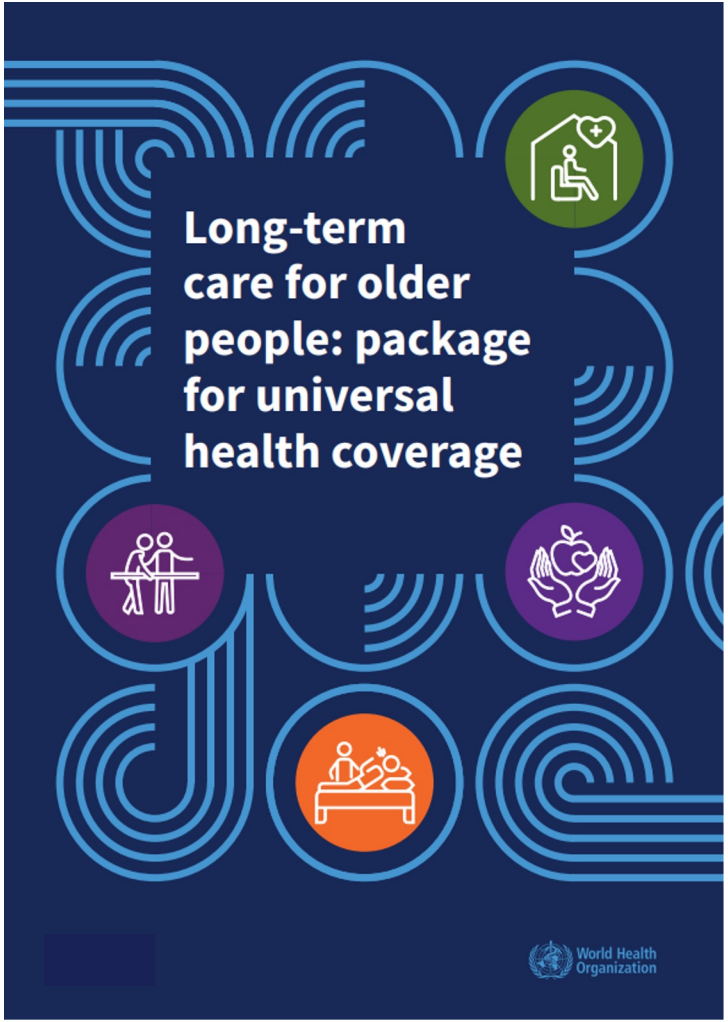


Long-term care for Older People: Package for Universal Health Coverage

Dr Samar ElFeky

Regional Adviser for Health Promotion & Social Determinants of Health
Regional Focal Person for Health for Older People
World Health Organization
Eastern Mediterranean Regional Office

World Health Organization

What is long-term care?

- Long-term care includes a broad range of personal, social, and medical services and support that ensure people with, or at risk of, a significant loss of intrinsic capacity (due to mental or physical illness and disability) can maintain a level of functional ability consistent with their basic rights and human dignity.

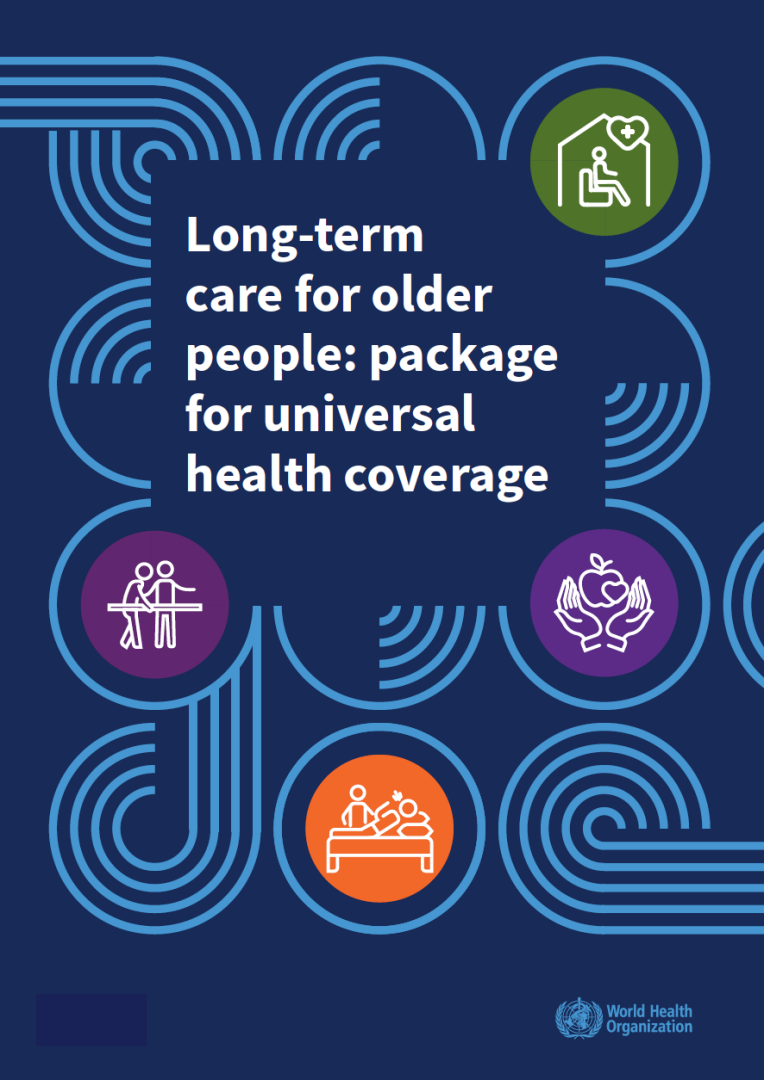
- Long-term care is provided over extended periods of time by family members, friends or other community members (also called informal caregivers) or by care professionals (also called formal caregivers).

- Formal long-term care aims to prevent, reduce, or rehabilitate functional decline and it can be provided in different settings, such as home care, community-based care, residential care, or hospital care.

Long-term care for older people: Package for universal health coverage

The Package

- Provides a list of long-term care interventions for countries to consider, prioritize and provide and could integrate within health and social care sectors, depending on their context
- For governments and policy-makers responsible for planning and implementing long-term care service provision at national or subnational level
- Addresses the vital role of unpaid carers as both care providers and receivers

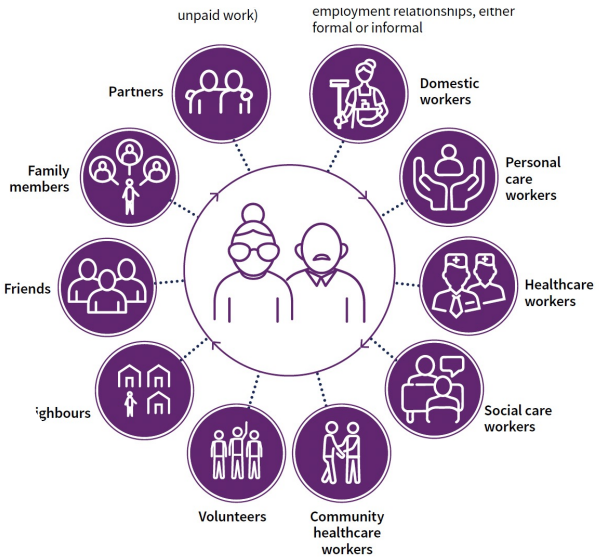


Goals of the Package

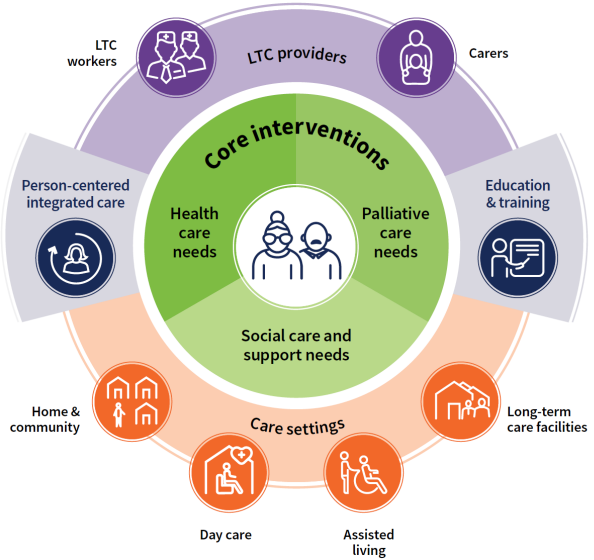
Support countries in designing, establishing and expanding LTC systems and services towards UHC by providing recommended interventions and facilitating factors

Content

- Interventions to address needs of
  - Older people
  - Their carers
- Provided by different actors depending on the context (network)



- Various care settings
- Across the care continuum
- Facilitated by:
  - Person-centered, integrated care approach
  - Education and training



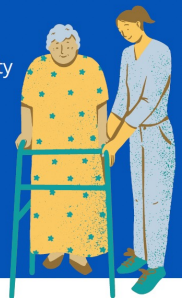
Three groups of Interventions

Health Care Needs

To screen, assess, and manage priority health conditions associated with decreased physical and mental capacity and functional ability so that older people can maintain their autonomy and independence as much as possible

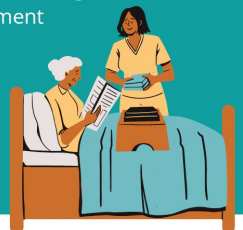
Interventions

Cognitive decline
Limited mobility
Falls
Physical inactivity and sedentary behavior
Malnutrition
Unhealthy diets and substance abuse
Eye conditions and visual impairment
Ear diseases and hearing impairment
Depressive symptoms and anxiety
Polypharmacy
Pain
Urinary and faecal incontinence
Skin pressure injury
Infections
Oral diseases



Palliative care needs

To improve the quality of life and of death for older people with a serious illness or who are reaching the end of their lives, by preventing or relieving physical, psychological, social and spiritual suffering for themselves and their families, including regular assessment and management



Interventions

Physical
Psychological, social, and spiritual

Social care and support needs

To mitigate limitations and optimize functioning by providing help and support for older people in several dimensions, and to support carers' needs so they can sustain a satisfactory, healthy, caring relationship and reduce strain and isolation

Interventions

Older People
Support and assistance with activities of daily living
Participation in community and social life
Accessibility and transportation
Provision of assistive products

Carers
Psychosocial support
Respite care

Need	Assessment	Management
Polypharmacy	Strategies and actions to ensure that older people are routinely screened for use of unnecessary, ineffective or duplicated medications for their comorbid conditions by obtaining a complete medication history and determining whether any of the medications affects capacity (e.g. limits mobility or interferes with balance or causes cognitive disorders such as delirium)	Interventions for the management of polypharmacy can include providing advice and guidance on managing non-adherence and negative effects of medications (e.g. education of older people and carers about each medication, signs of adverse drug reactions, side-effects, drug interactions), creating a pill card, reviewing medications and withdrawing them as appropriate.
Pain	Strategies and actions to assess the characteristics and impact of pain and associated factors (e.g. physical, psychological, nutrition, sleep) with standard instruments (e.g. pain scales, questionnaires)	Interventions for management of pain can include provision of pharmacological and non-pharmacological interventions such as pain-relieving positioning, physical exercise, use of orthoses, relaxation training, massage and use of thermal and electronic pain relief equipment.
Urinary and faecal incontinence	Strategies and actions to identify defaecation and urination problems and functions (e.g. constipation, faecal impaction, overflow diarrhoea, recurrent urinary infections), including urinary and faecal incontinence	Interventions for the management of urinary and faecal problems and incontinence can include use of laxatives, nutrition management, bowel and bladder management training (e.g. pelvic floor training, timed voiding), provision and training in use incontinence products (e.g. pads and diapers).
Skin pressure injury	Strategies and actions to ensure that older people receive proper screening for early stages of pressure injury, comprising identification of risk factors, routine initial screening on a validated risk assessment scale and ongoing monitoring and documentation of healing	Interventions for the management of pressure injury can include preventive and therapeutic strategies (e.g. pressure relief cushions and mattresses, positioning for pressure relief and routines to promote skin hydration, dressings, creams, ointments), functional positioning, provision of home wound care and referral to specialist assessment
Infections	Interventions to strengthen prevention of lower respiratory, enteric and urinary tract infections, including taking a history, conducting physical examinations, tests (e.g. pulse oximetry, X-ray, computed tomography) and clinical assessment for early recognition of need for referral	Interventions to prevent and manage infections can include counselling, measures (e.g. washing, sanitation, and hygiene, nutritional counselling), education for home monitoring of danger signs and use of a pulse oximeter, counselling on increasing fluid intake, acute care referral) and vaccination against vaccine-preventable diseases according to individual characteristics (e.g. COVID-19, seasonal Influenza).
Oral diseases	Actions to ensure routine screening and assessment of oral health status (e.g. soft tissue and intraoral examination) for further action, such as referral to oral health professionals if necessary	Interventions to promote oral health and to prevent and manage oral diseases can include counselling on daily oral hygiene, including brushing with fluoride toothpaste, exposure to fluoride such as application of fluoride varnish on tooth surfaces, pit and fissure sealants, provision of services for the management of dental caries (e.g. stopping caries and simple restorations, depending on the training of the health-care worker) and referral to a higher level of care if necessary

Key points

- These interventions include promotion of a healthy lifestyle, prevention of declining intrinsic capacity and management of underlying problems and health conditions *(8,14)*.
- The ICOPE approach can be used for screening and assessing intrinsic capacity in five domains: cognitive, locomotor, vitality, sensorial and psychological. Instruments might be required to evaluate the needs of older people with substantial losses.
- As the domains of intrinsic capacity are interrelated, a decline in one domain may affect others. Measurement of declines in intrinsic capacity must therefore be assessed and managed in an integrated, person-centred approach. Preventive and rehabilitative interventions in one domain might impact other domains, especially in older people with many complex chronic conditions.
- Screening allows detailed assessment of the health and social care needs of older people by identifying those who are most likely to experience loss in intrinsic capacity and by determining whether such losses are already reducing their independence or preventing them from leading a meaningful life.

Actions

- Start by screening and assessing vision, hearing, cognition, locomotor capacity, psychological state and vitality in any setting to identify needs and to prepare an integrated care plan.
- Detect problems at an early stage to improve health, reduce disability and functional decline and improve social participation, as prevention mitigates losses in critical functional abilities and allows early detection of health and social issues.
- Support early detection and provision of feasible, evidence-based interventions with community engagement.
- Support older people and their families and communities in taking control of their own health and well-being, even without direct contact with health services *(37)*.
- Engage multidisciplinary teams in providing counselling and education to increase the ability of older people and their carers to manage illness and to adopt a healthy lifestyle.
- Support development of local leaders and empowerment of people and communities.
- Establish referral systems, including for rehabilitation and palliative care.
- Rehabilitation at home, in residential care homes or in adult day-care centres can be provided by a dedicated team, when available, or by community therapists and trained carers. Rehabilitation is an essential component of integrated health services. Approaches to rehabilitation differ among countries and health systems due to differences in social, economic, health and cultural systems and structures. The WHO Rehabilitation Competency Framework *(38)* includes advice on customizing rehabilitation according to the context and providing useful rehabilitation to individuals and their families. A package
rehabilitation includes infor
and the assistive products, e
required to deliver intervent
- WHO guidelines and docume
evidence-based intervention

Case study 4. Uruguay *(59)*

Uruguay has passed legislation (Law no. 19.353) establishing a national system of care, coordinated by a national secretary of care under a national steering committee on care, composed of the Ministry of Social Development, the National Administration of Public Education, the Social Security Bank, the Congress of Mayors, the Institute for Children and Adolescents of Uruguay, the ministries of Economy and Finance, Education and Culture, Health, Work and Social Security, and the Office of Planning and Budget to ensure care and a better quality of life for children, for older people with functional loss and for people with disability.

One action was creation of the occupation of "personal assistant" to serve people over 80 and under 30 years who require assistance in performing ADL, for 80 h monthly. Personal assistants help with activities such as grooming, showering, transferring, going to the toilet, shopping and recreation. Working days and activities are discussed with older people and their families. Subsidies are offered according to household income and the number of people living in the house.

Personal assistants must complete a training programme. There are currently 6500 personal assistants, who are certified by accredited 25 organizations. The service is regulated under norms and conditions to ensure the rights, obligations and responsibilities of personal assistants and older people.

- Descriptions about assessment and management
- Key points, actions and country case examples

Two Facilitating Factors

Person-centred integrated care process

To integrate services, actions, and interventions to facilitate the adoption and implementation of coordinated and integrated care.
The goal is to ensure that older people and their carers receive timely person-centered care through the coordinated integration of the full spectrum of health and social services and the collaborative actions of a multidisciplinary team

Process components:

- Older-person-centred health and social assessment
- Assessment of carers' needs
- Assessment of needs for assistive products
- Care and support plan development
- Care coordination
- Promotion of self-care

Education and Training

To build and strengthen human resources capacity by addressing the educational and training needs of carers and LTC workers to increase their knowledge, skills, and competencies to provide safe and quality interventions

For Carers
and
For LTC workers

Person-centred integrated care process
Process and components description
Country examples

Component	Description
Person-centred health and social assessment	Comprehensive assessment of an older person's health and social issues with standard processes and tools. The assessment includes health conditions and risk factors for noncommunicable diseases, intrinsic capacity and need for and availability of support in basic ADL (eating, grooming, dressing, toileting, bathing, transferring) and IADL (ability to use a phone, shopping, food preparation, housekeeping, laundry, transport, responsibility for own medications, ability to manage finances). It is crucial to involve older people and their carers in making decisions whenever possible and in establishing goals to address each person's unique needs, goals, values, priorities and preferences.
Assessment of carers' needs	A comprehensive person-centred assessment of carers' health and their needs (including for specific training) includes their perceived psychological burden and the risk of financial disadvantage. The intensity and frequency of assistive care, difficulty in performing activities (e.g. moving, lifting, managing toileting and incontinence), possible safety issues, organizational problems and carers' skills and knowledge should be established. Information on the background and context of care should also be sought (e.g. the carer's perception of the health and functional status of the care recipient, the health and well-being of the carer and involvement of support groups and the community).
Assessment of need for assistive products	Selection of the assistive products that best meet the older person's clinical and functional conditions, lifestyle and preferences and where the products will be used
Development of a care and support plan	A goal-oriented plan to address the unmet needs of older people (and eventually of their carers) should take into account their preferences, needs, values and priorities. The care and support plan should be designed for timely, appropriate intervention on priorities identified by the multidisciplinary team of health and social care workers. It should include the opportunities available in the spectrum of health and social care services. The plan should be reviewed over time, with follow-up and re-evaluation to address changes in the health and social needs of the older person and the carer.
Care coordination	Activities and strategies to connect services, providers and care to ensure that older people and their carers receive integrated, safe, timely, effective, person-centred LTC interventions along a continuum of promotion, prevention, treatment, rehabilitation and palliation, with the aim of promoting healthy ageing.
Promotion of self-care	Activities to identify opportunities to improve self-care, provide counselling on self-care and discuss and implement a care plan that involves improvement of adherence and education for self-management of chronic conditions.

Education and Training:
Carers and LTC workers
Key messages & training topics

Topic	Summary
Training in promoting physical activity and avoiding sedentary behaviour	Strengthen knowledge and skills for adoption of physical activity recommendations and for supervising exercises. Raise awareness that all older adults should undertake regular physical activity, even those with chronic health conditions and who are frail, by discussing the benefits of physical activity for health. Ensure that professionals are aware of the specific recommendations for physical activity by older people and how to prescribe and implement strategies to increase the adoption of and adherence to regular exercise and active behaviour (e.g. identify barriers and facilitators and implement behavioural techniques), ensuring safety measures.
Training in care for people living with dementia	Strengthen knowledge and skills for preventing and coping with behaviour changes and provision of everyday care. Dementia can be due to several diseases, which affect people differently depending on the severity, individual progression, general health and functioning and the environment. Care workers should recognize different stages of dementia through a comprehensive assessment and plan care according to the role of each professional (e.g. pharmacological and non-pharmacological interventions, everyday care needs, palliative care), develop skills in communication, interaction and in dealing with behavioural changes (e.g. memory loss, aggression, depression, anxiety or apathy, delusions and hallucinations, wandering). They should receive proper training in identification of reversible conditions (e.g. severe dehydration, delirium, polypharmacy) and associated conditions (e.g. delirium) and problems of memory, orientation, speech and language and difficulty in performing key roles and activities, including testing orientation, memory and language.
Training care workers in preventing malnutrition	Strengthen knowledge and skills in screening for and assessing malnutrition and dehydration, and promote better nutrition for older people, including oral care, food selection, preparation and presentation (e.g. adapt food to disease and care needs, flexible menus, modification of dining environments). Strengthen knowledge and skills in recognizing factors that lead to reduced food intake (e.g. impairment in taste and smell, satiety signals, chronic diseases and influence of medications, missing teeth, limited mobility, loneliness and bereavement) and strategies to implement nutritional interventions, including discussion of the responsibilities of various professionals in nutritional support.
Training care workers to identify and manage incontinence	Strengthen knowledge and skills to identify and manage urinary and/or faecal incontinence, offering good-quality, dignified care for older people who need assistance in toileting, who are incontinent or require bladder or bowel care. The knowledge includes age-related changes that could contribute to incontinence and factors and conditions that can cause or contribute to leakage, such as diseases (e.g. dementia, stroke, diabetes, osteoarthritis), medications, limited mobility and cognition, lack of adequate assistive products (e.g. proper pads, diapers, commodes), unsupportive environments (e.g. inaccessible toilets, lack of privacy) and lack of continence care that respects dignity (e.g. respect, autonomy, empathy, trust, communication)
Training care workers in swallowing dysfunction	Strengthen knowledge and skills to identify and manage swallowing problems (dysphagia) and prevent malnutrition, dehydration, poor oral hygiene, choking and aspiration pneumonia. The knowledge includes age-related changes that affect the anatomy and physiology of the head and neck, which increase the risks of dysphagia, and associated factors such as neurological diseases (e.g. stroke, dementia, Parkinson disease), oral feeding problems, cognitive and sensory problems and strategies to minimize aspiration risk, facilitate eating and drinking and improve nutritional status (e.g. modifications of food and fluids, including changes of texture, consistency and quantity; swallowing strategies such as manoeuvres and sensory techniques; positioning and postural techniques; external strategies such as carer support, the environment; administering food and drink; and behavioural and cognitive techniques).

Table 8. Considerations for hearing and acting on the voices of older people and carers to support meaningful engagement when implementing this package

Step	Consideration
1. Define means for listening to voices and meaningful engagement.	• Design a plan, with the participation of older people and carers at all stages, for implementing the package that includes strategies and actions for voice and meaningful engagement, including the necessary resources and capacity. The plan should include strategies and actions for working with and responding to existing groups rather than creating new groups in a top–down approach. • Engagement should not be imposed on older people by the government or service providers. • Engagement can be assured in many ways, including face-to-face meetings, roundtables, forums, peer-led consultations, surveys, focus groups, digital meetings and telephone conversations. Consider using several methods. When choosing a method, consideration should be given to: ◦ the preferences and values of the community; ◦ current engagement, including previous experience, outcomes and participant satisfaction, perhaps compiling a list of good engagement programmes and practices in the community; and ◦ anticipated constraints, such as digital access or illiteracy, geographical and language barriers, difficulty in communication due to sensory, cognitive or locomotor impairment. • Define and communicate the level of engagement expected during the consultation.
2. Explain the importance of meaningful engagement.	• Discuss the guiding questions with the team that is organizing engagement, and define the steps necessary to achieve the desired outcomes of the consultation. • Consider using a trained group facilitator or someone experienced in engagement. The questions could address, for example, opinions on the package, the extent to which it addresses their needs and aspirations and how their preferences, choices and values can be addressed when implementing the package. • Consider group dynamics and trust. The facilitator should be someone known and trusted by the community, such as an older person or carer.
3. Choose participants to ensure their representativeness and legitimacy.	• Identify any unequal power dynamics, such as whether the conditions will allow older people and carers to express their views openly, and determine whether they could undermine engagement. Rebalancing and reorientation of power dynamics is essential for meaningful engagement. • Conduct direct dialogue with older people, carers and with CSOs in the community, ensuring proper participatory spaces • Plan inclusion of older people and carers who are difficult to reach, including through nongovernmental organizations, volunteers and community workers. • Understand the constraints on the autonomy and engagement of some older people receiving LTC interventions (e.g. those who are frail, have cognitive or mobility limitations, live at home or in residential care or are isolated), who are not fully included or empowered to make decisions about their care or to advocate for others, due for example to systemic power imbalances, discriminatory staff attitudes, societal stigmatization, structural inequalities or violation of rights, and find strategies to overcome the constraints sustainably. • Ensure the participation of carers who have difficulty in participating in meetings, because they have no respite or have too many daily tasks, by dialogue with social partners. • Consider using appropriate available technology. • Recognize that care workers are crucial to legitimatize meaningful engagement, and make sure that their voices are heard.

Engaging older people and carers in the package implementation

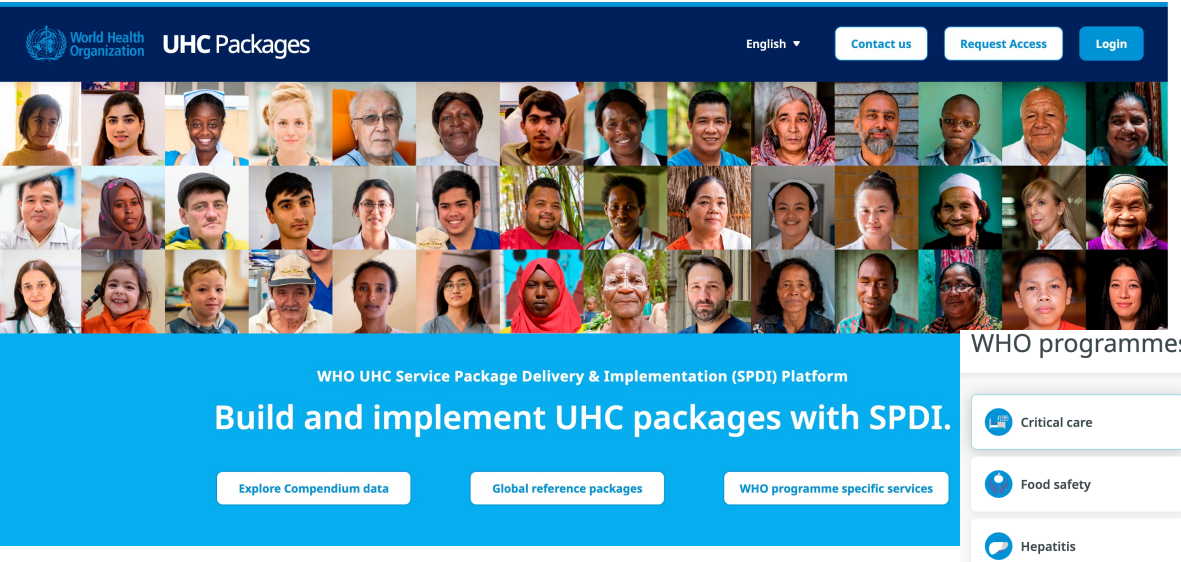
Step	Consideration
4. Organize practical arrangements.	• In shared decision-making with older people and carers, choose the venue, timing, frequency of engagements and hospitality. • Ensure the accessibility of buildings, the availability of restrooms, noise level and other considerations. Consider use of community venues, such as halls, pubs, clubs and cafes. Consider engaging older people where they receive care, such as rehabilitation facilities, recreational clubs and day-care centres. • Daytime activities may be more suitable for older people, although rush hours should be avoided so that they can use public transport. Also consider local weather conditions (e.g. heavy showers, hot days in summer, heavy snowfall). Carers might require a different approach. • Consider online consultations, but evaluate potential barriers such as digital literacy, income and functional limitations. • Consider offering refreshments or organizing sharing by participants.
5. Establish appropriate communication strategies, and measure impact.	• Seek the views of diverse people in the community with regards to culture, ethnicity, sexuality, education, interests, health, well-being, participation, lifestyle and life experience. • Avoid communication that supports stereotypes and ageist attitudes. • Consider using various media, such as local radio, ethnic radio, newspapers and other printed media, word of mouth, social media and social networking platforms. • Write a report of discussions, results and other outcomes. • Plan further consultations. • Achieve consensus on indicators and metrics to monitor meaningful engagement when implementing the package.

Steps and considerations for implementation Governance, service delivery, funding, information, monitoring and evaluation systems

Table 6. Macro (system), meso and micro (organizational and integration) levels for strengthening implementation of the package

Package element	Macro level	Meso and micro levels
Governance	• Action plan in collaboration with stakeholders such as government bodies, service providers, users, professional associations, carers' associations to identify barriers to and facilitators of implementation • Continuous communication and consensus-oriented decision-making to support the plan, with alignment of elements • Shared culture and vision among stakeholders on the principles for achieving an integrated, coordinated LTC system (see Box 1) • Regulatory frameworks to support the LTC service package with respect to accessibility, acceptability, availability and quality, assistive products, medication for pain management, transport and assistive care services	• Flexible, adaptable implementation of the package for each LTC setting (home, day-care centre, facility), aligned with the structure and culture of the local organization and clear definitions of care pathways • Solid organizational leadership for designing and supporting integration at each stage of implementation • Common goals and a shared vision of integrated care and a multidisciplinary approach in organizations • Alliances with organizations and actors in the geographical area to support interventions in the package, such as friendly environments and transport to promote mobility and links to religious organizations and carer groups to support training in the community • Concrete strategies to engage and ensure trustful bonds with the community • Shared accountability for care among local service providers

Next step (1) Integration into WHO UHC Compendium as a LTC sub-package



WHO programmes

- Critical care
- Disability
- Emergency care
- Environmental health
- Food safety
- HIV
- Health promotion
- Healthy ageing
- Hepatitis
- Immunization
- Injury prevention
- Malaria
- Maternal and newborn health
- Mental health, neurologic disorders and substance use
- Neglected tropical diseases
- Non-communicable diseases
- Nutrition
- Occupational health
- Other
- Palliative care
- Rehabilitation
- School health
- Sexual and reproductive health
- Surgery and anaesthesia care
- Tuberculosis
- Violence prevention

Next step (2) Integration into national health systems, UHC, or essential benefit package

- Interventions on healthy ageing (ICOPE) or LTC, targeting older people
- For diverse care settings including home, community, LTC facilities
  - Current UHC Compendium indicates PHC-secondary-tertiary levels
- By not only health workers, but also by care workers and unpaid carers
  - Current UHC Compendium assumes only health services provided by health workers (including community health workers)
- Cost-benefit analysis
  - When suggested to countries, governments want to be able to estimate costs and the effects when it's invested
- Social care and support in health benefit package

THANK YOU