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Innovating health and social care in rural areas – New approaches for Macedonia

in cooperation with the Municipality of Krivogaštani

Policy Brief and Report of the Workshop

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Contents

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1 Introduction

Macedonia is facing heavy challenges in establishing and restructuring the provision of user-centred social and health care services. The defined visions and aims of the "Health Strategy of the Republic of Macedonia 2020" (Ministry of Health, 2007) are based on the World Health Organisation's "Health for all in the 21st century" strategy for the European region, the Millennium Declaration of the United Nations, the public health policy of the EU and other international declarations, but their realisation has been heavily jeopardised by the global financial and economic crises. In fact, new challenges have surfaced, including political instability and the refugee crisis. 'These factors contributed to a situation where decisive performance indicators show stagnation, if not aggravation, with respect to the quantitative and qualitative development of services, resulting in consistent high values of infant mortality, unequal access to services and a lack of health and social care professionals, in particular in rural areas.

Despite of, or better: due to these contextual challenges, this Policy Brief sets out to provide suggestions and ideas for a step-wise transformation towards user-centred health and social care services in and by local communities. These entail

- the comprehensive assessment of individual needs,
- the use of local resources in partnership between public administration, formal service providers (public, commercial and non-profit organisations), professionals and citizens, and
- the coordination of services and stakeholders so that citizens receive the right services at the right place and at the right time (preventative approach).

These policy suggestions are also in line with the objectives laid down in the IPA II Indicative Strategy Paper 2014-2020 concerning better access to social and health services and to improve inter-institutional coordination.

Considering the values and targets defined in the Health Strategy 2007 this Policy Brief intends in particular to address shortcomings concerning the access to family- and community-oriented primary health care and the fragmentation of health and social care services. The emphasis in improving access to care in the community is all the more stringent as the current availability of care services in the FYR of Macedonia is extremely limited (only one public and sixteen private nursing homes are in operation, the latter operating under a hotel licence). At the same time, access to care services may also be hampered by the lack of resources of the population: approximately one in four Macedonians was below the poverty line in 2010.

In the first section, some basic considerations and definitions concerning the governance and organization of health and social care services (long-term care) will be presented. The central part of the Policy Brief will exhibit selected examples of good practice from other countries, in particular Austria, Czech Republic, Denmark, the Netherlands and other EU Member States.

Finally, and underlining the fact that different framework conditions call for the adaptation of ideas and concepts from abroad to the local context in Macedonia, suggestions have been made as an input for a social policy dialogue among participants of the multi-stakeholder workshop that took place in Krivogaštani on 6 and 7 June 2016. The aim of this workshop was to develop feasible projects for improving the local provision of social and health care services in a rural environment. The results of this workshop were then incorporated into the final version of this Policy Brief.

2 Social innovation and the new welfare mix

In order to overcome the difficulties for structural reforms two closely interlinked concepts have gained in importance over the past decade, namely social innovation and the shifting roles and responsibilities of various stakeholders in the production of welfare.

In general, social innovations 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” (European Commission, 2010; see also Murray et al., 2010). They can be realised as ‘new types of services’, ‘new job-profiles and modes of working’, ‘new business models’, ‘new forms of organisation in the public, not-for-profit and in the private sectors’ as well as in creating novel, participative interactions between the public sector, social enterprises, the social economy, the market and civil society, i.e. all stakeholders that may contribute to the production of welfare.

Social innovation has emerged as a broad concept to complement mere technical innovation and entails new mechanisms, processes and relationships that address social needs which are often neglected by traditional forms of market provision or state intervention. Social innovations are therefore often triggered by those groups of citizens that are directly affected, but they may as well be initiated and/or rolled out by public stakeholders.

Social innovation is needed because societies are in a period of transformative innovation due to the role of technology (particularly ICT), the influence of culture and values (putting people first with a greater democratic choice) and the disjunction between current institutions and the requirements of the new (Murray et al., 2010). This is even more the case in the so-called ‘transition countries’ where a fundamental change of political and economic systems has taken place following the collapse of Soviet power. It is therefore necessary to find “acceptable progressive solutions for a whole range of problems of exclusion, deprivation, alienation, lack of wellbeing” (Moulaert et al., 2013: 16) that have come about as a result of fast-evolving social dynamics, though at very different pace in individual jurisdictions.

In health and social care, recent publications (Davies & Boelman, 2016; Schulmann & Leichsenring, 2014; 2015) have shown that social innovations in this area are often characterised by

- new forms of user participation and the involvement of citizens,
- new types of working and collaboration,
- empowerment of service users/patients and their (informal) carers,
- new applications of information and communication technologies (ICT),
- new types of relationships between formal and informal care as well as between health and social care, and
- new forms of governance and financing.

These developments will create a novel mix of contributions and contributors to welfare, starting from users as co-producers of services, public authorities as funders not only of mainstream provisions, but also of ‘innovation funds’, citizens as creators of new social ties in the community and market forces as enablers of (or barriers to) innovation.

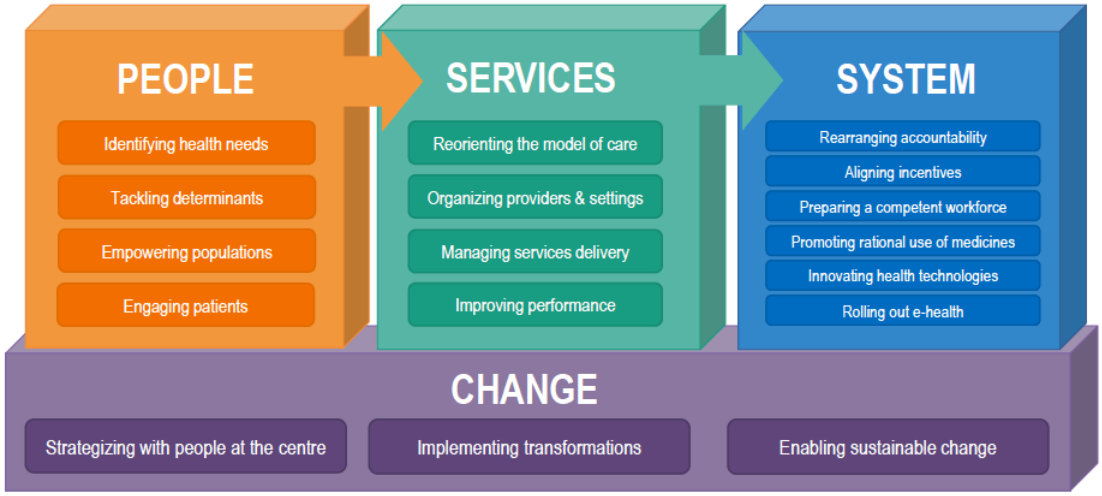
3 Health and social care in the (rural) community

Health and social care have traditionally developed in two distinct 'silos' resulting in a highly specialised, regulated and usually well-funded health sector on the one hand, and a more precarious, subsidiary social care sector based on rationales of social assistance. The rising number of patients/users who are in need of both health care and social care experience this 'health and social care-divide' as an additional burden, e.g. when it comes to eligibility criteria, co-payments and accessibility of services and support schemes. This is particularly true for older people with long-term care needs, e.g. due to chronic or multiple diseases, for people with disabilities at working age and for their informal (family) carers. Indeed, while professional health care is actually needed only in exceptional cases (acute phases of sickness, emergencies), it is often being used as a substitute for the lack of social care services. In the absence of both, particularly in rural settings, it is usually the families, and in most cases their female members, that compensate for missing links and gaps in the provision of appropriate services. This allegedly 'cheap' solution can, however, aggravate social inequalities and entails a number of potential individual and societal consequences, ranging from the inability of carers of working age to participate in the labour market, to potentially inappropriate care due to a lack of knowledge. Furthermore, it may increase the risk of carers to become dependent on care themselves.

The necessity to better coordinate or even integrate health and social care services delivery in all countries has been stressed and underlined by a large number of scholars and policy-makers across Europe and beyond (Leichsenring, 2004; Kodner, 2009; Lewis et al., 2010; Ham et al., 2011; Leichsenring et al., 2013). This has eventually led the WHO Europe to develop a European Framework for Action on Integrated Health Services Delivery (Tello & Barbazza, 2015). Similar efforts are taking place also at the global level. These are based on the general vision that "strengthening people-centred health systems, as set out in 'Health 2020', that strive to accelerate maximum health gains for the population, reduce health inequalities, guarantee financial protection and ensure an efficient use of societal resources, including through intersectoral actions consistent with whole-of-society and whole-of-government approaches" (WHO Europe, 2016).

The involved stakeholders are well aware of the fact that developmental pathways, legacies of the past and the concrete local and regional frameworks are heavily conditioning change processes (social innovations) that are targeting people, services and the system level. Still, the framework's goals and related tools are a useful starting point to develop strategies for changing health and social care systems towards people-centred care (see Figure 1), and to moving away from hospital-centred health care towards primary health care that is closely coordinated/integrated with social care components and other resources in the community.

Figure 1: The European Framework for Action on Health Services Delivery



Source: WHO Europe, 2016.

The implementation of transformations to enable sustainable change needs to focus on people – their needs, their empowerment and their engagement are decisive preconditions for reorienting the model of care towards user-centred delivery, new forms of organisation and the improvement of system performance. At the system level this calls for preparing a competent workforce and investment in innovation with appropriate incentives for all stakeholders.

4 Social innovation in health and social care: Practice examples

This section is dedicated to the presentation of practice examples that illustrate some crucial aspects to be considered for initiating processes to establish people-centred health and social care services at the local level. In particular, the following dimensions of social innovation and change will be highlighted:

1. Raising awareness
2. Involving citizens to create win-win situations in rural areas
3. New forms of service design
4. Smart use of information and communication technologies (ICT) to enhance basic security for people with care needs living in the community
5. Embedding prevention by coordination between hospitals, primary care and social care in the community
6. Creating new types of financial incentives for cooperation of stakeholders

4.1 Developing awareness for care needs in rural areas

The need for help and care is often being neglected as it is assumed that family members, mainly women, are able to and responsible for care. However, an increasing number of people with chronic diseases or patients being discharged from hospital with care needs require professional care at least daily in order to avoid re-admission to hospital and/or high burden on family carers.

In order to develop awareness for these issues it is necessary to improve the competencies of managers, staff and local decision-makers, not only in the health sector, as the modernisation of care in the rural setting also offers opportunities for creating employment in the context of innovative concepts. The role of modernisation of care as an employment creator is all the more relevant as it can contribute to raise employment opportunities for disadvantaged groups and may serve to attract people at working-age to rural areas and/or to offer perspectives to the local population. In the Macedonian context this is particularly salient as the unemployment rate is very high (28%), particularly among women (53%) and younger age groups (54%).

In Austria, an INTERREG-Project '*Care as a labour market of the future – Developing competencies in care'* was coordinated by the Upper Austrian Chamber of Work (2011-2014) to address these issues in cooperation with seven pilot municipalities. A number of public events, seminars and workshops for professionals and the distribution of information and knowledge were organised to improve general awareness and much needed competencies.

4.2 Involving citizens to create win-win situations in rural areas

Rural depopulation and migration of younger people has become a major challenge in many European countries. Furthermore, and partly as a consequence of migration, traditional types of local solidarity and help among neighbours have often eroded. As a result, loneliness in particular among the older population has been identified as a major social determinant for the use of health services and facilities. In many cases this could be avoided if some kind of support with instrumental activities of daily living, ranging from

shopping to transport and gardening, was accessible, in particular for people with care needs.

An Austrian NGO called *'Village Service'* (Dorfservice) has addressed these issues by establishing itself as a regional development agency since 2007. In 12 Carinthian municipalities (District of Spittal) 'Village Service' has created a support network with altogether 10 employees and more than 100 volunteers. Ten jobs were thus created for formerly unemployed women who were trained in 'community animation' and serve to recruit, train and monitor volunteers who provide no more than 4 hours of voluntary work per week consisting mainly in informal transport and visiting services, help in case of emergencies, and information on health and social care services.

The professional support thus facilitates civil engagement by which gaps in social support can be closed and a lively process of social integration has been created. The municipalities serve as important partners and as contact points for the users (older people, families with children in case of emergencies). By capping the amount of voluntary work provided by volunteers – many of which are older people themselves – this initiative also ensures that older people are able to remain active without overburdening them and without the risk to turn volunteer work into a *de facto* replacement for professional services.

4.3 Re-designing primary health care and home care in the community

The Netherlands' primary care system got international attention due to its high performance at low cost. Primary care practices are easily accessible during office hours and collaborate in a unique out-of-hours system. After the reforms in 2006, there are no co-payments for patients receiving care in the primary care practice in which they are registered. Financial incentives support the transfer of care from hospital specialists to primary care physicians, and task delegation from primary care physicians to practice nurses. Regional collaborative care groups of primary care practices offer disease management programmes. The quality assessment system and the electronic medical record system are predominantly driven by health care professionals. Bottom-up and top-down activities contributed to a successful primary care system.

In this context, the *non-profit organisation 'Buurtzorg'* has revolutionised the delivery of home care by establishing small, autonomous teams of community nurses that provide comprehensive care ('zorg' in Dutch) services in the neighbourhood ('buurt' in Dutch). By activating local resource networks of users (primary health care, friends, shops etc.) to satisfy needs, users are also enabled to (re-)activate their own competencies and to receive support in a network.

Apart from this pro-active approach to care, the key asset of *Buurtzorg* consists in its novel way to organise home care. Rather than dividing tasks and responsibilities in a hierarchic organisation, well-trained professionals provide individualised care in autonomous teams. If one team has enough clients, a new team will be founded in the next neighbourhood. The teams are supported by a small back-office, responsible for the administration, monitoring and coaching, and by a dedicated software.

Altogether, *Buurtzorg* has grown from one team in 2006 to more than 850 teams (10,000 nurses) today. It produces better quality for less costs than traditional providers because it keeps overhead costs low and is able to reduce the number of patients with unplanned

hospital admissions and transfers to care homes (Leichsenring, 2015; Monsen & de Blok, 2013; Huijbers, 2011).

4.4 Enhancing basic security and access to services in the rural context

People with care needs who are living in the community face a high risks of not receiving timely adequate services or of not being able to access services at all, as they are not available at all times. A basic service to ensure a safe home environment, especially for frail older people living in the community, has therefore been established in most countries by introducing a specialised alarm system that is often organised and run by NGOs providing home care and other services, e.g. the AREÍON (Rapid Assistance Messenger) system managed by ŽIVOT 90 in the Czech Republic (Horecky, 2013). The advantage of such systems is that they disencumber ambulance services or other health care providers from unnecessary interventions, e.g. in the case of critical situations that are not health related, and provide appropriate support in unexpected situations.

Based on relatively cheap technical devices (e.g. a bracelet with a SIM card and a fixed telephone line) emergency support is coordinated between different parties ranging from police and the fire brigade to ambulance services, General Practitioners, home care services or a designated contact person (family, friends, neighbours, etc.).

4.5 Embedding prevention by coordination between hospitals and care in the community

Major shortcomings at the interface between hospitals and community care consist in problems related to the flow of information between hospital and home care services, a lack of clarity on responsibilities and the distribution of work, ad-hoc hospital discharges and a lack of service integration. As a response, Finland developed and implemented a generic ‘Integrated home care and discharge practice for home care clients’ (PALKO model) in a number of municipalities. The intervention was elaborated by home care and hospital staff and promoted clients’ participation in decision making. The main principles to better integrate care consisted in the development of shared visions and aims, and shared practice, resources and risks across care pathways.

All stakeholders identified their place and tasks across the care pathway so that service users perceive their care as ‘seamless’. This also implied the standardisation of practices and the introduction of written agreements between hospitals and home care agencies, and between home care providers in each municipality. Practices, responsibilities and support tools for the client’s entire pathway from home to hospital and from hospital to home were specified in writing and made available to all stakeholders involved. Furthermore, a care and case manager pair was assigned to each home care client as central contact person for the client inside the multidisciplinary team (Hammar, 2011).

In Denmark, a paradigm-shift was started by the municipality of *Fredericia*, mainly due to envisaged budgetary pressures. The main aim of their reform was to reduce the dependency of older people and to prolong the period of self-care by means of a pilot-project. The so-called ‘home-rehabilitation’ starts within two days from hospital discharge or in case of a request for home care and consists of an intensive training period of about 70 hours during one month at the home of the client. Multidisciplinary teams were

trained to co-ordinate and deliver the training that aims at re-mobilisation and self-care. This implied important efforts in the collaboration between hospital staff and community care professionals. Furthermore, staff attitudes needed to be changed from 'caring' to 'activating'.

The model was successful in terms of substantially reducing the number of people who receive home help and in bottom-line savings, i.e. the initial investment for training and organisational development was compensated within the first three months of operation. Furthermore, satisfaction of users and staff increased significantly (Campbell and Wagner, 2011).

4.6 Creating new types of financial incentives to establish care in the community

Cooperation between health care providers, and in particular between these and the area of social care in the community has to a large degree been hampered in most countries by financial disincentives and fragmented funding mechanisms. The general funding mechanism based on fee-for-service payments has been heavily criticised:

- On the individual level fee-for-service payments to reimburse GPs or individual specialists are likely to incentivise overtreating, rather than to search for potentially cheaper and more appropriate alternatives. Individual contracts might furthermore tend to avoid teamwork or multi-professional cooperation (Andersson and Liff, 2012).
- On the organisational level hospitals depending on reimbursement by per-diem charges are likely to prolong patients' length of stay; home care providers being reimbursed by fee-for service based on time-logs might be hesitant to participate in unpaid co-ordination meetings with other stakeholders.
- On the system level there is ample debate about whether regulated markets and price control are detrimental to efficiency gains (Pope, 2013), but it may also be questioned, whether more user choice and market-oriented governance are able to bolster enhanced cooperation and the delivery of integrated care (Mason et al., 2015).

However, new models of financial incentives to overcome fragmentation, to increase efficiency and to reduce transaction costs have emerged only recently and on a narrow scale (KPMG, 2014). The question is whether the traditional path – to first construct sophisticated fee-for-service models and only subsequently look for alternatives – can be overcome. Some of the following instruments to underpin change in health care delivery with financial incentives could be envisaged:

- The regulating body (the Government) might use *incentive payments* to steer the allocation of funds (e.g. via health insurers) rather than imposing such programmes by decree. For instance, in Germany, sickness funds have been incentivized to develop disease management programs by an additional flat rate payment for patients enrolled in such programmes (Hernández-Quevedo et al., 2013).
- *Bundled or 'pooled' budgets* are paying multiple providers a single sum of money for all services related to an episode of care (e.g. a hospitalisation plus a period of post-acute care), rather than reimbursing them for each individual service (Bertko & Effros, 2010) to promote a more efficient use of services. However, it is unclear if, in a context of lack of service providers, this would lead to the emergence of new providers or just to a re-destribution of funds among existing stakeholders.

Unfortunately, experiences with 'bundled budgets' in the Netherlands have not included post-acute care facilities. Including such services and facilities in the bundle "would clearly affect decisions about when the patient was ready for transfer from the acute care hospital to another facility and how payments are distributed among providers" (Bertko & Effros, 2010).

- *Alliance contracting* has its origins in the construction industry and is based on the assumption that multiple organisations can achieve better things by working together on agreed pain/gain contracts. Originally developed in New Zealand, first attempts to implement the model also in the UK have been made due to its impressive success in terms of financial performance – the 'Canterbury Health System' in NZL came from a $21m loss in 2006 and achieved an $8m surplus in 2008 – and the reduction of waiting times by 1.5m days of waiting within 3 years (Timmins & Ham, 2013). This is a promising approach that, however, necessitates investments in building necessary framework conditions to realise a number of preconditions such as financial, legal and procurement skills as well as monitoring and organisational development skills, trust-building and appropriate time-frames to make new organisational models happen, and to involve local communities by supporting the crucial role of the third sector (Addicott, 2014; ACEVO, 2015).
- Finally, the move towards *population-based payment* in health care has led to the establishment of first 'Accountable Care Organisations' (ACO) in the United States. This is a health care organisation composed of doctors, hospitals, and other health care providers who voluntarily come together to provide coordinated care and agree to be held accountable for the overall costs and quality of care for an assigned population of patients. The payment model ties provider reimbursements to performance on quality measures and reductions in the total cost of care (Damberg et al., 2014) Given the short period of implementation, the evidence of the few evaluation studies carried out during the past few years is scarce and restricted to few indicators and measures. However, ACOs are expected to implement a variety of quality improvement and care management programs, information technology, and patient registries, which have the potential to improve quality of care more broadly and which could generate positive spillover effects.

5 The multi-stakeholder workshop in Krivogaštani

The definitions, theoretical considerations and examples of good practice that were exhibited in the previous sections served as an input to a workshop and policy dialogue between relevant stakeholders (see List of Participants, Annex 2). This event took place on 6 and 7 June 2016 in the rural municipality of Krivogaštani, which is situated in the Southern part of Macedonia near the City of Prilep (see Programme, Annex 1).

Following an introduction and the presentation of participants and their expectations (Table 5.1), the policy paper was presented to clarify concepts and definitions as well as to present examples of good practice that could serve as sources for potential improvements.

Table 5.1 Expectations of participants

Katerina	Nurse	learning from other experiences
Tamara	Nurse	share experiences and coping strategies
Nicola	Centre for education and development	new approaches in rural areas, mobility
Sotir	Ass. of people with disabilities	applying good practice examples
Fance	Ass. of people with disabilities	domestic care for people with disabilities, volunteering, avoiding institutionalisation, improving accessibility
Daniela	Local Association	to work together for improvement
Maja	Centre for Social Care	Primary, secondary, tertiary care
Zoran	Social Worker	comparison of legal matters
Zorica	Nurse in private clinic	sharing experiences, improving services
Nicola	Municipality	improvements with a small budget
Slobodan	Health Care Fund	extending the range of services offered

After the first break main challenges were identified by asking all participants: “What are the key challenges of health and social care services in the region of Pelagonia (Krivogaštani)?” Participants noted all issues on sticky notes that were then clustered under principal titles and prioritised by means of points allocated by each participant. The results of this are exhibited in Table 5.2.

Table 5.2 Key challenges and priorities

Topic	Issues	Points	Rank
Database	Municipalities should have a data base with all information required by different categories of people	1	-
Services for children with special needs	**Opening a day centre for children with special needs, Professional support for children with autism**	**11**	**1**
Create employment in social care	Socially useful work should be provided by the state	3	-
Training for people with disabilities	**Social inclusion for people with disabilities**	**8**	**3**
Increasing multi-disciplinarity	Having a dentist who will work at night at the ambulatory care centre	3	-
Care home/home care in the community	Long-term care centre for older people, home care centre for old people	5	-
Quality of aides	To reduce the time of usage of orthopaedic aides	3	-
Employment protection for people with disabilities	Protection of the employees and possibilities of reemployment, if they get fired	2	-
Improve accessibility	**People in a wheel-chair should have access to all institutions**	**9**	**2**

It was then decided to work on the three improvement projects that had attained most votes: Services for children with special needs, Social inclusion through training for people with disabilities and the improvement of accessibility.

5.1 Services for children with special needs

It seems that parents are often still not aware of their children's needs. Special instittions are missing in the rural areas and transportation possibilities are missing. Therefore a special facility would be needed to provide day care with specialised staff and transport service for about 20 children and young people with disabilities (6-26 years). Social workers, nurses, pedagogues would be needed to establish the day care centre, which would need to be funded by central government, the municipality and (potentially) EU funding. The project proposal would need to involve parents to clearly manifest their and their children's needs.

Further planning includes data collection until September 2016 (by CfSC and HIF, Nicola). Based on this a project proposal will be drafted by December 2016 by the Local Action Group.

5.2 Improving accessibility

There is very scarce accessibility of public buildings (not only, but particularly in rural areas). Legal regulations (including the UN Convention) would be favourable, but implementation is lacking. It would be necessary to introduce sanctions for not respecting the law: improve access, raise awareness, introduce personal assistants. Apart from people with disabilities themselves, all citizens, police and architects should be addressed by this project in Krivogaštani.

As a first step, all public buildings in Krivogaštani that need to be accessible (institutions, shops etc.) will be identified by the organization MOBILNOST (Nico) until September 2016. This list will be presented to the Mayor Toni Zatkoski and the Director of construction of the Municipality to discuss further proceedings (by December at the latest).

5.3 Social inclusion for people with disabilities through training

Vulnerable groups are currently not included in any activities. People with disabilities (about 8,000 registered, another 8,000 not registered) are suffering a clearly medical approach to needs assessment. Furthermore, there are no data about employed people with disabilities. A SWOT-Analysis of the situation should therefore be made until December 2016 (Local Action Group, MoSA, NGOs, HIF etc.) with a list of priorities and the definition of target groups (involvement!). It is then necessary to facilitate networking between business, social workers and (organisations of) target groups to promote awareness raising, training and education.

Participants were relatively optimistic about the feasibility of these projects, although funding will be needed (proposals will be made to various funding bodies) and sustainability will remain a challenge. In Macedonia, this can mean for successful bottom-up projects to be taken over by statutory authorities that will then be ‘politicised’.

An important strategy could be to explain the ‘social business case’ of the above projects, e.g. for day-care services for children and youth: parents may then search for employment, their children would become more independent and additional employment would be created.

5.4 Feedback and conclusion

Participants provided a very positive feedback on the workshop (see Figure 1) that had provided “professional skills” and “useful examples of good practice”.

According to the participants, it had shown that the “group can work together” and “exchange experiences”. With the “different institutions round the table” it was felt that challenges can be overcome by “further cooperation”.

Figure 1 Evaluation of the workshop

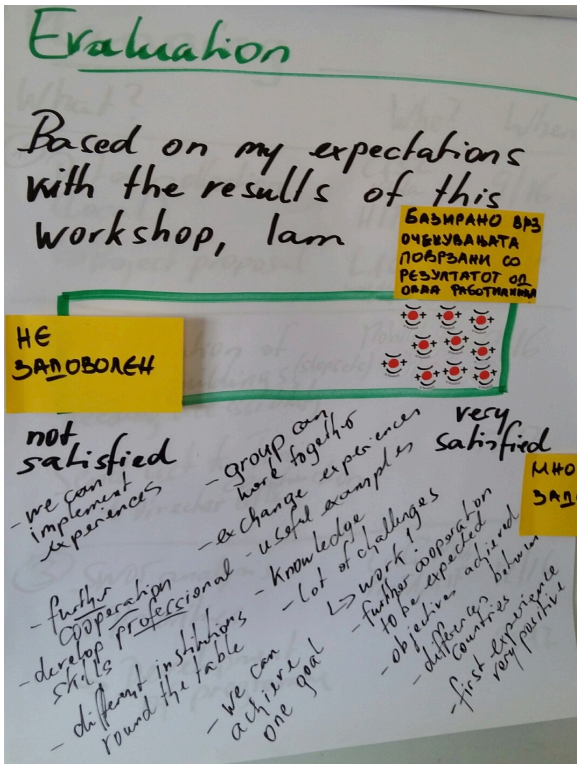


Figure 2 Some impressions from the workshop in Krivogaštani

6 Concluding remark

This document contains a Policy Brief that has been conceived as a background paper to a multi-stakeholder workshop for developing improvement programmes for health and social care in rural communities (Krivogaštani, 6-7 June 2016), and a brief report about the implementation and the results of this workshop.

The social context of the FYR of Macedonia encompasses a number of challenges, namely relatively low income levels among a great share of its population, limited access to care services, migration coupled with high unemployment rates. These challenges are even more acute in rural areas of the country. It will be a key task of workshop participants to continue the now initiated collaboration across institutional and organisational boundaries. The Local Action Group with its most engaged members as well as the Municipality of Krivogaštani are in a good position to further advance social care issues in this region. However, further support is needed to not only build capacities but facilitate tangible improvement.

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References

Association of Chief Executives of Voluntary Organisations/ACEVO (2015) *Alliance Contracting. Building New Collaborations to Deliver Better Healthcare.* London and Leeds, ACEVO.

Addicott, R. (2014) *Commissioning and contracting for integrated care.* London, The King's Fund, available at: http://www.kingsfund.org.uk/sites/files/kf/kings-fund-commissioning-contracting-integrated-care-nov14.pdf.

Andersson, T.& Liff, R. (2012) Multiprofessional Cooperation and Accountability Pressures, *Public Management Review*, 14(6), 835-855.

Bertko, J. & Effros, R. (2010) Increase the Use of 'Bundled' Payment Approaches, RAND Corporation (TR-562/20-HLTH), available at http://www.rand.org/pubs/technicalreports/TR562z20.html

Campbell, L. and L. Wagner (2011) Rehabilitation and prevention at home, http://interlinks.euro.centre.org/framework

Damberg, C.L., Sorbero, M.E., Lovejoy, S.L. Martsolf, G.R, Raaen, L., Mandel, D. (2014) *Measuring Success in Health Care Value-Based Purchasing Programs.* Santa Monica et al., RAND.

Davies, A & Boelman, V. (2015) *Social Innovation in Health and Social Care.* London, The Young Foundation.

European Commission/Bureau of European Policy Advisers (2011) *Empowering people, driving change: Social innovation in the European Union.* Luxembourg, Publications Office of the European Union.

Evers, A. & Ewert, B. (2014) *Approaches and instruments in local welfare systems: innovation, adoption and adaptation.* Giessen et al., WILCO Project. Available at: www.wilcoproject.eu.

Ham, C., Imison, C., Goodwin, N., Dixon, A. & South, P. (2011) *Where next for the NHS reforms? The case for integrated care.* London, The King's Fund.

Hammar, T. (2011) Integrated home care and discharge practice for home care clients (PALKOmodel), http://interlinks.euro.centre.org/framework

Heinze, R.G. & Naegele, G. (2012) 'Social innovations in ageing societies', pp. 153-167 in H.W. Franz, J. Hochgerner & J. Howaldt (eds.) *Challenge Social Innovation.* Berlin and Heidelberg, Springer.

Hernández-Quevedo, C., Llano, R., Mossialos, E (2013) Paying for integrated care – An overview, *EuroHealth*, 19(2), 3-6.

Horecky, J. (2013) *Dignity first – priorities in reform of care services. Comment paper – Czech Republic.* Prepared for the Peer Review in Social Protection and Social Inclusion programme coordinated by ÖSB Consulting, the Institute for Employment Studies (IES) and Applica, and funded by the European Commission. Vienna, ÖSB Consulting.

Huijbers, P. (2011) Care in the neighbourhood: better home care at reduced cost, available at http://interlinks.euro.centre.org

KPMG (2014) *The primary care paradox. New designs and models.* London, KPMG & Nuffield Trust.

Leichsenring, K. (2015) Buurtzorg Nederland – Ein innovatives Modell der Langzeitpflege revolutioniert die Hauskrankenpflege, *ProCare*, 8, 20-24.

Lewis, R., Rosen, R., Goodwin, N., Dixon, J. & South, P. (2010) *Where Next for Integrated Care Organisations in the NHS?* London: Nuffield Trust.

Mason, A., Goddard, M., Weatherly, H. & Chalkley, M. (2015) Integrating funds for health and social care: an evidence review, *Journal of Health Services Research & Policy,* OnlineFirst, published on January 16, 2015 as doi:10.1177/1355819614566832, 1-12.

Monsen, K. & J. de Blok, J. (2013) Buurtzorg Nederland, *American Journal of Nursing*, 113(8), 55-59.

Moulaert, F., MacCallum, D., Mehmood, A. & Hamdouch, A. (eds.) *The international handbook on social innovation: collective action, social learning and transdisciplinary research.* Cheltenham, UK: Edward Elgar.

Murray, R., Caulier-Grice, J. & Mulgan, G. (2010) *The Open Book of Social Innovation. Social Innovation Series: Ways to Design, Develop and Grow Social Innovation.* London et al., The Young Foundation and NESTA.

Pope, C.M. (2013) Legislating Low Prices: Cutting Costs or Care?, *Backgrounder*, 2834 (August), 1-16.

Schulmann, K., Leichsenring, K. et al. (2014) *Social support and long-term care in EU care regimes. Framework conditions and initiatives of social innovation in an active ageing perspective.* Vienna et al., European Centre for Social Welfare Policy and Research et al. (MoPAct Report, #8.1).

Schulmann, K., Leichsenring, K. et al. (2015) *A qualitative inventory of the key drivers of social innovation in the delivery of social support and long-term care.* Vienna et al., European Centre for Social Welfare Policy and Research et al. (MoPAct Report, #8.3).

Staflinger, H., Mayrhofer, P. & Terhoeven, G. (2013) PlegeWISSEN braucht WissensPFLEGE. Alten- und Plegeheime auf dem Weg zum Wissensvorsprung, *WISO*, 36(1), 134-158.

Timmins, N. & Ham, C. (2013) *The quest for integrated health and social care: a case study in Canterbury, New Zealand.* London, The King's Fund.

Websites:

http://www.dorfservice.at/hneu/ (in German)

http://www.buurtzorgnederland.com/ (in Dutch)

http://interlinks.euro.centre.org/model/example/NeighbourhoodCareBetterHomeCareAtReducedCost

http://www.euro.who.int/__data/assets/pdf_file/0008/85391/E93667.pdf

http://www.nivel.nl/en/news/health-systems-in-transition-netherlands

Annex 1: Programme of the Workshop

Objectives

- To gather a network of stakeholders that are ready to promote enhanced coordination and integration of health and social care services in the region of Pelagonia, in particular in Prilep and Krivogaštani
- To present a draft policy paper providing an overview of existing policies and good practice with a focus on long-term care for older people in rural areas
- To link examples of good practice from other countries to the context of social and health services in Krivogaštani and Prilep
- To develop 3-4 tangible projects for improving the provision of social and health care services in the rural context of Krivogaštani and Prilep (coordination, primary care, long-term care, prevention etc.)
- To define responsibilities and to plan next steps to implement these projects
- To gather input for the final version of the policy paper

Methods and languages

- Generic moderation methods in combination with short inputs, interactive working groups, reflection and planning sessions. Involvement of all participants.
- Working languages: English and Macedonian (consecutive translation)

Media and technical support

- Projector for PowerPoint Presentations
- Flip chart and/or 10-15 sheets of large kraft paper
- Markers and pens, paper, glue stick, adhesive tape, sticky notes …

Venue of the workshop

- Krivogaštani, Municipal office

Monday, 6 June 2016

Time	Subject
9.00	**Arrival of participants and registration**
9.30	**Welcome and introduction** • *Toni Zatkoski*, Mayor of Krivogaštani • *Gabriele Janezic,* Consul of Austria, Skopje
10.00	**Introduction of participants and programme** • Introduction of participants (affiliation, professional background, and expectations) • Presentation of the workshop programme, *Kai Leichsenring*
10.30	**Presentation of the policy paper** • Innovating health and social care in rural areas – Examples from selected European countries *Kai Leichsenring*
11.00	**Break**

11.15	**Presentation of the policy paper** • Questions and answers
11.45	**Assessing areas of major need for improvement** • "What are the key challenges of health and social care services in the region of Pelagonia (Krivogaštani)?" • Brainstorming and Clustering
12.30	**Lunch break**
13.30	**Identifying priority issues** • Discussion ("What challenges can we address and influence ourselves?") and voting (selection of priority issues)
13.45	**4 Working groups on selected issues (Scenario Work)** • How is the situation concerning issue … now? • What needs to be done to improve the situation? (What could we learn from examples of good practice)? • Who should be involved? What would be the first step?
14.45	**Presentation of results** • Presentation and discussion
15.30	**Break**
16.00	**Discussion of results and comments from Austrian and Macedonian perspectives**
16.45	**Wrap-up of first day** • What is missing? What do we need to address tomorrow?
17.00	**End of first day**

Tuesday, 7 June 2016

Time	Subject
9.00	**Arrival and welcome** • *Attaché Harald Fugger*, Austrian Ministry of Labour, Social Affairs and Consumer Protection, Vienna • Notes and new insights/questions
9.30	**The roles of NGOs and local authorities** • Tools to strengthen the role of users as co-producers of health and welfare – the roles of NGOs and local authorities, *Kai Leichsenring*, European Centre • Discussion
10.30	**Break**
11.00	**Planning** • Plenary: What? How? Who? With whom? When? • Definition of responsibilities • How will we know that service provision has improved? (Evaluation tools and indicators, follow-up)
12.00	**Feed-back and evaluation** • Tour-de-table
12.45	**Conclusion and farewell**
13.00	**End of workshop**

Annex 2: Participants

Name	Organisation
Katerina Muloska	BRZA POMOS
Tamara Papuchkoska	BRZA POMOS
Satir Jonovski	MOBILNOST Bitola
Fance Georgievska	MOBILNOST Bitola
Nico Jankov	MOBILNOST Bitola
Zivko Petrovski	MOBILNOST Bitola
Nikilche Dimeski	CED
Slobodan Djorceski	FZOM-Makedonija
Daniela Cvetanoska	LAG AGRO Lider
Marina Tosheska	LAG AGRO Lider
Nicolce Papukoski	Municipality of Krivogastani
Zoran Malkoski	JU-MCSR, Prilep
Maia Vrskoski	JU-MCSR, Prilep
Zorica Cagaroska	Private Ambulatory, Krivogastani
Petre Najdoski	Private Ambulatory, Krivogastani
Nadica Lelova	Pharmacy, Krivogastani
Nico Jankov	MOBILNOST Bitola
Harald Fugger	BMASK, Austria