United Nations
Economic Commission for Europe

Policy brief

Innovative and empowering strategies for care

UNECE Policy Brief on Ageing No. 15
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2002 Regional Implementation Strategy of the Madrid International Plan of Action on Ageing (MIPAA/RIS), Commitment 7: To strive to ensure quality of life at all ages and maintain independent living including health and well-being; In order to work towards a sustainable society for all ages, societies need to increase the quality of life and ensure the continued contributions of older persons to society.

2012 Vienna Ministerial Declaration: A Society for All Ages: 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 fulfillment in later years, as well as their participation in social and economic development. (section 3; 9(e); II (c,e,f,g)).

Contents

With good practice examples from:

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

Challenging context

The stratum of older people is growing and it is also becoming more heterogeneous internally. The diverging lifestyles, physical, mental and social capabilities, lead to different demands and needs regarding care. Societal and institutional dynamics such as changing family patterns and living and care arrangements impact on care needs too. Many older people live in single households with no family support within reach. And 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 as well as higher costs for care provision. Many poorer people face financial barriers in accessing adequate care. Current public cost-cutting efforts in many UNECE countries press for 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 in the local community are effective ways to react to social changes and to respond to the wish of many older persons to live independently. A shift of paradigm from passive to active care gives the 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 also promotes knowledge transfer between public and private spheres, shifting the commercial focus to the target group of older people. The support and the implementation of new technologies in care makes use of the opportunities that technological advancement offers to improve the quality of care provision, to extend the range of care services and to increase their efficiency.

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Expected result

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 wellbeing with care services tailored to their needs.

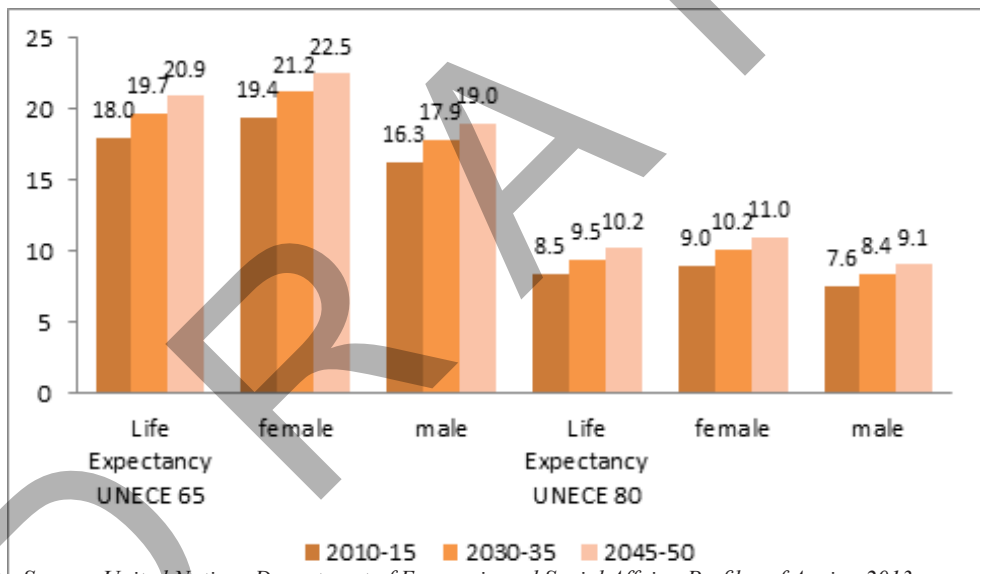
Introduction

Demographic changes

Population ageing is a distinct trend across all UNECE countries. UN Population Division projections show that in the UNECE region, the share of population 65 years and older will increase from 15% in 2013 to 20% in 2030 and to 24% in 2050, while that of 80+ will more than double, from 3.9% today to 8.3% in 2050.[1]

Along with low fertility, an important factor behind this trend is the rise of 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] Health adjusted life expectancy at age 65 for men accounts on average to more than a half of the remaining life years and for women less than a half.[3] Hence, the chronological age of 65 does not automatically translate into dependency, frailty and need for care.

Figure 1
Life Expectancy at 65 and 80 in UNECE region



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

High 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 older population in need for 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

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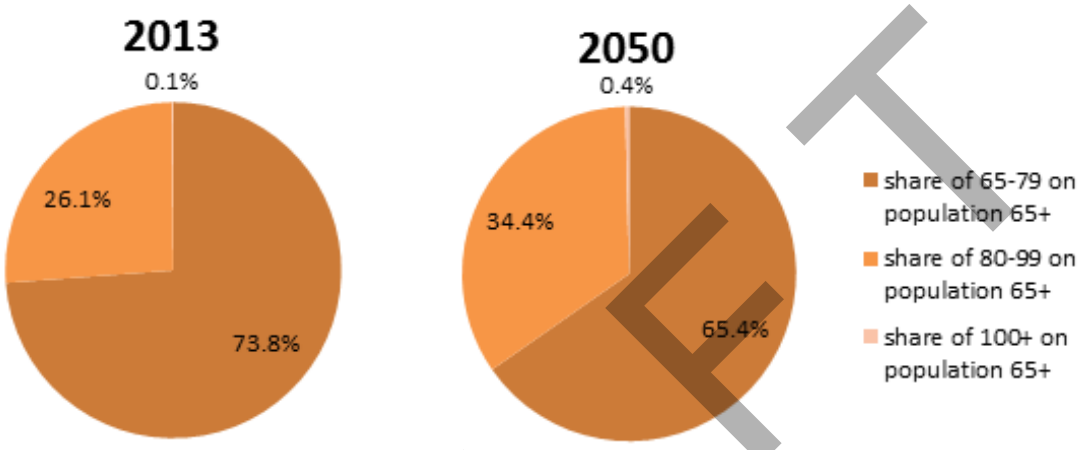
"New old"

Older age is an important and lengthening period of life in which needs, abilities and resources differ from person to person but also over the course of an individual's life time. To assess the diversity of care needs, in addition to the age structure of current and future older population, socio-economic characteristics such as educational attainment, prevailing occupational fields, etc., need to be taken into account.

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 fourth of the 65+ age group are aged between 65 and 79, with those born after WWII accounting for one half . The share of population aged 80 years and above (so called "older olds") today accounts for one fourth and it is projected to be more than one third in 2050. The share of centenarians among the 65+ age group is projected to quadruple by 2050.[4] The faster increase in "oldest olds" may suggest a rise in the demand for care services as the probability of chronic diseases and need for care rises with higher age. However demographics is not the only source of change in a society; alongside, other social, medical, cultural and political developments can influence the care needs and have to be taken into account when developing new care strategies.

The research shows that in general, the generations born after WWII meet old age with far better resources than any generation before them. The "new old" are healthier and usually more active and independent than previous older generations. Many more of them are used to taking decisions and to being an active part of the family, community and society and want to maintain this in older age. They can and want to contribute to family life, the community and society as a whole in various ways and demand 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 share 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]

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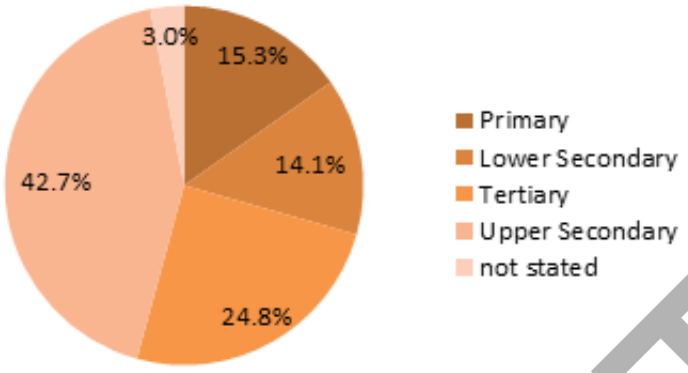
[4] Data from: United Nations Department of Economic and Social Affairs (UNDESA) (2013): Profiles of Ageing 2013, own calculations

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

[6] Computer use ranges from currently 9% of people aged 55-74 in Turkey to 91% in Iceland. The percentage of people aged 55-74 using the internet weekly is again lowest in Turkey with 8% and highest in Iceland with 85%. Regional and national differences in ICT access and use are significant but the tendency of increasing ICT use is the same. (UNECE Statistical Database, 2013)

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 need for care is far from increasing proportionally to the rise in the number 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 previous generations.

Care today and future challenges

Care comprises a range of services aimed at promoting, monitoring and reestablishing health and wellbeing. Commonly, health care and social care are distinguished although a clear cut differentiation between those two elements of care is difficult to make. Generally health care is regarded as medical services provided by professional staff while social care is mainly provided by local authorities, the private sector and informal carers and consists of personal assistance aimed at increasing the recipient's wellbeing. Even though a "silo" mentality often predominates among service providers, various links and intersections between health and social care exist and cooperation and integration should be furthered in the interest of the user.

Care is provided through formal or informal channels whereas the demarcations between those two sectors are becoming more blurred. Formal care is denoted as paid care service provided by trained, licensed and qualified professionals. The services are controlled by the state or other organizations and caregivers are generally entitled to labour rights including social rights and working regulations such as a fixed amount 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) and not formalized; there is no contractual agreement and no formal entitlement to social rights or working regulations.

The distribution between formal and informal care as well as institutional and home-based care varies 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 shared between family and public institutions. Many countries in which publicly funded care services have dominated now

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increasingly focus on informal care settings and promote the responsibility of the family and the community. The countries in which the majority of care tasks are performed informally try to strengthen the public care sector by improving the quality and accessibility of publicly funded care services. In addition to this, the organization, regulation and provision of care are being increasingly decentralized, entrusting regional and local authorities 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, the 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: a median age of professional care staff is high and rising faster compared to other sectors. Responding to the staff shortages through migrant carers is a common practice in many UNECE countries,[9] with implications for both, country of origin and recruiting country.

Future challenges concern the human resources and 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 calls for attention.

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

Moving from passive to active care

'Active care' presents a different approach to care that gives the users an active and decisive role in the care process. While users of care services are often seen as passive objects, they have to be involved, both in decisions regarding care and in the organization and provision of care services itself. 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 which the "new old" carry. The shift from passive to active care is a shift **from care provided for people to care provided with people**. Users can actively contribute 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 production of care strategies and services.

Active user influence and power

Unfortunately today, too many decisions in the care setting are made without consulting people affected by them. This often happens based on the assumption that older people are passive and dependent members of the society when in reality they can play an active and participating role. 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.

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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: World Health Organization (WHO): Health Care Migration in the European Region: Country Case Studies and Policy Implications. 2006

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

The project sets out to give older people a more active role by including them in the decision making of their care setting. The 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

A cornerstone of 'active care' paradigm is the inclusion of users, their opinions and ideas, in the design and provision process of care services. To ensure that users get the influence and power they deserve, it is important to enlist support and involvement of other actors in the care field such as care personnel and informal caregivers, representative bodies for health- and social-care workers, community and political leaders and regulatory bodies.

Co-creation and co-production are terms to describe the active involvement of citizens into public service delivery. Citizen participation can refer to three different aspects: citizens as co-implementers of public services, citizens as co-designers and citizens as co-initiators. In every case, citizens are engaging in a partnership with other actors in the care field and bring in their own resources to design or deliver care services, shifting the balance of power, responsibility and resources from professionals to individuals.[10]

Sweden - The Act on System of Choice in the Public Sector

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

The reform leaves the local municipality still responsible for all services irrespective of who is providing them. The public authority is the contracting authority and lays down the price in advance so that there is no price competition, but competition through quality. A persons who doesn't want to choose, will not have to do so, a non-choice (default) alternative is offered.

In 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-service being the most common area. An investigation has shown that the number of providers has risen sharply and that over 70 per cent of the providers offer services with specific profiles – languages being the most common profile. Other examples are providers which offer specific expertise in the fields of dementia and Alzheimer's disease and some providers have for example special knowledge about LGBT in their profile. Surveys indicate that users are satisfied with and appreciate the possibility to choose. In 2013, a national survey showed that though the vast majority of older people are satisfied with their health, those who had chosen their provider of home care services were satisfied to a higher degree compared to those who hadn't made a choice.

The reform promotes active user influence which in turn fosters an empowering strategy for care. People, who have been given the opportunity to choose, often say that their ability to stay in charge of their own lives increases as well as the potential for independent living. Ensuring competition through quality instead of price among service providers generates care quality improvements. 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 higher extent.

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

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

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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". The goal of care services can be derived from this definition; it is not restricted to nursing but rather comprises the support in the maintenance and rehabilitation of health in all areas, including physical, mental and social wellbeing. Therefore social and health care services should put an increased focus on health promotion, disease prevention and physical and mental rehabilitation. The scope of care has to be broadened to address all aspects of health including social wellbeing. 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 be an integral part of care services.

Finland/Estonia – VIRTU

The aim of this project is to prevent social isolation and increase the access to professional services in remote, rural areas by means of information and communication technology. In this way it helps older persons in the archipelago area to live at home, supports 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 internet connection and a login request, everything else is previously set-up. It allows users to participate in discussions and question times on various topics, including medical questions, information about nutrition, health, as well as 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

An extended scope of care requires in turn broadening the range of care services in order to activate users socially, physically and culturally and achieve the goal of supporting overall health and wellbeing. Daytime activity programmes are often seen by practitioners and users as the missing link in the care services. Such activities are essential since they add meaning to people's daily lives and make a leap from care ensuring the survival of people to care fostering their wellbeing. When physical, social and cultural activities are included in care strategies, the quality of life can be improved in many ways. Physical activities help maintaining or restore good health and play an important role in securing older people's independence. Social and cultural activities contribute to the overall wellbeing by improving social connectedness and inclusion of older people and addressing the need to feel being full and appreciated members of society. Some activities help to maintain or improve the skills of older people (for ex. memory enhancing groups or music groups) and can be used therapeutically to counteract anxiety and depression. Activities can help older people in leading an enjoyable and meaningful life and contribute to improving their self-esteem as well as their physical, mental and emotional capabilities and thus help maintaining an active, independent lifestyle.

Independent living

Enabling older persons to live independently is one of the goals of the 2012 Vienna Ministerial Declaration: III.(h) 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.[11]

[11] UNECE (2012): 2012 Vienna Ministerial Declaration

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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 realizing 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 (see box).

The Fredericia Model - "Life Long Living"

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

Older persons requesting professional or personal assistance are offered a 6 to 8 weeks rehabilitation programme where they are trained to perform care tasks themselves. Patients 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 professionals and patients.

The results the initiative has generated are promising. After the intensive rehabilitation program, the patients' need for practical and personal assistance falls considerably, and many of them become fully self-sufficient. The number of requested care services in Fredericia has decreased significantly after the introduction of the initiative, and subsequently the cost has decreased. According to the former Director of Care in Fredericia, the Model provides an efficiency dividend of around 15 per cent annually. At the same time, it increases 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. "Life Long Living" was awarded in 2012 with 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

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. This comprises personal assistance through formal and informal caregivers but also technological aid.

Technological enhancement of active care

Technological advancements have an impact on virtually every part of life and thus they also shape the care field influencing which services are offered, in which way and to whom, how they are organized and carried out. Care technologies range from relatively simple tools, such as hearing aids, denture, wheelchairs and syringes, to highly complex devices, such as robotics or electronic health records. They are employed in the field of nursing and medical care and used also in social care in order to facilitate everyday life for users (for example, walkers, stairlifts, specialized beds and mattresses or orthotics).

The Information and Communication Technologies (ICT) in the care sector have a wide application area and can assist in a variety of care tasks in virtually any part of life. The ICT contribution to care services can range from medical monitoring devices for sick people to social networking tools which aim to increase social interaction and the quality of life of seniors.

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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 particularly benefit from technologies that help them 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 they can enhance a feeling of relevance through social networking tools that serve as an interactive outlet to the world. Technologies can also facilitate everyday life for older people through e-services such as commerce, personal finances or medication.

Telecare services can enhance health, safety and security of older people and contribute to preventive care. One quite widely used tool today, for instance, is a device that features 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 warning signal to the centre if there are unusual patterns. This gives people a sense of security as they know they can always reach help if needed and thus encourages them to continue living in their own home. These technologies are very popular as they are easy to use and meet the desire of many elderly people to live independently for as long as possible.

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

The Telecare in Gdynia is provided to all older users entitled to the municipal care services as well as other senior citizens in town. It is based on the use of a telephone with extended features. There are three buttons in different colours – red, green and blue – each enables calling for different services. The red button on a telephone or a bracelet is used to call the Alarm Center which operates 24h/7 and contacts immediately 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 Center calls on ambulance. What makes the system in Gdynia rather special are the assistance services and care services. The green button calls for assistance services that include conversation, provision of information or consultation with an expert, for instance a psychologist. The blue button calls for extra care services including, for instance, rehabilitation specialist or services related to cleaning and small repairs. The system is serviced by a private enterprise. It is provided for free to the 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 EUR per month for a user. Some services are charged additional fee, for instance rehabilitation.

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 1000 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 the decision making on care services for older people.

Sources: Source: Information provided by 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 designed for people with diseases and helps in monitoring their medical condition and detecting deteriorations as soon as possible. Selected biomedical parameters of a patient are measured and transmitted to a hospital for monitoring. Depending on the data, it can be measured automatically and constantly or with the help of the patient at certain times. The triggering of an alarm if parameters deviate significantly can also be configured. These technologies relieve hospital staff and capacities as parameters can be monitored at a distance. In addition, it also improves the quality of healthcare as data can be measured continuously whereby deviations can be detected immediately, speeding up reaction time to a – possibly lifesaving – maximum.

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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, and to detect early the deterioration of health status and comorbidity in elderly patients with a chronic disease that has already been indicated.

Patients diagnosed with chronic heart failure, patients after a heart attack, and newly diagnosed with diabetes are monitored using a telemedicine service enabling measurement of selected biomedical parameters remotely without the need of continuous assistance of medical staff. In this way, comorbidities as well as an impairment of the patient's condition can be detected and treated at an early stage. The project is carried out in two separate practices: Telemonitoring of patients with advanced heart failure and acute myocardial infarction in senior patients. In the first practice, 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 practice, the course of treatment of patients with acute myocardial infarction with newly-diagnosed diabetes is long-term monitored using telemedicine services.

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

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

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The use of ICT in care settings can present a win-win-win situation for all, the users, care providers and the society at large. Overall welfare benefits can be achieved through healthcare savings, reduced care needs of older people, and through the provision of older people-related content and services.

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 of new technological devices and solutions for care services in the future.

Challenges in Technological implementation

Technological, social and scientific developments progress rapidly and impact onto all spheres of our life. Holding on to existing systems and technologies sometimes seems to be more convenient and certain resistance to progress or change is observed in many areas and not in the least in the care field. Not everyone can access and use new technologies easily. This may refer to the care users as much as care practitioners in particular in informal sector. The socioeconomic differences in technology access and use, referred to as a digital divide, lead to a low and limited ability to access digital products and services among structurally disadvantaged groups, such as less-skilled migrants or elderly people, for instance. Therefore, efforts to foster social inclusion may also help to benefit everyone from ICT-based products.

The uptake of new technologies by the end users – carers or care-users – is also determined by their acceptance of a device, its usability and utility. A low take-up and usage of the new technology may result from the products development of which is one-sidedly technology driven and is not aligned with the abilities and needs of the end users in broader sense. In active care, involvement of users in finding out in which way and in which situations technology could help and what design is more user-friendly could bring benefits to all. For a successful technology implementation process in care field it is essential to be aware of all the stakeholders involved and their differing requirements.

It should be also noted that not everything that is technologically feasible is wanted and appreciated by the users, especially in a field like care that touches on the private lives of people. Fear that technology is introduced to care services only to increase efficiency and to lower costs by replacing human interaction should be taken seriously. Open and clear communication of the advantages and application possibilities of technology in the care sector would help to increase the acceptance of new technological means 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 in to the local community

Institutional care comprises different degrees of personal and nursing care to elderly people. 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 take 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. Many older people wish to continue living at home for as long as possible, therefore 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 the general wellbeing and quality of life. It also opens up new resources in care: The local community can support care on aspects of social integration and wellbeing as well as in providing assistance and basic care tasks.

Home-based care is less costly than institutional care and more sought for among the users. However, efforts need to be made that such care does not one-sidedly focus 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 medical home care in Vienna

Public social security institutions and private care service companies have joined in this initiative to provide home-based care free of cost for the recipient. Care services that are carried out 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 medical home care whenever possible and 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 medical home care in 2013.

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

Quality of care is an important aspect of care service organization and delivery in order to ensure a life in dignity for all people with care needs. Crucial factors are the qualification of care personnel and the ratio of care staff to care recipients. Standards of quality and criteria to assess the adherence to them need to be developed; and it has to be combined with an effective monitoring in order to ensure high quality care.[12]

[12] See Policy Brief 7 for further details

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Ways to support the family / social network

The main element 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. In the 2012 Vienna Ministerial Declaration, the goal to support family carers was agreed on: "III.(m) 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."[13] The family or social network providing care is best supported through a care plan which pursues an integrative approach and combines different policy measures.

Informal care providers can benefit from supportive measures offered by public care services, be it financial remuneration, a legal right to take leave from work, flexible working arrangements or other support like counseling, 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% and 80% of the wage, respectively. The duration of unpaid leave for carers differs across countries: Belgium, France and Spain provide long leave of one or more years, Austria and Germany allow leave of six months while Canada, UK, USA and the Netherlands provide relatively short leave of up to three months. 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 their late work careers, care leave could become a pre-retirement option.[14]

In addition to that, respite care, training and counseling have been found to be effective ways to support informal carers.[15] Many family carers are under a lot of stress and feel overstrained at times, due to high demands, emotional burdens but also lacking expertise. They are not always knowledgeable about the disease or health impairment they nurse and would welcome more information and some basic training from care and health professionals.

New ways of cooperation between public care services and community, non-profit sector or private sector

Networking, community-based care, co-production and collaborative (public / private) partnerships have become crucial in shaping policies in different areas while innovation, improvement and guidance may no longer be provided by any single 'social planner'.

Public care entities, communities, non-profit sector and enterprises have different working styles and approaches, different priorities, resources and areas of influence. Bringing them together can create synergistic effects and impulses for new concepts and ideas. The aim of cooperation is to make use of each stakeholder's comparative advantages and specific resources in order to generate the best possible output. Joining forces and pooling resources can create a better output with regard to user acceptance, efficiency, coverage and quality of services. For this reason, ways of cooperation should be explored and furthered.

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[13] 2012 Vienna Ministerial Declaration, III.(m)

[14] Colombo, F. et al. (2011), Help Wanted? Providing and Paying for Long-Term Care, OECD Health Policy, pp.122-127 Studies, OECD Publishing.

[15] 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.

Cooperation between public care services and families/ communities

Formal and informal care are not an either/or decision but can complement one another for the best results. To this effect, new ways of cooperation between public care services and the family, neighbourhood or community network need to be explored. One example for such cooperation is an innovative approach to providing palliative care in the Netherlands. In this approach, professionals, public care services and volunteers form a network around a palliative patient 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 patient and his/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 allows the care providing social enterprise to as much as possible support the care-recipient as well as family and relatives. The results so far are very promising, supportive and humane, and they are achieved at lower costs with a higher perceived quality-of-life.[16]

Italy – Cohousing project "Casa alla Vela"

Casa alla Vela is multigenerational housing project aimed at offering elderly persons a housing solution shared with contemporaries. The cohousing setting includes apartments comprising single rooms, services and common space. Elderlies share the costs of food, electricity, water, rent and care givers (who are also in charge of cooking), whose presence is assured 24/7. 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 elederly 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, provides the supervision of the entire initiative, supported by other volunteering associations. The house is currently hosting five elderly women and six students.

This family type 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 enabled to live independently and avoid to be admitted to a nursing home for a longer time.

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

A promising way of developing new and innovative care strategies is a bottom-up approach where different actors from the non-profit, public and/or private sector 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. Numerous local initiatives ensure a diversity of approaches, concepts and ideas and create experiences to learn from, they also relate to the subsidiarity principle which is based on the assumption that a decentralized provision of care close to the recipient leads to more appropriate care solutions.

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

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Germany – Local Alliances for Persons with Dementia

The 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 stand by the families affected by dementia. The Federal Government wishes to assist in setting up and funding 500 local alliances nationwide for persons with dementia. The important thing is that all actors, the families, and 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, the associated dementia guide will be progressively developed into a communication, qualification and support platform.

As of now, there are more than 300 local initiatives active with over 150 newly selected and starting their work in September 2014. The alliances include a wide range of projects like multigenerational houses, associations, organisations, parishes, hospitals, enterprises, cultural institutions and municipalities.

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

The new senior market

Private commercial businesses increasingly focus 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 $15tn by 2020,[17] they present an important share of overall purchasing power in an economy. In the US for example, consumer spending by people aged over 50 accounts for about 60% of the total spending and in the UK 50%.[18] During the economic crisis, the income and expenditure of older people has proven to be more robust than that of the working age population which makes them a 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 arrangements of care. More and more private care providers enter the markets and the resulting competition in the field of care services may foster efficiency and quality. A number of commercially developed and supplied devices enhance care services: walkers, stairlifts, telecare/telemedicine tools and a number of other technological solutions support and enable independent living.

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

[17] Bank of America & Merill Lynch (2014): The Silver Dollar – Longevity Revolution

[18] Financial Times, 20.10.2014, p. 5

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Public Private Partnerships in care

Public Private Partnerships are used increasingly in many fields of the public sector as they offer the possibility to include 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.

Ireland – The TRIL Centre

The Centre is a public private partnership of the Irish Industrial Development Authority (IDA), the Intel Corporation and several Irish universities and functions as a co-ordinated collection of research projects. Research and development efforts are aimed at 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 identifying 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 presumed to improve some cognitive functions such as memory, attention and speed processing.

Source: 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 that area can help to extend the use of ICT in care by making costly technology broader available and used in care activities. Public private partnerships are widely used 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 of cross-national projects that involve small and medium enterprises, research bodies and user's organizations.[19]

Joining forces in a public private partnership can be put to advantageous use in the care sector. However, their benefit is highly context-dependent so decisions about public private partnership projects in care have to 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 rise in complexity that public private partnerships entail.

[19] http://www.aal-europe.eu/

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Conclusions and recommendations

Changing and diversified care demands have made many policymakers open to structural and strategic change in the care setting. This Policy Brief attempts to give an overview of approaches for innovative and empowering strategies for care. One important aspect is to integrate the user into all stages of the care process and to change the way the user is perceived, from regarding older people as passive care recipients to 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 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 society as well as commercial businesses. Cooperation and integration should also be furthered among public institutions. Health care and social care need to work closely together to serve all people with care needs. Demarcations between elderly care and care for other user groups such as people with disabilities should be abandoned as the heterogeneity within the user groups is often much bigger than between them. Instead, diverse care services and flexible care arrangements should be offered to fit individual needs, making use of synergy effects in the organization and provision of services.

Wherever possible and for as long as possible, care services should aim at supporting independent living, complying with the wish of most older people to live as independent 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 needed and suitable strategy in every national context. Especially in countries with prevailing informal care, 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 show 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, this potential has to be adapted to the national, regional and local characteristics, to general governance approaches and individual needs and expectations of citizens. 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

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