United Nations
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Policy brief

Innovative and empowering strategies for care

UNECE Policy Brief on Ageing No. 15
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2002 Regional Implementation Strategy of MIPAA, Commitment 7: To strive to ensure quality of life at all ages and maintain independent living including health and well-being.

2012 Vienna Ministerial Declaration — Ensuring a society for all ages: Promoting quality of life and active ageing. In fostering the implementation of MIPAA/RIS in its third implementation cycle (2013-2017), UNECE member States "are committed to raising awareness about and enhancing the potential of older persons for the benefit of our societies and to increasing their quality of life by enabling their personal fulfilment in later years, as well as their participation in social and economic development." (goal III: Dignity, health and independence in older age).

Contents

Challenging context

The number of older people is growing and this group is forming an ever-larger share of our populations. At the same time, the diversity amongst this age group is increasing. The range of lifestyles and of physical, mental and social capabilities amongst older people leads in turn to diverse demands and needs regarding care. Societal and institutional dynamics such as changing family patterns and living and care arrangements also impact on care needs. Many older people live in single-person households with no family support within reach. Many prefer to continue living independently instead of being admitted to institutional care.

Difficulties in ensuring adequate and affordable care coverage abound. It is often problematic in rural and remote areas due to the rural exodus of the working age population that exists in many countries, as well as to higher costs of care provision. Many poorer people face financial barriers in accessing adequate care. Current public cost-cutting efforts in many UNECE countries necessitate the reorganization of care provision and its financing, to make it more efficient, financially viable and fit for the future.

Suggested strategies

New care arrangements need to be developed to respond to changing demands. Developing modern policies for care as well as extending home-based services and furthering the integration of care into the local community are effective ways to react to social changes and to respond to the desire of many older persons to live independently. A shift of paradigm from passive to active care gives older people more influence and power, and thus ensures that their needs and wishes are better reflected in care provision.

The cooperation between public care services and the private sector creates new financing models and promotes knowledge transfer between the public and private spheres, shifting the commercial focus to the target group of older people. The use of new technologies in care facilitates improved quality, range and efficiency of care services.

Expected results

The inclusion of new and empowering strategies into the care setting in response to social changes broadens the scope of care, increases care coverage and improves quality, efficiency and target group orientation. The aim is to help older persons remain active as they age and to enhance their quality of life and overall well-being with care services tailored to their needs.

With good practice examples from:

Austria, Czech Republic, Denmark, Estonia, Finland, Germany, Ireland, Italy, Malta, Poland, Sweden.

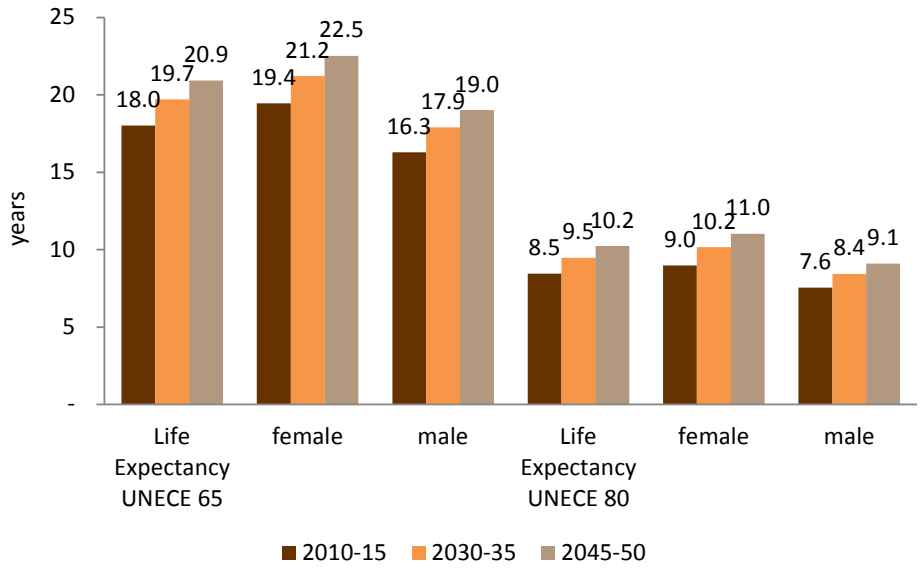
Introduction

Demographic changes

Population ageing is a significant trend in all UNECE countries. The United Nations Population Division projects that in the UNECE region the share of population aged 65 years and older will increase from 15 per cent in 2013 to 20 per cent in 2030, and to 24 per cent in 2050, while the share aged 80 years or older will more than double, from 3.9 per cent in 2013 to 8.3 per cent in 2050.[1]

Along with low fertility, an important factor underlying this trend is increasing longevity. In the UNECE region, men who are 65 years old today are expected to live on average another 16.3 years, and women 19.5 years. At age 80, average life expectancy amounts to 7.5 and 9 years, respectively.[2] On average more than half of the remaining life expectancy for men aged 65 is expected to be healthy life, based on health-adjusted life expectancy calculations.[3] For women, however, the opposite is true. Hence, chronological age is not an automatic determinant of dependency, frailty and the need for care.

Figure 1
Life expectancy at age 65 and at age 80 in the UNECE region



Source: United Nations Department of Economic and Social Affairs, *Profiles of Ageing 2013*, own calculations

Life expectancy beyond age 65 is greater for women than for men, and as such, women form the majority of older persons. Since care needs differ along the lines of age, gender, socioeconomic background and physical abilities, this Policy Brief suggests that policies should be centred on individuals and individual needs.

Large migration flows of working-age population in many UNECE countries from rural to urban areas and from emerging economies towards Western Europe or the Russian Federation are another important demographic development impacting ageing. In migrant-origin countries, this leads to a significant number of older people and children being left behind, often in 'skipped-generation' households consisting only of grandchildren and grandparents. The lack of other family members to support them can result in insufficient care availability. In migrant-receiving countries, ageing migrants add to the socio-economic heterogeneity of the older population in need of care.

[1] Data from United Nations Department of Economic and Social Affairs (UNDESA) (2013): *Profiles of Ageing 2013,* own calculations.

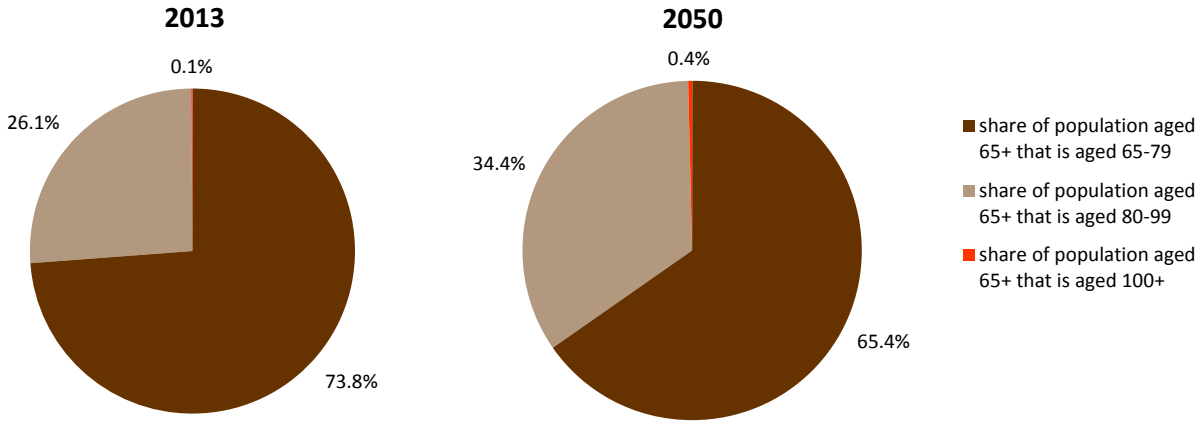
[2] Life expectancy varies considerably within the UNECE region, ranging from 11 years for 65-year-old men in Kazakhstan to 19 years in Iceland, and from 15 years for women aged 65 in Moldova to 23 years in France. *Ibid.*

[3] United Nations Economic Commission for Europe (UNECE) (2012): *Synthesis Report on the implementation of the Madrid International Plan of Action on Ageing in the UNECE Region.*

The "new old"

Older age is an important and lengthening period of life in which needs, abilities and resources differ both from person to person and over the course of an individual's lifetime. To assess the diversity of care needs, we need to consider not only the age structure of the current and future older population, but also socioeconomic characteristics such as educational attainment, prevailing occupational fields, income etc.

Figure 2
Age structure of population group aged 65 and above, UNECE Region



Source: United Nations Department of Economic and Social Affairs, *Profiles of Ageing 2013*, own calculations

Roughly three-quarters of the population aged 65 years and older are aged between 65 and 79, with those born after the Second World War accounting for 40 per cent of the latter. People aged 80 years and above (so called 'older old') now account for one quarter of the group aged 65 and above, and this share is projected to reach more than one third by 2050. The share of centenarians among the 65+ age group is projected to quadruple by 2050.[4] The faster increase in the 'oldest old' group may lead to rising demand for care services since the probability of chronic diseases and need for care increases with age. However, demographic change does not take place in isolation; social, medical, cultural and political developments can influence care needs and must be taken into account when developing care strategies.

Research shows that in general, the generations born after the Second World War are meeting old age with far better resources than any generation before them. This group, termed the 'new old', is healthier and usually more active and independent than previous older generations. Many more of them are used to taking decisions and to being active participants in family, community and social life, and want to maintain this in older age. They want to and can continue such participation and they therefore require care services that enable them to do so.

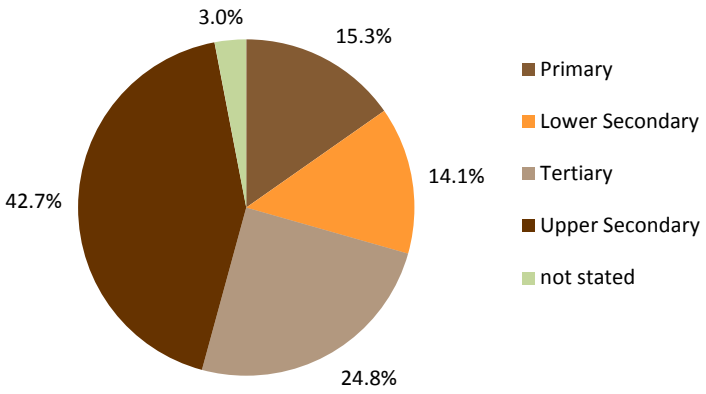
On average, older people today have a higher level of education than previous older generations[5] and are more experienced in the use of technology. Across the UNECE region, the proportion of people aged 55-74 using a computer and using the Internet has increased considerably over the last ten years, albeit on very different levels across countries.[6]

[4] Data from: United Nations Department of Economic and Social Affairs (UNDESA) (2013): Profiles of Ageing 2013, own calculations.

[5] For instance, in 1950, a person aged 15 or over had spent on average 7 years in formal education in Western Europe, 4.7 years in Eastern Europe and 9.6 years in North America and Australia. In 1980, average years spent in formal education for those aged 15 years or over increased in these regions to 10.1, 8.1 and 11.8 years respectively. OECD (2014): *How was life? Global well-being since 1820*, p. 96, table 5.4.

[6] Computer use currently ranges from 9 per cent of people aged 55-74 in Turkey to 91 per cent in Iceland. The percentage of people aged 55-74 using the Internet on a weekly basis is again lowest in Turkey with 8 per cent and highest in Iceland with 85 per cent. Regional and national differences in access to and use of information and communication technologies (ICTs) are significant, but the trend of increasing ICT use is the same (*UNECE Statistical Database*, 2013). Available from http://w3.unece.org/pxweb/.

Figure 3
Educational attainment of population group aged 50 and above
UNECE Region, 2012 (or latest available)



Source: *UNECE Statistical Database*, compiled from national official sources

The increase in care needs is far from proportional to the rise in the number or share of older people. The active and healthy lifestyle of many older people contributes to a longer life span in good health, and with the right support many older people can live independently for a much longer period than was true for previous generations.

Care today and future challenges

Care encompasses a range of services aimed at promoting, monitoring and re-establishing health and well-being. Commonly, a distinction is made between health care and social care, although a clear-cut differentiation between these two elements of care is difficult to make. Generally, health care is regarded as medical services provided by professional staff whereas social care is mainly provided by local authorities, the private sector and informal carers and consists of personal assistance aimed at increasing the recipients' well-being. Although a 'silo' mentality may predominate among service providers, various links and intersections between health and social care do exist, and cooperation and integration should be furthered in the interests of users.

Care can be provided through either formal or informal channels—albeit the demarcation between these two sectors is becoming increasingly blurred. Formal care is defined as paid care services provided by trained, licensed and qualified professionals. The services are controlled by the state or other organizations, and caregivers are generally protected by labour rights including social rights and are subject to working regulations such as a fixed number of working hours. Informal care, on the other hand, is mainly provided by family, friends or neighbours with little or no professional care expertise. The work itself is generally unpaid (although informal carers may receive financial contributions); there is no contractual agreement and no formal entitlement to social rights or applicability of working regulations.

The proportions of care that are formal or informal, and the proportions that are institutional or home-based, vary across the UNECE region. In Europe, care provision patterns differ along geographical lines. In Northern Europe care is mainly provided by the public sector and is characterized by a high share of formal care and lower family engagement in day-to-day care. In Southern and Eastern Europe, the family is the main provider of care services. In Central Europe, the care responsibility is more evenly shared between family and public institutions. Many countries in which publicly-funded care services have dominated in the past now focus increasingly on informal care and promote the responsibility of the family and the community. Countries in which the majority of care tasks are performed informally may have policies in place to try to strengthen the public care sector by improving the quality and accessibility of its services. The organization, regulation and provision of care

are increasingly being decentralized, with regional and local authorities being entrusted with more responsibilities.[7] There is also an important shift away from residential care and an increasing focus on ambulatory, home-based and community-based care, particularly in the European Union countries.[8]

Among other factors, a lack of care personnel is forcing these developments. Often unattractive working conditions and low payment have led to recruitment problems, in particular among younger people: the median age of professional care staff is high and rising faster than in other sectors. Responding to staff shortages by recruiting migrant carers is a common practice in many UNECE countries, with implications for both countries of origin and recruiting countries.[9]

The future will present further human resources challenges, as well as challenges in the financing of care services, both on the public side and the individual side, as many older persons and their relatives face problems in finding affordable care services. The quality of care as well as the adjustment of the scope of care services to provide for the diverse demands of a highly heterogeneous group of users demands attention.

Envisaging forthcoming challenges is one step towards developing new care strategies, but it is equally important to consider the aims and resources of all stakeholders involved and ensure that strategies fit these requirements. Care strategies that aim to empower older persons and ensure their dignity in older age need to promote active user involvement in the design and provision of care services to improve their quality and to increase user satisfaction.

Moving from passive to active care

Unfortunately today, too many decisions in the care setting are made without consulting the people affected by them. Leaving older people out of decision-making processes forces them into a passive role and denies them the influence and power they deserve. The result is that they feel overlooked and that care services are not as well adjusted to their needs as they could be.

'Active care' is a novel approach to care that affords users an active role in their own care, with the power to make their own decisions. It is based on the idea that older persons should be able to enjoy the same rights to which all people are entitled. Older people, like all people, have the right to live independently and to make their own decisions. This is especially true when it comes to care. The concept of active care asserts that care users should be involved both in decisions regarding care and in the organization and provision of the care services themselves. When a rights-based approach is followed, care users are empowered to make free choices, to live independently and to access adequate health support. A focus on how older people's own resources can be employed and fostered in the care setting helps to create innovative and empowering strategies for care that make use of the potential offered by the 'new old'. The shift from passive to active care is a shift from care provided for people to care provided with people. Users can contribute actively to their own care and cooperate with other actors for the provision of care services. The aim is to include and empower users as well as other stakeholders involved in the creation and delivery of care strategies and services.

Active user influence and power

A cornerstone of this 'active care' paradigm is the inclusion of users, their opinions and ideas, in the design and provision process of care services. This can be achieved in various ways, depending on the context. The Residents' Board in Malta represents a way to formalize the influence of older people on matters affecting their environment.

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[7] Verbeek-Oudijk, D. et al. (2014): *Who cares in Europe? A comparison of long-term care for the over-50s in sixteen European countries*. The Hague, Netherlands.

[8] UNFPA (2012): *Ageing in the Twenty-First Century: A Celebration and A Challenge*, p.114.

[9] See: Buchan J. and Perfilieva G. (2006): *Health Worker Migration in the European Region: Country Case Studies and Policy Implications*. WHO. See also Policy Brief 7: "*Towards community long-term care*", available from http://www.unece.org/pau/age/policy_briefs/welcome.html.

Malta – Residents' Boards in Long-Term Care settings and in Day Centres for the Elderly

This project sets out to give older people a more active role by including them in the decision-making processes of their care setting. Committees have been established both in government residential homes for the elderly and in all day centres in Malta. The members of the Residents' Boards meet on a monthly basis and their suggestions are passed on to the officer in charge, who is obliged to consider them. The project enhances the social participation of older persons and ensures that their voice is heard and their needs and opinions are considered in the design of care services.

Sources: Information provided by the Ministry for the Family and Social Solidarity of Malta

Another participatory approach has been pursued in Norway and the United Kingdom. The Norwegian Dementia Plan 2020 systematically gathers and includes the opinions of stakeholders on the design and provision of dementia care into policymaking. Field research is undertaken across the country in order to gather feedback from people who have dementia, their families, volunteers and staff on how to improve dementia care and create a more dementia-friendly community.[10] To ensure that care users have the influence and power they deserve, it is important to enlist the support and involvement of other actors in the care field such as care personnel and informal caregivers, bodies representing health and social care workers, community and political leaders and regulatory bodies.

The active involvement of citizens in public service delivery, including care service delivery, can be described using the terms co-creation and co-production. Such involvement can occur in any or all of three different aspects: citizens as co-initiators, as co-designers and as co-implementers of public services. In each case, citizens engage in a partnership with other actors in the care field and contribute their own resources to design or deliver care services, shifting the balance of power, responsibility and resources from professionals to individuals.[11]

Sweden – The 'System of Choice in the Public Sector' Act

The 'System of Choice in the Public Sector' Act (2008:962) entered into force on 1 January 2009 with the aim of empowering users of care services by enabling them to choose their care provider.

Under the reform, the local municipality remains responsible for all services, irrespective of who is providing them. The public authority is the contracting authority and determines the price of services in advance so that competition between providers is based only on quality, not on price. A person who does not want to choose is not obliged to do so, since a non-choice (default) alternative is offered.

By April 2014, more than 60 per cent of Sweden's 290 local municipalities had introduced or decided to introduce free-choice systems within one or several service areas, with home help being the most common area. A study has shown that the number of providers has risen sharply and that over 70 per cent of the providers offer services with particular features –specific language capabilities being the most common feature. Other examples include providers with specific expertise in the fields of dementia and Alzheimer's disease, or with special knowledge about provision of services to lesbian, gay, bisexual and transsexual (LGBT) persons. Surveys indicate that users are satisfied with and appreciate the possibility to choose. In 2013, a national survey showed that although the vast majority of older people are satisfied with their health, those who had chosen their provider of home care services were more satisfied than those who had not made a choice.

The reform promotes active user influence, empowering users of care services. People who have been given the opportunity to choose often say that this enhances their ability to remain in charge of their own lives and to live independently. Ensuring competition between service providers based on quality instead of price promotes improvement in care quality. Today there are over 600 private providers offering home help, of which 72 per cent are small newly-formed local business. The range of services has increased, allowing older persons to have their specific needs met to a greater extent.

Sources: Information provided by the Ministry of Health and Social Affairs
http://www.kkv.se/t/Page____5848.aspx

[10] Information provided by the Norwegian Ministry of Health and Care Services.

[11] Freire, K. and Sangiorgi, D. (2010). *Service design and Healthcare innovation: from consumption, to co-production to co-creation*, p.3.

From nursing to rehabilitation and social networking

Health is defined by the World Health Organization as "the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[12] This in turn suggests a definition of care, in which the right to health is central; care is not restricted to nursing but rather comprises support in the maintenance and rehabilitation of health in all areas, including physical, mental and social well-being. Social and health care services should therefore place particular emphasis on health promotion, disease prevention and physical and mental rehabilitation.

The Canadian initiative 'Assess and Restore' focuses on the rehabilitative potential of older people and aims to restore their capabilities in an integrative and coordinated approach which includes all stakeholders.

Canada – Assess and Restore (A&R)

The 'Assess and Restore' initiative was developed in the province of Ontario with the aim of helping seniors with complex conditions to recover from illness or injury and live safely at home. The Ministry of Health and Long-Term Care included A&R in its strategy for 2013-14 and advances it through the issuance of a guideline and targeted funding.

The 69 pilot projects that were funded under A&R provide services focused on restoring functional skills and abilities for frail seniors, and older adults in general, and on enhancing access to and capacity of specialized interventions across the province. All actions were geared towards keeping frail seniors out of hospitals and enabling them to be supported in their communities.

The A&R funding initiative improved patient care and experience by providing:

- Enhanced clinic-based rehabilitation services in hospital day programmes and outpatient clinics
- Innovative short-term in-home rehabilitation therapy services
- Coordinated care among geriatric health care providers for individual patients, including physiotherapists, occupational therapists, mental health professionals and primary care physicians
- Standardized tools and supports to identify those most at risk early on and to determine appropriate services for these seniors.

An estimated 6,300 frail seniors were helped as a result of the 2013-14 funding initiative. A&R achieved a number of positive outcomes such as reduced post-acute alternate level of care rates*, reduced acute length of stay and thus lower acute care costs, as well as increased walking distance and improved function.

Of Ontario's 1.9 million seniors, only a relatively small proportion (150,000 persons) meets the clinical and functional criteria for frailty, with about one quarter of these frail seniors (40,000 persons) experiencing a sudden loss of mobility or other function each year (following illness, injury or a flare-up of a chronic disease, for example) that can be reversed through timely and appropriate care interventions. This functional loss represents the largest threat in terms of loss of independence, medical complications, caregiver burden, avoidable hospitalizations, and premature placement in long-stay long-term care homes.

A&R is an organized, proactive response that targets these at-risk frail seniors and seeks to provide them with timely access to targeted and appropriate assessment, prevention, and restorative care services that are critical to minimizing the frequency and extent of functional loss. The preventive and rehabilitative measures in this initiative support seniors to continue 'ageing in place'.

* The term alternate level of care (ALC) is used in Canada to identify patients who no longer require the level of treatment or care services they are currently receiving.

Sources: Information provided by Ministry of Health and Long-Term Care
http://www.health.gov.on.ca/en/pro/programs/assessrestore/docs/ar_guideline.pdf

The scope of care needs to be broad enough to encompass all aspects of health, including social well-being. Many older people live alone and face the threat of social isolation. Innovative strategies to foster social participation and social networking improve the quality of life of older persons and should therefore be an integral part of care services.

[12] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p.100) and entered into force on 7 April 1948.

Finland and Estonia – the VIRTU Channel: 'Virtual Elderly Care Services on the Baltic Islands'

The aim of this project is to prevent social isolation and to increase access to professional services in remote, rural areas through the use of information and communication technologies. The project helps older persons in the archipelago area to live at home, enhances their social interaction, improves their quality of life and increases their safety.

The service, which uses a simple touch-screen device, allows the users of the VIRTU channel to interact via video and audio transmissions simultaneously with two or more people. The device requires nothing more than an Internet connection and login details. It allows users to participate in discussions and question times on various topics, such as health and nutrition and medical topics, and to participate in exercise and singing sessions. The transmissions are developed together with the users based on their own interests. Outside of the scheduled broadcasts, the VIRTU channel offers the opportunity to keep in touch with other users, such as peers or care staff.

Sources: Information provided by Tallinn University, Estonia
http://www.virtuproject.fi/

Physical, social and cultural activities

Extending the scope of care requires in turn broadening the range of care services in order to stimulate users socially, physically and culturally and to support health and well-being. Daytime activity programmes are often seen by practitioners and users as the 'missing link' in care services. Such activities are crucial in adding meaning to people's daily lives. They make the difference between care construed as something whose role is to ensure the survival of people, and care as something which fosters their well-being. When physical, social and cultural activities are included in care strategies, the quality of life of users can be improved in many ways. Physical activities help maintain or restore good health and play an important role in securing older people's independence. Social and cultural activities contribute to overall well-being by improving the social connectedness and inclusion of older people and by giving them a sense of being appreciated as full members of society. Some activities help to maintain or improve the skills of older people (for example memory enhancing groups or music groups) and can be used therapeutically to counteract anxiety and depression. Activities can help older people to lead an enjoyable and meaningful life and contribute to improving their self-esteem as well as their physical, mental and emotional capabilities, thus helping to maintain an active, independent lifestyle.

Independent living

Enabling older persons to live independently is one of the goals of the 2012 Vienna Ministerial Declaration: "Ensuring 'ageing in place' by promoting services and support to the individual and the family to enable older persons to continue living for as long as possible in their own environment and community. These services should take into account the special needs of women, in particular those who are living alone." [13]

The majority of older people want to remain in their current residential environment and live independently for as long as possible. The task of care services is therefore to help them realize this wish by providing a supportive and enabling environment. Care services can help in maintaining or restoring the physical abilities needed to live independently. The Danish model project Fredericia is a good example of care services committed to achieving this goal.

[13] UNECE (2012): *2012 Vienna Ministerial Declaration*, paragraph 10, III.(h).

Denmark – The Fredericia Model : 'Life Long Living'

This project is a model for interaction between senior citizens and their hometown social services and aims to change the way senior citizens are perceived - from passive patients to citizens with active resources.

Older persons requesting professional or personal assistance are offered a six- to eight-week rehabilitation programme in which they are trained to perform care tasks themselves. Participants are trained to do simple things such as daily shopping, light cleaning tasks, taking their medication, doing laundry, cooking, etc. The model brings together professionals and asks seniors, "What would you like to be able to do again?" focusing on bringing back the ability to function in a self-reliant way. The public service is treated as an intervention rather than a long-term relationship with the citizen. A big part of the model is the co-production of the rehabilitation plan between care professionals and care users.

The results generated by the initiative are promising. After the intensive rehabilitation programme, the participants' need for practical and personal assistance falls considerably, and many of them become fully self-sufficient. The number of care services requested in Fredericia has fallen significantly since the introduction of the initiative, and subsequently the cost has decreased. The project has been found to increase citizen satisfaction and quality of life. In 2010, 'Life Long Living' received the Innovation Prize from the Association of Danish Local Authorities. The model received a European Public Sector Award (EPSA) 2011 Best Practice Certificate. In 2012, 'Life Long Living' received the European Year for Active Ageing and Solidarity between Generations Award in the category of Age-Friendly Environments.

Sources: Information provided by the National Board of Social Services, Denmark
http://www.fredericia.dk/FFF_ny/LMIEL/Sider/About-the-project.aspx
http://ec.europa.eu/archives/ey2012/ey2012maina85f.html

Technological enhancement of active care

If older people are physically, cognitively or mentally impaired, care services can provide assistance through which users can maintain the highest possible degree of independence. Technological aids, in particular, can play an important role in complementing personal assistance provided by formal and informal caregivers.

Technological advancements have an impact on virtually every part of life and as such they can shape the care field, influencing which services are offered and to whom, how they are organized and how they are carried out. Care technologies range from relatively simple tools such as hearing aids, dentures, wheelchairs and syringes, to complex devices such as robotics or electronic health records. They are employed not only in nursing and medical care but also in social care to facilitate everyday life for users (for example, walkers, stair lifts, specialized beds and mattresses or orthotics). Technologies can complement the active care paradigm if they are applied with the aim of empowering the users.

Information and Communication Technologies (ICTs) develop especially rapidly and carry an immense potential yet to be tapped for innovative use in the care sector. They are becoming increasingly important in the care sector since they can assist in a variety of care tasks in virtually any aspect of life. The contribution of ICTs to care services can range from medical monitoring devices to social networking tools which aim to increase social interaction and the quality of life of older people.

A large number of older people live alone, many of them feeling lonely and isolated at times. Some live with impaired physical mobility. They can benefit from technologies that help them to exchange and communicate with others and that involve them in social interaction. ICTs can help people to stay in touch with family and friends, and can enhance a feeling of relevance through social networking tools that serve as an interactive connection to the world. Technologies can also facilitate everyday life for older people through e-services such as commerce, personal finances or administering of medication. With simple tools like these, users hold the power to shape their lives and to make decisions.

'Telecare' services are services which are provided remotely, without the physical presence of a care provider. They can enhance the health, safety and security of older people and can contribute to preventative care. One tool that is quite widely used today, for instance, is a device featuring an emergency key which can be pressed if assistance is needed. Some new telecare devices help to track the movement of care recipients and send a warning signal to a tracking centre if there are unusual patterns. This can give people a sense of security knowing they can always reach help if needed and can thus encourage them to continue living in their own home. While some people perceive these technologies as an intrusion into their privacy, they generally prove to be very popular as they are easy to use and meet the desire of many elderly people to live independently for as long as possible. Following the active care approach, the employment of such technologies should be at the users' discretion.

Poland – Telecare in Gdynia – monitoring of older citizens in their homes

Telecare is provided to all older persons in the town of Gdynia who are entitled to municipal care services, as well as to other senior citizens in the town. It is based on the use of a telephone or bracelet with extended features. There are three buttons in different colours – red, green and blue – each of which enables the user to call for different services. The red button is used to call the Alarm Centre which operates 24 hours a day, seven days a week. Upon receipt of a call from this button, contact is immediately made with the older person or his/her minder, family, neighbours or other people who can verify what kind of help is needed. If this is not possible the Alarm Centre calls an ambulance.

What makes the system in Gdynia special is the range of assistance services and care services. The green button connects to assistance services that include conversation, provision of information or consultation with an expert, for instance a psychologist. The blue button connects to extra care services including, for example, rehabilitation specialists or services related to cleaning and small repairs. The system is serviced by a private enterprise. It is provided free of charge to those users entitled to the municipal care services and at a favourable price for other Gdynia residents, thanks to co-financing by the city authorities. It costs about €7.00 per month per user. Some services are charged an additional fee, such as rehabilitation services.

Currently about 100 older persons in Gdynia are provided with the Telecare service as part of the municipal care services and a number of other senior citizens use it. The Telecare system was introduced as a result of wide social consultations called 'Gdynia's dialogue on quality of care services' performed in 2010-2011. About 1,000 stakeholders, including older persons, took part in the consultations. The Telecare project was the direct answer to the security needs that were expressed. Therefore it is also a good example of empowering the residents of Gdynia in decision-making on care services for older people.

Sources: Information provided by the Ministry of Labour and Social Policy Poland and the Municipal Welfare Centre in Gdynia
http://www.mopsgdynia.pl/www/index.php?option=com_content&task=view&id=1406&Itemid=1
http://www.gdynia.pl/wydarzenia/70_92680.html?page=11

'Telemedicine' is the delivery of medical care through remote means. It is designed for people with diseases and helps in monitoring their medical condition and detecting any deterioration as soon as possible. Selected biomedical parameters of a patient are measured and transmitted to a hospital for monitoring. Depending on the nature of the parameters in question, data can either be monitored automatically and constantly or with the help of the patient at certain times. It is also possible to configure such systems to trigger an alarm if parameters deviate significantly from expected values. These technologies reduce pressures on hospital staff and resources since parameters can be monitored at a distance. In addition, telemedicine also improves the quality of health care because data can be measured continuously and therefore deviations can be detected immediately, reducing reaction time to a – possibly life-saving – minimum.

The use of ICTs in care settings can present a 'win-win-win' situation for all actors; users, care providers and society as a whole. Overall welfare benefits can be achieved through health care savings, reduced care needs of older people, and through the provision of content and services relevant to older persons.

These are only few examples of what is already possible and in use today. Research and development in this area is extensive, so it can be expected that there will be many more new technological devices and solutions for care services in the future.

Czech Republic - Targeted remote monitoring of patients with chronic diseases

This project aims to improve care for chronically ill patients, especially older persons with heart failure after myocardial infarction (heart attack), and to detect early the deterioration of health status and comorbidity in elderly patients with a chronic disease that has already been detected.

Older people diagnosed with chronic heart failure, those who have had a heart attack, and those newly diagnosed with diabetes are monitored using a telemedicine service that enables measurement of selected biomedical parameters remotely without the need for continuous assistance from medical staff. In this way, comorbidities as well as any deterioration of the patient's condition can be detected and treated at an early stage.

The project includes two separate telemonitoring activities: first, telemonitoring of senior patients with advanced heart failure and second, telemonitoring of acute myocardial infarction in senior patients with newly-diagnosed diabetes. In the first of these, the progression of patients with chronic heart failure and structural damage of myocardium and left ventricular dysfunction is monitored using innovative telemedicine services, enabling continuous remote monitoring. In the second activity, the course of treatment of patients with both acute myocardial infarction and newly-diagnosed diabetes is monitored in the long term using telemedicine services.

The project is very successful, with the number of patients benefiting from remote monitoring growing rapidly. The practices in this project are gradually introduced so that they are available for 15 per cent of the target population in the region of Olomouc. They are also disseminated to other hospitals in the Czech Republic and other countries.

Sources: Information provided by the University Hospital Olomouc.
http://www.ntmc.cz

Using technology in care: challenges and limitations

Technological, social and scientific developments progress rapidly and impact all spheres of life. Holding on to existing systems and technologies sometimes seems to be more convenient and a certain resistance to progress or change is observed in many areas, not least in the field of care. Not everyone can access and use new technologies easily. This applies both to care users and to care practitioners, especially in the informal sector. Socioeconomic differences in technology access and use, referred to as 'the digital divide', lead to a limited ability to access digital products and services among structurally disadvantaged groups, such as less-skilled migrants or older people. Efforts to foster social inclusion may therefore help to ensure that everyone benefits from ICT-based products.

The uptake of new technologies by end users – carers or care-users – is influenced not only by access but also by their acceptance of a device, its usability and its utility. Low take-up and usage of a new technology may result from one-sided, technology-driven product development which is not aligned with the abilities and needs of the end users. In active care, benefits could be achieved for all by involving users in investigating how and in what situations technology could help, and in researching user-friendly designs. For a successful technology implementation process in the field of care, it is essential to be aware of all the stakeholders involved and their differing requirements.

It should also be noted that not everything that is technologically feasible is wanted and appreciated by the potential users, especially in a field such as care which touches on the private lives of people. Fear that technology is introduced to care services only for the purpose of increasing efficiency and lowering costs by replacing human interaction should be taken seriously. Open and clear communication of the advantages and possible applications of technology in the care sector would help to increase the acceptance of new technologies and thus maximize their beneficial impact. User utility and not just resource-efficiency should be the main goal of technological support in care.

From institutional care to home-based services and integration into the local community

Institutional care refers to personal and nursing care of elderly people in institutions rather than in their own homes. Institutions range from residential homes for older people with a low level of supervision and care to nursing homes and hospices where more intensive medical and nursing care is provided. While some countries where informal care prevails today are taking steps to strengthen and extend the supply of institutional care, the major trend among UNECE countries is towards flexible, open institutions and home-based care.

Home-based care consists of in-home nursing services and practical, non-medical assistance. To respond to the desire of many older people to continue living at home for as long as possible, care services need to focus on the potential that home-based care offers. Staying at home and being integrated in the local community contributes to general well-being and quality of life. It also opens up new resources in care; the local community can contribute to social integration and well-being and can provide assistance and perform basic care tasks.

Home-based care is less costly than institutional care and more sought-after by users. However, efforts need to be made to ensure that such care does not focus solely on medical treatment and nursing to the detriment of early intervention, prevention and rehabilitation. It is also important to ensure that home-based care is of high quality and reaches all people in need.

Austria – Free provision of home-based medical care in Vienna

Public social security institutions and private care service companies have joined in this initiative to provide home-based care free of charge for users. Care services that are delivered by qualified medical nurses include administration of medication and infusions, wound care and giving injections. The goal of this project is to avoid or shorten hospital stays by providing home-based medical care whenever possible, thus ultimately improving the quality of life of older people by enabling them to stay at home. Demand for the service increases annually with close to 7,000 people receiving home-based medical care in 2013.

Sources: Information provided by FSW – Wiener Pflege- und Betreuungsdienste GmbH. http://www.fsw.at and http://www.mobile-hauskrankenpflege.at

Quality of care is of fundamental importance in the organization and delivery of care. Crucial factors are the qualification of care personnel and the ratio of care staff to care users. The design and development of care services are also critical for the quality of care. Standards of quality and criteria to assess the adherence to such standards need to be developed; and this should be combined with effective monitoring in order to ensure high quality care.[14]

Supporting the family and social network

The main form of citizen participation in care services today is the provision of informal care, mostly for family members. Informal carers are often put in stressful and emotionally challenging situations, especially when they provide care for family members or have to manage different care tasks and/or employment at the same time. It is therefore necessary not only to focus on the rights of older persons, but also to ensure that the human rights of informal carers are protected, especially the right to rest and leisure and a reasonable limitation of working hours. In the 2012 Vienna Ministerial Declaration, the goal of supporting family carers was agreed upon: "Recognizing and supporting family carers, who are mostly women, in accomplishing their demanding tasks, including provisions for reconciliation of work and family duties, as well as social protection measures."[15] The family or social network providing care is best supported through a care plan which pursues an integrative approach and combines different policy measures.

[14] For further details, see Policy Brief 7: "Towards community long-term care", available from http://www.unece.org/pau/age/policy_briefs/welcome.html.

[15] UNECE (2012): *2012 Vienna Ministerial Declaration*, paragraph 10, III.(m).

Informal care providers can benefit from supportive measures offered by public care services. Such measures can include financial remuneration, a legal right to take leave from work, flexible working arrangements or other support such as counselling, training or respite care. A number of UNECE countries offer leave for carers, though most often under restrictive conditions and without pay. Belgium provides the longest publicly-paid care leave, for a maximum of 12 months, while Scandinavian countries tend to pay the most, with remunerations in Norway and Sweden equating to 100 per cent and 80 per cent of the wage, respectively. The duration of unpaid leave granted to carers differs across countries: Belgium, France, Spain and Hungary allow long leave of one year or more; Austria and Germany allow leave of six months; while other countries provide relatively short leave with up to three months in the United States and up to two months' leave to care for gravely ill family members in Canada. Taking into account the episodic nature of illnesses, health conditions or changes in the availability of formal care, it is advisable to strengthen the support for informal carers through leave options and flexible working arrangements across the region. For some informal carers in the later stages of their working careers, care leave could become a pre-retirement option.[16]

In addition to this, respite care, training and counselling have been found to be effective ways to support informal carers.[17] Many family carers are under a great deal of stress and feel strained at times, due to high demands, emotional burdens and often also due to a lack of expertise. They are not always knowledgeable about the disease or health impairment of the person for whom they are caring, and would welcome more information and some basic training from care and health professionals.

New forms of cooperation between public care services and other sectors: the community, the non-profit sector and the private sector

Networking, community-based care, co-production and collaborative (public-private) partnerships have become crucial in shaping policies in different areas. In this new collaborative environment, no single actor has the sole responsibility for innovation, improvement and provision of guidance.

Public care entities, communities, non-profit organizations and enterprises have different working styles and approaches, different priorities, and different resources and areas of influence. Bringing them together can create synergistic effects and stimulate new concepts and ideas. The aim of cooperation should be to make use of each stakeholder's comparative advantages and specific resources in order to generate the best possible outcome. Joining forces and pooling resources can create better outcomes in terms of user acceptance, efficiency, coverage and quality of services. For this reason, forms of cooperation should be explored and extended.

Cooperation between public care services, families and communities

Formal and informal care are not mutually exclusive. Indeed, the best results are often obtained when the two are used in complementary ways. To this end, new forms of cooperation between public care services and the family, neighbourhood or community networks need to be explored. One example of such cooperation is an innovative approach to providing palliative care in the Netherlands. In this approach, professionals, public care service providers and volunteers form a network around a palliative care user and jointly provide 24-hour care, which allows people to die at home in their familiar surroundings. If a volunteer has less time, social welfare providers or the professional caregivers take more responsibility. In this system, the care user and his or her family play an important role in decision-making and their wishes and quality of life are at the heart of the project. The use of volunteers permits the care provider to support both the care recipient and their family as much as possible. The results so far are very promising, and they are achieved at lower costs with a higher perceived quality of life than was the case before the project.[18]

[16] Colombo, F. et al. (2011), Help Wanted? Providing and Paying for Long-Term Care, OECD Health Policy Studies, OECD Publishing, pp.122-127, Available from www.oecd.org/health/longtermcare/helpwanted.

[17] Pickard, L. (2004): The Effectiveness and Cost-Effectiveness of Support and Services to Informal Carers of Older People, Audit Commission PSSRU, University of Kent, London School of Economics and University of Manchester.

[18] Source: http://www.invoorzorg.nl/ivz/interview-ActiVite-een-regelarm-zorgarrangement-voor-de-laatste-fase.html.

Italy – Cohousing project 'Casa alla Vela'

'Casa alla Vela' is multigenerational housing project offering elderly persons a housing solution which they share with contemporaries. The cohousing setting includes apartments comprising single rooms, services and common space. Older people share the costs of food (with cooking provided by carers), electricity, water, rent and caregivers, whose presence is assured 24 hours a day, seven days a week. In the same building, another apartment hosts a group of specifically-selected students who support their older neighbours on a voluntary basis, thus encouraging intergenerational solidarity. The social and community relations of elderly persons are also maintained and reinforced by the visits of their friends and relatives.

The social cooperative SAD, which is in charge of managing the project, supervises the entire initiative, supported by other volunteering associations. The house currently hosts five elderly women and six students.

This family-like setting makes the costs of assistance and daily life more sustainable for older persons and fosters their social integration by providing the setting for intra- and intergenerational exchange. With home-based care services and community assistance, the elderly people are empowered to live independently and are better able to avoid the need to be admitted to a nursing home.

Sources : Information provided by Department of Health and Social Solidarity, Province of Trento, Italy
www.cooperativasad.it/casa-alla-vela

A promising strategy for developing new and innovative care strategies is a bottom-up approach where different actors from the non-profit, public and/or private sectors join in local initiatives and projects which are supported by the public care sector through financial aid, coordination or the provision of cooperation and networking opportunities. Having a variety of local initiatives ensures a diversity of approaches, concepts and ideas and creates learning opportunities. It is often found, too, that decentralized provision of care close to the recipients leads to more appropriate care solutions.

Germany – Local Alliances for Persons with Dementia

This project focuses on pooling and networking the potential of citizens, associations, business, educational institutions, politics and local government in a bid to improve the living conditions of persons with dementia and their relatives in the long term.

In recent years, a host of measures, research activities, pilot projects, recommendations and pieces of legislation have been dedicated to managing and coping with dementia-related problems. It is the mission of this Alliance for Persons with Dementia to help bring all of these diverse initiatives together, to coordinate them and, above all, to join forces and further develop them. The Alliance is also intended to heighten public awareness of dementia. Consequently, it is not just about implementing a project with a limited shelf-life, but about changing society's awareness over the long term, a movement that reaches out into all segments of the population. Local alliances are to be created and supported to help and to stand by families affected by dementia. The Federal Government of Germany wishes to assist in setting up and funding 500 local alliances nationwide for persons with dementia. The important thing is that all actors – families, professional caregivers and last but not least, the volunteers – act as agreed, with each party assuming their part of the shared responsibility. As the Alliance takes shape, an associated dementia guide will be progressively developed into a platform for communication, qualification and support.

There are currently more than 300 local initiatives active, with over 150 of these newly selected and having started their work in September 2014. The alliances include a wide range of projects such as multigenerational houses, associations, organizations, parishes, hospitals, enterprises, cultural institutions and municipalities.

Sources : Information provided by the Ministry for the Family Affairs, Senior Citizens, Women and Youth of Germany

The new senior market

Private commercial businesses focus increasingly on older people as a target group for their products and services. With the global spending power of people aged over 60 forecast to reach 15 trillion United States dollars by 2020,[19] this age group represents an important share of overall purchasing power in an economy. In the United States, for example, consumer spending by people aged over 50 accounts for about 60 per cent of the total spending and in the United Kingdom, 50 per cent.[20] During the economic crisis, the income and expenditure of older people has proven to be more robust than that of the working age population, making them a more reliable and stable source of demand for enterprises. Private businesses are still far from tapping the full potential of the senior market but they are gradually discovering it by developing and offering more products and services adapted to the needs of older persons. Their increasing interest in the older target group leads to more commercially-provided goods and services in the care sector which can be deployed in new care arrangements. More and more private care providers are entering the market and the resulting competition in the field of care services may foster efficiency and quality. As discussed above, a number of commercially-developed and supplied devices are enhancing care services: these include walkers, stair lifts, telecare/ telemedicine tools and a variety of other technological solutions which support and enable independent living.

Since entrepreneurial decisions are generally guided by a profit-maximizing principle, incentives may have to be offered for private enterprises to engage in research and development or in the supply of care services and goods. In some cases, the purchasing power of older persons may be incentive enough, but in other cases, the public sector may have to step in and provide incentives such as subsidies or opportunities for public-private cooperation. The public sector should also use legal frameworks to ensure equal access to markets for all actors, protect freedom of choice of supplier for users and channel care providers towards quality-based competition.

Public-private partnerships in care

Public-private partnerships are used increasingly in many fields of the public sector as they offer the possibility to incorporate private capital, knowledge and expertise as well as operational skills into the public procurement process.

Seen as an alternative financing model through which projects can be funded and realized, public-private partnerships can help to ease the financial strain of public institutions and add to the range and number of public services provided. More importantly, however, public-private partnerships can improve the quality and cost efficiency of public services as both parties pool their resources and benefit from each other's specific qualities. Private companies often have specialized knowledge and expertise that can be made available for public services in a public-private partnership. In the care sector, examples of public-private cooperation include various projects ranging from research and development, civil engineering projects and care service provision to technological enhancements of care.

[19] Bank of America & Merrill Lynch (2014), *The Silver Dollar – Longevity Revolution: Growing the Silver Dollar in Europe.*

[20] Financial Times (2014), 20 October, p.5.

Ireland – The TRIL Centre

The TRIL Centre is a public-private partnership of the Irish Industrial Development Authority (IDA), the Intel Corporation and several Irish universities. It functions as a co-ordinated collection of research projects. Research and development efforts are aimed at identifying technology solutions to support independent living for older people, with a focus on three key areas: improving health and social participation for older people, detecting and preventing falls in the home, and helping those with memory loss to maintain their independence. To this end, different research approaches are pursued: ethnographic and anthropological research is undertaken to learn more about what older people need and how their quality of life can be improved by observing their day-to-day lives. Clinical modelling allows the identification of behavioural markers which can be correlated with specific conditions. The resulting models are then implemented on a computing platform with engineering support.

A range of products is already on trial, such as 'Engineering Alertness', a project which offers home-based training to help older people increase their alertness levels using biofeedback.* Periodic increases in alertness are thought to improve some cognitive functions such as memory, attention and processing of speed.

* Voluntary control of normally involuntary physiological functions by monitoring with electronic sensors.

Sources : http://www.ict-ageing.eu/?page_id=1589

Co-funding and co-producing ICT-based services and products, as well as research and development in this area, can help to expand the use of ICTs in care by making costly technology more broadly available and more widely used in care activities. Public-private partnerships are used extensively in the construction and operation of buildings such as hospitals and nursing homes. For instance, the EU-supported Ambient Assisted Living Joint Programme funds and promotes public-private partnerships in the area of care-related technological research and development. It fosters the development of innovative ICT-based products, services and systems to be used for care services at home or in the community and provides funding for cross-national projects that involve small and medium-sized enterprises, research bodies and users' organizations.[21]

Joining forces in public-private partnerships can offer great opportunities in the care sector. However, the benefit of such partnerships is highly context-dependent. Decisions about public-private partnerships in care must therefore be made on an individual basis, taking into account all particularities of a project and bearing in mind the high costs of coordination and the increase in complexity that public-private partnerships might entail.

Conclusions and recommendations

Diverse and changing care demands have made many policymakers open to structural and strategic change in the care setting. This Policy Brief has presented an overview of innovative and empowering strategies for care. It has demonstrated that the most important aspect is to integrate the user into all stages of the care process and to change the way the user is perceived, moving away from regarding older people as passive care recipients and towards seeing them as active care users who have resources of their own that they can contribute. This implies that care services should be carried out in a reciprocal cooperation between care users and care providers. Cooperation is a guiding principle featured in many new strategies for care. In place of a "silo" mentality, all stakeholders should be encouraged to pool their resources and work together in order to provide quality care services close to the recipient and tailored to the users' needs. This involves cooperation between public institutions and the family and social network that often provide informal care, the community and civil

[21] Source: http://www.aal-europe.eu/

society as well as commercial businesses. Cooperation and integration should also be furthered among public institutions. Health care and social care providers need to work closely together to serve all people with care needs. Since the heterogeneity within user groups is often much bigger than that between them, demarcations between elderly care and care for other user groups such as people with disabilities should be minimized. Instead, diverse care services and flexible care arrangements should be offered to fit individual needs, making use of synergies in the organization and provision of services.

Wherever possible and for as long as possible, care services should aim to support independent living, complying with the wish of most older people to live as independently as possible. Technology can be useful in facilitating care, improving quality of life and enhancing independent living of older persons. Guiding principles for the use of technology in care should be usability and utility.

The institutional setting of care provision should be open and responsive to changing user demands. A broad trend in user demand from institutional care towards home-based care is becoming apparent and should be accompanied by public provision of more flexible care solutions, expanding provision of ambulatory, home-based and community-based care services. However, a shift to home-based care is not necessarily the most suitable strategy in every national context. Especially in countries where informal care prevails, an expansion of the institutional and residential care setting may be favourable in order to ensure the availability of different care options for people with care needs.

These recommendations and examples suggest potential ways to improve the performance of care policies in the UNECE member States by integrating innovative and empowering strategies into the care setting. However, the nature of this potential differs according to national, regional and local characteristics, to general governance approaches and to individual needs and the expectations of citizens. Strategies must therefore be adapted to each specific situation. The transfer of knowledge and its translation to local contexts will be an important task among the next steps that governments should take.

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Checklist: Innovative and empowering strategies for care		
Main areas	**Areas of implementation**	**Key elements**
Design of care services	User influence	• Co-initiators of care services • Co-design • Co-provision
	Scope of care	• Prevention • Rehabilitation • Long-Term Care • Palliative Care
Provision of care services	Quality of life and well-being	• Social participation • Physical, social and cultural activities • Independent living
	Technology	• Research and development • Usability & target group orientation
Organization of care	Formal care	• Flexible institutional care/open institutions • Ambulatory care • In-home nursing services • Home-based practical assistance • Community-based care
	Informal care	• Flexible work arrangements • Respite care • Financial support • Training & counselling
	Enabling choice	• Legal environment • Range of suppliers • Means to choose
	Quality assessment	• Quality standards & criteria • Monitoring
Potential for cooperation	Cooperation with the community	• Co-creation and co-production
	Cooperation with non-profit sector or private sector	• Commercial care market
		• Public-private partnerships