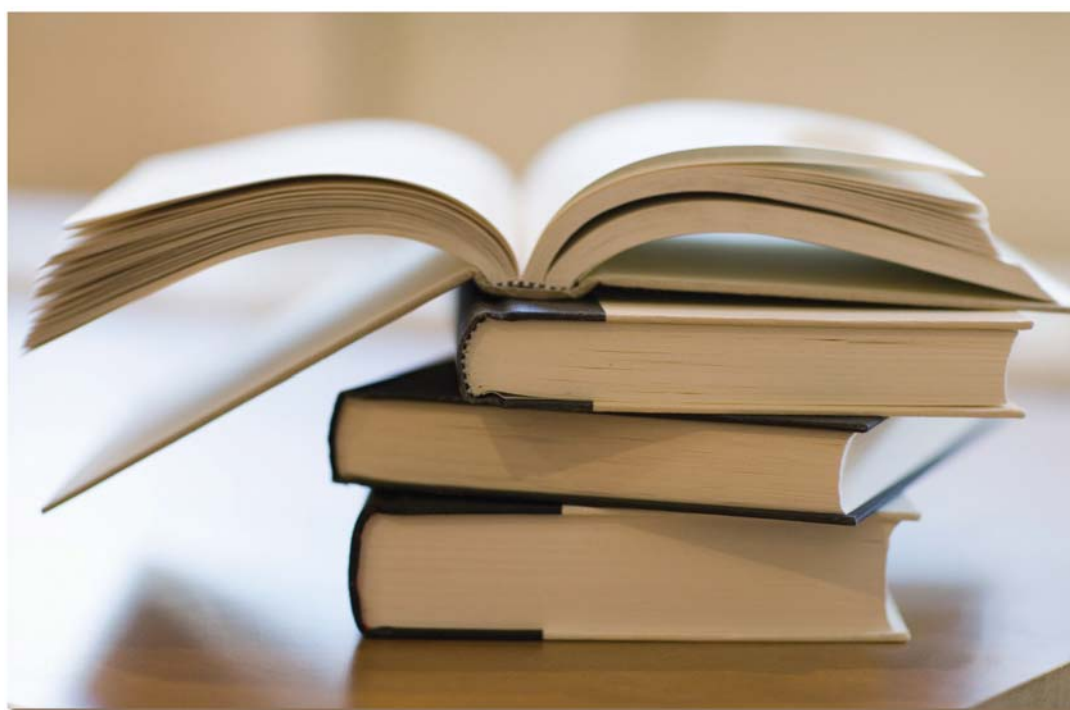


Ageing health workforce

Ageing patients



Ageing health workforce Ageing patients

Multiple challenges for
hospitals in Europe

REPORT ON HOPE AGORA

HOSPAGE BERLIN
12-13 June 2012



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FOREWORD

HOPE, the European Hospital and Healthcare Federation, is an international non-profit organisation representing national public and private hospital associations and hospital owners, either federations of local and regional authorities or national health services. Today, HOPE gathers 35 organisations – national hospital associations, national federations of local and regional authorities and national health services – coming from the 27 Member States of the European Union, Switzerland and the Republic of Serbia. HOPE mission is to promote improvements in the health of citizens throughout Europe, high standard of hospital care and to foster efficiency with humanity in the organisation and operation of hospital and healthcare services.

One of the major objectives of HOPE is to support the exchange of knowledge and expertise in Europe. To this end, since 1981, HOPE organises the Exchange Programme, four weeks abroad targeted to hospital and healthcare professionals involved in management. The programme aims at leading a better understanding of the functioning of healthcare and hospital systems in Europe. Each year, a different topic is associated to the programme. At the end of the four weeks, participants gathered by country of destination work together to prepare a presentation about what they have learned. During a final conference, hosted and organised by a HOPE Member, the annual topic is discussed and participants show their findings, underlying what they have discovered and learned about their hosting country.

In 2012, the HOPE Exchange Programme has reached its 31st edition. In this rather long history, the chosen topics have always mirrored needs and priorities of hospitals and healthcare services in Europe. During the last years, some of the hottest topics and most important innovations in the hospital and healthcare systems have been investigated: the role of IT (2008), new roles and skills of health professionals (2009), the efficient and effective management of chronic conditions (2010) and the way the relationships between hospitals and the other components of the healthcare system can be improved to ensure the wellbeing of population (2011). Participants of the HOPE Exchange Programme 2012 dealt with another broad and complex topic, which embraces and challenges all European countries, especially in this time of crisis. Indeed, they were invited to explore and report about issues, opportunities and solutions arising from the increasing ageing of population and healthcare workforce.

The findings of the 31st HOPE Exchange Programme and the broad topic of “Ageing health workforce - Ageing patients” were extensively discussed during a one-day conference held in Berlin on June 12 and an evaluation day on 13 June 2013, hosted by the German Hospital Federation.

The two days, which opened with a scientific policy conference HOSPAGE, gathered around 250 participants among national and local coordinators, HOPE members, guests and participants of the HOPE Exchange Programme, benefited from the contribution of many important subjects: notable representatives of the international research and policy organisations – such as the European Observatory of Health System and Policy of the World Health Organization (WHO) and the European Commission –, outstanding personalities from German politics – such as the Ministry of Health and the German Parliament –, experts from international organisations – such as the International Hospital Federation (IHF), the European Social Insurance Platform (ESIP), the European Patients’ Forum (EPF) and of course the European Hospital and Healthcare Federation (HOPE).

The present report illustrates the contents and findings of the HOPE Agora 2012. Mainly following the structure and contents of the first day conference, it goes through the debates and results and gives notice of the solutions and situations identified by the HOPE Exchange Participants. It complements and completes the Reflection paper “Population aging and the role of hospitals” prepared by Mr. Bernd Rechel, from the WHO European Observatory on Health Systems and Policies, on purpose for the event.

The HOSPAGE conference was divided in three parts: an opening session and two parallel sessions.

The plenary session had prominent contributions from:

- Mr. George Baum, President of the European Hospital and Healthcare Federation (HOPE) and CEO of the German Hospital Federation;
- Mr. Daniel Bahr, German Minister of Health;
- Mr. John Dalli, European Commissioner for Health;
- Mr. Tom Dolan, President of the International Hospital Federation;
- Ms. Prof. Rita Sussmuth, former President of the German Parliament;
- Mr. Josep Figueras, director of the WHO European Observatory on health systems and policies;
- Ms. Iglesia Gomez, European Commission;
- Mr. Franz Terwey, President of the European Social Insurance Platform (ESIP);
- Mr. Anders Olauson, President of the European Patients' Forum (EPF).

The parallel session on "Ageing health workforce" had contributions from:

- Prof. Juhani Ilmarinen, Juhani Ilmarinen consultancy
"Safeguarding work efficiency of aging health workforce in hospitals";
- Ms. Eva Weinreich-Jensen, Danish Regions
"Who cares for ageing health workforce? Managerial perspective of hospital owners";
- Prof. Walter Sermeus, Catholic University of Leuven and coordinator of EU-funded project RN4cast
"Forecast the need for nurses - the RN4cast project";
- Ms. Caroline Hager, European Commission
"Action plan of the European Commission on health workforce".

The parallel session on "Ageing patients" had contributions from:

- Dr. John M. Cachia, Past-President of HOPE, Commissioner for patients' rights, Malta
"Requirements and entitlements of ageing patients – the Maltese Example";
- Mr. Bozidar Voljc, AGE-platform Europe, Slovenia
"Demographic change in patients' needs – a European perspective";
- Ms Prof. Elisabeth Steinhagen-Thiessen, Charité Hospital, Germany
"Typical problems of geriatric patients in hospital".

A further presentation "Trend or Taboo – what about the reconciliation of work and care?" was given by Ms. Anine Linder, project manager of "Network Success Factor Family", Germany.

1. INTRODUCTION

The literature available tells us that the demographic development, result of increasing life expectancy and decreasing fertility rate in more or less all European countries, will produce a higher health consumption and will translate in higher periods in retirement, at least if measures and interventions are not taken by governments. Hence, ageing citizens are likely to require more health and social workforce, doctors and care-givers as a whole. But healthcare workforce is ageing as well posing two strains of problems, a generational one and a gender one. First of all, if population in Europe is ageing, there are less and less new generations able to take care of the older ones. Secondly, more and more women, who once assumed the role of informal carers, are fully involved in the working population. They find it difficult to take also the role of care givers within the families towards older relatives.

Moreover, this situation also challenges the healthcare systems in two directions. From the financial side, increasing health consumption and inactive population shrink health financing, while expanding health expenditure. From the organisational side, the demographic changes lead to an increasing need of long-term care, but a reduction in formal and informal care-givers at any level.

Then, is better health (increased life expectancy), besides being a societal success, also a fiscal failure? This is one of the provocative questions left open by Josep Figueras, from the WHO EU Observatory while discussing myths and realities of evolving patterns.

The topic is relevant, now more than ever, and calls to action at all possible levels. At European Union level, the Year of Active and Healthy Ageing and the European Innovation Partnership on Active and Healthy Ageing, as highlighted by the European Commissioner John Dalli, follow the overarching objective of fostering share of knowledge and smart investments in health, addressing the actual and changing needs of patients and population. At the same time, the Action Plan for the EU health workforce - adopted as part of the Commission Communication for a job rich recovery in Europe - aims to assist Member States to tackle the challenges posed by an increasing need of health workforce in times of economic and financial constraints and sets out actions to foster European cooperation and share good practice to help improve health workforce planning and forecasting, to anticipate future skills needs, to improve the recruitment and retention of health professionals while mitigating the negative effects of migration on health systems. At national as well as at local level, initiatives are multiplying towards both improving working conditions for health professionals and improving well being conditions of population, through actions aimed at improving prevention and promoting healthy lifestyles, increase and improve workforce planning and reduce unnecessary hospitalisation. The need and importance of learning from each other, foster innovation to counterbalance the effects of ageing health workforce and get to know and exchange good practices are deemed more and more important and all contribution to the discussion are valuable.

THE EUROPEAN PARTNERSHIP ON ACTIVE AND HEALTHY AGEING (EIP-AHA)

INCREASE THE AVERAGE HEALTHY LIFESPAN BY TWO YEARS BY 2020

Action in three areas:

- prevention and health promotion,
- care and cure,
- active and independent living of elderly people.

A positive vision on Ageing:

- from burden to asset
- from passive care to active ageing
- from curing diseases to improved functioning

Added value :

FACILITATING SCALING UP & MULTIPLYING

JOINING UP
RESOURCES
&
EXPERTISE



BRIDGING
GAPS
&
SPEEDING UP
INNOVATION
PROCESS

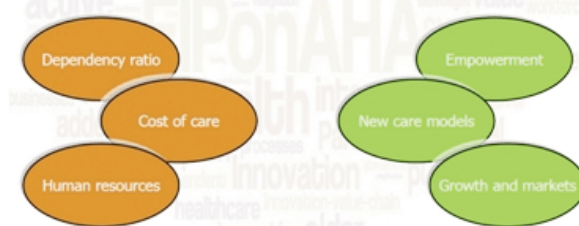
IMPROVING FRAMEWORK CONDITIONS

European Innovation Partnership Active & Healthy Ageing

Why?

Ageing also offers great prospects!

From **social challenge** to **major opportunity**



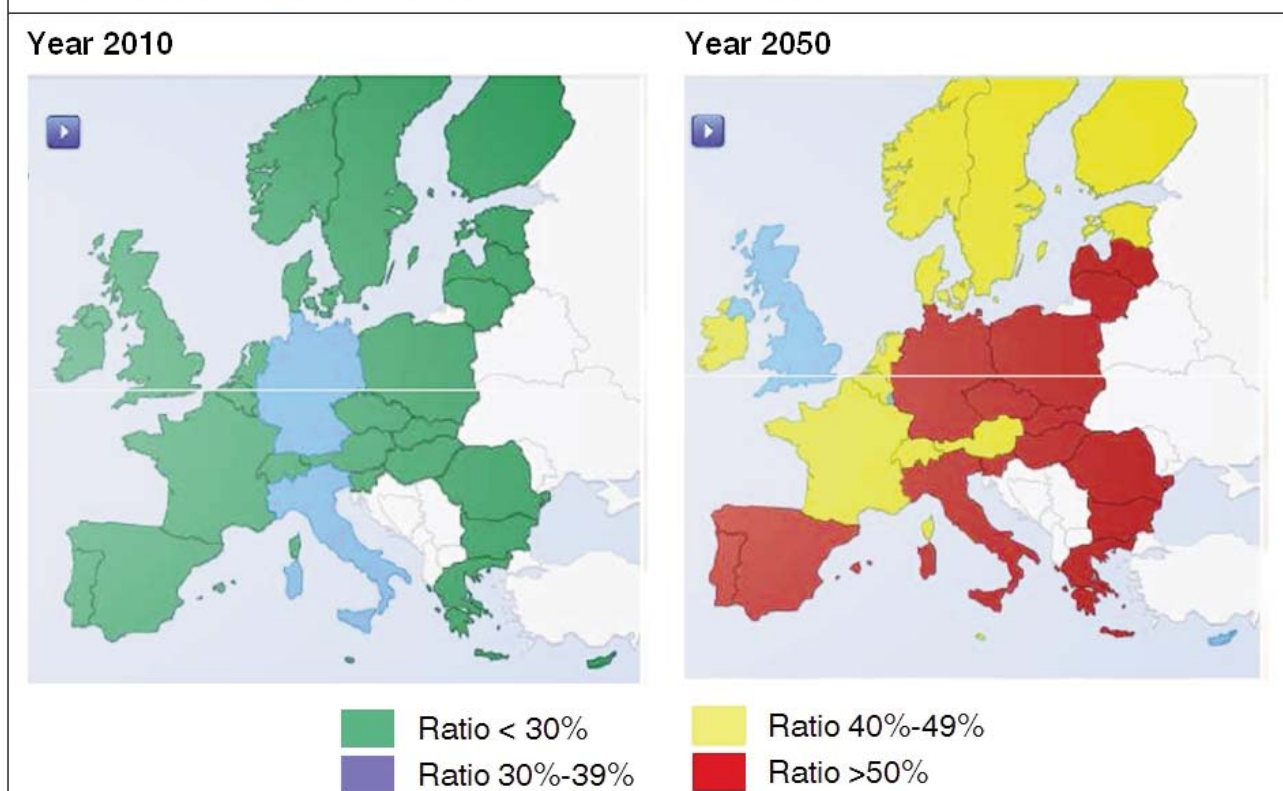
Triple win for Europe:

- enabling EU citizens to lead healthy, active and independent lives while ageing;
- improving the sustainability and efficiency of social and health care systems;
- boosting and improving the competitiveness of the markets for innovative products and services, responding to the ageing challenge at both EU and global level, thus creating new opportunities for businesses.

1.1 EVIDENCE FROM THE LITERATURE

Some objective figures can be analysed and were discussed by Mr. Figueras during the HOSPAGE conference. The question behind data refers to any presence, and the threatening level of a “demographic bomb” and a “pathology bomb”.

Fig. 1. Old Age Dependency Ratio in EU 27. Source: EUROSTAT

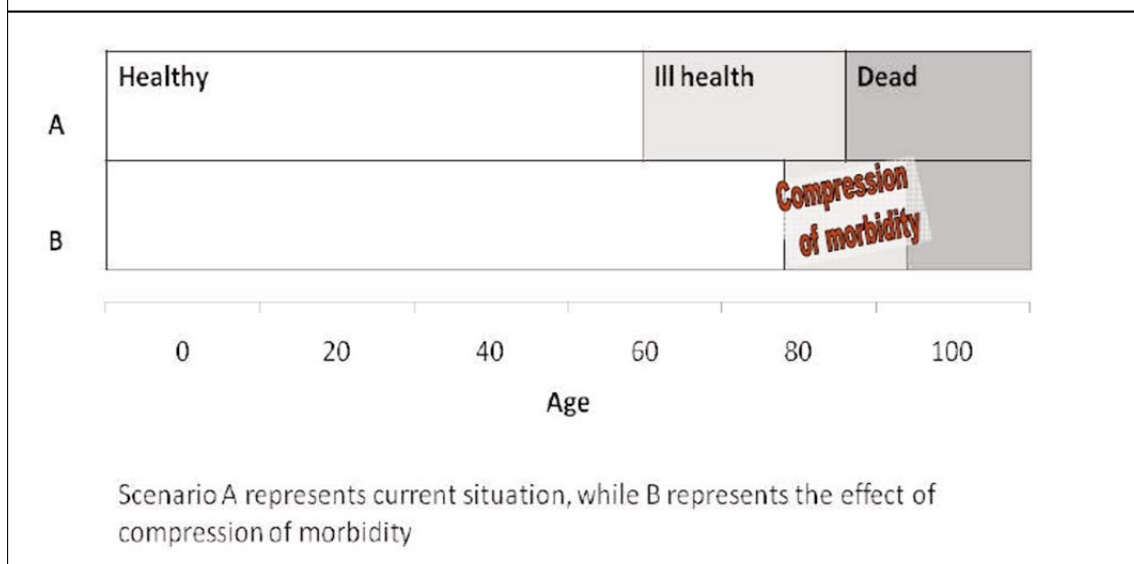


Life expectancy of population, and lower birth rate, are leading to a big change in the proportion between active and inactive population. The Old Age Dependency Ratio (Fig. 1) represents the proportion of population aged 65+ relative to population aged 15-64 (active population). Today, this ratio is lower than 30% in all Member States of the European Union except Italy and Germany. In these two countries the proportion between active and inactive population, as measured by this indicator, is already 3 to 1: there are three persons of working age for every pensioner. By 2050, in almost all countries of the EU27, the rate of working aged people to pensioners will be higher than 50%.

Chronic diseases represent the higher burden for population, in terms of care and financial costs¹:

- chronic diseases represent 86% of all causes of death and are the main cause of disability/lost of healthy life (disease burden);
- the disability-adjusted life year (DALY) – that is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death – for non-communicable disease are about 115 per year;
- healthcare costs associated to chronic conditions are estimated between 1 to 6 % of GDP in Europe;
- cardiovascular diseases account for 7 to 15% of total healthcare costs;
- diabetes accounts for 2,5 to 15% of total healthcare costs;
- multiple chronic conditions can be even more than 5 after 60 years old;
- people with dementia is projected to more than double in Europe between 2010 and 2050, representing 3,3% of the total population and 10,1% of the population over 65 years.

Fig. 2. Current situation vs compression of morbidity. Source: WHO European Observatory.



Despite the large differences between and within countries, overall data also show a decrease in severe disability, and increase in mild disability. So people tend to stay healthier for longer, living for fewer years in poor health conditions. If this is true, and we are going towards a compression of morbidity, as shown in fig. 2, then two considerations about capacity and financial resources can be made:

- hospital utilisation: between 2008 and 2030 hospital cases are projected to increase from 17,9 million to 19,3 million in the current scenario, but only to 18,3 million in case of “compression scenario”;
- impact of ageing on health expenditure: projections 2008-2060 show that health expenditure is going to increase on average by 1,5% of GDP; nonetheless, the increase is estimated by 0,7% of GDP in the hypothesis of longer life expectancy in good health².

It is not only a compression of morbidity but it has been defined by Figueras as a dynamic equilibrium: more people suffer from chronic diseases and disabilities, but, at least in principle, we are able to cope with it better. We are not going to live longer, to suffer even longer.

But, what does it mean for hospital utilisation? And how does it affect the current pattern of care? Do we still run hospitals as if we have normal, predictable patterns of care?

And how healthcare costs are really affected?

The costs associated to care and to the utilisation of health services are estimated to be higher in the last year of life, but, in general, to decrease with the older population. It is estimated that per capita consumption of health services by elderly people is 3 to 5 times higher than for young people, but there is also increasing evidence of discrimination in allocation of more costly interventions based on age. The costs of technology have been representing so far the majority of healthcare costs, and are likely to continue being high. The thing is that prevention, good health and ageing well, community services and long-term care, if and when properly developed, help to reduce acute episodes and so the impact on the utilisation of hospital services. Do, in the end, hospital pay the financial and societal cost of broader failures in the health systems?

And what about healthcare ageing workforce?

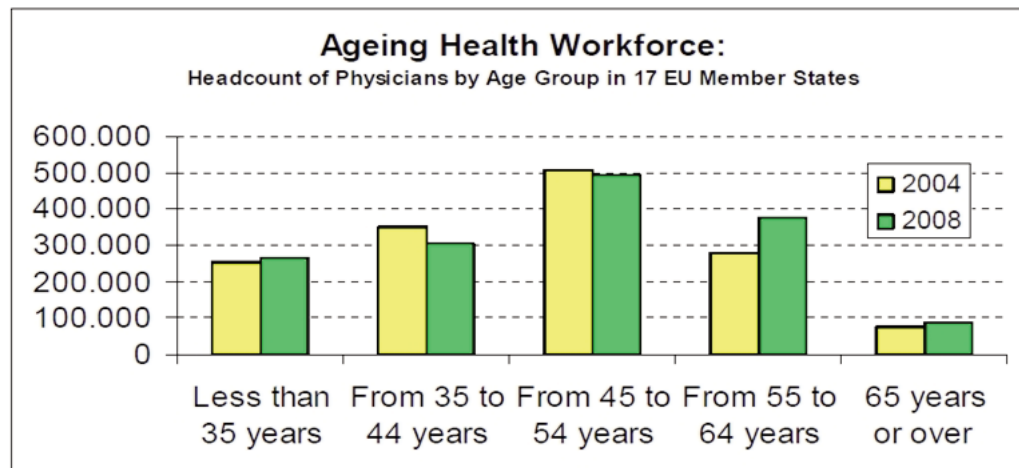
Healthcare workers represent about 8% of total workers in the European Union. Healthcare is in fact a highly labour intensive sector. Data from EUROSTAT show that between 2000 and 2010 the number of jobs in the sector increased by 21%, and even during the economic crisis, in the period 2008-2010, employment in healthcare grew by half a percentage point, creating more than 770.000 new jobs, while overall employment fell by 5 million³. Moreover, as highlighted by Ms. Caroline Hager from the European Commission, between 2010 and 2020 more than 1 million new jobs are expected to be created, plus about 7 million additional job openings due to replacement needs.

But, in the next decade, the issue of ageing population poses new and big challenges:

- the demand for healthcare is going to increase dramatically;
- long-term care and formal institutionalisation patterns are going to be more requested because of the reduction in informal carers and change in family structures as well as because of the increase of multiple chronic diseases and rising need of palliative care;
- critical workforce shortages – especially in certain health professions and medical specialisations or geographic areas – will be faced and could be exacerbated if no action is taken.

In fact, one of the main issues for the period to come is the retirement bulge, which is drastically shrinking the EU's healthcare workforce (Fig. 3a).

Fig. 3a. Number of physicians by age group in 17 EU member States in 2004 and 2008. Source: European Commission Action Plan for the EU Health Workforce.



Source: Eurostat, 2011. Absolute numbers. Data available from 17 MS: AT, BE, CZ, DK, DE, ES, FI, FR, HU, IT, LV, LT, NL, RO, SK, SE, UK – note that for F, NL and IT data refers to professionally active doctors who may or may not have direct contact with a patient.

In 2009, about 30% of all doctors in the EU were over 55 years of age, and by 2020 more than 60.000 doctors or 3,2% of all European doctors are expected to retire annually. Based on data collected by some Member States the average age of nurses employed today is between 41 and 45 years.

Apparently, not enough young recruits are coming through the system to replace those who leave. Indeed, in some countries, ageing of the workforce means that the rate of retirement is already outpacing the replacement of the workforce. On the one hand, there is a shrinking supply of candidates entering training, on the other hand, different public employers, different sectors and different countries are increasingly competing for the same workforce and skills⁴.

Besides, but also interlinked to demographic challenges, some further issues deserve to be mentioned while discussing the future healthcare workforce shortage:

- new patterns of care, specifically long-term care, palliative care and chronic care, will require new different and broader skills for health professionals;
- technological and medical progress will open up new opportunities to compensate for shortage of professionals (through eHealth and Telemedicine), but will also require new and differently skilled professionals with a technical know-how in addition to clinical knowledge to work with them;
- mobility of healthcare professionals, reliance on foreign healthcare workforce for some countries and “brain drain” in other countries.

1.2 HOW TO COPE WITH IT?

Given the number and complexity of factors involved, it is not easy, and not possible, to forecast a trend in healthcare utilisation and expenditure (fig. 3b).

Fig. 3b. Evolution of cost scenario. Source: WHO European Observatory.

Factors affecting lifetime health care expenditures	
Factor	Impact on expenditure
Less disease and disability at a given point in time	Decrease
Additional years of life (degree of cost increase depends on health status and the extent there is compression of morbidity)	Increase
New more expensive future technologies	Increase
Lower acute health-care costs of dying at older ages	Decrease
Higher long-term care costs of dying at older ages	Increase
Overall effect	Unknown

Source: Figueras and McKee 2012

Health Systems and Policies

Fully reliable and comprehensive information is not available today concerning the future needs of workforce.

Some indications and suggestions involve the general economic policy, together with labour, health and social cohesion policies. At different degrees, all European countries are going towards an adaptation of the working life to the average life expectancy of population, with the double effect of increasing productivity and economic contribution (late retirement) and increasing social contribution. Looking at older persons not as social burdens needing care, but as resources by incentivising volunteering and “active ageing”, helps ageing well and social integration. It could also help to cope with shortfalls in health workforce. The healthcare system should be adapted to the dynamic changes, especially strengthening health promotion and prevention, and enhancing integrated care at all level.

However, in general, as highlighted by Ms. Sussmuth, former President of the German Parliament, a new way of thinking needs to spread across Europe, involving in particular European policy and decision makers. There is a need of anticipating the future both for health professionals and for patients, seeing both of them as citizens requiring conditions of well-being rather than older persons requesting care, if not cure.

Hence, the new policy actors need to be a generation of pioneers, able to think out-of-the-box. The problem of ageing population and ageing workforce cannot expect to be just solved thanks to migration. International recruitment may be a faster and cheaper solution for problems such as domestic underproduction, inadequate skill-mix or geographical misdistribution but it does not resolve the underlying causes of workforce problems, and foreign health professionals may not fill the “right gaps”⁵. Social networks of policy actors and active population need to be strengthened, including both young and older ones. Population itself needs to be committed in finding a new way of living, the different generation need to be committed in finding a new way of cooperating. On the other side, research should not only follow the system strain, but also look at human needs and requirements. Healthcare workforce should be looked at as a source of value, which is different at different ages, in this way.

Data are not yet telling much about future skills that medical and paramedical staff will need, but they are already telling something about the needs of people, about their job and working conditions, about the need to look for the potential of people and fostering continue long-life learning and re-learning. It is not only progress in medical technology that matters, but also trust and relationships in the society.

The key message that can be drawn is that population ageing and ageing workforce - representing the crucial issues for the next decade - despite being purposely tackled through specific and aimed strategies, are somewhat linked and twisted problems, somehow they get to trigger one another and for this reason they need to be consistently analysed, correlations must come to light and different solutions must in the end follow a sound and coherent pathway.

2. AGEING HEALTH WORKFORCE

The first parallel session of the conference on the topic of “Ageing health workforce” was opened by Prof. Juhani Ilmarinen (Juhani Ilmarinen consultancy) who gave an overview of the change of work ability across life and highlighted some elements – such as work arrangement, continue training, flexibility, promotion of alternative lifestyles, fair treatment – that improve work ability and satisfaction in older professionals reducing absence rates and work disability and increasing productivity.

Then, Eva Weinreich-Jensen (Danish Regions) gave the perspective from a regional authority. Focusing on skills, not on age, considering age and experience a resource, not a weakness and then evaluating options to adjust the job when relevant, are the answers to changing needs of patients and to professional patterns more adapted to the changing needs of the workforce.

Prof. Walter Sermeus (coordinator of EU-funded project RN4cast) illustrated some findings of the project RN4cast aimed at forecasting the future needs of nursing staff in Europe and in the United States. Despite the large variability across hospitals and health systems, the project results show that perceptions of nurses and patients about hospitals are related, does exist a high consistent relationship between working environment and indicators of job satisfaction (burnout, intention to leave) and nurse staffing has a significant impact on patient outcomes (mortality) in 9 European countries.

Finally, Ms. Caroline Hager (European Commission) illustrated the Action Plan for the EU health workforce. Pursuing the aims of improving workforce planning, anticipate skills needs, increase recruitment and retention, foster international ethical recruitment the action plan foresees better cooperation between Commission, Member States, stakeholders and social partners, better coordination across policies and an increasing use of European funds across these actions.

Findings presented by HOPE Exchange Participants

PRODUCTIVITY / GENERATION MANAGEMENT

In **Austria** ageing workforce **is not a problem of figures but of managing healthcare workforce.**

Physicians are theoretically enough:

- 468 per 100.000 inhab. (average in EU 27: 330)
- Demand for compensating retirements 2025: 17.000 (39%)
- Estimated number of graduates until 2025: 20.000
- Dynamic development of highly qualified workforce in hospitals (higher medico-technical services, qualified nurses, doctors, midwives, nursing assistants)

But:

- Uneven geographic distribution
- High migration trends
- Low attractiveness of geriatric speciality and general practice
- Many doctors stay outside public HC system
- Lack of information on workforce age, data, studies and action plans in preparation

If elder patients are treated predominantly in hospitals, Austria will need even more hospital capacity

Answer: the **project “Productive ageing”** moves from the assumption that productiveness is not about age but about the organisation and management, so it works on:

- improving capacity of work and professional challenges until a late age of work, combining work ability and workplace surveys;
- fostering dialogue between generations and between different providers of the Health Care System.

In the **Netherlands** the **Personal Life Phase Budget** has been introduced in 2010 by the collective agreement for hospitals. With the personal life phase budget, each year an employee receives a certain number of hours of additional annual leave. Employees can save these hours and use them when they find it necessary in their life phase. They can decide for to work less. In this way, employees can shape their careers to their own wishes and needs. Moreover, through the life phase arrangement employees can save parts of their gross salary for a period of unpaid leave.

In **Switzerland** attention to working conditions means flexibility of work-time and work flow for ageing workforce, competitive salary and health promotion. **Generation management** embraces:

- diversity management: focus on age differences and individual situations of life, i.e. night shift markets;
- health management: attention to sick leaves and safe return to work;
- transfer of knowledge: mentor programmes, job sharing, career plans at 50+, follow trends in staff mix.

In the **United Kingdom** the **quality Act 2010** is the law that bans unfair treatment and helps achieve equal opportunities in the workplace and in wider society. Within the boundaries of the Act, positive action which treats people differently according to their age is allowed. This is when the action being taken prevents or compensates for disadvantages experienced by, or meets the particular needs of, such age groups; or when it encourages people from particular groups to take advantage of opportunities when underrepresentation has been identified.

RETENTION

Belgium experiences problems with recruitment and retention of nursing and medical staff because of work life balance, being this one a female-dominated profession. Solutions found include the following.

- Additional annual leave at 45 - 55 - 65 for nursing staff
- Retraining and allocation of another post if unable to fulfil due to sickness episodes
- Healthy employee schemes – sports, massage
- Newsletter – health information / guidance

In **Hungary** the high rates of migration have negative impacts on the health system as a whole.

- More than 50% of medical doctors are more than 50 years old
- Current workforce delays retirement
- No return in education investments
- Generation gap: loss of expertise
- «Brain drain» effect, produce health professionals is very costly if not looked at in the long run. If brain drain is not stopped it will only be expensive, but there will not return on investment.

Solution pass by different pathways.

- Produce more health professionals, increasing the number of students in general, mainly nurses, GPs, anaesthetics, radiologists, neurologists...
- Reduce emigration and/or enhance return to Hungarian labour market by increasing wages, improving job conditions (working hours, administrative burden...) and developing European exchange programs with return commitment.
- Strengthen workforce in primary care improving the current situation of GPs and making easier the access of new GPs.
- Training
 - Information & Communication Technologies
 - Nurses & Allied workers to develop delegated tasks
- Reorganise workforce
 - Redistribute current health professionals following a new design of hospital system and other facilities (nursing homes)
 - Increase delegation from physician to nurses & allied workers
 - Eliminate informal payments
 - Introduce public campaigns for proper use of health services

In **Lithuania** problems are linked to:

- Health System highly dependent on working pensioners, physicians in particular continue working after retirement
- High dependency from female activity: 85% of healthcare workforce are women
- 3 different and non-communicating Health Human Resource databases
- Lack of free training courses
- Internal migration to the big cities
- Decreasing number of High-School students (drop out rate of Health Sciences students by 25%)

Needed intervention concern:

- Investigating the reasons why medical and nursing students drop out, assessing the number of Primary Care GP's needed until 2025 and the need for new admissions in Health Science Studies
- University psychological support for Health Sciences students
- Audit Units to get feedback from professionals to improve the quality and safety of Health Care

The strain on which it can be worked in the future are:

- A single National Register System for Healthcare workforce
- Bigger investment in training programmes for the ageing workforce
- Measures to attract Healthcare workers who have left the system, and retraining programmes

In **Slovenia** lack of workforce is not a problem today, but will be experienced in the following decades, especially with regards to physicians and anesthesiologists. Good practices and future challenges include:

- Make it attractive to work for the organisation
- Flexible and well equipped workstations
- Flexibility in job description, in particular changing of job description due to age, e.g. people in risk management, in simulation centre, in complaint dept
- Keeping retired physicians in the workforce in reduced hours
- Increasing the numbers of medical staff in community
- Reorganisation of work schedules
- Combining teams to consist of both young and senior workers
- Dividing workday with a longer break

IMPROVING HEALTH/WORK ENVIRONMENT AND WORKING CONDITIONS

In **Belgium** changes introduced to support healthcare professionals include re-training for other roles to prevent or face stress and risk of burn out and healthy employee schemes to support wellbeing of employees.

In **France** the bimonthly commission for individual counselling employees in the Hôpital Nord Ouest – Villefranche sur Saône – has the role of identifying employees with health problems, gathering the information needed to assess their situation, searching for a solution, so that the employee can continue working and implement the solution. Composition: occupational physician and occupational nurse, director of human resources, director of patient care, social worker, responsible organisation training.

In **Germany**, strategies and actions to improve working condition include:

➤ Facilities and Promotion

- Good wages
- Better image
- Good education
- Accommodation
- Children day care

➤ Health Programmes

- Healthy food
- Accident prevention
- Lifestyle coach
- Physiotherapy, Ergo-coach, Lift-techniques
- Fitness and sport-clubs
- Job-place analysis

➤ Triple win migration

- Migration from partner lands
- Know-how transfer
- Personnel development

In the **United Kingdom**, strategies implemented include:

- Lifestyle intervention programmes
- Long term workforce planning
- Occupational Health
- HR redeployment register
- Pre-retirement courses
- Healthy Working Lives programmes
- Flexibility

NEW ROLES/SKILLS

Switzerland has introduced:

- ➔ Improvement of educational system with pre-nurse programmes and Bachelor and Master programmes for nurses
- ➔ Skill and grade mix. Integration of the new nurse discipline to the nurse concept, focus on competence, delegation and interdisciplinary teamwork, it match the needs of the organisation and allows staff satisfaction in tasks and development.
 - Five professional profiles for delegation and responsibilities in nursing
 - Tandem planning (matching skill and grade)

INFORMATION AND COMMUNICATION TECHNOLOGIES

In **Switzerland** IT-solutions like Telemedicine and video conference and other eHealth tools relieve the burden of physicians and help to shift responsibilities towards nurses.

In **France** some changes consist in the empowerment of patients through the use of technologies, in order to alleviate duties and burdens of professionals. In Toulouse two eHealth solutions deserve to be mentioned:

- **MEDINEO**. Platform for monitoring elderly people from the hospital to their home in an urban environment.
- **SACHA**. Development and validation of a solution to monitor frail elderly, dependent or demented people, capable of generating functions and warning to detect situations of falling, presence beyond a perimeter of normal life or request help.

3. AGEING PATIENTS

As highlighted in the previous chapter, the demographic and epidemiological trends in all the EU27 Member States show an increasing number of older persons and a reduction in the numbers of new generation people; an increasing importance of chronic disease and multiple chronic conditions as well as increasing mild disabilities rather than severe disabilities, with a consequent shift from acute patterns of care to long-term care, with use of technologies remaining the same and representing one of the most important cost elements of healthcare expenditure.

The policy options that can be delineated include⁶:

- ensuring an adequate response from health systems;
- building adequate systems of long-term care;
- supporting economic and social integration.

In summary, it is needed to develop new and more efficient patterns of care, especially implementing long-term care and geriatric care, but also strengthening primary care, giving more precise tasks and implementing skills of healthcare professionals, and making a better and more effective use of technologies, so that the permanence of patients in the hospitals and healthcare facilities becomes shorter and care is more efficient. It is also necessary to develop new patterns of community care, strengthening home care but also, even more importantly, enhancing promotion and prevention (healthy ageing). Finally, a change of mind is needed which leads to consider older generation as productive ones and to enforce their role in the community (active ageing).

3.1 EFFICIENT HOSPITALISATION: INTEGRATED CARE AND MULTIDISCIPLINARITY

As highlighted by Mr. Božidar Idar Volj Voljč (AGE Platform Europe) - from the Anton Trstenjak Institute of Gerontology and Intergenerational Relations, Slovenia - there is all over Europe a pattern of change that is going to focus on primary care and prevention, overcoming hospital-centrism, improving coordination between hospitals and primary care, and increasing home-care supply after hospital discharges. This change has not been sufficiently realized yet, and some evidence shows that emergencies and specialists still too often are directly approached, there are some problems of communication and exchange of information between different care-givers, and sometimes professionals are not skilled enough to detect and care specific geriatric illnesses and co-morbidities. Senior-friendly hospitals should develop care in accordance with senior organisations and geriatrician should become regular member of hospital teams, so that integral treatment of actual problem and of co-morbidities could be effectively and easily addressed.

The European Commission itself requires to develop patient-centred health care, through effective and safe treatments, that can only be ensured if there is a good coordination between levels of health care, focusing on primary care, as referral system, and support of out-patient care⁷.

Integrated care in ageing has to comprise:

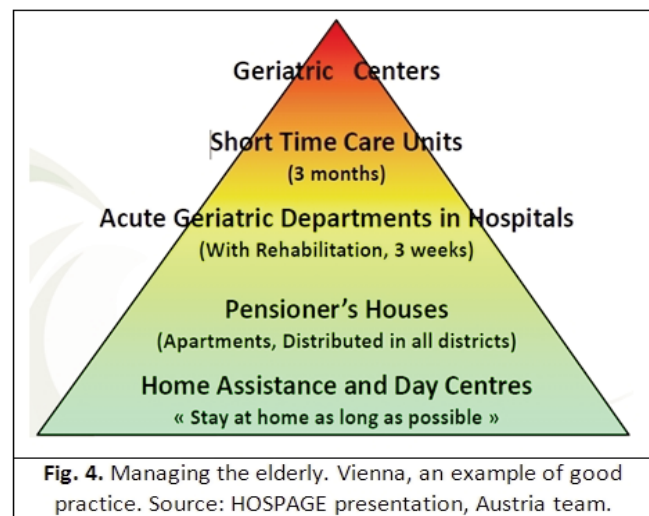
- In-patient long-term care (nursing home)
- Physio/ergotherapists, logotherapists
- Counselling
- Social worker
- Out-patient care
- Nursing ward
- General medicine
- Art and music therapists
- Specialist
- Psycho-social treatment in palliative medicine/hospice
- Pharmacists

In general, more piloting and more testing seem to be still needed to reorganise the system in view of more cost efficiency and more effective multidisciplinary and patient centred care focus on older generations' needs.

Findings presented by HOPE Exchange Participants

In **Austria** the “Fonds Soziales Wien” (Vienna social fund) offers (Fig. 4):

- Integrated gate for orientation
- Guidance through the system,
- Information on services for the elderly



In **Germany** Case Management consist of:

- Continuity of care
- Planning from admission to discharge
- Coordination & linking
- Evaluation & information

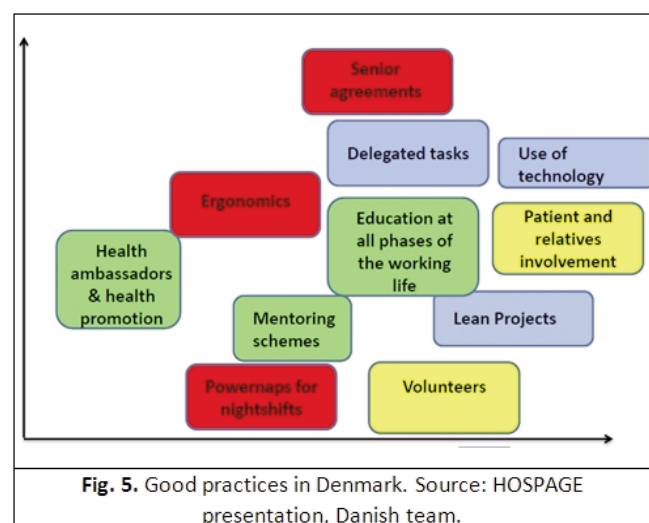
Palliative Care Team offers:

- Treatment plan
- Network with professionals
- No hospitalisation
- 24 hour service
- At home
- Involvement family and doctor

In **Denmark** the strategies to face ageing patients and ageing workforce are correlated and include (Fig. 5):

- Improve processes & innovation (blue boxes)
- Adapt services & increase awareness (red boxes)
- Education (green boxes)
- Involve & empower patients, families and third actors (yellow boxes)

The elements on the left at the bottom require less efforts but have lower impacts. Going towards the rights side, at the top, the elements require more effort, but have higher impact.



The Danish health legislation imposes the regional council and the municipalities to sign an agreement on the handling of the tasks within health and psychiatry, with the purposes of strengthening cooperation between hospitals, municipalities and the general practice and, in the end, ensure continuity of care. Most of the efforts in the health agreements support the challenges of ageing patients.

The **SAM:BO agreement** describes guidelines concerning cooperation, communication, information to patients and monitoring of the quality and is supported by electronic communication. SAM:BO ensures cooperation and continuity of care and has the following characteristics:

- Discharging starts as soon as you are hospitalised
- Continuity and flexibility through dialogue
- Patient involvement
- Flow charts describes what each sector is expected to do before, during and after hospitalisation

As part of SAM:BO there is a special agreement about seriously ill and dying patients. The agreement describes requirements for collaboration, communication and information for these patients and their relatives, particularly focusing on the transitions between sectors. In psychiatry there is a special agreement on dementia intervention in all the cooperating sectors⁸.

Finland has as an objective to improve the linkages between health and social care and providing a continuous pattern of care and prevention starting from the birth towards the entire working life and elder time of a person. An important target is to ensure integration of care, and cooperation among municipalities, especially in education of healthcare workforce.

In Galicia (**Spain**), the **Programme for chronic patients with pluripathology** is a programme for elderly patients involving surveillance and delivery at primary care or outpatient level and multidisciplinary action. Reached impact:

- Reduction of re-admission by 37%
- Reduction of emergency admissions by 43%
- Life prolonged by 9 months
- Shorter hospital stay if re-admitted
- Reduction of costs
- Improvement of interactions between primary care and hospital care

In **Lithuania** primary care results well organised, providing GP, Nursing, Odontologic, Social and Psychologist services, devolving resources to prevention, with five Main National Preventive Screening Programmes and having multidisciplinary teams working together for inpatients and university studies about the future needs in number of homes for elderly people.

The strain on which it can be worked in the future are:

- Better coordination across Primary Care, Hospitals and Social Services
- Implement Geriatric Units in Hospitals
- Promote healthy ageing programmes

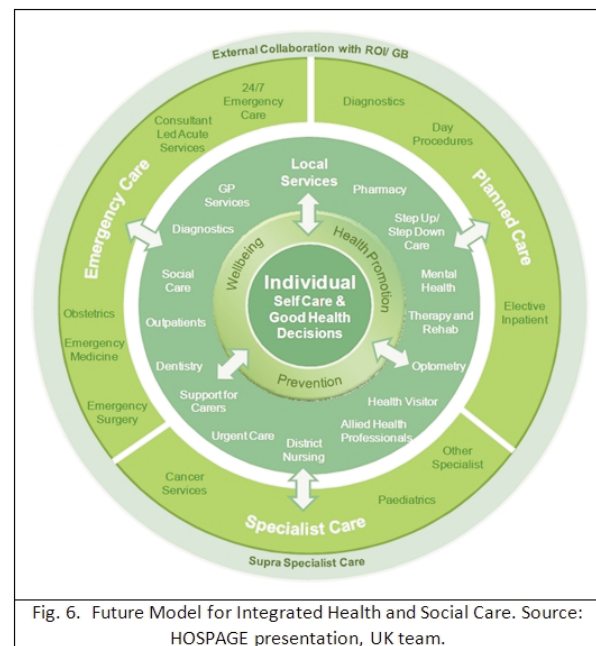
In **Portugal**, strategies are addressed to:

- Identify the group of >65 at risk using scoring matrix and dependency ratios
- Pro-active management: being proactive in the management of complex conditions allows providing timely the most effective treatment
- Coordinating services, which allows directing patients to the right service
- Providing patient centric services giving patients information, tailor made health care and actively involving them in the care

United Kingdom. “Transforming your care” or “Review of Health and Social Care” proposes the development of a model for integrated health and social care, including acute hospital configuration, the development of primary health and social care services, the interfaces between sectors to ensure a strategic, focused and planned approach to the delivery of Health and Social Care which responds to the changing environment. The model places the patient, and not the institutions at the centre, quality of care and patient outcomes are the key factors in shaping services.

The principles of the model (Fig. 6) are that:

- Patients should be better supported to care for themselves and make good health choices;
- Health and social care services should be provided closer to patients, in local areas
- There will be a significant shift from provision of services in hospitals to provision of services closer to home in the community and/or GP surgeries, where it is safe and effective to do so
- GPs are to perform an important role in Integrated Care Partnerships;
- A greater use of technology will be implemented to support the delivery of services.



Emergency Frail Unit. Short stay elderly unit to avoid admission to hospital, through examination of the patients medical, social and overall care needs with the multidisciplinary team. It is designed for patients over 65 years, frail, vulnerable or potentially at risk but in no life-threatening condition. The unit ensures discharge within 24 - 48 hours and with a modest use of beds allows better care and higher efficiency.

In **Sweden**, it has been implemented a service that **Fast Track** from ambulance to ward bypassing the Emergency Department and possibly being directed towards “**Mäva**”- **medical elderly care facilities**. Mäva are Special Wards for elderly patients with multiple chronic diagnosis needing a lot of medical attention. In this way, Mäva-patients take advantage of the possibility for direct admission, thus reducing emergency room visits. Mäva-patients are older than 75 years and have recurring need for hospitalisation due to chronic internal medicine disorders. For all patients cared diagnostic codes and hospitalisation files are recorded.

In the **Netherlands**, **Transfer Officers** are independent patient advisors who work across the traditional hospital and Care Home/ Home Care boundaries, responsible for the coordination of onward care for patients being discharged from hospital. They allow the early identification of need and the facilitation of timely transfer.

3.2 GERIATRIC CARE

As highlighted by Prof. Elisabeth Steinhagen-Thiessen - from the Charité university hospital of Berlin - while primary prevention foresees an assessment of factors of risk and secondary prevention make use of the usual diagnostic and therapies, tertiary prevention should encompass a comprehensive geriatric-assessment, useful to add quality of life to longevity.

Geriatric Assessment (or Multidimensional Diagnostic) has to consider:

- Medical-physiological status
- Comprehensive anamnesis (self and external rating)
- Comprehensive internist clarification
- Neurological status
- Laboratory status
- Non-invasive diagnostic procedures

The geriatric assessment is a multidimensional, multidisciplinary diagnostic instrument that focuses on elderly people with complex problems examining both their functional status and their life quality and lifestyles. In particular, it differs from other medical evaluations performed by multidisciplinary teams for the rest of population because of two elements.

- **Contents.** The geriatric assessment focuses on prevalent medical and psychosocial problems and functional capabilities and limitations of elderly patients, that are crucial to the successful treatment and prevention of disease and disability in older people. These are often referred to as the "Five I's of Geriatrics": intellectual impairment, immobility, instability, incontinence and iatrogenic disorders (complications after a medical or surgery treatment).
- **Outcome, data and information collected** are generally used by geriatric practitioners to develop treatment and long-term follow-up plans, arrange for primary care and rehabilitative services, organise and facilitate the process of case management, determine long-term care requirements and optimal placement, and ultimately make the best use of health care resources.

Ideally, an interdisciplinary team - representing medicine, psychiatry, social work, nutrition, physical and occupational therapy and others - performs a detailed assessment, analyzes the information, devises an intervention strategy, initiates treatment, and follows-up on the patient's progress. The teams can designate a case-manager or caseworker to coordinate the entire pathway. Most assessments take place in medical offices and inpatient units over multiple visits. If possible, however, at least one member of the team attempt to visit the patient at home.

Findings presented by HOPE Exchange Participants

In **Austria** the “**Vienna’s Geriatric Concept**” is based on: best quality closer to people. Geriatric Centres offer 24 hours medical care; integrated care (doctors, nurses, physiotherapists, ergotherapists, psychologists); participation and social inclusion with better geographic distribution and building new modern houses closer to people.

Belgium has followed a consistent pathway aimed at facing the ageing of population and focusing on **Geriatric care**.

- ➔ In 2005, Geriatrics has been recognised as a medical speciality requiring 3 years of internal medicine instead of 5 and 3 years of geriatric medicine instead of 1.
- ➔ In 2007, specialised experience has been deemed necessary for nursing and other MDT members on geriatric wards (4 for 24 beds): diploma after 450 hours additional training or 5 years experience on a geriatric ward plus additional 150 hours training.
- ➔ The Law of 29 January 2007 introduced the ‘**Care Programme for the Geriatric Patient**’, that ensures:
 - A standardized, multidisciplinary approach to every patient aged 75 years and older with a geriatric profile in order to optimise the functionality, the quality of life and to facilitate the discharge to home
 - A greater continuity of care through the different levels.

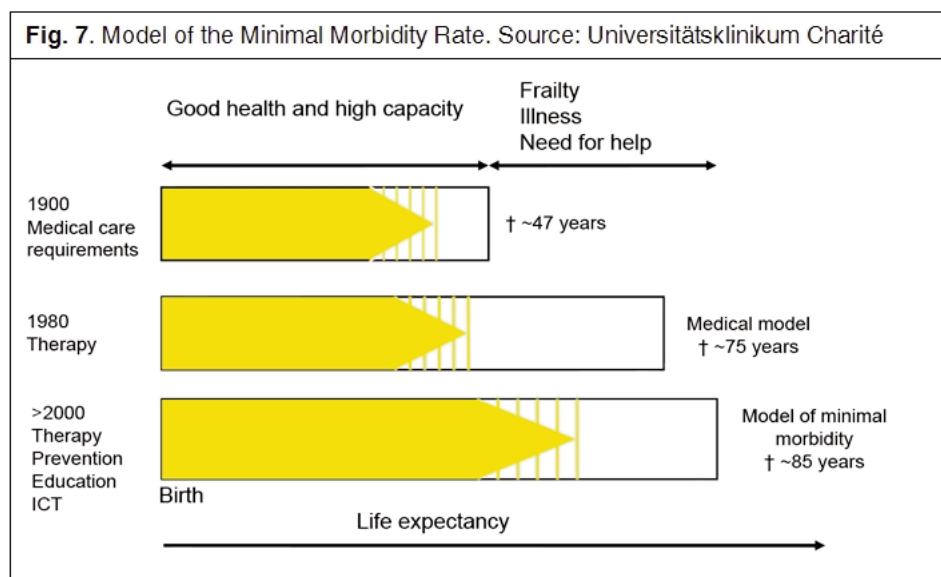
The geriatric care programme include:

- Acute Geriatric Wards
- Ambulatory Care
- Geriatric Day Hospitals, used for assessment, diagnostic and support services, with a multidisciplinary approach – OT, Dr’s, Psychologists – and a closer follow up after discharge
- Internal Hospital liaison team, that guarantees a multidisciplinary team approach. It is a reference nurse for nurses working on the ward, providing advice and guidance, and assessing all patients over 75 who are not hospitalised on a geriatric ward. All patients discussed at weekly geriatric MDT meeting and individualised care is provided according to their needs
- External liaison team

In **France**, the **mobile geriatric team in the Hôpital Nord Ouest – Villefranche sur Saône** – has the role of coordinating and liaison the activities towards geriatric patients, advice for geriatric patients admitted at hospital and whenever possible help preventing hospital admission. Composition: physician, nurse, secretary, social worker, ergo therapist.

3.3 IMPROVING CARE: BETTER USE OF TECHNOLOGIES AND BROADER SKILLS FOR PROFESSIONALS

Better health for ageing population not only requires comprehensive geriatric assessment and multidimensional teams in healthcare facilities and nursing home, but need also to be supported by two essential factors: good technologies and professionals' ability. These are crucial elements to face or reduce frailty, illness and need of help, achieving a minimal morbidity rate (Fig. 7), as explained by Prof. Elisabeth Steinhagen-Thiessen from the Charité university hospital, Germany.



The Information and Communication Technologies (ICTs) can be of help in:

- the prevention of social isolation (communication tools);
- the prevention, care and monitoring of episodes of illnesses (Telemedicine, eHealth);
- preventing and tackling frailty and loss of independence (instruments for active assisted living).

Findings presented by HOPE Exchange Participants

In the Flanders region (**Belgium**) in 2012-2013 all health care providers will be able to enter into a central **IT hub** – to look different organisations patient records being able to use the information, without downloading or changing it.

In **Estonia** **Telemedicine** helps to move responsibility from doctor and nurses, who assume the role of supervisors and consultants, to patients, who become more responsible for their own health, and, in the end, it allows the system to work as a comprehensive health care system.

In **Greece**, the Hospital of Sotira in Athens extensively use ICTs.

➔ eHealth unit. A project together with Spain and Norway whose goal is to educate the chronic patient, make better life quality and reduce hospitalisation.

➔ Use of technologies

- Multimedia, web-based electronic health record
- Real-time transmission of patients' vital signs (ecg, spirometry, oximetry, blood glucose, weight, blood pressure)
- Videoconference with patients' homes

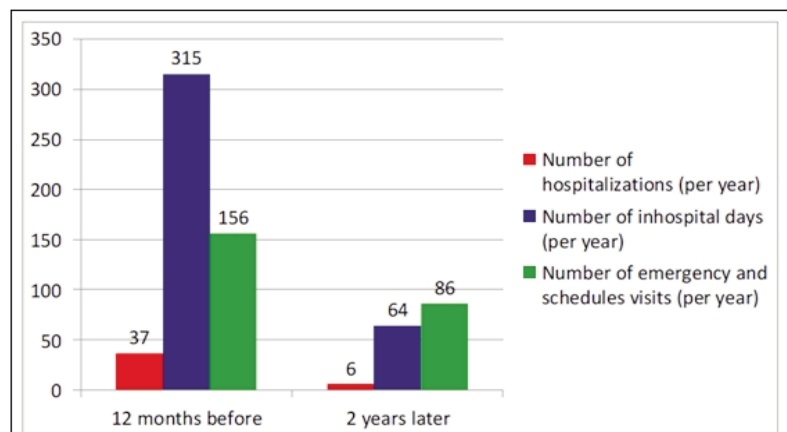


Fig. 8. Sotira hospital. Benefit of the use of technologies. Source: HOSPAGE presentation, Greek team.

The advantages of the use of technologies are shown in Fig. 8.

In Estremadura (**Spain**) the **Telemedicine programme** is the healthcare system's response to overcome geographical, demographic and social barriers.

Patient benefits from:

- Improved accessibility
- Equity of access
- Local delivery of care and diagnosis
- More efficient follow-up to diagnosis

Health system benefits:

- Cost reductions
- Real time consultations, unlike the typical medical consultation
- More effective working between primary and secondary healthcare staff
- Knowledge and info sharing
- Available to all specialties

Healthcare professionals, at any level, need to acquire and expand their skills in order to be able to face broader needs of older persons, manage ICT tools and achieve a range of expertise that allows to read the needs of older people not only in terms of medical requirements but referring to social and personal needs. Indeed, older patients have not only medical or nursing needs but social, psychological, nutritional and mobility needs that require addressing. Therefore, professional skills of healthcare workers are moving from a model of 'silos', based on specialization, to general knowledge of the needs of the patient. Specific learning patterns are developing in order to educate health care professionals working with elderly people and also to provide them with instruments to deal with their families and carers.

Findings presented by HOPE Exchange Participants

In **Belgium** the **Brussels Geriatric School** has been created with the objective of developing a culture of geriatric care for all health care professionals and to ensure clinical practice is consistent and universal across all areas. It focuses on topics relating to elderly care such as nutrition, mobilisation, neuropsychology.

The **Ethical Centres Simulating Care Environments** is a two-day course where health care providers are placed in the patients situation and can assess their reaction to the interventions.

The **Linnea Project**, developed in **Sweden**, aimed to find out Linnea's (a typical elderly citizen) main problem in her contacts with caregivers and to improve the network between actors around Linnea so that she can feel safe and confident. It was found out that the main problem for patients was the lack of information and participation and that the access to doctors and nurses could be improved. This project allows to improve a continuous active network of care, cooperation within multidisciplinary teams and to organise the environment around the patient and in this way to prevent high admission rates.

In **Malta**, of the 81.000 persons over 60, less than 6% live in long-term care facilities, while the rest live in their homes, in their own communities, of those, about 9% are registered as disabled and about 16.3% have multiple impairments. Malta has 225 Geriatric rehabilitation in-patient beds in 2012 (increase of 400% in the last 20 years) offering geriatric follow-up care, community liaison nursing, speech language, physio & occupational therapy, dementia care.

Efforts are addressed to:

- Build upon competent & confident workforce with rich skill mix
- Developing advanced skills in the community
- Increase opportunities for younger population to limit 'brain drain' – training incentives

In the **United Kingdom** the **Butterfly scheme** is a practical strategy for improving the care of patients with dementia and other cognitive deficits. The Butterfly Scheme can be voluntarily embraced, and allows people whose memory is permanently affected by dementia to make this clear to hospital staff by at-a-glance discreet identification by butterfly symbol and provides staff with a simple, practical strategy for meeting their needs by specific five-point targeted response and easy-to-use carer information sheet. The patients receive more effective and appropriate care, reducing their stress levels and increasing their safety and well-being, and staff are happier and less stressed.

3.4 PROMOTION AND PREVENTION – CORRECT LIFESTYLES

Prevention, promotion of correct lifestyles and integration of health and social care in the communities are important factors to enhance healthy ageing, people's self-responsibility, well-being and efficiency in the pathways of care. In fact, not only better rehabilitative care, specific geriatric teams and effective post discharge home care services, but also attention to nutrition, hygiene, mobility support, help with medication, reduction of environmental hazards and regular medical check-ups are of fundamental help to reduce hospitalisation, hospital stay, hospital readmissions or nursing home admissions⁹.

John Cachia - Maltese Commissioner for Older Persons - indicated four main strains for promotion and prevention.

- **Correct administration of medicines**, enhancing awareness both among older persons and their carers at home and among professionals, also auditing the prescribing habits in free medicines system.
- **Risk assessment culture to fight malnutrition**, which is often underestimated, but needs to be kept in consideration concerning both those who live alone, and cannot always feed themselves, and those who live in wards, nursing homes and in the community.
- **Results and impacts of falls prevention policies**, whose analysis of results allows the identification of strengths and weaknesses in the actions implemented, for continuous improvement.
- **Involvement of primary care staff, older persons themselves and relatives and carers** in the clinical treatment protocols for chronic disease management.

Findings presented by HOPE Exchange Participants

Belgium. With Kortrijk **Occupational Therapy at Home**, occupational therapist from hospital goes with the patients to their home before discharge to assess what modifications / appliances they may require. This increases patients confidence, allows minor length of hospital stay, reduces the risk of falls following hospitalisation and re-admission rates.

In **France**, the **Alzheimer take care in the Roanne Region** provides families with respite care; helps people to remain at homes, provides patients with social simulation and provides therapeutic interventions like gardening, computer, art, music and relaxation, and constantly monitor patients' conditions.

In **Latvia** the Public Health Strategy to be achieved by 2017 aims to prolong the healthy life years of the population and to prevent untimely deaths, while maintaining, improving and restoring health.

Priorities for Latvia are:

- Co-operation between generations
- Increase the value of elderly
- Reduce age discrimination in labour market
- Facilitate active and healthy life styles

The **challenges** for the coming period is:

- To increase personal responsibility for individual health
- To make a healthy choice an easy choice
- To strengthen common understanding of health as a value and benefits of well-organised and promoted public health
- To implement measures to ensure equal health possibilities to all inhabitants

In **Poland**, the WCO (Wielkopolskie Centrum Onkologii), the Greater Poland Cancer Centre offers:

- A wide range of **health promotion and cancer prevention activities** towards citizens and employees. In particular the Quality Department realizes activities about promotion of healthy life styles, multisport activities semi-financed by the Hospital.
- **Integrated Quality System**
 - ISO 9001:2008 in imaging diagnostics, nuclear medicine and radiotherapy
 - ISO 14001 environmental management
 - OHSAS 18001: OHSAS norm 18001 "Safety management system and occupational health - requirements".
- **Psychological Department.** Meets specific needs on a multidisciplinary basis offering:
 - Group activities – meetings with doctors, with psychologists for families of the patients, with the social insurance expert and the beauty consultant, who can give some advices after radio and chemotherapy.
 - Entertainment for patients like many concerts in Winter Garden, movies and art workshops.

In Andalusia (**Spain**) the Public health initiative “**One million steps**” is part of the public health strategy of the Ministry of Health of the Andalusia Government, addressed to local associations that through the practice of group rides reach a total of at least one million steps in a month by the contributions of all participants. The steps are measured by pedometers or other means.

It allows:

- Promoting physical activity or increase the maintenance of activity in those who already make sport
- Intervene on health determinants related to physical activity, both physical, and mental and social
- Demonstrate the potential "active health" with the participants and the associations involved
- Develop partnerships with stakeholders to capture new members and spread their experience
- Strengthen community life of the group on which intervenes by performing a shared task
- Promote social organisation in learning the use of limited resources. The group manages the pedometers provided
- Strengthen partnerships with local government based on shared actions
- Promote and disseminate healthy practices and behaviours

Sweden:

- **Intervention of prevention in the community**
 - School Meals
 - Senior Meetings
 - Activity Prescriptions
 - Advice and Information Centres
- **Healthcare at Home**
 - Community Nurses
 - Mobile Doctors
 - Psychiatric Teams
 - Rehabilitation at Home
 - Senior Alert

In the **United Kingdom** the **Single point of access** is a single telephone number system to avoid inappropriate admissions of older persons to hospital. Calls from GPs or community nurses are answered by healthcare professionals who clinically navigate patients to the most appropriate service in community.

3.5 THE ROLE OF THE COMMUNITIES AND SOCIAL INCLUSION “AGE FRIENDLY LIVING”

As highlighted by John Cachia - Maltese Commissioner for Older Persons - physical and social environments are key determinants of whether people can remain healthy, independent, autonomous long into their old age. Moreover, elderly people are not just recipients of pensions or health and long-term care; they also provide a large proportion of care for other elderly people, including spouses, grandchildren and other relatives, providing an important input into society that would otherwise have to be purchased in the marketplace¹⁰.

The improvement of cities and communities in the direction of becoming more supportive of active ageing of elderly people can be obtained by:

- creating inclusion and opportunities for active contribution in all areas of community life, for example incentivising participation, civic contribution and social employment of people outside the working environment, but still productive;
- developing flexible responses to needs and preferences, through better communication and inclusion and with targeted community support and health services;
- creating a more friendly physical & social environment, for example creating housing, sporting and leisure activity and support services like transports more ‘elderly friendly’.

Many countries today have implemented some kinds of community responses. From services simply aimed at getting people to know each other and share experiences, to activities aimed to keep people abilities lively. In other countries, the development of volunteering is obtaining the double achievement of keeping elderly people active and letting them giving a valuable contribution to the society even after retirement.

Findings presented by HOPE Exchange Participants

In the **Care Farms** in the **Netherlands**, care consists of providing people with a daytime occupation that is worthwhile. The participants, also called help farmers, work along at the farm. For elderly participants the farm mainly provides an environment where they can feel at home. Everyone contributes according to their own capacities. It is not the person’s limitations that are the main focus here, but rather their possibilities. For the most part they are people who need much guidance. Therefore, care farming is not an example of cheap labour. The farmer and his wife invest much time in their guidance.

In the **United Kingdom Dementia cafés** are places to enable older persons with dementia and their carers to socialise, meeting once a week in the community to share experiences, guided by professional facilitators (nurses, occupational therapists, social workers). A 2011 evaluation study shows that Dementia cafes promote social inclusion, prevent isolation and improve the social and emotional well-being of attendees.

In **Slovenia** the low birth rate and low population growth coupled with increased life expectancy anticipate a future problem of population ageing. People aged 65+ will double from 16.6% to 33 % by 2060 and already now care for 80+ in nursing homes is increasing.

Good practices and future challenges include:

- Training of volunteers in educating in preventing falls (2000 instructors nationwide)
- Nursing unit at UMC
- Major contribution of volunteer work throughout the health system
- Emphasizing the need of a healthy lifestyle and active ageing
- Shift for more care in people homes (requires changes in financing the health system – Current way of financing health services gives an incentive for admitting patients to inpatients care – a change should lead to higher degree of outpatient care)

4. RECONCILING FAMILY AND WORK

The “Network Success Factor Family”, is an initiative developed in Germany, launched in 2007, with the support of the European Commission. The network, that currently has 4000 members (employers), was established in 2007 as an initiative of the Association of the German Chambers of Industry and Commerce and the German Federal Government. Being based on the idea that companies learn from each other and turn family friendliness into a trademark, the network provides information and services about the reconciliation of work and family life, shows companies’ commitment to family friendly human resources strategy. The German Hospital Federation is a network partner and currently over 280 hospitals as network members, providing specific information for hospitals.

Considering the increasing number of female-employed staff, upcoming demographic changes, the shift in male and female roles in society and the shortage of skilled staff that is facing some sectors of employment, the implementation of family-friendly policies surely play a role in the employees’ satisfaction and in their retention, designing a triple win situation.

- For employees: less stressed and more productive, healthier and happier.
- For companies: easier retention of employers, less costs of staff recruitment, higher productivity of the company, since employees who are happy and motivated and enjoy more flexibility at work also perform better, contribute to creating a better working atmosphere, are healthier, reduce turn-over, absenteeism and sick leaves.
- For the society: less social costs for care of family members and for employers who get stressed because of working reasons, increased sustainability and life-balance.



Fig. 9 Government programs support the possibility of caring time. Source: HOSPAGE presentation, Anine Linder Netzwerkbüro „Erfolgsfaktor Familie“.

However, as it is easy to talk about children care, it is more difficult to talk about elderly care. Ms. Anine Linder, project manager of “Network Success Factor Family”, illustrated some facts and figures.

- 70 % of the people in need of care are looked after in their homes by relatives
- Caring is “female”: two thirds of the caregivers are women
- Care is provided mainly by partners or by children
- 17 % of the people needing care have to be cared for longer than ten years
- More than 50% of the caregivers are employed – and numbers are increasing

Moreover,

- 40 % of the companies say they have had experience with employees taking care of dependants
- 9 % provide support
- Almost two thirds of companies interviewed cannot name any measures
- Support is mainly individual
- (Older)care is hardly visible

The need for a better reconciliation of work and care for dependants is clear and in particular the problem of (older) care at some point arises in everyone's life and cannot be solved by professional care alone.

To reconcile work and care, caregivers need:

- Time
- Solutions for dependants living at long distance
- Psychological and medical support
- Information about household reconstructions for the needs of elderly people
- Support in finding the right services
- Information about financial support
- Advice regarding medical and legal decisions

This challenge is not to be faced through unilateral strategies, but needs synergies.

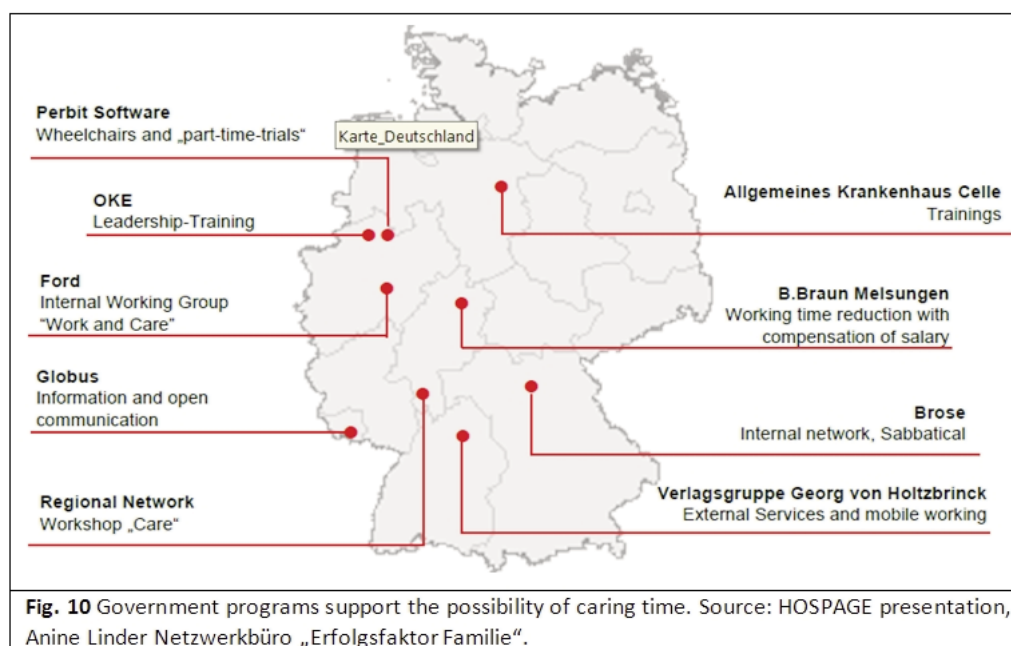
Employers do play a role in creating a solution:

- Talking about the taboo
- Creating and supporting infrastructure to support carers
- Creating a corporate culture which enables employees to be successful and to take care of dependants

The German government actively supports the possibility of caring time.

Some good practices include:

- Training on eldercare, with modules including practical care, depression, dementia, legal issues
- Internal network „Care“ for mutual support and exchange of experiences and advises.



5. COUNTRY INFORMATION

FINDINGS PRESENTED BY HOPE EXCHANGE PARTICIPANTS

AUSTRIA

HOPE National Coordinator

Gertrud Fritz

Exchange Participants 2012

Boerge Knudsen (Denmark)
Jonathan Belcastro (France)
Ana Marta Tortosa Gil (Spain)

In Austria some main structural features can be identified.

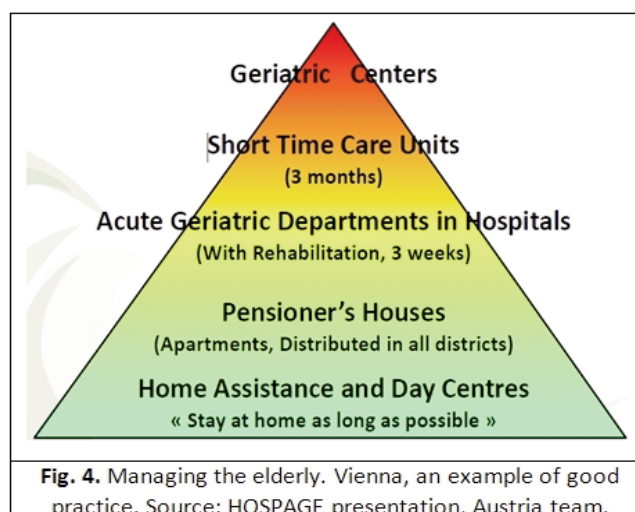
- GPs are not always gatekeepers
- Mostly self-employed doctors
- Weakly co-ordinated
- 264 Hospitals, 131 Public
- 557 beds / 100.000 inhabitants (average EU27: 372)

Ageing patients

Trends show that the old age dependency ratio is going to grow from about 25% to about 48% between 2010 and 2050 and the number of single household is going to increase by about 50% from 1990 to 2030.

Answers move the focus from illnesses to prevention.

- Vienna social fund, managing the elderly. The **“Fonds Soziales Wien”** offers: integrated gate for orientation; guidance through the system, information on services for the elderly. The principle is shown in the Fig. 4.
- **“Vienna’s Geriatric Concept”**: best quality closer to people. Geriatric Centers offer 24 hours medical care; integrated care (doctors, nurses, physiotherapists, ergotherapists, psychologists); participation and social inclusion, Better geographic distribution, building new modern houses closer to people.



Ageing workforce

Not a problem of figures but of managing HC workforce. Physicians are theoretically enough:

- 468 per 100.000 inhab. (average in EU 27: 330)
- Demand for compensating retirements 2025: 17.000 (39%)
- Estimated number of graduates until 2025: 20.000
- Dynamic development of highly qualified workforce in hospitals (higher medico-technical services, qualified nurses, doctors, midwives, nursing assistants)

But:

- Uneven geographic distribution
- High migration trends
- Low attractiveness of geriatric speciality and general practice
- Many doctors stay outside public HC system
- Lack of information on workforce age, data, studies and action plans in preparation

If elder patients are treated predominantly in hospitals, Austria will need even more hospital capacity

Answers: Project “**Productive ageing**”

Productiveness is not about age – but about the organisation and management

- Improving capacity of work and professional challenges until a late age of work, combining work ability and workplace surveys
- Fostering dialogue between generations and between different providers of the Health Care System

BELGIUM

HOPE National Coordinator	Colberte De Wulf
Exchange Participants 2012	Viviane Beaumatin (France) Françoise Montalbetti (France) Lisa Jones (UK Wales)

Ageing patients

Belgium has followed a consistent pathway aimed at facing the ageing of population and focusing on **Geriatric care**.

In **2005** Geriatrics has been recognised as a medical speciality requiring 3 years of internal medicine instead of 5 and 3 years of geriatric medicine instead of 1.

In **2007** specialised experience has been deemed necessary for nursing and other MDT members on geriatric wards (4 for 24 beds): diploma after 450 hours additional training or 5 years experience on a geriatric ward plus additional 150 hours training.

Law of 29th January 2007 introduced the '**Care Programme for the Geriatric Patient**', that ensures:

- A standardized, multidisciplinary approach to every patient aged 75 years and older with a geriatric profile in order to optimise the functionality, the quality of life and to facilitate the discharge to home.
- A greater continuity of care through the different levels

The geriatric care programme include:

- Acute Geriatric Wards
- Ambulatory Care
- Geriatric Day Hospitals, used for assessment, diagnostic and support services, with a multidisciplinary approach – OT, Dr's, Psychologists – and a closer follow up after discharge
- Internal Hospital liaison team, that guarantees a multidisciplinary team approach. It is a reference nurse for nurses working on the ward, providing advice and guidance, and assessing all patients over 75 who are not hospitalised on a geriatric ward. All patients discussed at weekly geriatric MDT meeting and individualised care is provided according to their needs.
- External liaison team

Ageing workforce

Belgium experiences problems with recruitment and retention of nursing and medical staff because of work life balance, being this one a female-dominated profession.

Solutions found include:

- Additional annual leave at 45 - 55 - 65 for nursing staff
- Retraining and allocation of another post if unable to fulfil due to sickness episodes
- Healthy employee schemes – sports, massage
- Newsletter – health information / guidance

Innovative practices

Brussels Geriatric School created with the objective of developing a culture of geriatric care for all health care professionals and to ensure clinical practice is consistent and universal across all areas. It focuses on topics relating to elderly care such as nutrition, mobilisation, neuropsychology.

Kortrijk Occupational Therapy at Home. Occupational therapist from hospital goes with the patients to their home before discharge to assess what modifications / appliances they may require. This increases patients confidence, allows minor length of hospital stay, reduces the risk of falls following hospitalisation and re-admission rates.

Ethical Centers Simulating Care Environments. Two day course where health care providers are placed in the patients situation and can assess their reaction to the interventions.

Dementia. centres of excellence providing:

- Education programmes for health care professional
- Support groups for those with dementia and their families
- Provide additional information about dementia via the web site

Information Technology. In the Flanders region in 2012-2013 all health care providers will be able to enter into a central IT hub – to look different organisations patient records being able to use the information, without downloading or changing it.

DENMARK

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Ageing patients are going towards worst health conditions, increasing demand of care and higher flow to hospitals.

Ageing workforce is going towards worst health, less motivation, reducing availability.

The answer is correlated and, as shown in Fig. 5, it includes:

- Improve processes & innovation (blue boxes)
- Adapt services & increase awareness (red boxes)
- Education (green boxes)
- Involve & empower patients, families and third actors (yellow boxes)

The elements on the left at the bottom require less efforts but have lower impacts. Going towards the right side, at the top, the elements require more effort, but have higher impact.

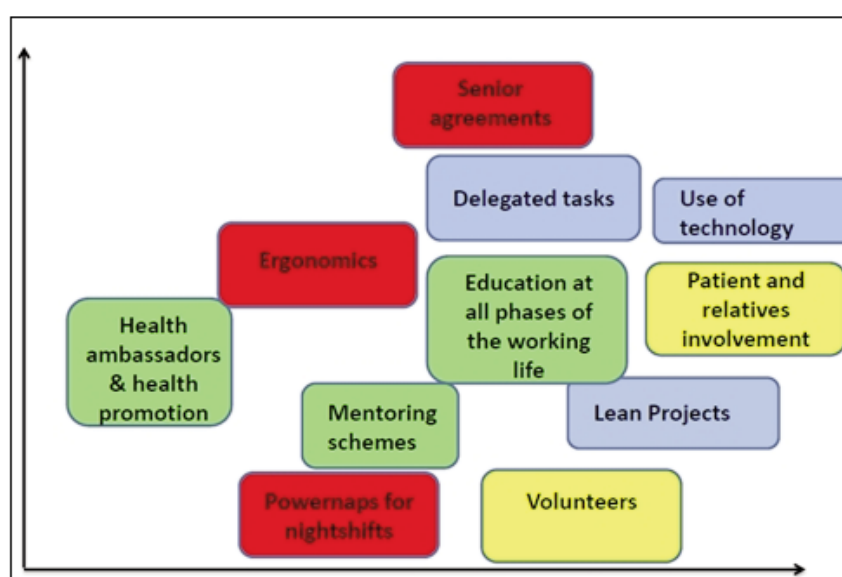


Fig. 5. Good practices in Denmark. Source: HOSPAGE presentation, Danish team.

Many other interventions have a good effect on patients and workforce. In particular, the Danish health legislation imposes the regional council and the municipalities to sign an agreement on the handling of the tasks within health and psychiatry, with the purposes of strengthening cooperation between hospitals, municipalities and the general practice and, in the end, ensure continuity of care. Most of the efforts in the health agreements support the challenges of ageing patients.

The **SAM:BO agreement** describes guidelines concerning cooperation, communication, information to patients and monitoring of the quality and is supported by electronic communication.

SAM:BO ensures cooperation and continuity of care and has the following characteristics.

- Discharging starts as soon as you are hospitalised
- Continuity and flexibility through dialogue
- Patient involvement
- Flow charts describes what each sector is expected to do before, during and after hospitalisation

As part of SAM:BO there is a special agreement about seriously ill and dying patients. The agreement describes requirements for collaboration, communication and information for these patients and their relatives, particularly focusing on the transitions between sectors. In psychiatry there is a special agreement on dementia intervention in all the cooperating sectors .

ESTONIA

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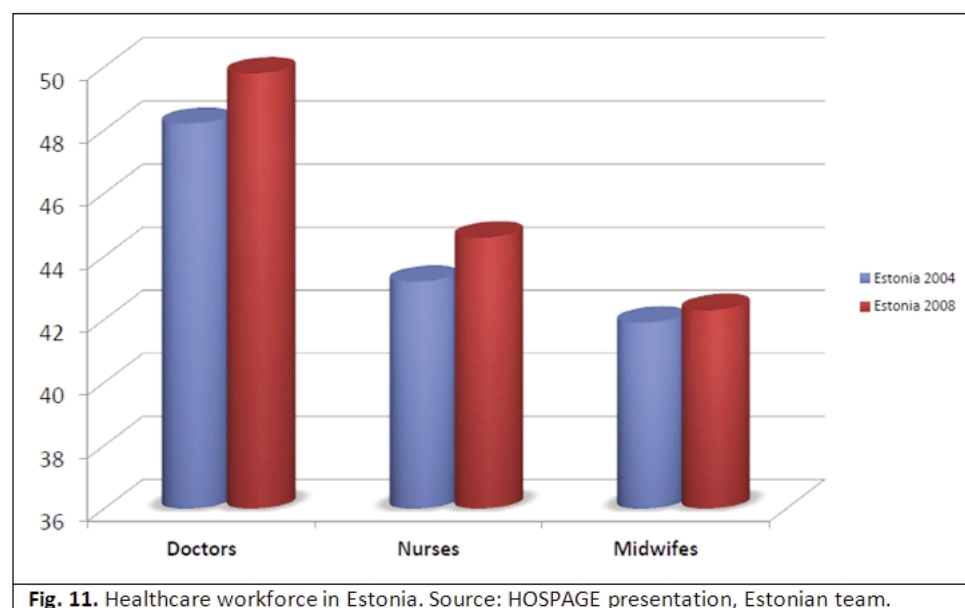
Antonio Clemente Collado (Spain)

Ageing patients

Not a new issue for Estonia, it is made worst by the presence of chronic diseases and abuse problems.

One of the main items helping improving care for elderly people is **Telemedicine**. Telemedicine helps to move responsibility from doctor and nurses, who assume the role of supervisors and consultants, to patients, who become more responsible for their own health, and, in the end, it allows the system to work as a comprehensive health care system.

Ageing workforce



As shown in Fig. 11, ageing workforce in Estonia is not problematic. Nonetheless Estonia suffers a high rate of migration, mainly due to low salaries and better working conditions. Another problem concerns the lack of integration between professionals. The use of resources should be optimised and the older workers should act as mentors towards younger professionals, sharing their experience and expertise.

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Ageing patients

The main challenges that Finland faces concerns the demographic trends and the distribution of population, which is mainly concentrated in the southern part of the country. Finland has as an objective to improve the linkages between health and social care and providing a continuous pattern of care and prevention starting from the birth towards the entire working life and elder time of a person. An important target is then to ensure integration of care, and cooperation among municipalities, especially in education of healthcare workforce certainly helps to reach this objective.

Ageing workforce

The main challenge related to workforce is linked the decreasing number of staff and to the difficulties of hiring people outside the country, due to the different language. The structure of healthcare is still doctor-driven, but nurses are taking a generic role, especially in rural areas. Moreover voluntary activity can be improved.

FRANCE

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Ageing patients

National Health Strategy

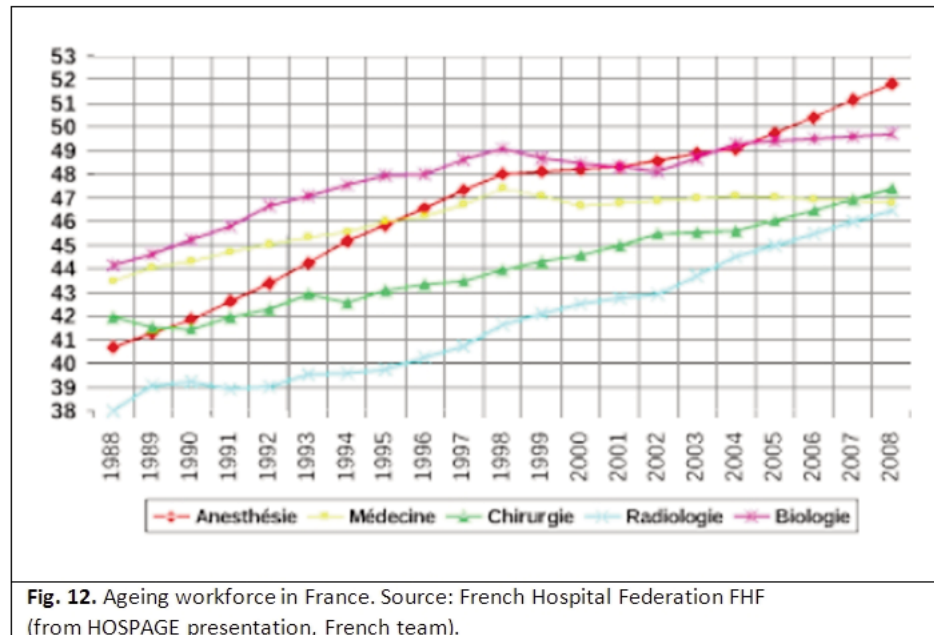
Among those the **National Alzheimer Plan** and the **National Heat Wave Plan**

Development of new structures across primary and secondary care

- The **Alzheimer take care in the Roanne Region** provides families with respite care; helps people to remain at homes, provides patients with social simulation and provides therapeutic interventions like gardening, computer, art, music and relaxation, and constantly monitor patients' conditions.
- The **mobile geriatric team in the Hôpital Nord Ouest – Villefranche sur Saône** – has the role of coordinating and liaison the activities towards geriatric patients, advice for geriatric patients admitted at hospital and whenever possible help preventing hospital admission. Composition: physician, nurse, secretary, social worker, ergo therapist.

Ageing workforce

The situation of healthcare professionals in France is exemplified by the Fig. 12. Solution found consist in the creation or enhancement of good working conditions for health professionals and in the empowerment of patients through the use of technologies.



- **Adaptation of the working environment**

The **bimonthly commission for individual counselling employees in the Hôpital Nord Ouest – Villefranche sur Saône** – has the role of identifying employees with health problems, gathering the information needed to assess their situation, searching for a solution, so that the employee can continue working and implement the solution. Composition: occupational physician and occupational nurse, director of human resources, director of patient care, social worker, responsible organisation training.

- **New technologies and equipment**

eHealth in Toulouse

MEDINEO. Platform for monitoring elderly people from the hospital to their home in a urban environment.

SACHA. Development and validation of a solution to monitor frail elderly, dependent or demented people, capable of generating functions and warning to detect situations of falling, presence beyond a perimeter of normal life or request help.

- **Partnership working**

It consists in the involvement of all levels of care, and in particular General Practitioners (GPs), but also patients and elderly themselves in the patterns of care and prevention. It has been created a new platform that allows to evaluate the conditions of frailty to prevent dependency with the help of GPs.

GERMANY

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Ageing patients

Care demand is increasing. It needs more care at home and autonomy.

Case Management

- Continuity of care
- Planning from admission to discharge
- Coordination & linking
- Evaluation & information

Palliative Care team

- Treatment plan
- Network with prof's
- No hospitalisation
- 24 hour service
- At home
- Involvement family and doctor

DRGs

- National database
- Chronic patients
- Duration of stay
- Care intensity
- Patient Complication and Co-morbidity Level (PCCL)

Ageing workforce

Mental and physical problems are increasing. It needs better equipment, optimal productivity, healthy people.

Facilities and Promotion

- Good wages
- Better image
- Good education
- Accommodation
- Children daycare

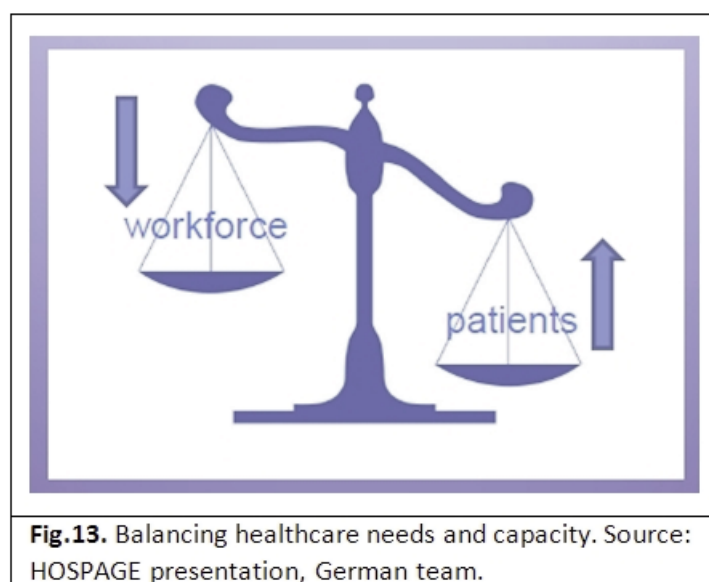
Health Programmes

- Healthy food
- Accident prevention
- Lifestyle coach
- Physiotherapy, Ergo-coach, Lift-techniques
- Fitness and sport-clubs
- Job-place analysis

Triple win migration

- Migration from partner lands
- Know-how transfer
- Personnel development

Optimising workforce and patients healthcare



GREECE

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Ageing workforce and ageing patients

In Greece, the very centralized health system make it difficult to implement change, since decisions can only be made by the Ministry of Health; working conditions for the health staff are difficult, only in the last year they suffered a 25% cut in their salaries; there are cases when equipments cannot be used because of the lack of staff.

The following changes in the health system would need to be discussed:

- Decentralization of the health system
- Make strategies and let the leader of the unit decide how to do.
- Make money follow responsibility
- Develop the first level of care
- Start with small changes at the units
- Educate the patients to selfcare
- Invest in information technology

However, some examples of good practices are available in the Hospital of Sotira – Athens – whose advantages are shown in Fig. 8.

eHealth unit

It is a project together with Spain and Norway whose goal is to educate the chronic patient, make better life quality and reduce hospitalisation.

Use of technologies

- Multimedia, web-based electronic health record
- Real-time transmission of patients' vital signs (ecg, spirometry, oximetry, blood glucose, weight, blood pressure)
- Videoconference with patients' homes

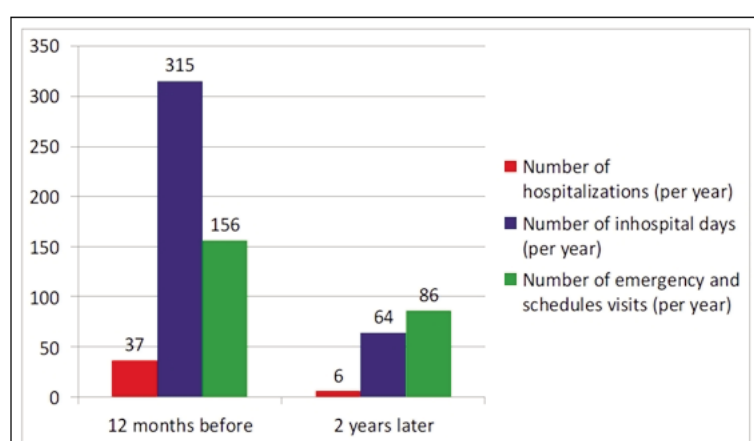


Fig. 8. Sotira hospital. Benefit of the use of technologies. Source: HOSPAGE presentation, Greek team.

HUNGARY

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Ageing workforce

The main problem in Hungary is represented by the high rates of migration, that has negative impacts on the health system as a whole:

- Lack of health professionals
- Current workforce delays retirement
- Ageing workforce, more than 50% of medical doctors are aged more than 50
- No return in education investments
- Generation gap: lost of expertise
- «Brain drain» effect, produce health professionals is very costly if not looked at in the long run. If brain drain is not stopped it will only be expensive, but there will not return on investment.

Solution pass by different pathways.

Produce more health professionals

- Increase number students in general, mainly nurses
- Increase number of residents (GP, anaesthetics, radiology, neurology...)

Reduce emigration and/or enhance return to Hungarian labour market

- Increase wages
- Improve job conditions (working hours, administrative burden...)
- Develop European exchange programs with return commitment

Strengthen workforce in primary care

- Improve the current situation of GPs
- Make easier the access of new GPs

Training

- Information & Communication Technologies
- Nurses & Allied workers to develop delegated tasks

Reorganise workforce

- Redistribute current health professionals following a new design of hospital system and other facilities (nursing homes)
- Increase delegation from physician to nurses & allied workers
- Eliminate informal payments
- Introduce public campaigns for proper use of health services

LATVIA

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Ageing patients

Latvia has a clear health policy. Indeed, Latvian Public Health Strategy to be achieved by 2017 aims to prolong the healthy life years of the population and to prevent untimely deaths, while maintaining, improving and restoring health.

Objectives

- To increase by two years the healthy life years of individuals (for men: from 52.6 in 2009 to 54.7 in 2017, for women: from 55.8 in 2009 to 57.8 in 2017)
- To decrease by 20% the potential years of life lost

Priorities

- Co-operation between generations
- Increase the value of elderly
- Reduce age discrimination in labour market
- Facilitate active and healthy life styles

Challenges

- To increase personal responsibility for individual health
- To make a healthy choice an easy choice
- To strengthen common understanding of health as a value and benefits of well-organised and promoted public health
- To eliminate injustice in the field of health, by implementing measures to ensure equal health possibilities to all inhabitants of Latvia

LITHUANIA

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Ageing patients

Main problems concern:

- Lack of coordination between Primary Care, Hospitals and Social Services
- Lack of continued care as Outpatients
- Lack of healthy ageing programmes
- Heritage for long stays in Rehab. Hospitals

However, primary care results well organised, providing GP, Nursing, Odontologic, Social and Psychologist services, devolving resources to prevention, with five Main National Preventive Screening Programmes and having multidisciplinary teams working together for inpatients and university studies about the future needs in number of homes for elderly people.

The strain on which it can be worked in the future are:

- Better coordination across Primary Care, Hospitals and Social Services
- Implement Geriatric Units in Hospitals
- Promote healthy ageing programmes

Ageing workforce

In Lithuania 85% of healthcare workforce are women and problems are linked to:

- Health System highly dependent on working pensioners, physicians in particular continue working after retirement
- 3 different and non-communicating Health Human Resource databases
- Lack of free training courses
- Internal migration to the big cities
- Decreasing number of High-School students (drop out rate of Health Sciences students by 25%)

Needed intervention concern:

- Investigating the reasons why medical and nursing students drop out, assessing the number of Primary Care GP's needed until 2025 and the need for new admissions in Health Science Studies
- University psychological support for Health Sciences students
- Audit Units to get feedback from professionals to improve the quality and safety of Health Care

The strain on which it can be worked in the future are:

- 1 National Register System for Healthcare workforce
- Bigger investment in training programmes for the ageing workforce
- Measures to attract Healthcare workers who have left the system, and retraining programmes

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Ageing patients

Challenges and possible solutions.

Quality and Safety

- Build upon the high standard services in community
- Shift emphasis from beds to community
- Improve use of ID
- Public engagement

Access

- Densely populated country enabling easy access to services
- Demographic challenge – ‘Youth Brain Drain’ V Ageing Population
- Acknowledgement and ownership of the ageing agenda

Workforce

- Build upon competent & confident workforce with rich skill mix
- Developing advanced skills in the community
- Increase opportunities for younger population to limit ‘brain drain’ – training incentives

Cost

- Robust integrated financial planning and control required
- Added value through joint working (integration) and resultant increased capacity

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Ageing patients

Future challenges and possible solutions

- Managing individual expectations
- Changing focus from hospital to community based care
- Promote personal responsibility, independence and self-directed care
- Implement patient centered care planning
- Deliver patient centered care at or as close to home where possible

Good practices

Transfer Officers

They are independent patient advisors who work across the traditional hospital and Care Home/ Home Care boundaries, responsible for the coordination of onward care for patients being discharged from hospital. They allow the early identification of need and the facilitation of timely transfer.

Care Farms

Care consists of providing people with a daytime occupation that is worthwhile. The participants, also called help farmers, work along at the farm. For elderly participants the farm mainly provides an environment where they can feel at home. Everyone contributes according to their own capacities. It is not people's limitations that are the main focus here, but rather their possibilities. For the most part they are people who need much guidance. Therefore, care farming is not an example of Good practices.

Personal Life Phase Budget

- Individual decision by individual employee at any age
- Collective agreement for hospitals introduced in 2010
- 35 hours yearly added to a personal account
- Can be used according to individual needs
- Will be transferred to new employer when employees change jobs within the health services

Volunteering

In the Netherlands there is a significantly higher rate of volunteers especially in the provision of long-term care of the elderly. This is possible because of the presence of different factors:

- More part-time workers
- Fewer women full-time working compared to other countries
- Dutch culture encourages volunteering: mandatory volunteering in schools, volunteering days in companies, volunteering as a part of life.

POLAND

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Ageing patients

The proportion of Poland population aged 65 or over is currently comparatively low, and is projected to increase slowly until 2020. According to this, ageing patients perspective is not exactly (at short term) the same as in other countries, but is important in an oncology hospital like WCO (Wielkopolskie Centrum Onkologii), the Greater Poland Cancer Centre.

Ageing workforce

In Poland as a whole, evidence suggests a shortage of health care professionals, in some specialities of medical and nursing professions. It is needed to attract people and to retain them, when concluding university studies. There is a lack of mid-age professionals.

Best practices concerning the WCO

Prevention towards citizens and employees

- The Epidemiology Unit offers a wide range of health promotion and cancer prevention activities
- The Quality Department realizes activities about promotion of healthy life styles, multisport activities semi-financed by the Hospital

Integrated Quality System

There is a culture of quality and a lot of people are involved in this activity. The Integrated Management System is in conformity with:

- ISO 9001:2008 in imaging diagnostics, nuclear medicine and radiotherapy
- ISO 14001 environmental management
- OHSAS 18001: OHSAS norm 18001 "Safety management system and occupational health - requirements"

Project HERO - Health Economics in Radiation Oncology

It is among the most important project conducted by ESTRO - the European Society of Radiotherapy and Oncology (ESTRO). It aims to obtain the current knowledge on infrastructure and employment in radiotherapy in Europe and to develop a model for assessing the cost of radiotherapy. Two WCO employees are members of the task force HERO.

Psychological Department. Meets specific needs on a multidisciplinary basis offering:

- Group activities – meetings with doctors, with psychologists for families of the patients, with the social insurance expert and the beauty consultant, who can give some advices after radio and chemotherapy
- Entertainment for patients like many concerts in Winter Garden, movies and art workshops

PORTUGAL

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Ageing patients

Strategies

- Identify the group of >65 at risk using scoring matrix and dependency ratios
- Pro-active management: being proactive in the management of complex conditions allows providing timely the most effective treatment
- Coordinating services, which allows directing patients to the right service
- Providing patient centric services giving patients information, tailor made health care and actively involving him/her in the care pathway

SLOVENIA

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Ageing patients

In Slovenia the low birth rate and low population growth coupled with increased life expectancy anticipate a future problem of population ageing. People aged 65+ will double from 16.6% to 33 % by 2060 and already now care for 80+ in nursing homes is increasing.

Good practices and future challenges

- Training of volunteers in educating in preventing falls (2000 instructors nationwide)
- Nursing unit at UMC
- Major contribution of volunteer work throughout the health system
- Emphasizing the need of a healthy lifestyle and active ageing
- Shift for more care in people homes (requires changes in financing the health system – Current way of financing health services gives an incentive for admitting patients to inpatients care – a change should lead to higher degree of outpatient care)

Ageing workforce

In Slovenia a lack of workforce is not a problem today, but will be experienced in the following decades, especially with regard to physicians and anesthesiologists.

Good practices and future challenges

- Make it attractive to work for the organisation
- Flexible and well equipped workstations
- Changing of job description due to age, e.g. people in risk management, in simulation centre, in complaint dept
- Keeping retired physicians in the workforce in reduced hours
- Increasing the numbers of medical staff in community
- Flexibility in job description
- Reorganisation of work schedules
- Combining teams to consist of both young and senior workers
- Dividing workday with a longer break

SPAIN

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Ageing patients

Spain has one of the highest rates of ageing worldwide.

Spanish National Health Strategy has to be carried out through all 17 autonomous regions. The National Quality Plan focuses on patients' needs:

- Patient safety
- Adapting human resources of the national health system to the citizens' needs for health services
- Preventing lifestyle related diseases and falls
- Promoting health policies based on best practices

Best practices

Andalusia - Public health initiative "One million steps"

This initiative is part of the public health strategy of the Ministry of Health of the Andalusia Government, addressed to local associations that through the practice of group rides reach a total of at least one million steps in a month by the contributions of all participants. The steps are measured by pedometers or other means. It allows:

- Promoting physical activity or increase the maintenance of activity in those who already make sport
- Intervene on health determinants related to physical activity, both physical, and mental and social
- Demonstrate the potential "active health" with the participants and the associations involved
- Develop partnerships with stakeholders to capture new members and spread their experience
- Strengthen community life of the group on which intervenes by performing a shared task
- Promote social organisation in learning the use of limited resources. The group manages the pedometers provided as appropriate
- Strengthen partnerships with local government based on shared actions
- Promote and disseminate healthy practices and behaviours

Galicia - Programme for chronic patients with pluripathology

It is a programme for elderly patients involving surveillance and delivery at primary care or outpatient level and multidisciplinary action. Reached impact:

- Reduction of re-admission by 37%
- Reduction of emergency admissions by 43%
- Life prolonged by 9 months
- Shorter hospital stay if re-admitted
- Reduction of costs
- Improvement of interactions between primary care and hospital care

Estremadura - Telemedicine programme

Telemedicine is the Estremadura healthcare system's response to overcome geographical, demographic and social barriers. Patient benefits:

- Improve accessibility
- Ensure equity of access
- Ensures local delivery of care and diagnosis
- More efficient follow-up to diagnosis

Health System benefits:

- Cost reductions
- Real time consultations, unlike the typical medical consultation
- More effective working between primary and secondary healthcare staff
- Knowledge and info sharing
- Available to all specialties

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Ageing patients - best strategies

Intervention of prevention in the community

- School Meals
- Senior Meetings
- Activity Prescriptions
- Advice and Information Centres

Healthcare at Home

- Community Nurses
- Mobile Doctors
- Medication Review
- Psychiatric Teams
- Rehabilitation at Home
- Senior Alert
- Linnea Project. Aim of the project was to find out Linnea's (a typical elderly citizen) main problem in her contacts with caregivers and to improve the network between actors around Linnea so that she can feel safe and confident. It was found out that the main problem for patients was the lack of information and participation and that the access to doctors and nurses could be improved. This project allows to improve a continue active network of care, cooperation within multidisciplinary teams, organise the environment around the patient and in this way to prevent high admission rates.

Hospital care

- Global Electronic Medical Record
- Medical Reviews
- Early Discharge Planning
- **Fast Track** from ambulance to ward bypassing the Emergency Department and possibly being directed towards "**Mäva**"- **medical elderly care facilities**. Mäva are Special Wards for elderly patients with multiple chronic diagnosis needing a lot of medical attention. In this way, Mäva-patients take advantage of the possibility for direct admission, thus reducing emergency room visits. Mäva-patients are older than 75 years and have recurring need for hospitalisation due to chronic internal medicine disorders. For all patients cared diagnostic codes and hospitalisation files are recorded.

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Ageing workforce

A package of strategies to face the issue.

Attention to **working conditions** through flexibility of work-time and work flow for ageing workforce, competitive salary and health promotion

Case/patient management

IT-solutions. Telemedicine – video conference - eHealth

Improvement of educational system with pre-nurse programmes and Bachelor and Master programmes for nurses

Skill and grade mix

Integration of the new nurse discipline to the nurse concept, focus on competence, delegation and interdisciplinary teamwork, it match the needs of the organisation and allows staff satisfaction in tasks and development.

- Five professional profiles for delegation and responsibilities in nursing
- Tandem planning (matching skill and grade)

Generation management

- Diversity management: focus on age differences and individual situations of life, i.e. night shift markets
- Health management: attention to sick leaves and safe return to work
- Transfer of knowledge: mentor programmes, job sharing, career plans at 50+, follow trends in staff mix

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Ageing workforce

Implemented strategies

Equality Act 2010

The Equality Act 2010 is the law which bans unfair treatment and helps achieve equal opportunities in the workplace and in wider society. Within the boundaries of the Act, positive action which treats people differently according to their age is allowed. This is when the action being taken prevents or compensates for disadvantages experienced by, or meets the particular needs of, such age groups; or when it encourages people from particular groups to take advantage of opportunities when underrepresentation has been identified

Lifestyle intervention programmes

Long term workforce planning

Occupational Health

HR redeployment register

Pre-retirement courses

Healthy Working Lives programmes

Flexibility

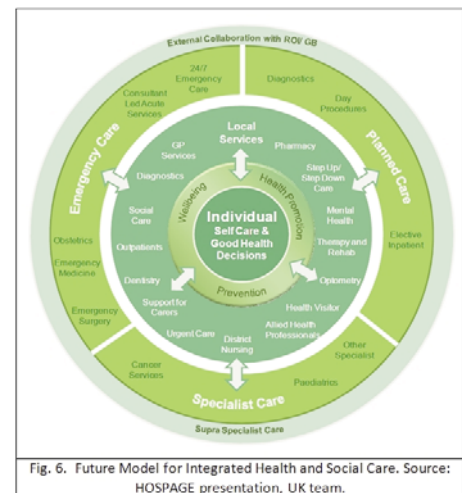
Ageing patients

Interventions and best practices

“Transforming your care” or “Review of Health and Social Care” proposes the development of a future model for integrated health and social care services including acute hospital configuration, the development of primary healthcare services and social care, and the interfaces between sectors to ensure a strategic, focused and planned approach to the delivery of Health and Social Care which responds to the changing environment. The model places the patient, and not the institutions at the centre, quality of care and patient outcomes are the key factors in shaping services.

The principles of the model (Fig. 6) are:

- Patients should be better supported to care for themselves and make good health choices
- Health and social care services should be provided closer to patients, in local areas
- There will be a significant shift from provision of services in hospitals to provision of services closer to home; in the community and/or GP surgeries, where it is safe and effective to do so
- GPs are to perform an important role in Integrated Care Partnerships
- A greater use of technology will be implemented to support the delivery of services



Hospital services

- **Emergency Frail Unit.** Short stay elderly unit to avoid admission to hospital, through examination of the patients medical, social and overall care needs with the multidisciplinary team. It is designed for patients over 65 years, frail, vulnerable or potentially at risk but in no life-threatening condition. The unit ensures discharge within 24 - 48 hours and with a modest use of beds allows better care and higher efficiency.
- **Acute response team.** Acute nursing interventions within the patients home activate through a referral from GPs or hospital consultants. Allows to avoid hospitalisation and to achieve earlier discharge from hospital. In 2011-2012 the acute response team in Carmarthenshire, Wales, treated 411 patients with IV antibiotics at home thereby reducing hospital admissions by 4100 bed days saving £1 million.
- **Butterfly scheme.** A practical strategy for improving the care of patients with dementia and other cognitive deficits. The Butterfly Scheme can be voluntarily embraced, and allows people whose memory is permanently affected by dementia to make this clear to hospital staff by at-a-glance discreet identification by butterfly symbol and provides staff with a simple, practical strategy for meeting their needs by specific five-point targeted response and easy-to-use carer information sheet. The patients receive more effective and appropriate care, reducing their stress levels and increasing their safety and well-being, and staff are happier and less stressed.

Community care

- **Dementia café.** A place to enable elderly people with dementia and their carers to socialise, meeting once a week in the community to share experiences, guided by professional facilitators (nurses, occupational therapists, social workers). A 2011 evaluation study shows that Dementia cafes promote social inclusion, prevent isolation and improve the social and emotional well-being of attendees.
- **Single point of access.** A one telephone number system to avoid inappropriate admissions of elderly to hospital. Calls from GPs or community nurses are answered by healthcare professionals who clinically navigate patients to the most appropriate service in community.

FOOTNOTES

1. Source: Busse, R., Blümel, L., Scheller-Kreinsen, D., Zentner, A. Tackling Chronic Disease in Europe Strategies, interventions and challenges Observatory Studies Series, No 20, WHO Regional Office for Europe.
2. Source: European Commission, 2009 Ageing Report.
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4. Source: Matthias Wismar, Claudia B. Maier, Irene A. Glinos, Gilles Dussault, Josep Figueras, Health professional mobility and health systems. Evidence from 17 European countries.
5. Source: Matthias Wismar, Claudia B. Maier, Irene A. Glinos, Gilles Dussault, Josep Figueras, Health professional mobility and health systems. Evidence from 17 European countries.
6. Source: Rechel, B., Y. Doyle, et al. (2009). How can health systems respond to population ageing? Joint Observatory/HEN series on Health Systems and Policy Analysis, Policy Brief No. 10. Copenhagen, World Health Organization, on behalf of the European Observatory on Health Systems and Policies.
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10. Source: Rechel, B., Y. Doyle, et al. (2009). How can health systems respond to population ageing? Joint Observatory/HEN series on Health Systems and Policy Analysis, Policy Brief No. 10. Copenhagen, World Health Organization, on behalf of the European Observatory on Health Systems and Policies.

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