

Policy

Planning elderly and palliative care in Montenegro

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Abstract

Introduction: Montenegro, a newly independent Balkan state with a population of 650,000, has a health care reform programme supported by the World Bank. This paper describes planning for integrated elderly and palliative care.

Description: The current service is provided only through a single long-stay hospital, which has institutionalised patients and limited facilities. Broad estimates were made of current financial expenditures on elderly care. A consultation was undertaken with stakeholders to propose an integrated system linking primary and secondary health care with social care; supporting people to live, and die well, at home; developing local nursing homes for people with higher dependency; creating specialised elderly-care services within hospitals; and providing good end-of-life care for all who need it. Effectiveness may be measured by monitoring patient and carers' perceptions of the care experience.

Discussion: Changes in provision of elderly care may be achieved through redirection of existing resources, but the health and social care services also need to enhance elderly care budgets. The challenges for implementation include management skills, engaging professionals and political commitment.

Conclusion: Middle-income countries such as Montenegro can develop elderly and palliative care services through redirection of existing finance if accompanied by new service objectives, staff skills and integrated management.

Keywords

planning, elderly, palliative care, economics, Europe

Introduction

Background

Montenegro is situated on the Adriatic coast between Croatia, Bosnia-Herzegovina, Serbia and Albania. Once a principality and then kingdom in the nineteenth century, it was part of greater Yugoslavia in the twentieth century and regained full independence at a referendum in 2006. Montenegro has a population of around 650,000 resident citizens, including 50,000 living abroad, and 30,000 displaced persons. The pattern of disease in Montenegro is broadly similar to elsewhere in Europe—the 'epidemiological transition' from infectious to non-communicable diseases is completed. Life expectancy was 71.4 years in 2003 for men and 76.5 years for women, above the European

average, reflecting low industrialisation and good nutrition of the Mediterranean region.

Health-system reform, including renewing financing systems and control, improving capacity and developing the role of primary care, has been supported by a US \$10 million loan from the World Bank [1] over the period 2004–2009. One element, with specific funding support by the Canadian International Development Agency [2], has been for improving health and social care for the growing proportion of elderly people. The present paper draws on work by the authors for a consultancy to review palliative care (long-term and end-of-life care) in Montenegro and to make proposals for service development. The results and recommendations below are offered to contribute to the limited literature on either health planning or elderly care in the Balkan and other middle-income countries.

The study was undertaken over a four-month period during 2007. In line with traditional planning in the country, there was a strong request for clear ‘norms’ of staff and facilities, which could be included in the broader national health plan and financial allocations. National reports, statistical information and political directions were identified and further information was gained through interviews with experts in three government departments and agencies, three hospitals (one being long-stay), two community health offices and the national NGO representing older people. The findings were considered at a multidisciplinary forum arranged by the ministry and the ministry’s medical expert adviser and then written as a report submitted to the Minister.

Models of palliative care

Health-care systems and services in Europe vary as a result of differing national histories, political systems, economic resources and populations. There is little guidance by the World Health Organisation European Region on care systems for the elderly, although the Healthy Cities ‘Solid Facts’ series has recently addressed home care [3] as well as palliative care [4]. The Open Society Institute (Soros Foundation) has given special attention to palliative care in Eastern Europe countries, including an analysis of the palliative care systems in Ukraine, Moldova and Romania, supporting education for health professions and seeking integration of palliative care within national health systems planning and provision [5]. The International Observatory of End-of-life care, funded by OSI [6], has country reports on all countries (with Montenegro included with Serbia) in a narrative form. The European Association of Palliative Care also provides descriptions of European national services on its

website and its annual conference records continuing developments. Palliative care services reported in the countries of former Yugoslavia are presented in text Box 1.

International experience suggests that service models for palliative care have developed along a path of recognising palliative care needs within whole populations and responding through existing clinical and social structures rather than creating separate new services (text Box 2). Palliative care services need to be patient-focused, provided in all settings where people end their lives (at home, in nursing homes, and hospitals) and assure end-of-life care for the whole population (not just one disease group of patients, e.g. those with cancer). The concepts of palliative care should be practised by all staff. Specialist hospital services can lead in recognising the needs of their own patients, for example provision of good pain control, or handling of rapid clinical decline in younger as well as older people. Hospitals and domiciliary services can establish specialist teams which provide expert advice to health practitioners (similar to other advisory health services, such as laboratory services and social work). These teams may work directly with some patients and also contribute to clinical team meetings discussing all palliative care patients.

Elderly and palliative care in Montenegro

Setting

The World Bank supported a consultancy on Elderly care in Montenegro in 2004 [14] which recommended creating multidisciplinary age-care assessment teams at municipality level, improving non-hospital institutional care, reforming nursing education, creating a

Box 1. Current developments of palliative care in the countries of the former Republic of Yugoslavia

In Serbia, palliative care is not a separate discipline. One general hospital has a palliative care team and the Institute for Oncology and Radiology of Serbia has a small inpatient unit and a community supportive-care team. There is also a private ‘centre for palliative care and palliative medicine’ with external funding [7]. The Institute for Gerontology Care has a palliative care service for elderly citizens at home serving 10 municipalities in Belgrade [8]. A National Task Force for Palliative Care for Serbia and Montenegro was established in 2005 [9] and guidelines for management of cancer pain, dyspnea and nausea have been published.

In Bosnia-Herzegovina, Sarajevo has a hospice for leadership and education, and a domiciliary palliative care team providing services for cancer patients [10].

In Croatia, Zagreb has a hospice-home care service run by volunteer health professionals of the Croatian Society for Hospice/Palliative Care, with a visiting service to patients in a local nursing home. In several other cities and towns there are less developed groups with palliative care interests, while in Koprivnica Kizevci county a primary health care development project funded by the World Bank has made recommendations for local palliative care service provision [11].

Slovenia has developed ‘hospices without beds’ which support hospital palliative care and give training in three major cities, Ljubljana, Maribor and Celje. There are two hospital palliative care teams and outpatient pain clinics in twelve hospitals. Bereavement services are also established [12]. There are guidelines for pain management, especially opioids, and training on pain management [13]. The Ljubljana Palliative Care Development Institute has collaborated in a European project of introducing the ‘Liverpool care pathway’.

Box 2. Steps towards integration of palliative care in clinical and social care

<p>Model 1. Inpatient hospice Often developed for cancer patients only, providing care at the (relatively short) final period when pain control and heavy nursing are required</p>	<p>Model 2. Extended care hospice Provides care—including symptom control, social and emotional—to patients and families as ‘outreach’ from a hospital unit as well as inpatient terminal care</p>
<p>Model 3. Specialist support team Provides ‘working with’ support to medical, nursing and social staff—and sometimes intensive or out-of-hours services—may be either inpatient or domiciliary or both</p>	<p>Model 4. Integrated palliative care An active register of patients who are considered in need of palliative care by each multidisciplinary clinical team (hospital, domiciliary). Patient care is discussed regularly at staff meetings to achieve action and continuity of care</p>

Gerontological Research Unit and seeking international grants for implementation of these proposals.

In 2005, the Montenegro Ministry of Health produced a *Master Plan 2005–2010* for the health system [15]. This far-sighted report is “a professional and political document [...] and [...] the basic instrument of health policy” [15, p. 3]. Of the nine developmental priorities proposed, No.7 recommended:

“The Ministry of Health will prepare for the Government [a] strategy and programmes for elderly health care that will include institutional and non-institutional care. These programmes will be funded from different sources: the insured themselves and their families, Health Insurance Fund, Social Welfare and the Budget for Social Services and Social Welfare. The establishing of old people’s homes, for the insured to whom long-term care could not be provided at their own home, will be proposed.” [15, p. 54–55]

The World Bank’s Montenegro Health Improvement Plan [1] has set out plans for the reform of the primary health care sector. The Health Insurance Fund [16] has described activities of the existing ambulatory care services based on 18 Dom Zdravlja (primary health care centres) across the country. A draft human resources strategy [17] gives recommendations on services and finance as well as training. This is now being followed by planning for secondary care services (capacity and referral, specialties and outpatient balance, human resources, medical technology, governance, information) and financing (including a ‘basic benefits package’ and methods to distribute funds to providers).

Healthcare system

The healthcare system is strongly based on the country-wide network of Dom Zdravlja (primary health care centres). Patients can now choose their primary care doctor, and so these primary care physicians are called in Montenegro ‘Chosen doctors’. The Chosen doctors are gatekeepers for hospital care: that is, non-emergency patients are referred by the Chosen doctor to hospital outpatients, where assessment is made of the need for further investigation or care. Chosen doctors will under-

take individual preventive as well as curative care and will, therefore, need the support of staff teams in the Dom Zdravlja. The Dom Zdravlja also supports a wider role of community health services. Home nurses work with the chosen doctors in teams for home visits. There is a sufficient number of administrative staff, but they are less educated than the technical and clinical staff.

Apart from the Clinical Centre (teaching hospital) in Podgorica, seven general hospitals provide secondary care in the main towns of the three regions of Montenegro—coast, central (around Podgorica) and continental (in the more mountainous north-east). The Clinical Centre serves the city (200,000 population) for internal medicine and greater proportions of the national population for paediatrics (50%), mental health (45%), maternity/gynaecology (40%) and all tertiary care. About 12% of all hospital care, both secondary and tertiary, is provided outside of Montenegro, mainly in Belgrade in Serbia.

There is a single health insurance system covering all residents. Services at present are free at the point of delivery. Finance from the Health Insurance Fund goes to providers through annual allocations. Limitations of the present system, described in the Master Plan [15], include weak employment control and low salaries.

Demography and health needs

The proportion of people age 65+ (12.1%) is lower than in the EU15 (16.2%), but has risen substantially since 1991 (8.3%). The death rate has doubled from 5 per 1000 in 1975 to 10 per 1000 in 2000. The proportion of young people (age 0–14) has fallen from 25% in 1991 to 21% in 2003. The low birth rate means that the proportion of children will decrease further in the future and the population will not expand, unless by immigration. The smaller family sizes also mean less capacity to look after elderly dependents.

In the existing health system, care of the elderly has mainly been the responsibility of outreach teams from the health centres. A home-help service, developed in the past two years, now covers most of the municipalities. The hospitals do not provide separate services for elderly people. There is a single hospital for elderly

people at Risan, on the Adriatic coast. There have been proposals to develop public nursing homes, but at present there are only two small private homes in the capital, Podgorica.

There are about 6000 deaths each year in Montenegro. While 10% of the population is older than 75, almost half of all deaths in Montenegro occur in age group 75+. In the period 2000–2006 [18] there was a reduction of deaths in hospitals from 50% to 30%, and equivalent rise in deaths at home from 50% to 70%. Over a longer period the percentage of deaths 'receiving medical treatment' has risen from 71.4% in 1980 to 79.2% in 1990 and 86.1% in 2005.

About one death in six is due to cancer, and one in eight due to stroke—two conditions with known heavy nursing needs for some patients. However, dementia is probably under-recorded—in the Health Statistical Yearbook [19, table 7.1.6] under 'Diagnosed diseases in non-hospital services', 25 patient care episodes are recorded for dementia out of a total of more than 750,000 episodes.

Finance estimates

There are no data available that describe discharge rates by age and sex (or by speciality) from hospitals or for Dom Zdravlja services, so it is not possible to make an accurate estimate of how much health services finance is currently going to elderly people. However, it has been noted in other western health systems that, on average, the greatest expenditure on healthcare in a person's lifetime happens in the final year [20]. In Montenegro in 2006, 46% of deaths were people aged 75+, and a further 28% were people aged between 65–74 [8]—i.e. three quarters of deaths are elderly people, of whom a minority also might have had social problems.

In data from the Health Insurance Fund expenditure on 'pensioners' in 2005 was stated as being 33% of total health expenditure [21, table 7]. Expenditure in 2005 totalled 108 m €, and was divided as 41 m € for primary care (about 40%), and 56 m € (about 52%) for secondary/tertiary care (including 8 m € on refer-

als out of the country). If people aged 65+ use 33% of these resources, then this would mean approximately 13.7 m € for primary care and 18.7 m € for secondary/tertiary care.

Table 1, relating to contributions to the Health Insurance Fund, shows that half of the adult population is categorised as 'employed' and provides almost three quarters of the income and uses half of the expenditure on health. On the other side, the group of 'unemployed' and 'independent' spends about 13% of the healthcare budget, but contributes fewer than 3%. Pensioners (22% of the adult population) contribute 20% to and use 30% of the health care budget.

Proposals for planning elderly, long-term and palliative care

Principles

The national Health Strategy indicates three overlapping care groups of concern: social and mixed medical care for elderly people; long-term care for younger people with chronic disability, especially neurological; and palliative care for people with terminal illnesses.

In development work with stakeholders, five principles were identified:

- Local care: for both cultural and practical reasons, people wish care services to be local
- Coverage: services for older people were seen as a social 'right', part of social solidarity, and not discretionary. The health system should ensure that all people in need should receive these services
- Solidarity: as part of social solidarity, there must be transfers from the working population to the dependent population. There is a balance to be struck between support from the informal sector (families) and the formal sector (employed population).
- Collaboration: no single service as presently organised can provide the range of care and services. There must be collaboration between agencies.

Table 1. Adult population groups, income and expenditure of the Health Insurance Fund in Montenegro (years 2003, 2005)

Adult population groups	%	Income M. €	%	Expenditure M. €	%
Employed	51	75.7	71.4	51.6	47.7
'Unemployed' and 'independent'	23	3.0	2.8	14.0	12.9
Farmers	3	0.3	0.3	2.3	2.1
Pensioners	22	20.6	19.4	32.3	29.9
Displaced persons	1	1.5	1.4	2.0	1.9
Total	100	106.4	100	108.9	100

Sources: Master Plan [15, tables 18a and 18b], Health Insurance Fund [16, table 7].

- Patient-centred: while the health system must get organisational structures right, it is crucial also to have patient and carer representation, input to planning, and monitoring.

Existing services

The long-stay hospital at Risan, near the coast, is a campus of two-storey buildings from the mid-twentieth century. The fabric of the premises is poor, with dormitory bedrooms for 3–6 people and crowded facilities, but the hospital provides a range of medical, nursing, psychiatric and social care and has good morale through its organisation as a ‘therapeutic community’, with weekly ward meetings which provide the management focus and patient engagement. There are four groups of patients—simple social care of people without family support; long-term physically disabled; long-term chronic mentally disabled; and short-term terminally ill patients. Most residents are provided care to their death. Nursing care, occupational therapy and physiotherapy is provided. In 2006 there were 114 admissions, 20 discharges and 79 deaths. Funding came independently from families for a quarter of patients, from the family and state together for another quarter and from the state alone for the remainder.

Proposals for development

Ministry of Health, Labour and Social Welfare

The Ministry of Health, Labour and Social Welfare at present has no lead responsibility for elderly people. However, an appropriate department for this lead on elderly people within the present Ministry structure is the Social Welfare and Child Care Sector. The lead person would need to coordinate downwards with the eight regions in the country, for which eight Regional Elderly Leads are proposed, coordinating across stakeholders (see section Role of the regions—development of local care below). Similarly, there should be liaison across the Ministry with the Health Care Sector (for both operational and strategic planning), Ministry of Employment (paying home-help services to older people), and Ministry for Pensions (and disability insurance).

There should also be liaison with the national Health Insurance Fund, with a remit to ensure a sufficient proportion of health funds available for older people, and the ‘solidarity’ balance through health fund contributions from the whole population of working age. There should also be collaboration with the Ministry Sec-

tor responsible for health care reform, with the prime objective of maintaining, in the new system, full coverage and range of benefits for all people of pensionable age, for primary, secondary and tertiary care.

Role of the regions—development of local care

While Risan Hospital has played an important role for the country, it is accepted that Montenegro now needs social provision for older people local to their own residence. There should be a range of facilities, including home support, day care and long-term care, both through medical and social welfare structures. The eight Regions, covering the 24 municipalities, form the organisational structure. For the health sector, local services should be coordinated around the catchment of the (regional) general hospitals, and associated Dom Zdravlja services. The links between primary and secondary care services, both admission and discharge, is the axis for good elderly care. Similarly, for home care, links with allied municipal services are needed.

Elderly care stakeholder interests

The main organisations and their potential contributions to elderly care are considered here.

Patients and carers associations

The national Gerontology Society has members across the country and is represented centrally in Podgorica. The Society needs to create regional groups that can provide input to the planning and running of services for elderly people. Regional ‘platforms’ bringing together all non-state agencies, including Red Cross and ‘charities’, including those funded from abroad, would be valuable.

Hospitals

The eight general hospitals will create policies for care of older people.

- Management: Reviewing the present use and access of older people to hospital services, describing how patients move between different services, and ensuring non-discrimination on grounds of age. The hospitals will need to review their admission procedures to ensure that social dimensions of care are recorded and understood early in patient care, to enable more efficient and effective discharge.
- Long-stay ward(s): Each hospital should establish a service for continuous (long-term care) nursing of elderly frail people. This is likely to be in a ward block

separate from acute medical care. Ward policies should be patient-centred, with staff supported by hospital policies that maintain strong service values.

- Acute services: Key services, including acute medical, surgical and orthopaedic admissions, will need to develop team care for older patients, in liaison with social work department. All hospitals will need social work liaison for inpatient and outpatient services. Teams will also need to ensure contact with the primary care services, so that discharge can be smooth and effective.
- Tertiary care: Older people should have access to tertiary care equal to that of younger adults in proportion to the effectiveness of interventions.
- Training: The hospital staff training programmes will need to provide appropriate emphasis on skills and systems needed for elderly people.

Community (Dom Zdravlja)

- Primary care: All elderly people, as other adults, will be able to register with their chosen doctor. Health staff should be trained in specific care of elderly people—acute care, continuing care and terminal care—including physical, emotional, social and spiritual care.
- Home care: Nursing and technician support staff should be designated for community care geographically, linking to Chosen doctors, with trained team leaders.

Municipality homes

Municipalities should review their policies towards housing allocation, and develop facilities for sheltered housing and social homes. These would be clearly defined within the elderly care system. Social care homes would be staffed by trained staff (this may be by transfer of staff from the health system, or new provision by municipalities) with well defined care policies and review mechanisms. Homes may also be provided by voluntary agencies for their clients, but with regulation overseen by the municipality.

Home support

Services should be provided by appropriate agencies, including the Employment Agency, municipality or NGOs. Staff will liaise with healthcare staff, and services include home helps (cleaning, shopping, laundry, waste) and meals (overseeing cooking, or providing from another source).

Social work department

Casework for individuals: family violence protection, disputes on care. Allocations: overseeing budget allocations, e.g. for admissions to hospital, access to home help and meals services. Managing the regional team service allocation meetings.

National Agency for Palliative Care

A National Agency for Palliative Care can be established to provide leadership and coordination in palliative care. The Agency would be directly responsible to the Ministry of Health, Labour and Social Welfare. It should have a strategic role, bringing together stakeholders—including civil society and professionals—and maintaining momentum in promoting palliative care.

The functions of the Agency can include:

- Ensuring implementation and delivery of the palliative care programme.
- Liaison in development of finance for the programme.
- Intersectoral coordination at national level.
- International liaison.

The National Agency may coordinate through regional stakeholder committees, which bring together health services, social care, social protection and patients' organisations.

Service structures

Pathways and services for elderly care are shown in Figure 1. Elderly care in hospitals should be developed through the specialty of gerontology. Each hospital shall have a gerontology department responsible for (a) acutely ill patients with mixed medical and social needs, (b) long-term care of patients requiring full nursing care. The department is to be led by a specialist in gerontology. Each gerontology unit will have a norm of 10 acute beds and 20 long-stay beds per 100,000 population served. From the point of entry to the hospital, gerontologists should share with other clinicians the care of patients with mixed medical and social needs, so as to maximise patient care planning and minimise inefficiency (e.g. 'bed-blocking'). Gerontologists will also work in teams with the hospital rehabilitation and social work departments and hold out-patient sessions for referrals from and advice to Chosen doctors.

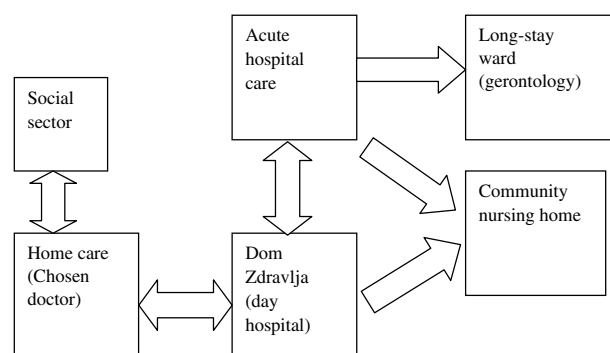


Figure 1. Diagram for elderly care.

The primary care of elderly people can be provided through Chosen doctors and other staff of the Dom Zdravlja. Each Dom Zdravlja should have a day hospital for elderly people, which can provide a Chosen doctor with an assessment of their patient's medical and social condition. Chosen doctors and nurses will provide direct care for older people through teams, both at the Dom Zdravlja and at home. The norms for care will take account of the greater time required for staff access to patients in rural areas of Montenegro.

Community nursing homes should be established by municipalities, in relation to existing Dom Zdravlja. The homes can be 'mixed-use', with both public and fee-paying patients. (Risan hospital currently is half fee-paying.) The 18 community nursing homes will significantly reduce the number of people in long-term hospital accommodation, and also provide local services for people who are able to pay for long-term care.

Each community nursing home can be organisationally overseen by the Dom Zdravlja and Municipality (through joint management and regulations), and may share staff also. Development and ownership of the community nursing homes can be through public-private partnership arrangements. State funding for residential stay will be means-tested: funding will be from social work funds. Residents will be accepted to these homes (for both public and privately-funded patients) through joint assessment between health and social agencies.

Palliative care

Terminal illnesses require a different approach from every-day medicine. The focus changes from curative treatment to support concerned with physical, social, emotional and spiritual needs, both of the patient and carers. Much of the work of end-of-life care is done willingly by carers, but they need support at certain times (for example, in heavy nursing, or in good management of symptom control). Palliative care can be done by all clinical staff, but education, training and continued specialist advice are also needed. Pathways and services for palliative care services are shown in [Figure 2](#).

There should be a Palliative Care Support Team in each region of Montenegro (north, central, south). The norm for a team will include one doctor, two nurses, one social-care worker and an administrative assistant. The teams will provide advice to other clinical services and a bridge to the Dom Zdravlja for services to patients at home. The teams will provide out-of-hours advice (e.g. by telephone) and, where

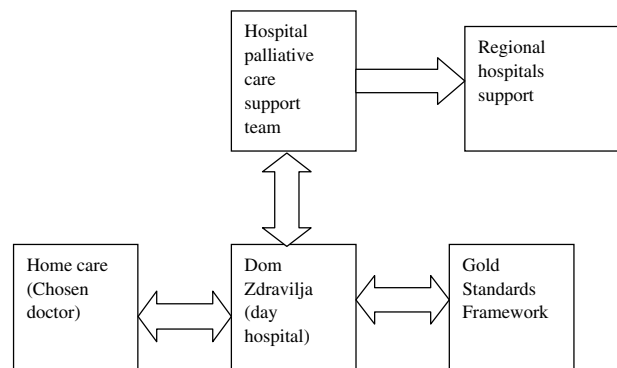


Figure 2. Diagram for palliative care services.

necessary, mobilise resources from hospitals if specially needed by patients (e.g. home-care equipment). Each team will have an important educational role for clinical staff in each of the general hospitals and in the Dom Zdravlja in their region. Statistical records will be kept by the administrative assistant.

Staff of the Dom Zdravlja will undertake most end-of-life care for their patients through ordinary clinical practice. Following the Gold Standards Framework [22] is recommended for community palliative care. Each Dom Zdravlja will appoint a Palliative Care Coordinator who will manage a register of patients. The register will record patients identified by the Chosen doctor and patronage nurses as needing palliative care, especially end-of-life care. The Coordinator and clinical staff will meet weekly in small teams for discussion of patients receiving palliative care: they will coordinate visits of staff, assessments, treatments and referrals. Statistical records will be kept by the Coordinator. All clinical staff of the Dom Zdravlja will have at least one day's palliative care training each year. Palliative care should also include bereavement counselling for relatives and carers as an integral part of locally-organised services.

Monitoring

Monitoring of the needs and results of palliative care should be made by the Institute of Public Health, on behalf of the National Agency for Palliative Care. The following suggests the pattern of monitoring, and needs to be expanded for implementation by the Institute.

Qualitative measurement

The experiences of patients and relatives receiving palliative care should be recorded by external measurement. The recorded statements of patients, and carers, are the foundation for assessing the extent that services meet needs. Monitoring these experiences over time will provide evidence of success in implementing the palliative care programme.

The important dimensions of end-of-life care include symptom control, communication, psychological and spiritual concerns; and management (including place of death). Interviews with carers about three months after the death have been shown to be valid and acceptable. Reports on social and nursing care, in nursing homes and community settings, for elderly and younger chronic sick patients, should be made.

The sampling of palliative care patients should be rotated by area and category. Study patients for end-of-life care can be drawn from registers of deaths held by the municipalities, and registers with long-stay institutions. The survey should be on-going, and provide reports back to the local services as well as a cumulative picture nationally. The reports should be publicly available, and contribute to increasing public awareness of palliative care in Montenegro.

Quantitative measurement

Simple monitoring activity data can be collected directly from service providers—the Dom Zdravlja—through the palliative care coordinators, in hospitals by the palliative care support teams, and from community nursing homes and social care services directly by the Institute of Public Health. Once the system is established, these data will be reported electronically. More detailed measures of performance may also be developed for local use by palliative care teams.

Education and training

Education and training are essential in palliative care, with the final objective of making palliative care an integral part of the health and social care system. The National Agency for Palliative Care will provide oversight of education and training, and coordination can be by the university Faculty of Medicine.

Each palliative care support team should provide training to other clinical staff, in both hospitals and with home-care services. This can be through short courses (e.g. day-release), seminars on-site, review meetings and external visits. Norms of educational provision were requested by the Ministry of Health. While no standards are internationally available, we suggest 30 hours of palliative care training should be included in the curricula of secondary and higher education of nurses, undergraduate training of doctors, and for other professions—including pharmacy and physiotherapy. Staff of community nursing homes should have training and qualifications for their basic work, and receive continuing education in palliative care through 20 hours per year.

Programme and norms

An outline programme for development of elderly and palliative care in Montenegro is shown in [Table 2](#). The norms and standards proposed here were developed by the authors, at the request of the Ministry of Health, as realistic within the perspective of the development of services in Montenegro.

Discussion

In all developed countries, the growing proportion of elderly people, and falling number of young people, requires a redistribution of health resources, and their more integrated use. Active older people can enjoy a good quality of life, and enhanced contribution to society. But as the proportion of older people rises, the needs for health care will also rise.

The former Yugoslavian system for elderly care was organised centrally, from the capital in Belgrade. There had been little development of the services within Montenegro, little coordination between primary and secondary care services, and no provision of specialist palliative care [3]. A further dimension is the changing role of doctors in primary care, who are now taking on shared community care roles with nurses. As elsewhere in former Yugoslavia [23], hospitals in Montenegro have no tradition of specialised care for elderly people. General hospitals admit patients of all ages in a similar way, and with poor quality of the hospitals, some sick older people are cared for in settings that reflect those in Western Europe some decades ago. Also, there is no tradition of public residential facilities for older people, apart from Risan Hospital, and the private sector has not been encouraged to invest in these services.

In planning its health services as a newly independent country, Montenegro has wished to draw on broader European models. The international literature has shown benefits for integrated care of elderly people through: good organisational structures for collaborative working; multidisciplinary case management led by a single team member; provider networks joined together by standardised procedures and service agreements; and financial incentives to promote prevention, rehabilitation and supporting home care [24]. However, European health systems show considerable variation in the organisation of elderly care [25–27], and European guidelines in palliative care [28] are broad. Our project suggests the need for further research on translating organisational principles into service practice, especially for European countries in economic transition.

This project required input norms for provision of services. Norms were traditionally used in former

Table 2. Action proposals

Elderly care		
	In-patient	18 Dom Zdravilja (Dz)
Organisation: diagnoses include stroke, respiratory disease, and dementia. Special links with rehabilitation, social support	8 'general' hospitals: Gerontology department to be created (acute and long-stay); rehabilitation facility; occupational therapy 18 community nursing homes to be created: long-term care	Each Dz Day hospital for assessment, rehabilitation. Assessment for social care support, community nursing homes and hospital admission Liaison with municipality, social fund, patients organisations
Staff	Hospital department: Gerontology specialist, 2 junior doctors, 15 nursing staff, 2 occupational therapists, 2 social workers Community nursing homes: Manager, care staff, nursing, visits by Chosen doctors	Each Dz: 1 Specialist doctor, 2 day hospital nurses, 1 physiotherapist, 1 social worker Chosen doctors, nurses
Protocols	Hospital department: Acute admissions for 'mixed' needs patients; Collaboration with other specialties, terminal care Community nursing homes: Joint admission assessments Dependency assessments For both: patients' advocacy	Shared care with social department; shared decisions on referral for admission
Benefits package	Hospital—fully funded by 2° care benefits community—user charges and social funds	Fully funded by 1° care benefits
Norms	Per 100,000 population served Hospital: 15 long-term beds (2 'respite', 10 acute beds Community: 25 long-term residential, 25 long-term nursing Places	per Dz 5 day patient places 100 patients per year
End-of-life care		
	In-patient	Day care, home care
Organisation: all diagnoses (support to specialties.)	Each (3) region Palliative care support team sited in regional hospital, providing support (e.g. pain control expertise) to other hospitals and Dz services	Each Dz Register of current care patients. Weekly clinical meetings (chosen doctors, nurses) to review cases, arrange services. Out-of-hours service Liaison with pharmacies for pain control
Staff	Each team: 1 senior, 2 nurses, social worker, admin support	Each Dz: 1 Palliative Care Coordinator, teams shall include psychologist and social worker as well as Chosen doctor and nurses for home care
Protocols	Advisory service to hospital staff—for assessment, terminal care Pain control protocols including opiate therapy Hospital/home interface cooperation procedures	"Gold Standard Framework" Team. Patients on register. Day treatment and homecare Average care 3 months (varies by diagnosis). Most patients at home for death. Pain control protocols include full opiate therapy. Care episodes include family and post-bereavement
Benefits package	Fully funded by 2° care benefits	Fully funded by 1° benefits NGO volunteers can contribute through Dz
Standards		
	Training	Monitoring (Institute of Public Health)
Organisation	Provide leadership and staff training for 2° and 1° level teams Work with National Agency for Palliative Care	Record patient experiences (outcomes) and quantitative activity data from teams (process)
Staff	Palliative care educational teams: short courses: 3 seniors, 3 juniors, 1 course manager, course teachers	1 senior + 3 junior—1 data manager, 1 qualitative surveyor/analyst, 1 quantitative collector/analyst

Table 2. (Continued)

Standards		
	Training	Monitoring (Institute of Public Health)
Protocols	Palliative care support teams to make external links	Qualitative: rotating (area, category) interview surveys: 15 elderly, 15 palliative care per quarter Quantitative: analysis of activity data from Dz teams and hospital specialist teams
Benefits package	Training funded by School of Medicine Attendees funded from institutional staff training budgets	Grant to Institute of Public Health from Ministry of Health
Norms	<i>Specialist palliative care staff:</i> Each to have 10 hours in-service training, and 10 hours away-site training, annually <i>Other clinical healthcare staff:</i> each to have 6 hours training per annum	Quarterly and annual reports to Ministry and national publication of findings

Yugoslavia, as they allow financial allocations to be linked to quantities of staff and facilities. Yet contemporary health systems in western European countries use different methods, based on funding, activity and process/outcome standards. Health and social care managers will need to learn new methods of service control, and allow greater flexibility in resource use. And health service staff will need to change their practice, through developing teamwork and managing care across boundaries within the system. For the best patient care, organisational arrangements require as much attention as clinical standards. There is a need for Montenegro to develop a management culture that empowers professionals, while also achieving cross-sectoral change.

The challenge for the Montenegro Ministry of Health, however, is less what to do as how to do it. Management of change in public services such as health-care requires political direction. Economic pressures, for example from the International Monetary Fund to reduce expenditure on healthcare in exchange for writing off international debts, and from employers and employees to reduce their contributions to the insurance fund for healthcare, can drive the health system towards structural rather than service reform. The Montenegro Employment and Budget ministries, especially, must maintain social solidarity through distribution of health insurance funds to the elderly, and address the current low contributions from the substantial 'unemployed' and 'independent' sectors of the adult population. At the service level, the Health Insurance Funds also have to control the budgets for drugs, as pharmaceuticals companies increase their influence doctors' prescribing and pressure grows for new medical equipment. Compared with these, it is a challenge to maintain political priority towards reorganising care for older people.

Finally, there are professional and cultural pressures on the model of service to develop. Agencies concerned with older people are often orientated towards maintaining older peoples' engagement in society, including reducing handicap and creating age-appropriate services. They have not traditionally focused on end-of-life care or the services provided to older people by hospitals and primary care services. By contrast, clinical palliative care services may press the needs of a relatively smaller group of patients, mainly with cancer diagnoses and often younger (sometimes children). Clinicians serving these patients are not generally oriented towards the broader issues and needs of older people and end-of-life care. These different perspectives may be in conflict for resources at policy level.

Conclusion

Plans have been developed to provide integrated elderly and palliative care in Montenegro. The existing staffing levels in the health service are sufficient, but training, skilled management and political commitment are needed to achieve change, create new services and raise quality of care. The next steps depend on the Ministry accepting the proposals of the report and the clinicians and integrated services working with the proposals. Such a process will take time and will need to be linked to wider health reform in Montenegro: but it should not become subservient to them. A champion for reform, perhaps the chair of the National Palliative Care Agency, will be needed. Beyond that, international partners with broad skills, including the academic community with experience in integrated care, can contribute to achieving quality services for elderly people in this sector of Europe.

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