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ACTIVE A.G.E. - Urbact II Thematic Network

II° TRANSNATIONAL WORKSHOP EXCHANGE Maribor, February 24th- 26th 2010

Report

1. Welcome: Setting the context

The second transnational workshop exchange meeting of the Active AGE project related to the issue of Age and Care took place in February from 24th to 26th in the city of Maribor (Slovenia). During the workshop partners shared their knowledge and experiences concerning local policies and practices about care services.

The meeting began with a session dedicated to the reflection on age and some care issues organized in subthemes. First of all Haroon Saad, the thematic expert of the Active Age Project, reminded to the partners some elements about Urbact Programme. He focused the participant's attention on the process of LAPs creation, on the role of Local Support Groups and last but not least on the importance of the exchange between all the participants of the project. He outlined once again that the creation of a LAP is a bottom up process supported by managing authorities which have to guarantee that the LAP will be concretized and will be included into a Regional Operational Programme.

Haroon Saad started the discussion thinking about age and care in practical way. The terms of the discussion were the following:

1. The cost of long term care
2. Collective vs individual provision
3. Institutional primary and preventive care
4. Integrated care

Health related issues are increasingly addressed at European level also in relation to the life expectancy increase. There are many levels of reflection:



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- Ageing population: elderly people live longer, but illness and obesity grow.
- Weakness of intergenerational solidarity (culture of individuality, less family solidarity, etc.)
- Unsustainability of current models of care: high financial costs of care services and reduction of economic resources.
- Changing role of actors (ex. migration flow, no attraction of health sector for young people).

After the introduction the first subtheme on Age and Care was started, and Haroon Saad suggested participants to think on creating a new idea to transform the care sector in a practical way, using key actions to support the LAP: the experience of transnational workshop, online and telephone support, local support group, LAP tools, bilateral visit between project partners and expert visit. During the presentation of the methodology all the participants gave each other some suggestions for the preparation of the LAP:

1. **Improving information.** For instance, the municipality of Edinburgh created a magazine to share information about available care services;
2. **Improving care sector workforce** through the development of different kind of competences
3. **Better coordination of care provision**
4. **Active Age actions**
5. **Improving access to care services**

2. Overview of the local strategies for long term care

The second part of the afternoon Annamaria Simonazzi, Lead expert, presented and discussed the cities' responses to a questionnaire aimed at mapping the current patterns of elderly care provisions in the cities of the Active Age network, concerning the availability and affordability of the elderly care. In the months that preceded the transnational meeting the cities of the network had drafted a descriptive document on who is in charge of providing care as disability progresses from mild to



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moderate to severe as well as on how to mix the provisions and of care providers change along with this progression. The main aim of the questionnaire was to stimulate the reflection on the different kind of care policy in the European countries, starting from the situation in the city involved in Active Age project. The questionnaire consists of a combined grid summarizing:

- the main types of provisions available in various EU countries (grids 1 and 2);
- the gender balance of carers and cared for at the various stages of disability (grid 3)
- the issues of affordability of professional home care and nursing home care (grid 4)
- the attitudes towards the different types of elderly care

The grid of the questionnaire is available in the appendix to the report. Below there are three summary tables comparing the results of the questionnaires, properly filled in and sent to the lead expert, in relation to:

1. Time related provisions
2. Cash transfer
3. Services

The summary tables refers in particular on the condition of care services of the following municipalities: Rome, Starogard, Dobrich and Prague. The choice of these cities is illustrative of the differences that exist in the care systems of our network.



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TIME RELATED PROVISIONS – SUMMARY TABLE			
ROME	STAROGARD	DOBRICH	PRAGUE
<p>1. Care leaves for other relatives</p> <p>2. Leaves until 2 years</p> <p>3. Flexible time arrangements to be agreed with the employer</p> <p>After some delays, Law 53/2000 and the Legislative Decree 151/2001 (modified and integrated by the Legislative Decree 115/2003) implemented into the Italia law the Council Directive 96/347EC of 3rd June 1996 on the “Framework agreement on parental leave”. This led to the introduction of significant changes in Italy for both regular and not regular employees. With specific regard to non self sufficient elderly care, the measures shown on the left side of the table were introduced. More specifically, who is assisting a person, relative or up to 3rd relative in law with a severe disability, is entitled to apply for three days of paid leaves per month, to use in a continuative or non continuative way on condition that the disabled person is not taken in a residential structure. The period of these leaves is included in calculating seniority. Moreover, each em-</p>	<p>Church association CARITAS: employs 7 persons 50+, among which 3 disabled (2 men, 1 woman), 1 nurse and 1 volunteer 50+.</p> <p>Annual leave (the only option): 26 + 10 days recovery leave.</p> <p>No law regulations parallel to maternity leave etc. Another option is unpaid leave.</p>	<p>1. <i>Targeted leaves</i> *10 days leave to take care of sick family member; * Every employee can use long-term unpaid leave with the employers permission on various occasions / including for family reasons such as childcare, dependent family member. In practice, it does not happen because of decreasing of the family income, possibility of losing job and time of unpaid leaves does not accept for length of service.</p> <p>2. <i>General leave schemes</i> - None developed schemes for balancing work and professional commitments related to care of non self sufficient members of the family.</p> <p>3 <i>Flexible time arrangements</i> - There are no legislative provisions. Flexible working hours can be negotiated with the employer if the position and the organization of workflow allows.</p> <p>Other There is a national program named "Personal Assistant". It may include persons other non-exercise a profession that in the first line kinship care for a family member with severe disabilities. Appointed on contract by the Directorate of Social Assistance, Social Assistance Agency, Ministry of Labour and Social Policy. The target group Is a living lonely elderly person with severe health problems.</p>	<p>Current economic system in the Czech Republic enable the possibility of long-term unpaid leave from work or to work under a flexible work arrangements to take care of a dependent person. People who take care of helpless people can receive care allowance.</p>



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<p>ployee, women and men, is entitled to apply for three days of paid leaves per year for serious family reasons. Alternatively, employee is admitted to agree flexible time arrangements with the employer to carry out his/her working activity. Public and private sector employees are entitled to apply for a leave to use in a continuative or non continuative way, up to 2 years, for serious and documented reasons, without salary and social security warranty, but maintaining the occupation.</p>			
CASH TRANSFERS – SUMMARY TABLE			
ROME	STAROGARD	DOBRICH	PRAGUE
<ol style="list-style-type: none"> 1. Disability allowances 2. Social pensions/allowance 3. Cash benefits for elderly people 4. Cash benefit to sustain rent costs 5. Cash benefit to sustain gas costs 6. Mobility card 7. Special fees for transport of over 65 8. Free card for transports for 70s and over 9. Annual reduction of waste fee 10. Cash benefits to implement safety devices at home – 	<p>Since 1998 many NGOs run and develop workshops Therapy by Work. As part of them we introduced in Starogard the Economy Training to teach how to properly value and asset, how to plan spendings etc. Participants receive their pocket money, phone cards. 100% training attendance grants extra bonus.</p> <p>Businesses of Protected Work (at least 6% of employees are disabled) are supported by National Disabled Persons Fund (3/4 of</p>	<p>Made by Directorate of Social Assistance, Social Assistance Agency, Ministry of Labour and Social Policy and are arranged by law, People with mild, moderate and severe disability - receiving disablement pension.</p> <p>1. <i>Disability allowances/pensions-</i> People with disabilities have the monthly allowances rights for social integration according to their individual needs and depending on the type, stage of damage. Types of assistance: transport, telecommunications services, diet and medicines, accessible information, spa and rehabilitation services / once a year /, Every integration municipal housing for single</p>	<p>Cash allowances: For people that are dependant on the care of other person Level of cash allowance depends on the level dependency (4 levels) 1st level: 2.000 CZK/month 2nd level: 4.000 CZK/month 3rd level: 8.000 CZK/month 4th level: 11.000 CZK/month</p> <p>Disabled allowances: <u>Full disabled pension (severe disability):</u> A person is fully disabled if due to long-term health conditions: a. decreased his ability to continuous employment for at least 66% b. due to his disability is capable of sustainment an</p>



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<p>“Safety at home!” project</p> <p>Disability allowances may be granted to severely disabled people only (stage 3). Social pensions/allowance to those have not deductions for insurance Cash benefits for gas, rent as well as special fees are aimed at sustaining elderly people whose annual income is lower than a given threshold</p>	<p>disabled wages, place of work equipment) – each of these businesses is obliged to create its own Disabled Fund which is then distributed to cover or support expenses on medicines, rehabilitation, treatment at a sanatorium.</p> <p>County Centre of Family Aid (County Authority): support NGOs applications on different issues; non-returnable flat refurbishment support.</p> <p>Starogard City Centre for Social Care: one-time or repeated aid for living standards; social care workers.</p> <p>Disabled pension: 400 – 600PLN monthly (ca: 110 – 160EUR)</p>	<p>persons with permanent disabilities. The size of every integration additive is appropriate percentage of the guaranteed minimum income/65 lv. /</p> <p>Persons have rights to technical assistance funds according to type of disease. Persons with severe disability have rights to financial assistance for the adaptation of the house.</p> <p>2. <i>Care allowances (e.g. an allowance to compensation for the family carer)</i> - For persons with severe disability - a pension supplement for companion /another's aid /</p> <p>3. <i>Vouchers</i> - Targeted assistance for heating - to the degree of disability and incomes, increased for persons living alone, level of disability, age over 75</p> <p>4. <i>Qualification for social contributions</i>- people receiving social grants are of Directorate of Social Assistance</p> <p><i>Other</i> - persons with reduced working efficiency - mild, moderate and severe have rights to free vignettes for regional roads in the country; Tax concessions</p> <p>* not owe tax for cars with power to 100 horsepower</p> <p>* tax incentives for private contributions for voluntary insurance and personal insurance and contributions to retirement pension</p> <p>* Persons over 65, disabled workers, pay 50% of the tax when have liberal professions.</p>	<p>economic activity only under very exceptional circumstances</p> <p><u>Partial disabled pension (moderate disability):</u></p> <p>Person is partially disabled if:</p> <p>a. long-term health conditions decreased his ability to continuous employment for at least 33%</p> <p>b. his long-term health conditions greatly hampers the general living conditions.</p>
<p>SERVICES – SUMMARY TABLE</p>			
<p>ROME</p>	<p>STAROGARD</p>	<p>DOBRICH</p>	<p>PRAGUE</p>



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Home care		Home care	Home care
<p>1. Basic home non medical care / Respite care (cooking, meals on wheels, cleaning, bathing, minding, remote assistance)</p> <p>2. Home nursing</p> <p>3. Tele-company, monitoring and assistance</p> <p>4. Bus services</p> <p>5. Summer stay</p> <p>6. "SAVer" assistance service for elderly people victims of abuse</p> <p>Semi-residential care</p> <p>1. Outpatient clinics</p> <p>2. Day-centres</p> <p>3. Alzheimer centres</p> <p>4. Centres for weak elderly people</p> <p>Residential care</p> <p>1. Long term care house</p> <p>2. Co-housing flats</p> <p>3. Public and private elderly home</p> <p>Active ageing services</p> <p>1. "A friend for the City" – service where elderly people are voluntary involved in social service by the schools</p>		<p>a. <i>Basic home care</i> For persons of retirement age with mild, moderate and severe stages of disability - The Service "Home social patronage - there is no limit of stages of disability when using the service on nutrition. Elderly persons who living alone , with moderate and severe stages of disability, use additional services of sanitary / cleaning, bathing / social worker and - administrative services - payment of electricity, telephone, haggling cleaning, bathing, growing, remote assistant</p> <p>b. <i>Home nursing-</i> People over 65 who living alone, with mild and moderate stage of disability have the opportunity to use the "Social Assistant" - aims to support older people to maintain independent living, assistance with cooking, in communicating and maintaining social contacts, escorting doctor , assistance with hospitalization, rehabilitation, measuring blood pressure, blood sugar monitoring intake of medicines. Social service "Home Assistant" –</p> <p>c. <i>Paramedical and medical care</i> Social services accompanies the person and the rehabilitation, physiotherapist, mental therapist</p>	<p>1. <i>Personal assistance</i> is the service designed especially for people with disabilities and seniors. Personal assistants help a person to become self-sufficient and participate in community life. For people with moderate disability</p> <p>2. <i>Nursing service</i> is mainly provided in the household. The service is intended mainly for people with disabilities and the elderly people. Carers help people cope with care of yourself and household.</p> <p>3. <i>Emergency care</i> is continuous telephone or other electronic communication with people who are at high risk of danger to health or life. For people with moderate disability.</p> <p>4. <i>Guide and reading services</i> are aimed at people who have reduced ability to communicate. These include people with sensory disabilities. For people with mild disability.</p> <p>5. <i>Support for independent living</i> is a service similar to the nursing service, but focuses more on strengthening the personal skills to live alone. Especially for people with mild disabilities.</p> <p>6. <i>Endurance service</i> may also be called shared</p>



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		<p>d. <i>Respite care</i>- Social Assistant provides services relating to the provision of recreation and organization of social contacts</p> <p style="text-align: center;">Semi-residential care</p> <p>e. <i>Outpatient clinics</i> - For individuals with moderate and severe degree of disability is provided an opportunity for sanatorium treatment and rehabilitation</p> <p>f. <i>Day-centres</i> - for individuals with mild and moderate degree of disability: Center for adults with mental and physical disabilities and Day Care Center for persons with mental deviations; Center for social rehabilitation and integration. Performed services: rehabilitation, occupational therapy, art therapy, psychological, speech services, medical surveillance, training in mobility, Braille, useful skills.</p> <p>g. <i>Community social services</i> - Pensioners' clubs and disabled clubs, providing an opportunity for social integration of persons over 65. Activities ;, activities of interest, providing contacts, hiking, singing and dance activities, information , Talks about keeping a healthy lifestyle</p>	<p>services. It is a combination of activities of care, which aim at sharing care for some time and take care of someone who is less self-sufficient. Most often is provided for people with mild disabilities.</p> <p style="text-align: center;">Semi-residential care</p> <ol style="list-style-type: none"> 1. <i>Centres of daily service</i> are services for people during the day, to provide assistance with personal hygiene and also to help with the settlement of personal affairs and offer social therapeutic activities. 2. <i>Daily day care</i> is a service regularly visited by people with reduced self-sufficiency. During the day there is ensured a comprehensive care with regard to the needs of users, while providing educational, therapeutic and socio-activating activity. For people with moderate disabilities. 3. <i>Weekly day care</i> is a residential service for people with reduced self-sufficiency in need of regular assistance of another person. The stay is provided during working days. The service offers comprehensive care, such as providing educational, therapeutic and socio-activ-
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		<p style="text-align: center;">Residential care</p> <p>h. <i>Nursing home</i> - Old people house with capacity 115 people, for persons over 65 years. Provides 24-hour social and health protection</p> <p>i. Sheltered homes or flats/residential houses -</p> <p>j. “<i>Protected homes</i>” for persons with mild and moderate mental disabilities</p>	<p>ating activity. For people with moderate disabilities.</p> <p style="text-align: center;">Residential care</p> <ol style="list-style-type: none"> 1. <i>Homes for people with disabilities</i> are residential services of all-year operation for people with severe disabilities in need of regular complex care as well as providing educational, therapeutic and socio-activating activity. This service is intended primarily for those people who can no longer provide assistance in their natural social environment. 2. <i>Homes for the elderly</i> are residential services of all-year operation for seniors with severe disabilities in need of regular assistance to the comprehensive care as well as offering a social therapeutic activity. This service is intended primarily for those seniors who, can no longer provide assistance in their natural social environment. 3. <i>Homes with a special regime</i> are residential services of all-year operation. Their services are tailored to the specific needs of people who suffer from mental illness are dependent on addictive substances or suffering from Alzheimer's disease or
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			<p>another type of dementia. For people with severe disabilities.</p> <p>4. <i>Sheltered housing</i> is a modern type of residential services for persons with disabilities, whose situation requires the help of others, but they have the ability to live more or less independently in an environment that is nearly identical with a normal apartment. For people with mild disabilities.</p> <p>5. <i>Social services in hospital care</i> shall be granted to people who need the assistance of another person while they can not be released from the hospital because it is not possible at this time to provide them care in their homes or in social services. For people with severe disabilities.</p>
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Annamaria Simonazzi introduced the purpose of the questionnaire and its main findings and supported the discussion among the participants to enable them to share the experiences done in their municipalities. The city of Edinburgh emphasized the importance of mapping the care services and benefits reserved for citizens: *“there are lots of benefits and people often don’t have the map”* said Roger Horam. This is the reason why during the last years the city of Edinburgh organized a number of campaigns to encourage citizens to use care services.

The discussion also shows other important critical points which can be summarized as follows:

- The need of assessment of care services for evaluation and modernization of structures, processes and human resources involved;
- The measures against illegal employment in health and home care services, trying to give cash transfer controlled;
- The training and qualification of care workers, in particular of old workers and immigrants: the city of Wolverhampton has noted the lack of adequate skills in health workers. Regarding this issue Giuseppe Panebianco, Lead partner of the Project, talks about an initiative of the Municipality of Rome in terms of qualification of immigrants: immigrants participated for three hours of training twice a week to learn Italian tongue to improve their communication with old people, but also to know the Italian meals, some main hygiene rules, etc.
- The development of an informal care sector: the emergence of initiatives such as the time bank (voluntary based) and the involvement of neighbours in the activity of caring for the elderly people. An example is UK government who encourage people’s neighbours at look out elderly people.

3. Reflections on the organization of care services

The following day Annamaria Simonazzi introduced some case studies through a reflection on the organization of care services in Europe. The main issue was the provision of time (the impact of care services for the organization of the family) and the financial resources: Participants were encouraged to answer the question: *which kind of provision are available on your city?* The majority of care in Europe is still inform-



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ally provided, mostly by female careers and it consists of a mix of provisions and actors of various kind:

- Domiciliary (home) care: family member sand paid workers (public or private; formal and informal)
- Residential/day care: public or private firms, voluntary/non profit organizations

The second dimension discussed was the cash, money transfer for care services. The current landscape records different mix of financing and the increasing of complexity and complementarity of financial flows:

- combined public and family funds;
- 'Informal' care: family bears the cost of caring but can be supported by various forms of monetary/non monetary benefits

In recent years the common trends of transition from residential to home care and from in kind services to cash for care, have had the following consequence.

1. Blurring of the boundaries between formal and informal care (different mix of state, family and market)
2. increasing care burden on family members
3. Need to support families (reconciliation between work and care)

In particular trend towards cash allowances (away from in kind provision) changes the pattern of employment, as well as its level. Economic benefits can be used in three different ways:

1. to compensate a family member, who would have cared for an elderly relative (thus reducing the amount of "unpaid" labour within the family);
2. to hire a private care-giver, in this case the dependent person and/or the family member turns from being an end user to becoming an employer;
3. to buy care services from the market

The three cases differ in terms of the creation of a market for care. The first case reinforces the model of care based on the family, while blurring the identity: family care work = unpaid work (but poorly paid). The other two cases may have different effects upon the "quality" of the labour market, depending upon whether the monetary trans-



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fer is tied or untied (that is whether the monetary transfers are given on certain conditions or unconditionally)

The labour market of care-giving is characterized by the following main features:

- **Mostly female job;**
- **Low pay, poor working conditions** (compared to the average in the economy)
- **Skills** Degree of qualification varies greatly across countries and among tasks
- **Precariousness** Atypical contracts are common, but high turnover and vacancies seem to be more related with poor job quality
- **Segmentation** wide disparity in working conditions between private contractors (or non-profit organisations) and public employment and for workers in home care compared to residential care.
- **Shortage of supply of both skilled and less qualified workers** (with the possible exception of Germany).
- **Large informal/irregular market employing immigrants** (very low paid)

In conclusion, the lead expert gave an overview on the quality of care work, comparing UK and Sweden. The different characteristics of the employment models have resulted in a widely different shortage of care workers and a consequently different resort to immigrant occupation. Sweden's supply of care workers is mainly from native workers. While demand for foreign-born workers may increase, Sweden is determined to avoid having a low-skilled, low-paid market for irregular eldercare workers.

The UK is experiencing severe problems of across-the-board labour shortages: low wages and other poor employment conditions largely explain the difficulty faced in workforce recruitment and retention.

4. A look at social care services of the network – Case studies



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The second part of the morning was dedicated to the visit of *the Senior Citizens Home Tezno* and to the presentation of the case studies about the following subthemes: *Home care, Employment & Enterprise in the care sector* and *Active Age*.

- *Subtheme Home care*

Mrs. Jasna Cajnko, director of the Home, welcomed participants and introduced Mrs. Franja Jacob, social service manager, who explained the first two case studies concerning the city of Maribor.

1. *Elderly care in the Republic of Slovenia*

The first presentation analyzed the *elderly care in the Republic of Slovenia*, and in particular some home-based care services for the elderlies.

By law, in Slovenia, institutional care includes all forms of assistance within an institution, other than family or any other form of organized living, whereby the primary aim is to replace the role of family or home, and ensure organized meals, personal care and medical assistance form participants. At the beginning of 2009 in Slovenia there were 56 public and 28 private institutions engaged in elderly care.

The costs of care services are covered by the residents themselves, their relatives, and municipalities. Prices of care services are determined by responsible authorities within management boards, according to an existing methodology and upon the approval of the Ministry of Labour, Family and Social Affairs.

1. **Basic services** provided by residential structures for the elderlies are:

- Accommodation in private or shared rooms;
- Cleaning and laundry services;
- Organized meals, suited to medical conditions of residents;



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- Personal assistance, social care and welfare.

2. **Additional activities** may include:

Supplementary activities or care services for residents, which are not listed as standard within the particular care level are the following:

- Daily care and assistance for seniors living at home, which includes specific care and services;
- Care and medical services for residents living in flats or apartments provided with assisted living;
- Appropriate meals and medical care as well as other forms of assistance for individuals or families living at home;
- Social services at home, for seniors and others who need such services;
- Cooperation with other organizations, communities and individuals, aimed at providing leisure activities for seniors outside their home.

Prices for additional services are determined by the management bodies of the Homes. The law does not forbid the execution of market activities, however, the profits made have to be invested in improvements, in order to ensure better conditions for the implementation of primary activities of the Home

2. *Senior Citizens Home Tezno*

The second case study concerned the experience of *Senior Citizens Home Tezno*. The retirement home in Tezno is a public social welfare institution providing institutional social care. It includes basic personal care, accommodation and organized meals, as well as social and medical care according to the existing healthcare legislation. The Home started in February 2004 and it currently accommodates 200 residents in 99 rooms. There are 32 private rooms, 50 double rooms and 17 shared rooms. Residents with disabilities have available rooms specifically equipped and are assisted by professional operators that follow them throughout the day. Residents can spend their time socializing, reading, playing cards, board games or watching TV. The primary goal of socializing is creating new friendships in order to be able to live a full life in a new environment. Residents can share moments together during

15



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community events, in groups of interest, self – help groups and other initiatives like excursions, picnics, workshops, cooking, cinema performances, lectures, and birthday parties. In the Home, books, library and internet access are also available. Individual work is an important activity as well as intergenerational socialization between residents and young people. For example children organized sports events for residence people of Tezno.

Mrs. Jacob explained also that the staff employed in the structure consists of 86 employees shifting 24 hours out of 24 a day. Organization of work in the Home provides for professional activities to be carried out under supervision of trained professionals and in cooperation with other bodies of the Home, thus following the principle of uniformity and individual treatment of residents.

After the presentation of Mrs. Jacob, the delegate of the Slovenian Ministry of Labour, Managing Authorities for the city of Maribor, drove the discussion on three key points about care and health services:

1. collaboration between national and local political level on the care issues: the role of local community and the increase of cooperation at all the level
2. European indication about the development of home care services
3. Promotion of intergenerational solidarity

3. “Help to person”: a soft home-care service to support elderly people in their daily life”– A case study in Rome by Caritas

Fiorenza Deriu, thematic expert of the Active Age project, explained a soft home-care service to support elderly people in their daily life. The experience was promoted and developed at municipal level by Caritas to meet elderly people aid needs in managing activities of their daily life. The project was self funded with the support of Cacciò Foundation.

The “Help to person” service is aimed at facing the following critical points of the local welfare in elderly assistance:

- ✓ Long waiting lists for in-home assistance



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- ✓ Lack of residential long-term care structures
- ✓ Lack of semi-residential care structures
- ✓ Lack of day-care centre for elderly people

The main aim is to provide families with an effective support to the daily burden due to elderly people non-medical care needs. The key issues to be addressed are presented in the following points:

- ✓ Need of support in daily non-medical needs
- ✓ Widespread of loneliness among elderly people
- ✓ Weakening of formal and informal relationships network
- ✓ Excessive care burden on family members
- ✓ Reduction of self-sufficiency in old age

The project proposed the implementation of the connection with a public network “The house of voluntary workers” that represents the main reference point for elderly people living in Rome (67% of users) and the connection with a local network of social actors engaged in supporting elderly people and their families (13% of users). Among the activities conducted there are also the offer of company and spiritual assistance, the training of volunteers on helping elderly people to face at their daily commitments and the assistance in carrying out little commitments, bureaucratic matters, accompaniment.

The service realized in two Municipal districts (I and X district in Rome), has registered 90 users in 2008, 100/110 users in 2009 and about 7000/8000 interventions in a year. The most important lessons learned are the follows:

1. To improve and enhance this kind of services that have a significant impact on family home-care burden
2. To sustain an effective integration at local level among the different social actors engaged in helping elderly people in non-medical assistance – creation of local network
3. To share resources and information is a crucial point in managing this kind of services



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4. To promote a public participation in funding these activities, at the moment completely realized on a voluntary base

4. *Health @ Home (H@H) – a case study in Sevilla*

Currently, the health systems of most of the European countries are facing significant transformations. The demand of home-care based services is increasing due to these main reasons:

- a. increase in the number of elderly people;
- b. high costs of hospitalization;
- c. Reduction of the average stay in care centres;
- d. High risk of infections and syndromes
- e. High possibility of physical and mental improvement
- f. General tendency to hospitalize patients in the acute stage of disease or chronic diseases with subsequent “closure” for long stays ¹

In this respect Francisco Pascual from Sevilla described the case of the Ambient Assisted Living (AAL), a joint research and development funding programme implemented by 20 European Member States and 3 Associated States (<http://www.aal-europe.eu/>).

The H@H (Health at Home) project aims at solving social problems related to the provision of healthcare services for elderly citizens with cardiac chronic pathologies. The main aim is to improve the quality of life of elderly citizens, especially with cardiac problems and, as a final result, to propose a new integrative European model for the management of information.

The goal of Project H@H is to design, realize and demonstrate a complete and *integrated model of home care of the chronic patient*. By reaching this important scientific goal, H@H will be able to make a positive contribution to the progress of knowledge in the field. Especially, concerning clinical knowledge, technological

¹ Linda Marks of Durham University (UK)



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knowledge, new approaches to chronic patient problems and the adoption of international healthcare standards.

After the presentation of Maribor, Rome and Sevilla case studies, the Lead expert Annamaria Simonazzi introduced the second subtheme on *Employment & Enterprise in the care sector* as well as the case studies of the city of Dobrich and Prague.

- *Subtheme Employment & Enterprise in the care sector*

5. Societa – social service in Prague

SOCIETA is a public service company that provides services for disabled and elderly people. The principles inspiring the project are the mutual assistance, the employment of disabled people and the improvement of social services. The societa majority of employees are disabled people who provides the following services:

1. *transport of disabled and elderly people* – people with different degrees of disability are employed in a service of transport in Prague and its surroundings to centres of daily care, care homes, rehabilitation centres, doctors, offices. The service offers also individual and private transport to cultural, sport and social events.
2. *dispatching* – the dispatchers receive calls, handle orders and cooperate with the drivers and transport. The service involves operators with severe disabilities and it is guaranteed continuously 24 hours a day.
3. *social therapy workshop and care services* – Societa offers assistance for people who need these services because of their disability, age or illness.

6. For a dignified life –Dobrich



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The main problem on the issue of health and care in the city of Dobrich is the increase of people with disabilities; most of them are unable to leave their homes, to obtain food, to communicate with the institutions and so deprived of the opportunity to participate in the social life.

“Human Resources Development” 2007-2013 Operational Programme provides an opportunity to apply for “Care in Family Environment For Independent And Decent Living Of People With Different Types Of Disabilities And People Living Alone – Activities “Social Assistant” And “Domestic Assistant“ procedure.

The aim is to improve the quality of life of people who need permanent assistance in their daily activities as well as to improve the quality of life of their families.

Objectives to be achieved are:

1. To improve the quality of life of people with disabilities and people living alone, creating conditions for an effective exercise of their right to an independent life and to social inclusion;
2. To improve services "Social Assistant" and "Domestic Assistant" for persons in need of permanent care in their daily lives;
3. To create new jobs in the social service sector for professionals seeking extra work.

To achieve these objectives social assistants, domestic assistants, a trainer consultant were involved and in 12 months the following activities were carried out:

- ✓ Needs assessment of all potential service users - equal access rights;
- ✓ Selection of service users for Social assistant and Domestic assistant;
- ✓ Selection of the Social assistants and Domestic assistants among the unemployed and persons wishing to supplement income;
- ✓ Induction training;
- ✓ Qualification training.

The project has achieved the following results:



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1. Improved quality of life by providing support to 62 persons including 52 over 65 years with different stages of disability and living alone
2. Provided work to 12 social assistants and 11 Domestic Assistants including:
 - 11 unemployed persons under 56 years
 - 10 persons from 57 to 64 years as extra work
 - 2 persons over 65 year
 - 23 trained persons to provide services as "Social Assistant" and " Domestic Assistant ", 10 of them with professional qualifications - Social Assistant.

These case studies relate point out two topics: the action of support to the elderly alcoholics that the City of Edinburgh will activated through the development of the LAP and the care house model promoted by the municipality of Wolverhampton as a direct alternative to residential care.

- *Active Ageing Subtheme*

7. Support to elderly people abusing alcohol consumption – Edinburgh

The over 65 Scottish population is expected to increase considerably in the next 25-30 years - by 2027 the over 50s will make up roughly 55% of the adult population and by 2031 the number of people aged 75+ will increase by 75%. Additionally, drinking surveys have shown that the levels of alcohol consumption among elderly people have been rising steadily over the past 20 years.

From the above mentioned background the Municipality of Edinburgh intends to achieve the following objectives through the organization of research, promotion, dis-



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semination events as well as the development of materials and locations to get the information disseminated:

1. Involving people in issues on alcohol consumption
2. Defining how and why alcohol is a critical issue
3. Developing awareness on the risks alcohol-related, raising campaigns
4. Reducing alcohol consumption and dependency

The most important objectives of the research will be:

- a. Examine the alcohol related experiences of older people;
- b. Gather qualitative information from women aged 55+ to gain a better understanding about their relationship with alcohol, including knowledge around individual awareness as well as general attitudes and beliefs;
- c. Gather quantitative information from people (men and women) aged 55+ to gain a better understanding of their relationship with alcohol;
- d. Explore knowledge of the impact alcohol may have on health care effectiveness;
- e. Develop and pilot a training package for Carer Support Workers of older people who may have issues with alcohol.

8. The Extra Care Housing Model – Wolverhampton

Extra Care Housing was developed with the aim of providing a direct alternative to residential care, which incorporated all the advantages of both residential care and living in ones own home – but with none of the disadvantages of either.

Older people in fact prefer to remain in their own home with domiciliary care and adaptations instead of residential care, accepted very reluctantly as last option.



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The physical environment of extra care housing consists of 40-50 flats of at least a minimum of 42sq.m.with own living room, 1/2 bedrooms, bathroom & kitchen, wide internal 'streets', lounge, activities room, computer room/library, gym, hairdresser, gardens and greenhouse. Extra care housing consists of 40% public space and 60% private space. Care and support are available 24 hours a day and offer a varied flexibly according to changing needs of the elderly people and security of tenure – not linked to care agreement.

Wolverhampton has 9 Extra Care Housing schemes: the first one opened in 1994 and the last one in November 2009, for a total of 431 accommodation units (413 flats 18 bungalows).

In recent years many people have expressed their satisfaction with this solution offered: *“ I am able to retain my independence, but help is on hand if I require it. I have made a lot new friends, but my old friends and neighbours still visit me” ; “I can now administer my own medication, control my own finances and can choose what to eat... enhanced my life enormously”*.

At the end of case studies presentations, partners have been invited to give a feed back of the lessons learning in the day. All partners have recognized the usefulness of the exchange of different experiences on the same theme. All the participant showed interest in the presentation of the transportation service for elderly people achieved in Prague. Partners of Maribor shared that charity organizations are not so developed like in other countries: *“Slovenian people thought that care services is a right and the government have to pay”*. Partners agree on three lines of actions for the development of local action plans:

1. Promote a clear strategy at national and local level;
2. Develop information point on care services;
3. Promote co-housing as a form of cohabitation and assistance of elderly people which incorporated all the advantages of both residential care and their own home.

Active Age – Report by of Paul Kingston



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The second day of work ended with the contribution of Paul Kingston Professor of Health and Social Care and Director of the Centre for Ageing and Mental Health of the University of Staffordshire – Wolverhampton.

Paul Kingston illustrated the framework of Active Ageing in Europe and focused participant's attention on seven key principles that should not be forgotten in dealing with this topic:

1. activity should consist of all meaningful pursuits that contribute to the well being of the individual concerned;
2. activity should be a primarily preventative process;
3. active ageing should encompass all older people, even those who are to some extent frail and dependent;
4. the maintenance of intergenerational solidarity should be an important feature of active ageing;
5. the concept should embody both rights and obligations, therefore rights should be accompanied by taking advantage of education, training and remaining active etc;
6. active ageing should be participative and empowering;
7. active ageing has to respect national and cultural diversity.

In this regard Paul Kingston recalled the thought of Walker who argues that the popular discourse of 'disengagement theory' articulated in North America led to the social movement of active ageing focusing on a productivist model outlined firstly by emphasising employment, and latterly pensions².

Walker argues that more recently we have recognised a wider agenda in which active ageing “... constitutes in itself a comprehensive and sustainable approach which must employ a range of tools beyond retirement reforms” (European Commission,2006). Walker further argues that active ageing should be “... a comprehensive strategy to maximise participation and well being as people age.”

² Walker, A. (2009) Commentary: The emergence and application of active ageing in Europe. *Journal of Aging & social Policy*, 21(1):75-93



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Therefore, active aging project must operate taking into account simultaneously different kind of dimension: individual (lifestyle), organisational (management), and social policy (policy).

5. Workshop Using C-Maps Tool

During the last working session of the TEW Fiorenza Deriu, thematic expert of the network, presented the software C-map. The aim of the workshop was to propose a theoretical and practical framework for the development of Active AGE LAP.

At first Fiorenza Deriu gave partners an introductory presentation about concept maps and the opportunity to use them to facilitate planning through the activation of metacognitive processes. Then the thematic expert explained how can use "Cmap" tool to create concept maps starting from the reproduction of the C-Map diagram of a problem tree on the second subtheme *Employment and Enterprise in the care sector*.

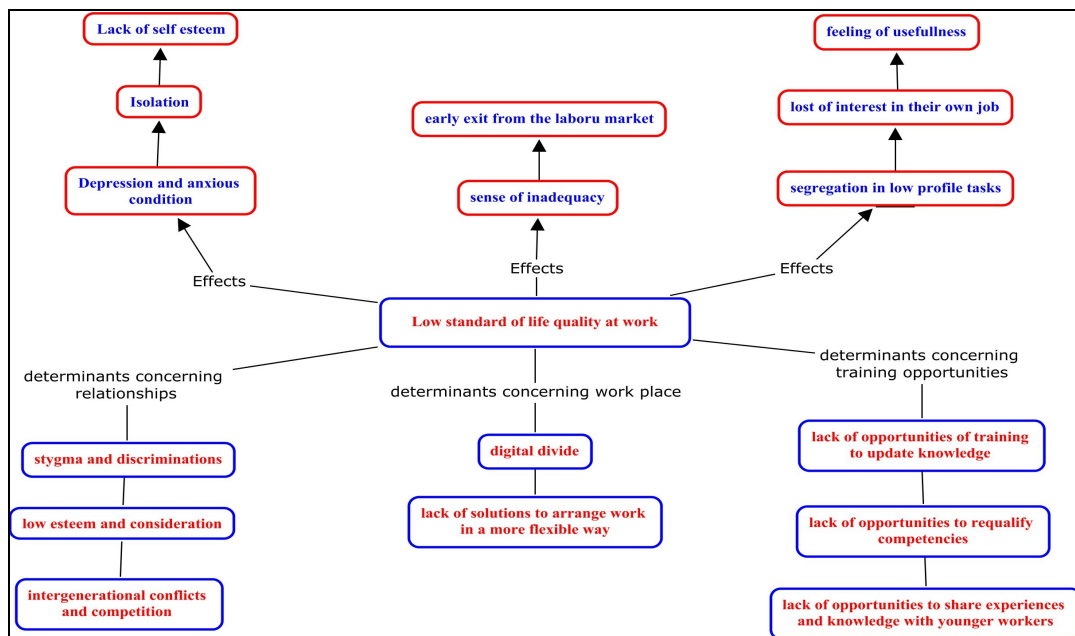


Figure 1 - problem tree on the subtheme Employment and Enterprise in the care sector



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The workshop then continued with the creation of three discussion groups about age and care subthemes and with the representation in a plenary discussion of the C-map problems tree of each partners.

The conceptual maps produced and attached below will be a starting point for development Age and Care Local Action Plan:

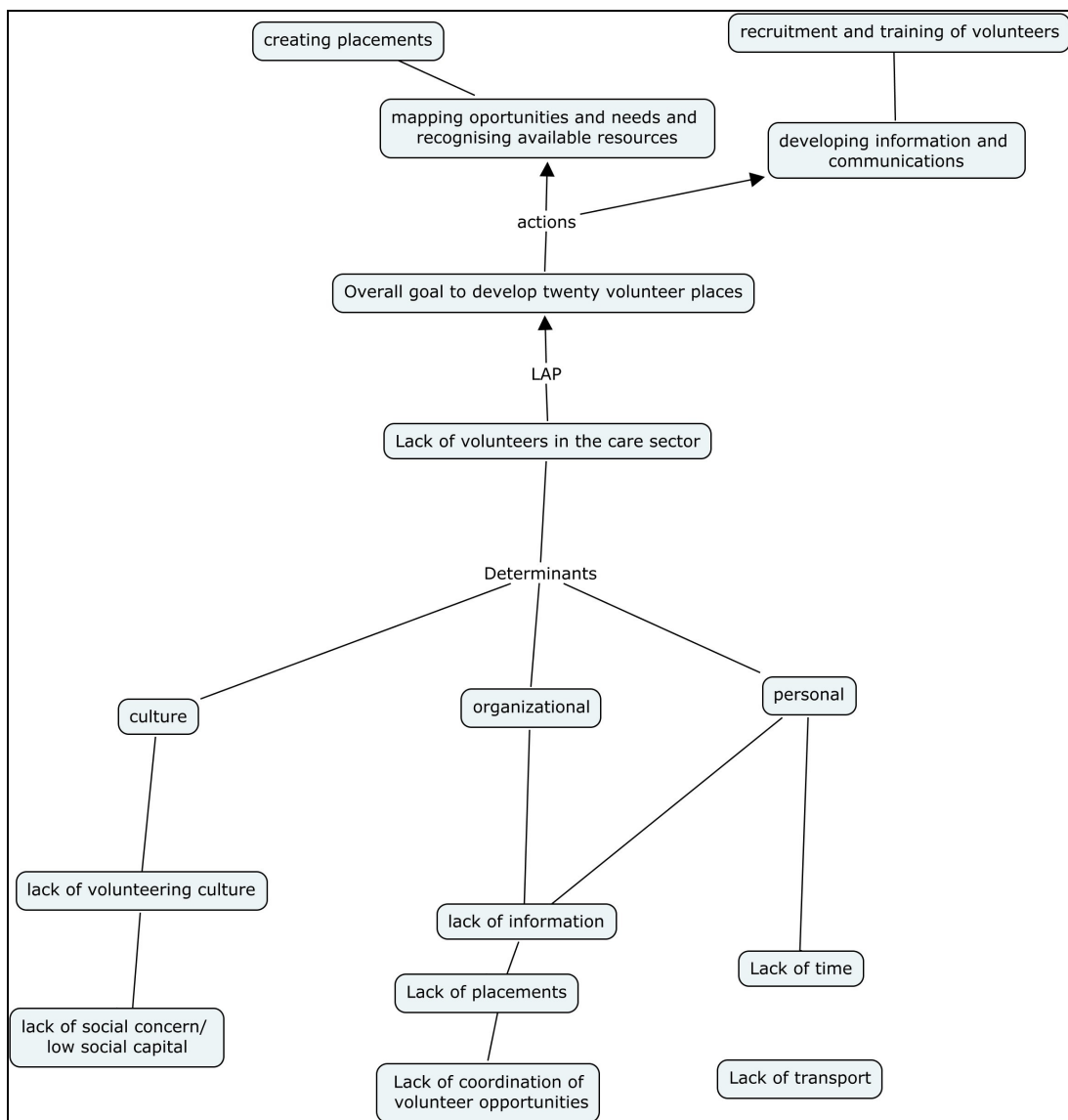


Figure 2 – Starogard Age and Care problem tree



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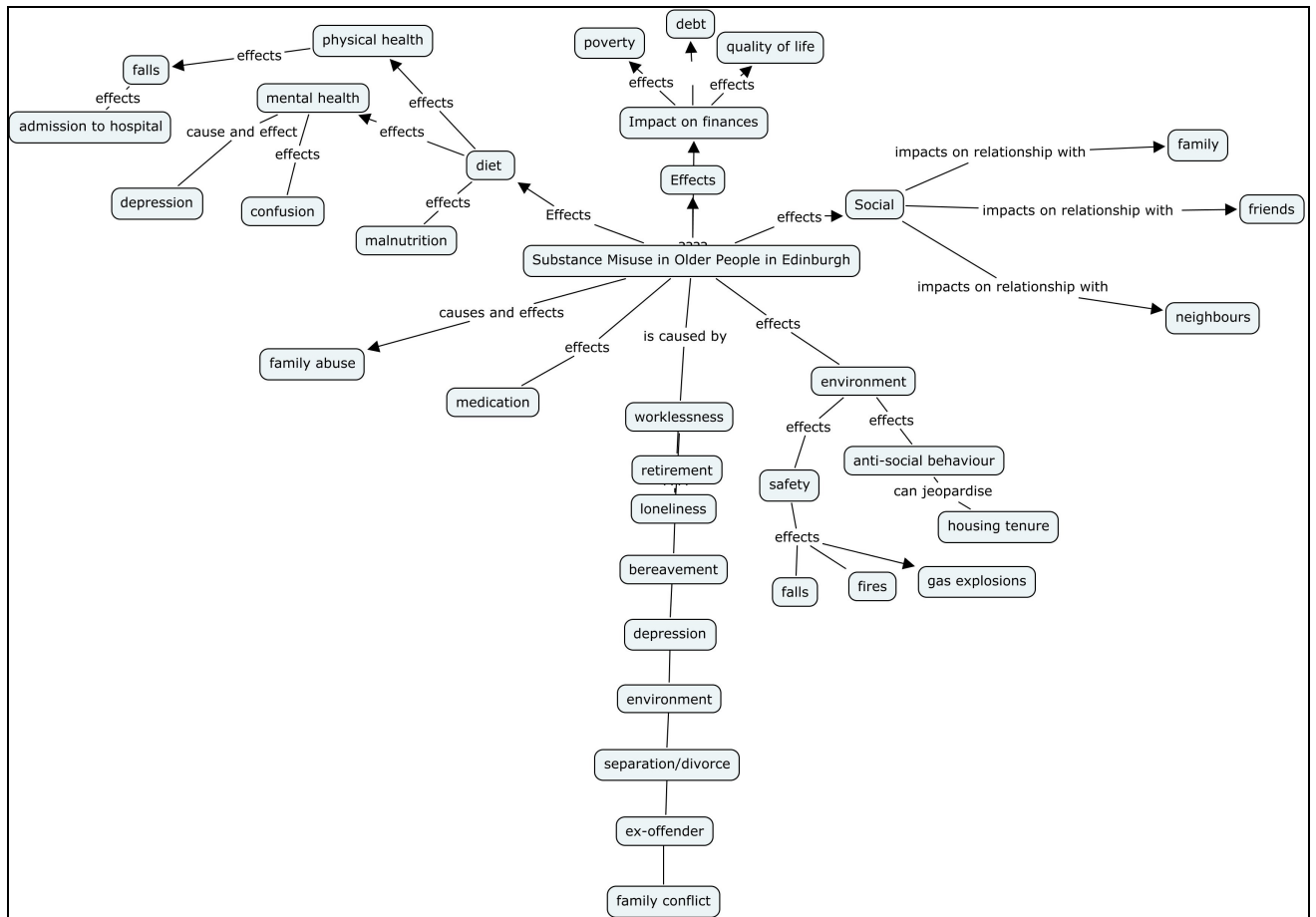


Figure 3 –Edinburgh Age and Care problem tree





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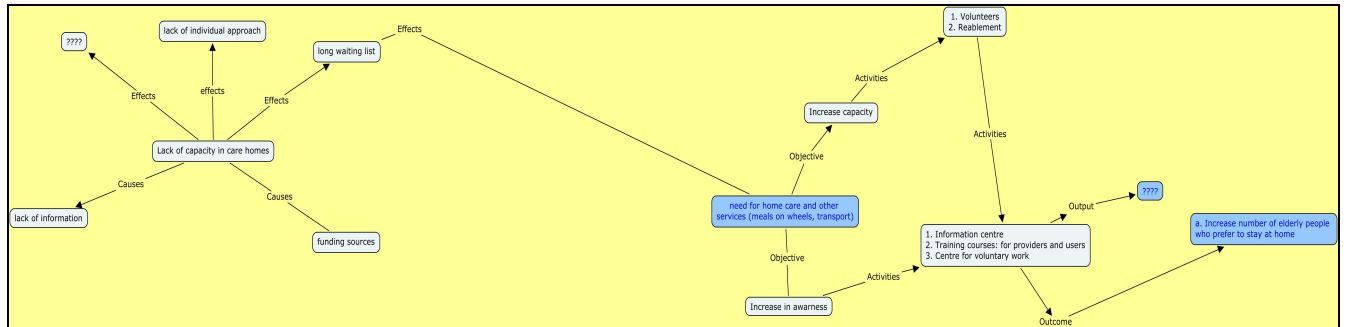


Figure 4 – Prague Age and Care problem tree



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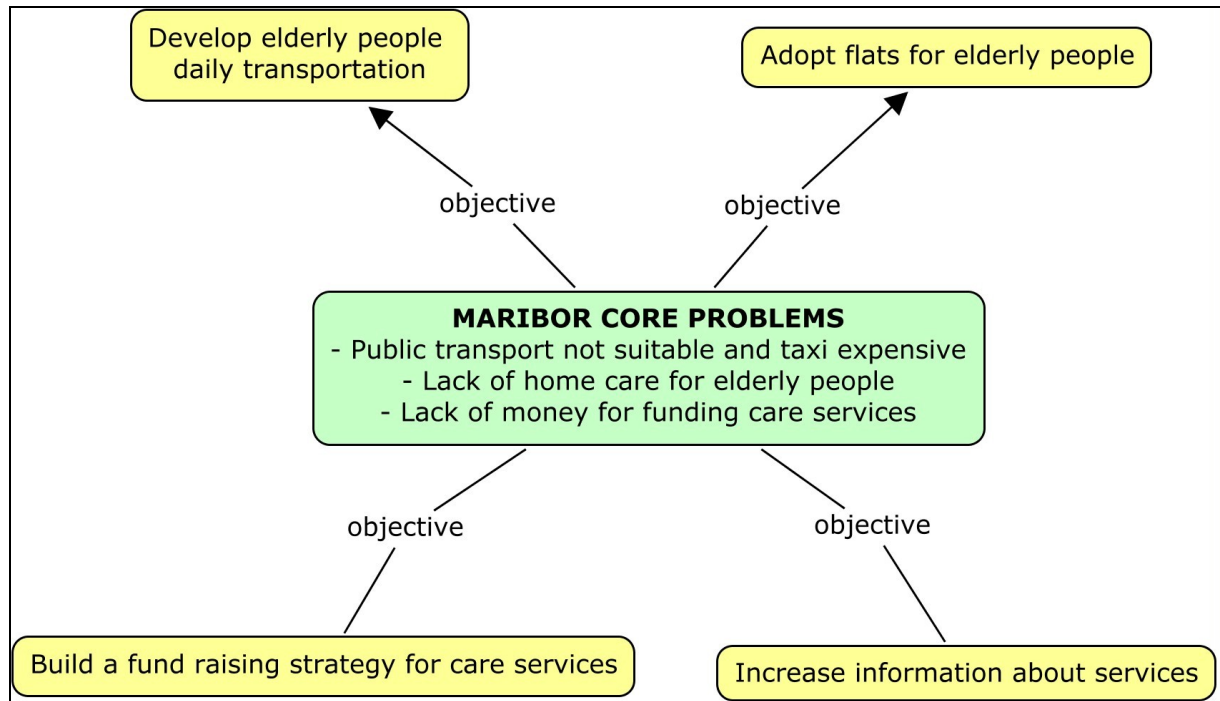


Figure 5 – Maribor Age and Care problem tree



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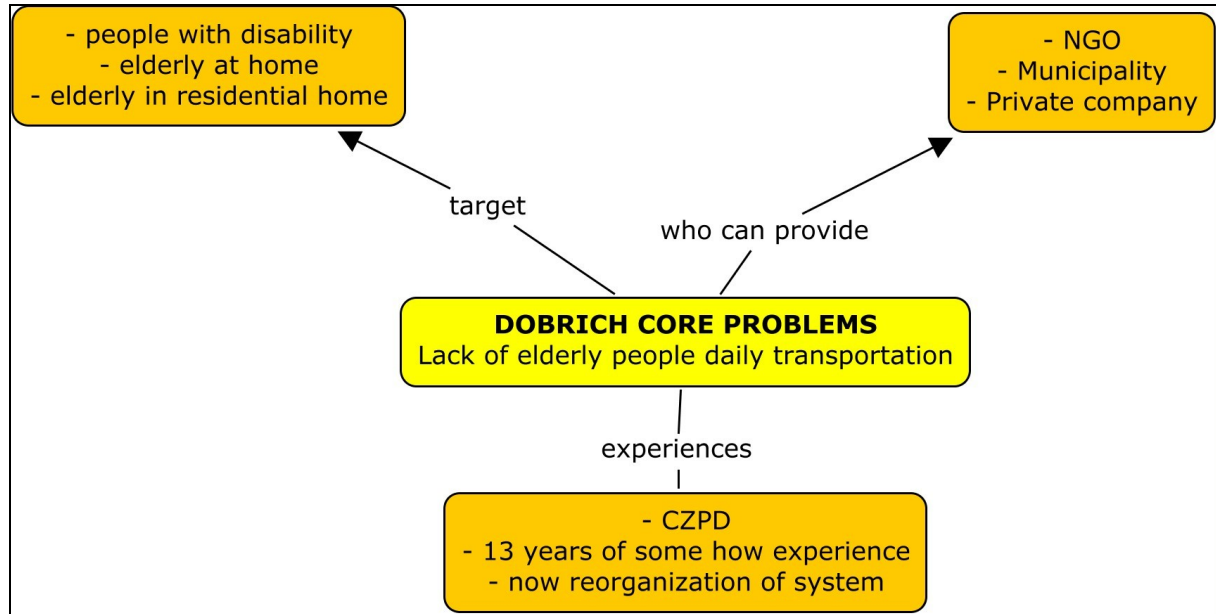


Figure 6 – Dobrich Age and Care problem tree

At the conclusion of the TEW Haroon Saad announced the partners that the next steps of the project will be the implementation of the local action plan on age and care subthemes and the active involvement of primary stakeholders and the local discussion and dissemination. The next baselines of the project are:

- First draft of the LAP template “Age and care” to be submitted to the Lead Partner - within September 1st 2010)
- LAP - “Age and Care” final version - within October 30th 2010
- Identification of the new ALS members - September 1st 2010
- Registration form III TEW and abstract case studies to be submitted to Lead Partner - within September 15th 2010
- III TEW In Starogard “Age and Insecurity” (13 -15 October 2010)



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APPENDIX

QUESTIONNAIRE - “Overview of the local strategies for long term care”

Grid 1. Types of provisions and their usage according to stage of disability.

Type of provision	Brief description	Prevalent use at different stages of disability: mild (1), moderate (2), severe (3)
Time related provisions , including 4. Targeted leaves 5. General leave schemes 6. Flexible time arrangements Other		e.g. flexible time arrangements may be used when disability is low or moderate (stages 1 and 2)
Cash transfers , including 11. Disability allowances/pensions 12. Care allowances (e.g. an allowance to compensation for the family carer) 13. Vouchers 14. qualification for social contributions Other		e.g. disability allowances may be granted to severely disabled people only (stage 3)
Services , including		



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<p>Home care</p> <ol style="list-style-type: none"> 1. Basic home care (cooking, meals on wheels, cleaning, bathing, minding, remote assistance) 2. Home nursing 3. Paramedical and medical care (chiropodist, physiotherapist, mental therapist etc.) 4. Respite care <p>Other</p> <p>Semi-residential care</p> <ol style="list-style-type: none"> 2. Outpatient clinics 3. Day-centres 4. Community social services <p>Other</p> <p>Residential care</p> <ol style="list-style-type: none"> 1. Nursing home 2. Sheltered homes or flats/residential houses <p>Other</p>		<p>e.g. a combination of basic home care, home nursing and respite or semi-residential care may be the prevalent arrangement for moderately disabled elderly (stage 2)</p>
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The level of disability is typically assessed by means of a disability scale (see McDowell 2006 for a review). A simpler and more qualitative classification suffices for the purposes of filling the grid here. Consider three main ability areas: the ability to take care of one's own person (self-care: eating, bathing, toileting, telephoning etc.); mobility; mental competence. Furthermore, classify levels of disability in each area as mild (1), moderate (2), and severe (3). An overall assessment of mild disability may be thought of as entailing partial disability in at least one but no more than two of these areas. An overall moderate level of disability may be thought of as resulting from partial disabilities in all the three areas, while severe disability arises when at least one of these areas is severely impaired and a second area is at least partially impaired.

An example of mild disability is that of a person who needs at least some assistance in order to take a bath and/or needs a walking aid. Moderate disability arises when this same person begins to frequently experience lapses of memory which may further compromise her/his ability in the other areas. Finally, severe stages of disability may involve dementia (a serious impairment of mental competence) whereby the elderly person is incapable of taking care of herself/himself even if her/his mobility is unaffected; alternatively, very poor mobility (e.g. confinement to bed) also implies inability to take care of self, even if mental competence is unaffected.



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Grid 2. Source of care for the elderly

Source of care services	Home care (% share)	Institutional care (% share)
Family and/or friends		(not applicable)
Not-for-profit organizations		
Public authorities		
Private carers / for profit firms		

Note: This grid asks about actual providers of care, i.e. those who deliver the care; if the percentage share is not available, please, give rough estimates or simply describe the prevalent combination.

Grid 3. Coverage rates* (breakdown by gender if possible)

Age group	Home care	Semi-residential care	Residential care
65+			
75+			

Note: *% share of elderly cared for in the age group.

Grid 4. User fee for different services (moderate level of disability)

Type of services	User fee, Euro (specify also year if not the current figure)
Publicly subsidized nursing home or equivalent residential care (specify)	Average user fee per month
Day care	Average user fee per day
Home care package if publicly provided (about 3 hours daily)	Average user fee per month

Note: *If average is not available, please give the range.

Grid 5. Pay for care workers, by skill level (please, breakdown by gender if available)

Type of care worker*	Average salary per hour or month, Euro (specify hourly/monthly, and consider full-timers for monthly data; please, also specify year)	
	Home care	Nursing home care
Basic care worker (no or little formal qualifications required)		
Nurse		

Note: * Please, specify the type of employer (public, private firm, family).



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