertaken under the auspices of the district people's deputy council, the council of veterans, and volunteers, financed from a local budget and donations from private individuals.

6.5 Long-term care in a specific Ukrainian region: Ternopil

Ternopil oblast is located in the western region of Ukraine, and most of its population lives in rural areas in which the religious traditions of Orthodox and Catholic faiths are preserved. Accordingly, the church community plays a central role in providing care for elderly and disabled persons.

This factor has also an impact on the formation of intergenerational family relationships. These relationships are exemplified by the spirit of responsibility which is assumed for a frail and/or disabled close relative.

LONG-TERM CARE

These same attitudes are naturally shown by neighbours and volunteers. The latter provide free assistance for long-term care, along with the more common forms of LTC such as caregiving (variously from pensioner to pensioner, pensioners to children, and children to pensioners).

Inpatient/institutional long-term care is provided in the following institutions:

- Town hospital No. 1: A geriatric long-term care unit for chronically ill persons (30 beds) and a day geriatric inpatient hospital (20) beds have been established.

Six teams (four therapeutical, one neurological, and one surgical) have been established, in the organization of a centralized in-home service for chronically-ill persons and funded through the town budget.

- Specialized long-term care wards on the premises of town and district hospitals (predominantly funded by local budgets covering 40-60% of the cost of treatment, as well as by the central budget and by private and public donations).

- District village hospitals, geriatric long-term care wards have been opened. During the autumn-winter season, more than 300 elderly people, who are in need of social care rather than treatment, are placed in these wards for two to four months.

One such hospital has been converted to a socio-medical in-patient facility with 30 beds. It is funded by partial donations from the Ukrainian diaspora, with a large portion of the money coming from Canadian diaspora members.

7 General questions pertinent to LTC development

7.1 Present and future needs for long-term care and gaps between needs and provision of services

Any discussion of LTC provision in Ukraine must include statistics concerning the need for such services. The results of a socio-medical investigation of the retirement age-population, conducted by the Kiev Institute of Gerontology, show that:

- among the total elderly population, 4.3% of urban and 9.5% of rural residents are in need of prolonged hospitalization (institutionalization) at social care facilities for patients who have lost the ability for self-care, or at divisions for long-term stay of chronically-ill persons, or at nursing care units.
- 13.2% of urban and 6.6% of rural residents aged over 70 years and living alone are in need of partial outside assistance with activities of daily living; when such assistance cannot be organized in their homes, these persons must be transferred to general wards (units) of boarding homes for the aged.
- 13.8% of town and 2.7% of village residents aged over 70 years and living alone are in need of everyday social, daily living, and medical service to the full extent of that care; alternatively, they need to be placed in hospital wards (units) of boarding/nursing homes for war and labour veterans, when such kinds of services cannot be organized in their own homes.

The main task of socio-medical services is to promote the option of keeping an elderly person in his own health/needs class for as long as possible. A comparative longitudinal study has shown that living at one's own house or in special apartment houses with an adequate number of residents and provided with a set of socio-medical services appears to be the most favourable option. By contrast, excessive help produces an equally negative effect. Moreover, the 'clusterization' of individuals with marked psychic and physical disorders in nursing homes accelerates the process of dependence development.

LONG-TERM CARE

The acuteness of rises in dependence indices is significantly higher for men than for women. These findings provide evidence of poorer reserves among men of the mechanisms for adaptation to limitations imposed by ageing.

Indices of dependence according to physical capability, social activity, and psychological status show the greatest rise in old age. Analysis of data has shown that the accelerated rate of rise of the dependence is influenced by an increased frequency of acute and exacerbation of chronic illnesses, motor passivity, excessive weight, and 'social uselessness' among the elderly.

However, despite the heterochronicity of ageing of organs and systems, and the peculiarities of rises in indices of the dependence upon outside assistance relative to gender and other individual characteristics, the main negative breakdown occurs on average within the same age interval – after seventh decade of life. This should be defined by medical services as a super-risk period, during which an intensive long-term health care and rehabilitation – including preventive measures – are required to reduce the acuteness of this process.

Among other groups of patients who are in need of long-term care (including those with cancer, tuberculosis, psychic disorders, HIV/AIDS, alcoholism/drug addiction) morbidity levels have risen constantly. For example, morbidity from various causes rose as shown in Table 1.

Table 1. Cases of morbidity per 100 000 population

	1990	1995	1999
Neoplasms	1297		1525
Tuberculosis	190		239
HIV-infected cases		2.9	52.9
AIDS		0.1	1.5
Psychic disorders	1946		2425
Drug addiction	6.6		21.5

In promoting long-term care at the local level through existing infrastructures of the health or social care system, the challenge is to:

- introduce geriatric patronage medical nurses into the staffs of outpatient clinics;
- increase the number of Red Cross nurses;
- increase interactions between the respective State and public structures;
- provide medical personnel to deliver care for patients in their homes, with portable diagnostic and physiotherapeutic equipment;
- develop industries to manufacture necessary appliances for caring fo patients in their home environments; and
- establish locations for obtaining such devices.

Throughout the country, a wide gap exists between the care needs of elderly people and the satisfaction of those needs. Ambulatory-polyclinic services (therapeutic and specialized) needs are met at an average rate of only 53%; rehabilitative out-patient treatment 19%; home care 29%; emergency medical care 67%; in-patient treatment 74%; and social care of single persons 80%.

Generally, health and social care remains inaccessible to the greatest degree among elderly people who reside in rural areas. For example, the needs of rural people of retirement age for ambulatory/outpatient care are met at an average rate of only 39%; emergency medical aid 42.7%; and in-patient treatment 67.3%. This last need is met predominantly at the expense of using the beds of district rural hospitals, rearranged for purposes of LTC and care of chronically-ill persons. Medical rehabilitation and home-based care have an incidental character, or may never be used in the community.

Results of experts' evaluation of LTC provision have revealed significant inadequacies in the diagnosis and treatment of elderly patients, as a result of insufficient personnel qualification and violation of the stages of service provision. Wrong diagnoses were registered in every tenth case, and overdosing and multi-morbidity in every second case, while the continuity in treatment between separate medical sub-units was totally absent.

LONG-TERM CARE

From a cost–effectiveness perspective, the most advantageous were either those institutions with home-based long-term health and social care units and rehabilitation units within their structures or those which used non-traditional forms of long-term hospitalization (in-home hospitals and day centres). These were able to reduce the number of emergency aid calls by 2.5 times and the number of expensive hospitalizations by 3 times.

The principal shortages in meeting LTC can be summarized as follows:

- Absence of a State-coordinated long-term health and social care system.
- Absence of specialized home care at night, much required for single disabled persons and oncological patients.
- Shortage of staff specially trained in rehabilitation; lack of portable equipment to conduct diagnosis, treatment, and rehabilitation in the home; shortage of medical supplies to care for patients (particularly bedridden persons); and devices for moving around in and outside the home.
- A slow rate of development of a network of LTC hospitals, nursing hospitals, and hospices (only 10% of this need is met). There are almost no daytime in-patient facilities for psychochronically-ill persons, or clinics for social-psychological rehabilitation.
- The unresolved question as to the method of payment for medications for various groups of chronically-ill persons – primarily for expensive medication for chemical therapy for oncological patients.
- Urgent need for special educational programmes for training medical and social personnel engaged in LTC service, including: physicians, medical nurses, and social workers, as well as staff dealing with rehabilitation (preventive, medical, social, and psychological).
- A need to develop special programmes for education of patients' relatives (carers) on the specifics of care, and for training schools at territorial medical and social centres.

7.2 Planned or current changes/reforms which are likely to affect the provision of LTC.

From an understanding of the socioeconomic and demographic situation of Ukraine, and of its potential for developing national medical services, there emerges an urgent need for radical reform measures. A systematic approach towards long-term and geriatric care organization is also needed.

Successful reform of the organization of health and social care for chronically ill and disabled persons lies in the creation by the State of a well-coordinated service system. Such a system can be organized at a high and modern scientific-technical level, based on a concept that has been developed by the Kiev Institute of Gerontology in the course of its long-term research.

This concept has two fundamental bases – it must be:

- purpose-oriented (assessment of the position of geriatric care within the general health care system, its essence and goals and its major objectives, priorities, and principles of activity); and
- legal (assessment of the legislative basis for socio-medical protection of the population beyond the working age, and forms of management, use of staff, resources, financing, and planning).

The concept also relates to the organizational and structural information bases for the development of health and social care for elderly people. Priorities in the staged development of medical-sanitary and stationary care are determined. These are linked, with an enhancement of the district geriatric activity and an introduction of rehabilitation structures.

Particular emphasis is placed upon:

- the need for arranging annual medical examinations for people of retirement age;
- free choice of a doctor by these people; and
- proper equipment for and financial incentives to medical personnel serving primarily the elderly.

LONG-TERM CARE

Considered in detail are:

- the prospects for the organization of geriatric care at home;
- development of a nursing service, polyclinic socio-medical units, mobile gerorehabilitation teams; and
- the specifics of providing consultative and medical first-aid to elderly patients.

Modern trends in the development of inpatient care services are defined. These trends include – on the one hand – geriatric hospitals, units, wards, nursing care hospitals and hospices, and – on the other hand – non-traditional in-patient forms of care (e.g. day inpatient hospitals and in-home hospitals).

A very important question concerns the need to enhance geriatric assistance to rural residents, based in village district hospitals, village medical ambulatory hospitals, medical-obstetric stations, and specialized mobile services.

Special attention is given to consideration of the new forms of geriatric care to be developed in Ukraine. These include such innovations as geriatric centres, geriatric polyclinics, nurse screening teams, crisis centres, night services providing health and social care for the elderly, information-referral phone services, gerorehabilitation centres for mentally ill persons, gerotechnical equipment and manufactured goods centres.

An additional component of the concept is devoted to the need to:

- revise the norms for the provision of the principal kinds of health, social, and daily living services (estimated standards) for the elderly;
- assess the position of the elderly in medical insurance; and
- determine average resource costs and insurance risks, in accordance with terms and degree of dependence upon assistance.

CASE-STUDY: UKRAINE

The key element in the organization of assistance to elderly people involves substantiation of the necessary guaranteed level and volumes of services, with differentiation according to the degree of functional capabilities. Adequate assistance will prove both effective for the individual's health, and cost-effective for society.

Such establishment of LTC for chronically ill and disabled people would reflect the State's responsibility for the health of its citizens. It would serve as an additional guarantee that citizens can realize their constitutional right to health and to sound care in old age.

Home health programmes are an integral part of primary care, and initiatives are provided for the integration of personal care and homemaking services into the system (mainly for those who live alone). Physicians at primary health clinics receive a three-month course of special training in geriatrics, and nurses also receive some special training in this field.

Reform is also focused on improving both primary medical care and long-term care. Strong emphasis is placed upon strengthening the role of secondary prevention.

Important reforms aimed at improving the medical and social branches of this effort are in progress. The Ukrainian parliament has passed several decrees, including laws on:

- Social care
- Health insurance
- The status of war veterans and the guarantee of their social protection
- Social protection of the disabled
- Main directions of social protection of labour veterans and other groups of elderly citizens in Ukraine

Mention should be made of the amendments to a Ukrainian law on pension provision. Also notable are existing laws and normative Acts concerning issues of health and social care of the population.

8 Concluding thoughts

Once again, it should be stressed that Ukraine has no nationwide, unified system of health and social long-term care. At the same time, this type of service is being more highly developed in certain regions which have greater opportunities for additional financing from their local budgets.

It is noteworthy that the Ministry for Labour and Social Policy has been highly effective in enabling the development of infrastructure services involved in LTC provision. Conversely, the Ministry for Public Health has shown greater conservatism in the development of long-term health care and rehabilitation services, and this process is therefore proceeding very slowly.

The coordination of activities of separate services, and the rational use of available budget and extra-budgetary funds, are in large measure controlled by the regional administrations. Accordingly, such coordination depend upon the extent to which local authorities are aware of the significance and financial expediency of investing in primary and long-term care for the chronically ill and invalid persons in their homes. Such an approach would make it possible to save money spent on expensive various kinds of inpatient medical services and emergency medical services.

Generally, the complexity and problems associated with providing LTC arise not only from inadequate financing and limited resources, but also as a result of the absence of a coordinated organizational structure – that is, of a specialized system able to satisfy long-term care needs. The situation is even more complicated – and the quality of care provided even lower – as a result of the absence of service standards responsive to the real needs of a population which is undergoing economic transition. This, in turn, hampers control of the quality and cost-effectiveness of the proposed services.

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