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1 ABSTRACT:

Demographic ageing is one of the most serious challenges Europe. It means that there will be more than twice as many old people aged over 80 years old in 2050. Changing in the population age groups will influence to health and social sector in many ways. The Social Protection Committee (2011) highlighted increasing the effectiveness, sustainability and responsiveness of healthcare and long-term care. On the focus is promote access, quality and sustainability of LTC. There is an increasing trend towards to organizing more services in home care. The challenges of the future are in workforce planning (recruitment and retention practices) as well in skills anticipation of future HHCP by training of staff and /or new workers. Population ageing is generating a need and a demand for more and better jobs in long-term care.

This report is referring the skill and competency needs in the homecare sector. The report based on findings of questionnaires of HHCP, structured interviews of older persons in CARESS project partner countries Italy, Spain and Finland as well on literature view of other EU countries.

Analyses highlighted the increasing demands for health and social care and greater need for a trained health and care workforce. The main skills drivers for health professionals over the next decades will be financial, organisational, legislative, demographic and technological, several of these are interlinked. The now demanding role of HHCP means a broad range of skills, depending on practice needs which may include health assessment, empowerment, communication, health education, greater sensitivity and advocacy for clients' rights, case management, ICT skills and group work.

There are three general trends in homecare sector: moving from institutionale care to home care, moving from 'traditional' approach to innovative approach including reducing of ageing stereotypes, long-term 'cure' to flexible customer-orienteted long-term 'care´ and moving from informal care to formal. The challenges of the future will be highlighting on dignity, rights-based and guality of life-based approaches including prevention, rehabilitation and social support. Services are developing more customer-focused approaches, creating more choice in home care service delivery. Future home care would to organise interdisciplinary by providing innovative welfare technology solutions. ICT and technological solutions tend to be more cost-efficient and effective by providing support and services at home.

2 KEYWORDS:

Home care (community based care); Home Health Care Practitioners (HHCP); Long Term Care (LTC), Formal and Informal Care; Knowledge, Skills and Competence (KSC)

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Identification of skill and competency needs in the home care sector: main definitions, issues and challenges	Sirje Hassinen	Full Partner	Omnia	30.5.16
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6 Table of Contents

7 INTRODUCTION: STRUCTURE AND AIMS OF THE DOCUMENT.

This report will introduce the skills and competences what will need in the home care sector. The aims of the document are:

- collect and analyse information about skill and competency needs in the field of homecare;
- gathering secondary data such as available literature, statistics, available researches/projects results about the specific sector and other available documentation;
- gathering primary data during e-questionnaires for HHCP (involving VET providers, professional association, regulatory institutions, both participating in the project and not) and structured interviews of older people (involving representatives of end users) and analysing the skill and competence needs.

The founding of this documents will be the general preparation material, collecting and mapping background information for the design of the EU Framework (WP3), the design of national pilots (WP3) and their implementation (WP4 and WP5) and evaluation (WP6).

Chapter 7 gives the general terms and main definition of CARESS project. The review of identification of skill and competencey needs in the home care sector (Chapter 7) is based on previous studies, literature and other publications concerning the changing in population age group, new needs in home care sector and analyse of skill and competency needs in the future. Chapter 7 describes the EU policy context and presents statistics on expenditure in the home care sector in Europe, the recipients of care, and employment in the sector. The analyses of skills and competency needs in Italy (Chapter 8), Spain (Chapter 9) and Finland (Chapter 10), the partner countries, is based on the answers of HHCP questionnaires and interviews of older persons, as well on the anticipation researchers and analyses. Chapter 11 gives a short review of skill and competency needs in the other EU countries. The overview

based on the literature. Chapter 12 provides a summary and discussion of the outcomes of the collected material and results. Chapter 13 draws a number of conclusions from the study and offers a list of needed skills and competences.

8 IDENTIFICATION OF SKILL AND COMPETENCY NEEDS IN THE HOME CARE SECTOR: MAIN DEFINITIONS, ISSUES AND CHALLENGES

Main definitions

Home care is care delivered at home. A specific definition provided to **the home-care services**: Home care services are a combination of health and social care to be provided in the social environment of the needy person. Home care – community based care: the term 'home care' can have different meaning in different countries and in some countries a narrower meaning. By review of literature the term 'community-based care' is used in preference, while at the same time the people involved are called 'home-care workers', which better describes their activities than the term 'community-based care workers'.

Home Health Care Practitioners (HHCP) are all the professional figures providing "domestic aid services, personal care and supportive, technical and rehabilitative nursing" at home. This definition shows that the discussion does not address one specific occupation or profession. A profession often defines itself by a specific professional identity, a professional history or self-organisation. Definitions of professions and occupations can, however, differ considerably across different countries. NACE code 88.10 (social work activities without accommodation for the elderly and disabled), including home carers, social care workers, social workers, activity workers,4 community nurses and other professions, such as therapists. Certain occupational groups in primary healthcare, such as family doctors and dentists, are excluded.[1]

There are both formal and informal carers providing home care services. **Long Term Care** (LTC) is a range of services and supports needed to meet clients' personal care needs. Most long-term care is not medical care, but rather assistance with the basic personal tasks of everyday life, **Activities of Daily Living** (ADLs). This report analyses knowledge, skills and competences (KSC) of HHCP needed in the home care sector. **Knowledge** means mastering of knowledge that forms foundation for work; the outcome of the assimilation of information through learning. Knowledge is the body of facts, principles, theories and practices that are related to a field of work or study. **Skills means** the ability to apply knowledge and use know-how to complete tasks and solve problems and will understand as mastering of tasks, working methods, tools and materials as well some lifelong learning key competencies. **Competence** will understand as mastering of work processes. Competence is the proven ability to use knowledge, skills and personal, social and/or methodological abilities in work or study situations and in professional and personal development.

Change in the age structure and increasing need of care services for older persons

EU population and age structure will change strongly in the coming decades. Dramatic increasing is projected from 507 million (2013) up to 2050 by almost 5%, when it will peak (at 526 million) and will thereafter decline slowly (to 523 million in 2060[2]). It means that there will be more than twice as many old

[1] https://www.oecd.org/els/health-systems/PolicyBrief-Good-Life-in-Old-Age.pdf, 2013: 2, 5–6.
[2] http://ec.europa.eu/economy_finance/publications, 2015: 1.

people aged over 80 years old in 2050 compared situation in 2013[3] and moving from having four working-age people for every person aged over 65 years to about two working-age persons[4].

By Eurostad statistic analyse can expect higher life expectancy (Table 1) and longer healthy and active ageing years to be free from conditions affecting their ability to manage daily living activities. Older persons like continue independent living even as they become frail. The risk of needing long-term care rises steeply from the age of 80 and 25–50 % of them will expect need help in their daily lives[5].

Table 1. Expectancy of healthy life years[6]

	Total years life expectancy at 65, men	Healthy years life expectancy at 65, men	Percentage of healthy years life expectancy at 65, men	Total years life expectancy at 65, women	Healthy years life expectancy at 65, women	Percentage of healthy years life expectancy at 65, women
EU-27	16.5	8.4	51.0%	20.1	8.6	42.7%

Source: Eurostat Statistics Database; Joint Action European Health and Life Expectancy Information System (JA EHLEIS). http://dx.doi.org/10.1787/888932702936

Analyses will show that LTC affects men and women very differently: older women have a higher life expectancy, so most LTC recipients are women. It is expected that long-term care is the fastest-growing division within the health and social care sector. New users of care services demand more voice and control over their lives[7].

Changing in the population age groups will influence to health and social sector in many ways. There will be need for more flexible serveces, more educated staff and extra budgetary. The current modes of LTC of older peoples' are not sustainalbe in view of the major demographic shift. Population ageing poses a challenge for the public finances (pensions, health care, long-term care and education) in the EU. Looking at the components of strictly age-related expenditure, the increase between 2013 and 2060 is mostly driven by health care and longterm care spending, which combined is projected to rise by about 2 pp. of GDP (Health care: +0.9 pp., Long-term care: +1.1 pp.)[8]. The document of European Commission (2013) *Long-term care in ageing societies – Challenges and policy options* argues that Europe needs to prepare for a tripling of the number of people in the age group most likely to need long-term care (people aged 80 years and over) by 2060[9]. By OECD (2011) estimates that the number of people working in long-term care will double by 2050[10]. LTC services are increasingly being delivered in care recipients' homes. There is a clear trend towards deinstitutionalising care. It is expected that the number of people in home-based care will increase by 130% by 2050[11].

[3] https://www.oecd.org/els/health-systems/PolicyBrief-Good-Life-in-Old-Age.pdf, 2013: 1.
[4] http://ec.europa.eu/economy_finance/publications, 2015: 1.
[5] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf*, 2014: 6.
[6] https://www.oecd.org/els/health-systems/PolicyBrief-Good-Life-in-Old-Age.pdf, 2013: 1.
[7] https://www.oecd.org/els/health-systems/PolicyBrief-Good-Life-in-Old-Age.pdf, 2013: 1.
[8] http://ec.europa.eu/economy_finance/publications, 2015: 4.
[9] http://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1353en.pdf, 2013: 10.
[10] http://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1353en.pdf, 2013: 14.
[11] https://www.oecd.org/els/health-systems/PolicyBrief-Good-Life-in-Old-Age.pdf. 2013: 8.

The Social Protection Committee (2011) highlighted increasing the effectiveness, sustainability and responsiveness of healthcare and long-term care. On the focus is promote access, quality and sustainability of LTC. The Social Protection Committee focuses the most relevant objectives[12]:

- enhancing the provision of long-term care services (a mix of home, community and institutional services) to all layers of the population;
- reducing geographical differences in availability and quality of care;
- prioritising tailor-made care and support services to ensure that people live in their home for as long as possible;
- creating quality assurance measures;
- placing emphasis on health promotion at all ages including old age, disease prevention and rehabilitation policies;
- ensuring sufficient human resources through formal staff training, motivation and working conditions;
- facilitate and promote intra-EU labour mobility and better match labour supply and demand with appropriate financial support from the structural funds'.

Home-care care services are already prevalent across the EU as providing care and support for older people and for those with disabilities in a financially sustainable manner. The balance of community-based versus institutional care for adults with disabilities varies across countries. According to data for 2010 from Eurostat, personal (home care) services represented 5.4 million jobs in the EU. As number of older persons and home care services is increasing OECD suggests approximately 80% of workers and about 228,000 new health professional jobs in the sector are involved in care for the elderly[13]. Much of this growth is anticipated for health professionals working outside of the traditional health sector as well in the number of health professional jobs requiring medium-level qualifications (+38% from 2013 to 2025)[14]. Mobility of HHCP will grow and one trend is right now mobility of East European health professionals who choose to work in countries where pay levels are higher.

However, home care sector has an image problem and is not very attractive among young people. Home care is as associated with low recognition and salaries, difficult work in poor terms of working condition, leading to high staff turnover. Partly of the subjective perception caring is not a high-status occupation. Many of home care workers are informal, without special education and training. The vast majority of both informal and formal carers are women[15]. There is quite strong cultural tradition in some countries, that family members should be solely responsible for their care at home. Cultural attitudes towards the care of older peoples have to change and open to availability of home care services. This will contribute to the independence of older people as well improving the quality of life of their families[16].

New direction: from institutional care to homecare

There is an increasing trend towards to organizing more services in home care. The home care appears to be driven by lower costs, policies promoting the greater independence of older people, the preferences of clients and the potential of assisted-living technology. Innovative welfare technological and assisted-living technological developments could lead to higher labour productivity in home-based care and care at home has become more feasible. The challenges of the future are in workforce planning (recruitment and retention practices) as well in skills anticipation of future HHCP by training of staff and /or new workers.

[12] http://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1353en.pdf; 2013: 9.
[13] http://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1353en.pdf; 2013: 14.
[14] http://skillspanorama.cedefop.europa.eu/sites/default/files/AH_HealthProfessionals_0.pdf.
[15] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf.* 2014: 10.
[16] http://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1353en.pdf; 2013:61.

There suggested four overall strategies to combat the labour market discrepancies: targeting labour reserves; promoting and facilitating education for potential employees; improving the circumstances of current employees and improving the operational management and labour productivity of organisations[17].

More as numbers and ressources will higligted flexible services: different type of services, integrated and person-centered services. “Quality of life” relates to LTC recipients’ ability to live at their highest physical, mental, emotional and social potential, in condition of consumer choice, autonomy, dignity, comfort, security, relationships and social activity. There are some indicators of quality of home care as waiting time for LTC services access, bed-sores, medication use, weight loss or elderly falls and related fractures (collected only in about a third of OECD countries) but only a minority measures of depression among old dependent people (Finland, Iceland, the Netherlands and the United States)[18]. Quality, dignity and fight against elder abuse (control, monitoring, support) will be key challenges in the future development. Aspects as effectiveness and safety, patient-centredness and responsiveness, and care co-ordination are generally accepted as critical to quality of care.

Often healthcare and social services are mixed and healthcare services (or the contrary) offering additional social support. There are diversity berween countries and in the countires. Home care is delivered informally by families/children and friends and formally by care assistants who are paid under some form of employment contract. Pressure for increased public provision and financing of home care services will grow substantially and especially in Member States where the bulk of LTC is currently provided informally. 5-146

For offering flexible services and quality of life, two dimensions are to be taken into account: the future availability of potential informal carers and their propensity to provide care. European Commission (2012) aimed to identify strategies for dealing with better work–life balance, achieved through increased transfer of daily tasks done in the home to service providers; job creation for the relatively low-skilled, particularly in housework services and improvement in the quality of care.[19] Staff qualification requirements differ in EU countires and are not regulated in home care. The hours, settings, training modules, and final certification process vary from around 75 hours in the United States and from 75 weeks of total training in Denmark to three years training for certified care workers[20]. In the future staff shortages will potentially increasing. Staff shortages have encouraged countries to develop policies to attract unemployed people and migrants to home care sector as well to stress to education and training.[21] The goal is to increase the motivation and professional competences of carers and to increase cross-border labour mobility for geographical reduce of labour market shortages[22].

Identifying skills and competences of future HHCP

A key issue for home care professionals is widespread recruitment difficulties, particularly given the specialised skills profile. Identifying the skills that will be necessary for LTC care workers is challenge. Home care services includes a range personal care services to help older people with basic activities of daily living, as well as basic medical services, nursing care, prevention, rehabilitation or palliative care; including also domestic help and help with administrative tasks. There are several projects in EU mapping skills and competences in the healthcare sector, European Sector Council on Employment and Skills for the Nursing and Care Workforce, aiming to contribute to the EU Skills Panorama (overview of emerging skills needs and will contain a common multilingual classification of occupations and skills. A skills forecast from Cedefop

[17] http://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1353en.pdf; 2013: 11, 16, 57.
[18] https://www.oecd.org/els/health-systems/PolicyBrief-Good-Life-in-Old-Age.pdf. 2013: 2–3.
[19] http://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1353en.pdf; 2013: 10.
[20] https://www.oecd.org/els/health-systems/PolicyBrief-Good-Life-in-Old-Age.pdf. 2013: 4.
[21] http://ec.europa.eu/economy_finance/publications. 2015: 147.
[22] http://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1353en.pdf; 2013: 12.

will be another building block of this panorama. The Commission states in a directive on professional qualifications that Member States need to mutually recognise professional qualifications.[23]

Following skills and competences will needed by HHCP in the future in home care sector:

- **Communication skills:**[24]
  Excellent oral and written expression;
  Comprehension skills;
  Presentation skills, generally and in the specific technical discipline.
  Supporting families (psychosocial interventions and the creation of social support networks to community-based programmes, including breastfeeding and antenatal care);
  Communication with different organisations, skills for working intersectorally;
  Methods how to communicate emotional support and warmth.
- **Customer and personal service skills, social skills**
  More general competences in personal service;
  Management, business and counselling skills.
- **Ethics and the quality of services**
- **Assessment and guidance skills**[25]
  Knowledge and skills to assess customer needs, meet quality standards for services, and evaluate of customer satisfaction;
  Promoting healthy lifestyle working in partnership;
  The information and techniques of their particular branch of health in order to diagnose and treat human (and animal) injuries and diseases (including understanding symptoms, treatments and their alternatives, proactive and preventative health care measures);
  Knowledge and skills to use Mesuramants of customers needs, standardised assessment tools (examples: the Resident Assessment Instrument RAI, the AGGIR scale, KATZ);
  Better care guidance skills for people with complex neurodegenerative conditions such as dementia;
  A holistic approach to identify the health needs of older people, and by focusing on prevention of ill health and disability.
- **Administration and management skills**[26]**:**
  Strategic planning, resource allocation, leadership, and coordination of people and resources;
  Organisational skills, skills division of tasks;
  Entrepreneurial skills;
  Problem solving and decision making skills;
  Critical leadership skills include change management, strategic planning, the ability to form alliances and communication.
- **Therapy and counselling skills**[27]**:**
  Principles, methods, and procedures for diagnosis, treatment, and rehabilitation of physical and mental conditions, injuries and diseases;
  Understanding of a range of specialist equipment; the use of new technologies and the use of different diagnostic techniques;
  Guidance for clients to gain acceptance of the technology;
  Skills in preventative care.

[23] http://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1353en.pdf; 2013: 11-12.
[24] http://skillspanorama.cedefop.europa.eu/sites/default/files/AH_HealthProfessionals_0.pdf; 3-17, 23
[25] www.euro.who.int/__data/assets/pdf_file/0017/.../E73039.pdf. 2000: 18, 20. https://www.oecd.org/els/health-systems/PolicyBrief-Good-Life-in-Old-Age.pdf. 2013: 5.
[26] http://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1353en.pdf. 2013: 51. www.euro.who.int/__data/assets/pdf_file/0017/.../E73039.pdf. 2000: 20.
[27] http://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1353en.pdf. 2013: 11.

- **Psychology, sociology and anthropology skills:**[28]
  Knowledge of individual and group behaviour and dynamics; individual abilities, personalities, learning and motivation;
  Knowledge of societal trends and influences, human ethnicity and culture;
  Team working skills in multi-disciplinary teams, in self-directing teams;
  Partnerships with clients, patients, communities, other health care personnel and other sectors, including housing, welfare and education, are essential in achieving maximum potential in health and health care.
- **Active learning, listening and comprehension skills:**
  Understanding oral and written information, its interpretation and implications;
  Learning of using of new equipment, treatments and prevention.
- **Sector specific knowledge and skills:**[29]
  Specific educational programmes addressed such areas as sexual health, family life and breastfeeding as well as in generic areas, including leadership development, skills training in community work, decision-making, teamwork and partnership development.
  Knowledge in mental health systems, promoting positive mental health.

The main skills drivers for health professionals over the next decades will be financial, organisational, legislative, demographic and technological, several of these are interlinked. The now demanding role of HHCP means a broad range of skills, depending on practice needs which may include health assessment, empowerment, communication, health education, greater sensitivity and advocacy for clients' rights, case management, political skills and group work. Home care nurses need to be sensitive to assess the availability of social support networks in the community and, if needed, organize different kinds of support groups[30].

Conclusion

Long-term care will face three major, related and simultaneous challenges: huge increase in need, the supply of long term carers and ensuring care quality. There is a clear trend towards deinstitutionalising care, an increase in demand caused by ageing and a reduction in the availability of informal carers.

The other trend is moving from 'traditional' approach to innovative approach including reducing of ageing stereotypes, long-term 'cure' to flexible customer-orienteted long-term 'care´ with highlighting on dignity, rights-based and guality of life-based approaches including prevention, rehabilitation and social support. Services are developing more customer-focused approaches, creating more choice in home care service delivery. Future home care would to organise interdisciplinary by providing innovative welfare technology solutions. ICT and technological solutions tend to be more cost-efficient and effective by providing support and services at home.

Third trend is moving from informal care to formal. The challenges of the future will be formalizing non-fromal employment, recruitment of new workers included unemployed persons and migrants, educate and train more home care workers. Population ageing is generating a need and a demand for more and better jobs in long-term care.

[28] www.euro.who.int/__data/assets/pdf_file/0017/.../E73039.pdf. 2000: 20.
[29] www.euro.who.int/__data/assets/pdf_file/0017/.../E73039.pdf. 2000: 17.
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9 IDENTIFICATION OF SKILL AND COMPETENCY NEEDS IN THE HOMECARE IN ITALY

Data from the Italian Statistical Institute (ISTAT) reveal a nation with an alarming old age/young ratio, reaching the 151,4 % in 2013 and 154,1 in 2014. At regional level Liguria is the one that has the higher old age index 239,5% as registered for years, followed by Friuli Venezia Giulia (196,1%) and Tuscany 190,1%.

Between 2014 and 2050, the old age dependency ratio[31] is expected to increase from 54,6 (64.7 in Liguria) to an extreme 61 (less than 2 persons of working age for one elderly person), and the mean age will increase from 43 to 49 years [data 2014 - ISTAT]. The most intense growth, certainly compared to the rest of Europe, is in the age group of 85+ which will more than triple, up to 7.8% of the total population in 2050.

The demographic evolution occurring in Italy, characterized by simultaneous increase in average life expectancy and incidence of the elderly population, means that a growing number of families will be called upon to offer informal care for increasingly lengthy periods of time.

Even today, the family is the largest welfare institution in Italy. The alternative of institutionalization is rarely preferred and usually limited to cases where the elder has no sons living nearby or they have particular problems. The tendency to keep non- self-sufficient older people at home as long as possible implies a restrained number of institutionalized older persons with respect to those ones living at their own homes. To identify the number of non- self-sufficient older people it is necessary to consider both the about 2 million and 80 thousands disabled persons identified by ISTAT report (2008) with about 161.000 people institutionalized [ISTAT, 2008], obtaining an estimation of about 2.500.000 non-self-sufficient

people. In this context, only 22 hours of health and social homecare per person in a year are provided, against the 28 hours of "youngest" Germany [Istituto Superiore di Sanità, 2016].

A detailed description of the main social and health homecare services envisaged by the Italian national and local law has been provided in Deliverable 2.1 ("Report on HHCPs role, skills and competencies"). The quality and the quantity of the provision of the service is heterogeneous and changes between regions. The ratio between North and South is 10 to 1, and it is the same in the last 15 years.

The Integrated Home Care (ADI – Assistenza Domiciliare Integrata) is the most important model of assistance, both for its intrinsic organizational complexity and for its potential in fitting end-users needs [Pesaresi, 2007]. As a matter of fact, it envisages an integration of different professional competencies and, above all, the integration of two institutional levels (national and local) since social and health services are managed respectively by Municipalities and Regions, often in a "organ-pipe" separation model.

The relation between the healthcare system and the social system as disciplined by law is not even. The healthcare system seems to be the most important aspect while the social system seems to be just a part that must be integrated with the first one. Furthermore, the basic levels of social services have not yet been defined at National level. This leads to a lack of funding by the State. Evidently this situation prevents a real integration between the healthcare and the sanitary systems resulting in a serious difficulty in managing all the human and material resources available at their best potential.

A survey delivered in 2010 by the Italia NNA (Not-Self-Sufficient Network) revealed that older people who actually receives and integrated (social and health) homecare are 8,2 per thousand of the whole over-65 population. Often, what is currently named Integrated Homecare, is managed with huge difficulties especially due to the fact that different Ministries (at national level) and Divisions (at local level) has to manage the social and the health dimension of the homecare.

One of the main problems of this integrated model is the **professional integration of different professionals normally referring to different services:** nursing care, rehabilitation, social assistance, home help, etc. The complexity begins with the patient PIC (*presa in carico*), which is the administrative process for the access/admission of a patient with a social or health problem to an institutional/public care process. It is normally managed by a multidisciplinary equip which draw down an Individualized Assistance Plan (*Piano Assistenziale Individualizzato*). It normally should plan the involvement of both social and health professionals. Actually, the management of the IAP is different between regions and often is limited to the health dimension; then social homecare could be activated through the municipality, but often there's no strict interaction between the health and the social PIC.

Another problem is **the integration between public and private homecare**. The NNA report [2010] stated that about the 48,6% of the families experiencing a public homecare service has to integrate it with further services for pay. The poor provision of public homecare, especially in the south of Italy and with regard to home help [NNA, 2010], and the tendency to keep non- self-sufficient older people at home as long as possible, fed the growth of a solid network of NGOs and volunteers association operating in social care as well as the growth of a huge class of homecare assistants ("*badanti*"), who are often strangers, with irregular employment and with inadequate competencies [Istituto Superiore di Sanità, 2016].

In 2015 2,2 millions of Italians turned to homecare assistants and Social-Health Operators (OSS) to get a nursing service; this is mainly due to the high cost of a professional nurse (33,7%) and to the belief that some performances don't need a nurse to be carried out (31,5%) [Colicelli, 2015].

This tendency feeds up the problem of service inadequacy and the risk connected to no-professional performances [Colicelli, 2015].

In this context, another problem is connected to the high number of professional figures that has been historically involved in home nursing. ASA - Social-Assistance Auxiliary (ausiliario socio assistenziale), OTA Assistance Technical Operator (operatore tecnico addetto all'assistenza), OSA Social Assistance Operator (operatore socio-assitenziale)and ADEST Homecare and Tutelar Services Assistant(Assistente domiciliare e dei servizi tutelari) are some examples of figures who have been trained and employed in the homecare sector in the last years. A State-Regions Agreement in 2001 stated a new figure named **OSS – Social-Health Operator** (operatore socio-sanitario) which should replace all of the previous mentioned figures; after that conference, each region should have ratified this recommendation in local laws, specifying how to manage the necessary integrative training for people who already got ASA, OTA, OSA and ADEST qualifications in order to convert them into OSS qualification. This issue has been managed at local level in different ways, so at national level there's no uniformity about the training paths followed by these professionals.

Aside to homecare assistant, other professionals are normally involved in homecare as free-lance: nurses, physiotherapists, speech therapists and other specialized rehabilitators. In case of particular disabilities, specific associations provides homecare services to older adults, both directly, through specific agreements with the public institutions, and indirectly through a network of specialized and certified private professionals.

The difficulties of an actual Integrated Homecare, the importance of informal caregivers, the presence of a dual PIC process (health and social PIC, managed by regions and municipalities) and the relevance of private homecare in Italy are the main causes of a **scarce integration of homecare information about a single patient** and the difficulties of formulating an effective Individualized Assistance Plan, without taking into account all of the older adults needs and the carers who fulfil them.

To improve the homecare service in Italy an important work has to be carried out in order to start from the real needs of the end-users, taking into account the important perspective of professionals directly involved in their care. To this end, within the CARESS project, an important survey has been carried out targeting both older adults and HHCPs (Home Health Care Practitioners), with the aim to point out the main needs of the end-users and the main issues of the professionals in fitting these needs. In the following section, a detailed description of the results of these surveys will be provided, focusing on HHCPs skill and competency needs.

In a general analysis of the Italian homecare context, some points emerge as crucial for improving the effectiveness of homecare [Boerma et al, 2013; CARESS, 2016; Colicelli, 2015; EUROFAMCARE project, 2006; Istituto Superiore di Sanità, 2016; NNA, 2010; Pesaresi, 2007].

1. **The homecare service should be focused on a global, multi-perspective and multidisciplinary view of the patient**, with the objective of improving his/her perception of the quality of life. To this end, the Individualized Assistance Plan should take into account all of the dimensions of the person and all of the possible services which could be activated to enhance the individual independence.
2. **Patients and their families should be involved** in the definition, monitoring and evaluation of the Individualized Assistance Plan.
3. Home care should be **provided actually in an integrated way,** by formulating, monitoring and evaluating a unique individualized plan, where both public and private, both social and health care are

taken into account; professionals should be able to collaborate and coordinate themselves in a equip, even if they refer to different institutions or are public-employees or free-lance. The homecare service should clearly refer and be integrated with the complex network of health and social services available in the territory.

4. A more detailed description of the roles that each HHCP should play within the homecare process should be provided, in order **to avoid gaps and overlappings in the integrated service provision**.
5. **Specific tools and documentation** should be identified and provided to professionals in order to report properly their activity, foster their collaboration and to support the creation of a unique set of information about the patient homecare, integrated with the National Health System databases; in particular, the integration of information from private and public homecare is crucial.
6. Specific resources of the patient (cultural, physical, etc.), of his/her family and of the social fabric in which he/she lives should be enhanced and promoted in the Individualized Assistance Plan with the aim of **building up with the patient a renewed independent personal life path,** including participation, social and relational aspects**,** which should be known and fostered by all of the professionals taking care of the older adult.
7. Normally the health homecare service replies to assistance and care problems in crucial phases of specific diseases; normally the indicator for the need of an homecare service is not the disease itself, but the problems taken by the disease (bedsores, need for mobilization, etc.). Homecare should be considered as a fundamental instrument **not only for secondary and tertiary prevention, but also for primary prevention**, aiming to prevent diseases or injuries before they ever occurs.
8. Co-morbidity is naturally spread in older adults population, but the most provided homecare services are often the simplest, connected to a single performance which don't take into account the whole complexity of the patient context. An Integrated Homecare Assistance should start from the end-user needs and **take into account co-morbidities, as well as other need of the patient such as independence, social participation and self-realization**.
9. Patients and their families **demand more and more for psychological assistance and are often unsatisfied** by the service provided. According to Cittadinanzattiva report [2006], psychological assistance is envisaged by the 63,2% of the Local Health Agencies, but actually provided to the 16% of the families.
10. More controls should be set on the **competency level of social homecare professionals** contracted by home help agencies (sometimes in agreement with municipalities) or directly contracted by families. Local or regional databases of professionals with a standardized qualification could help to solve this problem, especially if the use of public vouchers or grants for home aid is linked to the service of a professional registered in the database.

A final important dimension to be considered in order to set up an effective homecare service is the role of Information and Communication Technologies in telecare, primary care and health monitoring.

In the last 10 years, telecare has been used more and more for older and disabled people [Boerma et al, 2013]; the client using a tele-care service may ask for help through a dedicated phone or sometimes through specific devices or apps on a mobile device connected with a medical unit. Anyway, this service can provide a support only in emergency situations. Other initiatives, mainly carried out by NGOs and patients associations, are focused on primary care and prevention and aims to monitor fragile individuals through

periodic telephone calls. Sometimes specific "Toll-free telephone number"[32] services are set up with the aim to share information about services, initiatives, awareness campaigns, etc. targeting older adults and their formal and informal carers. By means of this contact older adults in difficulty can also ask for interventions of volunteers (who keep them company at home, go with them to specific offices, take them the shopping, etc.). In the last years new **ICTs has been developed in order to support telecare and primary care in a systematic and effective way**, keeping tracks of patients need and putting them in a network of services and personal relations with improve the quality of their lives. Important investments should be taken this direction in order to support homecare effectiveness. Another important resource can be **remote patient monitoring technologies**, which enables patients with severe chronic diseases or conditions to monitor their blood pressure and other health factors from their homes and share this information electronically with their physicians and other healthcare providers. Italian regions are investing at different levels in remote health monitoring, but in general it is limited to experimental initiatives involving a limited number of users.

The above mentioned Italian contextual elements implies important consequences on HHCPs skill and competency needs, which can be summarized in the following points:

a) HHCPs should **get specific competencies for working in equip**, both if they work in health and in social homecare, both if they are public-employee and they are free-lance; they should be **able and available** to collaborate and cooperate with other professionals in order to **build, monitor and evaluate a Personalized Assistance Plan**, contributing for their specific part, but taking into account the whole objective of improving the older adults quality of life.
b) HHCPs should have specific **competencies concerning the main objectives and aims of primary, secondary and tertiary care**; a specific focus **on primary care** should be provided in their training in order to allow them to contribute, with their specific service, to prevent and early diagnose diseases or health problems, in coordination with the GP and other HHCPs.
c) HHCPs should be aware of the importance of enhancing and promoting patient, families and social fabric resources in order to foster the older adult **to carry out a renewed independent personal life path.**
d) HHCPs should get specific **psychological and relational competencies** in order to support older adults and their families with their need of psychological support and social participation.
e) **HHCP should be able to manage specific tools, report models and documentation**, even supported by ICTs, in order to effectively report their activity and share information about the patient homecare with other professionals and, in general, with the National Health System databases.
f) HCCPs should be trained, each one for the specific service provided, **to use new ICTs supporting telecare, primary care and remote health monitoring.**

Once formalized specific roles in homecare for each HHCP**, specific training courses should be organized to integrate the competencies acquired through the general qualifications and degrees (nurses, physiotherapists, etc.) with specific competences required by the homecare service.**

[32] See for example the"Toll-free telephone number" (+39 800995988) set up by AUSER Liguria and Televita-Agapé, in collaboration with Regione Liguria.

9.1 Overview on the older persons homecare needs in Italy: report on primary data

214 subjects completed the online questionnaire but only 190 have carried out an older adult homecare activity in the last 5 years. The distribution with respect to the different HHCPs answering to the questionnaire is represented in Figure 1. In this report we will present the results of the 190 responders divided by professions.

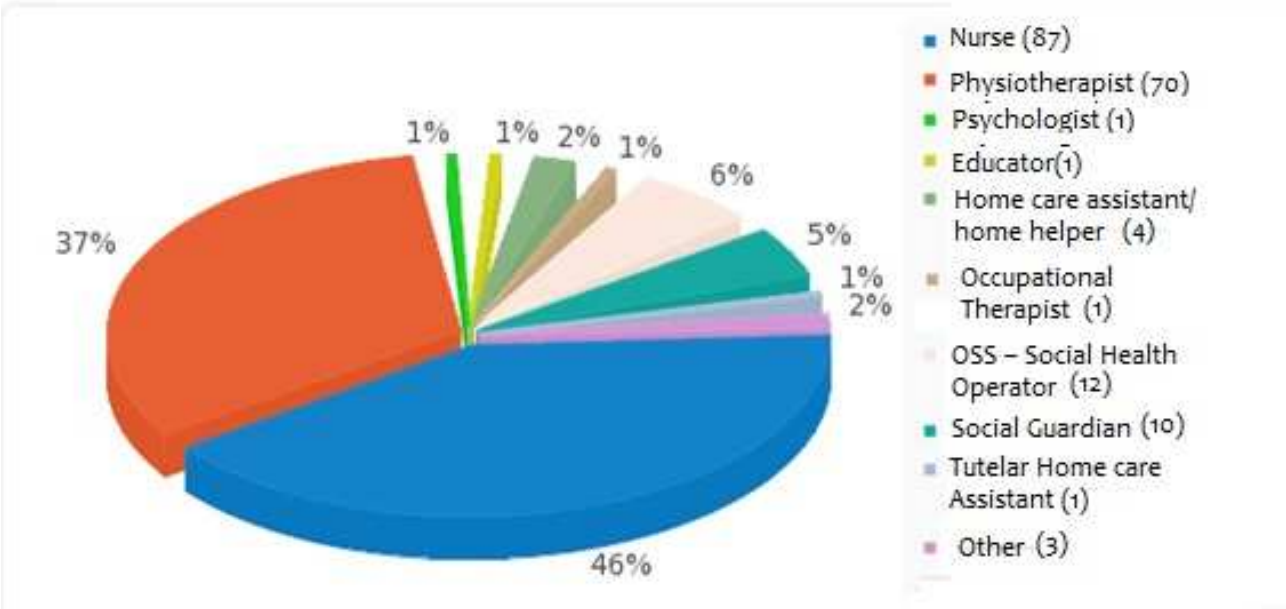


Figure 1. HHCPs answering the questionnaire

The number of older adults interviewed are 28. Type of HHCP involved in the home care service received by the older persons interviewed was: 12 Homecare assistant/Home helper (43% of the total number of subjects interviewed), 9 social guardian (21% of the total number of subjects interviewed), 1 educator (4% of the total number of subjects interviewed) and 6 rehabilitation staff (21% of the total number of subjects interviewed).

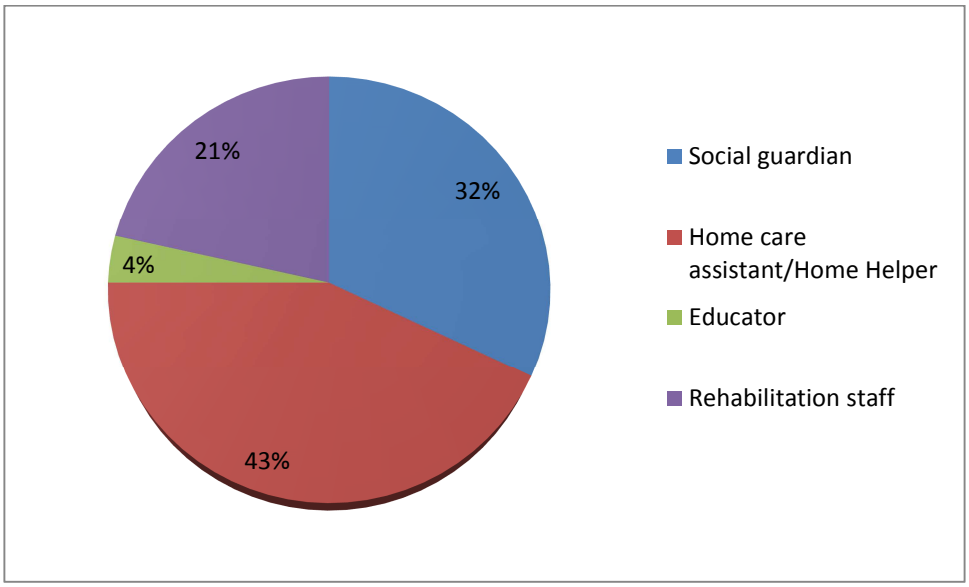
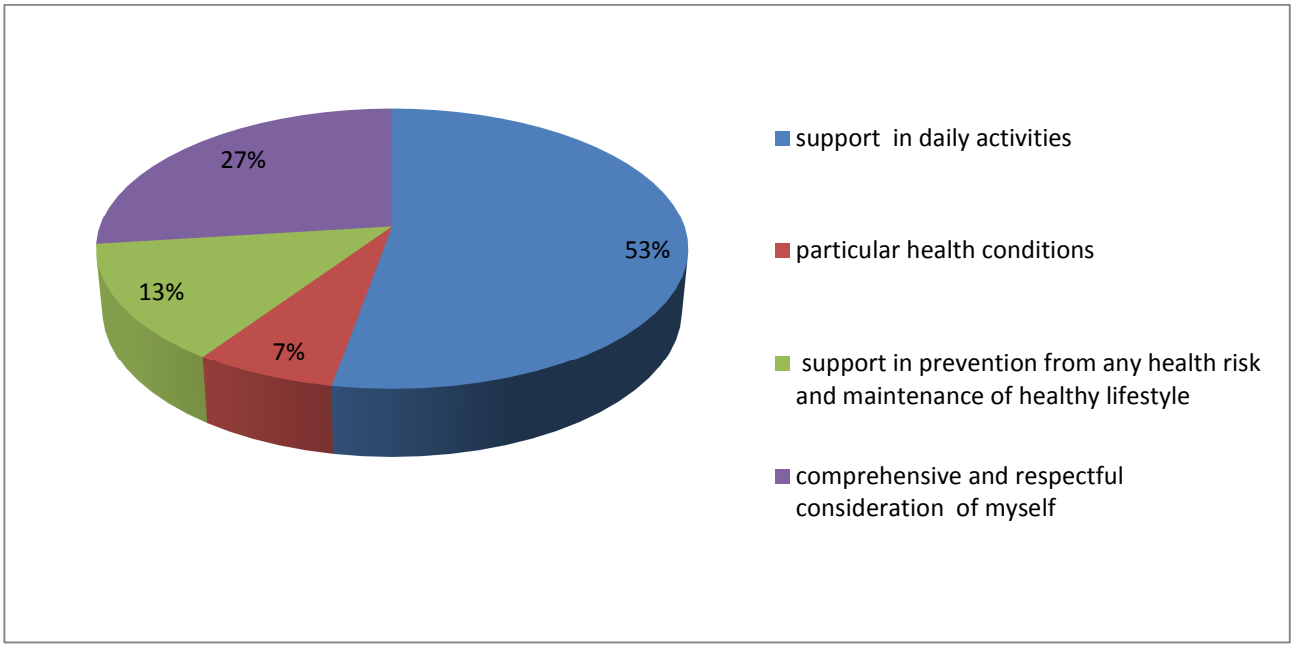


Figure 2.

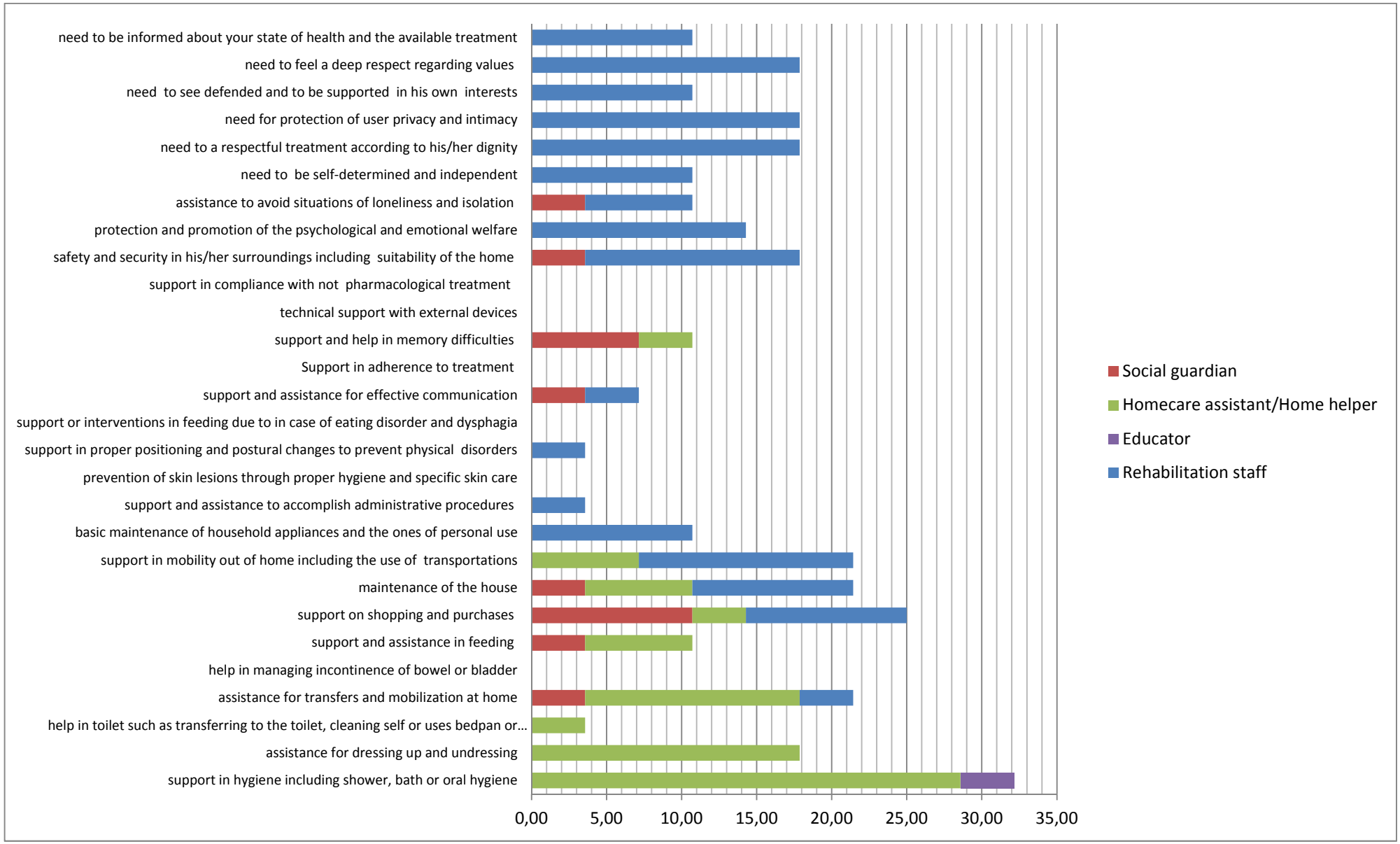
Investigating the needs that the professional fulfilled providing the service (QUESTION 2.1), the older adults interviewed pointed out: [47 (53%)] need to be supported in daily living, 6 (7%) support for particular health conditions, [12 (13%)] support in prevention health risks and mantainance of healthy lifestyle and [24 (27%)] of them was related to comprehensive and respectful consideration of self (Figure 2). In particular older adults reported that the need most satisfied from healthcare services provided by HHCP included support in hygiene including shower, bath or oral hygiene (32,14%); support in shopping and purchasing (25%) maintenance of the house including cleaning the floors, laundry, organization of the clothes inside the home etc. (21.43%) and support in mobility out of home including the use of public or private transportations (21.43%) (Table 1).

Figure 3. Older adults needs satisfied by HHCP



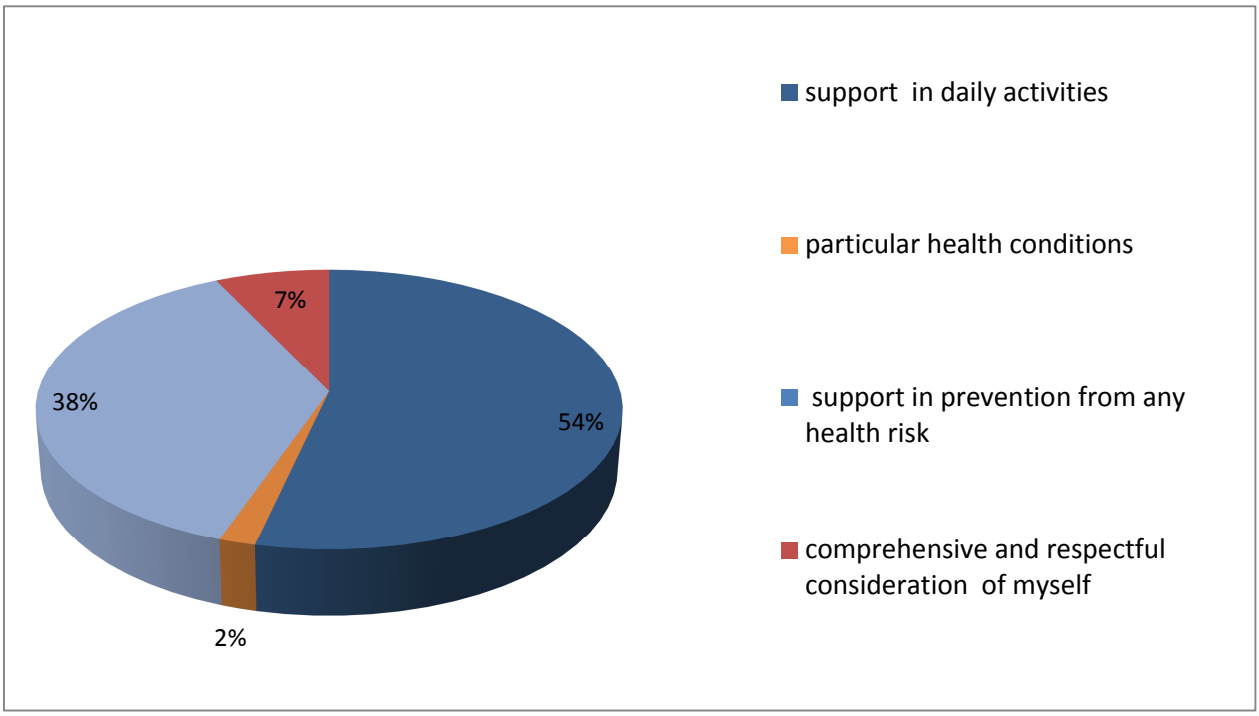
Focusing on needs that you'd like to have satisfied but the professional doesn't fulfilled (QUESTION 2.3), only 4 subjects reported that there was some needs unsatisfied and most of them referred to the support in prevention from any health risk (including home suitability) and maintenance of healthy lifestyle and wellbeing including physical health, in particular every one of the subjects interviewed pointed out assistance to avoid situations of loneliness and isolation and half of them protection and promotion of the psychological and emotional welfare and 2 of them the needs to be assisted in maintenance of the house and need to be informed about their health status.

Figure 4. Older adults needs satisfied per HHCP



The most relevant needs for users included (question 2.4 of the interview): care for and clean the home environment; help in daily activities; help in the mobilization inside the house; meal preparation; greater flexibility on the part of the operators; support personal hygiene; need understanding and attention; socializing and having simple and short dialogues. Clustering the different type of needs per area, the most relevant needs reported was for 54% Need of support in daily activities (including hygiene, mobility, dressing, cleaning, food, mobility in and out of home etc.) and managing home and own interests, 38% was need for support in prevention from any health risk (including home suitability) and maintenance of healthy lifestyle and wellbeing including physical health (such as physical exercises or walks) mental wellbeing, and social relationships, 7% the need of a comprehensive and respectful consideration of myself, according to my dignity and values including privacy, intimacy, independency and protection from mistreatments, 2% Support in particular health conditions that require specialists such as skin lesions, technical help in managing medical tools, assumption and management of therapy.

Figure 5. Priority needs area.



Asking for the most requested by users skills/characteristics, the subjects reported mostly the following ones: honesty, respect, understanding, gentleness, patience, kindness, helpfulness, empathy, education, expertise, professionalism. Clustering the skills/characteristics based on the typology (relationship/ professionality/healthcare competences), we can appreciate that the relationship has been considered as the most important aspect required by an HHCP.

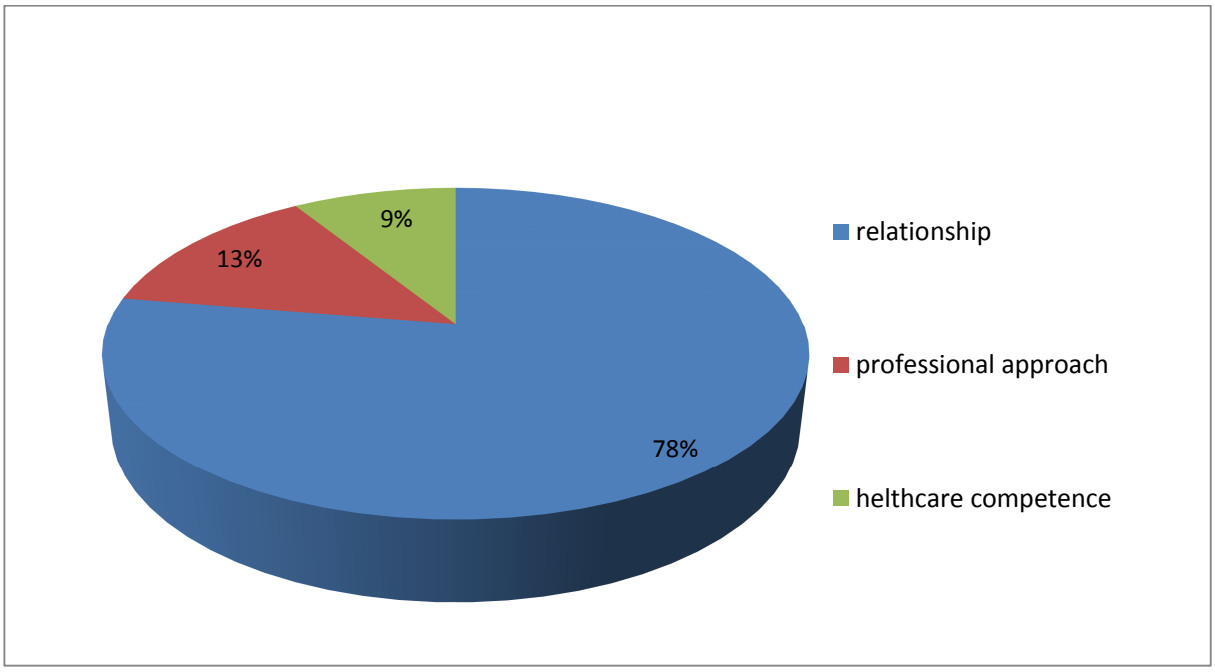


Figure 6.

9.1.1 Nurses

All the Nurses provided complete answers to the questionnaire are not freelance, the 82,76% works for Public institutional homecare providers and the 17,24% for private providers, no freelancers. Unfortunately no freelancers nurses have been reached by the questionnaire proposed.

Following the structure of the questionnaire the first question is related to the needs Nurses address with their activity. In Figure 7 is represented the distribution of the answers.

The section of needs related to the *basic personal attention* has received the less number of selection by the nurses as well as the section of needs related to a *comprehensive consideration of the person* and *needs in situations involving particularly prevalent diseases in aging* are the two section of needs with the higher selection by nurses, i.e. more perceived as related to nurses activity.**Error! Reference source not found.** resume those percentages.

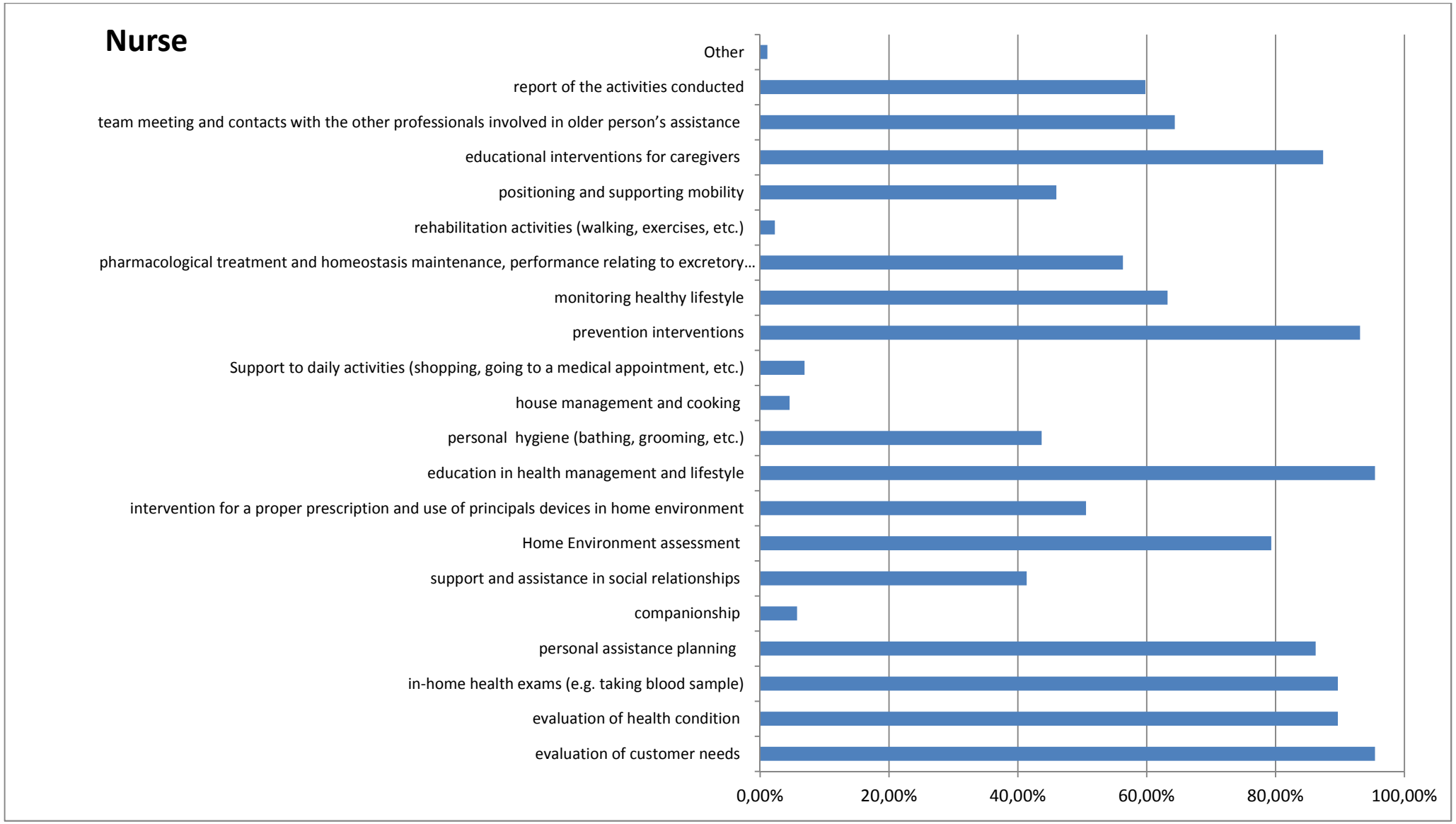


Figure 7. Nurses answers on activites carried out

Need for protection of user privacy and intimacy .	*73,56%*
Need to a respectful treatment according to his/her dignity.	*77,01%*
Need of technical support with external devices: Oxygen, NIMV (non-invasive mechanical ventilation), feed pumps, infusion pumps, home peritoneal dialysis, etc ...	*78,16%*
Need to be informed about your state of health and the available treatment and care options	*78,16%*
Specific care of urinary and fecal incontinence.	*79,31%*
Need to be supported and educated in proper positioning and postural changes to prevent physical disorders.	*80,46%*
Prevention of skin lesions through proper hygiene, postural changes and specific skin care.	*88,51%*

Table 2. Needs that received the higher percentage of selection by nurses.

We proposed a list of competences, asking to subjects to identify which are required, their level of mastery and how they acquired such competence. Nurses 31 recognized as required 31 of the 42 competences and 5 of the 11 competences perceived as "not required" are recognized in the same manner by the other professions, i.e. probably those competences are not significant et all.
The trend of the answers to the questions is common to all the item of the lists recognized as required, those competences has been declared, by the majority of the responders, managed with high mastery acquired both "attending a school, a training course or an academic course" then "working practice". Only few items have a different behavior in the answers trend.
The item **Basics in social-health services organizations and networks** has been recognized as required competence by 4 type of Italian practitioner but there is no an homogenous perception of how they manage this competence for Nurses. The reason can be found in the acquisition of this competence.

Competences	Nurses
Low Mastery	20,69%
Mean Mastery	32,18%
High Mastery	34,48%

Tabella 3 Overview of answers to how the practitioner master the competence "basic in social health services organizations and network"

The 44.83% of nurses acquired the competence during courses (with respect to a 33.33% that indicate not during courses) but at the same time the 80.46% of nurses declare to have learned such competence by working practice. This can suggest the need to introduce/improve the training on this competence. Similarly the **Basics in law and human rights frameworks** competence for Nurses has a medium/low level of mastery (29,89% medium and 26,44 low) even if it has been acquired by the majority of the responders both at official courses and working practice.

Some additional competences have been proposed by nurses in particular ***competence on relating with familiars and other informal caregivers*** seems to be the most required.

With respect to the proposed competence and needs few nurses (9.20%) identify possible further older persons' needs that they could address during they activity at home. In particular three needs acquired the major number of choices (62%):

1. Need to be supported in hygiene including shower or bath or oral hygiene.
2. Need of assistance to avoid situations of loneliness and isolation and facilitate family and social relations or participation.
3. Need of support in compliance with non pharmachological treatment including active and health lifestyle such as prescribed diet, food intake control, physical excercises

In correspondence to the identified additional need Nurses indicated also the required competences and how they manage them. Also in this case, as happens in the previous section, the 9,20% of nurses indicated the additional needs recognized 39 on 42 competences as required with the usual trend.

The majority of them perceived the level of how they master the competence Average or High level. The competences have been acquired attending a school, training courses or academic courses and have been improved during working practice. The only competence that deviates from this trend is the item **Competencies for terminal illness support**, for it there is not a defined majority identifying if this competence has been acquired attending at courses or not (50% equally distributed). More over this competence has no a clear majority on the question related to how they manage it, in fact 25% answered low mastery, 25% answered average mastery, 37,5% answered high mastery and 12,5% preferred to avoid answering.

9.1.2 Physiotherapists

The questionnaire has been disseminated by the Italian association of Physiotherapists (AIFI) but unfortunately only 70 of them concluded the on-line procedure.

Differently from the other involved practitioners, the majority of Physiotherapists are freelance with a high level of education EQF 6.

With respect to the proposed list of needs they normally address in their activity at old person's home, the needs related to the *Comprehensive consideration of the person* and the needs *in situations involving particularly prevalent diseases in aging* received the majority of choices by physiotherapists, instead the needs related to *basic personal attention* have been less addressed.

To give an overview of the main addressed needs (are detailed reported in deliverable D2.1 CARESS, 2006) in 4 we reported the list of the main needs identified by the Physiotherapists with the related percentage.

Need to a respectful treatment according to his/her dignity	*70,00%*
Need of assistance for transfers and mobilization at home	*71,43%*
Need to be informed about your state of health and the available treatment and care options	*72,86%*
Need to feel safe and secure in his/her surroundings including suitability of the home to prevent "static causes "of falls (assistance in removing barriers and adaptation of the home).	*88,57%*
Need to be supported and educated in proper positioning and postural changes to prevent physical disorders	*92,86%*

Table 4 main needs identified by the Physiotherapists

After the identification of covered needs the required competences identified by Physiotherapists are almost half of the proposed, i.e. 21 on 42. For all the required competences the practitioners opinion about how they manage them is mainly at high mastery level, as well as they declared to have acquired them during official training and by practicing.

The greater percentage of consensus on required competences, have been reached by the competences more related to their activity (Table 5) and , as expected, that they manage at high mastery level.

Competence	*IS THE COMPETENCE REQUIRED?*		*SELF-EVALUATE THE LEVEL YOU MASTER THE COMPETENCE*		*COMPETENCE ACQUIRED ATTENDING A SCHOOL, A TRAINING COURSE OR AN ACADEMIC COURSE*		*COMPETENCE ACQUIRED BY WORKING PRACTICE*	
Basics in anatomy and pathology	Required	94,29%	No answers	4,29%	No answers	4,29%	No answers	10,00%
	Not Required	5,71%	Low Mastery	0,00%	No	0,00%	No	12,86%
			Mean Mastery	12,86%	Yes	95,71%	Yes	77,14%
			High Mastery	82,86%				
Basics in older person's healthy lifestyles	Required	94,29%	No answers	7,14%	No answers	8,57%	No answers	10,00%
	Not Required	5,71%	Low Mastery	2,86%	No	22,86%	No	7,14%
			Mean Mastery	34,29%	Yes	68,57%	Yes	82,86%
			High Mastery	55,71%				
Knowledge about the main aids and devices for older and disabled people	Required	98,57%	No answers	1,43%	No answers	5,71%	No answers	5,71%
	Not Required	1,43%	Low Mastery	2,86%	No	14,29%	No	5,71%
			Mean Mastery	17,14%	Yes	80,00%	Yes	88,57%
			High Mastery	78,57%				
Procedures for customer moving	Required	98,57%	No answers	0,00%	No answers	1,43%	No answers	2,86%
	Not Required	1,43%	Low Mastery	1,43%	No	4,29%	No	4,29%
			Mean Mastery	11,43%	Yes	94,29%	Yes	92,86%
			High Mastery	87,14%				

Table 5 List competences recognized as required by Physioterapists with the relate percentage of selection

As reported in 5 only the competence **Basics in older person's healthy lifestyles** seems to have been learned mainly at working practice.

The competences identified as required by a minor number of responders are reported in Table 6.

	IS THE COMPETENCE REQUIRED?		*SELF-EVALUATE THE LEVEL YOU MASTER THE COMPETENCE*		*COMPETENCE ACQUIRED ATTENDING A SCHOOL, A TRAINING COURSE OR AN ACADEMIC COURSE*		*COMPETENCE ACQUIRED BY WORKING PRACTICE*	
Other specific basic medical procedures related to my profession	Required	50,00%	No answers	48,57%	No answers	52,86%	No answers	51,43%
	Not Required	45,71%	Low Mastery	4,29%	No	8,57%	No	1,43%
	No answers	4,29%	Mean Mastery	20,00%	Yes	38,57%	Yes	47,14%
			High Mastery	27,14%				
Procedures for fostering customers going out of home	Required	64,29%	No answers	28,57%	No answers	32,86%	No answers	31,43%
	Not Required	35,71%	Low Mastery	5,71%	No	47,14%	No	4,29%
	No answers	0,00%	Mean Mastery	25,71%	Yes	20,00%	Yes	64,29%
			High Mastery	40,00%				
Providing the customer with	Required	51,43%	No answers	47,14%	No answers	51,43%	No answers	45,71%

contextualized and personalized information about the network of services he/she can rely on	Not Required	48,57%	Low Mastery	7,14%	No	35,71%	No	2,86%
	No answers	0,00%	Mean Mastery	25,71%	Yes	12,86%	Yes	51,43%
			High Mastery	20,00%				
Competences for evaluating customer mental health status	Required	57,14%	No answers	38,57%	No answers	42,86%	No answers	40,00%
	Not Required	42,86%	Low Mastery	11,43%	No	12,86%	No	7,14%
	No answers		Mean Mastery	27,14%	Yes	44,29%	Yes	52,86%
			High Mastery	22,86%				
Competencies for supporting the customer in building up an independent living path.	Required	55,71%	No answers	40,00%	No answers	45,71%	No answers	47,14%
	Not Required	42,86%	Low Mastery	5,71%	No	32,86%	No	7,14%
	No answers	1,43%	Mean Mastery	21,43%	Yes	21,43%	Yes	45,71%
			High Mastery	32,86%				

Table 6 List competences recognized as required by Physioterapists with a lower percentage

The item reported in Table have a different behavior with respect the general trend since they was mainly acquired by working practice and no on training courses, as well as there is not a clear characterization of the level they declare to master such competences.

Very few Physiotherapists declared the presence of additional needs that can be addressed by their working activity but the majority of them required the competence **relating with familiars and other informal caregivers** as to be more improved.

Table 7 reasume the needs identified by Physiotherapists with a higher percentage.

Specific care of urinary and fecal incontinence.
Need of support and assistance to accomplish administrative procedures including those relating with health.
Need of support in mobility out of home
Need of assistance to avoid situations of loneliness and isolation and facilitate family and social relations or participation.
Need to be supported in the self-management of his/her physical health.
Need to be supported in the self-management of his/her mental health
Need to feel safe and secure in his/her surroundings including suitability of the home to prevent "static causes "of falls (assistance in removing barriers and adaptation of the home).
Need of support in compliance with non pharmacological treatment including active and health lifestyle such as prescribed diet, food intake control, physical excercises
Need of support and rehabilitation of cognitive abilities (memory, attention, orientation etc.)
Need of technical support with external devices: Oxygen, NIMV (non-invasive mechanical ventilation), feed pumps, infusion pumps, home peritoneal dialysis, etc ...
Need to a respectful treatment according to his/her dignity
Need to be informed about your state of health and the available treatment and care options

Table 7 List of additional needs selected by Physiotherapists with an higher percentage

Only 11 competences has been recognize to be required for providing the additional needs, and almost all of them have been acquired attending at school, a training course or an academic course. Basics in social-

health services organizations and networks instead has not perceived very well mastered and there is not a defined instrument of acquisition of this competence.

9.1.3 Rehabilitation professional

The older adults interviewed on the needs satisfied (Figure 8) by the rehabilitation staff highlight the importance of three different aspects of the homecare delivery in particular support in daily activities (including hygiene, mobility, dressing, cleaning, food, mobility in and out of home etc.) and managing home and own interests; The need of a comprehensive and respectful consideration of myself, according to my dignity and values including privacy, intimacy, independency and protection from mistreatments. and Need for support in prevention from any health risk (including home suitability) and maintenance of healthy lifestyle and wellbeing including physical health (such as physical exercises or walks) mental wellbeing, and social relationships. Compared to the interview of older adults that received homecare from other professionals arise that rehabilitation staff are characterized by a strong attention to comprehensive and respectful consideration of the person. From data arise some needs unsatisfied in particular assistance to avoid situations of loneliness and isolation and protection and promotion of the psychological and emotional welfare.

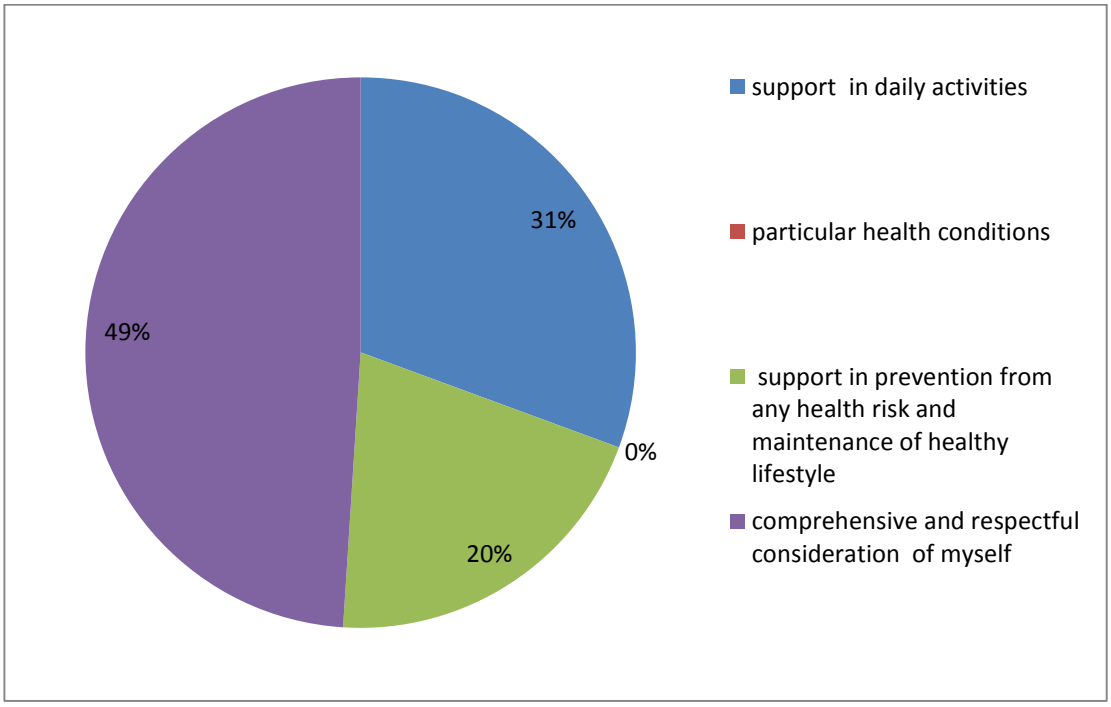


Figure 8 Older adult needs satisfied by rehab staff

9.1.4 Social Health Operator

All the Social Health Operator (*OSS*) provided complete answers to the questionnaire are not freelance, the 83,33% works for Public institutional homecare providers and the 16,67% for private providers.

To the question related on needs addressed by OSS with their activity,

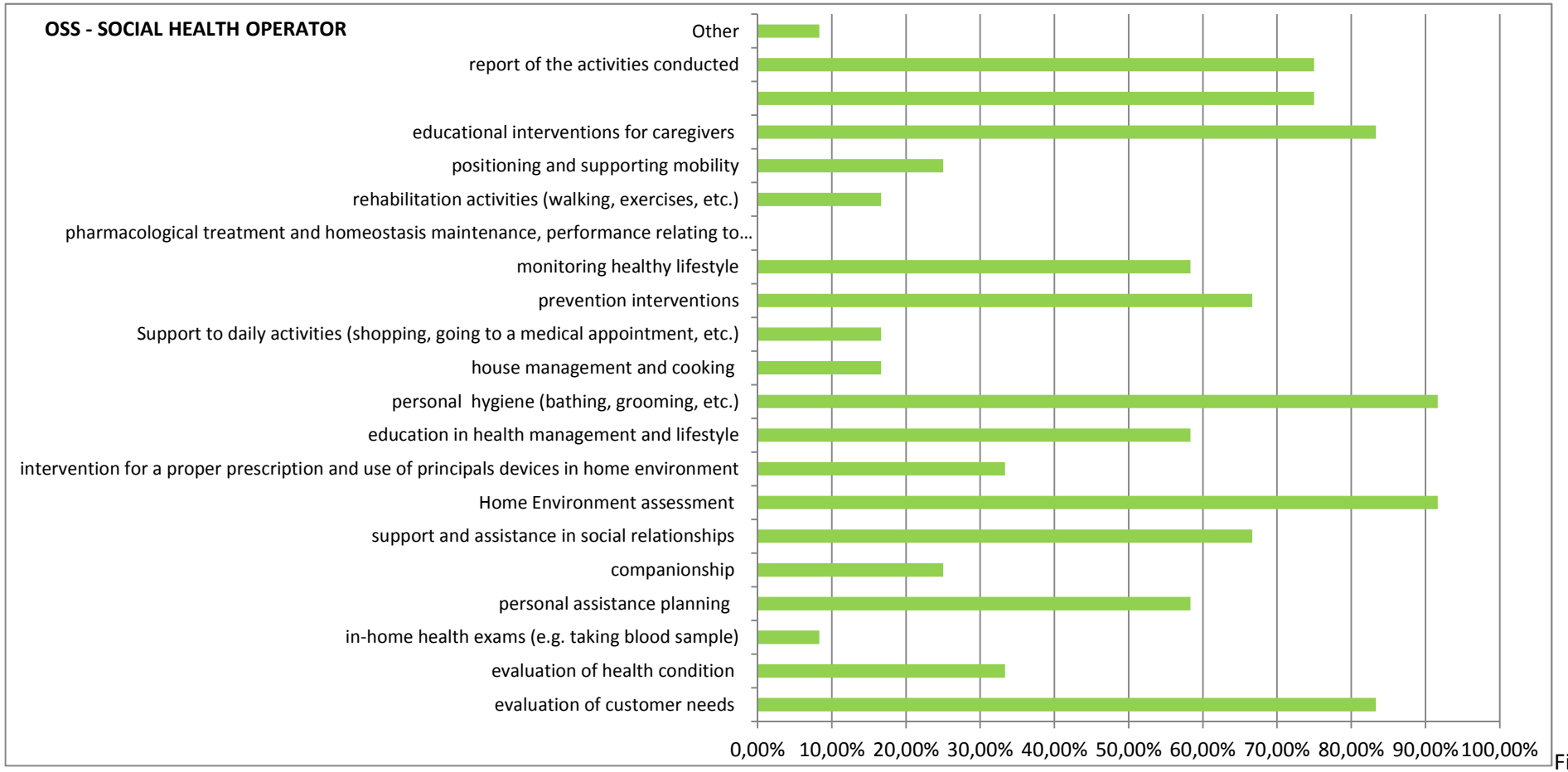
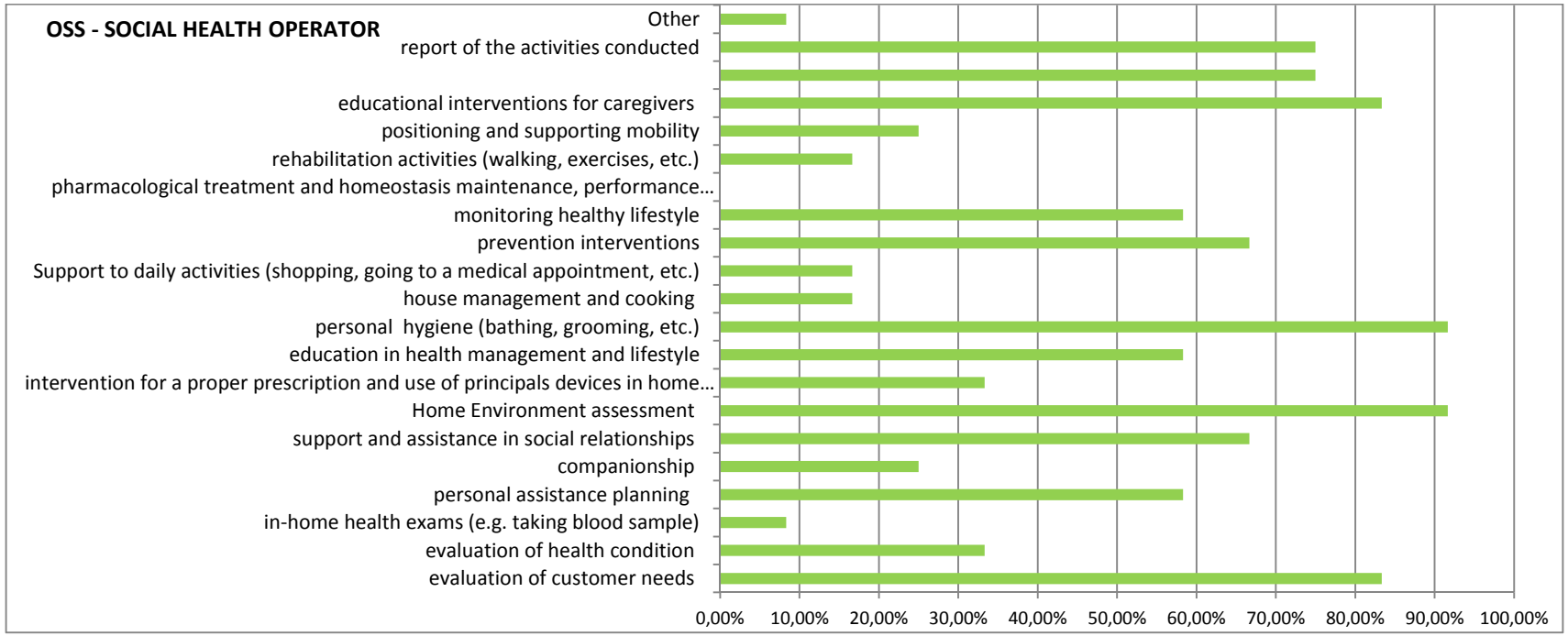
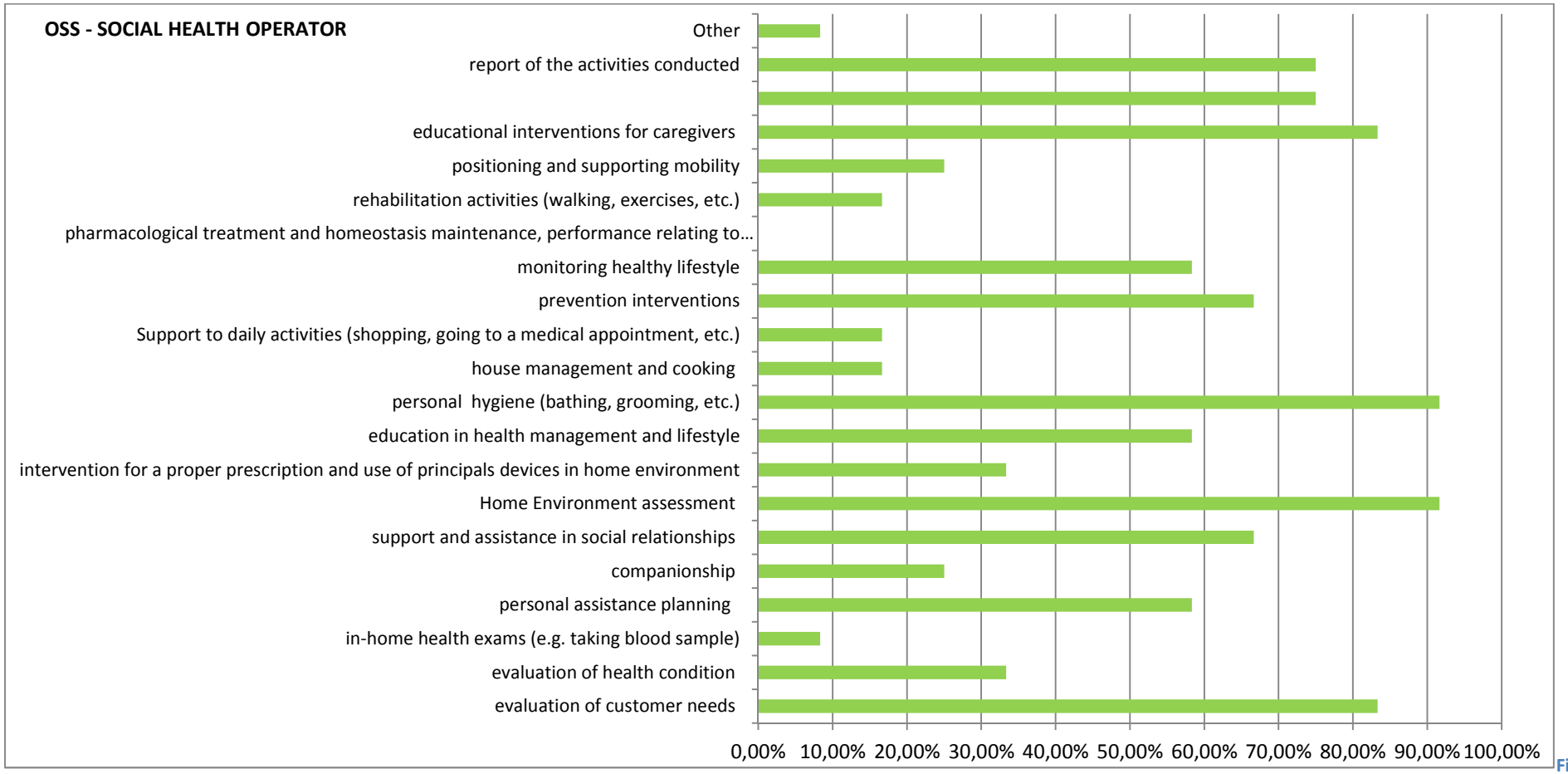


Figura /Figure 9, there is no a clear identification of the needs section that acquired the majority of minority of selection, there is a distribution of needs covered by OSS activity between the different section proposed. Table 8 (Tabella 3) indicates the needs with higher and lower percentage of OSS choice.


OSS - SOCIAL HEALTH OPERATOR
Other
report of the activities conducted
educational interventions for caregivers
positioning and supporting mobility
rehabilitation activities (walking, exercises, etc.)
pharmacological treatment and homeostasis maintenance, performance...
monitoring healthy lifestyle
prevention interventions
Support to daily activities (shopping, going to a medical appointment, etc.)
house management and cooking
personal hygiene (bathing, grooming, etc.)
education in health management and lifestyle
intervention for a proper prescription and use of principals devices in home...
Home Environment assessment
support and assistance in social relationships
companionship
personal assistance planning
in-home health exams (e.g. taking blood sample)
evaluation of health condition
evaluation of customer needs
0,00% 10,00% 20,00% 30,00% 40,00% 50,00% 60,00% 70,00% 80,00% 90,00% 100,00%


OSS - SOCIAL HEALTH OPERATOR
Other
report of the activities conducted
educational interventions for caregivers
positioning and supporting mobility
rehabilitation activities (walking, exercises, etc.)
pharmacological treatment and homeostasis maintenance, performance relating to...
monitoring healthy lifestyle
prevention interventions
Support to daily activities (shopping, going to a medical appointment, etc.)
house management and cooking
personal hygiene (bathing, grooming, etc.)
education in health management and lifestyle
intervention for a proper prescription and use of principals devices in home environment
Home Environment assessment
support and assistance in social relationships
companionship
personal assistance planning
in-home health exams (e.g. taking blood sample)
evaluation of health condition
evaluation of customer needs
0,00% 10,00% 20,00% 30,00% 40,00% 50,00% 60,00% 70,00% 80,00% 90,00% 100,00%

Figura

Need of basic maintenance of household appliances and the ones of personal use, including protection and security review tasks of housing (ventilation, gas, electricity ...).	*0,00%*
Need of support for the management of technological devices for home health monitoring	*8,33%*
Need of technical support with external devices: Oxygen, NIMV (non-invasive mechanical ventilation), feed pumps, infusion pumps, home peritoneal dialysis, etc ...	*8,33%*
Need of assistance for transfers and mobilization at home	*75,00%*
Need to a respectful treatment according to his/her dignity	*75,00%*
Need to feel a deep respect regarding values (including religious beliefs and spiritual needs)	*75,00%*
Need to be supported in hygiene including shower or bath or oral hygiene	*83,33%*
Prevention of skin lesions through proper hygiene, postural changes and specific skin care.	*83,33%*
Need of support and rehabilitation in toilet habits.	*83,33%*
Need for protection of user privacy and intimacy.	*83,33%*

Table 9 List of needs that received lower of higher number of choises by OSS with the related percentage.

Relating the proposed list of competences, OSS recognized as required only 18 of the 42 proposed. Also in this case there is a common trend of the answers of the required competences as happened for Nurses.

Only the item **Basic in dietetic** did not have a specific characterization. It has been recognize by OSS as a required competences but there is not a clear majority on how they mastery this competence (25% low mastery, 25% mean mastery, 16,67% high mastery), even if the 41.67% declared to had acquired this competence at school and no on working practice (33,33%).

No additional competences have been proposed by OSS.

9.1.5 Homecare Assistant

Considering data arising from the questionnaire administered to Homecare Assistants inside the proposed list of 42 competences only 5 have been perceived as required by Home care Assistant , instead the other 24 competences have been recognized as not required for their specific activity (see Table 11. Practitioner identification of required /not required competences with respect to those presented in questionnaire for an overview).These data show how the Homecare assistance perception of competences need is very low compared to the other HHCP.

	Social Guardian	Home care assistant/ home helper
Public institutional homecare provider	10,00%	0,00%
Private homecare provider	**70,00%**	**50,00%**
Freelance professional activity	0,00%	25,00%
Other	20,00%	25,00%

Table 10 Overview of the HCCPs italian context

Competences	Nurses	Physioterapists	OSS	Social Guardian	Home Care Assistant
Required	31	21	18	12	5
No required	11	20	19	22	24

Table 11. Practitioner identification of required /not required competences with respect to those presented in questionnaire

Responders evaluated also their ability in managing the competences as managed appropriately and almost all the item recognized as required has been declared managed with high mastery. The same competences have been acquired, by the majority of the responders, both “attending a school, a training course or an academic course” then “working practice”. Only few items have a different behavior in the answers trend. Section 2 of HHCP questionnaire shows that all the Home Care Assistant answer negatively to the possibility to address other needs of old adults with their activity (100%).Section 4 of HHCP questionnaire shows that they think to have proper competences to set their intervention for 75% of the participant to the questionnaire.

Considering the interview administered to older adults that received homecare services from Homecare Assistant, data show that people interviewed refer to feel satisfied the needs for: help in performing physiological functions (21,43%); assistance in dressing and undressing (21,43%); assistance transfers and domestic mobilization in the environment (21,43); home care including cleaning floors and washing (21,43%); safety in its environment to prevent falls (17.86%); in smaller quantities there is the exterior home environment outside mobility (10.71%). Most of needs satisfied by Homecare assistant/Home helper are included in the section related to support in daily activities (including hygiene, mobility, dressing, cleaning, food, mobility in and out of home etc.) and managing home and own interests. Older people

report being generally satisfied with support received, however, refer to as unmet need family from the server to the company in moments of solitude, with particular reference to the festive day Sunday.

People report that they feel like they need support in carrying out daily activities to meet priority and need to support in maintaining a healthy lifestyle. The key features of a family assistant for the older adults interviewed have to include education, professionalism and honesty.

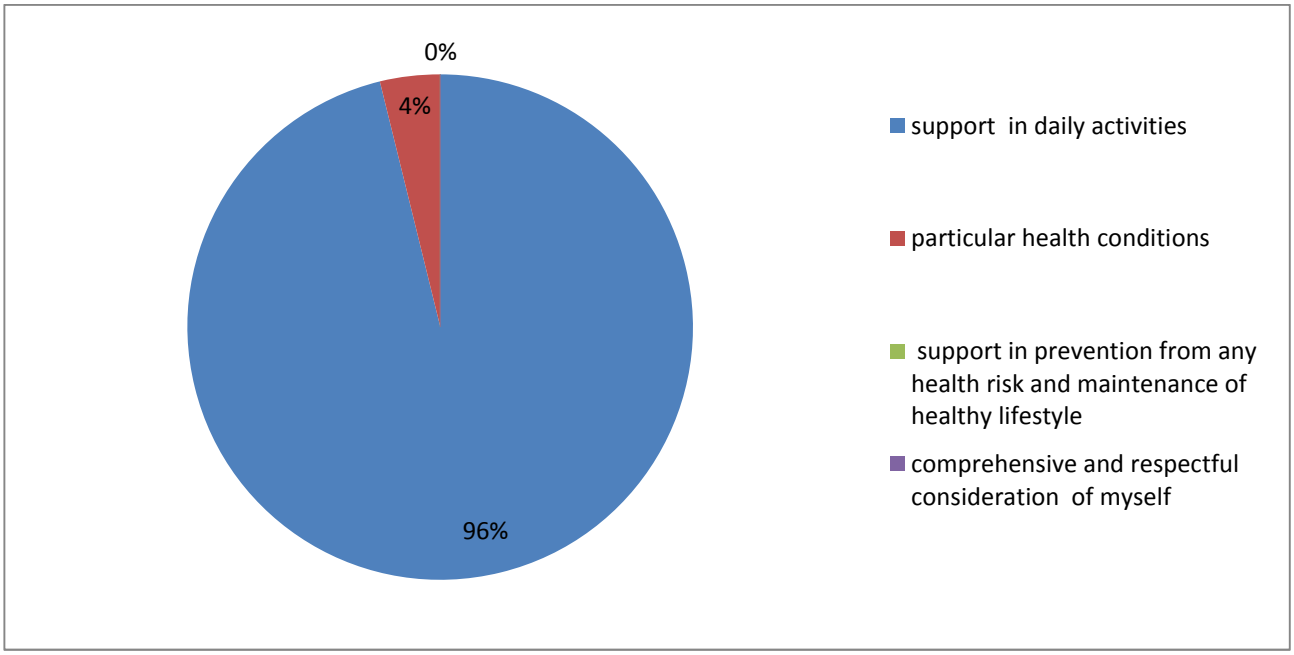


Figure 11. Older adult needs satisfied by Home care assistant/Home Helper

9.1.6 Social Guardian

Social guardian that responded to the questionnaire comes mainly from private homecare providers (70%) and a small part from public institutional homecare provider (10%) (Table 12).

	Social Guardian	Home care assistant/ home helper
Public institutional homecare provider	10,00%	0,00%
Private homecare provider	**70,00%**	**50,00%**
Freelance professional activity	0,00%	25,00%
Other	20,00%	25,00%

Table 12. Overview of the HCCPs italian context

In general the proposed list of 42 competences has been perceived as required by Social guardian, 12 of them have been recognized as required by their specific activity (see Table 11. Practitioner identification of required /not required competences with respect to those presented in questionnaire for an overview)a and 22 not required.

Competences	Nurses	Physioterapists	OSS	Social Guardian	Home Care Assistant
Required	31	21	18	12	5
No required	11	20	19	22	24

Table 13. Practitioner identification of required /not required competences with respect to those presented in questionnaire

For some competence Social Guardians answering differently with respect to the common trend. **Basics in domestic safety and prevention** has been recognized as "not required competence" by the majority of the Social Guardians responders (70%) at the same time the 60% of such figures declared a high level of mastery for this competence, even if it has been acquired only working by practice. The item **Basics in social-health services organizations and networks** has recognized as required by the 80% of Social Guardians and the 70% of them declared to master it with a High Mastery level. At the same time they declared that this required competence has been acquired mainly by working practice (80%) and not learned during training course (30%). At the same time *Social Guardians* differences their answers from the general trend also for other 6 competences. Those competences are recognized as required, but in all the cases the acquisition of these competences happens mainly by working practice instead of school or courses.

Table gives an overview on the percentage of positive answers to the questions 1.5 of the 6 competences.

Competences	Required competence	Acquired by working practice	Acquired by attending courses…
Procedures for monitoring healthy lifestyles	60%	70%	30%
Basics in older person's healthy lifestyles	80%	90%	50%
Managing errands	80%	70%	20%
Usage of reporting and monitoring tools	60%	60%	30%
Fostering customers social and familiar relations	60%	70%	30%
Providing the customer with contextualized and personalized information about the network of services he/she can rely on	80%	70%	30%

Table 14. Comparison between the answers of social guardians to the questions "is the competencies required to perform the activity", "how do you master these competencies" and "how did you acquire these competences" for 5 Competences that hve been acquired mainly working practice.

All the Social Guardians answering negatively to the possibility to address other needs of old adults with their activity (100%).In this session we asked to practitioner it they think to have proper competences to set their intervention and the 80% of the participant to the questionnaire affirmative.

People interviewed assisted by the Social Custodian refer to feeling satisfied needs refer to support in making purchases (10.71%); support and help in case of memory problems (7.14%).Clustering the needs satisfied reported by older adults who received support from social guardians and interviewed, the data show that the main need area satisfied is Need of support in daily activities (including hygiene, mobility, dressing, cleaning, food, mobility in and out of home etc.) and managing home and own interests (figure 11). Older people report being generally satisfied with support received, however, refer to as unmet such as preventing and avoiding situations of loneliness and isolation and facilitate family and social relationships (3.75% and highlight that it would be a comfort element if the social guardian could support them during they go out from home with the 'car and not having to use public transport (55%), followed by Support in particular health conditions that require specialists such as skin lesions, technical help in managing medical tools, assumption and management of therapy (27%) and support in prevention from any health risk (including home suitability) and maintenance of healthy lifestyle (18%). People report that they feel as the most important needs: [1] support in carrying out daily activities to meet priority and need for profit company to support the maintenance of a healthy life style, and [2] the need to be treated with respect. Older people identify as fundamental characteristics of a family assistant education, professional competence and discretion. From the answers emerged if the social guardian emerged that the older adults keep particular attention to the activities of daily living, management of the and monitoring of the health condition and living.

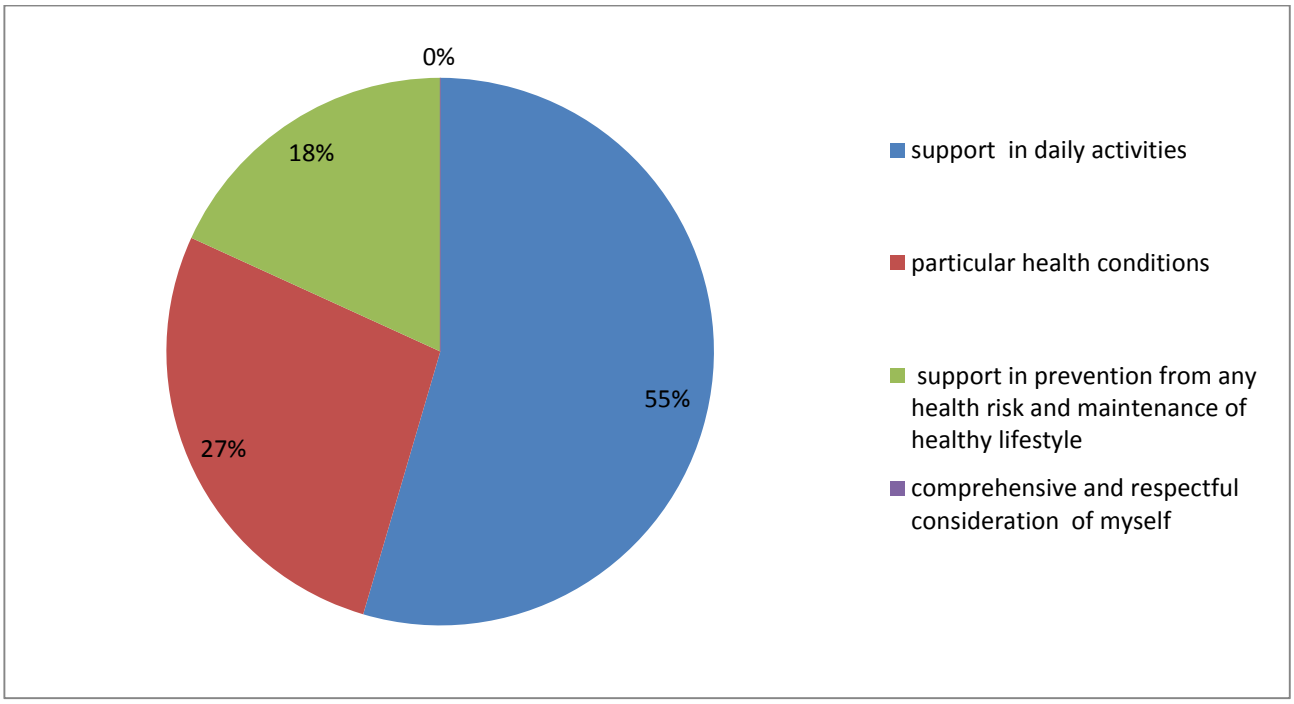


Figure 12. Older adult needs satisfied by social guardian

9.2 Discussion

In this report an initial analysis on what are the main issues and challenges of homecare in Italy has been provided. In the following sections the results of two surveys have been proposed, focusing on specific HHCPs perspectives. Starting from these premises, the skill gap of Italian HHCPs can be categorized into two main typologies: *a skill gap connected to how Italian homecare is organized and managed and a skill gap related to specific activities and performances carried out by HHCPs.*

***A skill gap connected to how Italian homecare is organized and managed*.** Skills and competencies needs in this case are related to specific issues, faults or peculiarities of Italian context, laws and culture; to be able to work in equip, to build, monitor and evaluate a Personalized Assistance Plan (each one contributing for his/her own specific part), to be able to foster older adults in carrying out their own independent personal life path, etc. are some examples of the competencies which could improve the quality of the service of every HHCPs. The problem of the parallel management of health and social homecare and of public and private services should be solved both in a top-down approach, with a review of homecare system management, and in a bottom-up approach with a renewed attitude of HHCPs towards collaboration and equip-work.

Within these kind of skills and competencies needs we can also include those connected to the scarce definition of HHCPs roles. The 2001 State-Regions Agreement which stated that the Social-Health Operator (OSS) figure would replace ASA, OTA, OSA and ADEST figures, on the one hand organized a very confused sector identifying a unique reference figure, but on the other hand, leaving to regions the task of organizing the transition to a unique figure, created an heterogeneous situation across the country. In some regions ASA, OTA, OSA and ADEST certifications are still used, while in other regions only OSS certifications are admitted. The transition to a unique figure is one of the main challenges Italy has to face in the next years.

In the private market, the perception of skills and competencies gap is also related to the tendency of turning to the wrong professionals, guided by the high cost of a professional nurse and to the belief that some performances don't need an health professional to be carried out. Often OSS and homecare assistant are employed to perform both home aid and simply nursing performances, although they've not been trained to carry out them.

A skill gap related to specific activities and performances carried out by HHCPs. Skills and competencies needs in this case are related to the task performed by the professionals and to the needs expressed by the end-users. From the questionnaires targeting HHCPs and the interviews targeting older adults analyzed in the previous sections, comes to light that, in general, professionals have a positive view of their competency level. Once identified the needed competences, the majority of them declares that they master at high or medium level that competencies, acquired both by formal education and by working practice.

Specific skills needs are identified by single professionals connected with activities that are not central for the service they provide, but can improve the whole perception of the quality of the service itself. For example, nurses would like to improve their knowledge about ethics and human rights and about the network of services provided by the National Health System; they would like also to improve their competencies in managing the relations with family caregivers and in managing terminal illness.

Another key element is the context in which HHCPs acquire the competencies they declare to master. For example, physiotherapists deem important knowledge and skills about older adults healthy lifestyles, network of services, the enhancing of mental health and the fostering of independent living paths; they declare to master these competencies but they say that they've been not trained about them, since they got these competencies by working practice.

The most important data emerging from the interviews to older adults are related to their needs. Among the unsatisfied needs there's a prevalence of the need of assistance to avoid situations of loneliness and isolation and of the need of support in social relations and participation. The importance of this dimension is confirmed by the suggestions of older people for the characteristics/abilities required by a HHCP: relational characteristics, such as polite, enjoyable, pleasant, etc., are more important than other characteristics related to the professionality (eg. punctuality) or to the service provided.

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10 IDENTIFICATION OF SKILL AND COMPETENCY NEEDS IN THE HOMECARE IN SPAIN

10.1 Overview on the older persons homecare needs in Spain

Improvements in general living conditions of the population have allowed since the early twentieth century that the number of Spanish people has increased significantly. In particular, from the year 1900 to the present day, the Spanish population has multiplied by 2.5. However, it is the age group of 65 years and over who have experienced a major increase. Since 1900, the number of people aged 65 and over has multiplied by over more than eight. [Deliverable 2.1.]

Population:
46.423.064 people

- men 22.807.603
- women 23.615.461

Age structure:
65 years and over: 17.5% (male 3,582,643/female 4,833,478) (2014 est.)
population pyramid:

Dependency ratios:
total dependency ratio: 50.3 %
youth dependency ratio: 23.2 %
elderly dependency ratio: 27.1 %
potential support ratio: 3.7

Median age:
total: 41.6 years
male: 40.4 years
female: 42.9 years (2014 est.)

Sex ratio:
65 years and over: 0.74 male(s)/female
total population: 0.97 male(s)/female

Life expectancy at birth:

total population: 81.47 years
country comparison to the world: 18
male: 78.47 years
female: 84.67 years

Based on the stated demographic data, we can guess that in 2050 there will be just over 15 million elderly people, almost twice as at present and that they will represent more than one third of the Spanish population (36.4%)

Ageing of ageing. - Another expected trend is the so-called "aging of the elderly population". In Spain, those people over 80 years have changed from representing 0.6% of the total population aged 65 and older in the early twentieth century, to 1.2% and to 5.2%. Population projections indicate that by 2050 people over 80 will represent 14.9% of the total adult population, which has implications related to the need for care due to the increase of dependent elderly people.

The situations of care of the elderly people are designed to provide assistance so that elderly people feel that their physical, social and emotional needs are met, which involves a significant time and energetic dedication and it also involves tasks that may not be comfortable or pleasant.

According to data from the IMSERSO (Institute of Social Services and the Elderly), in Spain it is estimated that the percentage of older people who have a significant dependency is between 10 and 15% of older people over 65 years and it is usually the family who bare the major burden of care of these people, with the difficulties that it implies and where in many cases the concurrence of an external caregiver is necessary, as we find in the report presented.

Why homecare is a basic need in Spain?

It is a fact that Spanish population is a progressively aging, since nowadays people tend to live to older ages, and this increases the number of long-term old age dependents. When people analyze their choices in finding a way to be assisted in this situation of dependency, they realize that hospitalization and nursing homes often are not adequate options due to the fact that expenses are very high. In the past dependents resorted to their family and friends when in need, but due to changes in family relationships and in informal support (provided by family, friends…) this is no longer an option for most of them. Finally, when asked they express their willingness to stay at home as a personal choice.

10.2Report on primary data about homecare needs in Spain

The questionnaire of HHCP was sent to 1,100 people involved in home care for elderly people, 155 people (14.09%) answered the survey. Of those who answered the questionnaire, 80.95% has been doing home care services to elderly people in the last 5 years. The professions are divided into:

Considering the distribution according to their institutional body we find:

- Dependent on a public institution:43.53%
- Private: 38.82%
- Self-employed: 3.53%
- Other: 14.12%.

The average age of the caregivers is 44 years.

Regarding the elderly person´s needs, the caregivers generally attend those presented in the table provided below:

Option	**Percentage**
The need for support in hygiene including shower, bath or oral hygiene	69.41%

The need for assistance in dressing and undressing	60.00%
The need for assistance to move or moving within the household.	60.00%
Support for an adequate housing maintenance including cleaning and order. Washing, ironing and organization of the clothes within the household.	56.47%
Prevention of skin injuries with proper hygiene, changes in posture and specific skin care.	52.94%
Specific care for urinary and faecal incontinence.	44.71%
The need for support and assistance in the food handling including the preparation of menus and acquisition of food supplies.	37.65%
Basic needs for maintenance of small household appliances and personal care equipment including household protection and safety review tasks (ventilation, gas, electricity.)	20.00%
The need for support and assistance in complying the administrative procedures including those related to health.	29.41%
The need for support in handling electronic devices for the home health monitoring.	16.47%
The need for support for mobility outside the habitual residence.	50.59%
The need for protection and promotion of psychological and emotional well-being and its protection.	40.00%
The need for assistance to avoid situations of loneliness and isolation and facilitate family and social relationships or their participation.	47.06%
The need to be supported in the self-control of their physical health.	38.82%
The need to be supported in the self-control of their mental health.	32.94%
The need to be supported and educated in the modification of positional and posture changes to prevent physical disorders.	36.47%

The need to feel secure and safe in their environment including the adequacy of housing to prevent “static causes” due to falls (assistance in removing environment barriers and housing adaptation)	30.59%
The need for support and rehabilitation of physiological habits.	30.59%
The need for support for the adherence to treatment including the preparation of medication, its revision and adjusted dosages.	40.00%
The need for support in the compliance of non-pharmacological treatments including healthy and active ways of life, such as the monitoring of prescribed diets, food consumption controls, physical exercise.	38.82%
The need for support or intervention in handling menus in the case of eating disorders or malnutrition.	28.24%
The need for support and assistance for effective communication.	35.29%
The need for support and rehabilitation of cognitive skills (memory, attention, orientation,etc.)	35.29%
The need for support and management of behavioural disorders associated with dementia.	38.82%
The need of technical support with external equipment: oxygen, non-invasive mechanical ventilation, feed pumps, home peritoneal dialysis.etc.	16.47%
The need to know how to make their own decisions ad be autonomous.	35.29%
The need to maintain a respectful treatment according to their dignity.	51.76%
The need for the protection of privacy and intimacy of the person.	55.29%
The need to feel protected and supported regarding their own interests.	34.12%

The need to feel a deep respect with regard to the values (including religious beliefs and spiritual needs)	37.65%
The need to be informed about their health status and the different treatment options and care available.	31.76%

The tasks which these homecare providers more often carry out are, among others, elderly needs assessment, home treatments -such as taking blood samples, supervision for healthy life styles or team meetings and contacts with other professionals related to elderly care.

When they were asked about the needs of the elderly they usually have to deal with, their responses are the following: 71% of the times they need to be very respectful with the values the elderly more cherish –including religious beliefs and spiritual needs. 57% of the respondents comment on their need to try to prevent skin lesions by providing elderly with an adequate hygiene, repositioning and taking good care of the skin; care providers also need to be instructed on repositioning in order to avoid provoking bedsores and pressure sores; they also need to be educated in the specific care to be given to *urinary* and *fecal incontinent patients; they need to be trained in helping elderly in developing a* strict discipline in complying with non-pharmacologic treatments, including active and healthy lifestyles, such as adherence to prescribed diets, control of food consumption, exercising; finally, 43% of the people interviewed comment their need to be supported in supervising self-controlling physical health, in rehabilitating elderly physiological habits and in overseeing adherence to treatments –such as preparation of dosage, revision and adjustment of new doses, etc.

As for the tasks these care providers more often have to carry out, among others, they need to assess their clients needs. They also have to take care of the personal hygiene of the elderly as well as help them in their everyday activities. Finally they need to supervise they have healthy life styles.

When asked about the tasks they need to take care of during their daily activity, 69% of them assist elderly in their personal hygiene –taking a shower or bath, cleaning their teeth, etc; 60% of the respondents regularly help clients dressing up and also moving around at home; finally, 56% of care providers help elderly in their house cores, i.e. cleaning, tidying up, doing the washing, ironing and organizing their laundry.

We enclose, together with this document, a table in which information obtained from secondary sources has been gathered. This has been arranged in terms of the different categories implied.

Homecare: tasks and activities

Sanitary Services

- **Attention to patients in acute phase**
  - Medical patient *monitoring* and acute illness control, as frequently as needed. Follow-up as required.
  - Nursing attention
- **Attention to patients with chronic illnesses**
  - Nursing attention: follow-up, signs and symptoms control, treatment control, treatment compliance, specific treatments (treatment of pressure ulcers), catheter care, control and replacement (SNG, PEG, S.V.) etc...
  - Medical attention
- **Post clinical attention**
  - Medical and nursing follow-up care.
    E.g.: ongoing care for pluripathological patients
- **Geriatric attention**
  - Medical and nursing homecare provided to elderly patients
  - Medical and nursing provided to elderly patients in a residence after being dismissed from hospital.
- **Palliative care**
  - Medical and nursing care to control symptoms, medication and special techniques (paracentesis...)
- **Home hospitalization**
  - Patients with chronic pathologies requiring complex medical or nursing techniques (such as dialysis, intravenous feeding or non-invasive mechanical ventilation) are in need of informal support (provided by family, friends…) and/or sufficient social coverage. The social coverage can be updated when the medical assistance is given.

Social Services

- **Personal Attention Service**
  - Personal care (persona hygiene, dressing, food, personal appearance…)
  - Help in getting up or getting in bed, help in mobility, in moving around the house and when going out from home.
  - House chores support.
  - Sociosanitary activities (supervision in medicines intake, supervision in adequate diet intake,…)
  - Assistance in personal paperwork.
  - Teaching how to do different household chores.
- **Tele-home care services**
- **Home-delivered meal services**
- **Home-delivered laundry services**
- **Home cleaning services**
- **Home hairdressing services**
- **Home chiropody services**
- Support to carers

- **Education and involvement with family, and promotion of personal autonomy.**
- **Technical assistance to improve home accessibility.**

10.3Discussion

Problems faced by the homecare profession

One of the problems that homecare has to face is that specialized sanitary homecare and homecare professionals are still scarce in the labor market (there is a lack of occupational therapists, psychologists, nursing assitance, psychiatric attention, physiotherapists, psychomotor activity). Also, more financing should be allotted to better prepare these professionals and to better help those in need, e.g. a quicker and more immediate attention should be given, there should be a better response capacity –a variety and adequacy of services and benefits. Professionals should also be more flexible to adapt to changes. Besides, there are great difficulties in maintaining the present system and there should be a better sociosanitary coordination.

As for the conditions in which many elderly live, there is a need for homes to be adapted to the patient's new requirements.

Customers

Homecare sanitary services users

- Elderly who, due to their health condition or to other criteria previously established by the team, cannot get about.

Homecare social services

- Elderly with limitations to get around in their everyday life, with difficulty in their personal autonomy, dependent.

10.3.1 References

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11 IDENTIFICATION OF SKILL AND COMPETENCY NEEDS IN THE HOMECARE IN FINLAND

11.1Report on primary data about homecare needs in Finland

In Finland the results of HHCP survey indicated that majority of responders thought that almost all the competences included in questionnaire used in study are required in working in home health care. In self – evaluation of HCCPs skills and competences level, the responders evaluated their competence level satisfactory in knowledge of social- and health service system inc. social services and benefits client is entitled to Knowledges, skills and competences were also evaluated mostly in categories of satisfactory or good in procedures for providing physical therapies, fostering clients social and familiar relations, competences to support for coordinating the work of other practitioners, competences for evaluating clients mental health status and competences for caring clients with terminal illness and grief support.

HCCPs had acquired competence mostly by working practice in following skills: basics in social-health services organizations and networks, knowledge about the main aids and devices for older and disabled people, procedures for fostering customers going out of home, providing the customer with contextualized and personalized information about the network of social services and benefits he/she can rely on, competences for collaboration with other practitioners and competences for evaluating customer needs and adapting the service. Competences in basics in anatomy and pathology, basic procedures in medical assistance (eg. make injection, provide drugs, change medication) HCCPs have gained mostly by attending a school, training course or academic course.

HCCP didn't take a part of the first evaluation and forming a clients' care and service plan. This is probably the reason why they evaluated their knowledge of social services and benefits lower than expected. However HCCPs were involved in modifying and assessing clients care plans in continued care. Yet they thought that they could have competences to do it, if given time, education and authorization. It seems that in division of tasks in home care doing the care plans especially on beginning of the care of the new client is done by the registered nurses or registered public health nurses

11.2 Discussion: Social and health care vision for the future and competence needs

Changes in working life

Summary of qualitative foresight reports for National Education and Training Committees:

- operating environment change factors and situations require new ways of thinking and new approaches
- personal and individual needs are emphasised
- the provision of education and training must be more flexible and customised

- developing the use of information and communications technology (ICT) in instruction (ubitechnology)
- increased level of multiculturalism, internationalisation and globalisation
- studies becoming less and less dependent on time and place
- ability to distinguish competence development from knowledge development
- robotics applications (p. 15) in the field of social and health care
- virtual learning environments, electronic examination systems, games, ePortfolios, cloud services
- 3D printing (prosthetics)

future paths:

1. Intensively social work path
   - abilities and competence needs: ability to critically assess the quality and significance of information
   - ability to challenge and cope with the demands of a competitive society
   - ability to exercise media criticalness, understanding and knowledge
   - sustainable and perpetual skills: difference between information and opinion
   - nationality and human relations skills: skills in sharing and interaction
   - feeding intuitiveness (p. 19)

2. Contextual and peer-network type work path
   - self-management and self-organisation
   - networking competence
   - command of technology and processes
3. Neogrowth as a basis for work path
   - (environmental) technology competence
   - information and communications competence
   - network competence
   - manual skills (pp. 19–20)

Ubiquitous development of information and communications competence integrated in all learning (p. 22). Future experts must possess co-operative skills and networking skills. Creativity and innovativeness are key. A working life orientation is vital in VET. Attention must be given to entities and a learning life-cycle must be made in education and training. (p. 22). (Saarimaa, R. Mantere, J.cf. Korhonen, S. 17.5.2016: Kasvava valinnan vapaus; terveyden uudet teknologiat; ihmiset ja yhteisöt) Increasing freedom of choice; new health technologies; people and communities

4 scenarios: citizen – institutions
promoting significance – smart prevention
vertical exercise of power on the axis
horizontal promotion of health

- scenarios: Democracy of the Fittest – participation fosters well-being
- Open Health – information promotes health, when there are entirely new types of tools available for this purpose
- “Neokuusian society” – health in all policies – a society engaged to foster functional capacity

- Hero doctors – usage and experiential data, behavioural science and health research data in shaping daily environments

Basis: human-driven, general socio-economic, cultural and environmental conditions. The social determiners of health are emphasised differently in different scenarios.

- anticipating changes in needs
- better services and living environments

  Perspective: Human-driven approach will revolutionise the health business. A number of new actors will solve the major challenges facing health in the future.

Key skills for the future:

- creative thinking ability
- ability to create new combinations from old operating models
- ability to adapt to rapid changes and even control them (p. 38) Saarimaa, R. Mantere, J.

Korhonen, S. Competence needs:

- co-operation and curiosity are emphasised
- interest in the world is emphasised
- ability to solve various problems is key
- growth and development
- co-operation
- digital literacy

GENERAL WORKING LIFE SKILLS

(Vesterinen, p. 50)

development needs:

- client orientation
- client-oriented thinking and acting

- Team and network competence

Basic competence in and overall command of one's own field (Vesterinen, p. 52)

development needs:

- command of the service system
- role-assignment and functions in the promotion of health and well-being
  developmental skills

- economic fundamentals and understanding of entrepreneurship

- managerial/supervisory skills

- basic competence in working the elderly

- knowledge of chronic diseases and competence in treatment referrals

- ICT (ADP) competence and command of electronic operating systems cf. Hautamäki, A. 17 May 2016

PRACTICAL NURSE:

1. Telephone service and service expertise
2. Assessing the need for treatment (dialogue, client-oriented attitude)
3. Registration
4. Referring to the right person in the process
5. Using the information system: laboratory x-ray referrals
6. Strong, clearly-defined professional identity
7. Maintenance of one's own occupational capacity and well-being
8. Working life rules (Vesterinen, p. 61)

Taipale-Lehto – Bergman:

Future competence needs in the field of elderly care:

The following apply to all education in the field:

- client-oriented approach and skills in quality thinking
- cross-disciplinarity and multi-professionalism (service co-ordination)
- innovation competence (incl. skills in developing one's own work)
- ethical competence and acting responsibly
- (holistic) knowledge of human functions
- competence in multiculturalism
- knowledge of recommendations, regulations and legislation

Practical nurses:

- medical administration and calculation
- interaction, communications and communicating skills
- documentation and reporting skills
- ethical expertise, command of professional ethics
- acting in accordance with ethical values
- adequate language proficiency (multiculturalism)
- competence in elderly care services
- knowledge of diseases
- daily basic care situations
- client referral and consulting skills in social and health care services
- promoting the functional capacity of clients
- skills in using new technologies

- knowledge and understanding of laws, regulations and standards concerning elderly care services and how they affect the work of a practical nurse
- group leadership skills, group management skills
- ensuring and observing stimulation
- basic knowledge of the effects of exercise on health promotion
- palliative care skills
- developmental approach to work, developing one's own work and work performance
- personal attributes: motivation, commitment, activeness, positive work attitude, Responsibility, expanding one's own competence
- (Taipale-Lehto – Bergman, pp. 28–30).

Vesterinen , pp. 68–80:

Practical nurse in elderly care and social services:

- client-specific service plans
- networked provision of services (public, private and third sector)
- preventive, health-promoting and functional capacity-promoting
- service system
- national diseases
- competence in working with the elderly
- competence in working with mental health and substance abuse
- medication
- clinical nutrition
- palliative care
- entrepreneurship in the social and health care field
- technology

EFEC:

Personal competence:

- Able to empathize
- Able to reflect and take care of oneself
- Flexible, Friendly, Helpful, Cheerful
- Willing to learn
- Happy to work,
- Open to change
- Respects the rules Physically strong and healthy hard working
- Conscientious thorough reliable
- Trustworthy Honesty Self-dependent

- Patient Responsible Concentrate
- Tolerate stress Precision in carrying out the tasks Punctual Motivated
- Social competence:
- Communication Skills
- Able to deal with conflict
- Communicate with and relatives doctors
- Teamwork skills and interdisciplinary collaboration
- Able to bring people together
- Helping with a social network
- Appreciate of democracy
- Aware of values

Specialist competence:

- Basic knowledge about diseases
- First aid course
- Some medical knowledge

- Acquire new knowledge
- Holistic approach
- Psychological support
- Knows how to listen
- Knows laws that benefit the elderly
- Bills payment
- Structured working
- Knowledge of house-keeping
- Nutrition Providing meals
- Able to serve food
- Personal hygiene care
- Language skills
- Managing the shopping budget of household
- Paperwork

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12 IDENTIFICATION OF SKILL AND COMPETENCY NEEDS IN THE HOMECARE IN OTHER EUROPEAN UNION STATES

12.1 Identification of skill and competency needs in the homecare in Austria

According to forecasts, the population of Austria will continue growing, i.e. from currently 8.4 to about 9.5 million in 2050. As in other countries, the age structure is shifting significantly towards older persons.

In Austria in 2010 a total of 14.8% of population were aged below 15 years, 62.1% were of working age between 15 and 60 years and 23.1% were of retirement age or were aged 60 years and older. In the medium term (up to 2025), about 28.7% will belong to the age group 60+, and this percentage will increase to more than 30% (34.1%) in the long term (approx. as from 2050).

Important increases in the share of very old people (80 years and more) in the total group of elderly are expected: from 397,000 in 2011 to 590,000 in 2030 and to almost 1,000,000 in 2050. The group of older persons aged between 65 and 79 will grow drastically.

The growth of this population group is mainly due to the steady increase in life expectancy, the high birth rates around 1940 and 1960 as well as decreasing birth rates in the present. Life expectancy increases by one year at five-year intervals.

In this contest, demand for mobile, community-based care services is rising in Austria: according to the Federal Ministry of Labour, Social Affairs and Consumer Protection (BMASK) and the BAG, up until 2020, 6,400 additional full-time care workers will be needed in mobile services for older people

The demand is mainly rising for elderly care workers, home helps and social workers. The demand for nurses will rate increase with upcoming retirements in the coming years

Therefore, training in the homecare sector needs to be promoted and made more attractive.

One of the greatest long-term challenges of the Austrian federal government is safeguarding the required labour force in the health and care sector and to identify instruments to recruit more people to the sector and to retain employees focusing on:

- raising awareness among potential future homecare workers (by offering possibilities for requalification);
- offering high-quality, accredited education for future professionals in the sector, as well as opportunities for further training and career development;
- improving the sector's image among those already working in it but also among the general public, and also improving working conditions.

Successful policies to cope with rising demand and an insufficient workforce in community- based health, care and assistance services for elders have to:

- recruit new employees by accessing untapped resources and promoting structural change, which may also reduce unemployment in other areas;
- improve the sector's image and its working conditions, to allow for higher retention of personnel.

In order to become more appealing, the sector requires high-quality standards in education and qualifications that are recognised across different sectors in all nine federal provinces. Career opportunities

that keep personnel motivated are another prerequisite.

Another weakness is due to the fact that in Austria, the federal government is responsible for healthcare and general social insurance matters, while the nine federal provinces (*Länder*) and the local authorities are responsible for social assistance and thus also for community-based care services. Home-care and mobile services are mostly offered by the large NGOs represented in the National Working Group on Non-statutory Welfare (BAG) (these NGOs include Caritas, Diakonie, Hilfswerk, Red Cross and Volkshilfe); some private sector enterprises also provide these services.

As the federal provinces have a rather large degree of autonomy in Austria, services offered, and the qualification and training requirements for staff in the health and care sector, vary throughout the country. In the past, efforts were made to mainstream services and to establish a more equal and transparent system Notwithstanding these improvements, fragmentation at the interfaces between formal and informal care, and health and social care, remains the main barrier to deinstitutionalisation in Austria.

The legal and organisational framework is still characterised by a strict division of competences and financing. A large variety of regional regulations affects the organisation and practices of residential care homes and professional education standards.

Despite the growing awareness of the need to integrate care and a series of efforts implemented to improve the situation, coordinated health and social care projects have not moved past the model phase.

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12.2 Identification of skill and competency needs in the homecare in Belgium

Belgium has a population of about 11 million inhabitants. While currently, people aged 80+ compose 5.3% of the population, this number will grow to 8.9% in 2060, while life expectancy at age 65 will rise from 17.4 years for men and 20.9 years for women to 22.3 years for men and 25.7 years for women. Accordingly, care needs are rising and the declining ration of people of working age to older people is putting a challenge to the financing of the long-term care system.

Currently, long-term care needs are mostly taken charge of by the federal public health insurance INAMI, which finances medical expenses, including in home settings, to a certain percentage. Normally, all health interventions include a part paid for by the user, although some systems exist to limit the costs to the user for vulnerable groups, such as the 'maximum billable amount'. Additionally, a benefit for the support of older persons exists for persons over 65 with limitations in activities of daily living and low or modest incomes.

Long-term care being a shared competence between the federal level and the language communities, systems differ in the different regions. In Flanders, a mandatory long-term care insurance exists (it is optional for people living in the Brussels region), being able to pay up to 130 euros per month. Discussions about a long-term care insurance are also ongoing in the French-speaking Community.

About 50% of long-term care patients are taken charge of in residential care, the others receive homecare. Home care is supported by the provision of service vouchers to pay non-medical expenses in activities of daily living, such as cooking, washing or cleaning. Service vouchers are available for everyone, dependent on long-term care or not, and subsidized by 2/3 via tax returns. The residential and home care system is complemented by partial services such as day-care services or short stay centres. Informal care is an important part of the Belgian care systems. In 2006, over 9% of the population over 15 years cared for another person, the majority of them women between 45 and 60 years.

With the existence of a formal long-term care service and a very structured system of industrial relations, VET requirements exist for most of the professions intervening in home healthcare.

Nurses are qualified by a bachelor's degree of academic level. Education of nurses entails a certain number of hours spent in a hospital environment in contact with patients. Work experience in a hospital environment is also needed to be able to register as an independent nurse, which will be more likely to intervene in home healthcare. By 2018, the training system for nurses will comply with the European sector directive 2015/55/EU and the Competence Framework of the European Federation of Nurses.

Nursing auxiliaries help nurses to provide hygienic care to patients. They have a legal status and an official vocational education pathway to obtain a certificate as a nursing auxiliary. Nursing auxiliaries can perform certain medical tasks by delegation of nurses and doctors.

Family helpers, along patient's guardians and household support workers and drivers are less regulated professions in the home healthcare sector. They provide help in activities of daily living that are not medical. Family helpers need to be in the possession of a certificate that proves the participation in a number of professional trainings of secondary education level. Most of the home healthcare professions additionally require a driver's license.

The data of social partners show the number of personnel employed in different sectors of long-term care. In 2014, there have been

- 50.370 full-time equivalents working in the **residential care** sector for older people (including day-care centres) – paritary commission 330..01.20
- 7.481 full-time equivalents working **in the home healthcare sector** – paritary commission 330.01.30; most employers (89%) employ less than 20 workers; most of employers in this sector are from the private sector and the overwhelming majority of the workforce are women (90%). In terms of distribution of age groups, the age group of 25-29 years and of 45-49 and 50-54 years is

slightly overrepresented relative to the categories of 30-34, 35-39 and 40-44 years of age – **pointing to possible future challenges when the current generation of 45-55 year-olds retires**.

The total amount of work in terms of hours worked in the not-for-profit social sector in Belgium has been rising since 2008 and until 2014 by 22%. It is the second-largest sector in terms of numbers of employees in Belgium, employing 14% of employees (after the paritary commission for the public sector and sectors without paritary commissions, employing 20% of employees). The health sector represents the largest sub-sector in the not-for-profit social sector with almost half of employees and hours worked.

FOREM, the French-Speaking Public Employment Service, highlights difficulties in recruiting nurses. It also highlights that the number of job offers for nursing auxiliaries has been declining in recent years, but several indicators show that it is an attractive profession for employers.

12.2.1 References

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12.3 Identification of skill and competency needs in the homecare in Bulgaria

In Bulgaria the governmental policy on home care is weak and no policy paper has exclusively addressed homecare.

As described in D.2.1 [CARESS, 2016], usually, healthcare services and social services are separately provided.

Home health care is managed under the Ministry of Health and provided by GPs and practice nurses who make home visits, covered by the basic health insurance. Home nursing is unknown in most parts of the country, since formal home nursing services are delivered on a very limited scale.

As organized nursing services at home are rare in Bulgaria, home care is often considered limited to social services, which are managed under the joint responsibility of the Ministry of Labour and Social Policy and the municipalities through three main schemes: Home Social patronage, Social Assistance and Social Service [Genet et al. 2013; Salonen & Kinos, 2012; Yanakieva, et al., 2014].

In this context, the main objective of Bulgarian government is to define and establishing an institutional framework for sustainable provision of homecare in Bulgaria, including proper legislative regulation, payment mechanisms, national quality standards and unified training programs for the HHCPs.

Aside to a systematic redefinition of homecare system and an integration of homecare policies and laws, the problem of HHCPs training is crucial.

As to home nursing, **NURSES** exclusively working in organized home care services are very scarce and their availability strongly differs between regions. Anyhow, nursing is not well developed in Bulgaria and hospital nurses are hired on a private basis by those who can afford [Genet et al. 2013].

In Bulgaria, the main providers of nursing education at initial level are medical colleges. The training is held according to the modern curriculum and syllabus which answer the European and world standards. After Bulgaria signed the Bologna Declaration [1999], the three-tiered higher education model (Bachelor's, Master's, and Doctoral degrees) was introduced on account of the amendments and additions put forward in the new Higher Education Act [Popova et al., 2011]. Since 2007 nursing study program in Bulgaria is a full-time four-year nursing course leading to a Bachelor of Science in nursing. Once obtained this degree a nurse can provide homecare: no specific training is envisaged for homecare nurses (IENE Project website - http://www.ieneproject.eu/).

Social homecare in Bulgaria is managed by three main figures: **SOCIAL ASSISTANT**, **PERSONAL ASSISTANT** and **HOME HELPER**. The distinction these figures has not been formally laid down [Toptchiyska & Vasileva 2009]. All three professions are described as persons providing meals, domestic aid and monitoring of the health status in the home environment and providing information to the GP [CARESS, 2016].

No specific education or training is needed to play the role of Personal Assistant. They are often unemployed people included in the national programme called "Social Assistant" which is aimed to provide employment to unemployed persons to meet daily needs of people with disabilities.

Home Helpers are normally working for NGOs, which plays an important role in Bulgaria for the qualification of homecare, especially concerning HHCPs training.

In particular, Bulgarian Red Cross (http://en.redcross.bg), which employs especially nurses and home-helpers, provides professionals with training in the specific aspects of care provision in home environment; this is a mandatory requirement for working at the BRC Home Care centers [CARESS, 2016].

The BRC is licensed at the National Agency for Professional Education and Training for the provision of a professional training in "So*cial services for children and older people with chronic diseases, physical and sensor impairments*" which has two modules: a) "Home-helpers and Hospital Attendants"; b)"Social Assistant". Unfortunately, this training courses are not mandatory outside BRC Homecare centers.

The Bulgarian Red Cross is currently implementing, by in the capacity of an Executing Agency (EA) in partnership with the Ministry of Health, Ministry of Labour and Social Policy and the Swiss Red Cross , the "*Home Care and Assistance Services towards Independent and Dignified Life*" Project (2012-2017) (http://en.redcross.bg) [CARESS, 2016]. The main results achieved in 2012-2015 include:

- Continuous training of the staff : the nurses and the home-helpers employed at the homecare Centers receive regular support and practical trainings by experts of the Swiss Red Cross with profound experience in home care. The trainings include different topics, among them: planning of cares, prophylaxis of decubitus, hygiene of the services provided at home, wound management, etc. These trainings raise the qualification of the staff and improve the quality of the cares provided leading to more adequate satisfaction of the needs of the beneficiaries.
- New qualification requirements elaborated for professionals engaged in integrated medico-social services provision. An important step directed towards achieving quality of home care services was the elaboration of new State Educational Requirements for the Social Assistant profession. The work in this area was provoked by the needs of adequate preparation of staff to be able to provide integrated services in the future. The Requirements were officially approved by the Management Board of the National Agency for Vocational Education and Training in November 2015 and after that submitted for approval to the Ministry of Education. Their decision is expected in 2016 (http://en.redcross.bg).

In conclusion, skill and competency needs in Bulgarian homecare are strictly related with a systematic redefinition of homecare system and an integration of homecare policies and laws.

HHCPs competencies are basic and need to be integrated according to renewed and sustainable vision of health cares and social services at home, including: specific competencies for working in equip, in order to provide an Integrated homecare service (social and health); competencies concerning primary care in order to allow them to contribute, with their specific service, to prevent and early diagnose diseases or health problems, in coordination with the GP and other HHCPs; competencies to use new ICTs supporting telecare, primary care and remote health monitoring.

Once defined specific profiles and roles for each HHCP involved in homecare, training courses should be defined to certify competencies of social assistants, personal assistants and home helpers. A good starting point could be the training initiatives carried out by the Bulgarian Red Cross and the ones experimented within the "*Home Care and Assistance Services towards Independent and Dignified Life*" Project.

An homecare specialization should also be provided to nurses in order to fit better older adults needs, aside to specific and single nursing performances.

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12.4Identification of skill and competency needs in the homecare in Croatia

Croatia has traditionally been a country of emigrants but there is not a clear migration policy. (In 2016, 1,293 people have already left the country). As of September 2014 the Croatian Medical Nurses Union conveyed that during the 12 previous months around 400 nurses went abroad, being employed in other European countries (mainly Austria, Belgium, Cyprus, Germany, Luxembourg, the Netherlands, Slovenia, Spain and the U.K.). So, definitely there is a lack of professional personnel.

The socialist legacy in eldercare brought a reliance on public residential capacities. Since the late 1900s, the reforms were aimed to unburden the public system from high social costs for residential care. And since 2013 they increased adult foster care, family-type homes and different community-based services such as home care, day care centers, gerontology centers etc. while the responsibility for residential homes was transferred at local level.

However, these services are insufficient to reach the growing demands. In 2016 the Republic of Croatia reached a population of 4,254,008. Life expectancy is currently at 75.8 years (above average of global expectation which, according to Population Division of the Department of Economic and Social Affairs of the United Nations, is at 71 years). And the ratio births/deaths have been coming across a constant decrease of 0.08 % for the past 4 years. There means 16.9% population is over the age of 65. Thus, age dependency ratio in Croatia reaches now 24.8% (data from U.N. Statistics Division). By 2020 the share of older people is estimated to be 26 %. The public system is characterized by non-transparencies (e.g. definition of service fees, absence of price methodology and public calls for new service providers.) The recent calls to solve these problems only led to confusion and politicization. They clearly indicated that the

government is planning to continue with the marketization of care and a policy which anticipates higher individual and family responsibility.

The challenges have their roots in the pre-crisis period, trying to cope with long-term problems related to transition, low employment, low wages, high poverty rates, failure in an adequate protection of the most vulnerable groups, etc. A lack of social insurance companies has also been noticed.

No information is available and seems to be missing or incomplete when searching for expenditure on home care as a proportion of the total health-care expenditure, although a lower private expenditure (long-term, rehabilitative and curative care) compared to public expenditure has been perceived.

There are no third party contributions. Agencies providing social home care services are funded by fixed budgets and clients must contribute our –of-pocket for publicly provided homecare. Over 56% of clients declared publicly financed home care services were said to be too expensive and not affordable and voluntary services are planned to be introduced. Thus, the smallest share of people served by homecare providers in all Europe was found in Croatia and difference between needs and actually accessible care restricts access.

No information of types of professionals providing domestic aid was found but the data from NOW organization tells that domestic aid in scheduled at a maximum of 4 months or less; 6 months in the case of the only two types of nurses they have. There is no recertification required for the only two types of qualified nurse levels without specialized requirements for homecare.

There are no formal complaints procedures though there is a regional (or national) institute in place for handling clients´ complaints.

In general, the most important fact is that there is almost no literature on present activities in this field for the country and transparency seems to be a major defiance.

As for educational concerns, according to what we have been able to draw forth, there is still a need to balance completely their formal academic system to meet European EQF for VET learning.

The present status of nursing education in Croatia is a controversial one. The basic nursing education is attained at the secondary school level. The program includes subjects such as Croatian language, geography, history and arithmetic, with just a few hours per week of medical sciences. It also includes some subjects related to clinical practice. Nurses qualify from these programs at the age of 18 and receive a license to practice in Croatia.

During the last two decades, known as “years of transition,” a diversity of programs flourished. Different schools offered courses of study that varied widely in length, level of prestige, and academic rigor. Some are under the umbrella of the ministries of education and health, others are semi-private or private, in alliance with vocational and technology institutes, polytechnics, or even national and private universities. In addition, some of them offer two-, some three-, and some four-year programs. Nursing education in Croatia is still inadequate and insufficient compared with European standards. All reforms must be concordant with other European countries. Nursing has to be an independent profession, with clearly defined responsibilities, rights, and obligations, equal to all other health-related professions.

12.4.1 References

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http://www.hzzo.hr/en/english-general-strategic-plan-for-the-2013-2015-term/

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2971660/

12.5 Identification of skill and competency needs in the homecare in Cyprus

In 2015 the Department of Nursing, School of Health Sciences, at Cyprus University of Technology in Limassol, Cyprus presented the results of a study "*Evaluation of Home Care Nursing for Elderly People in Cyprus"* where both types of participants (clients´ and home care nurses) were asked to reply to questionnaires for analysis of the current situation in Cyprus.

The results were:

- The main problem that must be coped with is that there is a need for a better collaboration between the Ministry of Health, Home Care Nursing Service and the Services for the Elderly of the Social Welfare Services as well as the local authorities as to fulfill older people´s needs. (Some clients did not understand the difference between social welfare and home care nursing service).
- There are no quality indicators for the service to be used for periodic audit and evaluation.
- Due to its short period in operation the service appeared to be experiencing infrastructural problems. Basic resources such as efficient systems of client-nurse communications and administration were reported to be lacking.
- Clients did not have adequate knowledge about the service and what it can provide. When a new service is being planned, it is imperative that service users are notified and consulted and that every effort is made to inform of its existence and how to access it.
- Clients expressed their desire to have its workforce increased so that they could receive more visits and suggested provision of other help, mainly from social care.
- There is a need for a better collaboration between the Ministry of Health, Home Care Nursing Service and the Services for the Elderly of the Social Welfare Services as well as the local authorities as to fulfill older people´s needs. (Some clients did not understand the difference between social welfare and home care nursing service).
- There are no quality indicators for the service to be used for periodic audit and evaluation.
- The lack of legal framework also means that there is no formal structure for collaboration between the various services for the elderly. The authors of the study recommend the development of model of Community Partnership in Care Nursing. This model supports the collaboration and integration of public and private sector services regarding community nursing and care.
- Home care nurses highlighted the need of forming a multidisciplinary team to provide holistic care to the clients, such as psychologists, physiotherapists, occupational therapists and not only doctors; a more "clear" hierarchy and a better coordination between the supervisors and the home care nurses (there is a lack of coordination and communication between staff and supervisors as well as between supervisors; each region has its own supervisor, each supervisor give its own opinions and administers the program in their own way; not all supervisors are informed about the needs of the program).

http://www.internationaljournalofcaringsciences.org/docs/15_kouta.pdf

12.6Identification of skill and competency needs in the homecare in Czech Republic

As described in D.2.1 [CARESS, 2016], usually, healthcare services and social services are separately provided. The Act on Social Services 2006 tried to improve the coordination between the two systems, social-care and health-care, by allowing cross-funding between the two system and flexible care allowance but this coordination is still imperfect mainly due to the strong financial incentives for patients to remain in health-care facilities, even unjustified. The flexible individual care allowance has also enabled some patients to pay for care by family members or volunteers. (Health Systems in Transition, Vol.17, no. 1 2015).

The compulsory health insurance funds the health care as well as the provision of home nursing (including personal care) and rehabilitation at home. Nursing is intended to care for persons after hospital or for chronical patients, and in general for qualified care provided by professional nurse.

Istead the provision of long-term care, including home care, is covered by social care services based on tax money and provided by municipalities.

The quality of social services is regulated by law (108/2006 Sb) and it is frequently checked by the municipalities, so the care providers are obliged to develop internal standards over the compulsory registration (social act 108/2006 Sb).

The time received by clients is 30 minutes weekly for home nursing, 0.01 hours for home care and 0.6 hours of home help (Garms-Homolovà, 2008).

No qualification for home-care services is required in Czech Republic only few domestic aid professionals were qualified, as well as no specifc recertification of nurses is required.

It is unknown the type of professionals providing domestica aid it is only known the minimun educational level, i.e. short training by employer (WHO 2012, Home Care Across Europe). This highlight the needs of specific regulamentation for basic services.

Personal assistance services provided are:

A. assistance with personal hygiene.
B. assistance with eating and drinking (not the preparation of food).
C. assistance dealing with incontinence and/or skin care (available if classed as part of home care)
D. Services offering companionship and social activities (some are on voluntary bases)
E. Ergotherapy/occupational therapy, home adaptations and assistive devices

But not sufficient in all the cases, as reported by Alzheimer Europe for example (http://www.alzheimer-europe.org/Policy-in-Practice2/Country-comparisons/Social-support-systems/Czech-Republic)

Some of the personal care educational level is regulated and starts from a minumun of 4 month training. Not a univoc regulation is provided.

Home nursing care provided services:

F. Professional qualified care.
G. assistance with mobility
H. Assistance/supervision taking medication (not by all the nursing agencies)

It is usually provided by nurses and their competences are well defined.

Home help

I. Assistance with housework
J. Help with the preparation of meals (including meals-on-wheels)
K. Transportation service
L. Assistance with shopping (non in all the municipalities)

Usually provided by familiar or informal caregivers, low level of regulation or training is provided.

General Home care Needs:

Even if the capillar quality control there are regional disparities on the provided services, for examples rural regions have scarse specialised care services and the cost of transportation of patients, to doctors or rehabilitation services, are not always possible. In rural area there are no relevant social services but this should change with the new law.

- There are no specialised services for people with different kinds of dementia.
- There is no support specifically designed to meet the needs of people with dementia and carers from ethnic minorities.

12.6.1 References

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12.7 Identification of skill and competency needs in the homecare in Denmark

Healthcare and welfare is primarily governed by the Health Act and Social Services Act. Currently, there are much focus on rehabilitation - the citizen must be able to fend for themselves as long as possible in their own lives, as well as increased privatization and including free-choice scheme which allows the citizen to choose between public or private homecare.

Generally, welfare and services in Denmark are under pressure due to longstanding savings and cut downs in the municipalities. This may explain the increasing focus on rehabilitation because it wishes to prevent admissions / readmissions and improve the work of early detection, so the cost of the elderly and infirm citizens is held down.

The Danish system of long-term care services for the elderly is among the most extensive and older in the EU. Earlier and more than other countries, Denmark has given explicit policy priority to home care earlier than other EU countries. Danish system is currently undergoing a process of retrenchment (somewhat

reduced services being offered to fewer people) and restructuring. During restructuring will strengthen the focus on prevention, rehabilitation and re-enablement to raise and maintain capacities for independent living and well-being and so as to free up resources for tending better to those with more severe needs.[33]

You can read more about the two educations here: http://www.sosuc.dk/om-sosu-c/english.aspx

12.8Identification of skill and competency needs in the homecare in Estonia

As described in D.2.1 [CARESS, 2016], Estonian population is ageing, the life expectancy is low and there is a large difference of life expectancy between men and women. Life expectancy for men and women at age 65 is projected to rise. The natural increase of population is low as well there is a high emigration rate. In the period 2013-2060 the share of people aged 80+ in the Estonian population is expected to grow from 4.7% to 11.7% (EU-28: 5.1%-11.8%).[34]

Table 1. Background statistics of Estonia[35]

Estonia (EE)

Demography

Elderly population as % of total population [1]	2013			2030			2045			2060			P.p. change (2013-2060)		
	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
65+	18.0	12.9	22.5	24.2	19.0	28.9	27.6	23.3	31.5	30.0	26.5	33.3	12.0	13.6	10.8
80+	4.7	2.5	6.7	7.1	4.2	9.7	10.0	6.8	12.9	11.7	9.0	14.3	7.0	6.5	7.6
85+	1.9	0.8	2.9	3.5	1.8	5.1	5.4	3.3	7.4	6.7	4.7	8.7	4.8	3.9	5.8
80+/65+	26.3	19.4	29.8	29.2	22.0	33.5	36.2	29.2	40.9	39.0	33.9	42.8	12.7	14.5	13.0
85+ /65+	10.7	6.5	12.8	14.6	9.4	17.6	19.6	13.9	23.5	22.4	17.6	26.0	11.7	11.1	13.2

EU-28

Elderly population as % of total population [1]	2013			2030			2045			2060			P.p. change (2013-2060)		
	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+ /65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1

Old-age dependency ratios, % [2]	Estonia (EE)									EU-28								
	2013			2060			P.p. change			2013			2060			P.p. change		
	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
20-64	29.3	20.0	38.4	61.1	51.6	70.9	31.7	31.6	32.5	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	20.4	13.0	27.3	44.7	37.0	52.6	24.3	23.9	25.3	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6

Health status

Life expectancy [3]	Estonia (EE)						EU-27					
	2010		2060		Change (years)		2010		2060		Change (years)	
	M	F	M	F	M	F	M	F	M	F	M	F
years at birth	69.8	80.1	81.6	88.0	11.8	7.9	76.7	82.5	84.6	89.1	7.9	6.5
years at 65	14.1	19.1	20.9	24.9	6.8	5.8	17.2	20.7	22.4	25.6	5.2	4.9
Healthy life expectancy [4]	2005		2012		Change (years)		2005		2012 (EU-28)		Change (years)	
	M	F	M	F	M	F	M	F	M	F	M	F
years at 65	3.4	3.6	5.4	5.5	2.0	1.9	8.6	8.9	8.4	8.5	-0.2	-0.4
Healthy life expectancy as % of the life expectancy	2005		2012		P.p. change		2005		2011 (EU-28)*		P.p. change	
	M	F	M	F	M	F	M	F	M	F	M	F
at 65 (%)	26.2%	20.0%	36.3%	27.3%	10.1	7.3	52.1%	44.5%	48.3%	40.4%	-3.8	-4.1

Expenditure on long-term care

Total public expenditure on long-term care as % of GDP [5]	2010	2060	P.p. change	2010	2060	P.p. change
	0.5	0.9	0.4	1.8	3.6	1.7

LTC is provided as an in-kind social service and is organised at the municipality level and regulated by Social Welfare Act. Care services can be provided by the state, institutions, public or private legal entities or their

[33] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf. 2014: 104.*
[34] *ec.europa.eu/health/**ageing**/docs/ev_20140618_co04_en.pdf, 2014: 110.*
[35] *ec.europa.eu/health/**ageing**/docs/ev_20140618_co04_en.pdf, 2014: 114.*

offices. In order to provide health care services in Estonia, an institution has to be certified by the National Healthcare Services Act. There are 47 institution-based service providers, 43 home nursing service providers and 1 cancer homecare, all of which are funded by the Estonian Health Insurance Fund (EHIF). In addition to this, 7 hospitals provide geriatric assessments.[36]

Children and kinsfolk are legally obliged to take care of their elderly relatives. Accessibility to services is uneven and often limited in different part of Estonia. The welfare and healthcare systems are financed from different sources and the finances are limited. Care services can be provided by the state, institutions, public or private legal entities or their offices.

There are over 200 municipalities in Estonia and many of them are very small. For this reason, it is impossible for them all to offer a full range of services. Nevertheless, home care services are offered mostly in bigger towns and only for persons who have got any relatives. But in rural areas with low population density and shortage of qualified specialists people's needs may partially be unmet. Older persons or their families can hire themselves a private carer (friend, voluntaries, student etc.). The level of co-payment for domestic aid and guidance varies across municipalities.

Home care in Estonia is under-delivered and there are still a lot of people who need nursing care but who do not have access to services they need. There continues to be a lack of qualified staff (nurses, social care workers) and appropriate financing. Older persons can find information about care options and other aspect of the organisation of home care is mostly available on the websites of those organisations (for example private providers: http://www.koduhooldus.ee/teenused/, http://makoabi.ee/, http://www.seniorcare.ee/et/, http://certis.ee/index.php). There is lack of educated HHCPs and older persons can use many informal services (clients' partners and others adult co-habitees). In response to these challenge the project of European Social Fund 'Pilot Project of Home Care Workers' (2004-2006) created a training course for unemployed persons to become home care workers (with the support of the Danish experience)[37]. Project highlighted developing of Estonia's welfare and health care systems and tried to activate discouraged persons, long-term unemployed and increased employment rate among the part of the Russian-speaking population for their return to the labour market in homecare sector. The new developed home care worker's curriculum meets the requirements of the professional standard Social Care Worker's professional qualification level.

The mainly activities of HHCP during visit at home are[38]:

- 14,7% nursing,
- 9 % caring and nursing procedures,
- 17% supporting and helping with daily activities and
- 20% supporting and guidance.

Home care in Estonia is developing but, the need for home care continues to grow due to the growing number of elderly people in the population. There are lack of qualified staff – both in home nursing as well as in domestic help, but also about scarcity of financial resources. Cooperation is poor between the health and social sectors which may cause difficulties in access and transition. Furthermore, there is a lack of common understanding of various requirements to quality of services and the evaluation of service quality is often complicated.

The biggest challenge in Estonia is old tradition what gives responsibility to care older person in family. Caring of older person is not motivating for younger person, care work is low paid. Many customers of home care are older women and carers are mostly 50+ years women, too. There is challenge to find

[36] *ec.europa.eu/health/**ageing**/docs/ev_20140618_co04_en.pdf, 2014: 111*
[37] EQUIP 2007–2009, 87–88.
[38] Koduõenduse tegevusjuhend, 2015: 21.

information about different possibilities to have some help and support at home and the best way so far would be ask neighbors or use personal network to find some helper (cheaper way).

The following general developments lines are relevant to home care in Estonia[39]:

- Increase of the share of outpatient nursing care services.
- Development of human resources and appropriate financing schemes for home care services.
- Development of quality assurance mechanisms in home care.
- Need for integration between the PHC and social welfare systems.

There are need to offer home nursing around Estonia 7 days per week and 24 hours. The access to home care needed more in smaller villages, country side, as there live mostly older population. For visits HHCP needs a car and more time resources[40].

There is need to develop and train following knowledges and skills of HHCP[41]:

Home team members need more skills for assessment and monitoring of individual needs to design and organize home care services. There are need for multi-disciplinary teams.

The home care nurse have practice minimum 3 years after graduation before she can start in home care services. The other opportunity would be to undergone a Supervised practical training. The home care nurse have be able to perform all caring activities.
Communication and supervising skill.
Problem solving skills (family problems and abuse cases).
Knowledge about (home care) services and finances/payments. Guidance of customers.
Knowledge about dementia and psychiatric problems.
Knowledge about living environments of older person, guidance for older person.

Estonian suggestion for home care services' development[42]:

- there needed extra financial resources for organizing visits to country side (transportation ressources, car) and extra payment for HHCP
- There needed extra visits (more as two visits per day) for caring some persons
- There is need to use services of many different specialists in home care (physiotherapy , occupational therapy, logoped, diet counseling , foot care, diabetes nurse or other highly specialized consultations)
- Graduated home care nurse (HHCP) will need first supervising from experienced worker (minimum 4 months co-working and minimum one year supervising).
- All HHCP needs regular supervision and guidance, possibility for feedback and analyzing own work.
- There is need to develop a new guidebook for terminal care and home nursing care for patients with mental disorders

The results of survey in Järvamaa (2015) about needs of services highlighted the need of support services (daily activities) and guidance services (psychological support, financial guidance)[43].

Keywords for developing of home care services would be enhancing the image of care work as a profession and educate and train each (informal) worker in home care.

[39] http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf, 2013: 84.
[40] Koduõenduse tegevusjuhend, 2015: 13.
[41] Koduõenduse tegevusjuhend, 2015: 21-22.
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https://jarva.kovtp.ee/documents/6653157/11415984/J%C3%A4rvamaa+arendustegevuste+anal%C3%BC%C3%BCs+.pdf/1e9167f5-2061-4329-8f12-5e5109489f91

12.9Identification of skill and competency needs in the homecare in France

The next decades will see increasing rates of care-dependent older people and non-communicable diseases as the leading cause of chronic illness and disability. The break-up of the traditional large family group and urbanization will also lead to gaps in the care of older or disabled family members. These changes in needs and social structure require a different approach to health and social sector policy and services since a disease-oriented approach, alone, is no longer appropriate. An answer to these issues could be home care, a sustainable approach to prevent the need for unnecessary acute or long-term institutionalization and maintain individuals in their home and community as long as possible.[44]

As a result, home help is intended to provide assistance with everyday tasks to people aged 60 or more to enable them to carry on living in their own homes. The aim of home nursing care services is to prevent, postpone or shorten stays in hospital or residential care institutions.

Although its organization was presented in a parliamentary bill in 2002, the institutional quality-assurance system in France is still undergoing construction. This system relates to home-based care organizations or units and their provision of care and help in day-to-day activities. The quality of the care rendered is not taken into account; rather, the institutional system is based on the following elements:

1. responsibilities and procedures that organizations and units must respect to enter into and remain in the sector;
2. a quality assessment system (with internal and external evaluations);
3. the National Agency for the Evaluation of Social and Health Care (Agence Nationale de l'Evaluation Sociale et Médico Sociale, ANESM).[45]

[44] ***HOME CARE IN EUROPE*** Edited by Rosanna Tarricone & Agis D. Tsouros
[45] ***QUALITY ASSURANCE POLICIES AND INDICATORS FOR LONG-TERM CARE IN THE EUROPEAN UNION COUNTRY REPORT: FRANCE*** Beatrice Fermon And Marie-Eve Joël

All organizations or units providing long-term care (LTC) and coming within social and health care sectors are subject to an authorization process for their establishment, transformation and expansion. For long-term care, this authorization is issued by the president of the departmental general council.

The request for authorisation must, in effect, demonstrate the ability of the organization or unit to guarantee users' rights and carry out the evaluations planned.

The users' rights are specified as follows:

1) respect for the dignity, integrity, private life, privacy and safety of the person receiving care;
2) free choice among the services offered;
3) customised provision of care and assistance that promotes development, independence and integration, is adapted to age and needs, and respects the informed consent (which must be sought systematically);
4) confidentiality of the information concerning the person receiving care;
5) access to information concerning the person receiving care;
6) information on the basic rights and the legal and contractual protection offered, as well as the possible paths of recourse; and
7) participation, either directly or with the help of his/her legal representative, in the setting up and implementation of the plans to receive and assist the person.[45]

For organisations or services approved to offer home-based care services, the quality criteria cover areas of external evaluation to which more specific aspects are added, linked to the fact that these organisations come under the accreditation system. The decree of 24 November 2005 sets out the elements of the evaluation criteria in the following way:[45]

General instructions

- respect for the privacy of service beneficiaries and their families, for their cultures, their life choices, their personal space and possessions;
- respect for confidentiality regarding information received;
- guarantee of the exercise of personal rights and freedom;
- knowledge of local, social and health care contexts corresponding to the population for which the organisation or unit caters;
- work in synergy and coordination with other workers and organisations;

Organisation of high-quality reception

- the physical and telephone reception, consistent with the services offered;
- availability of written documentation;
- the posting of tariffs in public reception areas;
- adapted premises;
- ability to respond to emergency situations;

Tailored operations

- recognition of the beneficiaries' direct requests and those of their friends and family when the beneficiaries cannot express their needs;
- adaptation of the treatment methods to the beneficiary (it is advisable to act in the place of the beneficiary, to help the beneficiary perform tasks him or herself, to teach the beneficiary to carry out these tasks, etc.);
- coordination of the service offered with other possible operations;
- information on possible financial help and the steps to take;

Clarity and quality of the offer of service

- existence of a free estimate for every service offered entailing a monthly cost of more than €100 (taxes included) or for every beneficiary who requests one;
- existence of a written contract;
- the right to cancel up to seven days after the signing of a contract between the beneficiary and administrator;
- clear and detailed invoicing;

Operational methods

- continuation of operations on Saturdays, Sundays and bank holidays, if necessary, and good coordination among the different services provided;
- information on the general conditions for replacement caregivers, which must be systematically offered when the regular caregiver is absent, including for annual leave;
- information on the identity and qualifications of caregivers;
- respect for the predefined hours of operation and nature of the service offered;
- the monitoring of every service is ensured by a designated representative within management, whose name is given to the beneficiary;
- caregivers are informed of the specific needs of the beneficiary. Management ensures that it is clear which services are to be carried out (instructions, tasks to be completed, etc.);
- caregivers participate in the operation's personalised monitoring system. They inform the service of significant events concerning the beneficiary and are included in discussions leading to changes in the care package;
- caregivers are included in the coordination of care with other caregivers;
- caregivers respect the confidentiality and privacy of the persons;
- caregivers are prohibited from being given by the beneficiary any delegation of authority for assets, property or rights, any donation, any deposit of funds, jewellery or valuables;
- administrators contribute to abuse prevention, notably by increasing public awareness and training adapted to caregivers. When necessary, the administrator informs the relevant authorities;
- caregivers are supported in their professional practices in different ways, such as training, meetings for the exchange of techniques and private meetings;
- the administrator implements a personalised monitoring system for services, in conjunction with the beneficiary and caregiver and in agreement with the beneficiary. The definition of the services offered is reviewed at least once a year;
- for regular services carried out at the beneficiary's home, a caregiver/user log book (or equivalent system) is maintained;
- the administrator manages any conflicts that arise between the caregiver and beneficiary;
- in the case of an unresolved conflict with the administrator, the beneficiary can call, with a view to asserting his/her rights, a qualified person chosen from the list in Art. L. 311-5 of the CASF, also found in the appendix of the reception booklet.[46]

Selection and qualifications of the persons carrying out services

- the administrator ensures that the candidates' abilities are suitable for the proposed job, and to this end, organises the recruitment process;
- the caregiver

[46] http://www.ancien-longtermcare.eu/

- either has a diploma, certificate or status awarded by the government or certified body, or registered in the national directory of professional certifications, proving his/her competences in the field concerned;
- has three years of professional experience in the field concerned, and will benefit from training or coaching in order to receive certification of experience, with a view to receiving training leading to a diploma;
- has a government-assisted contract associated with professional training or vocational training;
- has benefitted from training to adapt to employment followed by training for a diploma in the appropriate field.[45]

There are a lot of different institutions concerned by homecare services sector (General Councils, Family Allowance Fund, CRAM (Regional Health Insurance Fund), retirement pension fund, municipalities, CCAS (Central Social Care Fund) and so on.

The solid quality system that rules the delivering of homecare assistance in France is expected to guarantee the elderly an high services level.

The main planning instruments are the Interdepartmental Disability And Loss of Autonomy Assistance Programmes (PRIAC). They are defined every three years at 'regional' level and identify the financing needs of nursing homes.[47]

Benefits

Personalised allowance for autonomy (APA) is the main allowance in LTC. APA is intended for people over 60 years to support expenses linked with their new loss of independence. It can be allocated for people who decide to enter a residence or remain at home, or to assist them in their daily lives. The amount allocated is determined as a function of the individual's level of dependence and their disposable income.

Public expenditure for APA was about €6 billion in 2008 (€4.5 billion for people staying at home, €1.4 for those in institutions) for 1,115,000 people.[47]

The average APA benefit is about €490 for a person at home and €410 for one in an institution (Prévot, 2009).

Departmental authorities are in charge of assessing the dependent person's needs and they evaluate the final implementation of the care package. To be eligible for APA the person must live in France, be aged 60 and over and have a recognized dependency need. The severity of the latter is established by the AGGIR scale (Autonomie Gérontologie Groupes Iso-Ressources).

The need for LTC (Long Term Care)

The sector of the population aged 60 years and over was 12.6 million in 2005 (22% of the French population), and will reach 20 million in 2030, and about 22 million in 2050, which will be equivalent to almost one third of the whole population. The population aged 80 and over (age when dependency usually increases very fast) will reach 4 million in 2020 (+80% in comparison with 2000) and 7 million in 2040 (a threefold increase compared to 2000) (Colin, 2000).

In France, 12 million people aged 60 and over (and a third of people aged 75 and over) live in aprivate household. 28% of the 12 million people aged 60 and over, i.e. 3.2 million (57% of whom are women) are in

[47] **THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN FRANCE** *MARIE-EVE JOËL SANDRINE DUFOUR-KIPPELEN CATHERINE DUCHÊNE MATHILDE MARMIER ENEPRI RESEARCH REPORT NO. 77*

need of help in their everyday lives.[47] 50% of these 3,230,000 informal care recipients receive exclusively informal care and 29% receive both informal and formal LTC.

Among these informal care-givers, 66% are women and 85% belong to the family of the 'cared-for' old person. Some of them are neighbors or friends (9%) .

Caring tasks

When considering need in the case of dependency, it is not surprising that housework is the main area of care provision, or that these daily tasks are performed by formal (51%) as well as informal (42%) care-givers .

Care policies for family carers

The severity of needs is correlated to the consequences of being a care-giver: almost 42% of informal care-givers for very dependent relatives declare having negative consequences, especially psychological (75%) and physical (50%).[47]

Three measures tend to increase the value of informal care:

- The creation of a specific status of informal care-giver in law.
- the creation of 'the informal care-givers' notebook' which gives information to the caregivers about their rights;
- the possibility for informal care-givers to be paid, thanks to the APA allowance.

The availability of family carers over the next few decades is expected to decline, the need of formal homecare givers will increase consequently.
The French home services for older people include a wide variety of help and support. The system relies on different services to cope with social and nursing needs:

- home nursing care services (SSIAD,) included in the health sector;
- home care services (SAAD,) that have belonged to the medico-social sector since 2002(law of 2 January 2002);
- multipurpose home care services (Spasad) created by the decree of 25 June 2004; they group social and nursing services. There are actually very few of them.

The borderline between home nursing care and home care is not an easy one to draw, especially when sharing out tasks between paramedical staff and social helpers.

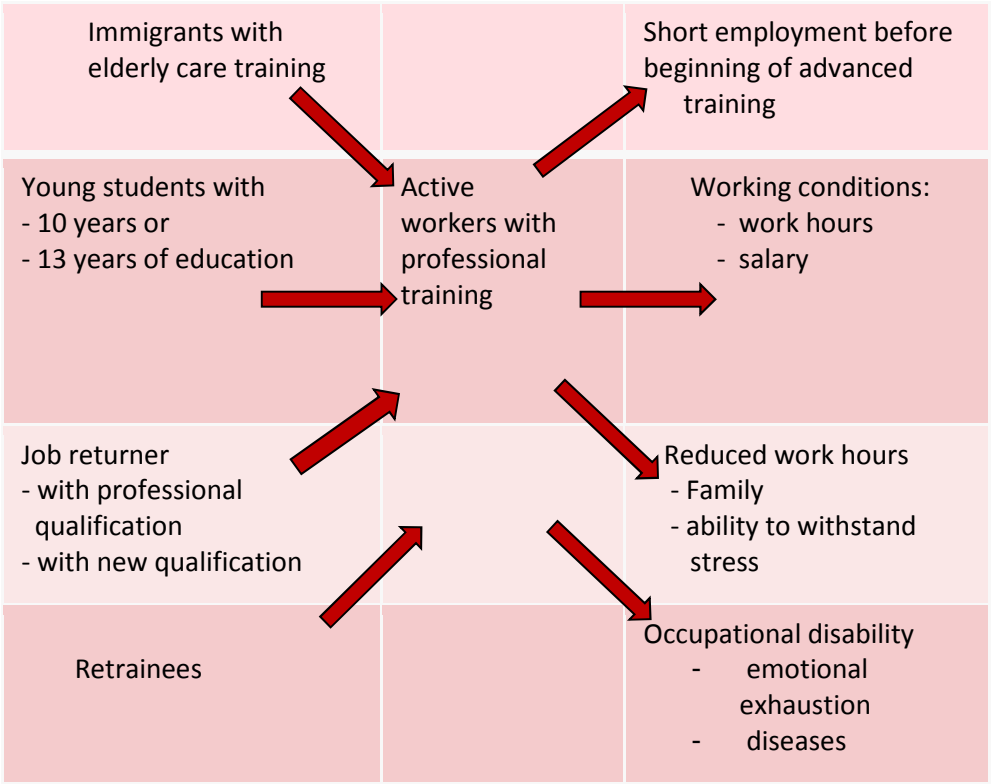
Recent reforms aimed to simplify the organization of health system by the institution of Regional Health Agency (26 in the whole France) had the complementary result to improve LTC with special regard to mental disease suffering old people. The objective is to coordinate the sector of health, the social sector, hospital and private practice, in both public and private sectors.

According to informal reports, improving care givers skills in providing assistance in day-to-day life and in evaluating health (mental and physical) risks and difficulties in home environment is one of the challenges for the very next years.

12.10 Identification of skill and competency needs in the homecare in Germany

The population of very old persons (80+) is expected to increase from 5.4% to 13.4% in Germany. The natural increase of population is negative (2015) but due to external migration the population increased by 251 712.[48]. The population is expected to decrease to 74,512,858 until 2050[49].

The majority of older people in need of care receive either a care allowance or home care in kind "care at home prior to residential care". Family care was and is very important in Germany so also nowadays many elderly people are expecting to be cared for by their children, if care should become necessary. Mostly (informal) carers are either spouses or children between the ages of 50 to 65 years. Around 414.000 informal carers were insured in SPI in 2010.



However, when current 50 – 65 years old possible carers will reach the age of 80 themselves, starting from 2025, and family members will become rarer and thereby increasing demand for professional care is to be expected. The nursing staff cohort is aging rapidly.

One big challenge is to enhance attractiveness and to broaden job perspectives in home care. The recruitment of staff is extremely difficult. As there is strong tradition of informal family care for older people, the geriatric infrastructure within the health care sector is still not well developed. Many long-term care facilities provide services of low quality. The attractiveness of the job of a HHCP is discussed broadly. There is the current and expected lack of qualified nurses and difficulties in finding qualified personnel in Germany. Immigration of qualified nurses from outside Europe is promoted.

[48] http://countrymeters.info/en/Germany
[49] http://www.worldometers.info/world-population/germany-population/

The regulations and procedures of vocational elderly care training (Altenpflegehilfe) vary in the individual German states (Figure 2). The main education for formal home care nurse/care worker varied from one to three years. The government is working on new regulations and programs what aim to develop special education and training for the three-year vocational training. The new education will merging of nursing education and training for geriatric care to a generalized care training.

Duration: one year	**Duration: two years**
865 h theory	2700 h theory
770 h practical training	920 h practical training
The practical training takes place in residential nursing homes , non-residential care services, hospitals and gerontological psychiatry	
Institutions:	
Non-profit organisations and private schools	Public vocational schools
Training contract receipt of unemployment benefit (SGB II/III)	student status
vocational qualification	DQ: **vocational qualification** and MSA or EBBR

The goals of prevention, health promotion, and maintenance, as well as of rehabilitative care have not been reached yet in domiciliary LTC in Germany. There is reported a major need of new staff in future. Highly qualified nurses that would like to work in home care are almost not available at labour market. Important tasks are the legalization of the work of migrants in home care and diversity management. One of future challenges is improving working conditions and to introduce health promotion programmes for aging professional caregivers. Clearer information about different services' providers will help potential clients and their relatives to be interested in formal home care.

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12.11 Identification of skill and competency needs in the homecare in Greece

As described in D2.1, the Greece health and social care system relies mainly on public founding and the service offered is regulated by law, that fix the boundaries of eligibility for clients and skill and competency needs for staff. The field of homecare for older adults is a wide work sector in Greece, counting more than 120,000 employers, due to high levels of average age population and the increase of longstanding disease or health problems.

Functions	Estimated number 2009
Domestic aids	1500–2000
Personal carers at home	50.000–70.000
Home nurses	n.a.

Most of the workers in the homecare services for older adults are middle aged woman; performing undeclared work and immigrant from Balkans or the Eastern block countries. The Eurofamcare of 2006 on Greece reports that 7% of the family member that have a role as informal caregiver also employed a homecare worker coming not regularly. Only in Sept. 2009 has been defined in detail the roles and tasks defining the homecare services. As reported in D2.1 the homecare services in Greece can be divided in to two main programmers Social Care/help at Home programmer, providing home health care, and Centers for Daily Care for the Elderly, providing home care services for members and some day care.
Despite the older adults declare to be satisfied about the service offered by Homecare staff (EETAA study 2008), the entire expert highlight how there is a wide amount of home services not declared and not clear, that is a risk for health of people.

Home care services, as defined and ruled by laws, include three main typology of staff: social workers, involved in coordination and assessment of users' needs, home helpers (including social careers and homecare assistant, and nurses.
Greek laws define also the levels of education required for each of them. Despite these detailed description a large part of staff in homecare services have not received any vocational training.

Based on the results of the ECVC "Elderly Care Vocational Certificate "project, founded by European Commission inside the programmer Leonardo da Vinci from 2005 2007, has been identified some theatrical knowledge that need to be obtained by staff working in elderly care, including

- Vocational awareness
- Basic ageing pathology
- Environmental care
- Basic body care
- Hygiene
- Nursing
- Handling incontinence
- First aids
- Physiotherapy

- Mobility and entertainment
- Tools and materials

Despite the priority should remain the arising of the hidden homecare work, and the regulation of it basing on law standards and staff competences requirements, Hellenic Agency for Local Development and Local Government (Kirkoglou, 2011) identified as priorities for staff working in homecare services the following transversal competences:

- Social characteristics (patience, kindness, etc.)
- Organizational skills (especially for social scientists, responsible for the coordination and operation of the unit)
- Communication skills
- Ability to understand the seriousness of situations

12.12 Identification of skill and competency needs in the homecare in Hungary

Hungary is a Central- European country with 10 million habitants. The socio-demographic context in Hungary is characterized by population ageing and a general decrease in the population size. The population over 65 and 80 in currently 17% and 4% respectively.

It has an insurance-based public health care system funded by income-related social health insurance contribution.

In Hungary, long- term care patients can receive services from the health and the social care system. The health care system operates under de National Health Insurance, while the social care system is managed at a local level.

The central government is responsible for the health care legislation, as well as the financing for Long-term care. The local governments assume primary responsibly for organizing and delivering social care, which includes home care and nursing care, under the framework set out by the central governments.

Home care as defined in Hungary includes:

- Domestic care: Basic social service provided to persons being unable to care for themselves in their home as well as to psychiatric patients, disabled persons and addicts who due to their condition, need help in performing the tasks necessary for independent life.
- Club for the aged: provides day care for elderly people who are partially capable of looking after themselves and in need of social and mental support, and enables them to maintain social relations, satisfy basic hygienic needs and to get daytime meals upon request.
- Day home for disabled: enables disabled or autistic person o over three years of age living in their own homes and not needing supervisions to find daytime shelter, maintain social relations and satisfy basic hygienic needs and to get daytime meals upon request.

The health care systems provides a primary medical assistances, operates a domestic medical nursing service for limited number of visits, and provides continuous outpatients special care for different type of chronically ill patients.

Institutional care is only provided to individuals who require more than 4 hours of help per day. Individuals in need of 2 to 4 hours of care receive home care services, while those who require less than 2 hours of

care per day receive no public assistance. Benefits are set at a national level but are often supplemented by additional benefits provided by local authorities.

12.13 Identification of skill and competency needs in the homecare in Ireland

As of 1 January 2016, the population of Ireland was estimated to be 4 696 141 people. This is an increase of 0.31 % (14 326 people) compared to population of 4 681 815 the year before during birghts and external migration.[50] Older people (65+) are 11,6 % from total population in Ireland and the number is Ireland onlowest rate of people over 65 in the EU. However, the aging of the population will have significant social and economic implications as well as increased demand for long term care. The share of people aged 80+ is expected to grow from 2.9% to 10.2% (during 2013-2060).[51]

Ireland's projected population growth is the fastest of the 27 EU countries over the next fifteen years and it reflects a strong increase in the working age population. Migration produces an increase in Ireland's working age population of 7.6% between now and 2026. In this case, Ireland differents in most other European contries.[52]

In Ireland the main government departments responsible of the home care for elderly people are: "Department for Health and Children", "Department of Social and Family Affairs" and "the Department of Finance".

Caregivers dependent of these departments have developed a document in 2008 known a "Long Term Care Report" which reflects many of the objectives that have influenced the current policies of the home-based caregivers in the country. In practice, there is a dominant strategy of the "Health Service Executive (HSE)" which is recruiting a significant number of health professionals and social workers, in addition to volunteers and other workers.

The following demographic statistics are from Ireland's Central Statistics Office (CSO), Eurostat and the CIA World Factbook.

Population
65 years and over: 11.7% (male: 243,314; female: 292,079)

Sex ratio

a) 65 years and over: 0.8 male(s)/female
b) total population: 0.99 male(s)/

Life expectancy at birthtotal population: 80.19 years

a) male: 77.96 years

[50] http://countrymeters.info/en/Ireland
[51] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf, 2014: 152.*
[52] https://www.kbc.ie/Blog/Economic-Updates/Irish-Population-Outlook-Still-Encouraging-%28And-Un

b) female: 82.55 years

The Health Service Executive (HSE) is the national public provider of health and social care. The Nursing Home Support Scheme (2009) is providing funding of nursing home care, both the State and individuals in aiming to 'make long term nursing home care accessible, affordable and anxiety free'. Home care is provided in three ways: the HSE has staff who directly provide homecare, the HSE contract the private sector to provide homecare and people buy homecare privately.[53]

Home care services in the form of home help and home care packages were formalised in the midle of 2000s. The government implement of caring for people at home and in the community and there is a substantial increase in home help as well need on increasing number of home care worker.

Homecare packages included the basis of assessed need, in order to keep older people out of hospital or nursing homes and at home. Unfortunately the reality is that it may be very hard to get home care services without a medical card or if you can afford those services. Many people in receipt of home help services have had their hours cut. 155

National policy is supporting older people to live independently and in their own homes for as long as possible. The National Positive Ageing Strategy and Healthy Ireland (2013) addressing the broader determinants of health and commits to addressing the healthy ageing, health and personal social services, carers, employment and retirement, education and lifelong learning, volunteering, cultural and social participation, transport, financial security, housing, the built environment, safety and security as well elder abuse. The other programmes of goverment are National Alzheimer's and Dementia Strategy (2013). [54] Unfortunately there is no specific policy on independent living in Ireland. Similarly, there are need to develop prevention and rehabilitation of older people. Nowadays there are many projects which aim to prevent, support rehabilitation and schemes to promote independent living such as age-friendly housing, ICT in Ireland.

When choosing the home-based caregivers there are a wide variety of criteria according to the different regions, due to the lack of a national standardisation. Home help and the personal care delivery is widespread in Ireland and is financed by the State and other Regional Institutions of the "Health Service Executive (HSE)" that allow an assistance funding through co-payment for those elderly people who are not entitled to a health card.

Family caretakers in Ireland are being recognized as a group of citizens with special rights. 60% of these family caretakers spend between 1-19 hours on caring responsibilities and 27% spend more than 50 hours per week caring for their relatives.

Ireland, for its part, has had an important growth in the private sector in these type of services. The main difficulty at national level is in the low-wages, particularly for unskilled workers.

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[53] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf, 2014: 152.*
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12.14 Identification of skill and competency needs in the homecare in Latvia

As described in D.2.1 [CARESS, 2016], population in Latvia will aging and during 2013-2060 the share of people aged 80+ is expected to grow from 4.7% to 11.0% (EU-28: 5.1%-11.8%). Life expectancy for men and women at age 65 is projected to rise from 13.5/18.1 years (EU-27: 17.2/20.7) in 2010 to 20.6/24.4 years (EU-27: 22.4/25.6) in 2060[55]. From 2005 to 2012 healthy life expectancy for men and women rose by 0.3 and 0.9 years, respectively.

[55] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf, 2014: 179.*

Latvia (LV)															
Demography															
Elderly population as % of total population [1]	2013			2030			2045			2060			P.p. change (2013-2060)		
	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
65+	18.8	13.3	23.4	25.3	19.5	30.3	28.0	22.6	32.8	28.3	23.8	32.4	9.5	10.5	9.0
80+	4.7	2.4	6.5	7.0	4.1	9.5	10.2	6.8	13.2	11.0	7.8	13.8	6.3	5.4	7.3
85+	1.9	0.8	2.8	3.6	1.8	5.0	5.2	3.1	7.1	6.4	4.2	8.4	4.5	3.4	5.6
80+/65+	24.8	18.2	27.9	27.7	20.8	31.5	36.3	30.1	40.2	38.8	33.0	42.7	14.0	14.8	14.8
85+ /65+	9.9	5.9	11.8	14.0	9.3	16.6	18.6	13.8	21.6	22.7	17.7	26.1	12.8	11.8	14.3
Elderly population as % of total population [1]	EU-28														
	2013			2030			2045			2060			P.p. change (2013-2060)		
	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+ /65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1
Old-age dependency ratios, % [2]	Latvia (LV)									EU-28					
	2013			2060			P.p. change			2013			2060			P.p. change		
	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
20-64	30.3	20.4	39.5	57.0	45.2	69.3	26.7	24.8	29.8	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	20.9	13.3	27.7	41.6	32.3	51.2	20.7	19.0	23.5	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6
Health status															
Life expectancy [3]	Latvia (LV)									EU-27					
	2010			2060			Change (years)			2010			2060			Change (years)		
	M	F		M	F		M	F		M	F		M	F		M	F	
years at birth	68.3	78.0		81.1	87.2		12.8	9.2		76.7	82.5		84.6	89.1		7.9	6.5	
years at 65	13.5	18.1		20.6	24.4		7.2	6.3		17.2	20.7		22.4	25.6		5.2	4.9	
Healthy life expectancy [4]	2005			2012			Change (years)			2005			2012 (EU-28)			Change (years)		
	M	F		M	F		M	F		M	F		M	F		M	F	
years at 65	5.0	5.5		5.3	6.4		0.3	0.9		8.6	8.9		8.4	8.5		-0.2	-0.4	
Healthy life expectancy as % of the life expectancy	2005			2012			P.p. change			2005			2011 (EU-28)*			P.p. change		
	M	F		M	F		M	F		M	F		M	F		M	F	
at 65 (%)	40.0%	32.0%		39.0%	34.4%		-1	2.4		52.1%	44.5%		48.3%	40.4%		-3.8	-4.1	
Expenditure on long-term care															
Total public expenditure on long-term care as % of GDP [5]	2010			2060			P.p. change			2010			2060			P.p. change		
	0.7			1.2			0.5			1.8			3.6			1.7		

The biggest problem that affects home care services is the lack of social work professionals in Latvia. Activities of home care providers are limited by volume of health care budget. Increasing the number of educated home care professionals has been among Latvia's priorities since 2005. There are no data available on levels of education of professional carers or no education requirements for them, but regular training courses are one of the formal requirements for caring staff[56].

Peoples who need (social) home care can choose between private home care and social home care bot the patient it is cheaper to stay in an institution. There is a lack of both informal carers and formal carers in Latvia. Small municipalities are not obliged to organise social care and in rural areas conditions for home care are poor. The reason for the challenge situation is low level of salaries and disadvantaged working conditions in the field. The other focus today is on developing and implementing an improved quality control system for long-term. Home care services are underdeveloped and high demand for institutional care is persistent.

Latvians are financially liable for their parents' care costs and their ability to care is taken into account. In general, the state and the municipalities are responsible for financing long-term care even if there are no client co-payments. Activities of home care providers are limited by volume of health care budget. Many times it is cheaper for the patient to stay in an institution.

[56] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf,* 2014: 184.

There are following practitioners working in home care services in Latvia: carer, social carer, social worker and certified nurses or doctor's assistances. Education is not required by carer, but they are usually trained by the provider; mainly providing personal care services. Most home care services are provided by social workers of local social services. As of January 1, 2013 a new service for persons with disabilities has been launched – a municipality based service of an assistant (up to 40 hours a week) for performing activities outside home[57].

All home care service providers are obliged to be registered by the Ministry of Welfare for quality assessment. There were 830 service providers registered on 1.5.2013 and even more than 40% of service providers not included in the Register[58].

There is need to develop and train following knowledges and skills of HHCP[59]:

- Need of extra financial resources for private social care providers. They rely on Latvian or foreign donations as a consequence new service providers have little or no interest in entering the market;
- Networking between social and health care. Poor division of job/tasks creates problems for providers as financing is provided through two different sources and accounting needs to be separated;
- The shortage of nurses is related to poor payment: modification of HHCP with better payment.
- Quality of home care providers, more well educated and trained workers
- Use of the open method of coordination of policy development at local level as regard social home care.
- Changes in these procedures for health care services provided at home are planned. More frequent monitoring.

The following developments relevant to home care[60]:

- Closing of hospitals and stronger focus on ambulatory and home care
- Development of health care at home. The Ministry of Health of the Republic of Latvia aims to substitute hospital services for outpatient services, including health care at home;
- Changing the home health care system: changing clinical criteria for home care so that impairment of functional ability will be an eligibility criterion independent from diagnosis.
- Professional qualification criteria for carers are planned to be laid down: the obligation of documentation of the care process (by a care plan and care protocol) will be introduced and there will be two tariffs of home health care visits, one for simple cases and one for complicated cases.
- The number of persons with diagnosed dementia in Latvia is constantly growing and HHCPs need more knowledge and skills for working with these persons[61].

The number of people receiving home care is increasing constantly. There is problem to access to home care services. The existence of long waiting lists for institutions for mentally disabled persons may be explained in part by the lack of suitable alternatives of community-based care[62]. The others growing waiting lists are also for technical aids for independent living. Although rehabilitation is theoretically accepted as a part of LTC, no prevention and rehabilitation programs exist specifically to the elderly.

[57] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf,* 2014: 184.
[58] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf, 2014:* 181-182.
[59] Home Care across Europe Case studies 2013.
[60] Home Care across Europe Case studies 2013.
[61] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf*, 2014: 183.
[62] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf , 2014: 182.*

12.14.1 References

Adequate social protection for long-term care needs in an ageing society. Report jointly prepared by the Social Protection Committee and the European Commission services. Council of the European Union. Brussels 2014. *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf*

Home Care across Europe Case studies 2013.
http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf

12.15 Identification of skill and competency needs in the homecare in Lithuania

As described in D.2.1 [CARESS, 2016] during 2013-2060 the share of people aged 80+ in the Lithuanian population is expected to grow from 4.8% to 11.5% (EU-28: 5.1%-11.8%). It is estimated that every third inhabitant of Lithuania will be an elderly person in 2050. Lithuania is the country with the largest gender gap in life expectancy at birth in the EU. In 2011, men were expected to live 68 years compared with 79 years for women[63].

In Lithuania home care services are in developing point. There have been a series of economic and social reforms leading to steady economic growth and stability after 50 of occupation[64]:

2003–2012: Reforming service provision; provider network restructuring and optimization of health-care institutions network (key stages)
2003–2005: expanding ambulatory care, long-term and nursing care
2006–2008: developing day care and day surgery
2009–2012: optimizing provider network and service restructuring
2006–2007: Defining public health care at local level (municipalities)
2009: Adoption of the Plan for the Improvement of Pharmaceutical Accessibility and Price Reductions
2009: Changes to health insurance contributions
2011: publication of the Dimensions of Lithuania's Health System's Development 2011–2020 and setting of future priorities
2012: introduction of DRG payments.

By background literature there is challenges of human resources issues in Lithuania and the availability of trained health-care workers and migration. The issue of health worker migration has been the subject of broad debate in Lithuania, particularly since joining the EU in 2004. A study conducted in 2006 showed that the main drivers for emigration among health and social care workers were low wages, excessive workload, poor working arrangements and unsatisfactory work environment[65].

[63] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.* 2014: 122.
[64] www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf
[65] www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf

Lithuania (LT)

Demography

Elderly population as % of total population [1]	2013			2030			2045			2060			P.p. change (2013-2060)		
	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
65+	18.2	13.3	22.4	27.4	21.6	32.3	30.1	24.0	35.5	26.0	20.9	30.6	7.8	7.6	8.2
80+	4.8	2.8	6.6	7.5	4.6	10.0	11.9	8.2	15.1	11.5	8.0	14.8	6.7	5.2	8.2
85+	1.9	0.9	2.8	3.9	2.2	5.4	6.0	3.7	8.0	7.3	4.7	9.7	5.4	3.8	6.9
80+/65+	26.4	20.8	29.2	27.5	21.2	31.0	39.4	34.1	42.6	44.3	38.1	48.2	17.9	17.3	19.0
85+ /65+	10.5	7.1	12.3	14.3	10.0	16.6	20.0	15.6	22.6	28.1	22.5	31.6	17.6	15.4	19.3

Elderly population as % of total population [1]	EU-28														
	2013			2030			2045			2060			P.p. change (2013-2060)		
	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
65+	18.2	15.8	20.5	23.9	21.5	26.1	27.6	25.2	30.0	28.4	26.0	30.7	10.2	10.2	10.2
80+	5.1	3.6	6.4	7.1	5.6	8.5	10.0	8.2	11.7	11.8	9.8	13.7	6.7	6.2	7.3
85+	2.3	1.5	3.2	3.5	2.5	4.4	5.3	4.0	6.5	7.0	5.5	8.5	4.7	4.0	5.3
80+/65+	27.8	22.9	31.4	29.7	26.2	32.5	36.1	32.5	39.0	41.5	37.7	44.5	13.7	14.8	13.1
85+ /65+	12.9	9.3	15.5	14.5	11.8	16.7	19.2	16.0	21.8	24.6	21.1	27.6	11.7	11.8	12.1

Old-age dependency ratios, % [2]	Lithuania (LT)									EU-28								
	2013			2060			P.p. change			2013			2060			P.p. change		
	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
20-64	30.0	21.1	38.3	52.0	39.2	65.3	21.9	18.1	27.0	29.9	25.4	34.4	55.3	49.2	61.6	25.3	23.7	27.2
20-69	20.9	14.0	27.0	37.3	27.1	47.6	16.4	13.1	20.6	19.9	16.2	23.5	39.9	34.7	45.2	19.9	18.5	21.6

Health status

Life expectancy [3]	Lithuania (LT)						EU-27					
	2010		2060		Change (years)		2010		2060		Change (years)	
	M	F	M	F	M	F	M	F	M	F	M	F
years at birth	67.7	78.7	80.7	87.1	12.9	8.4	76.7	82.5	84.6	89.1	7.9	6.5
years at 65	13.5	18.4	20.4	24.2	6.9	5.8	17.2	20.7	22.4	25.6	5.2	4.9

Healthy life expectancy [4]	2005		2012		Change (years)		2005		2012 (EU-28)		Change (years)	
	M	F	M	F	M	F	M	F	M	F	M	F
years at 65	5.2	4.3	5.6	6.1	0.4	1.8	8.6	8.9	8.4	8.5	-0.2	-0.4

Healthy life expectancy as % of the life expectancy	2005		2012		P.p. change		2005		2011 (EU-28)*		P.p. change	
	M	F	M	F	M	F	M	F	M	F	M	F
at 65 (%)	40.0%	24.4%	39.7%	31.9%	-0.3	7.5	52.1%	44.5%	48.3%	40.4%	-3.8	-4.1

Expenditure on long-term care

Total public expenditure on long-term care as % of GDP [5]	2010	2060	P.p. change	2010	2060	P.p. change
	1.2	2.5	1.2	1.8	3.6	1.7

	Number of staff	Number of social workers	Number of assistants of social workers
Care institutions for elderly	2726 (2157)	228 (196)	640 (549)
Care institutions for disabled	3208 (2890)	343(328)	1481 (1406)
Houses of independent living	*174 (135)*	*28 (28)*	*63 (51)*

The strategic document "Outline of further health system development 2011-2020" (2011) is covering long term care nursing strategic goals, the nursing system and means how to achieve the goals[66]. A new Lithuanian Health Programme 2020, designed with an intersectoral approach, and more responsibility for population health has been transferred to other related sectors, aims at improving population health through safer social environment, healthy lifestyle and effective health care[67].

The health and social care systems based on three traditions:

- there is tradition to organize public care and nursing

[66] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.* 2014: 168.

[67] www.euro.who.int/ data/assets/pdf file/0016/192130/HiT-Lithuania.pdf, 114.

- elderly care based on hospitalization as cheaper and traditional way (long term care)
- traditionally family, children and neighbors are responsible of elderly care, caring is not granted by government and carers are untrained.

The key questions of development by Lithuanian Health Programme are health improvement and disease prevention; expansion of the health-care service market through fair competition; increasing transparency, cost–effectiveness and rational use of resources; and ensuring evidence-based care and access to safe and quality services. The Health System Development Dimensions document suggests structural changes, including reduction in the numbers of hospitals, hospital beds and physicians; the introduction of budgetary ceilings for health-care providers; and increase in cost-sharing through VHI, legalizing co-payments and introduction of fair competition and effective management principles in health care[68].

Future reforms up to 2020 envisage development in the following areas[69]:

- health improvement and disease prevention;
- expansion of the health-care service
- market through competition;
- increasing transparency, cost–effectiveness and rational use of resources;
- ensuring evidence-based care and access to safe and quality services;
- developing legislation on public health and promotion of healthy lifestyles;
- reducing mortality and prolonging average life expectancy;
- strengthening governance and financing of health-care providers;
- ensuring that only safe, effective and affordable medicines complying with EU standards are available in the Lithuanian market.

The Law on the Health System mostly focus on population health: prevention of death, disease and disability; longer healthy life expectancy; improvement of quality of life; and increase in economic and social productivity[70].

Conference “Creating Health for the Year 2020 Today” decelerated to invite municipalities[71]:

- Actively participate in the discussion, adoption and implementation of the Lithuanian Health Programme 2020 and other national programs;
- To create regional long-term community health programs focused on evidence of good and on clear targets for outcomes related to the resources available; formally known as outcome based or results based budgeting
- To encourage local authorities, non-governmental organizations, personal and public health professionals and communities to actively participate in health promotion movement.
- To strengthen training of health professionals, especially family physicians, giving adequate attention to health promotion, as well as prevention and control of non-communicable diseases in training programs.

The current plans to develop the home care and nursing of the Ministry of Health are as follows[72]:

- To accelerate development of nursing at home, integration of nursing and care;
- To assign several community nurses to a family doctor;
- To allocate more social workers, especially in rural areas;
- To expand rehabilitation services at home;
- To develop day-stay services;

[68] www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf, 120.
[69] www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf, 112-114.
[70] www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf, 122.
[71] http://sveikatosforumas.org/user/_files/261/declaration.pdf
[72] http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf, 2013: 178.

- To increase the extent of personal health care services at home;
- To establish units at nursing hospitals for palliative care at home;
- To improve the financing for nursing care at home;
- To decentralize personal health care institutions in order to improve access to the services;
- To give a special attention to medical care services in rural areas;
- To improve the financing for nursing care at home;
- To decentralize personal health care institutions in order to improve access to the services;
- To give a special attention to medical care services in rural areas;
- To increase financing, to promote preventive measures, to improve the quality of nursing;
- To develop long-tem monitoring system for patients with chronic diseases;
- To promote scientific research related to home nursing.

The Lithuanian Catholic Church plans are the following[73]:

- To built an ambulatory centre of nursing, psychosocial and spiritual services (an initiator is the
- Bernardinai monastery);
- To encourage volunteers to provide nursing, social and spiritual services at home in all the parishes
- (Caritas Lithuania);
- To establish voluntary palliative care centres, where treatment, nursing and spiritual help are intended to
- be provided.

There is difficult to find more information about developing of future knowledges and skills of HHCP. Lithuanian Health System Review pointed out that the mental health of the Lithuanian population worsened markedly, accompanied by spiking suicide rates, and spread of alcohol dependency and drug abuse. This field would be one where HHCP needs more knowledge and skills. [74]

12.15.1 References

Adequate social protection for long-term care needs in an ageing society. Report jointly prepared by the Social Protection Committee and the European Commission services. Council of the European Union. Brussels 2014. *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf*

Lithuania. Health System Review. Health systems in transition. Vol.15. Nr 2. 2013.
www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf

Declaration of the Conference "Creating Health for the Year 2020 Today
http://sveikatosforumas.org/user/_files/261/declaration.pdf

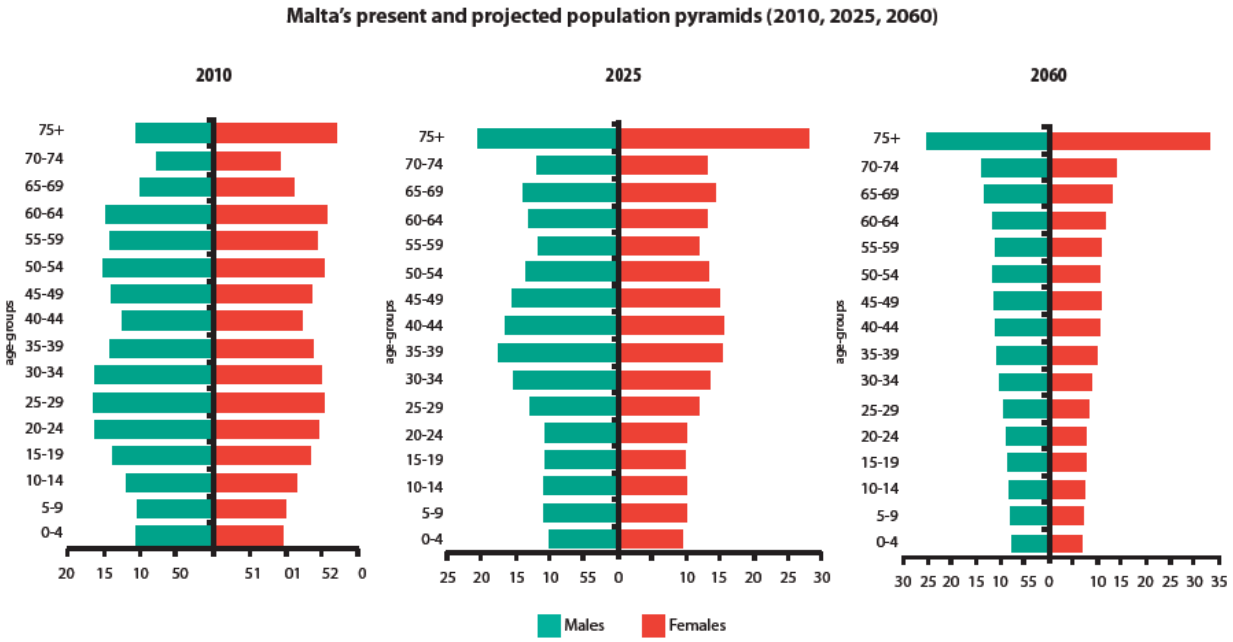
Home Care across Europe Case studies 2013.
http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf

12.16 Identification of skill and competency needs in the homecare in Malta

The research about Malta health and social care systems has not met particular difficulties as the Government website provides lots of information, acts and other key documents in English language. Moreover, about training of personnel delivering the services, it is possible to find a lot of information about the courses organized by the University of Malta.

[73] http://www.nivel.nl/sites/default/files/bestanden/Home-care-across-Europe-case-studies.pdf, 2013: 178.
[74] www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf, 117.

In 2014, Maltese population amounted to 427,400[75] and the life expectancy at birth reached 80.11 years[76]. The life expectancy of people over 65 is 20.07 in 2010 and 20.48 in 2014[77]. The average population density per km^2 was 1295.51 in 2010 and 1335.69 in 2014 and as a result Malta has the highest population density in Europe[78]. The risk of poverty of the Maltese population over 65 is very low. The following table represents Maltese population in 2010 by age and its projections in 2025 and 2060[79].



Health services are highly advanced and all residents access to the different services provided by the public centers and hospitals, such as: personal health services, rehabilitative, curative, diagnostic and preventive services. Nevertheless, the share of GDP allocated to social security benefits is lower than the EU27 average[80].

The Maltese system is public and centralized at the Government level in terms of governance, regulation provision and financing even if the recent reforms, in particular the Health Act, provides directions to work towards controlled decentralization and autonomy and the involvement of local government in community health care[81]. In Malta, the Social Security Act contains the main legislation on home care[82].

The Ministry for Health and the Ministry for the Family and Social Solidarity are respectively responsible for the organization and governance of the health and home care services. In the field of Long-Term Care, the services are provided by the state, the Church and the private sector.

[75] http://data.worldbank.org/country/malta
[76] http://www.indexmundi.com/malta/life_expectancy_at_birth.html
[77] http://data.euro.who.int/hfadb/
[78] http://data.euro.who.int/hfadb/
[79] National Strategic Policy for Active Ageing: Malta 2014-2020, page 13.
[80] Home Care across Europe, Case studies, Edited by Nadine Genet, Wienke Boerma, Madelon Kroneman, Allen Hutchinson, Richard B Saltman, European Observatory on Health Systems and Policies, World Health Organization, 2013, page 188.
[81] Malta Health system review, Vol. 16 No. 1 2014, Health Systems in Transition, European Observatory on Health Systems and Policies, Natasha Azzopardi Muscat, Neville Calleja, Antoinette Calleja, Jonathan Cylus, page 19.
[82] Social Security Act, Chapter 318, 1st January, 1987 available at http://justiceservices.gov.mt/

The Department for the Elderly and Community has been moved by the Health Ministry to the Ministry for the Family and Social Solidarity. For some experts, this move implies a shift from a medical to a social policy and as a result the incorporation of the social work services. Nevertheless, the Department has an inadequate number of social workers, mainly dedicated to the assessment of applications for residential, day or home care services[83].

The Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing (in the following the Parliamentary Secretariat) provides community Services to Older Persons (60 plus) in Partnership with Local Councils. These services include Day Centres Services, Respite Care Services (beds), and Night Shelter Services. Recently, the Parliamentary Secretariat has issued an invitation to targets Local Councils to explore the possibility that more services are initiated through Public-Private Partnerships, as the non-government sector can play key role in the future. A mixed financing system towards social and caring services will be able to continue providing an increasing number of older persons with the optimal level of caring services. As a result, Local Councils are invited to communicate their proposal describing their available resources, including edifices and human resources as well as envisioned forms of assistance they would require from the Parliamentary Secretariat[84].

The Department for the Elderly and Community offers services of residential cares in various facilities and also residential care in private homes under the Public Private Partnership Scheme. The network of services aims to support the elderly to continue living in the community and includes: Telecare Service, CommCare, telephone rebate scheme, incontinence service, Zejtun night shelter, handyman service, Home Help service and Day Centres. The Department also issues the Kartanzjan documents.

The services and the personnel training seem to be well defined by Maltese Government. Nevertheless, it is important to remark that the Government has to face the challenges caused by the ageing of the population.

As other European Union Member States, Malta has defined a specific plan, named “National Strategic Policy for Active Ageing: Malta 2014-2020” that aims at improving the quality of life and well-being of elderly and at reducing the need for institutionalised care providing. The strategy describes Maltese stance and policy directives in the field of population ageing, encouraging older persons to take responsibility for their own quality of life and well-being. It includes seven key principles: “First, activity refers to all meaningful pursuits which contribute to the well-being of older persons. Second, active ageing policies must involve all older persons including those who are relatively frail and dependent. Third, active ageing is primarily a preventive concept that focuses on the avoidance of ill-health and social exclusion in later life. Fourth, active ageing is intergenerational, with sectors of civil society being stakeholders in this undertaking. Fifth, policies premised on active ageing embody both rights and obligations. Sixth, strategies on active ageing are participative and empowering. Seventh, active ageing is sensitive to national and cultural diversity”[85]. The directives of the Maltese strategy mainly concern: the active participation in the labour market, the participation in society and the independent living. Regarding the independent living, the Strategy focuses on some subjects: the health prevention and promotion, the acute and geriatric rehabilitation, the mental health and well-being, the community care services, the age-friendly

[83] Long-Term Care of Older Adults in Malta: Influencing Factors and Their Social Impacts Amid The International Financial Crisis, Charles Pace, Sue Vella & Sophia F. Dziegielewski (2016), Journal of Social Service Research, 42:2, 263-279, DOI: 10.1080/01488376.2015.1129018, 2016, page 271.

[84] http://www.activeageing.gov.mt/en/Pages/Invitation-for-Collaboration-with-Local-Councils.aspx

[85] National Strategic Policy for Active Ageing: Malta 2014-2020, page 18.

communities, the dementia-friendly communities and services, the maximising autonomy in long-term care, the protection from abuse and the end-of-life care. The Strategy focuses on the community care services in different parts providing a set of interesting policy recommendations:

a. Participation in society - Support for informal carers: supporting and coordinating information sessions for informal carers of older persons in collaboration with Local Councils, nongovernmental organisations and the private sector; reinforcing residential and community based respite services for older persons, including the possibility of providing respite care in the home setting; exploring the possibility of introducing innovative financial support models for personal care services at home[86].

b. Independent living - Acute and geriatric rehabilitation: strengthening community health and rehabilitation services to allow a seamless transition between hospital-based and community services or other settings[87].

c. Independent living - Mental health and well-being: strengthening the current geriatric mental health services and expanding them to meet the needs of older persons in the community[88].

d. Independent living - Community care services: facilitating access to community care through a variety of access points across primary and acute care sectors and, in collaboration with Local Councils, to provide advice and information, as well as a coordinate pathways to professional assessment; ensuring alternative community care settings to cater for the needs of older persons; guaranteeing that beneficiaries of community care services have the opportunity to participate meaningfully in both service planning and provision, with consumer feedback being present at all levels[89].

e. Independent living - Age-friendly communities: promoting age-friendly communities to meet the needs of older adults; formulating inter-sectoral guidelines to create age-friendly communities through the appropriate development of accessible public spaces, housing and methods of transportation sensitive to the needs and responsive to the input of older adults; creating the necessary structure for communities to integrate their social services and voluntary organizations through home services, day centres and intergenerational initiatives that serve the social and security needs of older adults and caregivers living in that community[90].

f. Independent living - Dementia-friendly communities and services: adopting a national dementia strategy to address the growing prevalence of dementia in Malta; encouraging dementia-friendly communities, especially for public places and services frequented by older persons; strengthening training programmes in dementia care for people working in the health and social service sectors [91].

g. Independent living - Maximising autonomy in long-term care: establishing procedures supporting the autonomy of older adults in their decision-making process, including access to appropriate

[86] National Strategic Policy for Active Ageing: Malta 2014-2020, page 57.
[87] National Strategic Policy for Active Ageing: Malta 2014-2020, page 65.
[88] National Strategic Policy for Active Ageing: Malta 2014-2020, page 67.
[89] National Strategic Policy for Active Ageing: Malta 2014-2020, page 69.
[90] National Strategic Policy for Active Ageing: Malta 2014-2020, page 71.
[91] National Strategic Policy for Active Ageing: Malta 2014-2020, page 73.

medical, legal and community services; implementing measureable national minimal standards for long-term care and creating the necessary legislative structure for their regulation[92].

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National Strategic Policy for Active Ageing: Malta 2014-2020

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12.17 Identification of skill and competency needs in the homecare in Netherlands

In 2015 the Dutch Health care system has been characterized by an important reform.

The healthcare system of the Netherlands is now governed by four basic healthcare-related acts that represent the foundation of the Dutch healthcare system:

- the **Health Insurance Act** (Zorgverzekeringswet) - **ZVW** 2006,
- the **Long-Term Care Act** (Wet langdurige zorg) - **WLZ** 2015/2016,
- the **Social Support Act** (Wet maatschappelijke ondersteuning) - **WMO** 2015,
- the **Youth Act** (Jeugdwet) - 2015.

In 2015, the Long-Term Care Act (WLZ) has replaced the Exceptional Medical Expenses Act (AWBZ): parts of the AWBZ has shifted to the Health Care Insurance Act (ZVW) and the renewed Social Support Act (WMO 2015), that is now carried out by municipalities.

[92] National Strategic Policy for Active Ageing: Malta 2014-2020, page 75.

The reform essentially comes down to a shift in healthcare claims and a cutback and it is considered the largest overhaul of LTC since the AWBZ came into force in 1968.

Whereas the AWBZ provides a right to care, the WMO commands delivery of tailor-made support. Care, that falls under the WMO, is only awarded if the capacity of persons seeking care, among others their financial resources and social network, are insufficient. Higher contributions may also be requested, compared to the AWBZ. It should be noticed that these developments influence the experienced level of solidarity.

The overall goals of the LTC reform are: to save costs, and thus keep LTC affordable, starting with € 500 million in 2015, reaching saving of € 3.5 billion annually in 2018; to keep people self-sufficient for as long as possible; to improve quality and coordination of care.

Access to residential care is now only available for people that need permanent supervision or 24 h care. Municipalities are obligated to give support to clients, even if they have large policy discretion in making this obligation concrete. This may cause unequal access to LTC. Given the highly egalitarian culture in Dutch health care, 'postcode rationing' is very much disputed.

LTC continues to be a largely publicly funded provision and a statutory health insurance scheme is still foreseen for persons who need residential care. In addition, compared to most other European countries, the benefit package of LTC continues to be generous.

The Commission has emphasized the importance of the long-term care reforms that have been initiated for the sustainability of public finances.[93] The structural savings by restructuring the long-term care lead to, among other things, better care-to-need and partial decentralisation of LTC. The next step that has to be taken is to support in implementing the policy measures.

Although the good intentions of the reform, and even if it seems too soon to reach conclusions, there are already some negative considerations that come to light.

With the reform of LTC, the Dutch experience may teach some "policy lessons".

The first one underlines how a reform, even it seems well-prepared on paper, with large ramifications and in a short period of time, leads to many uncertainties and risks for the clients but also to all stakeholders involved. The government had to take many temporary accompanying measures to reduce these uncertainties and risks. Implementation is considered the 'Achilles heel' of the process.

The second lesson also regards implementation: it is important to take in consideration administrative and ICT-problems. A fundamental reform with new regulations and a new financing regime requires the set-up of a new administrative and ICT-infrastructure, but it always takes time to have such an infrastructure in place. Unfortunately, it soon turned out that the administrative and ICT structure did not work properly. These 'technical problems' may rapidly get a political loading as the State Secretary experienced when many personal budgets were paid out too late.

The third lesson concerns incentives. The new financing structure for LTC consists of three different regimes, each with its own implementing agencies, regulations, budgets, clients and so on. Such a structure may cause a great risk of coordination problems because of different incentives. For instance, municipalities may have an interest to refer a client to the ZVW-regime or WLZ-regime in order to save

[93] *National Reform Programmes 2015 – The Netherlands. Ministry of Economic Affairs*

money and vice versa. The success of the reform will strongly depend on how coordination problems will be solved and cost-shifting from one regime to another will be avoided.

In fact, contrary to what have been done with 2006 reform, that has changed only the payment system, the 2015 reform has changed the provision of care: new institutions (municipalities and health insurers) have to organise types of care which they lack previous experience and expertise. Provider of home care and youth care that have contracts with a limited number of payers, now have to negotiate with a much larger number of health insurers and municipalities. In addition, the SVB (The Sociale Verzekeringsbank), now responsible for paying on behalf of people with personal budget, has demonstrated serious problems as they were not ready to cope with this task.

In any case, because of the recent reform, a systematic evaluation of the implementation is not yet available. Furthermore, it has not been easy to find documents and/or analysis in English and updated.

Concerning the professional figures involved in the home care sector, the nurse is considered the main one.

The figures in the Dutch nursing system can be classified as it follows:

- Level 1: Zorghulp (Auxiliary helps/Care assistant)
- Level 2: Helpende (Home helper/health and welfare assistant)
- Level 3: Verzorgende (Individual health carer)
- Level 4: MBO-Verpleegkundige
- Level 5: HBO-Verpleegkundige
- Verpleegkundig Specialist : Master of Advanced Nursing Practice (MANP)

The first three levels can be categorized more as “caregivers” figures while level 4 and 5 are considered “nurses”. The last level is the highest specialized level of nurse.

The research of the professional figures has not be so easy because of the language gap: the majority of the information were in Dutch. In addition, because of the recent reform, it has not been easy to understand if the reform has an impact also on home care professional figures and their role.

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The policy and politics of the 2015 long-term care reform in the Netherlands – Health Policy

Long-Term reform in the Netherlands: too large to handle? – Eurohealth SYSTEMS AND POLICIES

National Reform Programmes 2015 – The Netherlands. Ministry of Economic Affairs

Healthcare in the Netherlands – Ministry of Public health, Welfare and Sport, January 2016

12.18 Identification of skill and competency needs in the homecare in Poland

The research about Poland health and social care systems for the elderly has met some difficulties mainly produced by the language: in fact, the Government official website and the key documents usually are not translated in English and as a result it is not easy to find information and reports to be considered updated.

Nevertheless, a key document to identify the gaps of the policy for the elderly in Poland is the "Long-term senior policy in Poland for the years 2014-2020 in outline": this document published in English describes the national strategy to face the ageing of the population and concerns both the health and social care systems.

In Poland, the families are the main source of care for the elderly[94].

As other European Union Member States, basing on the European Year for Active Ageing and Solidarity between Generations, or EY2012, Poland has worked on a new conception of the senior policy and implemented the National Programme of Social Activity for the Elderly for 2012-2013 (Rządowy Program na rzecz Aktywności Społecznej Osób Starszych na lata 2012 - 2013) and has created the Advisory Council for Seniority Policy (Rada ds. Polityki Senioralnej)[95]. Thanks to this experience, the Council of Ministers has adopted the so-called "Package for Seniors" on December 24th, 2014, that is the Long-term Senior Policy in Poland for years 2014-2020[96].

In fact, the main causes of the changes of the European society demographic structure are the low fertility rates and lengthening of life expectancy. As a result, the proportion of older people (60 +) is growing everywhere and also in Poland[97].

Proportion of people in different age groups of the EU-27 and Poland in 2011 (in%) (as of 31.12.2011)

	0–14	15–64	15–60	60–64	60+	65+
UE -27	15,6	66,6	60,5	6,1	23,9	17,8
Poland	15,1	71,1	64,7	6,4	20,2	13,8

Source: own study based on the Eurostat.

Moreover, Eurostat data show that people over 60 years will represent nearly 25% of the population of Polish society in 2020. These data are confirmed for Poland by the Central Statistical Office (forecast for 2008 – 2035)[98].

[94] Home Care across Europe, Case studies, Edited by Nadine Genet, Wienke Boerma, Madelon Kroneman, Allen Hutchinson, Richard B Saltman, European Observatory on Health Systems and Policies, World Health Organization, 2013, 215.
[95] Long-term senior policy in Poland for the years 2014-2020 in outline, page 53.
[96] Long-term senior policy in Poland for the years 2014-2020 in outline, page 4.
[97] Long-term senior policy in Poland for the years 2014-2020 in outline, page 6.
[98] Long-term senior policy in Poland for the years 2014-2020 in outline, page 7.

Forecast population in the years 2010-2035 by age groups (in%)

Age	2010	2015	2020	2025	2030	2035
0–14	15,0	15,2	15,6	15,0	13,7	12,5
15–64	71,4	69,2	66,0	64,1	64,0	64,2
60–64	6,1	7,1	7,0	5,8	5,7	6,8
60+	19,6	22,7	25,4	26,8	28,0	30,0
65+	13,5	15,6	18,4	21,0	22,3	23,2
85+	1,4	1,8	2,0	2,1	2,1	3,1

Source: own study based on Central Statistical Office data, Population forecast for 2008-2035.

As a result, Poland has defined its "Senior policy" that includes a package of actions performed by public administration at all levels and other organizations and institutions that perform tasks and initiatives shaping the conditions of a dignified and healthy aging[99].

Long-term Senior Policy in Poland for years 2014-2020 relates to seniors and challenges of imminent ageing population in Poland, resulting from the increase in life expectancy and reduction in mortality[100].

The policy is performing the obligations provided in the Government Program for the Elderly Social Activity for 2012-2013 (ASOS Program), the first nationwide program developed, designed for the elderly and intergenerational cooperation, to set the base for the senior policy, support and provide opportunities for active ageing in health and opportunities for continued self-reliant, independent and fulfilling life, even with some functional limitations[101].

The policy has a global approach towards seniors and mainly concerns the following key areas: health and independence; economic activity; educational activity, social and cultural activities; silver economy and intergenerational relations[102]. The health and independence area is the most interesting for the project purposes. In this area the policy aims to create conditions for independent living as long as possible and to maintain good health and autonomy[103] and faces the gaps of the health care system and of the social care system as they do not meet the standards of geriatric approach in terms of universality, quality, availability and comprehensiveness of meeting complex needs[104].

The first set of objectives and directions of interventions/recommendations regards the health care system in terms of knowledge, services, training in geriatric personnel, infrastructures and outpatient geriatric consultation rooms.

The health conditions of population over 50 register a lot of diseases (weight problems, cardiovascular diseases, physical limitations, etc.) both for men and women and the poverty is the most important determinant of life expectancy and healthy life. As a result, the senior policy identifies the following objective: the preparation in terms of knowledge about the physical and psychological changes during the ageing process. In order to achieve this goal, the identified directions of interventions mainly concern the

[99] Long-term senior policy in Poland for the years 2014-2020 in outline, page 8.
[100] Long-term senior policy in Poland for the years 2014-2020 in outline, page 4.
[101] Long-term senior policy in Poland for the years 2014-2020 in outline, page 9.
[102] Long-term senior policy in Poland for the years 2014-2020 in outline, page 4.
[103] Long-term senior policy in Poland for the years 2014-2020 in outline, page 11.
[104] Long-term senior policy in Poland for the years 2014-2020 in outline, page 15.

education of people, the sensitization of public opinion and the creation of mechanisms of psychological support for people in crisis or in need of support[105].

The policy also focuses on the deficit of specialists in the field of geriatric and other personnel that cares old people. As a result, another objective aims to develop geriatric medicine as a specialization and the related directions of interventions, such as enabling the training of doctors, nurses and other medical staff towards holistic and comprehensive health care for the elderly patient, strengthening the role of the primary health care (PHC) and PHC nurses in the care of elderly, creating a system of incentives for education in the field of geriatrics by students and graduates of medical faculties, developing specialist education of doctors in the field of geriatrics and increasing the availability of geriatric beds[106].

Regarding the healthcare infrastructures, the policy stresses the need of supporting and developing clinics and geriatric care in terms of providing of medical care to the elderly, solutions towards elderly patients affected by chronic illness (such as obtaining basic advice and prescription medications permanently), supporting the development of outpatient geriatric and geriatric consultation (especially in rural areas), supporting different actions in the field of medicinal entities realizing benefits in terms of geriatric care, of investment in infrastructure (such as transregional teaching hospitals and research institutes), of entities implementing the provision of long-term care and therapeutic entities pursuing palliative care and hospice and, finally, increasing the numbers and improving the care and treatment[107].

The second set of objectives and directions of interventions/recommendations regards the social care system.

A first objective regards the development of social services tailored to the needs and capabilities of older people. This objective can be achieved by planning and organizing social services and the needs of the elderly and adapting them to the needs and abilities of older people, enabling older people to enlist the help of assistants providing social services at home and outside the home and disseminating the use of care services based on new technologies[108].

Other objectives concern the promotion of appropriate lifestyle, including health education, and the development and promotion of physical activity. Different actions are mentioned in this field and the most relevant regard the extension of the educational offer for working people in contact with the elderly and the education of healthcare professionals in the field of physical activity, diet and a healthy lifestyle in old age[109].

Other two objectives regard caring for the elderly and the role of informal carers: the provision of adequate care with limited independence through the development of care services; and the creation of support systems for informal carers, particularly at local level. In order to achieve the first objective, some interesting directions of interventions have been identified: the improvement of access to care services; the development of the system of cash benefits in kind or checks to cover expenses; the creation of conditions to increase the diversity of care for seniors; the elimination of legislative and administrative barriers to employment legislation informal carers; the creation of conditions of stable sources of funding of care services; the adjustment of currently available services to the needs of the elderly and the development of

[105] Long-term senior policy in Poland for the years 2014-2020 in outline, page 12.
[106] Long-term senior policy in Poland for the years 2014-2020 in outline, page 13.
[107] Long-term senior policy in Poland for the years 2014-2020 in outline, page 14.
[108] Long-term senior policy in Poland for the years 2014-2020 in outline, page 15.
[109] Long-term senior policy in Poland for the years 2014-2020 in outline, page 18 - 19.

new solutions; the support to elderly people living in single households; the improvement of the quality of care (including nursing) for the elderly. In order to achieve the second objective, the policy recommends the following directions of interventions: the support to family and informal carers; the development of system solutions to support caregivers of the elderly; the creation of broad access to information on opportunities for carers; enabling the care of long and short-term over an older person; and the development of voluntary welfare (including neighbourhood and the local environment)[110].

Finally, we remark the objective to develop and implement telecare and the use of innovative technologies in facilitating the organization of care for the elderly. In fact, in Poland there is the necessity to introduce the ICT solutions in the area of telecare and telemedicine to support and improve the safety of the elderly and to support their caregivers. The directions of interventions foreseen by the policy are: developing minimum standards for telecare and other forms of indirect care services using new technologies (ICT); identifying the sources and principles of financing or co-financing of telecare and other forms of indirect care services; mobilizing local communities to create social (neighbourhood) self-help methods using new technologies (ICT); supporting the implementation of solutions using telecare; using new technologies for the development of prevention and health behaviors[111].

12.18.1 References

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[110] Long-term senior policy in Poland for the years 2014-2020 in outline, page 21.
[111] Long-term senior policy in Poland for the years 2014-2020 in outline, page 22-24.

12.19 Identification of skill and competency needs in the homecare in Portugal

The provision of health care and social support at home aims to the maintenance of users in their family and social environment. It takes place on two levels

I. Through the "network of national care continued integrated"

II. By social benefit of home support systems

National network of integrated continuing care "(RNCCI). "

The RNCCI is made up of entities ***public*** and ***private*** *(Private institutions of Social solidarity (IPSS) and Holy House of mercy)* that provide continued care health and social support when necessary, to persons in a situation of dependence, at home or in other institutions.
They used four types of resources: 1 - inpatient units. 2 units for outpatients. 3. hospital equipment of continued health care and social support. 4 **equipment home of care continued health and social support.**

Home of care continued health and support teams

Extension and capacity : The RNCCI is distributed throughout the country is their attention span - for all the resources, data of February 2016, 6.289 users: 1673 - North; 846 - Center; 2136 - Lisboa e Vale do Tejo; 549-Alentejo e 1085 Algarve. Access to the seats is subject to existing availability.

Regulatory authority : Ministry of labor and Social solidarity (MTSS), and ministries of health. (MS)

Financing : Co-financing. A part of the MTSS, National Health Service (belonging to MS), private institutions of solidarity Social (IPSS), Santa Casa de Misericordia (with own means from the game and other sources), or the users own. On the other hand the user, who only pays the costs of social support, total or partial form depending on the economic situation of personal and family.

Dependence and coordination:

· level National: MTSS

· level Regional: regional administrations of health of each of the five existing areas: North, Central, Lisboa and Vale do Tejo, the Alentejo and the Algarve; Through giving them regional coordination teams

· Local: teams, in principle of municipal level. The teams local coordinators are composed of at least one doctor, a nurse, a social worker and, whenever necessary, a representative of the local authority

Profile of beneficiaries : · functional dependence (unless motor) temporary or prolonged complex · elderly fragility · severe disability criteria, with a strong psychological impact or social · disease severe in advanced or terminal phase.

* Pre-requisite prior availability of some social support and not need hospitalization

Gateway to the service : · users in hospital: through the management team of high · users in the community: from the center of health through the doctor or social worker.

SOCIAL BENEFITS SUPPORT HOME

Is a system of social support that offers seven types of resource: · Centre of coexistence; · Centre day · middle of night · residential structure for elders· family shelters for older persons and adults with disabilities · homecare service.

Home care service.

Focusing on the "family helpers" who are workers who provide care basic social support, persons in situations of dependency, in your home.

Gateway to the service:

- Directly in the institution or establishment of social support that provides support;
- Santa Casa da Misericórdia of Lisbon.
- Care of the residence Social security services.

This type of service availability can also be found in the list of social resources on the web site of "*the Social Charter".*

Profile of beneficiaries : P eople who are in their homes in situations of physical or psychological dependence and cannot ensure, temporarily or permanently, the satisfaction of their needs of daily life, or have family support for the purpose.

Financing (: 1) Co-pay of the user (only in the aforementioned institutions) according to family income. 2nd) subsidy from Social Security.

12.20 Identification of skill and competency needs in the homecare in Romania

General information about the country

Extension 238.391 km2 (9th largest EU country)

Population: 21 million people, (7th largest country in the EU). 16.5% of the population is older than 65. The forecast for the year 2050 is that this rate will reach 30%.

Population in a situation of dependency At the end of 2015, the dependent population was 766 153 people. The 40, 89% of the dependent population has more than 65 years being predominantly women.

The **2.3%** are institutionalized in public nursing homes. **97.7%** remaining are at home being cared by caregivers or family.

Health coverage:

Health expenditure is higher than the EU average. The Ratio of nurses and doctors is less than EU average. There is a big difference between urban and rural areas, due to the accessibility problems, financial situation and geographical environment, as well as by the limited existing health transport network. The quality of care will depend on the social situation because there is only a basic coverage.

Health care at home is given by the home care team, which is composed by a social worker, doctors, psychologist and nurse. Related with their performance and needs valuation, the social coverage can be derived.

Other professionals involved in home health coverage are the nursing assistants, which intervene medically. Physical therapist, involved very occasionally, also after medical indication and finally almost testimonial form the speech therapist.

Occupational therapists are basically responsible for the transition from hospital to home and proposes the adaptation of the House, but don´t perform any other activity directly with elders.

Social protection:

Public social attention focuses mostly on orphanages and psychiatric institutions. Elderly care in institutions is low, it has a social-health character and it is carried out • elderly care Hospital (equivalent to nursing homes in other countries), which is accessed by a doctor report. • Nursing homes of the State, less health care and more social. • Private nursing homes with or without profit.

Elderly´s needs attention at home

It shows a very irregular distribution across the country. The legislative instability for years has directly affected this coverage.

There is a framework regulation that defines, under cover of law 17/2000, who are the elderly beneficiaries of the home care. These would be the following: people without family or caregiver assigned. People who have no home ownership or sufficient financial resources. People whose income is not enough to be able to take care of yourself alone. People with health problems who need specialized help. People with physical or mental problems who do not can take care of themselves.

Also under the protection of the law 292/2011 are defined standards of services, which are classified in: • services basic social assistance (of documentation management) • support services, • monitoring of medical treatment. Assistance in transport

Regulatory authority: Ministry of labor, Social Security and family.

Main document: *order of the Ministry of labor 2126 / 2014, annex 8, laying down minimum quality standards for home care for the elderly services*

Financing and access:

Home care services are financed through public funds, (with very small amounts allocated to Central or local budgets). It does not allow part-time or hourly payment for services. The same co-pay formulas are used. When service providers are direct relatives, there are formulas for compensation in the form of the labor and social benefits of face to the retirement of the caregiver. There is also a private coverage, usually through NGOs

The indication by doctor or medical specialist hospital after suffering an illness that has needed hospitalization is required for access to home care.

Human resources in home care: The coverage is carried out through two networks:

Informal network: formed by family, neighbors and friends; It supports more than 90% of the attention. The relatives are a group of support which is essential.

Network of authorized caregivers by the Government: with or without training.

• Caregiver without certifying: the vast majority

• Personal assistants: generally follow the training given by the local authority which authorizes them, but no particular requirements.

• Certified for elderly caregivers: often complete a training program for six months (620 hours) in care for the elderly, and receive a certificate;

• Caregivers certificates for ill persons they attend

Training of careers It is delivered from the public sphere or from the private sphere, in this case mostly by NGOs. The training courses have a variable length, from a few hours. The courses that have accreditation recognized are given from a length of 360 h contents theoretical and practical. Level of primary education (8 years) is required. Training courses, are developed in modules or topics, sometimes they have defined certain powers, but not defined explicitly and generally specific knowledge, skills, roles, etc., even if they come partially developed programs.

•Nursing: own nurses can act in this sector health and social mix. There is a lack of information regarding the work of the nursing home. There is the possibility of working on their own as a nurse at home but requires authorization.

12.21 Identification of skill and competency needs in the homecare in Slovakia

The Slovak system relies heavily on institutional care and informal care provision. The most important part of homecare is the informal care, most often given by family members or close contacts of the care recipient [Szüdi et al., 2016]

Long-term care lacks integrated home care, community, ambulatory or hospital health and social services. Both social and health care are subject to different legal frameworks and their competences fall into two different sectors [Szalay et al., 2011].

Although GPs (or their nurse) are legally obliged to visit patients at home, this only occurs sporadically. **HOME NURSING** (but personal care as well) is primarily provided by about 170 Home Nursing Agencies (ADOS) [Lezovic et al, 2007; Szüdi et al., 2016]. In Slovakia, nursing care at home aims to maintain and improve the quality of lives by alleviating suffering, rehabilitation and counselling, prevention of health complications and health education [Lezovic et al. 2007]. In contrast to personal care provided at home, home nursing is poorly developed. Agencies for nursing care services primarily provide nursing and rehabilitation care at home [Szalay et al., 2011].

The following professionals with their obligatory education are working in home nursing [Genet et al, 2013]:

- *Nurse*: performing injections, infusion, wound care, ulcer treatment, etc.; they got bachelor or masters education.
- *Health care assistant*: supervised by a nurse, providing elementary nursing, assisting in diagnostics, prevention and administration; they attend four years basic vocational training.

Home nurses and assistant nurses are contracted by ADOS, which in turn are contracted to health insurance companies. However, nurses may also be physician's employees.

The educational curriculums for nurses and health care assistants have been regulated nationally (by Government Regulation 296/2010) and the educational programmes must be accredited by the Ministry.

Since EU accession, instead of secondary vocational training at specialized high schools, nursing education is provided either as vocational training or at a Bachelor's (Bc) level. Further education at a Master's degree university level (Mgr) is optional, but not a condition for nurses to practise. Following this change, a rise in the number of university graduates in nursing can be observed, but the overall number of nurse graduates went down [Szalay et al., 2011].

Life-long continuous medical education is obligatory for every health professional, but a recertification scheme for nurses does not exist. Nevertheless, many nurses take additional courses even though these are usually not paid by the employer [Genet et al, 2013].

HOME CARE SERVICES are provided by municipalities and self-governing regions or, on their behalf, by private providers (either for profit or non-profit, such as charity organisations, Red Cross). Public as well as private providers of social home services may provide services to several municipalities. One can apply to the municipality for social services, while for personal assistance and paid informal home care one needs to apply to a Local Office of Labour, Social affairs and Family, a public organisation. In the municipality a municipal assessment teams performs the needs assessment. A **SOCIAL WORKER**, who has an higher education degree in social work (first and second degree), will assess the social situation, while a physician will examine the patient's health status [Szüdi et al., 2016].

The network of social service facilities are said to be insufficient to provide those who are eligible with the proper services. Furthermore, municipalities are insufficiently equipped, in terms of personnel, expertise, material resources and technical outfit.

Among long-term carers there are those educated for the job and those without such specific training.

A figure named **CARER** provides **PERSONAL CARE**: he/she attends full secondary vocational training with a focus on home care (nursing) and health care or accredited course (220 hours) for carers [Genet et al, 2013]. Most carers employed by municipality are employed with a salary, but some are employed through a work performance agreement (paid for a certain number of services to be provided instead of hours) [Genet et al, 2013].

FAMILY ASSISTANTS provide **DOMESTIC AID,** performing activities such as: shopping; accompanying the older adult to a doctor; appointment; getting medical prescriptions from pharmacies; help in the farmyard, care of animals, wood chopping; housekeeping (cleaning windows, tidying, food preserving in summer/autumn); mediation of social contact with peers; going for a walk, companionship, supervision of

seniors during the absence of their family members; ensuring and facilitating contact with authorities (social insurance, health insurance, post office, ministries); visiting elderly person living alone in hospital [Szüdi et al., 2016]. In 2010 the number of personal assistants was 9,340 (from that 212 were family members) and the number of untrained informal family carers was 56,434.

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12.22 Identification of skill and competency needs in the homecare in Sweden

The population of Sweden was estimated to be 9 822 093 people in 2016. The population is increasing of 0.83 % by number of births as well due to external migration. Sweden's population is expected to increase by about 1.5 million people up until 2050, the group aged 65-79 years is expected to increase by 45 % while the group aged 80 and over will increase by 87 %[112].

Swedes have come to trust and rely on the state to provide LTC services for the elderly. Since 1992, the 290 Swedish municipalities are responsible for long-term inpatient health care and care for older people. The available LTC services are home help in regular housing (home care), special housing (institutional care), day activities, home medical services (home nursing care), meal services, personal safety alarms and home adaptations.[113] One quarter of the adult population states that they provide help for a relative or friend as informal carers.

There are many projects which improving different indicator of home care services. Prioritary areas are preventive care, mental health, dementia care, improved drug prescribing and end-of-life and palliative care; indicators such as avoidable inpatient care and re-admittance within 30 days, decrease of medication with a high risk of side-effects, routine oral assessments and standardized care after a diagnosis of dementia. The other project is implementing of local 'dignity guarantees' within elder care.

[112] http://www.scb.se/statistik/_publikationer/BE0401_2006I50_BR_BE51BR0602ENG.pdf. 2006: 10.

[113] *ec.europa.eu/health/ageing/docs/ev_20140618_co04_en.pdf. 2014: 216.*

12.23 Identification of skill and competency needs in the homecare in UK

AgeUK.org, a major charity organization dedicated to elderly issues in the U.K., uploaded recently their yearly survey about older people. ***Later Life in the United Kingdom, May 2016***. The comments herein are mainly based on that survey.

In general, the main concerns of the elderly persons included in the survey were related with particular rights, dignity and security, better coordination between different types of homecare services, a better level of quality, the need of increasing the workforce. There is not social homecare nor home healthcare public insurance funding mechanism. Third party private funding contributions and in this field co-payments and private payments is quite usual. The types of payment for funding-providing agencies are publicly funded, generally by fee-for-service based on a number a care packages to be provided. Intensity of care is included in the fee. With ageing populations, governments may need to reconsider the affordability of a largely publicly funded home-care system. There is low flexibility, therefore the clients´ individual needs sometimes do not correspond to the services provided. Case management can also restrict freedom of choice. And if a special need has to be covered by a large co-payment, depending on financial eligibility becoming a common barrier to utilization for some groups of people.

In 2010 a set of social homecare indicators allied to inspection (excluding domestic care) were withdrawn as a result of national policy changes, reducing quality of care and poor regulations and quality assessment visits by the CQC were stooped.

When questioned about affordability of home care services, less than 40 % of respondents agreed that the professional care at home is available at an affordable cost considering it as the best option.

The skill and professionalism of care workers was often praised by respondents, but some were upset by slapdash and hurried work, failure to tidy up and lack of respect towards them and for their home. Older people receiving home care are particularly vulnerable if care workers verbally or physically abuse them. But respondents complained more about indifference, being treated ‘like a number’ and being ignored. They placed great value on continuity of care worker, on being able to build a relationship of trust, but this was not always on offer and could be a major cause of complaint. Clear instances of abuse by care workers were seldom mentioned to the researchers, however, a number of respondents had been subject to disrespectful treatment by individual care workers. Some had been refused a level of care they felt was important in order to protect their dignity (one example was a woman who was refused help at night to go to the toilet, being told instead to use incontinence pads for the purpose though she is not incontinent). Sometimes it was the service delivery that was found to be inadequate, for example when care workers did not turn up to provide essential help, or only one turned up for a task requiring two.

Timing issues in connection with care visits were a concern for most respondents. Unreliability and unpredictability –where visits sometimes did not take place at all, or care workers arrived late– caused a great deal of anxiety and had undermined people's personal autonomy, for example, being able to control their day, and take part in other valued activities. Where people need help to take medication, go to the toilet or eat, unreliability also had a serious impact. Not being told about delays adds hugely to the problem. Some respondents also commented on how care workers rushed through their duties in order to leave early. For those who needed help to prepare for bed, the usual scheduling of this early in the evening was often contentious. Being put to bed early can be demeaning and can also mean missing evening time together with a partner, or favorite television programs or, for some, the opportunity to go out in the

evening or to come back late from an outing. It can also mean spending a lot of time lying sleepless with nothing to occupy the mind.

Respondents could find care packages overly prescriptive with little flexibility for care workers to help out in ways not written into their care plan. There are also some aspects of care that they would like help with – such as nail-cutting – that are simply not provided.

Much that causes older people stress or upset may not be seen by them as 'important enough' to complain about. Assuming that they know who to complain to and how, they are more comfortable talking to people they know face to face than pursuing more formal routes. In general, respondents had low awareness of their right to complain and others were loath to exercise those rights.

Respondents were not well-informed about many aspects of their home care: the broader background issues such as how the system works or –in some cases– the specifics and particulars of their own situation such as which agency provides their care, and if they contribute towards the cost of their care and how much. The general picture is of a wider home care system in which older people are not effectively involved: which they do not understand, and which does not often make the extra effort required to involve them in ways tailored to their state of health and other needs. Information was not provided to them at a time and in a form they could fully take in. The right to an assessment of need by the local authority did not appear to be well known. Many respondents could not remember the initial assessment of their care needs, or only vaguely understood its import at the time, because it took place during a time of crisis. Many felt that a process had simply 'happened' to them and that they had had little choice about any aspect of the outcome. Some assessments that were recalled were found intrusive, abrupt, and even offensive to personal dignity. Most respondents had a care plan or folder in their home, but few consulted it readily or had a clear idea what it contained. Reassessments were experienced sometimes as more concerned with cutting costs than with looking at whether home care met respondents' ongoing needs.

Some respondents had made entirely private arrangements for home care: they were generally satisfied with the flexibility and choice this gave them. In the sample, only a small number of respondents made private arrangements and had a direct contractual relationship with a care worker. There were no apparent grounds for concern about dignity and security in these cases, and respondents often seemed better catered for than in the majority of interviews. (However, one respondent had altered his will in favor of a care worker and there must be concern about the possibility of exploitation, given the absence of oversight and governance of such arrangements.) There was little direct experience among respondents of personalization mechanisms such as direct payments and personal budgets; many had no knowledge of these, others were clearly reluctant to embrace a change that might involve additional administrative burdens for them.

Many of the instances cited by respondents would not necessarily make the news, though their cumulative impact on individuals could be profoundly depressing and stressful. Lack of confidence in their own judgement could be a barrier to raising issues directly with care workers. Another barrier could be reluctance to alienate care workers, damage relationships with them or invite further problems. Moreover, the social isolation of many recipients of home care means they are cut off from important informal information networks.

Not only in terms of protecting dignity and security, more could be achieved through better continuity of care which can help older people to establish relationships with their care workers. The most contented

respondents were those who had good, stable arrangements with care workers and whose care workers had got to know them, their homes and the way they liked things done.

Respondents often seemed to accept passively a lack of any real autonomy and choice as far as their home care was concerned. There was widespread resignation and lack of expectation of being consulted on key matters that affected them. There was little sense that respondents expected to have, what may be called, process rights in relation to their home care: rights to be consulted, to consent, to have access to advice and information, to have redress and appeals. The general picture, except when something was viewed as bad enough to justify a complaint, was that respondents acquiesced in a process which took a lot of decisions for them.

Most interviewees, being in poor health or frail or both, did not want to take on additional cares and responsibilities. They might welcome mechanisms and systems to improve consultation and choice, provided these did not require them to take on significant tasks of accounting, researching suppliers or carrying out status and training checks. Moreover those administering the system of home care need to understand that vulnerability may lie not just in ill-health and frailty, but in social isolation and loneliness.

Privacy.- Home care is essentially intrusive because it takes place in people's homes. Respondents were aware of the need for compromise between controlling access to their home and guarding their privacy, in order to get the care they need, but they were not always happy about it. A few respondents described incidents where care workers had gone into rooms in their homes without asking permission. Some felt exposed and uncomfortable when going to the toilet or being washed. It takes sensitivity to respect privacy while meeting fundamental care needs, and sometimes that sensitivity was found lacking from the evidence in these interviews. Inflexible care worker routines can interfere with the right to respect for a private life, and poor time-keeping by care workers can be an additional barrier.

Social and civic participation was clearly exceptionally difficult for most interviewees although a few respondents who had private care arrangements said their care workers had an important role to play in helping them to get out and about and mix with other people. Very many of the other respondents said their health conditions or impairments made it difficult or impossible for them to participate in any activity outside of the home. They did not raise it themselves as an aspect of their lives that care workers failed to offer help with, accepting almost without question that such help was not available. Many respondents would like to browse in a shop occasionally, not just have mail order clothes or things that other people bring for them from the shops. Others have given up interests ranging from jazz concerts to going to the bookies. Many miss just sitting in the garden, or the park where they can see the world go by. When they were probed on this subject, even though they had not seen it as relevant to a discussion of in-home care, it was clear that all were unhappy and frustrated about such severe limitations on their lives. However the idea of a 'right' to respect for social and civic participation was not a concept that came to many people spontaneously. Rather, there seemed to be a fatalistic acceptance that, as older people, they should not expect to be able to do things the rest of society takes for granted.

The areas for concern about human rights that were found in these interviews were not, on the whole, about intentional or reckless poor practice on the part of care workers or care providers. The big picture is one of a system that is essential and appreciated, but which is caught up in various imperatives: one is certainly to secure welfare and safety; another is to manage the logistics of meeting the different personal care needs of a huge number of people; a third is to distribute scarce resources according to needs ranked

and prioritized fairly. Taking a human rights perspective is essential to the delivery of home care, otherwise a focus on the individual needs and requirements of older people can be lost.

As for informal caregivers, they are entitled to specific social benefits only if they are not related to the care receiver. Nearly 1.4 million people aged 65+ in England and Wales provide unpaid care for a partner, family, or others, but only 77,635 of these (in England) receive any carer-specific support. The respondents also revealed that caring for another person also took its toll mentally, with 68.8% saying being a carer had damaged their psychological wellbeing, and 42.9% reporting that their mental health had worsened in the past year. Subsequently, the Princess Royal Trust for Carers wants GPs to provide health checks and screening for depression to carers once a year, and home visits where needed. It also recommends that training and lifting equipment should be provided to carers who need it and that breaks should be funded by the NHS and local council services.

19.9% (one in five) of the homes occupied by older people (60+) in England fail the decent homes standard (just over 1.7 million households).The UK has some of the worst levels of home energy efficiency in Europe. Over 6 million older people (55% of people aged 65+ in the UK) are concerned about the increasing cost of energy bills in the winter. 28% of older people (3 million people aged 65+ in the UK) say they are worried about staying warm in their homes in the winter. Nearly 1 million people aged 65 and over have had to cut back on food shopping over recent years to cover the cost of utility bills. 14% have gone to bed to keep warm and save heating costs, even though they weren't tired. 12% have lived in just one room to save heating costs. Age UK has calculated that the cost of cold homes to the NHS in England arising from the increase in hospital admissions and additional GP consultations is around £1.36 billion per year.

In a study based on 10,000 phone calls to a help-line up to 2004, the proportion of calls concerning the different types of elder abuse identified was as follows: psychological (34 per cent), financial (20 per cent), physical (19 per cent), sexual (3 per cent). 44 per cent of callers reported multiple abuse. According to a survey in December 2014, 2.9 million older people (65+) in Great Britain feel they have no one to turn to for help and support.

In 2015, 4.5 million people aged 65 and over have never been online (39% of this age group) Reasons for households not having Internet access (2014): 53% - Don't need Internet (not useful, not interesting, etc.), 32% lack of skills, 12% consider equipment costs too high, 11% estimate access costs too high

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12.24 Identification of skill and competency needs in the homecare in Switzerland

Homecare in Switzerland is not officially regulated. *Swiss* Federal Law on Health -1996, 101bis article- determines that the Swiss government must subsidize homecare services for elderly, but it gives cantons most responsibilities to plan and provide these homecare services.

In Swizerland, there is a balanced rate of male and female older people taking care of elderly. These care providers are not consider workers with a very high status.

The payment for homecare, even though the State bears subsidiary liability, is done by elderly and their families. Whenever these are unable then the State intervenes. At present there is a lack of political concern about economic and social aspects aimed at normalizing homecare services for elderly people in the country.

The payment to care providers is done in a variety of ways, using several means of payment, such as copay depending on the annual income of the elderly, prevailing the private homecare provider.

At present there is a debate as to which is the adequate financial assistance of the initiatives in favor of elderly care, promoting strategies to increase the involvement of relatives in the homecare provision.

Nurses in Switzerland have basic knowledge of health issues and of prevention, diagnostic, therapeutic, palliative and rehabilitation measures; they also have abilities on clinic reasoning, they are able to search and integrate information for their professional practice, they can give advice on health issues to patients. As for their capabilities, they are able to take responsibilities for their actions and respect their limitations, are autonomous in their work, are able to solve problems, communicate and participate in development, promote health and prevent illnesses.

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Projet Compétences finales professions de la santé HES. Annexe I.

http://www.hes-so.ch/data/documents/projet-competences-finales-professions-sante-HES-annexe-718.pdf

12.25 Identification of skill and competency needs in the homecare in Norway

The shortage in health and social personnel in Norway is being met in many ways, some of which the trade unions are highly sceptical to. Stong, multinational recruitment companies bring in people from abroad. The salaries, pensions (if they have any) and working conditions are some times below the standards that are set in the central agreements and the conditions, for example working hours, are often way beyond the limits set by our Working Enwiroment Act. Norway is dependant on these very able and hard working people, also within the health and care sector. It is a great shame that they are often offered working conditions and places to live, that are below standards and regulations, and the trade unions should intensify our efforts to set this straight.

There are a large number of enrolled nurses in the age group of 55+, and the recruitment of young people is low. In addition, Norway expects a high rise of old people in the near future. We need to encourage young people to choose the health sector.

There has been a lot of discussions related to a major reform move that was implemented some years ago. The aim is, amongst other beneficial goals, to ease off the pressure in the health services, especially within the hospital services. The reform draws up some general lines;

- Preventive actions; less sick people, less pressure. To be able to prevent; all sectors must collaborate.
- More (even more) responsibility to the local municipals, increased medical care in the local community, less entries to hospitals, quicker (even quicker) transfer back home from hospitals for non-surgical patients (of whom many are the very old patients).
- More funding to the local communities, due to the increase in responsibilities and tasks.
- More collaboration across sectors (horizontally) and between sectors (vertically; i.e. hospitals and the local community).

12.26 Identification of skill and competency needs in the homecare in Iceland

As of 1 January 2016, the population of Iceland was estimated to be 330 680 people[114]. Momentum aging rapidly increased after 2000 as shown in the lower spreadsheet, especially with women. Population forecast for half the increase in the next 50 years. There was almost 33.000 senior citizens (over 67 years) in Iceland (2015). About 11% (3.630) require admission to a nursing home. According to the literature that is expected to 10,8% of birth tunnel 67 years and older is in need of assistance.

Today there are waiting list for senior citizens to get a nursing home. They need to go through the evaluation and Rai have reached very ill to enter. That has changed in recent years to increase has been detached and lengthens the waiting list considerably.

The Icelandic authorities are aware of aging in European countries where the birth rate has reduced impact on population trends. Life expectancy changes as the improved living conditions and better medical service and medicines.

In general, life expectancy has increased but the service does not follow trends recovered quickly enough. There is a need for increased funds in the issue, however, the authorities try to do their best. Worth noting that recessions has been in the country since 2008 which affects the allocation of funds in health care system.

Practical Nurses are a small minority of staff who work in nursing home. Unfortunately nursing home employ unskilled workers receiving the lower wages. Possibly this is done to save the labor cost and no restricions for skills. Unskilled workers are foreigners who do not speak good Icelandic and this workers have little or no knowledge of nursing the eldery. Some of them are social workers who have college education (félagsliðar) or foreign unskilled labour.

Only 25 % of employees of nursing homes in Iceland are Practical nurses. It should be noted that the staffing is understaffed and have heavy work load which increases the strain on the staff. More as half of

[114] http://countrymeters.info/en/Iceland

workers are unskilled workers or staff who have few courses from Union Promotion (Efling) or low levels of educations. A large part of unskilled workers are foreigners who have moved to Iceland to get work and speak very poor Icelandic if any. Most come from Poland, eastern Europe and Asia. Some of the workers adapt well and learn the language and go to school and pick up health degree. But others have even a university degree from their home lands and work on other fields due to lack language.

13 Discussion: skill and competency needs in European Union

The main aims of the report D2.2 was to collect information about home care skills and competency needs in all European countries. CARESS project workgroup gathered special primary data during questionnaires for HHCP and structured interviews with older people. The other working method was gathering secondary data which based on available literature, statistics, available researches/projects results about the specific sector and other available documentation. Three partner countries Italy, Spain and Finland differ from the practice of home care as well of anticipation.

Gathering information from other EU countries was often challenge by reason of lack of connects or communication between working staff. The analyzing of home care needs what based only on written reviews cannot answer the aims and basic questions what are the skill and competence needs in future HHCP work and education. There was not material about Slovenia and Switzerland, and many analyses are narrow by lack of linguistic skills.

13.1Skills and competences HHCPs are lacking by HHCP surveys

From Italy report: A skill gap related to specific activities and performances carried out by HHCPs**.** Skills and competencies needs in this case are related to the task performed by the professionals and to the needs expressed by the end-users. From the questionnaires targeting HHCPs and the interviews targeting older adults analyzed comes to light that, in general, professionals have a positive view of their competency level. Once identified the needed competences, the majority of them declares that they master at high or medium level that competencies, acquired both by formal education and by working practice.

Specific skills needs are identified by single professionals connected with activities that are not central for the service they provide, but can improve the whole perception of the quality of the service itself. For example, nurses would like to improve their knowledge about ethics and human rights and about the network of services provided by the National Health System; they would like also to improve their competencies in managing the relations with family caregivers and in managing terminal illness.

Another key element is the context in which HHCPs acquire the competencies they declare to master. For example, physiotherapists deem important knowledge and skills about older adults healthy lifestyles, network of services, the enhancing of mental health and the fostering of independent living paths; they declare to master these competencies but they say that they've been not trained about them, since they got these competencies by working practice.

In Finland the results of HHCP survey indicated that majority of responders thought that almost all the competences included in questionnaire used in study are required in working in home health care. In self – evaluation of HCCPs skills and competences level, the responders evaluated their competence level satisfactory in knowledge of social- and health service system inc. social services and benefits client is entitled to Knowledges, skills and competences were also evaluated mostly in categories of satisfactory or good in procedures for providing physical therapies, fostering clients social and familiar relations, competences to support for coordinating the work of other practitioners, competences for evaluating clients mental health status and competences for caring clients with terminal illness and grief support.

HCCPs had acquired competence mostly by working practice in following skills: basics in social-health services organizations and networks, knowledge about the main aids and devices for older and disabled people, procedures for fostering customers going out of home, providing the customer with contextualized

and personalized information about the network of social services and benefits he/she can rely on, competences for collaboration with other practitioners and competences for evaluating customer needs and adapting the service. Competences in basics in anatomy and pathology, basic procedures in medical assistance (eg. make injection, provide drugs, change medication) HCCPs have gained mostly by attending a school, training course or academic course.

HCCP didn't take a part of the first evaluation and forming a clients' care and service plan. This is probably the reason why they evaluated their knowledge of social services and benefits lower than expected. However HCCPs were involved in modifying and assessing clients care plans in continued care. Yet they thought that they could have competences to do it, if given time, education and authorization. It seems that in division of tasks in home care doing the care plans especially on beginning of the care of the new client is done by the registered nurses or registered public health nurses

From Spain we were not able to get data or analysis from HCCP surveys.

Skills and competences HHCPs are lacking by Interviews of older people

13.1.1 MATERIAL AND METHODS OF STRUCTURED INTERVIEWS OF OLDER PEOPLE

The aim of the study was: To know the actual activities carried out at the elderly home by Home Health Care Providers (HHCP) and to know the needs perceived by the elderly, their priority and which of them are fulfilled by the service in their view. This study also aimed to know elderlies opinion about further activities that should be performed or activities that should be improved and to know the elderly satisfaction level.

1.1 Methods

Semi-structured interviews of the home care clients were carried out in three countries involved in this study: Spain, Finland and Italy. Approximately 42 elderly age seventy-five and older were interviewed in each of the three countries: the Spain (5 interviews), Finland (9 interviews) and Italy (28 interviews). One of the interviews was made for person age 56, with an 82% disability (Table 1). The interviews were conducted from February through March 2016 (In Finland and Spain) and they were structured by questionnaire made especially for this purpose in Caress project. The interviews were usually collected by interviewer present face to face in the interviewees own homes. Also one telephone interview was used in Finland.

Variables	Spain	Finland	Italy
	n=5 (%)	n=9 (%)	n=28 (%)
Gender			
Male	1 (20)	1 (11,1)	9 (32,14)
Female	4 (80)	8 (88,9)	19 (67,86)
Age			
< 75	1 (20)	0 (0,0)	7 (25,00)
75-79	2 (40)	0 (0,0)	9 (32,14)
80-84	0 (0,0)	2 (22,2)	2 (7,14)
85-89	2 (40)	4 (44,4)	4 (14,29)
90-94	0 (0,0)	2 (22,2)	3 (10,71)
95-99	0 (0,0)	1 (11,1)	1 (3,57)

13.1.2 RESULTS

Time spent with the client

HHCPs service time recipients at home was on average from 30 minutes to one hour (44% in Finland and 80% in Spain). In Finland It also varied from 15 minutes (22%) to 30 minutes (33%), but nobody had the caregiver at their home for more than 1 hour. In Spain one respondent had the caregiver from 1 to 2 hours a day. The amounts of visits that clients received on average by the caregiver in their home varied in different countries. Clients in Finland received on average the visit of caregiver in their home more than 7 times per week (56%). One client was visited once a week and one client received a visit from 5 to 7 times per week. One couple was visited once in every other week. In Spain two of the clients answered that HHCPs visited in their home from 2 to 3 times a week, one caregiver visited from 3 to 5 times a week and two from 5 to 7 times a week.

Activities carried out elderly home by HHCPs

The activities that HHCP normally carried out in the elderly`s home varied between three countries involved in this study. In Finland the activities that HHCP normally carried out in the elderly`s home were categorized in eight categories: Health promoting activities, Administration and assessing medications, Assistance in activities of daily living (IADL), Clinical nursing interventions, Domestic help, Assistance in application of social allowances and benefits, Rehabilitation activities and Support and assistance in social relationships.

In Spain the results showed that the activities agreed upon with the client and HHCP were accomplished. The activities clients got, were mostly household chores (housework/daily housekeeping services) in larger or less extend (such as bathing and personal hygiene, bathroom cleaning, washing floors and cleaning kitchen, cleaning the dust, making the bed, ironing and tending clothes), shopping and indoor and outdoor accompanying (going for daily walks), accompanying while shopping, outwear appearance and assistance in clients` clothing (dressing/ undressing), helping with clients mobility (helping in/out of the bed), going on errands. In general, the clients thought they don`t need other care needs, but one client considered the time that HHCP spend in their home wasn`t enough. This result is similar to the finnish study which showed that the clients thought HHCPs were too busy and they wished for more time to spent with them; to have a dialog, discuss and take walks.

In Italy 47 (53%) need to be supported in daily living, 6 (7%) need to support for particular health conditions, 12 (13%) need to support in prevention from any health risk and maintenance of healthy lifestyle 12 (13%) and 24 (27%) comprehensive and respectful consideration of myself.

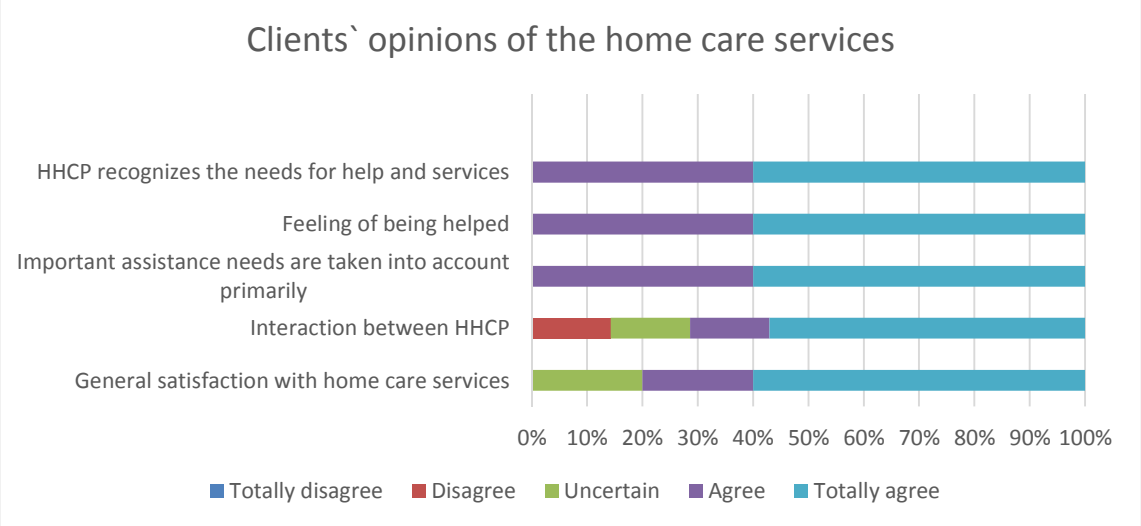
Care needs and priority of the care needs

The clients in Finland (78%) thought, they had received help needed. Clients' opinion about further activities that should be performed, the clients indicated that they would like to have more time for discussion (33%), walking tours (22%) and shopping (11%) with the HHCPs. In Finland the activities were mostly focused on nursing procedures and administering and assessing medications. This was also mentioned to be the most important priority care need to the clients.
In Spain all the clients interviewed estimated that they need no other services and they even got some extra help from the HHCPs. The 40% of the clients requested outdoor accompanying and 20% asked help to dispense medication. The activities clients considered most important were: going on errands and shopping, household chores (including ironing) and bathing and hygiene. Also nutrition, mobility, going for walks outdoors and making the bed were mentioned.

The need most satisfied from healthcare services provided by HHCP in Italy included support in hygiene (including shower, bath or oral hygiene), support in shopping and purchasing, maintenance of the house (including cleaning the floors, laundry, organization of the clothes etc.) and support in mobility out of home (including the use of public or private transportations). Only four 14,2% clients were unsatisfied and most of them referred to the support for example in prevention from health risks and maintenance of healthy lifestyle and wellbeing including physical health

Skills and competences of HCCPs assessed by elderly home care clients

The elderly home care clients were asked to describe their relationship with Home health care providers. In Spain the relationship was mostly described as friendly and professional, same result came out in Finland. The clients were also asked to consider abilities that should be fundamental for a homecare worker to have. Those mentioned in finnish interviews were; to ability to listen the client, to be emphatic, friendly, calm, determination, reliable and have a sense of humor. In Spain clients brought up qualities important to HCCPs as friendliness, being honorable, responsibility, doing job fast. In Italy mostly reported skills/characteristics requested by clients were: honesty, respect, understanding, gentleness, patience, kindness, helpfulness, empathy, education, expertise, professionalism.
In general the Finnish clients were satisfied for the services Home care provided. They were using expressions like `excellent` and `good` and ratings were from six to ten in the scale of one to ten (table 2). Interaction between the client and HHCP were described as friendly or close (67%) and interaction was also mentioned to be professional (56%). The HHCPs were described to be very polite and treating the clients respectfully as always asking clients opinion. However it was mentioned that interaction varied a lot between different HHCPs. Otherwise two of the clients described interaction very distant or lacking and criticized that the HHCPs who provided the care are constantly changed. Some of the clients had some bad experiences that nurses were very busy, intimidating and even have been working under the influence of the alcohol.



The clients were asked to mention to consider abilities that should be fundamental for a homecare worker to have. To ability to listen the client, to be emphatic, friendly, calm, determined, reliable, to have sense of humor. Professional skills were also mentioned, for example competence in drug therapy. Domestic skills as ability prepare meals and making coffee. Ability to assess the clients' heath condition in hole.

A worrying result was that administrating and assessing medications skills were satisfactory or even poor. One married couple answered, that the medication skills were good, but on the other hand, they meant registered nurses as well. Clinical nursing skills were said to be good as skills assisting activities in daily living although there was variation in skill level depending on the HHCP. Clinical nursing skills were said to be

good as skills assisting activities in daily living although there was variation in skill level depending on the HHCP. The clients' perceptions of the ethical competencies were mostly satisfactory level or it was varying. It was mentioned that knowledge was mostly excellent but it was also varying between HHCPs. Although the clients were using domestic care services, none of them mentioned it when asked about competence and skills of HHCPs.

The clients were asked to mention three things that HHCP provides that improve the quality of their life and helps them in managing in their own home. There were helping activities in daily living (hygiene, nutrition), medication (56%), measurements (blood pressure), clinical nursing activities (stoma care), support client`s in performing their errands (e.g. pharmacy, shopping), rehabilitation, maintain the social relationship for example helping to visit the spouse in nursing home or taking part of social activities.

13.2DISCUSSION

The interviews in Spain revealed that the clients would like to have some help with dispense their medication. Also in Finland the results show that in the future, HHCPs education needs has to be considered in the categories of administration and assessing medications and ethical skills. In Finland the interviews showed that despite the importance of the nursing procedures and administering and assessing medications as a care need, clients assessed the HHCPs competence level only satisfactory or even poor.

Also interaction skills as well as the HHCPs ability to plan the care needs individually and giving enough time for the client, are important aspects in all three countries. In Finland and also in Spain the HHCPs spent on average from 30 minutes to one hour in client`s home. This in some way may reflect the clients` need of the discussions with HHCP`s. Furthermore the stability of the staff should also be considered.

There was no mention from the skills and competences of HHCPs assessed by elderly home care clients in reports from Italy or Spain, so no specific conclusions can be made.

Summary of skill and competence needs by general reviews

Skills and competencies needs in Italy home care are related to specific issues, faults or peculiarities of Italian context, laws and culture; to be able to work in equip, to build, monitor and evaluate a Personalized Assistance Plan (each one contributing for his/her own specific part), to be able to foster older adults in carrying out their own independent personal life path, etc. are some examples of the competencies which could improve the quality of the service of every HHCPs.

The following Italian contextual elements implies important consequences on HHCPs skill and competency needs:

- HHCPs should **get specific competencies for working in equip**, both if they work in health and in social homecare, both if they are public-employee and they are free-lance; they should be **able and available** to collaborate and cooperate with other professionals in order to **build, monitor and evaluate a Personalized Assistance Plan**, contributing for their specific part, but taking into account the whole objective of improving the older adults quality of life.
- HHCPs should have specific **competencies concerning the main objectives and aims of primary, secondary and tertiary care**; a specific focus **on primary care** should be provided in their training in order to allow them to contribute, with their specific service, to prevent and early diagnose diseases or health problems, in coordination with the GP and other HHCPs.

- HHCPs should be aware of the importance of enhancing and promoting patient, families and social fabric resources in order to foster the older adult **to carry out a renewed independent personal life path.**
- HHCPs should get specific **psychological and relational competencies** in order to support older adults and their families with their need of psychological support and social participation.
- **HHCP should be able to manage specific tools, report models and documentation**, even supported by ICTs, in order to effectively report their activity and share information about the patient homecare with other professionals and, in general, with the National Health System databases.
- HCCPs should be trained, each one for the specific service provided, **to use new ICTs supporting telecare, primary care and remote health monitoring.**

Spanish analyse will highlighted following skills and competences:

Homecare sanitary services users

- Elderly who, due to their health condition or to other criteria previously established by the team, cannot get about.

Homecare social services

- Elderly with limitations to get around in their everyday life, with difficulty in their personal autonomy, dependent.
  - Support to carers
  - Education and involvement with family, and promotion of personal autonomy.

Technical assistance to improve home accessibility.

The survey of anticipation in elderly care in Finland (Competences and skills needs in services for the elderly), mentioned following competences and skills needs in the future:[115]

• terminal care skills
• knowledge of dementia, dementia care, skills in caring for persons with memory disorders
• Customer-oriented operating methods, understanding customer orientation, identifying needs and expectations
• command of basic medication, medical care skills
• interaction and communication skills
• rehabilitative work approach, motivation, encouragement etc.
• cost-awareness, economic thinking, results-oriented mentality
• mastering the daily basic care procedures of the customer/patient
• knowledge of geriatric illnesses, including knowledge of dementia
• knowledge of dementia-inducing illnesses and memory disorders.

The general finding from analyses of other European countries shows needs to develop following aspects:

General aspects	General attitude/personality	Skill and competence needs	New skills and innovations
Organisation of home care (planning, access to care services, information, guidance), a better level of quality	Customer based orientation, creating more choices (personal based care)	Hygiene of the services provided at home	Welfare technology, telecare – knowledge and skills to use as well guide and support clients and their families
More/extra financial	Flexible	To prevent and early	Technology/equipment

[115] Taipale-Lehto – Bergman, 2015: 34–35.

resources		diagnose diseases or health problems	at home
Flexible regulations and law, integration between health and social care	Relational characteristics, such as polite, enjoyable, pleasant, etc, able to emphasize	Remote health monitoring, assessment skills	Multidisciplinary teams, cooperation, better coordination between different types of homecare services
Integration between public and private homecare	Rights, dignity and security	Communication skills, social skills, guidance skills,	Mental health, memory disorders and dementia
More resources (persons, time, equipment)	Support to loneliness and isolation	Professional ethics	Terminal care
Better work condition, better life condition of client's home	Open to change, tolerant, motivated	ICT-reporting skills	Promoting healthy lifestyle, preventative care skills
Better image of care work, change in attitude and expectation for informal family care	Support in social relations and participation	Geriatric knowledge, rehabilitation	Management and business skills

One of the main problems of this integrated model is the professional integration of different professionals normally referring to different services: nursing care, rehabilitation, social assistance, home help, etc. The 'new home care worker' have to be multitasking, member of multidisciplinary team.

The main concerns of the elderly persons included in the survey were related with particular rights, dignity and security, better coordination between different types of homecare services, a better level of quality, the need of increasing the workforce. There are many projects which improving different indicator of home care services. Prioritary areas are preventive care, mental health, dementia care, improved drug prescribing and end-of-life and palliative care; indicators such as avoidable inpatient care and re-admittance within 30 days, decrease of medication with a high risk of side-effects, routine oral assessments and standardized care after a diagnosis of dementia.

14 Conclusions

Even today, the family is the largest welfare institution in many countries. HHCP is understood as difficult job with the need of forming a multidisciplinary skills/team work. Training in the homecare sector needs to be promoted and made more attractive.

Once formalized specific roles in homecare for each HHCP, specific training courses should be organized to integrate the competencies acquired through the general qualifications and degrees (nurses, physiotherapists, etc.) with specific competences required by the homecare service.

Analyses highlighted the increasing demands for health and social care and greater need for a trained health and care workforce. The main skills drivers for health professionals over the next decades will be financial, organisational, legislative, demographic and technological, several of these are interlinked. The now demanding role of HHCP means a broad range of skills, depending on practice needs which may include health assessment, empowerment, communication, health education, greater sensitivity and advocacy for clients' rights, case management, ICT skills and group work.

The main trend is moving from ‘traditional’ approach to innovative approach including reducing of ageing stereotypes, long-term ‘cure’ to flexible customer-orienteted long-term ‘care´ with highlighting on dignity, rights-based and guality of life-based approaches including prevention, rehabilitation and social support. Services are developing more customer-focused approaches, creating more choice in home care service delivery. Future home care would to organise interdisciplinary by providing innovative welfare technology solutions. ICT and technological solutions tend to be more cost-efficient and effective by providing support and services at home.

Following skills and competences will needed by HHCP in the future in home care sector:

- **Communication skills**
- **Customer and personal service skills, social skills**
- **Ethics and the quality of services**
- **Assessment and guidance skills**
- **ICT and telecare skills, knowledge about healthcare/welfare technology**
- **Administration and management skills**
- **Organizational skills**
- **Therapy and counselling skills**
- **Psychology, sociology and anthropology skills**
- **Team working skills**
- **Active learning, listening and comprehension skills:**
- **Sector specific knowledge and skills.**