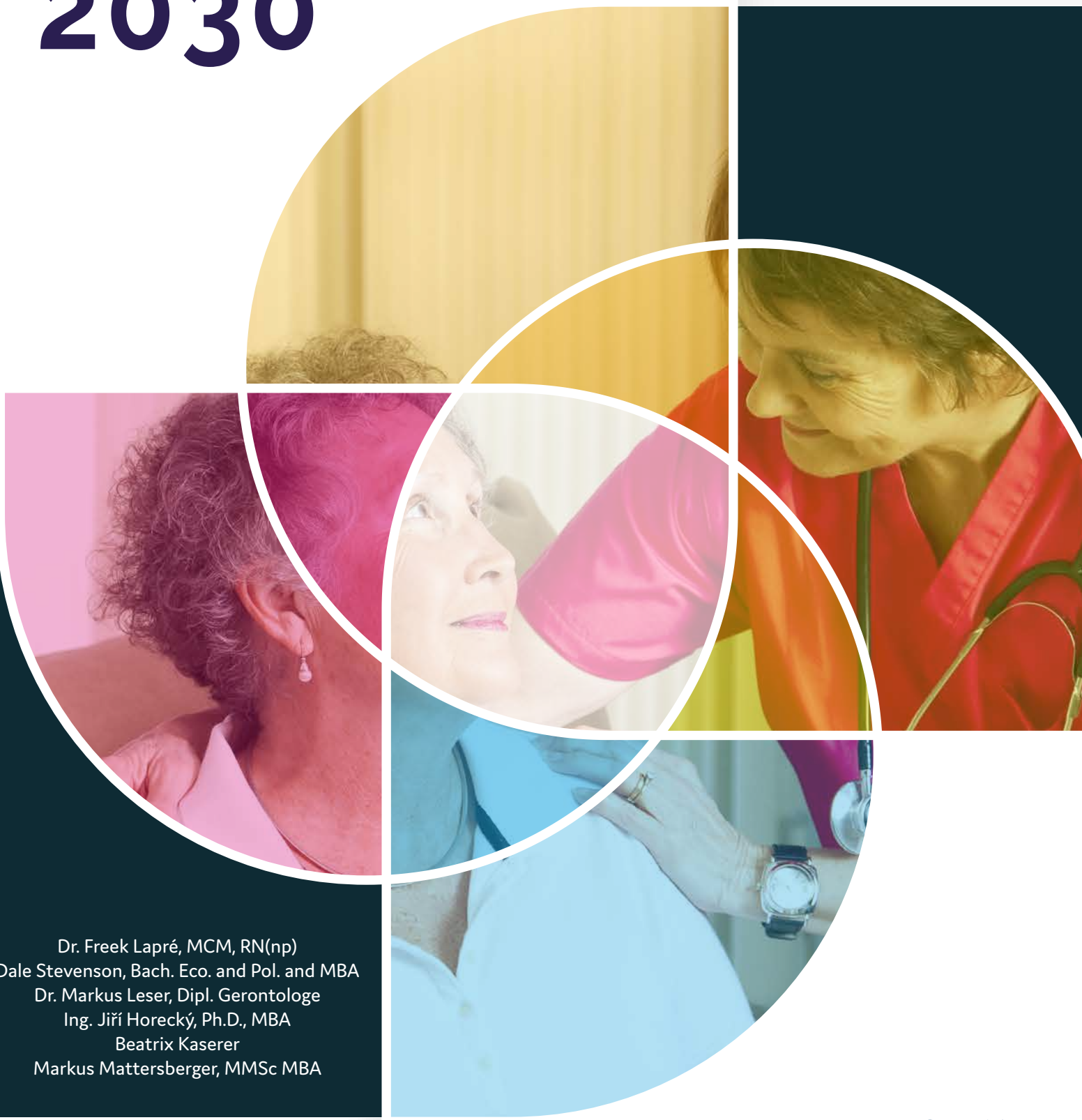
LONG-TERM CARE 2030



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2nd edition

EUROPEAN AGEING NETWORK
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FOREWORD

Long term care in Europe is undergoing crucial changes. We are going to face and are already facing key challenges. We also have to change to be able to ensure we can provide relevant support and care to elderly in the future. The people of Europe are getting older. The number of people living with dementia is going to be doubled in the next two decades. All of Europe is generally expe-riencing a lack of staff in social services. New technology and thus digitalization for social services is coming which aris-es many questions, expectations but also ethical dilemmas. The structure of long term care providers, the approach-es, the paradigms are changing. Families are fragmentized. Long term care costs are rising and the demand fails to meet the supply. In between all of those chang-es and storms stand the long-term care provider.

We as the European Ageing Net-work (EAN) fully realize that the role of providers will and shall be crucial in those processes and changes for the providers are the experts, knowing the demands of public authorities, the needs of clients, the expectations of family members and the possibilities of the employees.

Therefore, EAN appointed a work-ing group with a single task – to create our VISION 2030 for long term care in Europe. To open the key questions, data, and information. To show the ongoing changes. To bring recommendations to the providers.

This document has therefore more goals. We would like to open and stim-ulate an expert discussion about the present and future of long-term care in Europe. We want this document to be a tool for national Associations for their expert dialogue with the national public authorities about the needed and coming changes. We would like to help everyday providers in their planning and strategic goals.

And we hope that our effort will meet our goals. Allow me to thank all the 2030 working group members of their 18 months' work, to thank all the people and experts that were involved in this docu-ment.

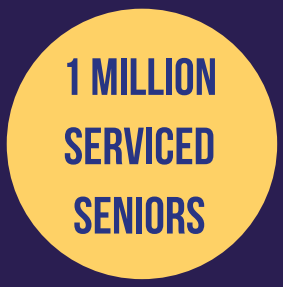
Ing. Jiří Horecký, Ph.D., MBA
President
European Ageing Network

EUROPEAN AGEING NETWORK

The European Ageing Network (EAN) groups **more than 10.000 care providers across the European continent.** Members represent all types of organizations and individuals active for older persons and all types of ownership including for profit, not-for-profit and governmental organizations. It is their vision and mission to improve the quality of life for older persons and support them in making each day a better day by providing high quality housing, services and care.

The European Ageing Network (EAN) is present in 25 European countries. With EAHSA well represented in Northwestern Europe and E.D.E. in the South-East, the combination makes of the European Ageing Network a truly pan-European organization. EAN does not stand alone in pursuing its vision, values and mission. It is affiliated with the Global Ageing Network (GAN), a global network with its office in Washington D.C. EAN and GAN bring together experts from around the world, lead education initiatives and provide a place for innovative ideas in senior care. They pave the way to improve best practices in elderly care so that older people everywhere can live healthier, stronger, more independent lives.

The members of the European Ageing Network (EAN) are servicing over 1 million older people in Europe. Longevity is one of the biggest achievements of modern societies. The Europeans live longer than ever before and this pattern is expected to continue due to unprecedented medical advances and improved standards of living. By 2020, a quarter of the Europeans will be over 60 years of age. Combined with low birth rates, this will require significant changes to the structure of European society, which will impact on our economy, social security and health care systems, the labor market and many other domains of our lives.



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As professionals we seek to improve the quality of care and supervision. Common training standards, reciprocal visits and observation, congresses and symposia all foster professionalism among care home directors and a greater understanding of the various forms of care and assistance. Creating humane living and working conditions in our homes is the vision we are all striving for in the EAN.

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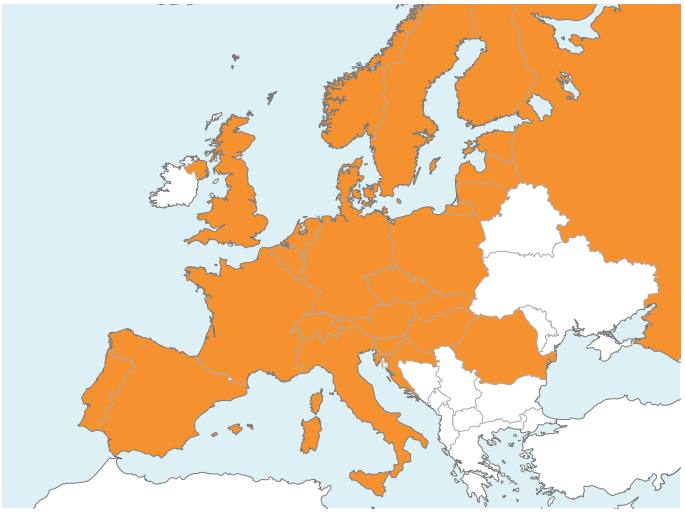


AUTHORS

Dr. Freek Lapré, MCM, RN(np)

Frederik Lapré worked as a registered nurse in several nursing homes in the Netherlands. He is a health scientist and holds a Master in Change Management and a doctorate in business administration. Dr. Lapré works now as a certified management consultant (CMC) mainly in the field of long term care, health care, health insurance companies, pension funds, investment banks and housing corporations for Dutch and international clients.

He is also involved in executive training programmes for management in health care as a senior lecturer at the TIAS Business School of the University of Tilburg and was for 10 years a visiting professor in the USA.

He is the President of the European Centre for Research and Education in Ageing Services (ECREAS) in Brussels, Belgium.

Dale Stevenson, Bach. Eco. and Pol. and MBA

Dale Stevenson is the principal of Clift Stevenson and Associates Pty Ltd, a specialist aged care consultancy. He has been operating this consultancy for the last 20 years. The focus of his work has been on the areas of ageing and care and services for seniors and the elderly in Asia and Europe.

He holds a Bachelor of Economics and Politics and a Masters of Business Administration.

He has extensive experience in both the public and private sector. The key areas of expertise and specialization are public and private policy and services development, programme delivery, management, financing and evaluation. He has over 25 years of experience in the Australian and Canadian public services, In the last 6 years of his public sector time he was responsible for major aspects of the Australian Government's policies, programmes and service for the elderly.

Dr. Markus LESER, Dipl. Gerontologe

Chairman of the working group

Markus Leser has studied Social Work and Gerontology and graduated with PhD, he has also received training in marketing (profit and non-profit sector). His professional ambition and goal is to bring the world of gerontology and the world of marketing into contact with each other.

In 2015 Markus Leser was celebrating 30 years of professional involvement in the field of gerontology. During that time he worked in a variety of roles: providing advice to elderly people and their families, as a lecturer at an institute of continuing education and training in gerontology and marketing, as a marketing manager for a leading company in Switzerland which creates retirement homes and brings them to market.

Today he heads the Old Age Department of CURAVIVA Schweiz – an association of homes and institutions (www.curaviva.ch), a research and development centre for the sector of elderly and nursing institutions in Switzerland. He is a member of the Board of the Global Ageing Network and member of the Executive Board of EAN.

In September 2017, his newest book «Herausforderung Alter – Plädoyer für ein selbstbestimmtes Leben» was published by Kohlhammer-Verlag in Stuttgart (available only in German).

Ing. Jiří Horecký, Ph.D., MBA

Jiří Horecký has been working in public services and especially social services since the beginning of his professional career. In his first role he worked as a director of a residential aged care facility. Since 2007 Jiri is President of the Association of Social Care Providers of the Czech Republic and since 2013 President of the Union of Employers' Associations in the Czech Republic. Since 2016 he is also President of the European Association for Directors and Providers of Long-Term Care Services for the Elderly (E. D. E.) and since 2018 President of the Europeean Ageing Network. Jiri is also Member of the Government Committee for Seniors and advisor to the Minister of Labour and Social Affairs of the Czech Republic.

Jiří Horecký is also a member of several expert groups and committees, e. g. Council for Social and Economic Agreement, Expert Group for Long-Term Care of the Czech Health Ministry, member of the Accreditation Committee for Education in Social Services by the Ministry for Labour and Social Affairs of the Czech Republic and other organisations related to social services and care.

Beatrix KASERER

Beatrix Kaserer has been chief secretary in a big Italian Spirits company where she could make her experience in business management. In 1995 she switched to the long term-care sector an started her career as director of a care home in South Tirol (Italy) in 1994, where she still works. Kaserer got the E.D.E. certificate for directors of residential care homes in 2013.

She is also president of the Directors of care Homes in South Tyrol (BFA – Berufsverband der Führungskräfte in der Atenarbeit in Südtirol) since 2010. And was also elected member of the executive board of the Association of Care Homes (VdS - Verband der Seniorenwohnheime Südtirols. At this level, the associations work close to the local government and can significantly shape the development of senior citizen residences. Now she has been assigned the task of project development of the project "Seniorenbetreuung 2030" in South Tyrol.

At the European level, Kaserer has represented the Southtyrolian Association on the Executive Board of the former E.D.E., now EAN, since 2015 and was entrusted with the task as the Treasurer.

Markus MATTERSBERGER, MMSc MBA

Markus Mattersberger has been President of the Austrian Association of Senior Citizens' and Nursing Homes "Lebenswelt Heim" since 2014. Mattersberger initially spent 18 years as a qualified health and nursing nurse in the acute inpatient sector, studying nursing management and health management part-time. In 2010, Mattersberger switched to the long-term care sector and initially took over the function of a nursing service manager in a nursing home in Vienna. Subsequently, Mattersberger was initially entrusted with the management of the nursing service and subsequently with the management of a nursing home in the province of Lower Austria. In the meantime, Mattersberger has been assigned the task of project development for the nursing and care centres of Lower Austria.

At the European level, Mattersberger has represented the Austrian Association on the Executive Board of the former E.D.E., now EAN, since 2015 and was entrusted with the interim presidency for several months and has since served as Vice President.

CONSEQUENCES OF THE STRATEGY FOR EAN MEMBERS AND EAN

People in Europe are living longer. That is a positive development but it has implications for the social systems of individual economies and so appropriate measures need to be taken to ensure that people can grow old with dignity throughout Europe.

Members of EAN are located all over Europe and face not only very different elderly care structures in their countries, but also widely varying legislation, financial situations and cultural attitudes. What all EAN members have in common is their desire to achieve the best possible structures for elderly people in care homes and to provide services at the highest possible level.

For individual care providers, the potential for influencing political decision-making processes is limited as are opportunities to share experience, work together and develop on an inter-regional basis. In order to address this situation, care homes are organising themselves in national organisations: firstly, to use their expertise to develop future structures and, secondly, to exert more influence over the decision-making processes and legislation. This presents members of the European Ageing Network organisation with challenges on a number of different levels and in different dimensions.

EAN MEMBERS LOBBY FOR THE INTERESTS OF THEIR CARE PROVIDERS AT NATIONAL LEVEL

The economies of every country in Europe are confronting demographic trends which are bringing about significant ageing of the population on the one hand and permanent changes in the structure of families and households on the other.

The care models of previous decades fall short because in the medium to long term, the family support networks in the form of relatives acting as carers will no longer be in place and nor can it be assumed that sufficient funding will be able to be made available by national economies to sustain satisfactory, high-quality care and support systems.

In this context, one of the roles of the national organisations is to communicate with politicians and ensure there is the necessary awareness of the problem. It is a question of adapting legal frameworks, redistributing the economy's resources and putting measures in place to ensure that appropriate structures are provided.

The national organisations are also required to work consistently to repre-

sent and stand up for the interests of the care providers and, in particular, of the people who live and work in them. This calls not only for the necessary expertise on social, nursing and medical issues but also for extensive knowledge of other legal regulations (e.g. employment policy), and, not least, the perseverance to initiate, implement and carry through change.

National organisations are also required to drive forward a common approach to change by care providers both on technical matters and, in particular, on ethical issues. First and foremost, there is the need to respect the rights of the elderly, something that will be reflected not only in ethical attitudes but also in the employment of suitably trained staff, the provision of appropriate buildings, and processes that put the needs of the elderly centre stage.

At the same time, the care providers are constantly walking a tightrope between what is feasible and what can be financed. This tension needs to be managed in relation to both the government and the care providers themselves and also clearly communicated to society with areas of responsibility unambiguously defined.

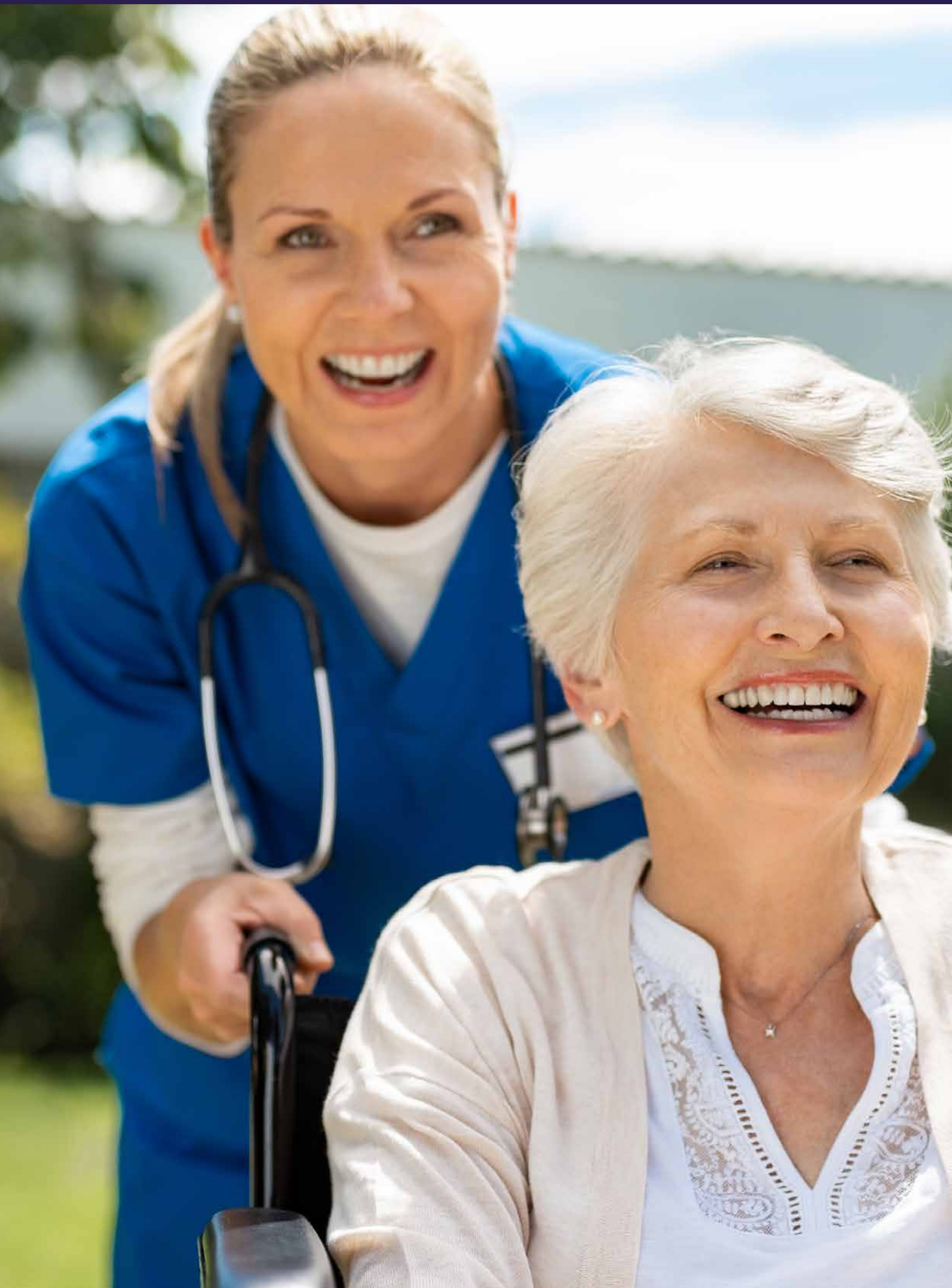
Another challenge is to find new partners in the world of business. It is the job of EAN members to position individual care providers as potential business partners. There are plenty of new opportunities especially in the European context and innovative solutions involving the use of technology could be decisive.

EAN MEMBERS AS PARTNERS AT A EUROPEAN LEVEL

At a European level, the national organisations have grouped themselves into the European Ageing Network. The main purpose is to share experience and promote constructive cooperation at the European level. The objectives that have been defined are ultimately in the interests of the wellbeing of our elderly. It is a question of exerting political influence at this level in order to bring about a convergence in national systems in the medium to long term and to define comparable quality standards where these are meaningful and practical.

In the light of the very different systems, stages of development and cultures, one of the key challenges for EAN members is to reconcile differing interests. Consequently, new concepts will be developed and implemented for different care scenarios in the future.

The challenge for individual EAN members is to break down the visionary or strategic ideas from a European to a national level so that these changes constitute real added value for each individual institution. Examples here could include ethical standards, flexible overall concepts, human resource management and a new approach to the career profile of care home managers.



The networking and sharing of experience described above is not only for EAN members among themselves.The intention is also to bring care home managers from different European countries into direct contact with one another. To that end, the EAN organises conferences at which management issues are addressed and discussed as well as other specific specialist subjects. To ensure the success of this networking, EAN members must always endeavour to raise awareness of the importance of such experience sharing.

However, first and foremost above all these and other issues comes the desire of EAN members to work at the highest European level for the common objective of implementing appropriate care structures. Since change is generally more effective when introduced bottom-up, here again members are required to carry out the necessary publicity work, communicate positive developments and highlight failings in the work of politicians.

INTRODUCTION

OUR REMIT

The EAN Working Group on Long Term Care 2030 was given the tasks:

- to identify the key existing and emerging developments and trends shaping the situation of the elderly in Europe;
- to assess the implications for the role and tasks of those concerned with serving the older population and the position of the elderly in society;
- to determine what will be required as a consequence of ensuring a quality life for the elderly in society; and
- to propose required elements of an effective response to the situation likely to be around 2030.

THE JOURNEY OF THE WORKING GROUP

Twas initially conceived in Bratislava, Slovakia in April 2017.

This Working Group was one of the first joint activities by European Association for the Directors and Providers of Long term Care Services for the Elderly, E.D.E. and the European Association of Housing and Services for the Ageing (EAHSA), the two principal European associations of the providers of elderly care and services. These two associations have now joined to form the peak association – the EUROPEAN AGEING NETWORK (EAN).

The initial stimulus for creating the Working Group was simple: what other body would come with a vision and new starting points for elderly care in 2030 than the providers of such services who are engaged in care and service provision every day. The members of EAN are experts from a broad range of European countries who possess precious specialist knowledge, long experience and have open minds to looking at future needs, risks, challenges and opportunities.

The way to the result and output of this Working Group 2030 was long and winding. Many hours of work, meetings, Skype calls, home work and research, positive arguments and discussions in meetings in Prague, Barcelona, Vienna, Bratislava, Torun, Bucharest and more.

A lot for energy, time and effort has gone into preparing the resultant Report that you are holding in your hands and reading right now.

Certainly it may not perfect. It is the work of the dedicated members of

the Working Group. It has been prepared to assist member organisations, associations and individual provider members, governments at all levels and the European Union and its Commission to open up very important discussions about the future of long term care and services in Europe.

THE CONCLUSIONS OF THE WORKING GROUP

The Working Group concludes that:

- governments are in denial. They are delaying a real emerging societal crisis and need to undertake a critical re-appraisal of their policies and strategies;
- business is failing to play a positive and constructive part in realising and addressing opportunities and challenges presented by the challenges and the needs of the elderly;
- the aged care sector continues to relax in its traditional "comfort zone" of government support, is failing to meet the challenges and opportunities of the changing environment and risks becoming unable to remain viable unless it re-invents itself; and
- society overall faces major threats to social cohesion unless a more inclusive and "normative" philosophy emerges.

The Working Group finds it totally unacceptable that society has an irrefutable, inclusive, positive, supportive and resource rich approach and philosophy to the young and to education. By contrast, its approach to citizens nearing the more senior years in society are so un-inclusive, negative, dismissive, and hugely under resourced.

The Working Group considers this situation totally unsustainable and a very high priority that must be addressed by 2030. The Working Group's Report is intended to assist in attaining these needed developments. It is to this end that its Recommendations set out in Chapter 8 are directed.

OUR VISION

INTRODUCTION

The majority of nursing homes have evolved from a hospital-based model and date back to a time when the focus of caring for and supporting the elderly was to address their shortcomings. The age of being focused around shortcomings belongs to the 1960s and has passed, never to return.

Since the 1980s, the focus has been on the faculties still retained by the elderly. Future generations of elderly people (i.e. the baby boomers) wish to be able to continue their self-determined life for as long as possible, despite their limitations and long-term care needs. In order for this to be possible, what is needed above all, are services that are tailored to the individual, in addition to, where needed, high-quality care and support.

Future providers of services for elderly people are therefore no longer "only" nursing homes, but increasingly also service providers and "facilitators".

The transition from a curative nursing home model (hospital model) to a modern service centre is one of the biggest challenges facing the long-term care sector.

There is no future for nursing homes as we know them today. They will serve in the future for people with very severe dementia and as a hospice for people in the last phase of their life due to the fact that they cannot stay for whatever reason at home. But care for people with dementia and palliative care do not require 24/7 medical care. It requires tender loving care for people to make their daily life as comfortable in which dignity, respect are the core values. We call this social care. Health care or medical care provided by physicians, nurses and nurse assistants is only required in the perspective of physical health or physical comfort. The latter can be the case in palliative care for example when pain relief is needed. Social care must be based on a service attitude that realises that the service (social care) will be perceived in the mental model of the client. So, a quality focus must not be on the service itself but on the perceived value that is formed by the mental and social needs of the client in the last stage of their life.

According to this concept, aged-care institutions will no longer consider themselves as a "large building", but as a service centre/focus/provider that enables elderly people who are reliant on care to continue to live independently in

their preferred home environment or live in a sheltered environment that is home like. It will no longer be essential for infrastructure to be centralised and large, but instead small and decentralised and with connected and complex services. For example, a nursing home starts providing day care and social activities or community based services in its surrounding area.

In such a model, collaboration between primary healthcare professionals and the local community will become more important than ever before. It is the community and neighbourhood that are becoming more important. In the future, providers will become "designers" of the entire living space for the elderly.

VISION

For elderly people, living "within their own four walls" is their ultimate wish and an expression of their will to be able to live independently until death with a good quality of life. These "own four walls" however do not exist in isolation but always form part of the overall residential community. What good is the most beautiful home to elderly people if the residential setting is unattractive or its design is insufficiently elderly or care-friendly? The gerontological concept of the "person-environment fit" has long called for the care and support environment to adapt to the elderly – not vice versa – especially in higher age groups.

Although the provision of specialist care services for dementia, palliative care, geriatric psychiatry, etc., will still be needed, our vision places the entire residential environment (community) at the centre of future developments. It is the intention that elderly people should continue to live a "full life", included in their entire social network and be able to draw on the necessary services as and when required. Such a model is intended to satisfy even more directly the increasingly vociferous calls for self-determination and autonomy of elderly people. In order for elderly people to be able to live independently in the community, they need a task and role that imbues their life with meaning. It is the remit of the aged-care sector to facilitate this for the elderly and to compensate for their reduced abilities by providing support services.

Hardly anyone wants to move into a nursing home voluntarily today. Nursing homes can no longer assume that their nursing beds will continue to be used to capacity in the future. We now already have examples in some parts of Western Europe that show that it is becoming increasingly difficult to fill the number of beds available. Vacancies are the result. This development requires a rethink in our sector. The care and support within and by institutions must turn into care and support within communities. Those who fail to achieve this change will have empty nursing beds to complain about in the future.

This means that we need to effect a transition of the elder care business instead of just optimizing the current systems and regulations. To realise this, we need tot start with a Vision as a reference for the future plans laid out in this report.

The "Vision" the EAN has formulated has dramatic implications for the current situation of our members, the aged care and service sector overall, all levels of government and society in general.

The "Vision" that the EAN has formulated can be summarised as follows:

"Ageing and becoming old is not a disease but a stage of life."

PRACTICAL IMPLICATIONS OF OUR VISION

The implications of this vision are affecting aspects of the sector our members work in.

The first implication is that the elderly or their families can decide for themselves very well so we need to focus on them as a client that we do not do things to, but for and with them. That means that we have to create a service quality culture instead of a culture where we think that we know what is good for them.

The second implication is that elderly care is not aiming towards quality of care but towards quality of life. Quality of life is the value that we are striving for, for our clients. We want to have happy older people instead of paperwork on subjects that have nothing to do with the quality of life. Quality is formed in the interaction between people and not between papers.

The third implication is that we are focussing on social support and services. Health care is a secure element in the background but is not the dominant element in the services and support for older people. Therefore, we are "life assistants" and a new role for nurses and doctors support quality of life.

The fourth implication is that the life of older people is the domain of EAN members and not only when people are in need of care. That means that prevention is an element that is part of our support and services to maintain the health of the elderly. This approach prevents the increasing demand of support and care in later stages of life.

The fifth implication is that support and services for older people is not a cost factor but an economic opportunity with job creation and technological and social innovations.

The sixth implication is that we realize all the care elements as we know them today are important in the current and future system. Thus, we need home care, ambulant care, respite care and residential care and also other various housing models and support services.

The seventh and final implication is that EAN Member must think outside the walls of their own facility and services but need to try to organise and manage a network that is integrated in local communities.

THE WORLD IS CHANGING WITH IMPLICATIONS FOR OUR SECTOR AND BEYOND

THE APPROACH

The EAN employed a universal, non-country specific, "Conceptual Framework" to identify the key influences, inter-relationships and interactions that define the environment faced. This Framework assistance determines the challenges and implications facing governments, provider groups, individual providers, families and the individual nature of quality services, support and long term care for seniors.

This framework enables any individual provider, organization, association or government to:

1. Assess and/or reassess their current situation, (policies and practices, etc.) and identify the challenges, threats and their implications; and
2. Explore options for the way forward towards 2030. (Appendix A shows the diagrammatic structure of this Conceptual Framework Model.)

There are four key elements, each with their associated "shapers", that define the environment for long term care up to 2030 in any given country or system. The EAN has defined four dimensions of the future of long term care. These are (see Figure 1):

i. The future of ageing

ii. The future of the system and structure of providing Senior Care/Services

iii. Future concepts of Senior Care/Services

iv. The future organization and leadership in elder care/services

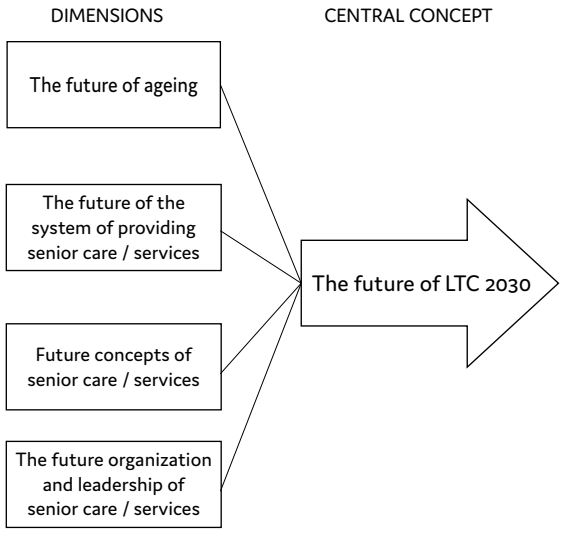


Figure 1: dimensions of long term care

The next step was that the EAN explored what determinants are relevant for each of these dimensions based on literature and experience of EAN-members.

THE ANALYSIS

"We live in a change of era instead of an era of change" is a common saying these days. People have the feeling that the world is turning upside down in a very short period of time. This feeling is due to changes in demographics, society, ecology, economy, technology and politics.

It is too difficult and too complex to describe all developments that are currently underway or emerging and that have an impact on our lives.

Instead, the EAN has chosen to focus on those developments that are impacting the context in which providers of elder care and services need to develop their future strategy.

DEMOGRAPHICS

An ageing population

Statistics of the OECD from 2011 as cited in Pacita Future Ageing (2017) show a rapid ageing population (see Figure 2).

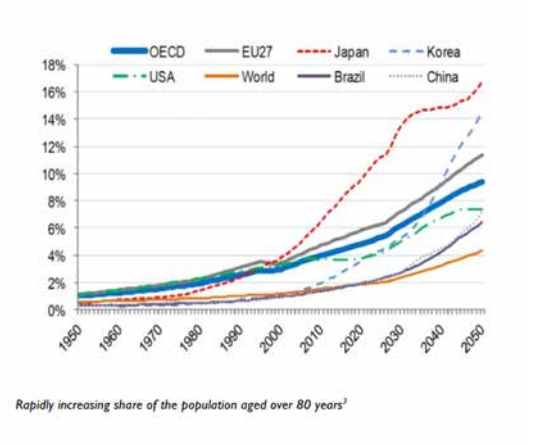


Figure 2: Rapid ageing society (Pacita, 2017)

The EU is confronted with an ageing population and has an average score above the OECD.

The ageing population also brings a shift in the balance between working and non-working populations.

In 2016, there was one person over 65 years for every four working persons in the EU. By 2060, this will halve to one person over 65 years for every two working persons (Eurostat, 2015). This change will happen quickly - in 2030 the dependency ratio will be one person over 65 years for less than less three working persons.

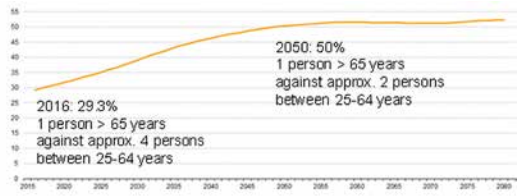


Figure 3: Dependency ratio (Eurostat 2015)

This has an enormous impact on the working capacity of an economy and the durability of public financed services. In particular, the question is how to maintain the future financial burden of the working population at least constant instead of increasing.

The life expectancy of the future older population will be higher

The average life expectancy for women in the EU will rise from 83 years in 2016 to approx. 85 years in 2030. While men will have a lower life expectancy

than women, it will rise from 77 years in 2016 to 80 years in 2030 in the EU (EC, 2012).

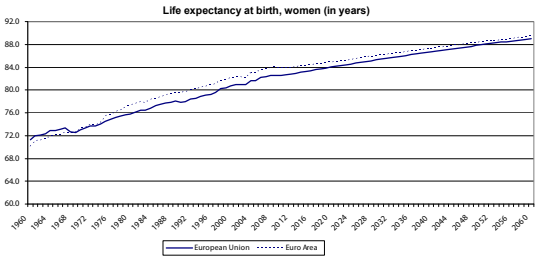


Figure 4: Life expectancy at birth, women (in years) (European Commission 2012)

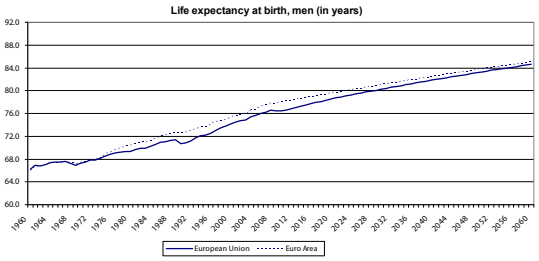


Figure 5: Life expectancy at birth, men (in years) (European Commission 2012)

Therefore, demographics are a relevant determinant for the future of ageing. But it also has an influence on the workforce capacity and thus, the future organization of senior care and services.

An ageing society comes with an increase of the incidence of dementia

There were an estimated 46.8 million people worldwide living with dementia in 2015 and this number is believed to be close to 50 million people in 2017. This number will almost double every 20 years, reaching 75 million in 2030 and 131.5 million in 2050. Much of the increase will be in developing countries. Already 58 % of people with dementia live in low and middle income countries but by 2050 this will rise to 68 %.

In Europe, the number suffering from dementia will increase considerably from about 10 million today to about 14 million in 2030.The cost prognosis will be rather similar in Northern, Western and Southern Europe while costs are considerably lower in Eastern Europe. The demographic forecast of costs will result in an increase in the whole of Europe by about 43 % between 2008 and 2030 to over 250 billion €.

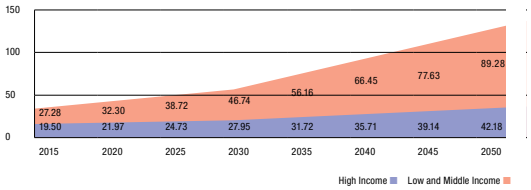


Figure 6: Number of people with dementia in low and middle income countries compared to high income countries (ADI, 2015)

SOCIETY

There are several fundamental potential and current developments in society.

Increasing Labour Participation of Women in the EU

The first development is the increasing labour participation of women

in the EU (ILO, 2015). Traditionally, women are the ones who take care of the parents. Now they are informal carers who have to do this in addition to a job. This puts a lot of pressure on these women. In other words, the informal care capacity is at stake and the perspective of an ageing society will affect this more negatively.

Increasing number of single households in the EU

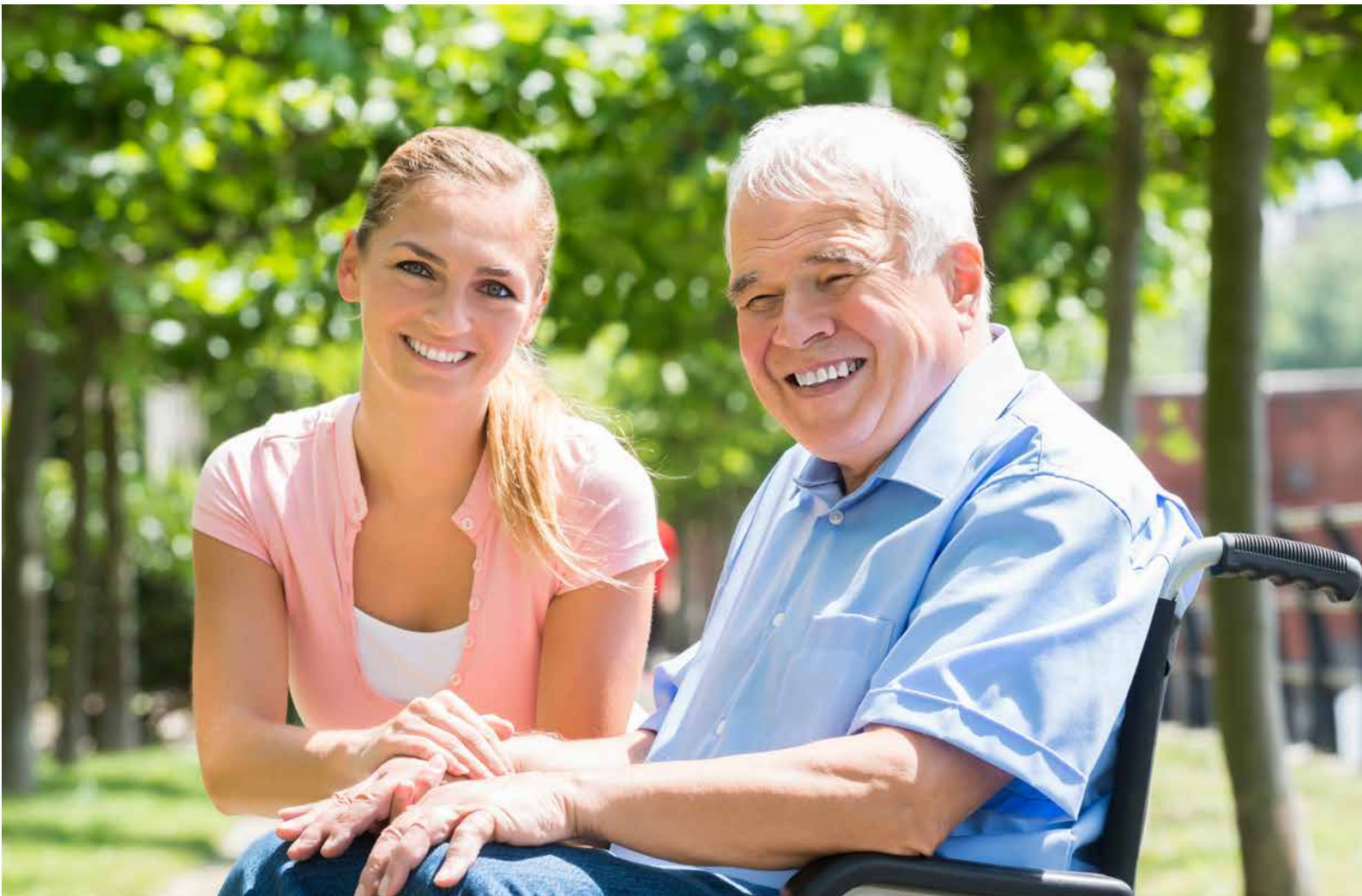
The second development is the increasing number of single households in the EU.

The reason is that more people are divorced, or people choose more consciously to live alone. In times of sickness or need for support, these people need more effort to organise informal support outside their own household. This can lead to more demands on professional support.

The fragmentation of the traditional large family group into small family units in an urbanized context reduces the number of people who can provide care to dependent family members. In addition, female labour market participation has risen steadily and greater emphasis is placed on facilitating paid work and enhancing career opportunities for women.

Our Society Becomes More Unequal

The share of national income claimed by the top 10% of society has become bigger and bigger (Piketty, 2014). This leads to segregation between the



top and middle income and the lower incomes. The people who have less are also facing a lower quality of life due to a lower health status and the absence of a better career or work perspective. The income and education inequality also leads to differences in longevity (Neumayer and Plumper, 2016)

Increasing focus on quality of life for older people.

An increasing focus on the quality of life for older people puts healthcare and professional care in general in another perspective. Health is seen as an important condition for the experience of a good quality of life but is not the only focus. This leads to a paradigm shift in the need for professional care: no longer is good medical care important but the way a vulnerable older person is supported in all aspects of life.

Therefore, "social inclusion" is a concept and principle that must become ever more important in the support of older people to prevent loneliness and feelings of helplessness.

Dignity of the individual is an equally fundamental principle that demands priority attention. The discussion about a "completed life" in relation to the end of one's life also becomes a relevant topic of discussion.

Conclusion

In conclusion, there is a higher demand for senior care services because of lacking informal care capacity and the increase of single households.

Inequality of income and social status are influencing the health status (longevity) of the elderly.

The focus on the quality of life leads to another position of the senior care and services system: the emphasis will evolve from health care to social care.

Finally, inclusion of vulnerable older people needs to be included in the development of senior care and services concepts.

ECONOMY

Economies become ever more intertwined. This means that on the European level, areas of activity like the broadly defined aged care sector become interdependent and interlinked across countries in a range of areas such as staffing, areas of expert services, the supply of specialist needs, etc., and more and more regulations will affect the national economies.

Most fundamentally, ageing of societies is increasingly influencing the level and nature of economic activity and hence the sources of public finances which most ageing care systems are heavily dependent upon (see figure below).

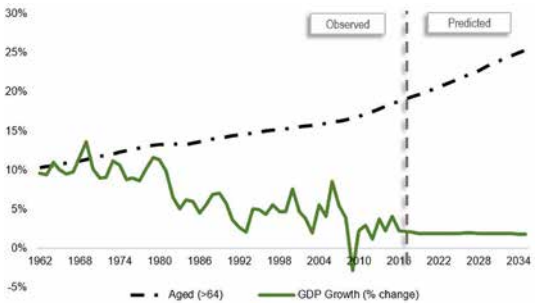


Figure 6: Ageing population figures and observed/predicted GDP growth in Western Europe (1962-2035)

Observed and predicted data from the OECD for Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Iceland, Italy, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland and the UK (OECD, 2017).

In particular, public and private pension systems will increasingly undergo pressure because a larger proportion of pensions will need to be guaranteed while less people are working and bringing in pension premiums. This will bring ever more pressure on welfare systems in the European Union.

Equally important, businesses (and governments at all levels) generally totally fail to recognise and respond to the economic and business opportunities and resources offered by older citizens to the market.

"The Social Services sector is a major job creator in Europe, employing over 10 million staff and creating over 1.8 million new jobs in Europe since 2008. Together with health services, the social services sector represents 7% of the total economic output in the EU 28. With changing demographics and family patterns, the social services sector is expected to grow significantly over the next few decades" (Social Employers 2018).

Another critical trend is the increasing mobility of workers and pensioners throughout the whole of the EU, mostly from the East and South to North West Europe in order to fill vacancies. These trends have large benefits and costs both in countries people move from and move to. However, the biggest impact of an ageing society is in health care and education with a huge number of job vacancies.

Also, pensioners move from Northern to Southern European countries to spend their retired life in a warmer environment (Gehring, 2018).

Economic developments are impacting the public financial coverage of senior care and services including transnational regulations for the provision of elder care and services and the workforce capacity.

TECHNOLOGY

Technological developments are huge and moving very quickly. The impact on daily life is very significant but often under-estimated and not appreciated by politicians in particular.

It can most importantly assist staff in residential facilities and in community care, freeing them for more skilled or "personal/human" focussed activities.

This phenomenon will turn our societies upside down in a way that is

comparable to the Industrial Revolution at the end of the 18th Century but at a stunningly higher pace.

The array of applications is extremely broad and will transform the elderly care industry in a dramatic way. A failure by governments and the sector to address these developments will see substantial consequences.

For example, home automation and detection systems will increase the independence of older vulnerable people who are now dependent on informal and professional care. Augmented reality can support people who suffer from dementia to help them around their own house and to create real life experiences based on memories from earlier in life. Robotics can give companionship to some people suffering from dementia and can assist with aspects of care, monitoring and support. Tele-health can provide care from a distance.

Technology will have a huge impact on the development of new elderly care and services concepts. But it will also change the way elder care and services are organized and operated. This requires new skills and awareness of clients, their families and professionals. It also brings new issues like privacy, ethics and the profiling of clients.

POLITICS

For society, there is an enormous political challenge: how to deal with an ageing society and its implications and impacts on economic activity and growth set against societal changes. Failure to address this provides a real threat to stability.

In particular, the rising costs of providing services and support and particularly health care to the ageing population, presents a huge challenge to all governments.

These issues are a "time bomb waiting" to explode in every society in Europe.

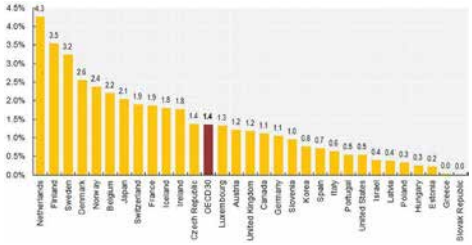


Figure 7: Cost of LTC as % GDP per country in 2014 (OECD, 2018)

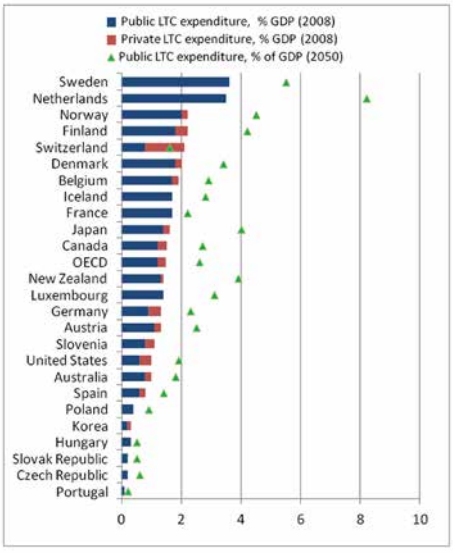


Figure 8: Projected cost LTC to 2050 (Rodrigues et al., 2012)

In order to control the cost of health care and elderly care and services, governments are restricting the public coverage and/or choosing for a neo-liberal policy: more privatization of elder care and services and the creation of a competitive environment. This must lead to lower cost and a higher quality.

Politicians are also aiming for "ageing in place": keep older vulnerable people who are in need of care and support at home as long as possible.

The political developments are impacting the discussion of public and private payments in elderly care and services and thus the future of the system of providing senior care and services.

In terms of the sustainability of the Long-Term Care system, there are co-pay models in the field of social services, such as in Span which are the source of important inequalities:

1. On the one hand, people with higher pensions are expelled from the public system who, however, are the ones that have paid more taxes related to work income. The universality of care becomes unreal when the person with the highest pension sees no advantage in receiving a public service.
2. On the other hand, home care services prevent people from having sufficient means to achieve a situation of stability and even sometimes subsistence.
3. Finally, there are users who end up co-paying free services for the all of the citizens.

The future of co-payment appears to be a short-term solution as minimum pensions will gradually rise in the coming years. However, the increasing requirements for access to public pension systems or attaining the maximum pension possible will return to that current curve which will be nothing more than a mirage.

THE CONCEPTUAL MODEL

Based on the above analysis, the EAN utilized the following conceptual model for the future of long term care. The EAN concluded that the key implications for each of these four areas are the following.

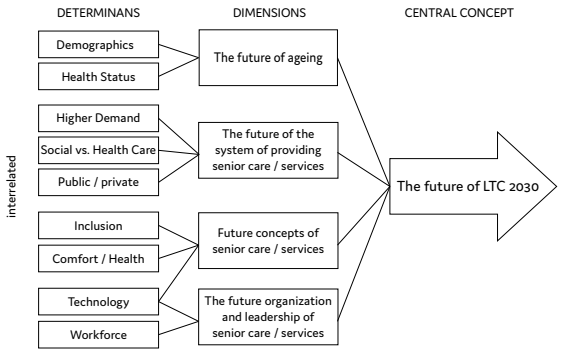


Figure 9: Conceptual model

THE FUTURE OF AGEING

There is an increasing need for care and support of older people

People will live longer. Simultaneously, the age at which people develop chronic illnesses has decreased by seven years for men and twelve years for women (CPB, 2016). This trend will continue. In the coming decades, more people will face chronic conditions such as cancer, heart and vascular diseases, and diabetes or dementia earlier in their lives. Together with a longer life expectancy, this means that older people will be chronically ill for a larger part of their lives.

This means that the need for care and support will develop more gradually over a longer time span. This increases the importance of prevention to keep older people fit and healthy.

There are less possibilities for informal/family support.

The traditional family care (children taking care of their parents) is crumbling because traditional roles have changed. Women have jobs so the availability of children to provide informal care is limited. This means that people who are in need of care and support need to find informal carers outside the family structures or are seeking professional providers.

At the same time, expectations from elderly people and families are increasing and there is a growing demand for a great variety of quality service and care offers.

A much stronger service culture is required and affordability and choices of quality care and support is ever more fundamental.

Equally, there are key implications arising from issues concerning health status.

i) The increasing incidence and range of life changing conditions that are accompanying more older and frailer

people requires increasingly diverse and special care and support offers. This will see new support and service opportunities and competition from new entrants into the sector.

ii) More holistic, integrated and multi discipline approaches will be needed. The dominance of the "medical model" is over and this must be reflected in what care providers offer.

iii) It is critical that providers must offer supportive "living environments" that aim to maximize the autonomy/ independence of people. People will demand more control and providers need to adopt the role of mentor, facilitator or "coach".

THE FUTURE OF SENIOR SERVICES AND CARE SYSTEMS

Budget Constraints due to Less Public Finances

Governments will control the costs for long term care in relation to a growing ageing population. This will lead to budget constraints in the long run and to less public coverage on elder care and services.

This means the opening up of systems to a better balance between public and private provision will result in new entrants, new ideas, competitive sources of funding and resources and greater diversity.

Existing providers/organisations/ etc. need to understand these trends, their practical implications and how to adapt to the emerging environment in their marketplace.

Public/private partnerships will become increasingly a source of solutions for the future.

More Competition

There will be a new and more diverse range of service providers emerging from the hotel and leisure sector especially in the field of serviced housing for older people and ADL support (independent living). This doesn't mean that these concepts are solely exclusive for older people: it can be also intergenerational.

This also creates new opportunities for existing providers. Private for-profit service companies will certainly become a key player due to the increasing limitations of public funding and service coverage.

An Integrated Approach

The interactions and tensions between the social care and health care regimes presents major implications for care/service systems.

There needs to be improved co-ordination and management at the facility/ service provider level and upwards between acute care and LTC and community care.

An effective system to address the needs of older people demands a better balance for funding of health and social care. This requires needs based services and care from community based care to residential and more acute services.

Existing systems are increasingly too inflexible to encourage and support innovative "market-driven" needs and expectations expressed by older people themselves. The private sector is a largely untapped resource in a majority of systems.

THE FUTURE OF SENIOR SERVICES AND CARE CONCEPTS

More Possibilities to "Age in Place" (in one's "home")

Policies of governments are aiming towards more ageing in place, sometimes at home in order to decrease the costs of elder care and services and also to meet the needs and expectations expressed by the elderly.

This gives a need for de-institutionalisation in many European countries and the increase of home care and services. It is therefore necessary to rethink the offer on a model of home operation regardless of the support structure or the place of residence.

This also creates an urgent need to develop far more integrated and holistic concepts towards the entire social setting and living space for elderly - between specific services and care provision, the community and other resources – to build appropriate and effective concepts. Viability can only be guaranteed through developing and adopting new models of co-operation that maximize the opportunities for integration. The challenge is to find workable balances between independence, autonomy and responsibility.

A model is the leisure industry where the integration of offerings results in constructing packages that people desire. One can imagine what is possible with this "client culture" in the aged care sector with a greater market focus (and the discipline the market brings).

There will always be a need for "residential care" but the needed capacity will be less than in the current situation. In some countries there are pressures for "deinstitutionalization". To meet these, there will be an increasing need of new concepts of senior housing with support services which can be compared to a care home but with bigger apartments, a greater diversity of services and new suppliers from the hotel and leisure sector. Therefore, the sector must develop broader perspectives and find appropriate organizational and management solutions to meet clients' needs in both residential and services housing.

The Balance between "Comfort" and "Health" Need to be Better "Blended"

Quality of life as perceived by the

client is the focus. Quality of health and quality of care are the supporting elements to accomplish this. Therefore, the "medical" dimension of service/care provision needs to be placed much more in the "background" and far less evident in the context of daily life in the service/care environment at all levels.

More Potential for Technological Innovations

As stated in the previous chapter the impact of technological innovations is huge. This means that providers need to prepare for technological innovations. These innovations can be aiming at:

- Increasing experiences for older people especially with dementia
- Decreasing the density of staff in activities by telecare and teleservices
- Increasing the possibilities to stay at home with a good quality of life.

There is a need for more "positive" strategies that emphasize healthy ageing through prevention, maintenance and rehabilitation as key elements of "holistic" service offerings. In one instance, specific "health" services/centres and wellness services associated with traditional care services are among the ideas that are gaining merit.

A major priority is the re-focusing or "fine tuning" of a myriad of services and products to make them more relevant or appropriate to the individual needs of seniors. This is something that is very slow in emerging but offers great challenges and opportunities to the aged care sector and beyond.

THE FUTURE OF MANAGEMENT AND ORGANIZATION

Less Staff will be Available

Because of the changing demographics and the increase of the number of old people, the availability of (potential) staff in elder care and services is, with constant means, decreasing. New technologies need to be developed to make the services and care less dependent on staff capacity

Staff training

Staff training is essential and should focus on three components:

- Service attitude instead of a "system" attitude. Staff must be more service oriented to fulfil the needs of clients. They should assess more in terms of what value it brings to clients in the perspective of their mental state (not only dementia, but the perspective of becoming older)

- Home care and service requires a completely different attitude than in a residential care environment. Staff cannot rely on a team but rather is solitary in someone's own home environment
- Use of technology: recent research shows there are 32 competencies needed for staff (Van Houwelingen et al. 2015) to comply with new technologies in health care:
- Assessing patient capacity to use telehealth
- Triaging incoming calls and alarms
    - Providing health promotion remotely
    - Coordination of care with the use of telehealth technology

Trust management

Services that are provided at home and not "between the walls of a building" cannot be controlled by management. It requires a management style that is based on trust that the staff will take the right decisions and give a high quality of services and care according to standards. That is a challenge for CEOs and management: be responsible without operations in close proximity.

Technology

Technology, like everywhere, has significant current and future implications for management and organization in the aged care sector.

i) Key implications and challenges arise in terms of:

- what technologies to use:
- how to use them; when to use them;
- the consequences for care; for support systems; for employees; for organizational structures and management; for training and development; for monitoring and accountability; and
- the maintenance and support of the technologies themselves and their associated systems.

ii) Major implications need to be faced in integrating new assistive and other technology into the care and services offered.

iii) Challenges arise from the two key different types of new technologies that must be addressed:

a) those designed to encourage and support independence and a high quality of life; and

b) those that assist support in the provision of care and services and that assist in making for a safer environment.

Workforce challenges

Workforce related consequences and implications is the other key area where there will be major challenges and implications for management and organization.

i) Suitably trained and qualified staff is becoming an increasing challenge and this involves major implications across the entire aged care sector.

ii) A major fact, with big implications, is that reliance on staff from other countries is not a sustainable option.

iii) New recruitment and training strategies need to be developed. "Care and Service" must be developed and promoted as professional work. This requires developing jobs/professions that have much broader skill sets than those that currently exist, including "nurses".

iv) The sector needs urgent action now to re-invent itself. Major industry wide initiatives are critical to create a modern, positive, professional and career-based image of the sector.

CHALLENGES AHEAD

CHALLENGES

Based on the previous analysis, the EAN has formulated challenges for the EAN members:

Decrease the Need for Professional Care

Currently, especially in the Northern European countries, the use of professional care is high compared to the southern European countries and the US.

Some predict an even higher use of professional care. Simultaneously, as noted above, the age at which people develop chronic illnesses has decreased. This trend will continue. Together with a longer life expectancy, this means that older people will be chronically ill for a larger part of their lives. This leads to rising expenditures in the future.

Beat the Upcoming Staff Shortages

The industry needs to beat the upcoming staff shortage in more than one way. The traditional way is to fill the vacancies. We also need to pay attention to decreasing the staff density in care and services with supportive solutions without compromising the quality of care and services.

Increase Financial Sustainability

The financial sustainability is not only a responsibility of governments and insurance companies but also the responsibility of the providers. If we do not recognise this responsibility, the rising costs will backfire in the future. So, we need to partner with governments and insurance companies in improving the financial sustainability.

Realise a transfiguration of elderly care and senior housing

The industry needs not only to transform itself, but needs to transfigure itself (compare it with a caterpillar that transfigures into a butterfly) by setting new paradigms (see next paragraph). This goes further than a transformation where parts of existing systems stay in place.

NEEDED PARADIGM SHIFTS

Based on the previous chapters, the needed paradigm shifts in care and services are:

From Care to Prevention and "Inclusion"

Care providers need to aim more for prevention and inclusion. Be active in a stage that the need for care and services is not present. Pay visits to older

people and check for example, the fridge. Activate communities to include older vulnerable people in the neighbourhood in community activities and even residents of nursing homes and care homes. Keep people socially involved and try to let them feel useful.

Shift from Quality of Care to "Quality of Life"

There is currently too much emphasis on the quality of care or the care activities (technical quality) and far too little attention on the way the care is provided (functional quality) and the effect of the quality of care on the quality of life.

New concepts like positive health and service quality need to be implemented in order to get more client focus in elderly care and services.

Redefine Institutional to "Home"

Ageing in place is a term that is misunderstood: it is interpreted as staying in your current home. That can be the case but it can also be in the form of a diverse range of other housing options that are life career resistant with some shelter.

Current care homes where people get service and ADL support are a concept that we will still need in the future but not in an institutional way. It can be seen as serviced apartments where residents have the choice.

Professional to "Co-creation with Family"

Providing care is not the mere domain anymore of the "care professional". For too long institutional settings have been closed systems.

When one of your loved ones enters into a nursing home, you would have to leave them and the world outside the nursing home is suddenly a world in which your loved one is separated from you. Co-creation with family involves the family in the direct care environment which maintains emotional relationships. Family can also play a part as an early warning by technology.

Shift from a Medical Focus to a "Social and Service Approach"

The "medical model" is still dominant in elderly care. This has the consequences that the care is too medical by giving the final responsibility to a physician. A social and service approach related to the quality of life should be dominant without denying that medical care plays an important role in the background when the client has no health problems.

Most people live in an institutional setting because of social problems. As an example, dementia is caused by a disease but in this state of life, no 24 hour medical care is needed. Palliative care needs also to refocus to the quality of life. It seems contradictory but the quality of life includes also the quality of dying.

Refocus from One Size fits all to "Lifestyle"

Lifestyle is part of someone's identity. "One size fits all" denies the uniqueness of a life that a resident has lived and makes people objects instead of individuals. Maybe most important of all is that a person gets the feeling that he/she is seen (see also the video "See me" on YouTube)

Organise from a System Dominance to "Client Focus"

The way care and services are organized is based on the most efficient way and according to sometimes irrelevant regulations. This affects the daily rhythm of a resident negatively and thus the experienced quality of life. If, for example, the resident wishes to sleep in on a day, then the organization of care must be organized according that wish and not the other way around

Decrease Staff Intensity with Technology

As outlined in a previous section, the array of technological applications is broad and can quite radically transform the elderly care industry in a dramatic way.Technology can never replace human contact but it can decrease the need for staff in various situations. Think about home automation and detection systems andassistive technology that can increase the degree of independence of the elderly person.

Use "Common Sense" instead of Critical Performance Indicators

Scientific management principles and Taylorism (function differentiation are still dominant in elderly care) gives the illusion of being in control. But it degrades workers with a caring heart to tick lists and seeking permission for every decision they want to make.

Most elderly care is not highly complex but actually very familiar to everyone: love and companionship. So use the "life experience" of employees, most of whom are women, as the front line employees: they know how to care and love. So use common sense instead of requiring "tick a list" employees.

NEEDED CONDITIONAL PARADIGM SHIFTS

Following on from these elements of the need for critical paradigm shifts are a second set of fundamental shifts that need to be made.

Move from Sole Public Finance to Co-payments and a Public/private Market

We expect that public coverage of elderly care will be limited in the future. As inevitably more co-payments emerge, this makes the client/family provider relationship far more important because they are the ones who then pay a higher share of the costs.

Also, as noted above, private for-profit companies will emerge more and more on the elderly care and services market. This can lead to more diversity which is a positive development. More diversity increases the possibility of fulfilling the lifestyle needs of older people. But in Europe we must be careful to avoid the inequality gap between poor and rich such as exists in the USA.

Create Staff Mobility by More Flexibility in the EU

Staff mobility throughout the EU must be made more possible. Not only because of staff shortages, but also because of the mobility of older people to more warm countries.

There are still barriers to staff mobility such as the recognition of diplomas. By recognising diplomas within the EU, the staff mobility can be increased. However, there are two remarks to make.

The first is an ethical one: most countries in the world are also in need of workers in this sector because of their ageing populations.

The second one is a quality remark: language and socio-cultural skills can form a barrier to providing a good quality of care and services, despite the professional quality of the "immigrant worker". Cultural and language knowledge are key in interaction with older people.

THE CHALLENGES FOR INDIVIDUAL ORGANISATIONS

REFLECTION ON THE CHALLENGES OF CARE PROVIDERS

Care providers have a responsible role to play in society by providing appropriate nursing care and support for older people who are no longer able to live within their own four walls. However, even though they have taken on this important role, the final responsibility remains with society. It cannot be delegated to the care providers. It is therefore up to society and government to provide, on the one hand, the necessary structures and, on the other, generous support for them in fulfilling this task.

The care providers, for their part, have a duty, firstly, to do their best to meet the needs of elderly people by continuously developing their services and, secondly, to comply with legal regulations.

The challenges that this presents for individual care providers are manifold. It is those institutions which address these challenges, and best adapt themselves to meet the needs and expectations of the different stakeholders involved which will ultimately be successful service providers in the long term.

EXPECTATIONS OF RESIDENTS

Despite the ever-growing need for care, people's autonomy and right to self-determination remain crucial. Residential institutions in particular are required to put in place measures which take account of and support these aspects as effectively as possible. This means not only that residents are actively involved in the delivery of the different kinds of nursing care but also that self-determination begins much earlier – namely at the point when the decision is being made as to whether nursing care should be provided, and if so, of what kind.

This does not necessarily imply a new understanding of professionalism. After all, giving support where it is sufficient and taking action where necessary has always been the credo. Rather, it is a question of two different perspectives: on the one hand, professionals acting as coaches in how to live an independent, self-determined life and, on the other, an emphasis on specific nursing care and support measures.

Taking the first perspective to its logical conclusion, it becomes apparent that it should not be the primary objective of care providers to push for improvements in occupancy or economic

indicators even though it is necessary and understandable from a commercial point of view. This approach conflicts with national economic considerations and inevitably ends up becoming the focus of criticism. So it is obvious that care providers must be driven not only by commercial interests but also by a strong sense of social responsibility towards their residents and towards society in general.

Care providers are therefore required to offer services which allow the maximum degree of self-determination and autonomy while reducing institutionalisation to a minimum. This realisation alone shows that there must be a much wider range of products available. One which is far better attuned to the needs and demands of older people in order to offer the best possible service which includes in a commercial sense! To put it in radical terms, care providers must reinvent themselves in order to survive!

SUPPLY AND DEMAND

Care providers need to offer new products that best cater for the wishes, needs and dignity of older people in order both to generate and meet a certain level of demand.

In the process, outdated ideas about care homes will be overturned and they will be more successful in improving their image. Creating that demand will require a consistent and professional campaign of public information.

In order to communicate these services and the concepts behind them effectively, they will need to be reconsidered and brought to the public attention on different levels: at the level of role models for the providers and receivers of the services, the level of processes and structures, the level of technological solutions and, last but not least, of architectural developments.

ROLE MODELS

Older people are a valuable part of our society. To highlight this, new role models are needed: people who present a positive image of old age, who can demonstrate the contribution they make to society. Older people and, with them, their care scenarios, should no longer be portrayed as a cost factor but rather as a wealth-creating factor in society where wealth creation is understood not only in an economic sense but also in the sense of values.

These role models, embodying self-determination, must then be reflected in the manner in which the services are provided. In this way, older people are no longer just passive participants in the system but become active contributors. We are thinking here, for example, about social involvement and interaction in new network sharing experience on multigenerational projects etc.

PROCESSES AND STRUCTURES

In terms of processes, it is a question of encouraging a more service-based mindset so that the recipient of the service is given the best possible support in leading an independent life. Especially in relation to permanent institutions, the basic principle of "structures follow needs" could be defined as a way of avoiding an excessive degree of institutionalisation. Regarding feasibility and implementation, both the social responsibility of the care provider and the responsibility of society to make resources available come into play here.

TECHNOLOGICAL SOLUTIONS

Care providers are a promising future market for the manufacturers of technical solutions. There are all kinds of ways in which technical innovations can be used. This may take the form of supporting older people in living independently (e.g. "smart home" solutions), assistive products for older people either at home or in a care home, or technical products which increase their feeling of security. In this context, care providers, with all their expertise, can be useful partners for developers and businesses.

LIVING ENVIRONMENTS

The current trend is definitely towards smaller units. However, that is only a short-term consideration. The main question will be to what extent is it sensible and possible to design buildings in such a way that they do not have a negative, institutional image? How can living environments be created so that they are perceived far more as a place to live in than as a place in which to receive care? Here again, questions arise about the possible role models for the providers and recipients of the services.

"People living in institutional communities need a sensitive environment on a human scale where the whole ambience is supportive," says Andreas Wörndl, an architect and expert specialising in housing concepts for older people. Architectural solutions should not be assessed in isolation but always in relation to the people who will live and work in them.

Care providers find themselves in the field of tension between the needs and demands of older people on the one hand and limited resources and financial possibilities on the other. Nevertheless, expectations are rising along with the need for:

i) better provision in terms of information and support

ii) prompt professional assessment of the need for intervention

iii) a range of readily accessible recommendations

iv) streamlined coordination between nursing care and support services and

v) simple but efficient overall management of the system.

Care providers, in whatever form they may take in the future, should ensure that older people have access to social resources, can participate in the life of their community and are free to make their own decisions. The most important factor in the success of service provision is the workforce and that is one reason why it deserves special attention.

WORKFORCE

With dwindling financial resources, an ever-increasing need for care, changing expectations on the part of residents and their families and, not least, the public interest in ensuring that care homes are run efficiently and without scandals, the pressure on the workforce in them is intensifying.

Their expectations of the workplace are also undergoing change. In the contest for the best employees, those businesses are most successful which can position themselves as attractive employers, genuinely and sustainably. To be perceived as an attractive employer, they need to take a new approach which credibly conveys not only a staff-focused style of management but also the opportunity for involvement, autonomy and a sense of fulfilment. Semi-autonomous structures and learning organisations can be seen as examples of modern management.

The widespread changes in the attitude of younger generations to work and lead must also be taken into account. The work-life balance plays a far greater role than it did for earlier generations and new management concepts will need to be developed if young professionals are not only to be attracted to the field of care for the elderly but also retained. Such new concepts also represent an opportunity to bring about a lasting improvement in the image of care homes in general and of the people who work in them in particular.

Furthermore, the changes in role models and expectations outlined above need to be taken into account with appropriate new training material, while fresh images of the career of caring for the elderly need to be presented. Whereas in the past it was mainly traditional carers with nursing expertise that were required, in the future multi-professional teams will be needed to satisfy all these demands. Not only will nursing staff with expertise in geriatric care be required but also therapists, doctors, psychologists and social workers. In addition to financing the necessary structures, decision-makers must also take steps early on to ensure that suitably qualified workers are available on the labour market. Here again, it is important to appeal to the sense of responsibility of society and government, because the individual institutions themselves have only a limited capability to influence the situation.

HOW TO BRING THE EAN VISION INTO PRACTICE

When EAN members, that is, providers follow the previous described paradigm shifts and vision to make their organisations sustainable for the future, there are many challenges ahead. In this chapter, these challenges are described following the structure of McKinseys "7S model" to describe the organisation in practice.

STRATEGY

The individual organisation follows a strategy that is centred on the following themes:

- Diversification of functions
- Setting up a network organisation
- Client focus based on service quality principles

STRUCTURE

The organisational structure must facilitate the integration of support and services in the community. That means that the organisational structure is not based on functions but primarily on geographical entities in which functions are organised and carried out. Primarily because some functions are to not viable when they are split all over geographical entities and will be organised on a higher organisational level.

Front line staff are social workers, hospitality and recreational staff. Health care staff like nurses, therapists and psychologists are organised in a separate health care unit that can be called in by the support and service staff when a health problem occurs.

SYSTEMS

Systems must facilitate the client focus and are reliant on the relation between a staff member and a resident. Electronic client/resident files must be accessible for the client/family to make a co-creation possible.

Technological systems must make it possible that the living environment of clients or residents becomes more comfortable. Tele-care and warning systems must support the staff in signalling problems and give attention to clients and residents from a distance.

Robotics can help in carrying out simple household tasks like vacuum cleaning while more human robots can play a role in dementia care.

Augmented reality systems can create experiences for people with dementia that can comfort them and make them at ease (snoezelen 2.0).

STAFF

The staff mix must be adjusted to meet the vision that is described earlier. This means that the proportion of social workers, hospitality and recreational staff needs to increase. Also the training programmes must be redefined and aim towards supporting the quality of life instead of the quality of care.

Interaction with clients needs to be the central theme as well as biographical context of the people they serve (cf. See me (YouTube)). Medical staff teams need to be called in when a health problem occurs. This will also give a shift in responsibilities.

CULTURE

The culture needs to shift from a system dominant culture to a client focused culture. Protocols and procedures are not key, interaction with clients and understanding the client needs are dominant.

This will be reflected in shared values that will be described further on in this paragraph.

The goals are to create experiences for clients and residents that support their perceived quality of life.

The culture also needs to be open and transparent for the families and give

the opportunity to them to support their loved ones the way they want to do it in co-creation with staff. Shared decision making and shared responsibilities are key elements in an open culture.

Staff need space to make their own decisions based on their professional knowledge and experience in order to customise the support and services to the needs and demands of the client and resident.

LEADERSHIP

In addition to culture, appropriate leadership on all levels is key in bringing the vision into practice.

Leadership that is based on control is not very stimulating in a service culture. Servant leadership gives the example for front line staff how to deal with clients and residents. The way front line staff is treated by their management is guiding the way that front line staff is treating their clients and residents.

Of course, a certain level of control is needed but this should be based on feedback from front line staff about the decisions they make and the activities they choose to carry out to meet the needs of their clients. The management's trust in their frontline staff is fundamental to it all. Better to say sorry one time than to ask for permission ten times.

SHARED VALUES

Shared values are the foundation for a client focused culture. The shared values are:

- Dignity, respect, love and friendship are the key elements of a client focused care and service
- Self-determination: Older people are capable of making their own decisions even when they suffer from dementia. So decision-making authority should be placed with the elderly or as close to the elderly as possible
- SHOW people you care about them, don't TELL them that you care
- Family and friends are part of the care team
- It is about living until the end, not about the end of living.

RECOMMENDATIONS

In order to achieve the vision proposed in this report, the EAN stresses that the process is a repetative one between the national level and the provider levels. So in this section, this report provides a preamble for the national associations and recommendations.

PREAMBLE

The EAN sees it as essential to open a discussion on a national level and find answers to the following fundamental questions to provide a clear, acceptable and sustainable system of social policy and security for the senior citizenry. It is a fundamental task for all national associations to start the discussion and to set the context for the future.

The key questions to be answered in this discussion are:

Responsibilities: who is responsible for the provision of support and care to older people in need: individuals, families, community, all levels of government?

Financing: is there a sustainable funding structure that supports the relevant responsibilities?

Structure: is the resultant structure comprehensive and integrated in addressing needs and is it accessible, equitable, affordable and adequately resourced?

Quality: who determines "quality" and is the quality system in accordance with the answers to responsibilities, financing and structures?

RECOMMENDATIONS FOR PROVIDERS

In addition to the context provided by the answers to the above questions, the EAN makes the following recommendations for providers.

The recommendations are provided at three levels:

- The strategic level
- The organizational level
- The operational level.

Strategic Level

- Aim primarily towards quality of life instead to quality of care
- Position yourself and your staff as experts in life issues for the elderly
- Position yourself primarily as a service organisation (services include care) without denying the health care functions (these are the support functions)
- Aim for prevention and inclusion by setting up programs supporting healthy aging in neighbourhoods prior to a need being formed for professional support and care
- Make a clear distinction between the housing function and the services function in order to create a "home" instead of an institution like a nursing home
- Focus on developing both private and public funding opportunities in order to make the business sustainable in the future
- Choose between the position of being a provider of broad, integrated services or as a creator/moderator of a network with other providers that integrate several functions like housing, transport, medical services, recreation, etc.
- Question and challenge the regulations and existing standards and "the accepted wisdom" to create real innovations

Organisational Level

- Split the organisation into a "housing and services" component and a "health care" component. The latter can be transformed into health centres for older people that also work in neighbourhoods on initiatives directed at prevention
- Use modern human resource instruments to raise the attractiveness of jobs in the care sector and your organization and support the responsibilities and empowerment of care workers. Your employees are central to your success
- Develop service quality concepts next to quality of care-concepts.
- Give clients a structural influence in the provider organisations by creating client/family

"councils" for example that advise on strategic, organisational and operational issues

- Focus on lifestyle and personal history instead of care needs to attract residents/clients

Operational Level

- Ensure that staff working in the fore front are primarily service/hospitality oriented with professional health care staff to support them
- Give social workers a key role in the coordination of services around the client
- Create co-creation with family by facilitating shared decision making and mutual responsibilities in the support of the client
- Use technology to:
  - Support the decrease of the intensity of staff but not as a replacement
  - Increase the safety and autonomy of the client
  - Increase the time staff and informal carers have available for informal care.

POLICY POINTERS

EAN has issued its vision on long-term care in 2030. The vision has been developed by dedicated EAN members and has been endorsed by the Board and General Assembly.

The EAN LTC 2030 Vision identifies and marks significant changes in LTC provision in the future. The Working Group concludes that:

- Governments are in denial. They are delaying a real emerging societal crisis and need to undertake a critical re-appraisal of their policies and strategies;

- Business is failing to play a positive and constructive part in realising and addressing opportunities and challenges presented by the challenges and the needs of the elderly;

- The aged care sector continues to relax in its traditional "comfort zone" of government support, is failing to meet the challenges and opportunities of the changing environment and risks becoming unable to remain viable unless it re-invents itself; and

- Society overall faces major threats to social cohesion unless a more inclusive and "normative" philosophy emerges.

PRACTICAL IMPLICATIONS OF THE EAN LTC 2030 VISION

The Working Group identified following practical implications of this vision on the future of LTC in Europe:

- Older people or their families can decide for themselves very well so we need to focus on them as a client that we do not do things to, but for and with them. That means that we have to create a service quality culture instead of a culture where we think that we know what is good for them.

- Elderly care is not aiming towards quality of care but towards quality of life. Quality of life is the value that we are striving for, for our clients. We want to have happy older people instead of paperwork on subjects that have nothing to do with the quality of life. Quality is formed in the interaction between people and not between papers.

- Focusing on social support and services. Health care is a secure element in the background but is not the dominant element in the services and support for older people. Therefore, we are "life assistants" and a new role for nurses and doc- tors support quality of life.

- Life of older people is the domain of EAN members and not only when people are in need of care. That means that

prevention is an element that is part of our support and services to maintain the health of the elderly. This approach prevents the increasing demand of support and care in later stages of life.

• Support and services for older people is not a cost factor but an economic opportunity with job creation and technological and social innovations.

• All the care elements as we know them today are important in the current and future system. Thus, we need home care, ambulant care, respite care and residential care and also other various housing models and support services.

• Elderly care providers must think outside the walls of their own facility and services but need to try to organise and manage a network that is integrated in local communities.

POLITICAL IMPLICATIONS OF THE EAN LTC 2030 VISION

In a working session along the EAN General Assembly of April 2019, EAN members discussed political implications of the EAN LTC 2030 Vision. Although they recognise the national and even regional differences and difficulties and also financial constraints, EAN members mentioned following issues to be further develop and to be addressed at a political level:

End of silo-thinking

Discussing the future of LTC in Europe should be freed from thinking in terms of silos and dogmas. There are plenty of paradoxes (literally, a statement or proposition which, despite sound reasoning from acceptable premises, leads to a conclusion that seems logically unacceptable or self-contradictory) that hamper re-shaping LTC: European vs. national competences, state vs. market, public vs. private, social vs. care, formal vs. informal, residential vs. community e.g.

Individual choice and personal freedom

One size doesn't fit all anymore. LTC in Europe has been shaped along the lines of large stereotyped cohorts of people: the ill and the old, and those that can and those that can't financially bare the burden. Solidarity – financially, socially, generationally – is at the core of EU health and elderly care systems. But "solidarity" has to be re-defined and adapted to the individual needs and preferences of the users of health and elderly care on the one hand and to financial arrangements on the other. Solidarity should no longer be used as an excuse to block innovations and the promotion of free choice.

Training & education

Perceptions of quality of care and of quality of life, and the way they are promoted, may have an impact on the way care professionals are educated and trained. Professional carers of the future should be trained less in medical, and

more in social dealings. Also, to recruit and to retain professionals curricula and requirements should be adapted to the new service-oriented professionals.

Data & ratios

Too often, health and elderly care are based on data and ratios: number of beds per inhabitant, professionals per bed, costs per patient, patients per institution etc. It is questionable whether these data are correct and/or relevant for the future delivery of elderly care and for the realisation of quality of life of older persons. Because policies are based on these data and simplified ratios, policies do not respond to underlying needs of older persons.

Tasks & responsibilities

Elderly care today is reduced to a set of tasks and responsibilities. It seems like the best quality care is related to the highest number of defined tasks and responsibilities. Instead of delivering true services to older people, professionals seem to only perform tasks and to fulfill tasks for management. Red tape and bureaucratic procedures challenge personalised care and create a mentality of delivering tasks instead of delivering service.

Safety

Ageing is not a disease, but a stage of life – with all inconveniences and risks that come with it. Frailty means a greater risk of falls, physical disorders and hence, the occurance of accidents. Elderly care nowadays is too much focused on avoiding accidents and minimising risks, leading to presumed good quality of care, but less of quality of life. Safety regulation in nutrition, living environments and activities seem to limit the promotion of quality of life.

Image

Politically, health and elderly care are framed as a cost factor and as a financial burden, and not as an investment. This negative framing of the sector harms its image, which negatively reflects on the willingness to work, invest and "live" in the elderly care sector. There is a need for positive approach, wording and attitude towards the sector.

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