

# Long-term care for older people

package for universal  
health coverage





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# Contents

Acknowledgements .....	v
Acronyms and abbreviations .....	vi
Glossary .....	vii
Executive summary .....	x
<b>1 Background .....</b>	<b>1</b>
1.1 Goals.....	1
1.2 Methods.....	1
1.3 Content .....	2
1.4 Use of the package .....	2
1.5 Recognition of carers and their needs.....	5
1.6 Scope .....	5
<b>2 Introduction.....</b>	<b>7</b>
2.1 Global ageing and LTC needs for UHC .....	7
2.2 LTC .....	8
2.3 Actors involved in LTC .....	9
2.3.1 Older people.....	10
2.3.2 Carers.....	11
2.3.3 LTC workers .....	11
2.4 Teamwork .....	11
2.4.1 Multidisciplinary care teams .....	11
2.4.2 Case managers .....	11
2.4.3 Care coordinators .....	12
2.5 Settings for delivery of LTC .....	12
2.5.1 Home .....	12
2.5.2 Communities .....	12
2.5.3 LTC facilities .....	13
2.6 Strengthening LTC systems globally .....	13
2.7 Alignment with the United Nations Decade of Healthy Ageing and Integrated Care for Older People.....	13
2.8 Challenges and opportunities in LTC .....	14
2.8.1 Lack of LTC systems and burden on families and women .....	14
2.8.2 Insufficient, underqualified, undervalued workforce .....	14
2.8.3 Discrimination and abuse of older people and carers .....	14
2.8.4 Fragmentation of services .....	14
2.8.5 Lessons learnt from the COVID-19 pandemic .....	15
2.9 Opportunities recognized by CSOs representing older people and carers.....	15

<b>3 Core interventions</b> .....	<b>18</b>
3.1 Health-care needs .....	19
3.2 Palliative care needs .....	24
3.3 Social care and support needs .....	27
3.3.1 For older people .....	27
3.3.2 For carers .....	29
<b>4 Facilitating factors</b> .....	<b>34</b>
4.1 Person-centred integrated care .....	34
4.1.1 Components .....	36
4.1.2 Person-centred health and social assessment .....	37
4.1.3 Assessment of carers' needs .....	38
4.1.4 Assessment of need for assistive products .....	40
4.1.5 Development of a care and support plan .....	41
4.1.6 Case management and care coordination .....	42
4.1.7 Promotion of self-care .....	44
4.2 Education and training .....	44
4.2.1 Education and training for carers .....	45
4.2.2 Education and training for LTC workers .....	46
<b>5 Considerations for implementation</b> .....	<b>50</b>
5.1 Macro, meso and micro elements to strengthen implementation .....	51
5.2 Macro, meso and micro elements for education and training .....	55
<b>6 Engaging older people and carers in implementation of the package</b> .....	<b>59</b>
<b>7 The way forward</b> .....	<b>63</b>
<b>References</b> .....	<b>64</b>
<b>Annex 1. Interventions in the package (core and extended list)</b> .....	<b>69</b>
<b>Annex 2. Methods of selection of LTC interventions for the package</b> .....	<b>70</b>
<b>Annex 3. Interventions on the extended list</b> .....	<b>73</b>
<b>Annex 4. Actors in the LTC network</b> .....	<b>75</b>
<b>Annex 5. LTC settings</b> .....	<b>78</b>
<b>Annex 6. Topics for education and training for carers and LTC workers</b> .....	<b>81</b>

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# Acronyms and abbreviations

<b>ADL</b>	activities of daily living
<b>COVID-19</b>	coronavirus disease 2019
<b>CSO</b>	civil society organization
<b>IADL</b>	instrumental activities of daily living
<b>LTC</b>	long-term care
<b>UHC</b>	universal health coverage

# Glossary

Most of the terms below are adapted from references 1–4.

**Activities of daily living (ADL):** The activities necessary for daily life, such as bathing or showering, dressing, eating, getting in or out of bed or a chair, using the toilet, and moving around inside the home.

**Assistive product:** Physical product, such as a wheelchair, spectacles, hearing aid, prosthesis, walking device or continence pad, or digital software and apps to support interpersonal communication, access to information, daily time management, rehabilitation, education and training. May also be for adaptation to the physical environment, such as a portable ramp or grab-rail.

**Assistive technology:** An umbrella term for assistive products and their related systems and services (5). Assistive technology is of fundamental importance for people with permanent or temporary functional difficulties, as it improves their functional ability and enables and enhances their participation and inclusion in all domains of life.

**Care coordination:** A proactive approach for bringing care professionals and providers together to meet the needs of service users and ensure that they receive integrated, person-focused care in various settings (6). “Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care” (7).

**Care coordinator:** A professional who ensures adequate communication and coordination of decisions and information among teams and services, facilitates navigation by older people and carers through various systems and ensures integrated care delivery. Case managers frequently act as care coordinators.

**Carer:** individual such as a family member, partner, friend or neighbour who delivers care to households or the community, who commonly share affective or social bonds with care recipients. They may provide regular, occasional or routine care or be involved in organizing care delivery by others. Carers are distinct from care workers, as they are not employed by organizations entitled to coordinate and deliver services and are usually unpaid. Carers in countries in which policies support their work may receive social benefits such as paid leave and cash-for-care transfers. In this package, the term “carer” is used to cover a wide spectrum of people who provide care close to older people, such as family members, partners, friends and community members, usually referred to as “informal” carers, partially covering paid care workers, given the informal nature and unclear boundaries of many practices.

**Case management:** Targeted, community-based, proactive approach to care that includes case-finding, assessment, care planning and care coordination to integrate services to meet the needs of people at high risk who require complex care (often from several providers at different locations), people who are vulnerable or people who have complex social and health needs. A case manager coordinates patient care throughout the continuum (6).

**Community care:** Health and social services delivered to the home and community to help older adults to remain safely in their homes, promoting independence and participation.

**Competence:** “The state of proficiency of a person to perform the required practice activities to the defined standard. This incorporates having the requisite competencies to do this in a given context. Competence is multidimensional and dynamic. It changes with time, experience and setting.” (8)

**Competencies:** “The abilities of a person to integrate knowledge, skills and attitudes in their performance of tasks in a given context. Competencies are durable,

trainable and, through the expression of behaviours, measurable.” (8)

**Continuum of care:** The spectrum of personal and population health care required at all stages of a condition, injury or event throughout life, including health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliative care.

**Empowerment:** Provision of support to people and communities to help them take control of their health needs, resulting, for example, in healthier behaviour or better ability to self-manage illness.

**Functional ability:** Health-related attributes that enable people to be and to do what they have reason to value.

**Integrated health services:** Management and delivery of health services to ensure that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services through the different functions, activities and sites of care in the health system.

**Interdisciplinary team:** A team consisting of people who work interdependently to develop goals and a common care plan, although they maintain distinct professional responsibilities and individual assignments. They share leadership functions.

**Intrinsic capacity:** Composite of all the physical and mental capacities on which individuals can draw, enabling them to develop and maintain functional abilities throughout the life course and to enjoy healthy ageing.

**Instrumental activities of daily living (IADL):** Activities that facilitate independent living, such as using the telephone, taking medications, managing money, shopping for groceries, preparing meals and using a map.

**LTC worker:** Includes domestic and institutional personal care workers and health and social care professionals who provide LTC who are in an employment relationship (either formal or informal) and receive payment or any profit for providing care for people who require it in their homes or in other settings. Health and social care professionals (e.g. medical doctors, nursing professionals, physiotherapists, occupational therapists, social workers, dieticians and nutritionists, community transport drivers, community health care workers) are usually part of a public or private formal service system. In this package, the term “LTC workers” is used to cover both health workers (the broad range of health, nursing and health-associated professionals) and care workers in more formally recognized professions or occupations, who are or should be appropriately trained to attend to various personal needs.

**Meet basic needs:** The ability of older people to manage

and meet their immediate and future needs to ensure an adequate standard of living as defined in Article 25 of the United Nations Universal Declaration of Human Rights (9). Includes being able to afford an adequate diet, clothing, suitable housing, health care and LTC services. Extends to support to minimize the impact of an economic shock due to illness, disability, loss of a spouse or the means of livelihood.

**Multidisciplinary team:** People in various disciplines, sometimes from one or more organizations, involved in the same task (e.g. assessing people, setting goals and recommending care), working with each other but independently.

**Person-centred care:** Assessment and care planned for conscious adoption of the perspectives of individuals, families and communities, considering them as both participants in and beneficiaries of health care and LTC that responds to their needs and preferences in humane, holistic ways. Requires that people have the education and support necessary to make decisions and participate in their own care.

**Physical activity:** Any body movement produced by skeletal muscles that requires energy expenditure.

**Respite service:** Offers carers (usually unpaid, such as by a family member or friend) temporary relief from the demands of care-giving demands. Can be provided through home support services (e.g. personal care workers, home-health aides), in the community by adult day services or by a short-term stay in a long-term facility (e.g. residential care home, nursing home, hospice)

**Screening:** “The process of identifying healthy people who may have an increased chance of a disease or condition. The screening provider then offers information, further tests and treatment. This is to reduce associated problems or complications. Screening should always be a personal choice”. (10)

**Sedentary behaviour:** Any waking behaviour characterized by an energy expenditure of  $\leq 1.5$  metabolic equivalents while sitting, reclining or lying. Most office work, driving a car and watching television are examples of sedentary behaviour; can also apply to people who cannot stand, such as wheelchair users. The guidelines operationalize the definition of sedentary behaviour to include self-reported low movement sitting (leisure time, occupational and total), television viewing or screen time, and low levels of movement measured by devices to assess movement or posture.

**Self-management:** The knowledge, skills and confidence to manage one’s own health, to care for a specific condition, to know when to seek professional care or to recover from an episode of ill-health.

**Service package:** A list of interventions and services (relevant, feasible and acceptable) along the continuum

of care that should be made available to all individuals in a defined population. It may be endorsed by a national or subnational government or agreed by a non-State actor.

**Social care:** A wide range of non-medical services provided by local authorities and independent bodies, including the voluntary sector, to meet the social needs of individuals, especially populations that are older, vulnerable or have special needs, to improve their quality of life.

**Telemedicine:** Delivery of health-care services when distance is a critical factor by health-care professionals using information and communication technologies to exchange valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health-care providers,

all in the interests of advancing the health of individuals and their communities (11). Telemedicine can function between clients and health workers who are separated by distance as well as among health workers based in different locations. The type of exchange may include remote consultations, remote monitoring of vital signs or diagnostic data and transmission of medical files, such as images, for review.

**Transition care:** Services to help individuals recover after a hospital stay, including short-term specialized care to regain or optimize functional independence. Can be provided in various settings, such as a short stay in a nursing home or residential care facility where care and support are available continually or services at home and in the community.

# Executive summary

The growing prevalence of morbidity and functional decline associated with global population ageing and gains in life expectancy have increased the demand for care and access to long-term care (LTC) to address the complex care needs of older people. While families remain the primary source of care and support in most countries, it is becoming apparent and undesirable to depend solely on family care and support. Rapid demographic and societal changes mean that care by families is less readily available in view of the demand for a fairer social distribution of care for older people and for family and women carers.

Lack of formal LTC systems and shortages of trained care workers contribute to the significant increase in unmet care needs and the financial burden on older people and families worldwide, particularly in low- and middle-income countries. The coronavirus disease 2019 (COVID-19) pandemic has disproportionately affected older people and exacerbated the gaps in LTC (12, 13).

WHO is mandated to support Member States in providing access to LTC for older people who need it in the public health framework for healthy ageing (14) and the United Nations Decade of Healthy Ageing (2021–2030) (15). These frameworks address the heterogeneous needs and trajectories of older individuals, the importance of a person-centred continuum of care and integration of health and social care in all care settings. Countries can identify system elements and actions according to WHO's LTC framework (16).

While health systems around the world have made substantial progress in improving universal health care for acute or short-term health needs, relatively few countries have developed an integrated system that can guarantee universal health care for LTC (17, 18). This is due partly to the tradition of relying on family and other forms of unpaid care and also because the services and social protection required for LTC are often

beyond the traditional limits of health systems. To ensure that older people and their families can access adequate, high-quality, long-term services to meet their care needs without exposure to financial hardship, countries should develop coherent LTC systems. This requires both systemic changes to deliver an integrated continuum of LTC (16) and development of specific LTC packages or service provision schemes through which everyone who needs care can access a set of essential interventions without financial burden to themselves or their household.

## The package

This publication includes a list of LTC interventions that all countries could consider, prioritize and provide and could integrate within health and social care sectors, depending on their context. The package should be implemented in line with overall plans to design, establish and expand formal, integrated LTC systems and services towards universal health coverage (UHC).

The package is intended primarily for governments and policy-makers responsible for planning and implementing LTC service provision at national or subnational level. It provides guidance in foreseeing and mainstreaming essential LTC interventions, which can be contextualized according to local needs and resources. The package is neither a clinical guideline for LTC service providers in daily practice nor a manual, standard operating procedures or specific steps.

While most interventions in the package are for the primary needs of older people, the package also addresses the vital role of unpaid carers as both providers and receivers, as caring is a dyad relationship, with mutual and systemic implications. Older carers in particular might face substantial difficulty in balancing their caring role and maintaining their own health and well-being (19).



The package comprises three groups of LTC interventions to meet older people's care needs, one of which includes support for carers. The three groups address:

- *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;
- *palliative care needs*: to improve the quality of life and death for older people experiencing a serious illness or reaching the end of life by preventing and relieving physical, psychological, social and spiritual suffering for themselves and their families; and
- *social care and support* to mitigate limitations and optimize functioning by providing help and support for older people in several dimensions, including personal care and activities of daily living (ADL), participation in community and social life, provision of assistive products, accessibility and transport; and to support carers' needs so they can sustain a satisfactory, healthy, caring relationship and reduce strain and isolation.

Annex 1 provides a list of core and extended interventions. The core list comprises recommended LTC interventions for UHC that can be implemented in low- and middle-income

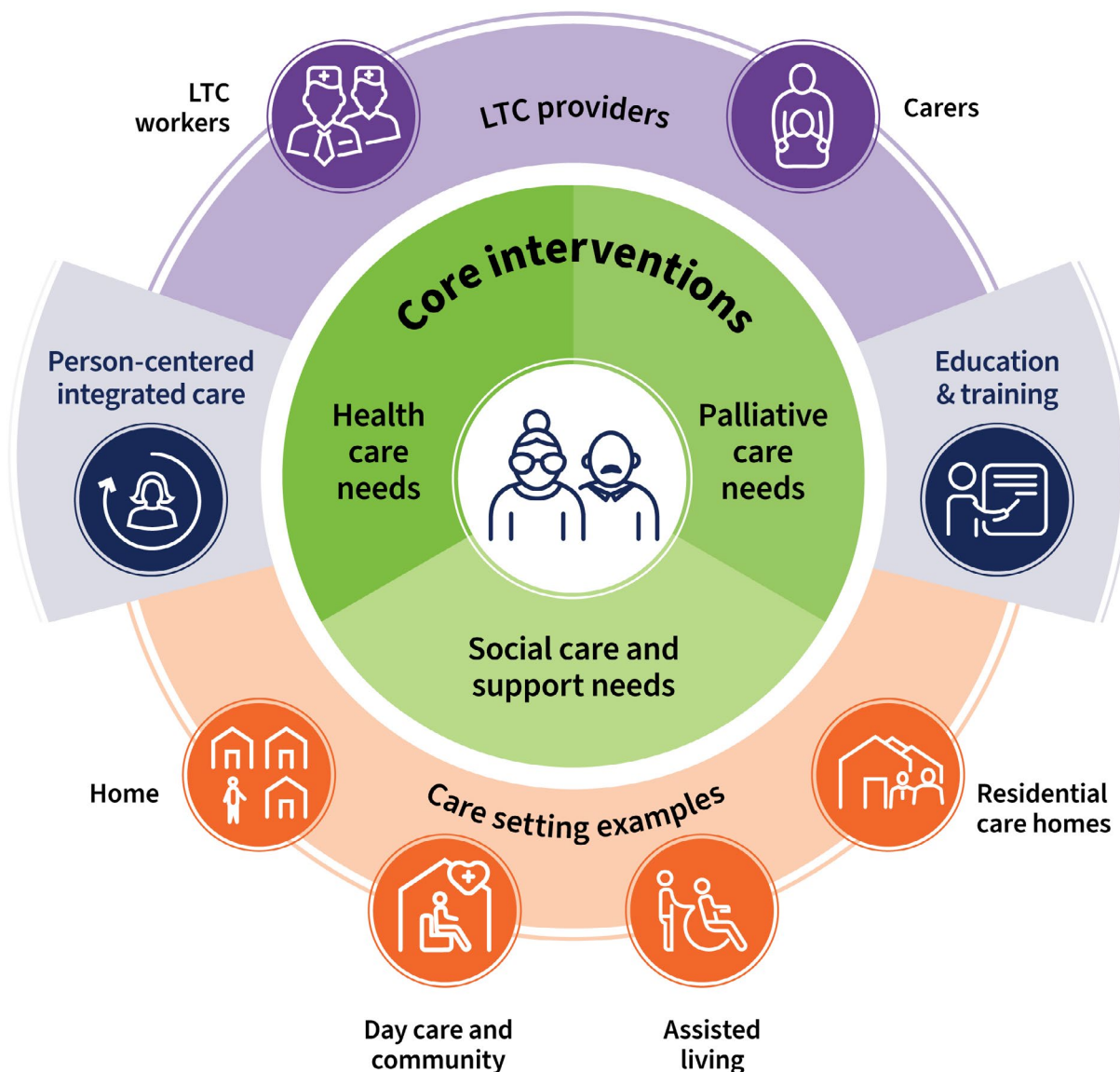
countries. The extended list includes interventions that can be implemented in expanded LTC service coverage, so that governments can increase the number of interventions provided according to their structure, capacities and resources.

The package includes two facilitating factors for these interventions:

- *person-centred integrated care* to ensure that older people and their carers receive timely, person-centred care through coordinated integration of the full spectrum of health and social services and the collaboration of a multidisciplinary team; and
- *education and training* to build and strengthen human resources for LTC by addressing the educational and training needs of carers and LTC workers by increasing their knowledge, skills and competence to provide safe, good-quality interventions.

Fig. 1 summarizes the elements of this package, with the three groups of core interventions to address LTC care needs, supported by facilitating factors provided by various actors in various settings. The structures, practices, financial resources and availability of LTC workers may differ significantly between countries and local contexts and should be considered during implementation.

**Fig. 1.** Groups of core LTC interventions and facilitating factors, provided by carers in various care settings



## Considerations for implementation

Implementation of the package can be influenced by interrelated factors in governance, service delivery, workforce, information, monitoring and evaluation systems and sustainable financing at the macro- (system), meso- and micro- (organizational and integration) levels. Mapping of the package “ecosystem” will facilitate understanding of the interdependent elements.

Education and training are essential for implementing the package. Programmes and courses for care workers

strengthen their knowledge, skills and attitudes in caring for older people and improve the quality of LTC. With few exceptions, personal care workers have limited access to specialized or relevant training. More evidence is required for designing a basic curriculum, requirements and minimal qualifications for certification.

A major impediment to successful implementation of the package is the disconnection between health and social systems because of the distribution among government ministries of governance and structures for providing LTC services. These are commonly the ministries of health and social affairs but include other ministries or sectors, such as the ministry of labour for the LTC workforce and subnational government bodies. A shared culture and a shared vision

of the principles necessary to achieve an integrated, coordinated LTC system could mitigate this problem.

At the organizational level, service managers may find it difficult to integrate care arrangements and to co-design the delivery of health and social care interventions, particularly regarding payment schemes, identification of providers in the community and building integrated human resource capacity. Bold leadership, common goals and a shared vision of integrated care, a multidisciplinary approach and establishment of alliances with organizations and local leaders can help to overcome barriers to integration. An LTC policy should therefore seek synergy in providing integrated, person-centred care for older people at home, in the community, in primary health care and in LTC facilities to achieve healthy ageing, reduce inefficiency due to fragmented delivery of health and social care and progressively build on sustainable, equitable LTC systems.

Meaningful engagement and dialogue with diverse population groups and stakeholders, including older people, carers and LTC workers, communities, civil society and social partners, can improve their visibility and ensure inclusion of their preferences and goals. Governments should engage

boldly with communities, especially the most vulnerable, by creating spaces for meaningful engagement to ensure that the principles of UHC and healthy ageing are achieved. Meaningful engagement can be facilitated by governments and service providers or initiated by older people, to enable them to influence decisions on the health and well-being of themselves and their communities.

The package provides practical steps and considerations for listening to and meaningfully engaging older people and carers, including identifying means for engagement, choosing participants to ensure representativeness and legitimacy, making practical arrangements, establishing appropriate communication strategies and measuring their impact.

While much remains to be done, this package provides an opportunity for countries to design and implement inclusive, comprehensive care services based on UHC and to fulfil the aspiration of the United Nations Decade of Healthy Ageing (2021–2030) to leave no one behind (14). Future technical products will address other critical issues in LTC, such as definitions and standards, integrated LTC models, a competency framework for carers and LTC workers, and key indicators of implementation.





Doctor Hildene Melo hugging her patient Regina Paixão, age 78 and diabetic for the past 21 years, at CEDEBA. Brazil, 2016  
© WHO / Panos / Eduardo Martino





# 1

# Background

## 1.1 Goals

The package provides lists of recommended interventions and facilitating factors for LTC for countries to consider, prioritize and use in designing, establishing and expanding LTC systems and services towards UHC. The package is intended primarily for government officials and policy-makers responsible for planning and providing LTC services nationally or sub-nationally and also for health, LTC and insurance organizations, regulatory bodies and care managers in public, private and CSOs.

Countries can adapt this global package to their national and local contexts and needs to strengthen, scale up and review their LTC systems and to design integrated, person-centred LTC services that are equitable and sustainable. The package will help countries to extend their portfolio of LTC services to be delivered by diverse health and care workers in various settings, to meet the heterogeneous care needs of older people throughout the continuum of care, from promotive to preventive, curative, rehabilitative, assistive and palliative care. The package can be a reference for health and care workers and researchers in LTC, CSOs and social partners, as well as older people, carers and their communities to advocate for universal provision of LTC and realization of the right to access LTC. It will thus support countries and societies in helping older people who have lost their intrinsic capacity and need LTC to protect, restore and optimize their functional ability and to enjoy their right to healthy ageing without financial hardship.

The package will help countries to:

- address the heterogeneous, unique, complex health and social care needs of older people and their carers that are the result of the growing prevalence of ageing and morbidity;
- allocate resources and plan services for LTC as an extension of UHC and social protection schemes,

to ensure that older people and their families receive timely care and services when and where they need them without suffering financial hardship;

- direct attention to the importance of making health and social care more integrated, person-centred and coordinated;
- progressively increase the provision and coverage of LTC services according to their context;
- recognize the importance of the work of unpaid carers, ensure that services are responsive to carers' health and social needs, extend discussion of gender inequality and social fairness, and prepare for the increasing demand for care; and
- identify common essential topics and establish the content of and standards for education and training of LTC workers and carers, which should help planning of the care workforce, including their profiles and skills, according to the broad spectrum of labour schemes and heterogeneous needs in different settings.

## 1.2 Methods

The first step in development of the package was a scoping review on LTC interventions for older people. This was followed by consultations with experts to reach consensus on a list of core interventions to be implemented through UHC. The expert panel comprised multinational and multidisciplinary experts in LTC and ageing and also older people, care providers and representatives of community support organizations. Consensus was achieved in three stages: (i) a consultation on an initial list of LTC interventions identified in a previous review (20); (ii) surveys to reach consensus on the criteria of importance, acceptability and feasibility; and (iii) panel meetings.

The literature review comprised systematic assessment of the scientific literature on LTC interventions and services for older adults published between 2010 and 2020. A combination of terms was used, and the search strategy was adapted to each database consulted (PubMed, CINAHL, EBSCO Host, Cochrane, and Google Advanced to assess grey literature) under the supervision of a librarian: Long-term care OR/AND, health services for the aged, and social services, AND/OR, social care, AND, interventions, OR services, AND long-term care facilities, OR assisted living facilities, OR nursing homes, OR homes for the aged, OR home care, OR community health services, OR Caregivers, AND older adult, AND frail elderly. A total of 305 articles were assessed, which reported on 273 similar interventions. These were grouped into 49 clusters (21).

A multistep expert consultation was conducted to reach consensus on the interventions to be included in the package, involving a broad range of international experts and stakeholders. The three steps were refinement of the list of interventions and preliminary consultation; a two-round survey and consultation; and grouping and description of the selected interventions. This process resulted in 31 interventions, with 23 on a core list and 8 on an extended list (Annex 1). The core interventions were selected according to the feasibility of implementation in low-resource settings, and the interventions on the extended list were those that were considered to require more resources and capacity and might be implemented to extend the package.

During the expert consultations, some of the interventions that were initially identified were considered to be factors that would facilitate delivery of core LTC interventions. These interventions were classified into two groups, one on person-centred care and the second on education and training.

Once the lists of core interventions and of facilitating factors were agreed upon, the experts suggested inclusion of further descriptions, points, actions and considerations for implementation of the interventions. They conducted a further extensive literature review to identify examples of implementation and to identify relevant points. Examples from countries or communities were included in boxes, according to their relevance, consideration as good practice and the geographical distribution.

To reflect the voices of older people and carers with respect to implementation, a 2-day virtual consultation was held with CSOs representing older people and carers in various regions. The participants provided comments and considerations for implementation and engagement, which are reflected in the separate section.

A detailed description of the methods is presented in Annex 2.

## 1.3 Content

The package includes a list of core LTC interventions to address the needs of older people and carers to be delivered in a continuum of care approach as part of UHC. The core interventions for addressing the LTC needs of older people and their carers are categorized into three groups: health care, palliative care and social care and support.

Two sets of facilitating factors were identified: person-centred integrated care and education and training. Factors relevant to person-centred integrated care are designed to facilitate coordinated, integrated care. They include holistic assessment of older people's and carers' needs and delivery of personalized care by multidisciplinary and community care teams and care coordinators. The focus is on supporting older people to live where their needs and preferences are adequately addressed (at home with community care services or in residential care homes), with consideration of the financial, emotional, physical and social needs of their carers. Delivery of LTC services within a strong, well-performing primary health-care system is critical to ensure coordinated, integrated care. Education and training are necessary to build and strengthen carers and care workers for LTC so that they can provide the safe, high-quality interventions included in this package.

The core interventions and the facilitating factors in the package (Fig. 2) are described in detail in the following sections. A few recommendations for practice and considerations for implementation are also provided, with examples from several countries.

## 1.4 Use of the package

Most countries already provide some of the services described in this document within their health and social care systems, and a few have already established LTC systems. In all countries, this package could help in assessing and planning LTC service provision. Services that are already provided could be revised in line with the elements described in this document, and new services could be designed and added.

Interventions can be selected and implemented flexibly and adaptably, depending on the stage of implementation of the LTC system and on the primary needs of older people, carers and care providers in each country. Interventions should be adjusted and extended continuously at many levels as part of dynamic, sustainable LTC implementation. The selection should be based on the local context, including broad sociodemographic profiles and geographical distribution of services, existing health and social services and allocation of resources.

**Fig. 2.** Core LTC interventions and facilitating factors in the package

## Long-term care 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

- Cognitive decline
- Limited mobility
- Falls
- Physical inactivity and sedentary behaviour
- 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 death for older people with a serious illness or reaching the end of their lives, by preventing and relieving physical, psychological, social, and spiritual suffering for themselves and their families, including regular assessment and management

- physical
- psychological, social and



### Social care and support needs

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

#### Older People

- Support and assistance with activities of daily living
- Participation in community and social life
- Accessibility and transport
- Provision of assistive products

#### Carers

- Psychosocial support
- Respite care

## Facilitating factors:



### Person-centred integrated care process

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 collaboration of a multidisciplinary team

Process components:

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



### Education and training

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

**For Carers and For LTC workers**

Implementation of the package of LTC interventions can also establish and optimize service coordination for older people's needs and preferences. LTC services that are clearly described and systematized will make it easier to navigate systems, identify gaps, foster institutional accountability, empower users by better understanding of the services to which they may be entitled, and enhance user services, sector-to-sector and team-to-team communication and shared decision-making. Care teams can be enlarged and given targeted training according

to the services being offered, and interdisciplinarity may be more clearly defined and established among service providers.

Implementation of the package will create conditions for strengthening the LTC system components. The WHO framework for achieving an integrated continuum of LTC (16) includes a checklist of strategies and actions on the key elements of sustainable financing; information, monitoring, and evaluation systems; workforce; service

**Fig. 3.** Six key steps for implementing the package





delivery; and innovation and research. This can be used to guide national planning and decision-making for resilient, equitable LTC.

Annex 3 provides an “extended” list of interventions that are considered more difficult to implement in low-resource settings. Countries should consider their structure, capacity and resources when deciding whether they have the necessary conditions and opportunities to extend the package.

The cycle for implementing the package consists of (Fig. 3):

- identifying the current needs of the national or local population for LTC;
- mapping existing LTC interventions in each setting and area and identifying gaps and inequality in providing LTC;
- designing the LTC package for UHC according to resources and capacity;
- integrating and aligning interventions in services and settings by building on the experience of existing partnerships;
- monitoring care delivery and coordination, including accountability for quality; and
- reviewing current coverage and extension of the provision of interventions at various levels and in various settings.

## 1.5 Recognition of carers and their needs

While the interventions proposed in this package primarily address older people’s needs for LTC, some extend to the needs of carers. Carers are family members, partners, friends and neighbours who provide care in households or in the community, often with affective or social bonds

with the older people for whom they care. Carers should be viewed not only as care providers but also as a group with physical, psychological and social needs. Identifying carers who themselves need help and support is essential to promote their health and well-being and for the sustainability of the dyadic caring relationship.

LTC services to support carers can include direct help and support, such as from personal care workers, assistive products and home modifications to facilitate their caring role. Interventions to fulfil the needs of carers comprise identification of their needs and connection to health and social care services, including helping them to cope with the consequences of caregiving, such as psychosocial support to address loneliness, anxiety or depression and respite care, and to help them thrive and flourish as individuals.

## 1.6 Scope

The package does not cover all LTC interventions. Its primary purpose is to propose a list of interventions that should be priorities in an LTC system to realize UHC, including in low- and middle-income countries with no formal LTC policy or programme. The package neither includes clinical guidance for LTC service providers in their daily practice, nor is it a manual, with standard operating procedures or specific steps. More evidence from systematic reviews or randomized controlled trials should be accumulated to provide such guidance.

Each country can develop LTC systems and services that reflect their national or local contexts and needs. The package is a starting point, providing a list of recommended LTC interventions for universal health coverage. All countries may not use all the interventions described in this package. Instead, government bodies that lead implementation could map the existing long-term services in various settings and areas, identify any gaps or inequality in the current provision of services and list the essential interventions that meet communities’ needs and can be implemented with the available resources.





Clients Exhibiting Any Flu like symptoms such as Cough, Cold, Fever, Runny Nose, Sore Throat, Shortness of breath are kindly asked to proceed to Casual Walk in Clinic or Scarborough Walk in.

DEAR CLIENTS AS U ENTER THE HEALTH CENTRE PLEASE USE HAND SANITIZER ON THE WALL OR WASH HANDS BEFORE APPROACHING MEMBERS OF STAFF.

VIEW ROOM

Bertil accompanies his mother Jane on her regular visits to the Community Health Clinic in Tobago, 2022  
© WHO / Alasdair Bell





# 2

# Introduction

## 2.1 Global ageing and LTC needs for UHC

The rapid global increase in the number of older people (aged 60 and over) in the past few decades has been accompanied by a rapid, disproportional increase in the prevalence of the noncommunicable diseases that are common in this age group. These conditions often lead to physical, psychological, sensory and cognitive impairment, which require complex, continuous, sustained care management in LTC systems. Although the number of older people globally who need LTC is expected to increase significantly, most countries – particularly those with low- and middle-income economies – still depend heavily on unpaid, informal care provided by families, partners, friends and neighbours, while insufficient, low-quality LTC services are provided or funded by their governments. Many older people who require LTC, particularly those at a social disadvantage, are therefore at risk of their needs not being met, jeopardizing their health, well-being and rights.

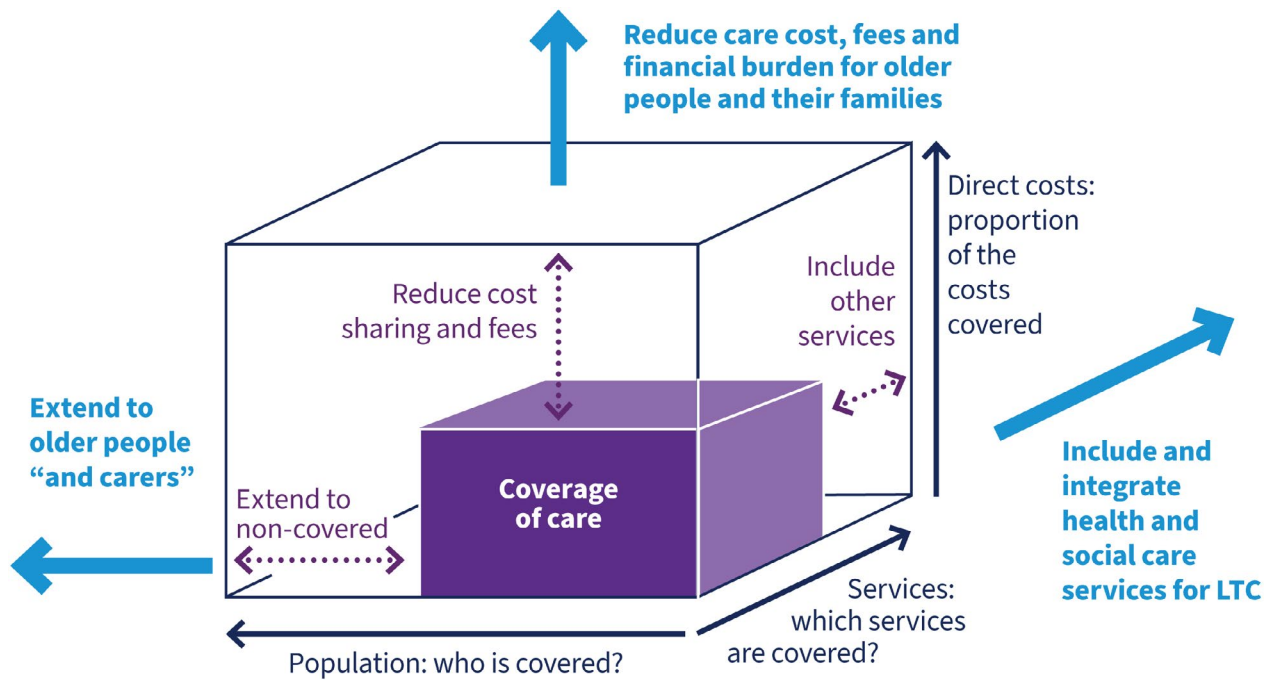
Heavy workloads, low salaries and generally difficult working conditions make it difficult to motivate and retain health and care workers, threatening the provision of LTC. Carers – usually women, unpaid and informal – are at high

risk of present and future poverty and of physical and mental health problems, because their work is generally isolated, unpaid, with no access to social security and with a heavy physical and psychological burden. Equal access to good-quality services is challenged by shortages of health and care workers and unequal distribution of the workforce that exists (22).

Many older people with needs and their carers are also at risk of impoverishment due to catastrophic expenditure on care services. Ensuring the provision of good-quality, affordable LTC services is therefore essential to guarantee UHC to older people (23). UHC can be achieved only if the health and social care needs of the increasing older population and their carers are met (24).

Three dimensions of coverage should be considered in LTC interventions for UHC (Fig. 4). The population should include not only older people who need LTC but also their unpaid carers, particularly family carers. The services should comprise health and social interventions, delivered in a continual, non-fragmented way according to older people's and carers' needs, and should be re-oriented to overcome silos of disease-oriented and fixed service structures. Financial schemes should be extended to cover not only health but also social protection.

**Fig. 4.** Three dimensions of coverage for implementation of LTC interventions for UHC



## 2.2 LTC

WHO considers that LTC comprises the activities “to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity” (4). LTC should meet the health, personal care and social needs of individuals. It may be continuous or intermittent but should be delivered for sustained periods to individuals who have substantially reduced intrinsic capacity and require support and assistance to maintain, recover or optimize their functional ability.

LTC should not be viewed as institutional or residential care or the provision of services to meet only basic needs, such as assistance with ADL. Rather, LTC includes a wide range of services and interventions in various domains and settings, from screening for decreased intrinsic capacity to provision of end-of-life support. It should be underpinned by a set of key principles (Box 1) (16).

### Box 1. Key principles of LTC provision

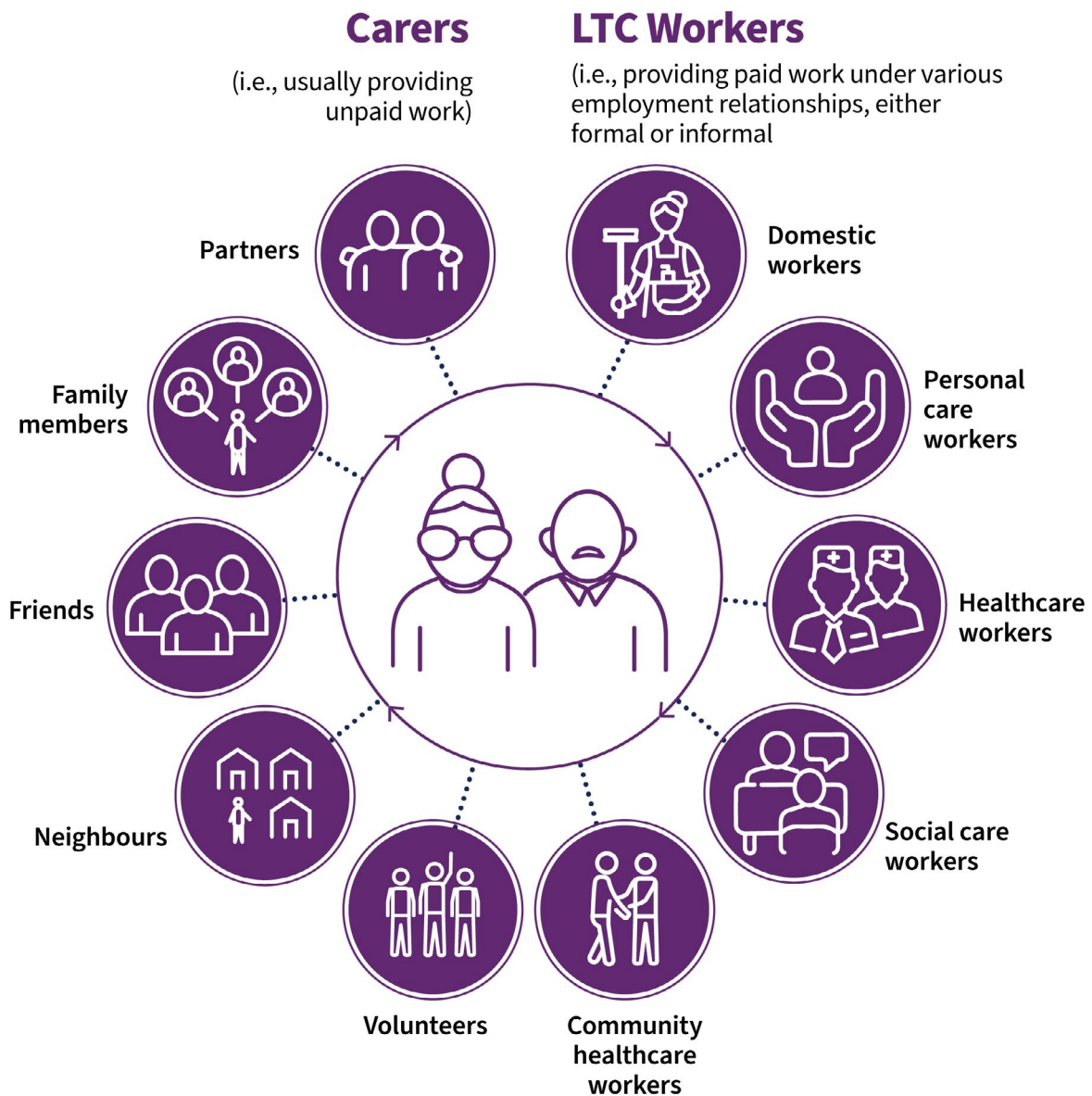
- Be person-centred and aligned with each person’s values and preferences.
- Optimize functional ability over time, and compensate for loss of intrinsic capacity.
- Be provided in the community to meet the expectation of older people of ageing in place.
- Ensure integrated services in a continuum, include prevention, promotion, treatment, rehabilitation, palliation, assistive care and social support to degrees that depend on the needs of the individual.
- Include services to empower older people and carers.
- Emphasize support for carers and care workers.

## 2.3 Actors involved in LTC

The people involved in LTC are both receivers and providers of care and vary widely by country and community. Older people themselves, who are traditionally viewed as care recipients, are increasingly providing care to family members and volunteering or acting as peer supporters in their communities. Carers should also be considered care receivers. In some countries, policies have been set to protect the health and well-being of carers, to facilitate not only their access to support in caring for older adults but also their quality of life and well-being. In countries

with no LTC policy or established services, most care relies on unpaid carers, particularly family members. Even in countries with developed LTC systems, unpaid carers are still considerably involved in providing care. They are frequently in contact with different care providers and navigate complex health and social care systems. The people involved in providing LTC care typically comprise two groups: carers such as family members, partners, friends, neighbours and volunteers, and LTC workers, such as paid personal care workers, domestic workers, health workers and social care workers (Fig. 5). The boundaries between the two groups are not, however, clear and differ by country.

**Fig. 5.** Actors involved in providing LTC, typically divided into two main groups: carers and LTC workers



Caring networks differ in the number of people involved, the patterns of interaction and the extent of connections, as do the availability and composition of the multidisciplinary care teams from the health and social sectors in each country. In order to align these groups and to ensure coordinated, integrated care, recognition must be given to the value of each individual and their work, paid or unpaid,

to ensure decent working conditions and social protection. Women are particularly affected by policies on care. Governments should recognize women's work and their responsibilities for care throughout their life course in order to achieve gender equality (25, 26). Box 2 provides broad definitions of key actors in LTC and interdisciplinary and coordination of care.

### **Box 2.** Actors in long-term care networks and interdisciplinary and coordination approach

**Carers (for example, family members, partners, friends, neighbours):** individuals who deliver care in households or in the community, who commonly have affective or social bonds with care recipients. They may provide regular, occasional or routine care or be involved in organizing care delivered by others. Carers are distinct from care workers, as they are not employed by organizations entitled to coordinate and deliver services, and most often provide unpaid care. Carers in countries with policies to support their work may receive social benefits such as paid leave and cash-for-care transfers.

**Volunteers:** individuals who are members of civil society organizations and give their time and work without monetary compensation. They usually receive training for providing LTC in various settings (e.g. home visiting, recreational activities in facilities, organizing events).

**LTC workers:** individuals who provide LTC as domestic workers, home or institutional personal care workers, health and social care professionals, who are in an employment relationship (either formal or informal) and receive payment or any profit for providing care for persons in need of such care in their own homes or in other settings. Health and social care professionals (e.g. medical doctors, nursing professionals, physiotherapists, occupational therapists, social

workers, dieticians and nutritionists, community transport drivers, community health care workers) are usually associated with a public or private formal service system.

**Multidisciplinary or interdisciplinary team:** an interdisciplinary team consists of members who work collaboratively and interdependently to develop goals and a common care plan for one or more patients, although they maintain distinct professional responsibilities and individual assignments. Leadership functions are shared. A multidisciplinary team consists of members of different disciplines, sometimes from one or more organizations, involved in the same task (assessing people, setting goals, making care recommendations), working with each other but functioning independently. As patients' needs and circumstances change over time, multidisciplinary team care should be flexible and adaptable.

**Care coordinators:** professionals who ensure adequate communication and coordination of decisions and information among teams and services, facilitating the navigation of older people and carers through various systems and ensuring integrated care delivery. Frequently, case managers act as care coordinators.

#### **2.3.1 Older people**

Older people should be entitled to receive LTC services when they need support and care from others, and have difficulty or are limited in performing basic ADL (e.g. bathing, dressing, using the toilet, eating, moving around) or IADL (e.g. preparing meals, shopping, managing appointments, medications and finances). A comprehensive needs assessment should be conducted to determine each individual's functional status and intrinsic and extrinsic resources and not just a specific clinical condition or disease, social vulnerability or age. The assessment and a care plan should be person-centred, developed collaboratively with the older person and family and address both permanent and transitory changes in functional ability.

LTC systems and providers should be prepared to recognize and adapt plans to the diversity of older people. Limitation of functional ability is multifaceted and may be due not only to ill health but also to social, economic and environmental factors. Defining and forecasting population ageing and growing needs for LTC interventions require a thorough assessment that includes epidemiological data, risk stratification, service use and registries, service provision and geographical distribution, social vulnerability, a comprehensive geriatric assessment and available resources. Adaptation of service provision to local needs and priorities should be defined by the government bodies responsible for planning LTC, ideally by a ministerial focal point for LTC. It should involve consultations with social partners, strong, reliable evidence and continuous analysis of health data (16).

### 2.3.2 Carers

Carers provide and sustain LTC for family members, partners, friends or community members. They have also been categorized as informal or unpaid carers or caregivers, as they provide unpaid care but are not linked to or employed by any formal care organization or do not receive any remuneration for the care they provide. The spectrum of actors involved in the care network can be classified in many dimensions, such as by role, skills, degree of formalization, payment, training and closeness to the person being cared for. Although consensus should be reached on the terminology and best way of representing all the dimensions of their work, there is general agreement that the activities of carers can be conceptualized as “work”. For example, the International Labour Office includes both “unpaid care work” and “paid care work” as care work (25).

Carers may provide regular, occasional or routine care or be involved in organizing care delivered by others. Most carers are women from a low socioeconomic background, who are often obliged to leave jobs and social activities to provide care (26) in the absence of accessible, affordable formal care. Several factors and women’s growing participation in the labour market will, however, reduce the number of carers in the coming years, including shrinking of families, greater geographical mobility, urbanization and other demographic trends.

Individual needs assessments should be conducted for carers with respect to their health, well-being, health literacy, training and knowledge of care, intrinsic and extrinsic resources, social and financial vulnerability and other factors so that a tailored support plan can be created and implemented collaboratively. Such assessments should be made routinely, as the needs of carers for support may change over time and different support mechanisms introduced according to their current situation.

### 2.3.3 LTC workers

LTC workers (see Box 2) include people with various educational levels, skills, remuneration, employment schemes and sectors of work. LTC is usually provided in health and social systems, with many interactions, such as with domestic workers, home and institutional personal care workers, doctors, nurses, social workers, physiotherapists, occupational therapists, dieticians, nutritionists, art therapists and recreational therapists. Workers in LTC may be hired directly or paid by families or by organizations and facilities, either formally or informally if they have no formal contract or work in informal facilities. Many countries still have a large informal market for domestic and personal care workers, with a blurred distinction between home care and domestic work. Informal LTC workers (self- and wage employed) who are not registered, regulated or protected within a legal or regulatory framework often have less favourable working

conditions, lack access to workers’ benefits and receive lower wages and social protection.

LTC services can be delivered by non-profit organizations (including faith-based organizations and cooperatives), public organizations and for-profit organizations such as home health care agencies, private health-care providers and LTC insurance companies. Annex 4 provides brief descriptions of the different types of workers. The types and roles of workers, however, vary widely by setting and LTC system. For example, physicians, nurses, social workers and other professionals may act as discharge planners, liaison officers, visiting health workers, service managers, case managers and care coordinators. They may also function as specialists or liaisons for specific types of care, such as for dementia, rehabilitation, palliative, end-of-life and respite care.

## 2.4 Teamwork

### 2.4.1 Multidisciplinary care teams

A multidisciplinary team for LTC can include a wide range of workers collaborating among sectors and settings to provide person-centred, integrated, continuous LTC and support for and with the involvement of older people and their carers. The nature, scope, expertise and competencies required depend on the needs and on the organization of LTC systems. A team may include a doctor, a social worker, a nurse and various allied health and social care professionals. In some countries, it may include community care workers and local volunteers. Delivery of a package of LTC services in practice requires the necessary competencies rather than certain professions. The services to be delivered by different types of health and care workers depend on the national contexts, the profile and availability of the workforce and the operation of their integrated team.

A multidisciplinary care team conducts screening and regular assessments of the care and support needs of older people and their carers in order to develop and implement individualized care and support plans. Usually, a team assesses, plans and manages collaborative care activities, contributing different knowledge, experience and skills to achieve the outcomes decided with older people and their carers. The goal is provision of comprehensive, continuous, seamless care.

### 2.4.2 Case managers

A case manager is responsible for monitoring and reassessing implementation of LTC and support plans over time. This professional is a point of contact between older people, carers and the wider LTC system as well as for LTC workers in a multidisciplinary team. In many cases, this role is assumed by a nurse or a social care worker.



### 2.4.3 Care coordinators

A care or service coordinator ensures adequate communication and coordination of information and decisions to multidisciplinary teams and services and supports navigation through the various systems. This professional is in contact with the services and case managers to ensure that LTC work and services are person-centred and integrated, focusing on the needs of the individual and not on the services. Often, this role is taken by a case manager, depending on how the system is organized and on the budget available to fund one of both roles (27).

## 2.5 Settings for delivery of LTC

LTC interventions can be provided in various settings, according to the needs, values and preferences of older people and their carers. LTC institutions or facilities include community centres, assisted living facilities, care homes, nursing homes, hospitals and other health and social care facilities designed for older people's needs that are conducive to ongoing care. LTC is thus provided not only in residential care institutions but also in acute care and community care settings to cover different needs along the continuum of care and care transitions. Assessment and monitoring of the complex needs of an older person can be initiated in an acute care hospital in order to avoid complications and to establish a plan for continuity of care at discharge. Care and support are usually organized at home or in the community, with coordinated delivery of care by a multidisciplinary team. Effective coordination and communication among care providers and between acute and community settings are crucial for integrated care.

Community LTC services (e.g. home care, day care, visits by volunteers, community programmes to reduce social isolation and loneliness) enable people to receive care where they live, avoiding unnecessary hospitalization or institutionalization. In addition, local services can leverage essential resources for the needs and priorities of local populations.

### 2.5.1 Home

Home care is one of the most common types of LTC. It is preferred by most older people and is aligned with the general goal of ageing in place. Home care typically includes professional visits for case management, assistive and supportive personal care services such as for basic ADL and IADL, medical and rehabilitation interventions, and carer support, depending on the needs identified during screening and monitoring. Older adults are usually assessed for health and care needs, including their eligibility for service coverage, at home.

In low- and middle-income countries, unpaid care provided by family members, partners, friends or neighbours according to traditional norms remains vital, sometimes with

the help of domestic workers. Although trained personal care workers or home health aides are becoming more prevalent, they are not replacing carers in many countries, mainly because of a lack of trained personnel. Community health programmes, with volunteers provided mainly by religious organizations, are significant sources of support, although they cannot function as a substitute for public assistance.

Even in high-income countries, most care still relies on unpaid work by family members, while a few home care programmes involve community health workers or specialized, professional health workers. In member countries of the Organisation for Economic Co-operation and Development, the proportion of older adults who receive LTC at home varies widely, depending on the LTC system, from about 30% in Denmark and Germany to less than 20% in Australia, Canada, Finland and the Republic of Korea (28). Older people and their families who receive home care services experience several common problems, such as inflexible service provision, lack of services over weekends and at night, and caps on the number of hours of service (29).

### 2.5.2 Communities

Community care settings include day-care centres, senior centres, adult day services, recreational centres and specialized day-care centres. Care is provided in various structures, such as health centres, churches and other community buildings and differ in size, target population and funding schemes. Community settings such as adult day-care centres may be used to complement or as an alternative to home care and can be used by carers who also work elsewhere or to have a break from their daily tasks, although access to these settings depends on social policies for addressing inequality and vulnerability.

Day-care centres differ according to the level of care provided. General health centres provide non-specialized care, for example for people with dementia or in palliative care, while specialized centres are suitable for older people with complex care needs and offer rehabilitation services similar to those of institutional LTC facilities. The programmes of such centres are implemented by various professionals who provide interventions such as screening and assessments, health-promoting activities, cognitive stimulation, leisure and rehabilitation activities, opportunities for socialization, psychosocial support, carer support and training, assistance in personal tasks and companionship.

These centres are frequently operated by public or non-profit organizations and are usually open during working hours on weekdays. They may be funded through schemes similar to those for home care services. Community centres are also often used to provide respite services for carers. Organizations that deliver day-care services are usually licensed by the government, with some level of certification, the criteria depending on the services provided and the population profile.



In Japan, day care comprises nursing care, rehabilitation therapy, supervision and socialization, which enables frail older people to remain active in the community. Often, older people in day-care programmes have several conditions and have lost some functional ability (30). In Singapore, day-care centres have many purposes, from socialization to day-care for dementia and psychiatric conditions, multidisciplinary medical care and hospice care (31). In Europe, various models are emerging, such as owned accommodation for retirement, older people communities and supported or sheltered housing in which the intensity of support is adapted to needs as people age (32).

### 2.5.3 LTC facilities

LTC facilities may have different names and serve different populations in countries, including nursing homes, skilled nursing facilities, assisted living facilities, residential care facilities, care homes and residential care homes. Although the composition, design, target population and quality of the facilities differ significantly by setting and context, they usually provide 24-h care and support for older people with health conditions of various severity, functional ability or social vulnerability, either continuously or intermittently (such as respite care). Besides offering assistance in basic needs (eating, hygiene, moving around, sleeping), the facilities may offer other services, including medical and assistive care, rehabilitation and end-of-life care. Some facilities also provide respite care to carers or a period of supported care to increase independence.

Intermediate care services may be provided as a transition from hospital to home. Although the structures and services labelled “intermediate care” differ, they may be proposed as an alternative to hospital care for patients who need skilled medical, nursing and rehabilitation care. The time that older people spend in intermediate care should be long enough for them to ensure adequate care at home.

While LTC facilities are one of the most common forms, they have been the target of social prejudice, as they have been linked with individual and family poverty, abandonment or family violence and with the idea of a total institution characterized by restrictive, controlling practices. These negative views often lead to denial of the need for such care and lack of quality, thus reinforcing the prejudice. Recently, there have been local and global movements to “deinstitutionalize” such structures, including the Convention on the Rights of Persons with Disabilities (33), which call for a shift from institutional to home and community care in order to ensure autonomy, independence, choice, control, dignity and ageing in place and also to reduce the heavy social cost of maintaining facilities. Annex 5 provides an overview of LTC settings and the activities commonly undertaken.

## 2.6 Strengthening LTC systems globally

WHO has increasingly emphasized the role of LTC as the global and national response to population ageing. The *Global report and the strategy and action plan on ageing and health* (34) set the direction for healthy ageing, defined the concepts of “intrinsic capacity” and “functional ability” and included LTC as a major area for addressing the increasingly complex health challenges related to ageing. Subsequently, “providing access to LTC for older people who need it” was identified as one of the four action areas in the United Nations Decade of Healthy Ageing 2021–2030 (15). The strategy and initiatives call for every country to have an LTC system as part of UHC, according to their population needs and economic and cultural context, with links among and between health and social services.

The first technical guidance for the United Nations Decade was the WHO publication *Framework for countries to achieve an integrated continuum of LTC* (16), which lists the elements that every country should consider for achieving an integrated continuum of LTC. The framework is intended to provide guidance for developing and strengthening long-term systems as part of UHC; ensuring access for older people and their carers to the services they need and that are suited for their functional abilities, values, preferences and culture; supporting ageing in place; and reducing the risk of financial hardship and disruption of connection with their communities and other social networks. It proposes actions for guiding national planning and decisions for implementing LTC systems, with six core elements: governance; sustainable financing; information, monitoring and evaluation; workforce; service delivery; and innovation and research.

## 2.7 Alignment with the United Nations Decade of Healthy Ageing and Integrated Care for Older People

Ageing is heterogeneous, as the needs of older people depend on their unique, dynamic trajectories, intrinsic capacity and functional ability. Irrespective of chronological age, their trajectories include stable capacity, some degree of decline requiring sporadic assistance, and irreversible loss of capacity that requires constant support. Even people with significant loss of capacity must be assisted to preserve and optimize their functional ability and experience healthy ageing. To address the diverse needs of older individuals with different capacity, an integrated, person-centred continuum of care is necessary, with coordination among health and social care settings.

The WHO Integrated Care for Older People (ICOPE) approach (35) proposes evidence-based interventions in six domains of intrinsic capacity and also social care and support to address older people's needs holistically in primary health care. This includes proposing preventive LTC services according to individual needs after person-centred assessments and by shared decision-making, multidisciplinary care, community engagement and carer support (16, 36).

The WHO ICOPE and LTC approaches complement each other, and both can be seamlessly integrated into a national healthy ageing policy and strategy. Challenges to integrating health and social care systems can be overcome by shared goals and financial pooling, which will improve outcomes and efficiency. An integrated system for monitoring individual health and care needs can result in responsive, personalized service provision, promote healthy ageing and eliminate unnecessary hospitalization. Furthermore, an integrated, LTC system can better address the heterogeneity of older people's needs and may reduce redundancy, improve allocation of resources and facilitate the continuum of care. Integration of ICOPE and LTC approaches within a public health framework could therefore enhance the intrinsic capacity and functional ability of older people according to their needs while improving the efficiency and sustainability of the system.

## 2.8 Challenges and opportunities in LTC

### 2.8.1 Lack of LTC systems and burden on families and women

Most countries do not have a sustainable, equitable LTC system, and many older people and their carers are left without support. Lack of comprehensive national and subnational LTC policies is common, especially in low- and middle-income countries. Inadequate political will and limited financing contribute to insufficient LTC services.

Most care for older people is currently shouldered by families, primarily middle-aged and older women in socially marginalized contexts. Often, caring is not their choice but is due to limited access to affordable formal care. Women find it difficult to balance their caring role with employment or education, at significant personal and social cost. Prioritizing carers' needs and supporting them are crucial, not only for care provision but also for their overall health and well-being (25, 37).

### 2.8.2 Insufficient, underqualified, undervalued workforce

Many LTC workers, predominantly women, lack formal training and often work informally or as domestic workers because of lack of formalization of the care sector (38).

Dependence on unpaid care is unsustainable, because of changing family dynamics and increased opportunities for women on the labour market (16). Anticipated shortages in both unpaid carers and LTC workers will exacerbate the challenge. Even paid care workers face deficits in job security, pay and social protection and also risks, such as a heavy workload, mental health problems and harassment. These issues compromise both the well-being of care workers and the quality of LTC services for older people.

LTC is at the crossroads of health and social systems, with a diverse range of services and ways of expressing them, complicating clear understanding of the workforce. LTC in various settings involves cadres with varying education and skills, from qualified doctors and nurses to people with no formal training. LTC workers may have unfavourable working conditions, including overwork, irregular hours, inadequate protection, low wages and exposure to hazards. Social dialogue is difficult owing to sector fragmentation, weak regulations, high turnover, informal employment and diverse contracts, which particularly affect migrant workers. Discrepancies in the recognition of care workers in different countries may particularly affect migrant women care workers. To address workforce shortages and strengthen LTC services, decent working conditions, social protection and LTC worker retention should be priorities.

### 2.8.3 Discrimination and abuse of older people and carers

Ageism and discrimination towards older people who need LTC can potentially lead to neglect in daily care-giving, resulting in inadequate or improper care. Respecting personal dignity, safeguarding vulnerable individuals from possible neglect, abuse or violence and training health and social care workers in effective communication and attitudes can enhance overall well-being, especially for older people with disabilities. To mitigate stigmatization and prejudice associated with care, particularly of people living with dementia and their carers, comprehensive workforce training and a strong focus on the quality of LTC should be in place, particularly in residential LTC settings.

### 2.8.4 Fragmentation of services

LTC services are fragmented because various units, facilities and programmes are not integrated into a care network, resulting in lack of coverage of the entire range of promotion, prevention, diagnosis, treatment, rehabilitation and palliative care services. Furthermore, services on different platforms of care are not coordinated, and services may be discontinued over time. The LTC services currently available in countries are usually divided between the health and social care sectors, frequently relying on out-of-pocket payments by families. A particular concern is the adequacy of services to address the complex needs of older people with decreased intrinsic capacity, as the services usually address acute health care needs and often

do not provide post-acute, chronic or rehabilitative care. Establishment of integrated LTC systems and services to achieve UHC for older people will enable countries to ensure equitable, high-quality care (23,39).

### 2.8.5 Lessons learnt from the COVID-19 pandemic

The COVID-19 pandemic has disproportionately affected older people, particularly those in residential care, which has led to global reconsideration of LTC (12,40). The crisis has prompted a shift towards home and community care services, as the pandemic exposed low quality and lack of support in institutional care. The pandemic also shed light on the complexity of LTC systems globally, indicating a need for restructuring and strengthening of the LTC sector. It showed that LTC service delivery should be increased while enhancing system aspects such as leadership, governance, accountability, financing and workforce, to ensure greater responsiveness to the needs of older people and their carers.

Despite immediate responses to urgent issues such as restrictions and protective equipment during the pandemic, challenges persisted, including inadequate coordination between health and social care, workforce shortages, insufficient training and limited support for carers. The fragmented nature of LTC systems became evident, which left many older people and their carers unattended, intensifying feelings of helplessness and isolation.

Positive transformations are taking shape in some countries, including robust infrastructure for LTC, while others are engaged in discussions and initiatives to reorient LTC policies and establish more effective care mechanisms (41,42). Governments are expected to enhance LTC services by strengthening and expanding public services and the state role in LTC provision or by regulatory mechanisms to improve the quality of care by private and not-for-profit providers.

## 2.9 Opportunities recognized by CSOs representing older people and carers

CSOs globally are pivotal in advocating for and providing LTC to older people and carers, actively participating in care networks and promoting equitable services. They amplify voices and advocate for accessible, affordable, rights-based LTC services to increase social inclusion and gender equity. The work of CSOs has been critical in advocating against unequal access to LTC services, which are still significant, due mainly to discrimination on the basis of race or ethnicity, socioeconomic status, disability and gender.

Moreover, CSOs echo voices for affordable high-quality LTC services and decent work for women, who constitute most LTC workers and unpaid carers.

By collaborating with CSOs, WHO underlines the urgency of responsive health and social care systems and services, to ensure that people have the care and support they need, provided in a way that respects their rights and dignity. Ultimately, universal, affordable, person-centred care and support services are aligned with advocacy for social protection, UHC, decent work and gender equity. To achieve these goals, CSOs that represent older people and carers must participate meaningfully in the design, implementation and quality management of services.

In the Decade of Healthy Ageing, WHO prioritizes listening to and meaningful engagement with older people, family members, carers and care workers in planning, designing and delivering LTC services, recognizing the significant role they play in promoting health and well-being (1). WHO has initiated consultations to collect perspectives on LTC implementation in order to integrate the insights of CSOs into LTC guidance and ensure that the package meets the needs of older people and carers.

The proposals from CSOs are as follows.

*Create a narrative to participate in critical discussions on health care.*

The LTC package could enhance LTC governance by ensuring participation in broader discussions on health care. Strategic actions include:

- integrating the LTC package into overarching health-care agendas, including the Sustainable Development Goals, UHC and primary health care, thereby reinforcing its significance and attracting increased attention and resources;
- highlighting the strong gender and social dimensions of LTC, thereby reframing the LTC discourse to encompass gender equity, women's rights and empowerment, aligned with broader societal factors such as socioeconomic status, class, labour, race and ethnicity;
- responding adeptly to evolving policy landscapes, particularly leveraging the post-COVID-19 policy environment that supports LTC, capitalizing on the new momentum for strengthening LTC systems; and
- fostering alignment of diverse stakeholders and sectors to ensure a unified approach to LTC priorities and strategies, thus maximizing the effectiveness of LTC governance.

*Facilitate shared visions and goals, and promote collaboration.*

Enabling discussions on the package can facilitate shared visions, goals and accountability and foster collaboration among stakeholders and sectors. This could include opening political and social dialogue among key stakeholders, including governments, civil society, social partners, older people and carers, to learn from the experiences of CSOs in delivering LTC. Identification of overlaps between rehabilitation and palliative care services, such as early implementation of palliative care, including for older people, at the onset of a noncommunicable disease or other health issue, might create scope for collaboration.

*Increase the visibility of the needs of older people and carers.*

Meaningful engagement of older people, communities, CSOs and social partners will raise awareness about invisible groups. The opportunities include:

- listening to the experiences, preferences and voices of older people and carers;
- recognizing unpaid carers as vital for LTC provision and identifying their unmet needs;
- ensuring carer recognition, training and support;
- recognizing, reducing, redistributing and rewarding unpaid care work, mostly by women; and
- enhancing participation and visibility by engaging older people and carers.





An old man jogging on a road. Thailand, 2011  
© WHO / Chadin Tephaval



# 3

## Core interventions

The goal of the core interventions is to establish strategies to ensure that older people's and carers' needs for LTC are addressed. The interventions should be in line with national and international evidence-based guidelines. The three groups of core interventions in this package are designed to meet needs for health care, palliative care and social care and support.

Health care needs include screening, assessment and management of priority health conditions that result in decreased physical and mental capacity and functional ability, so that older people can maintain their autonomy and independence as much as possible. They include interventions for cognitive decline, limited mobility, falls, physical inactivity and sedentary behaviour, malnutrition, an unhealthy diet, 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 and oral diseases.

The interventions for palliative care include those for improving the quality of both life and death for older people with a serious illness or who are reaching the end of life with one or more debilitating diseases (e.g. dementia, chronic obstructive pulmonary disease, cardiac insufficiency or a musculoskeletal disorder) by preventing and relieving physical, psychological, social and spiritual suffering for themselves and their families. The interventions include regular assessment and management of needs.

The intention of social care and support for older people is to mitigate limitations and optimize functioning

by providing help and support in ADL and in IADL, participation in community and social life, ensuring access and transport and provision of assistive products. The aim of interventions for carers is to support them so that they can sustain a satisfactory, healthy, caring relationship. They include creating and strengthening support networks and enabling community engagement (i.e. psychosocial support) and alleviating the care burden (respite care).

The groups are linked, reflecting the fact that the LTC needs of older people are due to many underlying health and social conditions and cannot be addressed separately. The interventions are delivered in different ways along the continuum of promotive, preventive, curative, rehabilitative and palliative care. For example, assistive products for mobility facilitate ADL (e.g. shower chairs and transfer belts), which is particularly helpful for family carers and personal care workers. Assistive products are also important for managing and prevent impairment, such as use of hearing aids to overcome auditory impairment and prevent cognitive decline. Interventions for common health conditions that affect older people are also interrelated. For example, management of pain and polypharmacy are relevant for the management of other problems, such as limited mobility, falls, depressive symptoms and anxiety.

Some of the interventions listed in Table 1 are available in the ICOPE handbook (35) for providing person-centred assessment and care pathways in primary care. Chapters 10 and 11 of the handbook describe the care pathways for people with substantial loss of intrinsic capacity who require LTC and for carers.

**Table 1.** Interventions in the package

Group of needs	Intervention target
<b>Health care</b>	<ul style="list-style-type: none"> <li>• Cognitive decline</li> <li>• Limited mobility</li> <li>• Falls</li> <li>• Physical inactivity and sedentary behaviour</li> <li>• Malnutrition</li> <li>• Unhealthy diet and substance abuse</li> <li>• Eye conditions and visual impairment</li> <li>• Ear diseases and hearing impairment</li> <li>• Depressive symptoms and anxiety</li> <li>• Polypharmacy</li> <li>• Pain</li> <li>• Urinary and faecal incontinence</li> <li>• Skin pressure injury</li> <li>• Infections</li> <li>• Oral diseases</li> </ul>
<b>Palliative care</b>	<ul style="list-style-type: none"> <li>• Physical</li> <li>• Psychological, social and spiritual</li> </ul>
<b>Social care and support</b>	<ul style="list-style-type: none"> <li>• Older people <ul style="list-style-type: none"> <li>◦ Support and assistance in ADL and IADL</li> <li>◦ Participation in community and social life</li> <li>◦ Accessibility and transport</li> <li>◦ Provision of assistive products</li> </ul> </li> <li>• Carers <ul style="list-style-type: none"> <li>◦ Psychosocial support</li> <li>◦ Respite care</li> </ul> </li> </ul>

### 3.1 Health-care needs

#### **Description**

Strategies and actions 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.

In Brazil, national and subnational policies and services for health promotion and disease prevention among older people are available as part of UHC. A Federal programme delivered through primary care services in municipalities is implementing the “Caderneta da Pessoa Idosa” (The Older People’s Brochure), which includes assessment of older people’s health and social needs and screening for health issues such as cognitive function, risk of falls, pain, health-

related risk behaviour, hypertension and hyperglycaemia. Actions are taken to promote health and prevent illness according to the assessment, including respect for the rights of older people, correct use of and access to medicines, healthy eating, oral health, prevention of falls, physical activity, sexuality and useful contact numbers in the system (43).

A national initiative in Denmark for preventive home visits to people aged 75 years and older is designed to maintain their autonomy, independence and functional ability, allowing them to continue to care for themselves (44). Municipalities organize visits to older people with declining functional ability, mental problems, poor self-rated health, risk of falls or medication problems or who are newly discharged from hospital. Visits are planned according to local needs and include other health-care initiatives. Preventive home visits, including by general practitioners,

include a structured, comprehensive interview to review the daily routines of older people, understand their functional ability in relation to their environment and pose

relevant, specific questions about social, mental and health aspects, including medications (1). Interventions for health care needs are listed in Table 2.

**Table 2.** Overview of interventions for health care needs

Need	Assessment	Management
<b>Cognitive decline</b>	Strategies and actions to ensure that older people are routinely screened and assessed for mild cognitive impairment and dementia. Includes a history and physical examination (e.g. asking older people and their carers about problems with memory, orientation, speech and language, and difficulty in performing roles and activities), conducting laboratory tests, computed tomography scan and magnetic resonance imaging, clinical assessment of cognitive function (e.g. memory, orientation, attention, language) and clinical assessment of depression	Interventions to mitigate cognitive decline and for management of dementia can include rehabilitation for dementia, including cognitive stimulation, cognitive training, reminiscence therapy, person-tailored activities, behavioural interventions and provision of assistive products for cognition, such as memory aids, pill organizers.
<b>Limited mobility</b>	Strategies and actions to ensure that older people are routinely screened and assessed for reduced mobility, including severe limitation. Includes a history and underlying conditions (e.g. fall risk, pain, undernutrition, depressive symptoms, polypharmacy), a physical examination and performance tests (e.g. chair rise, step and walking speed tests) and a nutrition assessment	Interventions for management of mobility limitation can include multimodal exercise programmes (strength/resistance, aerobic/ cardiovascular, balance, flexibility training), oral supplements (protein supplements for people at risk of malnutrition), topical analgesics for pain management, monitoring of weight.  Interventions for management of severe mobility limitation can include positioning to prevent contracture, muscle-strengthening exercises, mobility training (e.g. chair-bounding) and functional positioning.
<b>Falls</b>	Strategies and actions to ensure that older people are assessed for risk of falls (e.g. history of falls, gait and balance problems, fear of falling, visual or cognitive impairment, risky behaviour, environmental risks, increased drug-taking, cardiovascular problems). Post-fall assessments should be conducted to reassess risk factors and adjust interventions.	Interventions for management of the risk of falls can include preventive strategies such as medication review and appropriate de-prescribing of drugs that could increase the risk of falls, management of orthostatic hypotension, balance challenging and functional exercises, home modification. In care homes, interventions can include optimization of nutrition by including foods rich in calcium and proteins and vitamin D supplementation, and no use of physical restraints.
<b>Physical inactivity and sedentary behaviour</b>	Comprehensive strategies and actions to increase older people's level of physical activity and to reduce sedentary behaviour by assessing their capacity for exercise and their physical activity level, including sedentary behaviour	Interventions for increasing physical activity and decreasing sedentary behaviour can include counselling on physical activity, functional ability and fitness, multimodal/multicomponent physical activity and reducing time spent sitting or lying.



Need	Assessment	Management
<b>Malnutrition</b>	Strategies and actions to ensure that older people are screened and assessed for nutritional status and malnutrition by taking a history and conducting a physical examination, with appropriate diagnosis of wasting.	Interventions for the management of malnutrition can include oral nutritional supplementation to increase protein intake, dietary advice, weight monitoring, oral care, rehabilitation of oral muscle function, food and feeding modifications. Other strategies include overcoming barriers to nutritional health, such as encouraging family and social dining, facilitating access to groceries or provision of food by community catering services, volunteers or visitors.
<b>Unhealthy diet and substance abuse</b>	Strategies and actions to assess lifestyle risk factors and barriers to adherence to a healthy lifestyle	Interventions to promote a healthy lifestyle can include providing information to promote health and prevent disease (e.g. healthy nutrition, avoiding substance use) and counselling to address needs and difficulties in managing health conditions. Education, advice and support for a healthy lifestyle can be provided one-to-one or in group sessions.
<b>Eye conditions and visual impairment</b>	Strategies and actions to ensure that older people receive routine screening and diagnosis of eye diseases (e.g. cataract, glaucoma, macular degeneration, diabetic retinopathy) and visual impairment (e.g. difficulty in seeing far, reading, managing obstacles). Screening with tests for visual acuity, contrast sensitivity and visual field should be conducted regularly.	Interventions for the management of eye diseases and visual impairment can include vision skills training, orientation and mobility training, management of eye diseases (cataract, glaucoma), provision of and training in the use of assistive products such as glasses, magnifiers for reading, night lights and referral for specialist assessment.
<b>Ear diseases and hearing impairment</b>	Strategies and actions to ensure that older people receive routine screening and diagnosis of hearing loss with portable audiometry equipment or a whisper voice test, checking for cerumen and identifying the need for specialized hearing care	Interventions for management of hearing impairment can include cerumen removal, training in communication skills, provision and training in the use of assistive products for hearing (e.g. hearing aids, alarm signalers with light, sound or vibration) and referral to a specialist (audiologist, speech therapist) for assessment.
<b>Depressive symptoms and anxiety</b>	Strategies and actions to ensure that older people are routinely screened for depressive symptoms with standardized questionnaires and clinical assessment of depression and anxiety disorders by identifying common presentations (e.g. low energy, fatigue, sleep problems, depressed mood, anxiety) and associated conditions (e.g. cognitive impairment, hearing loss, pain, polypharmacy, loneliness and social isolation)	Interventions for the management of depressive symptoms and anxiety can include use of antidepressants, cognitive behavioural therapy, problem-solving counselling, multimodal physical exercise, mindfulness practice, motivation to remain mobile and socially connected and promotion of functioning in daily activities. Treatment of major depression requires referral to a specialist for assessment and management.

Need	Assessment	Management
<b>Polypharmacy</b>	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.
<b>Pain</b>	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.
<b>Urinary and faecal incontinence</b>	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).
<b>Skin pressure injury</b>	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
<b>Infections</b>	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).
<b>Oral diseases</b>	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 (15,24).
- 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 (1).
- 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 (45). 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 (46) includes advice on customizing rehabilitation according to the context and providing useful rehabilitation to individuals and their families. A package of interventions for rehabilitation includes information on workforce needs and the assistive products, equipment and consumables required to deliver interventions (47).
- WHO guidelines and documents are available on evidence-based interventions (3,48,49).

### **Case example 1. Costa Rica (50,51)**

After a preliminary assessment of the need for LTC, Costa Rica issued a Presidential decree for implementation of the National Care Policy for 2021–2031 for progressive introduction of a system to promote autonomy, support and care for people in a situation of dependence, based on the principles of universality and equal opportunities. It was found that about one in eight adults over 65 years of age needed help in performing their ADL, estimated to comprise 55 000 individuals. The number was projected to be 183 280 by 2050.

Implementation of the policy is coordinated by the Ministry of Human Development, with a dedicated secretariat, and is monitored every 2 years by an inter-ministerial council. The users are adults who have lost physical, mental, intellectual or sensorial autonomy, preventing them from performing ADL on their own. The programme provides three types of benefits: services, cash for care and caregiver training.

Costa Rica has a long-standing national scheme to establish community LTC networks of primary health care teams in health districts in every province, which provide comprehensive, coordinated screening and assessment. The teams comprise a doctor, a nurse assistant, a medical clerk and technical assistant in primary care. Unpaid volunteer programmes are linked to these networks, and community volunteer pensioners are trained directly by the National Council for Older Adults in 3-day workshops that focus on geriatric health, integrated community care and signs for identifying vulnerable older people. The volunteers provide a wide range of interventions at home, including assistance in nutrition, personal hygiene and taking medications.

Home-based care is the main model for delivering LTC interventions, with the support of telecare, and is managed by the Council. In 2018, 59 civil associations received a public subsidy of US\$ 85 per person per month and provided such services to 13 900 beneficiaries.

## **3.2 Palliative care needs**

### **Description**

Actions and strategies 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. Countries that provide examples of palliative and end-of-life care models and interventions include Australia, Bangladesh, India, Indonesia, Jamaica, Malaysia, Mongolia, Oman, Panama, the Russian Federation, Viet Nam and Zimbabwe (52). Interventions for palliative care are listed in Table 3.

**Table 3.** Interventions for palliative care needs

Need	Assessment	Management
<b>Physical</b>	A holistic approach for the regular assessment of physical symptoms and needs to improve the quality of life of patients and their families who are facing a serious illness or chronic debilitating condition (e.g. cardiac failure, chronic obstructive pulmonary disease, dementia, cancer). This includes proper identification of those who require palliative care, comprehensive assessment of physical symptoms and regular monitoring of treatment for symptom control (e.g. pain, breathlessness, fatigue, nausea, vomiting, anorexia, constipation, delirium, insomnia).	Interventions for optimal control of physical symptoms (non-pharmacological and pharmacological) and provision of comfort. Can include pain relief techniques, medications for treatment of pain and other symptoms such as nausea, vomiting and constipation, supplemental oxygen, mouth and skin care and training of carers. It includes setting explicit care goals, anticipating progression of the disease in order to meet the needs, preferences, values and beliefs of people receiving palliative care.
<b>Psychological, social and spiritual</b>	A holistic approach to regular, comprehensive assessment of psychological, social and spiritual needs, such as psychological distress, depression and anxiety, existential distress, stigmatization, discrimination, carer needs and bereavement.	Interventions for addressing the psychosocial and spiritual needs of older people and their families can include assessment and treatment of mood disorders such as depression and anxiety, psychological counselling for grief, trauma and bereavement, social support, management of spiritual distress (e.g. with meaning-oriented therapy, legacy-building, mindfulness meditation, art therapy) and support during bereavement.

**Key points**

- Palliative care should be provided by a doctor or nurse with at least basic training in palliative care. A specialist in palliative care is not necessary for relieving most physical, psychological, social or spiritual discomfort of older people.
- Problems may be associated with one or more serious illness or debilitating diseases (e.g. dementia, chronic obstructive pulmonary disease, cardiac insufficiency).
- Pain is one of the most frequent, serious symptoms experienced by older people and by patients with a serious illness who need palliative care. A palliative care approach to pain includes a comprehensive pain assessment, understanding of the patient's goals for pain management and use of pharmacological and non-pharmacological approaches to achieve optimal pain control. Such patients must be reviewed regularly, as they may require increasing doses of analgesia with progression of their disease.
- Palliative care, including end-of life, includes improving the quality of life and helping older people to live as independently and actively as possible until their death, despite having a clinical condition that is resistant to active treatment. It also includes services to help families cope with emotional, social or spiritual distress during the patient's illness and during bereavement.
- The goals of care change over time because of factors that include the disease trajectory and clinical condition. Interventions should be flexible and tailored to the specific, changing needs of older people and their families.
- Current or previously expressed preferences about future care (e.g. place of care, place of death, enteral tube nutrition, life-sustaining treatment, transfer to hospital) should be discussed carefully. The format of advance care planning may vary; however, it is an important part of setting the goals of care. The plan for care should be reviewed regularly with the patient or family, intermittently and after any major change in the health of the patient. The goals of care should be known to all those involved in the care network, particularly in care transitions.



### Actions

- Include palliative care interventions in the person-centred, integrated, coordinated care approach, including assessment of the physical, emotional, social and spiritual needs of older people and their families, and a care plan that reflects the patient's values and culturally and individually appropriate goals for care (53).
- Include identification and assessment of pharmacological and non-pharmacological treatment of physical symptoms, such as pain, dyspnoea, constipation, nausea, vomiting, diarrhoea, wounds, pruritus, haemorrhage and seizures.
- Identify, assess and relieve psychological problems such as anxiety, depression, delirium and agitation.
- Identify, assess and relieve social suffering, such as that due to extreme poverty, social isolation, stigmatization and lack of transport.
- Identify, assess and relieve spiritual distress, such as loss of meaning or faith.
- Communicate with the patient, family or carers, as culturally and individually appropriate, about a diagnosis, prognosis, treatment, symptoms and their management, particularly near the end of life. When planning and coordinating care, set priorities with patients and their families, as appropriate, to establish the goals of care, recognizing that the goals may change during provision of LTC.

### Case example 2. Kenya (54,55)

Kenya conducted a national situational analysis to identify gaps in palliative care, which guided development of a palliative care policy in 2018, to be implemented by national and county governments. The policy consolidates and standardizes existing services and provides a legal framework to ensure timely, evidence-based, holistic palliative and end-of-life care services delivered through UHC.

The Kenya Palliative Care Policy 2021–2030 is based on seven pillars: (i) advocacy and communication; (ii) leadership and governance; (iii) service delivery; (iv) availability and access to essential medicines and commodities; (v) human resources and education; (vi) health information systems and research; and (vii) health-care financing. Priorities have been set for each pillar.

The provision of palliative care in LTC includes its integration into care for all relevant chronic and emerging diseases until death, with an interdisciplinary team maintaining strong, well-defined links to community and home care systems. Interventions are tailored to prevent or mitigate suffering by offering physical, spiritual and psychosocial assessment and care and treatment by health-care workers and carers, including effective management of moderate-to-severe pain and end-of-life care (e.g. support for family and carers, care of the body after death, bereavement counselling). The policy also requires LTC facilities to have policies and procedures for handling death and the dying by trained, prepared staff.

To ensure the quality of palliative care interventions, the Kenya Government introduced strategies to strengthen the supply chain for essential palliative care medicines, equipment and commodities. The Kenya Hospices and Palliative Care association (<https://kehpc.org/>) helped to catalyse palliative care policies and to give a voice to people with palliative care needs, using a multisectoral approach to promote access at community level by engaging various partners, including palliative care providers, the Ministry of Health, county governments, development partners, communities and people with palliative care needs. The association also promotes leadership to deliver, access, educate and spread palliative care skills for health-care professionals, such as the Palliative Care Nurse Leadership Initiative in 2021 to strengthen the leadership skills of nurses to improve service delivery, teaching and advocacy.

### **Case example 3.** Ontario, Canada (56,57)

The Ministry of Health and the Ministry of Long-term Care in the Government of Ontario provide patient-centred, coordinated palliative care to relieve suffering and improve the quality of life of patients and their families at all stages of an illness. The holistic approach includes assessment and management of the progression of illness by physicians and nurses, pain and symptom management to improve comfort and quality of life, personal support services (e.g. homemaking), psychological and social services, and spiritual and bereavement support. Other services, such as physiotherapy, caregiver support and pharmacy provision, may also be provided.

Palliative care is delivered in all care settings (home, hospices, residential homes) and through various channels, such as primary health care providers, local home and community care support services, local hospitals and LTC facilities.

The Ontario Palliative Care Network is funded by the Ministry of Health and Ministry of Long-term care to provide coordinated, patient-centred hospice palliative care throughout the province. The Ontario Provincial Framework for Palliative Care helps to provide better, connected care and guides future work to ensure that palliative care is provided at every stage of life and at the end of the continuum of care. The Ontario Ministry of Health and the Ministry of Long-term Care support provide policy guidelines and funding for a patient-centred, coordinated palliative approach to care to relieve suffering and improve the quality of living and dying for every person with a serious illness. The palliative care framework is a holistic approach to care to help individuals and their families or caregivers to:

- address physical, psychological, social, spiritual and practical issues and patients' expectations, needs, hopes and fears;
- prepare for and manage end-of-life choices and death;
- cope with loss and grief;
- prevent and treat all issues; and
- promote opportunities for meaningful, valuable experiences and personal and spiritual growth.

Palliative care can complement other treatment throughout an illness. It is delivered in any care setting, including homes, residential and community hospices, LTC homes and hospitals by various health-care providers, such as primary-care clinicians (e.g. family physicians, nurse practitioners, family health teams, nurse practitioner-led clinics, community nurses, home health-care providers, pain and symptom management consultation teams, emergency care) or specialist clinicians (e.g. oncologists, internists, geriatricians, paediatricians, respirologists, cardiologists, nephrologists, neurologists, critical care physicians, surgeons).

The Ontario Palliative Care Network, part of Ontario Health, is funded by the Ontario Ministry of Health to coordinate a systematic approach for delivering palliative care. With the passage of the Compassionate Care Act, 2020, and the Fixing Long-term Care Act, 2021, Ontario is continuing to improve equitable access to high-quality palliative care for individuals, families and caregivers in all regions of Ontario. The Ontario Provincial Framework for Palliative Care can help to provide better, connected care and guide future work to ensure that all Ontarians receive the respect, dignity and care they deserve at every stage of life and throughout the continuum of care.

## **3.3 Social care and support needs**

### **Description**

Strategies and actions to mitigate limitations and optimize functioning by providing help and support for older people and supporting carers' needs so that they can maintain a satisfactory, healthy, caring relationship and reduce strain and isolation.

### **3.3.1 For older people**

Interventions for older people include supporting them in ADL and in IADL, enabling their participation in community and social life to reduce social isolation and loneliness, facilitating accessibility and transport to community services and provision of assistive products.

These interventions are crucial for managing older people's decreased functional ability and enabling them to live meaningful lives with dignity in the place of their choice. Examples of such initiatives are found in several countries, including Brazil (58), the Republic of Korea (59) and Thailand (60). The Brazilian scheme provides assistive care for dependent older people in disadvantaged communities through lay carers recruited from similar communities, given basic training and paid a basic wage. The Republic of Korea offers 360 h of training to certify personal care workers for assistance in excretion, bathing, eating, cooking, washing, nursing, treatment or recuperation. The initiative in Thailand is provided by carers specialized in LTC and by trained home care and village health volunteers in community programmes (51,60).

### Key points

- Many older people who require assistive services have complex needs, including cognitive impairment, limited mobility and multiple chronic conditions. It is therefore essential to identify and prioritize problems and needs.
- Individuals receive supportive or assistive care to mitigate their decreased functional ability in various domains. An older person might need help in one activity, such as in transferring from bed to a chair, but can carry out other activities, such as managing finances or making health appointments, independently. Rehabilitative strategies to promote as much independence as possible in ADL and IADL can be included either directly by referral to rehabilitation services or by training carers and personal care workers.
- Inability to move around a neighbourhood should not mean that older people are confined at home and lonely. Many strategies can be arranged, such as going out with the support of a carer or a personal care worker, provision of assistive products and ensuring age-friendly environments to facilitate access and transport to community services. Such strategies help older people to continue participating in activities that allow building and sustaining relationships with family, friends and the community.
- Social isolation and loneliness tend to exacerbate personal care needs, whereas socially inclusive interventions promote active ageing and reduce care needs. This is also the case for older people living in care homes, where intergenerational activities and engagement with local community organizations can be fostered.
- Older people and their carers should be able to choose, without undue difficulty or financial burden, the setting of their choice for receiving assistive care in (e.g. at home, in a day-care centre or in an LTC facility). The goal is to ensure a positive experience for older people and carers. Care

needs should be identified in an assessment of functional limitations, underlying health conditions, the availability of social support, the values and expectations of older people and carers and previous experience of services. Collaboration of an integrated, multidisciplinary care team can maximize the possibility of a positive outcome.

- Connecting older people with their neighbourhood and promoting interactions with the wider community are crucial in all settings. Transition, when necessary, from moderate care to more care without undue loss of autonomy is essential to ensure continued, sustained care provision. Age-friendly environments can support older adults with different levels of functional impairment to be as active as possible in their communities (61).
- Countries should seek a coherent balance of LTC services between care settings. The development of home and community-based services, including support for carers, as an alternative to institutional care can promote ageing in place, enhance social connections, and can improve the use of resources and expertise developed in communities (62).

Provision of assistive and supportive care at home includes understanding and coordinating the entire network of care in terms of processes and services offered in the local community. WHO has issued several guiding documents on assistive technology and products, including a list of 50 priority assistive products (63). Countries are not expected to provide all the products, but the list is a starting point for improving access and creating a national list of priority assistive products according to national need and resources (64).

### Actions

- Standardize assessments (who, when and how), including defining instruments for measuring functional ability and care needs in both basic ADL (eating, grooming, dressing, toileting, bathing, transferring) and IADL (ability to use a phone, shopping, food preparation, housekeeping, laundry, use of transport, responsibility for medications, ability to manage finances).
- Assessment must be followed by timely provision of effective assistive or supportive care, with regular follow-up to identify changes in functional status and to measure satisfaction by older recipients of services.
- Some groups of older people are more likely to experience inequality in care provision, such as those who live alone, in a rural or remote area or in a deprived neighbourhood and older gender-diverse people. These groups should be the target of specialized support and prioritized for intervention.
- Information should be made available to assist older people and carers in finding care services and pathways.

### 3.3.2 For carers

The goal of interventions for carers is to create and strengthen support networks, enable community engagement (psychosocial support) and alleviate the burden of care (respite care).

#### Key points

- The reasons for becoming a carer depend on various factors (e.g. traditional gender roles, socioeconomic restraint, cultural influences), some of which may increase the likelihood of physical and mental problems. Caring is a dyadic relationship, and factors that might contribute to a positive or negative relationship should be evaluated before any intervention.
- Support should be offered to family members and other unpaid carers, particularly when the care required is complex or extensive or is likely to impose a significant strain on the carer.
- Support groups can be complemented by education and training within a multicomponent intervention, such as respite care, cognitive behavioural therapy or psychological counselling.
- Widespread information and communication technology can be used to support interventions and be scaled up.
- The risks to carers of burden and strain are well known; however, the positive aspects of caring should be optimized.
- Attention should be paid to ensure that older carers receive health and social care services for themselves.
- WHO published a report on national initiatives to support carers of people with dementia (65), which describes the types of services offered (including digital support), progress with regards to implementation and accessibility, services and initiatives to protecting carers' rights and training in health and social care for carers.

#### Actions

- Set strategies to implement psychosocial interventions, create support networks (e.g. peer-led support groups, groups led by a trained facilitator, web-based and

telephone groups), and enable community engagement of carers. Psychosocial interventions may include psychoeducation, counselling, leisure and physical activity, cognitive behavioural approaches and support networks. The number of sessions, frequency and period vary. Interventions can be delivered by professionals (social workers, therapists) or informal supporters.

- Share the view that carers are crucial in care provision among agencies, service managers and clinical staff, not only for providing care but also as individuals who may suffer physically, emotionally, financially and socially due to their work. Preventing carers strain and health risks is fundamental for both themselves and the people for whom they care, whose conditions may worsen if they do not receive adequate support.
- Create a system to identify, update and provide continuous information on the availability of community resources and services, such as carers support programmes by religious organizations and volunteer agencies.
- Coordinate with health and social services to ensure that interventions for carers are part of the care plan, and ensure strategies to optimize and monitor adherence of carers to psychosocial support and their level of satisfaction.
- Introduce policies to ensure the availability and accessibility of psychosocial support groups in the community.
- Set policies to enable carers to maintain or reactivate their social networks, such as through personal care workers, volunteering programmes and respite care.
- Deliver psychoeducation information for carers through community support networks.
- Provide sustained respite care for carers, particularly family carers, to prevent them from breaking down (e.g. home respite care by personal carers, short-term residential care, day care, seeing a friend, neighbour or volunteer for a few hours).

Interventions for social care and support needs for older people and for cares are listed in Table 4.

**Table 4.** Interventions for the social care and support needs of older people and carers

Need	Assessment	Management
<b>For older people</b>		
<b>Support and assistance in ADL and IADL</b>	Strategies and actions to assess the need for assistance and support with basic ADL and IADL, including assessment, provision of care (frequency, intensity, difficulties), carer’s assessment (burden, strain, views and expectations) and problems with living conditions and finances.	Support and assistance in basic ADL (e.g. eating, grooming, dressing, toileting, bathing, transferring) and in IADL (use of a phone, shopping, food preparation, housekeeping, laundry, transport, responsibility for medications, managing finances) can include development of a social care and support plan with home and institutional personal care workers, counselling for community support services, training and coaching of carers, provision of ADL training and assistive products for personal care (e.g. shower chairs, grab bars, assistive products for toileting, drinking, dressing).
<b>Participation in community and social life</b>	Strategies and actions to assess the social network (family, friends, neighbours) of an older person and their participation in community and social life and understanding of the reasons for social isolation and loneliness, including clinical assessment of patients who may be at risk, and connecting them to community resources.	Interventions to build and maintain relationships, address loneliness and increase participation in the community can include intergenerational and group activities, volunteer visits, companionship, participation in focused interventions conducted by occupational therapists, social workers and professional counsellors, home support services, counselling on environmental modifications to facilitate social participation.
<b>Accessibility and transport</b>	Strategies and actions to assess the mobility of older people in the community, including difficulty in walking in the neighbourhood (e.g. built environment accessibility, violence, connectivity), facilitate access to and availability of transport services.	Interventions for accessibility and transport in the community can include counselling on moving safely in the community, transport facilities and assistance services for outdoor mobility, provision of assistive products (e.g. walking aids, wheelchairs), age-friendly neighbourhoods (e.g. barrier-free sidewalks, pedestrian amenities, adequate lighting).
<b>Provision of assistive products</b>	Strategies and actions to identify individual needs according to health and clinical condition, functioning and social support to select and fit appropriate assistive products for personal care, mobility and sensory impairment.	Interventions to provide assistive products can include selection, adjustment of an appropriate product to an individual, training and monitoring of use.  Assistive products for personal care include products to facilitate eating, drinking, bathing, dressing and going to the toilet (e.g. adapted plates and cutlery, pill organizers, chairs for bath, shower or toilet). Assistive products for mobility include products to support people who have difficulty in moving any body part freely and easily, from sitting upright or carrying objects, to walking and climbing stairs (e.g. walking aids, wheelchairs, prosthetics, orthotics, therapeutic footwear, portable ramps and grab bars). Assistive products for visual impairment help a person to see more clearly, to recognize their environment and to access information (e.g. glasses, magnifiers, braille equipment, talking or touching watches and white canes). Assistive products for auditory impairment can help people to interact with other people and the environment by improving their hearing or using other senses (e.g. hearing aids and alarm signallers with light or vibration).



Need	Assessment	Management
<b>For carers</b>		
<b>Psychosocial support</b>	Strategies and actions to assess the health and social problems and demands of caring that result in a burden, strain and social isolation of carers.	Interventions for psychosocial support can include psychoeducation, counselling, providing leisure and physical activity opportunities, cognitive behavioural approaches, development and connection with support networks and systems (e.g. peer-led support groups, groups led by a trained facilitator, web-based and telephone groups) and increasing the community engagement of carers.
<b>Respite care</b>	Strategies and actions to assess the need for respite care (i.e. interventions to relieve carers of the demands and stress of caring), promoting carers' health and well-being	Interventions for provision of respite care include home respite care by personal carers for various durations and frequency, such as short-term residential care, day care, seeing a friend, neighbour or volunteer.

#### Case example 4. Uruguay (66)

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.

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**Case example 5. Singapore (67-69)**

Carer Matters is a pioneering hospital-to-home nursing initiative in which family carers are integrated as valued partners in the care team. The initiative equips them with the essential knowledge, skills and support for enhancing their competence in caregiving and strengthens their resilience. Its aim is to empower family caregivers in providing sustainable care for their loved ones in the community, while preserving their psychosocial well-being. The initiative is based in Tan Tock Seng Hospital of the National Healthcare Group, a multidisciplinary hospital with strong roots in the community and which has been part of Singapore's public health-care system for 179 years. The Hospital has 2000 beds and hosts centres of excellence, such as the National Centre for Infectious Diseases, the Institute for Geriatrics and Active Ageing, the National Healthcare Group Eye Institute and the Tan Tock Seng Hospital Rehabilitation Centre.

Carer Matters has completed a pilot project and is being integrated into standard care, within a comprehensive framework of six domains:

1. assessing caregiver stress and offering standardized community resource packages to find support;
2. providing “tele-support” to assist caregivers in the demands of caregiving and reminders about self-care to prioritize well-being;
3. developing and conducting caregiver training workshops on a variety of knowledge and skills;
4. collaborating with community partners to connect caregivers to social support networks;
5. curating educational caregiving resources; and
6. providing group training in caregiver skills.

Project Carer Matters 2 was launched after recognition that support cannot be provided by the Hospital alone. Its aim is to develop solutions based on both technology and the social ecosystem of caregivers. Researchers, clinicians, technology and digital health experts and social service providers, with caregivers and older people, are collaborating in the design, implementation and evaluation of solutions, such as a caregiver activation mobile app and a chatbot. The objective is to provide cost-effective, sustainable support to caregivers and widespread adoption.

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Portrait of Ramatou, 56 in Ménaka on 19 December 2022. She is diabetic and hypertensive, and was glad to be vaccinated against COVID-19 © WHO / Fatoumata Diabate





# 4

## Facilitating factors

### 4.1 Person-centred integrated care

In order for services and service delivery to be integrated, actions and interventions should be designed in collaboration with social partners to ensure coordinated, integrated care. The goal is for older people to receive timely, person-centred care through coordinated integration of the full spectrum of health and social services and the collaboration of a multidisciplinary team.

A person-centred care approach consists of actions and strategies to meet the needs and goals of older people

and carers, while respecting their preferences, values and dignity. The approach has three main strategies: assessment of needs, development of a care and support plan and care coordination. It may change over time, as care needs may change during the progress of a disease and the caring context. Fig. 6 shows the strategies for establishing a person-centred care approach, which should be individualized according to the older person's capacity and ability and the setting in which the interventions will be delivered. Carers and LTC workers establish trusting partnerships with older people and therefore understand what is important to them and their needs, help them make decisions on their care, identify and achieve their goals and enable them to manage their health on a daily basis.

Fig. 6. Strategies for establishing a person-centred care approach

## Long-term Care Person-centred Integrated Process



### For older people

with decreased physical and mental capacities and functional abilities



### and for their carers



### Assessment of needs

#### Comprehensive assessment, including:

- Mental and physical capacity and functional ability (e.g., ADL/IADL)
- Underlying health conditions
- Socioeconomic and environmental situation
- Need for assistive products
- Carer's needs



### Development of a care and support plan

- Goal-oriented care plan tailored to older person's and carers' unique needs, values, priorities, and preferences, considering 3 groups of interventions:
  1. Health care, 2. Palliative care, 3. Social care and support
- Decisions shared between older people, their carers and multidisciplinary care team about where, who, and how care will be provided



### Care coordination

- Delivery of LTC interventions throughout a continuum (i.e., promotion, prevention, treatment, rehabilitation, palliation)
- Across settings
- Integration of health and social services
- Community engagement



### Care implementation

- Promotion of self-care
- Referrals for specialized care when appropriate
- Collaborative work and information sharing among LTC workers
- Development and dissemination of person-centered care practices



### Care monitoring

- Monitoring of plan outcomes and effectiveness
- Measurement of satisfaction of older people, carers, and LTC workers
- Identification of barriers to integrated care
- Regular re-assessments and when changes in health conditions or caring context occur



### 4.1.1 Components

The three main strategies for delivering person-centred, integrated LTC – assessment of care needs, development of a care and support plan and care coordination –

have several components (Table 5). The components did not represent a pathway for care provision but are interconnected and critical for the provision of interventions in this package, so they can be delivered in a person-centred, integrated, coordinated approach.

**Table 5.** Components of person-centred, integrated LTC

Component	Description
<b>Person-centred health and social assessment</b>	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.
<b>Assessment of carers' needs</b>	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).
<b>Assessment of need for assistive products</b>	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.
<b>Development of a care and support plan</b>	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.
<b>Care coordination</b>	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.
<b>Promotion of self-care</b>	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.

#### 4.1.2 Person-centred health and social assessment

##### Description

A comprehensive person-centred assessment of an older person, with eventual identification of needs for health and social care services. An example of a person-centred assessment is home care delivery in Netherlands (Kingdom of the) under the Healthcare Insurance Act, whereby home assessments are conducted by district registered nurses and certified nursing assistants. Registered nurses with a bachelor's degree conduct a formal assessment of care needs, create a care plan with the older person and deliver technical nursing care. Certified nursing assistants deliver mainly personal and psychosocial care, assist in personal activities and evaluate and monitor implementation of care plans (70).

##### Key points

- Older people and carers should be involved in making decisions when possible, in establishing goals and in addressing their needs, goals, values, priorities and preferences.
- An assessment of functional abilities is essential to allow individuals to live a life with meaning and dignity. It includes the type and complexity of care needs, organization and management, intensity, frequency and duration. Any unmet needs and their causes should be identified.
- The assessment should focus on the context of older people's daily lives as part of a family and a community. It is not limited to an assessment of underlying diseases and health conditions. Older people and carers should be informed about the rationale, process, format and duration of the assessment.

##### Actions

A multidimensional holistic assessment consists of:

- social (e.g. socioeconomic and financial situation, support structure) and environmental context of older people and their carers, including the costs for care needs;
- health conditions and diseases, including risk factors for chronic conditions and medications;
- intrinsic capacity (i.e. vitality, hearing and vision, cognitive, locomotor, psychological);
- functional ability, including need for support in:
  - basic activities (e.g. eating, grooming, dressing, toileting, bathing and transferring);
  - IADL (e.g. ability to use a phone, shopping, food preparation, housekeeping, laundry, use of transport, responsibility for own medications, ability to manage finances);
  - mobility (ability to move among various life spaces);
  - build and maintain relationships (loneliness and risk of social isolation);
  - learn, grow and make decisions (autonomy, independence, dignity, opportunities for life-long learning); and
  - contribute to society (e.g. social participation and pursuing cultural activities).

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### Case example 6. New Zealand (71,72)

Needs Assessment and Service Coordination are contracted by the Ministry of Health in each district of New Zealand to provide a multidimensional, comprehensive clinical assessment of older people to identify their clinical, functional (ADLs and IADLs), social and psychological needs. A needs assessment can be requested by a physician or practice nurse, by hospital staff for planning discharge process or by an older person or a family member.

An assessor (who must be a health professional who conducts assessments, such as a registered nurse, occupational therapist or social worker) conducts an assessment in the person's care setting, such as at home, in hospital, in a convalescent facility or in a hospice. The assessments address current function and factors that impact well-being, such as having carers, their roles and potential needs. The assessment also addresses present and future risks and identifies opportunities to improve function or prevent decline. The results of the assessment are used to design an individual plan of care, including any treatment or rehabilitation required.

Guidelines on best practices for assessing older people published in 2003 identified interRAI as the appropriate tool for home assessments and endorsed the configuration of adequate services, including formation of multidisciplinary teams, case management, monitoring and evaluation. Intersectoral work encourages cooperation among district service providers, between needs assessment and service coordination and supports appropriate training for those involved in assessments to maintain best practice standards.

Seniorline is a disability advisory service that provides information about how services are delivered to older people in New Zealand and advice on accessing an assessment, entry to residential care, financial support and finding the nearest NASC. Seniorline is supported by Te Whatu Ora/Health New Zealand.

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### Case example 7. South Africa (73,74)

Non-profit organizations working in a rural setting in Bushbuckridge local municipality in South Africa involve a cadre of lay health workers, known as community care workers, who volunteer to provide general home care services. Most of the organizations are registered to provide a community caregiver for older people, who apply at the nearest office of the Department of Social Development and meet some of the requirements regulated by the Non-profit Organisations Act.

Extension of the non-profit sector has reduced gaps in the health-care system, opened employment opportunities and created a platform for the empowerment of rural women. Community care workers, who are primarily women from local communities, observe, examine and interpret the physical and emotional conditions of older people and their households, identify their care needs and establish needs that are likely to guide care provision. A cyclical process is used to evaluate and adapt the package of services when the health and social needs of older people change. Primary care professionals are also engaged, and decisions on each case are shared among providers.

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#### 4.1.3 Assessment of carers' needs

##### **Description**

A comprehensive, person-centred assessment of carers' needs for health, training and support. In the United Kingdom, for example, carers are assessed by social workers, who then offer support, such as respite or home, to carers in difficulty (75).

##### **Key points**

- Person-centred care implies definition of an older person's social network, including family members, friends, volunteers and care workers (personal care and domestic workers).
- Carers and personal care workers can provide hands-on, personal, relational care for eating, showering, emotional support, transport, shopping and attending medical consultations, and also indirect care, such as meal preparation, housekeeping and repairs.
- The roles of different carers, particularly concerning the distribution of caring responsibilities within a family, should be distinguished, such as a carer responsible for arranging and coordinating care and a carer who makes health and financial decisions. Carers who respond to emergencies such as falls, visits to emergency services and hospitalization should be clearly identified.

### **Actions**

- Assess the burden of caregiving, including psychological distress and financial problems due to caregiving.
- Assess care provision in terms of intensity, quality and frequency, any difficulty in performing care activities and possible safety or organizational issues.
- Identify any lack of skill, resources, ability or knowledge necessary to provide care.
- Understand the background and context of care from the carer's perception of the health and functional status of the care recipient, including the carer's health and well-being and the involvement of family support groups and community services.
- Identify carers' experience of psychosocial and respite services to identify barriers and enablers.

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### **Case example 8. Singapore (76,77)**

In 2018, the Agency for Integrated Care was designated as the single agency for coordinating the delivery of aged care services and for service development and capacity-building in both health and social domains. The Agency was started as the Care Liaison Services under the Ministry of Health to coordinate and facilitate the placement of elderly sick people to nursing homes and chronic sick units. Their role was subsequently extended to discharge planning and facilitating transition of patients from hospitals to the community.

The Agency coordinates and supports integrated care to ensure the best outcomes. It works with community care partners in developing services and capacity-building to increase the quality of care and bring care support closer to those who need it.

As part of a plan for community mental health masterplan, the Agency forms community intervention teams, which are multidisciplinary teams that support people with mental health conditions, including dementia, and their caregivers in the community. The teams conduct needs assessments and provide counselling and psychosocial therapy for older people and their caregivers according to individual care plans.

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### **Case example 9. United Kingdom (78)**

The United Kingdom has enacted legislation on assessment of the needs of carers and provision of support, especially for carers who are looking after a relative with dementia. The legislation, the Carers and Disabled Children Act 2000 and the Carers (Equal Opportunities) Act 2004, outline the role of local authorities in providing services that can help carers to continue to care for older people while maintaining their well-being and also to recognize carers' right to proper assessment and support through access to social and health-care services. The legislation empowers local authorities to make direct payments to carers to meet their own needs and to provide voucher schemes for short-term breaks to allow carers to manage their own package of support. The Carers (Equal Opportunities) Act 2004 builds on existing rights and emphasizes the right to assessment of carers' needs.

The United Kingdom recognizes that carers are central to the care of older people and that support for carers' must reflect individual differences. As this premise is fundamental to organizing services, carers should always be offered a separate assessment of their needs and encouraged to think about maintaining their quality of life and their own needs. Organizations and agencies are encouraged to review their arrangements to ensure that they offer carers an assessment at any entry point into the LTC system (e.g. from hospital to home, specialist care) and achieve relevant outcomes.

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#### 4.1.4 Assessment of need for assistive products

##### Description

Assessment of need for assistive products includes identification of those that best meet older people's requirements and priorities, taking into account their health, preferences and lifestyle and where they will be used. Older people and their carers should be actively involved in assessments. A programme in Canada, for example, includes assessment of the need for certain assistive products, which can be obtained with financial support from governments, communities or non-profit organizations as part of a care package offered according to the results of a needs assessment (79).

##### Key points

- Assistive products can optimize older people's functional abilities in critical areas such as self-care, cognition, communication, hearing, vision and mobility and their well-being, participation and inclusion, ensuring that they lead more fulfilling lives in their families and communities.
- Use of assistive technology in LTC can reduce the level and intensity of assistive care. Responsive policies are required to ensure access to high-quality assistive products in health and welfare schemes in order to avoid out-of-pocket payments by older people and their families.
- Provision of adequate assistive products includes selecting those most appropriate for each person's

needs, preferences (e.g. aesthetics, features, safety issues), priorities and goals to ensure the greatest possible independence and to facilitate care provision with products that match individuals' functional difficulties. Services should be responsive to changes in the needs of older people and carers over time.

- Close integration between health and social care teams is essential for proper, timely prescription, fitting, training and follow-up of assistive products. Furthermore, integration of services ensures that assistive products are delivered as part of a continuum of care, obviating multiple appointments at different locations and providing interventions as and when needed.

##### Actions

- Determine the extent of integration between the policy for assistive technology and the plan of action, including an adequate budget and national and subnational LTC policies.
- Identify the accessibility and availability of assistive products and environmental modifications and any gaps in assistive technology service provision and workforce training.
- Create a list of products available locally.
- Assess the satisfaction of older people and their families with assistive products and barriers and facilitators to avoid adoption and then abandonment due to distrust, worry about privacy and safety and social stigmatization.

#### Case example 10. United States of America (80)

Staff of the Virginia Assistive Technology System meet monthly with Virginia No Wrong Door to coordinate awareness of and access to assistive devices and services in the No Wrong Door system. The System makes assistive technology kits available to No Wrong Door staff to address social isolation and personal safety among their constituents. Partners include rehabilitation hospitals, local agencies for ageing, centres for independent living and non-profit organizations, and collaboration among several state agencies, private industry and non-profit organizations is helping older adults and people with disabilities to acquire appropriate, affordable assistive devices and services. The Assistive Technology System has received funding from NWD, through the Coronavirus Aid, Relief, and Economic Security Act (2020) and the American Rescue Plan to purchase assistive technology kits for demonstration, short-term loans and training. The assistive technology specialist of the System is a member of the local No Wrong Door advisory council for coordination of access to assistive technology.

The partnership between the State assistive technology programme and No Wrong Door is evolving. The reach of both groups has expanded to meet the needs of older adults and people with disabilities, and awareness of assistive technology is increasing through information and assistance, demonstrations, short-term loans, training and public awareness campaigns by partners. For replication in other states, a solid relations must be built between assistive technology acts and No Wrong Door.



### **Case example 11.** Ontario, Canada (79,81.82)

The assistive devices programme in Ontario is administered by the Ministry of Health and the Long-Term Care Direct Services Division through the Ministry of Health and Long-Term Care Act, R.S.O. 1990. The programme provides person-centred support and funding to people with a long-term (6 months or longer) physical disability, including fair, affordable access to personalized assistive products appropriate for the basic needs of each individual.

The Government subsidizes equipment for people with long-term disabilities and covers 75% of the cost, paid directly to suppliers. The programme also covers replacements when the medical condition and/or functional ability changes and the current assistive product no longer meets the individual's needs, when body size changes or when the product cannot be repaired at reasonable cost and is no longer covered by a warranty. The types of assistive products include mobility devices, hearing aids, communication aids, visual aids, diabetic and respiratory equipment and supplies, home oxygen therapy, lymphoedema supplies, enteral-feeding pumps and supplies, and ostomy supplies.

#### **4.1.5 Development of a care and support plan**

##### **Description**

A care and support plan that is goal-oriented, addresses a person's unmet needs and respects their preferences, values, priorities and capacities by timely, appropriate activation of the necessary health and social services.

Countries that have developed person-centred assessment strategies for various settings with holistic attention to the needs of older people and their carers are likely to promote care plans that address those needs, ensuring that they receive an adequate package of interventions. This is the case in Netherlands (Kingdom of the) and the United Kingdom, as mentioned previously (70,75). Care and support plans in the person-centred approach have links to preventive, supportive, assistive and palliative interventions.

##### **Key points**

- A care and support plan is established after a comprehensive assessment that results in a list of possible problems to be prioritized and targeted, according to individual needs and goals.
- A care and support plan should include the expressed needs of older people and their preferences for care and ensure referral pathways and timely links to specialized geriatric care when necessary.
- Providers should include multi-component interventions, management of underlying diseases, self-care, self-management and social care and support.
- Planning of care should reflect the necessary transformation of health care from a reactive, disease-focused, fragmented model to a person-centred, proactive, holistic, more preventative plan.

- A care and support plan serves as a road map for integrated actions among care providers.
- A care and support plan can be used to measure progress in achieving established goals that are meaningful for the older person. Standardized re-evaluations should be conducted to detect any changes and consequent modification and updating of the care plan.

##### **Actions**

- Identify a care coordinator.
- Empower older people for self-care, and enable them and their carers to make informed decisions.
- Integrate health and social needs, and share appropriate information on health and social care and support plans with the team.
- Promote integration with other levels and types of care services. Care managers should be familiar with the local resources and services available to older people.
- Discuss and include advanced care planning when necessary.
- Establish links to specialized geriatric care.
- Consider the use of assistive products and home modifications.
- Conduct proactive follow-up by reviewing older peoples' needs periodically.
- Communicate the findings for action.
- Develop "smart" (specific, measurable, attainable, relevant, time-bound) goals and objectives.

### Case example 12. Thailand (83)

Thailand's LTC policy, implemented by the ministries of Public Health, Social Development and Human Security, Finance, the Interior, and the National Health Security Office, emphasizes "ageing in place" and developing and extending home and community care and support. The home support programme includes individual assessments, care planning and provision of 2–8 h of home support each week, according to need. If an older person meets the eligibility criteria, social services may help with housework, ADL, provision of assistive devices and activities outside the house. Medical services, including preventive services, physiotherapy and provision of rehabilitative and assistive devices, are also available for dependent older people through the LTC programme and the UHC package.

Home support is provided by carers specialized in LTC and by trained volunteers. Village health and home care volunteers for the elderly comprise more than 1 million carers. Village health volunteers work with health-care personnel in communities. Their responsibilities include home visits to follow up cases, data collection, health promotion, prevention supervision, basic health care and medication, rehabilitation, referrals, organization of community activities to promote health development and collaboration with community leaders and local administrations to develop public health systems in communities.

Home care volunteers follow a 70-h training course. Their activities include home visits; assistance with meals, eating, taking medicine and physical exercise; accompanying older people on visits to the doctor; consultations with a doctor for instructions on providing care at home; taking older people to community and recreational activities outside the home and to participate in religious rites, and assisting in improving their house and environment. They record personal information on the older people under their care, such as their degree of dependence, their problems and needs and the services provided to them. Home care volunteers are assisted and mentored by care managers, who are health-care personnel who have completed a 70-h care management course for LTC.

#### 4.1.6 Case management and care coordination

##### Description

Activities and strategies to coordinate services, providers and care and support actions to ensure that older people and their carers receive integrated, safe, timely, effective, person-centred LTC in a continuum (promotion, prevention, treatment, rehabilitation, palliation) to help older people to achieve healthy ageing and to protect the well-being of carers.

An example of such an intervention is the Agency for Integrated Care in Singapore (76,77,84), which is responsible for planning and coordinating all aspects of LTC service delivery by providers at all levels (home, community, centre), including coordination of referrals to intermediate and LTC services. "Cluster support" is a system within senior activity centres that facilitates coordination of community care and support services.

##### Key points

- Care coordination by integrating professionals in the health and social systems at all levels ensures that older people receive the care established in person-centred plans.

- Care coordination and referral to services and support for older people and their carers can decrease unnecessary use of medical services, delay institutionalization and improve the quality of life of both patients and their carers.
- Care coordination is critical for implementing the integrated care plan of an older person. Multiple promotive, preventive, assistive, supportive, rehabilitative and palliative care strategies and interventions can be provided simultaneously, depending on the underlying diseases, functional loss and other health and social needs and priorities.
- Care coordinators can simplify complex care, prioritize the most critical issues and facilitate and provide a person-centred, integrated care plan.

##### Actions

A care coordinator should have:

- a general view of support needs and complexity of care and should lead assessment, liaise and work with all health and social care services, including those provided by volunteers and communities and ensure that referrals are made appropriately;

- the capacity to provide older people with the information, skills and tools they need to manage their health conditions and minimize their functional limitation with family members, other carers, the community and the multidisciplinary team; and
- the capacity to generate a hierarchy of interventions, with the support of other health and social care workers and integrate different service providers and settings to address the unmet needs of older people.

### **Case example 13.** Sydney, Australia (85)

The HealthOne Mount Druitt programme at Mount Druitt Community Center was established in a socially disadvantaged part of western Sydney, Australia, with initial funding from the New South Wales Treasury and Ministry of Health as part of a State-wide initiative to co-locate services as a basis for community health. The programme targets older people with chronic and complex illness who are at risk of exacerbation and/or hospitalization and who would benefit from care planning and case management. Patients must be eligible for complex aged and chronic care services to be enrolled in HealthOne. They are referred by general practitioners, providers in the Western Sydney local health district, Government and nongovernmental organizations and family members.

The goal of HealthOne Mount Druitt is to establish community models of care that are patient focused and flexible and are continuous, coordinated and comprehensive across the primary care–hospital interface. Care is delivered in the most appropriate setting (e.g. home, general practitioner, other health facility, community outreach or community hub), and patients are expected to participate actively in planning and managing their care. Care is provided by multidisciplinary teams. General practice liaison nurses visit patients at home and identify their needs, organize multidisciplinary case conferences, coordinate care among various providers, and ensure that information about the patient is provided to a general practitioner or case manager in the multidisciplinary team. Patients, their carers and family members are invited to attend case conferences.

Governance and leadership are provided by a steering committee, and funding is provided by various levels of government. Permanent general practitioner liaison nurses are necessary to sustain the programme.

### **Case example 14.** Catalonia, Spain (86)

Initiatives for integrated health and social care centred on the individual in a local environment have been developed as part of the SUSTAIN project. One such initiative is a programme for patients with complex chronic and advanced disease and for the geriatric population of Osona, Catalonia. The programme coordinates primary, acute, intermediate and LTC for people aged 75 years and older with complex health and social needs and are living at home. It is based on planning individual care according to a multidimensional assessment of needs. Care coordination is optimized in formal case conferences among the multidisciplinary team of relevant professionals, followed by meetings of the care team with patients and carers to discuss and validate the plans resulting from the case conference. The case conferences are used to share views on the needs of patients according to information collected by the health and social care teams, including users' wishes and goals.

Coordination and integration are ensured by collaboration between health and social professionals on the most appropriate care for each person and by combining resources for implementation. The participation of relevant professionals enhances co-responsibility in managing care. Coordination results in integration of interventions such as home visits by a nurse or a general practitioner, periodic monitoring by specialists and new social resources, such as personal assistance with activities and housekeeping.

#### 4.1.7 Promotion of self-care

##### **Description**

Actions and strategies to identify opportunities for improving self-care and adherence, including older people's knowledge and perceptions about their health condition, and physical and mental capacity and functional ability. The strategies ensure that older people and their carers receive the support they need to manage the physical, emotional and social impacts of their conditions and to provide them with the necessary knowledge, skills and confidence in the context of their everyday lives. The interventions include counselling on self-care and discussing and planning care to improve adherence and education for self-management of chronic conditions.

##### **Key points**

- Support for self-management includes providing older people with the information, skills and tools they need to manage their health conditions, prevent complications, maximize their functional ability and live meaningful lives.
- It is important to recognize that people are different and may respond differently to strategies. Interventions should be tailored and a range of support options offered, such as telephone coaching, digital consultations, use of monitoring apps and group education.
- Self-management requires collaboration among LTC professionals with a common understanding and commitment to self-management strategies.
- Self-management support strategies include traditional consultations between a health-care professional and an older person who requires LTC condition but can be strengthened by professionals with specific skills, such as motivational interviewing, goal-setting and problem-solving.
- Multidisciplinary care teams could be trained in delivery of effective support for self-management, with tools and techniques.
- Processes should be established in which patients play an active role in planning their health care and improving self-management.

## 4.2 Education and training

In many countries, LTC services are generally provided by family, friends, neighbours, domestic workers, personal care workers and others who are not formally recognized or trained within the care system. As care work is often not recognized as “decent” work due to its social perception

and difficult job conditions, health and care workers in this field are often not sufficiently educated or trained to provide good-quality, evidence-based LTC. Education and training of both carers and LTC workers is thus essential for implementing the package and for providing high-quality LTC services. Education and training in LTC increase competencies to provide safe, high-quality interventions by two groups: carers (family, partners, friends and neighbours) and LTC workers (e.g. personal care workers, social workers, nurses, physical therapists, medical doctors).

Three features of training and education merit discussion. First, training programmes rarely address a single topic, apart from specific gaps in knowledge identified when providing services. Secondly, knowledge is often transferable and accumulates with training; for example, training in care for people living with dementia should include training in topics such as effective management of medications, with emphasis on the challenges of memory impairment for adherence. Thirdly, the depth and breadth of training and education on each relevant topic will depend on the professional group, LTC setting and whether the training is basic or continuous (“on the job”).

The priorities for education and training in LTC that were considered feasible for low- and middle-income countries (Annex 6) were identified during development of the package. Their applicability will depend on factors such as the setting, the trainees' background, and the roles and responsibilities of different occupational groups (such as general practitioners, nurses, community health workers, physical therapists, nutritionists, neuropsychologists, pharmacists and social workers), systems and the service organization.

The list should not be considered complete or exhaustive. Education and training in LTC could begin with a basic list of topics and be extended progressively to include more topics for more carers and LTC workers, in more educational and institutional settings. Current clinical guidelines, scientific evidence and national standards of care could be issued for each listed topic.

According to the principles of integrated, person-centred care, planning and organization of education and training should not be fragmented. As carers and LTC workers should be trained in delivering integrated interventions for LTC, topics should not be presented as stand-alone elements, because clinical and personal care for older people who need LTC are complex, heterogeneous and interrelated.

On-the-job training is important for obtaining the necessary competence, as pre-service education and training are often insufficient to address complex, changing care needs in practice. For example, staff working in nursing homes should receive training in the management of swallowing dysfunction when there is a recent increase in the prevalence of respiratory infections, and training in fall prevention should be emphasized when fall rates increase.

### 4.2.1 Education and training for carers

Educational and training programmes and courses for carers strengthen their competencies in providing care that meets the needs of the person they care for. Education and training not only ensure that they can provide high-quality care but also that they feel confident about their caring role. In addition, by developing skills and competencies, carers come to understand the needs of older people and how to prevent adverse health outcomes. For example, a fall due to orthostatic hypotension may be due to dehydration or to a urinary infection caused by inadequate hygiene after toileting.

The training topics in this package include helping with personal and IADL, managing health care needs and recognizing early signs of disease progression or functional loss, preventing falls, encouraging physical activity and avoiding sedentary behaviour. Additional training for carers of older people with dementia is included in the list of training topics. People with dementia have complex problems and have difficulties in many areas, such as incontinence, swallowing, gait and balance, with a high risk of falls. Distressing behaviour in particular disturbs their health and well-being and negatively affects the carer. Carers can participate in the multidisciplinary team by describing symptoms and looking for the causes of behavioural symptoms, such as pain, illness, discomfort, hunger and loneliness.

The WHO report on global progress in public health responses to dementia (65) describes several initiatives for the education and training of carers, including progress in implementation and accessibility. In addition, WHO has developed iSupport, a training and support manual for carers of people with dementia (87), which includes topics such as the provision of everyday care and dealing with behaviour changes.

#### Key points

- Education and training for carers can directly improve the quality of care for older people, as carers are frequently immediately available to support and help highly dependent older people, such as those with dementia.
- Most carers are family members and lay people who have received no formal training in care, such as neighbours, friends and volunteers. There is global recognition that policy measures should be taken to build the capacity of carers and to meet their physical, emotional and financial needs to improve their health and well-being. Education and training can ensure that they will provide good-quality care and gain confidence in their caring role.

- Strengthening carers' competence supports them in providing services and care, allowing carers to understand older people's needs and to prevent adverse health outcomes. Carers can thus contribute to ensuring that older people can live longer at home and avoid unnecessary, costly hospitalization and institutional care.
- Carers can collaborate with the multidisciplinary team in developing the care plan, anticipating needs with changes in health and functioning and helping older people to achieve the desired outcomes.
- Carers increasingly provide intensive care and must therefore learn certain complex tasks. Frequently, however, they consider themselves unprepared for such tasks. A balance should be found between preparing carers and ensuring that they are not used as unpaid substitutes for professional care workers. Adequate training is important for carers' health and well-being, particularly when they provide intensive care, which demands both physical and emotional energy.
- Learning should be tailored to the care that the carer will provide. For example, some family carers require disease-specific knowledge on prognoses, management of symptoms and care routines, such as transferring, bathing, dressing and feeding, and preventing injuries and accidents. Adequate training is also important for their own health and well-being.

#### Actions

- Include training for carers in plans to strengthen LTC provision and not as a stand-alone intervention. Training programmes should cover the continuum of care. Requirements for training are dynamic and evolve over time, and the need to adapt and tailor education and training over time should be monitored. Care coordinators in a multidisciplinary team should assess carers' learning needs and preferences to design training strategies and formats (88).
- Identify and address barriers to accessing education and training that may be linked to gender, ethnic, socioeconomic or geographical inequality. Unrealistic training schedules and formats can limit attendance for carers with many competing demands. Flexible training should be offered that is aligned with and adaptable to carers' expectations and routines.
- Delivery of training in communities according to a socio-ecological model of individual, interpersonal, organizational, health and social systems and cultural factors helps to define the content and pedagogical approach.



- Training should also be provided for transitions from hospital to home, as carers may be unprepared to respond to post-acute situations at home, frequently have high demands and must manage new medical care procedures. The care coordinator and multidisciplinary teams in the hospital and at home can link and reinforce education and training by identifying gaps in the care provided to an older person, which may affect their health condition, and by providing ongoing assessment and monitoring. Training should be available to respond to new needs of older people and carers, such as for changes in functional ability.
- Anticipate, discuss and address carers' concerns about increased or unclear responsibilities in relation to training, clarifying and agreeing on carers' roles and responsibilities in care coordination with LTC workers.
- Co-design strategies with a participative approach to increase uptake of training, as carers frequently lack information and self-awareness and lack support in freeing themselves from their caregiving responsibilities, family and professional commitments in order to participate in training.
- Create contextually and culturally adapted courses from the list of topics, and define the duration, learning model (hybrid, online, face-to-face) and learning strategies to provide competencies that care workers require. Determine whether the content requires a hands-on component.
- Engage all stakeholders in civil society and in the public and private sectors (e.g. carers' associations, professional associations, unions, older people, community organizations, educational organizations) in defining the content of training courses in order to meet needs.
- Consider diversifying the form of training to increase training opportunities, including in-person training, telephone coaching and home and online training. Flexibility in the types of training is essential to accommodate the competing demands on carers and to avoid overload.
- Define types of training, such training delivered by health and social care workers with formal certification, training developed by volunteers in vulnerable neighbourhoods, training developed by organizations in specific settings as part of a care plan (e.g. hospital discharge programmes, rehabilitation and palliative care programmes).
- Assessment of training outcomes and support for carers are essential for the continuity of person-centred, coordinated care.

#### 4.2.2 Education and training for LTC workers

Educational and training programmes and courses for LTC workers strengthen their competencies in the care of older people and ensure good-quality services in LTC. Education and training for LTC workers should be tailored to their roles and responsibilities and conform to national legislation and occupational requirements. Box 3 provides examples of formalization and certification requirements in some countries.

##### Box 3. Examples of formalization and certification requirements

The degree of formalization and certification for personal care workers tends to determine whether training is mandatory (6).

In Belgium, some local governments have introduced minimum qualification requirements, controlled by the region, for registrations as a personal care worker, while other local governments provide continuing training programmes for registration and for employers (89).

The Government of Ontario, Canada, has introduced a comprehensive, mandatory registry for personal support workers, and every residential care home is required to ensure that people hired as personal support workers have successfully completed a training programme that meets specific requirements (57).

For clinical practitioners, various continuing education programmes and boards are responsible for accreditation (29).

In Germany, the Federal Government and professional associations are responsible for regulating training and continuing education programmes for health-care providers. Physicians are accredited by regional chambers, which also organize courses (89).

##### Key points

- Provision of good-quality LTC services requires a wide range of types of competencies, levels of training and qualification in different settings.
- Clinical practitioners should be trained in geriatric care, including competence for addressing complex care needs.

- Personal care workers and nursing personnel provide LTC for an increasing population of older people. Shortages of workers are found in almost every country, limiting the provision of LTC. Gaps in educational capacity should be identified and strategies and collaboration established with organizations such as universities, workers' and employers' organizations and professional associations to offer educational opportunities.
- The tasks and activities of personal care workers include not only assistance in ADL but also more complex tasks, such as detecting and monitoring signs and symptoms of disease and functional decline, communication with older people with cognitive decline, sensory loss or language problems, facilitation of interpersonal relationships, provision of psychological support and effective contact with multidisciplinary teams and families. Dementia care also includes tasks such as dealing with behavioural changes.
- The content of training programmes for personal care workers differs widely among countries, and there is no consensus on a basic curriculum, requirements or minimal qualifications for these workers.
- In most countries, nurses in LTC have no experience in geriatric care and do not learn enough during undergraduate courses to assume responsibility for case management or care coordination.
- Education programmes for health-care workers should be revised. For example, schools of medicine, nursing, physiotherapy, occupational therapy, nutrition and social work should include specific training in the care of older people. Students should learn the concepts of geriatrics, gerontology and integrated care, with the specific competencies necessary to assess, treat and work with older people, so that systems could become more resilient and responsive to population ageing.
- Competencies to provide good-quality LTC will be required increasingly for the ageing population and their multiple, complex needs, particularly for frail older people and people with severe conditions such as Parkinson disease and dementia. Stratification of the complexities of care can indicate the core skills and knowledge required for training.

### **Actions**

- Determine the profile of the health and social care workforce, assess gaps to meet population needs, and agree on a package of interventions.
- Define the competence, skills, knowledge and attitudes required for minimum qualification and employment in home, community and residential LTC. Map existing resources and gaps to improve the quality of care and

support provided to older people and those who care for them. Identify the needs of people living with dementia and other conditions that require specific knowledge and skills (87).

- Develop tools to assess and anticipate the skills that will be required of the LTC workforce to enable governments, trainers and other stakeholders to respond proactively to gaps between demand and supply and contribute to the development of human resources.
- Create contextually and culturally adapted courses for the list of topics, defining the duration, learning models (hybrid, online, face-to-face) and learning strategies for achieving the best skills and competence to equip care workers to provide care. Indicate whether the content demands a hands-on component.
- Define the public or private entities that could provide training courses for certification.
- Provide various layers of training and requirements, with the right mix of workers and competencies in each LTC setting. For example, on-the-job training for experienced workers could be supplemented by tailored programmes, in which public and private organizations could collaborate to reduce costs.
- Define the required competencies and training for working in settings such as LTC facilities.
- Ensure continuing education and access to lifelong learning to reinforce use of evidence-based practices, develop interpersonal skills (e.g. communication, collaboration, active listening) and social skills (e.g. judgement and decision-making, time management and monitoring) (29).
- Co-design a collective approach to and strategies for workforce development with a person-centred, holistic view of care to reinforce cohesiveness, credibility and engagement and increase the quality of training programmes.
- Involve social partners to ensure the necessary skills for improving policy and to promote buy-in to the policy among stakeholders.
- Work with local education and training providers to develop curricula to prepare the future workforce for practice in realistic scenarios.
- Designate a government body to regulate, monitor and audit education and training programmes in order to evaluate their effectiveness and ensure compliance with any requirements for certification, and keep updated, transparent registries of health and care workers who provide LTC services.

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**Case example 15. Republic of Korea (90)**

LTC insurance for older people is provided by the National Health Insurance Service, which was established for UHC and is organized and coordinated by the Ministry of Health and Welfare in the Long-Term Care Insurance Act, 2007 (59). The social insurance scheme provides LTC to older citizens who have had difficulty in daily activities for 6 months or longer due to age-related diseases.

After a geriatric assessment and doctors' opinions, older people in need of LTC can be entitled to receive services that include visits by care workers at home to help them with physical and household activities, including cognitive stimulation for people with dementia, visits with bathing equipment, nursing visits, day and night care and residential care at LTC facilities. Most LTC services are provided at home (70.3% in 2019). Services are provided by various workers, including carers, social workers, nurses, nurses' aides, physical therapists and occupational therapists in a multidisciplinary care team. Personal care assistants represent 91% of the care workforce.

The Welfare of Senior Citizens Act (90) stipulates qualification of a licensed carer. The head of the local government (city mayor or *do* governor) is responsible for controlling and granting certification. Licensed institutions for the education of personal care workers also provide training for certification. The levels of training offered range from essential to professional qualification. There are no educational requirements for personal care workers. A person with no job experience or license can follow 360 h of training, involving classroom learning, practice sessions and on-the-job training, and pass the national qualification examination in order to be issued with a personal care worker certificate. They should undergo 8 h of training every 2 years after qualification.

The standardized training material comprises 11 chapters, including a caregiver's code of professional ethics and attitude, communication skills, basic medical and nursing knowledge (assessment of prior health status, common diseases, health promotion and disease prevention), bowel and bladder care, nutritional care (oral and parenteral), personal hygiene, help with medications, mobility (transfers, walking assistance), prevention of injuries and infections, dementia and end-of-life care.

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Narciso Vargas Huaman, 83 (left) and Hilda Salon Cruz, 77 (center) leaving the Taytawasi Senior Center in Villa Maria del Triunfo, Lima after having their visual examination, 2018  
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# 5

## Considerations for implementation

Countries require a holistic, sustainable, flexible LTC system to counteract the fragmented, disease-oriented model of care. Common problems arise from the disconnection between health and social systems, with separation of the governance and structure of provision of LTC services among different ministries, often, the ministries of health, social affairs and labour or employment. As a result, older people and their carers may find it difficult to navigate organizational structures, and their expectations for LTC are often frustrated. An LTC policy responsive to the needs of older people and their families should therefore generate synergies between health and social services, ultimately evolving into a single LTC system.

The agendas of many countries have included connection of services in various settings for the needs of older people and their carers in a proactive, coordinated approach. Policies should educate all stakeholders, foster cooperation and coordination among care sectors and transform the vision of care providers, service managers and care teams to create the foundations of integrated care.

Strategies at all levels are necessary to engage leaders and create comprehensive conditions to support integrated care. For example, a purely clinical or case management approach to treating medical problems is unlikely to meet the broader, heterogeneous needs of older people and their families. Rather, a multi-component, comprehensive, systematic set of strategies is required. Successful care coordination programmes are highly context specific, as models of care cannot be transferred as a fixed block of strategies and interventions from one setting and social context to another. Project leaders have to develop strategies that accommodate local specificities. Furthermore, coordinated care evolves over time. Governments must therefore adopt strategies to support systems as they develop and mature. In this package, the person-centred, integrated approach along a continuum of care ensures that older people and their carers are actively involved.

Mechanisms should be established to coordinate and monitor services and their quality, with a robust information system connecting sectors and services. The LTC system should be based on a comprehensive governance structure, a sustainable, equitable financial system and informed by evidence-based, culturally appropriate research (6).

The list of interventions in this package is not fixed but reflects the changing needs of older people and carers along the care continuum. Integrated care is dynamic and evolves continuously, and successful integration of health and social care takes time to build and sustain. Mapping and design of the “ecosystem” package will facilitate understanding of the interdependent elements to be integrated. Information on the longitudinal dimension of care provision (duration, actors involved, resources over time) is critical for understanding the complexities of care. Use of standardized assessment protocols, including degrees of dependence, health assessment criteria to qualify for assistance, preferences and older people’s and carers’ needs, facilitate the provision of person-centred interventions.

Use of an incremental growth model has been suggested for implementing integrated care (91). A stepwise approach is recommended to build on existing services and collaborative networks and to extend and broaden the scope of coordination of care gradually. Assessment of the perception of service quality by users and providers can identify feedback loops and monitor how services are delivered, continuously extending the provision of interventions and increasing acceptance by older people and carers.

Core elements could help countries to promote implementation of this package as they design, review and extend interventions. WHO’s *Framework for countries to achieve an integrated continuum of long-term care* (6) can assist countries in assessing their LTC system, as it includes a checklist of actions for governance, sustainable financing, information, monitoring and evaluation of procedures, the workforce, service delivery, innovation and research. The



checklist can be used by national and local government bodies to evaluate their readiness to implement the package, not as an isolated basket of interventions but as part of a comprehensive strategy to strengthen the LTC system.

Strategies to engage and integrate local communities into care networks and to promote continuous collaboration among the range of professionals involved are crucial. Models of coordination depend on local resources such as general practitioners and nurses and case reviews by multidisciplinary care teams and community workers. In many countries, LTC plans focus on supporting people in living at home, with strategies to facilitate transition from hospital to home and to care homes.

## 5.1 Macro, meso and micro elements to strengthen implementation

Critical elements in governance, service delivery, the workforce, information, monitoring, evaluation and sustainable financing are described as “macro” (system), “meso” and “micro” (organizational and integration) elements. They can be used to strengthen implementation of the package and to support education and training (Table 6).

**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
<b>Governance</b>	<ul style="list-style-type: none"> <li>• 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</li> <li>• Continuous communication and consensus-oriented decision-making to support the plan, with alignment of elements</li> <li>• Shared culture and vision among stakeholders on the principles for achieving an integrated, coordinated LTC system (see Box 1)</li> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• 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</li> <li>• Solid organizational leadership for designing and supporting integration at each stage of implementation</li> <li>• Common goals and a shared vision of integrated care and a multidisciplinary approach in organizations</li> <li>• 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</li> <li>• Concrete strategies to engage and ensure trustful bonds with the community</li> <li>• Shared accountability for care among local service providers</li> </ul>

Package element	Macro level	Meso and micro levels
<b>Service delivery</b>	<ul style="list-style-type: none"> <li>• Political recognition of care coordination as critical in the LTC system (i.e. role of care coordinators, responsibilities, competencies) aligned with regulations for qualification and certification</li> <li>• Readiness to implement interventions in the package that are not yet available (e.g. palliative care at home, social support for carers in the community) or in an underserved geographical area (e.g. rural and remote regions, boundaries)</li> <li>• Eligibility for interventions in the package reviewed regularly and revised to include unmet needs and a mechanism to identify older people in urgent need of the package, who are not in the LTC system (e.g. hospital discharges, consultations, specialized health clinics, families on waiting lists for social services)</li> <li>• Referral pathways to ensure a seamless transition for older people and their families when health conditions change (e.g. dedicated staff in each setting, a central line or a dedicated LTC management centre)</li> <li>• Promotion of interoperability among health and social care systems</li> </ul>	<ul style="list-style-type: none"> <li>• Definition of clear routines (e.g. case managers coordinate meetings with a multidisciplinary team) and sustainable structure (e.g. space, equipment, materials and technological support) to facilitate integration and implementation of interventions</li> <li>• Clear-cut definitions and processes of care pathways</li> <li>• Definition of strategies for timely provision of care (e.g. around-the-clock call centres that give guidance and counselling to older people and carers and match treatments to the urgency of their needs; good communication among older people, carers and care coordinators)</li> <li>• Strengthen existing integration (e.g. joint working and group practices) and progress towards greater integration (e.g. use of standard, comprehensive assessment tools, shared care protocols and procedures, interoperability in electronic records, risk stratification)</li> <li>• Adaptation and definition of the suitability of interventions to each LTC setting (e.g. home, day-care centre, facility) according to national and local contexts (e.g. existing structure, funding schemes, staffing, skills, working conditions, older people's values, culture and preferences, neighbourhood characteristics)</li> <li>• Identification of organizational barriers to delivering home and community care, such as heavy workload, poor wages and benefits, inconsistent work schedules and distance between the homes of personal carers and older people and agreements with providers to mitigate such barriers</li> <li>• Optimization of local programmes for self-care and better lifestyle behaviour in all settings and introduction of preventive interventions for older people with substantial loss of intrinsic capacity</li> <li>• Integration of interventions for dementia care, depression, restricted mobility and other conditions that may be stigmatized</li> <li>• Agreements with service providers for functional arrangements for provision of social care and support (e.g. 24-h care, helpline) to accommodate the needs of older people and carers and for other issues, such as absenteeism of nursing personnel due to, for example, illness, family problems and mental health issues</li> <li>• Integration of palliative care into health services in all settings (e.g. home, day-care centres, community care services, LTC facilities) and identification of gaps in symptom relief, such as pain management with opioid drugs outside a specialist setting (e.g. lack of medical staff, training and availability of essential medicines for palliative care)</li> <li>• Strategies to raise awareness about treatment choices, end-of-life issues and discussion of advance care plans at an early stage of disease with older people, their families and the community</li> </ul>

Package element	Macro level	Meso and micro levels
<b>LTC workforce (including carers)</b>	<ul style="list-style-type: none"> <li>• Definition of strategies to extend benefits and services to carers, not only to ensure high-quality care but also to address their health and well-being (e.g. cash benefits, accident insurance, care leave, respite care, facilitation of entry into the health system, web platforms to facilitate navigation of services) by recognizing, reducing and redistributing the work of carers</li> <li>• Ensure policies to create more decent work for care workers, in line with international labour standards</li> <li>• Development of gender-sensitive policies and practices to ensure fulfilment of the rights of women as care workers (particularly immigrants from low- and middle-income countries with poor working conditions)</li> <li>• Definition and promotion of legal entitlements for domestic workers to obviate informality, precarious jobs, low payment, lack of social protection or maternity benefits and other types of security (payment of overnight shifts, days off), in line with international labour standards</li> </ul>	<ul style="list-style-type: none"> <li>• Promotion of a multidisciplinary team culture</li> <li>• Availability of care coordinators (e.g. nurse-led, physician-led) with time and resources to fulfil the role (e.g. multidisciplinary team meetings to discuss cases, communication with other sites, domiciliary visits)</li> <li>• Definition of professional competencies required to deliver each LTC intervention and of staff requirements and training needs, and promotion of increased professional knowledge about integrated care and comprehensive geriatric and gerontological approaches</li> <li>• Definition of care providers' roles and responsibilities for integrating health and social care, avoiding siloed thinking and medical paradigms</li> <li>• Promotion of LTC professions (particularly nurses) and attractive schemes (e.g. better working conditions, remuneration, social security, protection, qualification, opportunities)</li> <li>• Promotion of positive attitudes by care workers (e.g. respect for older people's preferences and autonomy in receiving help to meet basic needs, combatting ageism, elder abuse and neglect) and to diversity in older age (e.g. care needs and preferences of older gender-diverse people)</li> </ul>
<b>Information, monitoring and evaluation systems</b>	<ul style="list-style-type: none"> <li>• Attention to the barriers to data-sharing (e.g. regulations on medical data protection, shortage of IT personnel, lack of funding for research and innovation)</li> <li>• Creation of regulatory frameworks to support the LTC package for safety, quality, professional practice, assistive products, medications for pain management, transport and assistive care services</li> <li>• Harmonization of quality assurance indicators (e.g. prevention of pressure injury, falls, pain management) and the requirements for professional competencies (e.g. certification after training, standards and accreditation by professional chambers, inspection mechanisms)</li> </ul>	<ul style="list-style-type: none"> <li>• Information on the degree of patient-centredness (e.g. patient and carer satisfaction, critical indicators, supervision) to improve service provision and continuity of care</li> <li>• Relay of data to providers, particularly in crucial situations (e.g. transition from hospital to home or a care home, emergency visits)</li> </ul>

Package element	Macro level	Meso and micro levels
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**Sustainable financing**

- Identify the resources necessary to deliver core components of the package in each setting and the related costs (for e.g. provision of assistive products, palliative care, personal assistants at home).
- Identify mechanisms through which the components of the package will be funded.
- Identify funding sources to ensure reliable financing. If funding is insufficient, revise the package accordingly.
- Define provider payment schemes, and set reimbursement rates.
- Provide infrastructure to support the package (e.g. workforce, built environment, material and equipment, technical support, health and digital technologies to store and share data).

**Key messages**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Nominate project leaders to strengthen connections between health and social services and to remove persistent barriers to integration.</li> <li>• Promote a shared vision for collaboration, and ensure conditions to strengthen interdisciplinary teamwork (e.g. team meetings, co-location of the workforce, shared information systems).</li> <li>• Engage and empower older people and carers to ensure that their voices are heard, and include their knowledge, skills and experiences.</li> </ul> | <ul style="list-style-type: none"> <li>• Select and train care coordinators, with continuous development of competence for integrated care.</li> <li>• Support continuous data collection in all facilities (e.g. tools to identify the early stage of pressure ulcers in older adults confined to bed, tools for screening hearing loss and visual impairment) to standardize routine care.</li> <li>• Develop capacity-building strategies, and train care workers in providing safe, high-quality assistive care (see section 4.2).</li> </ul> |
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## 5.2 Macro, meso and micro elements for education and training

Critical elements of governance, funding, service delivery and information, monitoring and evaluation systems are listed in Table 7 at macro (system), meso and micro (organizational and integration) levels to strengthen implementation of the package and to support education and training.

**Table 7.** Elements to support education and training

Package element	Macro level	Meso and micro levels
<b>Governance</b>	<ul style="list-style-type: none"> <li>• Collaboration and shared vision between national and sub-national ministries of health, education and related ministries (e.g. welfare, finance, labour, public service) in education and training of health professionals.</li> <li>• Leadership for engaging relevant public and private sector stakeholders to define and design implementation strategies for workforce training, with system-wide, multisectoral coordination.</li> <li>• Definition of the core competencies required for each occupational group in the multidisciplinary team (health and social care) in order to implement the package and to meet the evolving needs of older people, with regular review and updating of core competencies.</li> <li>• Definition and creation of regulations for accreditation, licensure (sometimes periodic re-licensure), professional inspection and compulsory continuing education for high-quality LTC.</li> <li>• With professional regulatory bodies, ensure that, at each level (e.g. technical, undergraduate and postgraduate), LTC skills and knowledge are appropriately promoted, evaluated and certified by regular training and evaluation methods.</li> <li>• Creation of boards responsible for reviewing and revising LTC workforce curricula (and carers' needs) periodically to ensure that the training and education provided result in high-quality care and improve carers' ability, self-efficacy and well-being over time.</li> <li>• Develop a sufficient competent workforce of educators and trainers, effective education methods and access to adequate infrastructure, equipment and learning tools.</li> <li>• Ensure education and training for carers and care workers in rural and remote areas (e.g. online courses).</li> </ul>	<ul style="list-style-type: none"> <li>• Develop curricula to address the complex needs of older people in LTC, including geriatric care.</li> <li>• Discuss a planned approach based on models, theories and frameworks (either implicit or explicit) for systematic translation of education and training programmes into the desired changes for improving the quality of routine practice.</li> <li>• Establish measures to ensure adherence to the system's standards for training, education, evaluation and certification of the LTC workforce.</li> <li>• With service providers, ensure that the skills and knowledge obtained in training and education meet the requirements for practice (with consideration of e.g. costs, team readiness and institutional culture).</li> <li>• Create appropriate organizational and infrastructure conditions to plan, deliver, evaluate and scale up training and education in each setting, including community placements.</li> <li>• Conduct education and training in evidence-based interventions, such as screening, assessing mild cognitive impairment and dementia, and providing cognitive stimulation therapy and activities.</li> <li>• Define strategies to improve the workforce's ability to deliver evidence-based, culturally appropriate, human rights-based health and social care for people with dementia in all settings (e.g. home, day care, residential care).</li> <li>• Standardize and ensure that training and education are aligned with the needs and learning abilities of the local LTC workforce (service providers), students (training and education institutions) and carers.</li> </ul>



Package element	Macro level	Meso and micro levels
<b>Funding</b>	<ul style="list-style-type: none"> <li>Identify and secure long-term financial investment and distribution for education and training (e.g. for updating curricula, providing comprehensive training, certification costs), including in rural and remote areas</li> <li>Identify cost-effective education and training for all settings</li> </ul>	<ul style="list-style-type: none"> <li>Ensure funding for participation in education and training (e.g. for staff replacement, staff time, for carers)</li> <li>Discuss possible strategies to increase participation, such as rewards</li> </ul>
<b>Service delivery</b>	<ul style="list-style-type: none"> <li>Establish formal collaboration and shared accountability among national and sub-national ministries of health, social affairs, welfare, education and related sectors (e.g. finance, labour, public service) for the education and training of health professionals</li> <li>Engage relevant public and private sector stakeholders and policy-makers to design and define implementation strategies, with system-wide, multisectoral coordination</li> <li>Ensure effective leadership and management, sound information systems and multisectoral commitment.</li> <li>Establish regulations for accreditation, licensure (sometimes periodic re-licensure), professional inspection and compulsory continuing education for high-quality LTC</li> <li>Strengthen existing health professional accreditation with proper legislation and standards. Ensure that the processes are transparent and evaluated periodically (e.g. personal assistants are not certified in many countries, often because professional bodies consider that their accreditation would threaten their professional boundaries)</li> <li>Ensure that staff at certification organizations have the necessary qualification and teaching and evaluation capacity to provide training in LTC</li> <li>Develop a competent, sufficient workforce of educators and trainers who can provide effective education and techniques and have access to adequate infrastructure, equipment and learning tools</li> </ul>	<ul style="list-style-type: none"> <li>Define organizational conditions and infrastructure to plan, deliver, evaluate and scale up training and education for carers and care workers in each setting, including community placements</li> <li>Align local education and training to the personal characteristics and roles of carers (e.g. age, background, experience, expectations) and to the qualification requirements of national standards through streamlined educational pathways or “ladder programmes”, to advance practices</li> <li>Engage a cohesive mix of people (e.g. care workers, carers, managers, older people, community organizations) to design local training programmes and to discuss delivery modes, avoiding unequal access and provision such as by considering digital literacy for online training, the literacy and health literacy of carers and care assistants, availability to attend face-to-face meetings and transport costs</li> <li>Promote real context-learning situations that represent daily problems, including practical strategies to address interventions (e.g. on-the-job training) with tailored learning programmes</li> <li>Promote bespoke strategies to develop knowledge and skills, such as mentorship for new carers</li> <li>Establish continuing professional development and in-service training relevant to the settings and local context</li> </ul>
<b>Information, monitoring and evaluation systems</b>	<ul style="list-style-type: none"> <li>Create national information systems for workforce training and education to allow comparison and surveillance within and among institutions, services and locations</li> <li>Determine the acceptability and adoption of evidence-based practice in LTC</li> </ul>	<ul style="list-style-type: none"> <li>Develop platforms to deliver training and education that meet the needs of participants and are usable, acceptable and feasible, avoiding unequal access</li> <li>Establish measures for periodic evaluation of the satisfaction, knowledge and skills of LTC workers and carers</li> <li>Identify channels for spreading education and training among individuals, groups and organizations</li> </ul>

### Key messages for education and training of carers

- Align education and training requirements with the needs of older people in the context of improving the quality of care and services.
- Carers' organizations, service providers and multidisciplinary teams working in the community should co-design local training programmes.
- Provide flexible training formats aligned and adaptable to carers' expectations and routines, as unrealistic training schedules and arrangements may limit the attendance of carers. Training should reflect the realities of carers and care workers in various circumstances.
- The content, duration and format of training should be suitable for the carer's educational level, health and digital literacy and respond to difficulties in the availability of resources and assistive products and in environmental conditions.
- Training should be available at the right time to respond to the changing needs of older people and carers to avoid unmet needs and complications.
- Carers can learn from the multidisciplinary team during home care visits and should welcome these visits as opportunities for training and support.
- Transitions from hospital to home provide opportunities to train and support carers in terms of knowledge and skills so that they are prepared to respond to new demands.
- Materials (e.g. manuals, flyers, videos, apps) should be available to facilitate learning and guide the performance of tasks, exercises and procedures.

### Key messages for education and training of LTC workers

- Emphasize education on empathy in communication, positive interaction and development of care workers' skills and characteristics (e.g. knowledgeable, attentive, caring, friendly, compassionate).
- Address difficulties in providing care for older people with complex problems and needs (e.g. cognitive decline, severe mobility and sensory problems, incontinence) by providing hands-on training. Older people in LTC frequently present disturbing, distressing behaviour and behaviour that is risky to themselves and to their carers. Managing such behaviour is essential in high-quality care.
- Engage and empower care workers at all training levels and in all settings.
- Promote a holistic, person-centred, integrated, interdisciplinary vision of care in which the needs, preferences and goals of older people are respected to ensure that their perspectives and autonomy are considered in shared decision-making, based on mutual respect and partnership.
- Be flexible and adaptable in applying regulations and rules on certification and licensing for care workers, particularly for personal care workers and domestic workers, in the face of local job shortages and demands.
- Offer continuing training programmes for further qualification, according to roles and job profiles.





Mrs Trieu Thi Mui, 87 during the yearly eye revision day at Thong Nhat Commune Health Center in Hoa Binh City in Northern Vietnam, 2018  
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# 6

## Engaging older people and carers in implementation of the package

Engaging older people and their carers in all their diversities and hearing, amplifying and acting on their voices, preferences and goals are critical to implementation of this package. Therefore, bold government engagement with communities is critical, especially with the most vulnerable, by creation of and responsiveness to spaces for meaningful engagement to ensure respect for the principles of UHC and achievement of the transformative change necessary to make progress in the United Nations Decade of Healthy Ageing (2021–2030). Meaningful engagement can be facilitated by governments and service providers or initiated by older people themselves, which enables them to influence decisions on the health and well-being of themselves and their communities (92).

Meaningful engagement of older people and carers should be not only aspirational but be designed as a practical mechanism for ensuring that LTC interventions are responsive and adapted to people's lives, experience, needs, preferences and goals. Older people and carers are not a homogeneous group: they represent diverse populations in terms of their capacities, abilities, experience, opinions, interests and concrete needs.

Meaningful engagement is based on listening to authentic voices expressing views and interests to influence policy and decisions and ensuring the engagement of everyone at all stages, from design through development, drafting, implementation and monitoring. Engagement is meaningful when older people and carers influence discussions on health and well-being through sustained, substantial, relevant involvement. The dynamics of meaningful engagement should allow communication in both directions, rather than being led by governments and service providers.

The mechanisms for ensuring meaningful engagement of the diverse community of older people, carers, care providers, organizations and institutions can be combined in various ways, according to countries' contexts, traditions, existing policies and political will. Policy-makers and service providers should find mechanisms that adequately promote meaningful, sustainable dialogue and empower people and communities. Examples of government or steered participatory spaces are in-person forums that are open to all, websites and social media platforms, consultations, policy dialogues, focus groups, citizen panels and deliberative opinion polls. Some countries have formalized, institutionalized mechanisms, such as health councils and district health committees. Whatever the mechanism, older people and carers should have access to appropriate spaces and means of participating. Barriers to meaningful engagement and voice should be identified, including power imbalance, language, education and digital literacy and access.

Services should regularly increase the participation of older people and carers, either directly or with CSOs, including older people in residential care homes, those with dementia who receive home care and those with disabilities in day-care centres. For example, roundtables and conversation rounds could be promoted. Older people want to be involved in decisions that affect them; therefore, opportunities and spaces for participation should be created to enable them to exercise choice. Five steps are proposed to hear and act on the voices of older people and carers and to support meaningful engagement when implementing this package (92,93) (Table 8).

**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
<p><b>1. Define means for listening to voices and meaningful engagement.</b></p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Engagement should not be imposed on older people by the government or service providers.</li> <li>• 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:               <ul style="list-style-type: none"> <li>◦ the preferences and values of the community;</li> <li>◦ current engagement, including previous experience, outcomes and participant satisfaction, perhaps compiling a list of good engagement programmes and practices in the community; and</li> <li>◦ anticipated constraints, such as digital access or illiteracy, geographical and language barriers, difficulty in communication due to sensory, cognitive or locomotor impairment.</li> </ul> </li> <li>• Define and communicate the level of engagement expected during the consultation.</li> </ul>
<p><b>2. Explain the importance of meaningful engagement.</b></p>	<ul style="list-style-type: none"> <li>• Discuss the guiding questions with the team that is organizing engagement, and define the steps necessary to achieve the desired outcomes of the consultation.</li> <li>• 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.</li> <li>• Consider group dynamics and trust. The facilitator should be someone known and trusted by the community, such as an older person or carer.</li> </ul>
<p><b>3. Choose participants to ensure their representativeness and legitimacy.</b></p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Conduct direct dialogue with older people, carers and with CSOs in the community, ensuring proper participatory spaces</li> <li>• Plan inclusion of older people and carers who are difficult to reach, including through nongovernmental organizations, volunteers and community workers.</li> <li>• 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.</li> <li>• 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.</li> <li>• Consider using appropriate available technology.</li> <li>• Recognize that care workers are crucial to legitimize meaningful engagement, and make sure that their voices are heard.</li> </ul>



Step	Consideration
<p><b>4. Organize practical arrangements.</b></p>	<ul style="list-style-type: none"> <li>• In shared decision-making with older people and carers, choose the venue, timing, frequency of engagements and hospitality.</li> <li>• 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.</li> <li>• 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.</li> <li>• Consider online consultations, but evaluate potential barriers such as digital literacy, income and functional limitations.</li> <li>• Consider offering refreshments or organizing sharing by participants.</li> </ul>
<p><b>5. Establish appropriate communication strategies, and measure impact.</b></p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Avoid communication that supports stereotypes and ageist attitudes.</li> <li>• Consider using various media, such as local radio, ethnic radio, newspapers and other printed media, word of mouth, social media and social networking platforms.</li> <li>• Write a report of discussions, results and other outcomes.</li> <li>• Plan further consultations.</li> <li>• Achieve consensus on indicators and metrics to monitor meaningful engagement when implementing the package.</li> </ul>



Elderly people waiting to get their visual examination during a visit of eye health workers at Taytawasi Senior Center in Villa Maria del Triunfo, Lima, 2018  
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# 7

## The way forward

Countries face common challenges in ensuring holistic, sustainable, equitable LTC systems and in changing the disease-oriented model of care, which results in fragmented care delivery, unnecessary hospitalization and catastrophic health expenditures for older people and their families. The aspiration of the United Nations Decade of Healthy Ageing (2021–2030) to promote good health for all older people within the integrated care approach can be achieved only if countries strengthen their LTC systems. The first two years of the Decade were struck by the COVID-19 pandemic, which revealed multiple unmet needs of older people and carers and unexpectedly provided an opportunity to highlight the significance of LTC and reframe its provision.

The deinstitutionalization of LTC from residential facilities to community care and engagement of older people and carers in changing policy are receiving more attention in recent discourse and practice. Although many countries have already evolved their LTC systems, proactive connection and coordination of care services among various care settings remain a challenge. Policies are essential to inform and educate all stakeholders, to foster cooperation and coordination among care sectors and to transform the vision of care providers, service managers and care teams.

Implementation of this package of LTC interventions for UHC will allow countries to address the growing demand for care and to realize UHC. The package provides a list of recommended priority interventions for LTC that should be considered by all countries according to their contexts and needs to protect, restore and optimize the functional ability of older people who need LTC. With this package, countries can increase coverage of LTC interventions in all settings, facilitated by the person-centred, integrated care approach and education and training of all care workers, including those in the informal sector.

The package will be implemented in various ways, depending on existing structures and contexts. The initial steps include assessment of the needs of older people

and communities, mapping existing LTC interventions in each setting and area and identification of gaps and inequalities in provision. The list of interventions should then be revised dynamically for various levels and settings. To ensure that the interventions reflect the diversity and heterogeneity of older people in terms of capacity, ability, experience, opinions, interests and needs, mechanisms should be found for meaningful engagement of older people and carers.

WHO will promote measures for progression toward universal coverage of LTC by including the package in the UHC Compendium with the UHC Service Package Delivery and Implementation tool (94) to support planning and implementation of the package of LTC interventions in countries. This tool allows countries to design contextualized services, assign them to a specific service delivery platform and define the necessary human and material resources. WHO will develop further technical guidance and tools for implementing the package, such as definitions, terms, indicators and standards for LTC settings, workforce and services.

WHO will respond to the increasing, urgent need for a competent, sustainable care workforce. The core competencies of LTC workers should be defined for integration and coordination of care among different cadres and professionals working in a multidisciplinary team. Education and training should be provided not only to professional care workers but also to unpaid carers, so that they provide care more efficiently, with a smaller burden and more support.

Countries should progressively but urgently realize universal coverage of LTC to improve the access of older people and their families to adequate, affordable, high-quality LTC services without financial hardship or an undue burden, eventually ensuring fulfilment of their capacity, function and meaningful lives with respect for their rights and dignity.

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# Annex 1. Interventions in the package (core and extended list)

**Table A1.1.** Core and extended interventions in the package

Interventions	Core list	Extended list
<i>For health-care needs</i>		
Cognitive decline	✓	
Limited mobility	✓	
Falls	✓	
Physical inactivity and sedentary behaviour	✓	
Malnutrition	✓	
Unhealthy diets and substance abuse	✓	
Eye conditions and vision impairment	✓	
Ear diseases and hearing impairment	✓	
Depressive symptoms and anxiety	✓	
Polypharmacy	✓	
Pain	✓	
Urinary and faecal incontinence	✓	
Skin pressure injury	✓	
Infections	✓	
Oral diseases	✓	
Sleep disorders		✓
Diabetic foot		✓
<i>For palliative care needs</i>		
Physical	✓	
Psychological, social and spiritual	✓	
<i>For social care and support needs</i>		
<i>For older people</i>		
Support and assistance with ADL and IADL	✓	
Participation in community and social life	✓	
Accessibility and transport	✓	
Provision of assistive products	✓	
Social protection		✓
Age-friendly community		✓
Modifications of the home environment		✓
Housing programme		✓
<i>For carers</i>		
Psychosocial support	✓	
Respite care	✓	
Environmental modifications for carers		✓
Transition care		✓



# Annex 2. Methods of selection of LTC interventions for the package

## A2.1 Scoping review

### A2.1.1. Literature search

A scoping review was conducted for a systematic assessment of the scientific literature on LTC interventions and services for older adults between 2010 and 2020. Systematic literature searches were performed with the abbreviation PCC (population, context, concept), defined as follows:

- population: older adults, frail elderly, older people, elderly;
- context: LTC facilities, nursing homes, home- and community-based services, community health services, caregivers, social services; and
- concept: LTC services or interventions, provision, package of services

Combinations of these terms were used, and search strategies were defined according to each database used (PubMed, CINAHL, EBSCO Host, Cochrane, and Google Advanced to assess grey literature) under the supervision of a librarian. The terms used were: long-term care OR/AND, health services for the aged, and social services, AND/OR, social care, AND, interventions, OR services, AND long-term care facilities, OR assisted living facilities, OR nursing homes, OR homes for the aged, OR home care, OR community health services, OR Caregivers, AND older adult, AND frail elderly. The Pubmed search terms are shown in Box A1.

### Box A2.1. Pubmed search terms

```
((((((((((((("long-term care"[MeSH Terms] OR ("long term"[All Fields] AND "care"[All Fields])) OR "long term care"[All Fields]) OR ("long"[All Fields] AND "term"[All Fields]) AND "care"[All Fields])) OR "long term care"[All Fields]) OR ("health services for the aged"[MeSH Terms] OR ("health"[All Fields] AND "services"[All Fields]) AND "aged"[All Fields])) OR "health services for the aged"[All Fields])) OR (((((((("social work"[MeSH Terms] OR "social"[All Fields] AND "work"[All Fields])) OR "social work"[All Fields]) OR ("social"[All Fields] AND "services"[All Fields])) OR "social services"[All Fields]) OR "social welfare"[MeSH Terms]) OR ("social"[All Fields] AND "welfare"[All Fields])) OR "social welfare"[All Fields]) OR ("social"[All Fields] AND "services"[All Fields])) OR (((((((((((("social"[All Fields] OR "socialisation"[All Fields]) OR "socialization"[MeSH Terms]) OR "socialization"[All Fields]) OR "socialise"[All Fields]) OR "socialised"[All Fields]) OR "socialising"[All Fields]) OR "socialities"[All Fields]) OR "sociality"[All Fields]) OR "socializations"[All Fields]) OR "socialize"[All Fields]) OR "socialized"[All Fields]) OR "socializers"[All Fields]) OR "socializes"[All Fields]) OR "socializing"[All Fields]) OR "socially"[All Fields]) OR "socials"[All Fields]) AND "care"[All Fields])) AND (((("intervention s"[All Fields] OR "interventions"[All Fields]) OR "interventive"[All Fields]) OR "methods"[MeSH Terms]) OR "methods"[All Fields]) OR "intervention"[All Fields]) OR "interventional"[All Fields])) OR (((("service"[All Fields] OR "service s"[All Fields]) OR "serviced"[All Fields]) OR "services"[All Fields]) OR "services s"[All Fields]) OR "servicing"[All Fields])) AND (((("long-term care"[MeSH Terms] OR ("long term"[All Fields] AND "care"[All Fields])) OR "long term care"[All Fields]) OR ("long"[All Fields] AND "term"[All Fields]) AND "care"[All Fields])) OR "long term care"[All Fields]) AND (("facilities"[All Fields] OR "facility"[All Fields]) OR "facility s"[All Fields])) OR ("assisted living facilities"[MeSH Terms] OR ("assisted"[All Fields] AND "living"[All Fields]) AND "facilities"[All Fields])) OR "assisted living facilities"[All Fields])) OR ("nursing homes"[MeSH Terms] OR ("nursing"[All Fields] AND "homes"[All Fields])) OR "nursing homes"[All Fields])) OR ("homes for the aged"[MeSH Terms] OR ("homes"[All Fields] AND "aged"[All Fields])) OR "homes for the aged"[All Fields])) OR (((("nursing"[MeSH Subheading] OR "nursing"[All Fields]) OR ("home"[All Fields] AND "care"[All Fields])) OR "home care"[All Fields]) OR "home care services"[MeSH Terms]) OR ("home"[All Fields] AND "care"[All Fields]) AND "services"[All Fields])) OR "home care services"[All Fields]) OR ("home"[All Fields] AND "care"[All Fields])) OR ("community health services"[MeSH Terms] OR ("community"[All Fields] AND "health"[All Fields]) AND "services"[All Fields]) OR "community health services"[All Fields])) OR (((("caregiver s"[All Fields] OR "caregivers"[MeSH Terms]) OR "caregivers"[All Fields]) OR "caregiver"[All Fields]) OR "caregiving"[All Fields])) AND (((("aged"[MeSH Terms] OR "aged"[All Fields]) OR ("older"[All Fields] AND "adult"[All Fields])) OR "older adult"[All Fields])) AND (("frail elderly"[MeSH Terms] OR ("frail"[All Fields] AND "elderly"[All Fields])) OR "frail elderly"[All Fields]))
```

### **A2.1.2. Data charting and analysis**

Interventions were extracted from the articles by internally validated charting, including the type of study, demographic characteristics of the study population, country, description of the intervention, delivery setting, provider, delivery frequency, duration, outcome measures and conclusions.

The identified interventions were analysed qualitatively to find and group similarities among the interventions. The thematic analysis and grouping were conducted in the following stages: (1) interventions were organized into thematic areas according to WHO's Healthy Ageing domains (intrinsic capacity, functional ability and environment and those provided explicitly by caregivers); (2) interventions in each thematic area were clustered by similarity and coded, followed by cluster analysis to identify common underlying concepts and associations; (3) clustered interventions were named according to WHO's official wording in guidelines and official reports. Two researchers independently clustered interventions, and decisions and disagreements were discussed. A third researcher reviewed the decisions.

The frequency of appearance of each intervention in clusters was calculated.

### **A2.1.3 Results**

The 305 articles assessed resulted in 273 similar interventions, grouped into 49 clusters, which were organized into four WHO healthy ageing domains:

- interventions to support caregivers and enable care planning based on a person-centred assessment;
- interventions for maintenance of intrinsic capacity;
- interventions for optimization of functional ability; and
- additional environmental and structural interventions.

## **A2.2. Delphi process**

A multistep expert consensus process was conducted to obtain the input of a broad range of international experts and stakeholders on the interventions to be included in the package. The process comprised (1) a pre-consultation round to discuss an initial list of LTC interventions identified in the previous scoping review and revised internally by WHO; (2) a two-round survey to reach consensus on a minimum list of interventions for LTC to be provided in UHC; and (3) panel meetings to finalize the consensus and draw up a final list of interventions to be included in the package.

### **A2.2.1 Refinement and preliminary consultation**

WHO reviewed the formulations internally and harmonized the language of the clusters according to WHO guidelines and guidance, resulting in 71 clusters of interventions. The clusters were adopted as interventions per se. A preliminary consultation with the WHO Global Network on Long-term Care was conducted for them to review the list of interventions and suggest any interventions that they considered to be missing. The experts added more 46 interventions, resulting in 117 interventions, which were then considered in a two-round survey.

### **A2.2.2 Two-round survey**

The online survey was conducted between November 2020 and April 2021 on the LimeSurvey server (LimeSurvey GmbH) with multinational and multidisciplinary experts in LTC and ageing.

The aim of the first round was to rank the 117 interventions by importance on a Likert-type scale, from 1 (not important at all) to 9 (extremely important). We defined "importance" as the degree to which the intervention provided greater value for optimizing functional ability. It should be available with minimal financial hardship to all older adults at risk or with significant physical and mental capacity loss and to their carers. The results were pooled, and we selected 81 interventions that attained a threshold of 80% agreement within the upper tertile (7–9 points) and an average of 7 points. The level of agreement was the

proportion of ratings in the same 3-point region (1–3, 4–6 or 7–9 points).

In round 2, we invited all experts to rate the remaining interventions for acceptability and feasibility on a 5-point Likert-type scale (1, strongly disagree, to 5, strongly agree). We defined acceptability as the degree to which providers and users would deem the intervention implementable or acceptable and feasibility as the degree to which the intervention could be delivered in low-resource settings.

We used the agreement level and the global score (i.e. the mean of the average score of acceptability and feasibility). Only interventions that scored a mean of 4 for both acceptability and feasibility and an agreement of 70% for both criteria were selected for discussion in the panel meetings. Both the resulting list of interventions and also conflicting interventions were discussed in the meetings. Conflicting interventions were considered to be those that were highly rated for importance in round 1 (mean, 8 points and 80% agreement) but did not reach the threshold for acceptability or feasibility in round 2.

After these two rounds, 41 and 9 conflicting interventions were selected for discussion and refinement in consultations.

### **A2.2.3 Consultation process**

Several consultations were conducted to refine the list of interventions for inclusion in the package. They comprised meetings with the Global Network on Long-term Care and internal discussions with WHO departments (e.g. rehabilitation, palliative care, oral health).

After this consultation, conflicting interventions and those related to the provision of assistive products and oral health were included for consideration as being critical for addressing LTC needs. In this phase, consensus was reached that some interventions were facilitating factors for providing person-centred integrated care and education and training for carers and LTC workers.

The list to be included in the package consists of 31 interventions, with 23 on the core list and 8 on the extended list. Core interventions are those considered to be feasible for immediate implementation, and those on the extended list are those considered to be feasible for implementation in some countries according to their resources and capacities, although, in most countries, they would be implemented as an extension of the package.

## **A2.3 Grouping and description of the selected interventions**

The taxonomy used to group the interventions was discussed extensively and tentatively adapted from the UHCC compendium. We defined three main groups of interventions to address LTC needs: health care, palliative care and social care and support, and two facilitating factors, person-centred integrated care and education and training.

## **References**

Arias-Casais N, Amuthavalli Thiyagarajan J, Rodrigues Perracini M, Park E, Van den Block L, Sumi Y et al. What long-term care interventions have been published between 2010 and 2020? Results of a WHO scoping review identifying long-term care interventions for older people around the world. *BMJ Open*. 2022;12:e054492. doi:10.1136/bmjopen-2021-054492.

Perracini MR, Arias-Casais N, Thiyagarajan JA, Rapson C, Isaac V, Ullah S et al. A recommended package of long-term care services to promote healthy ageing based on a WHO global expert consensus study. *J Am Med Dir Assoc*. 2022;23(2):297–303. e14. doi:10.1016/j.jamda.2021.12.019.

# Annex 3. Interventions on the extended list

**Table A3.1.** Health care needs

Intervention for	Assessment	Management
<b>Sleep disorders</b>	Strategies and actions to screen and assess sleep disturbances (e.g. sleep apnoea, insomnia, daytime sleepiness), associated conditions (e.g. pain, incontinence, medications, cognitive impairment, dementia, cardiovascular disease, depression) and lifestyle habits that interfere with sleep (alcohol consumption, nutritional habits, lack of physical activity).	Interventions to manage sleep problems can include pharmacological and non-pharmacological strategies such as counselling on sleep hygiene, cognitive behavioural therapy, medication review, use a continuous positive airway pressure machine and management of underlying conditions.
<b>Diabetic foot</b>	Strategies and actions to assess foot problems in older people with diabetes mellitus, including taking a history and conducting a physical examination (e.g. inspection, touch-pressure test for plantar sensory loss).	Interventions to manage foot problems can include provision of educational programmes, appropriate footwear, multidisciplinary foot care, wound management and offloading and other services to prevent and manage foot ulcers.

**Table A3.2.** Social care and support needs for older people and carers

Interventions for older people	Assessment	Management
<b>Social protection</b>	Strategies and actions to ensure that older people receive adequate assessment of social needs and have access to social protection to cover those needs, an adequate standard of living and respect for human rights.	Interventions to support social protection can include provision of housing, access to pensions and other subsidies, entitlements or benefits to support basic needs, including financial and legal services.
<b>Age-friendly community</b>	Strategies and actions to assess the community in which people live, to ensure that they can remain as independent as possible in the place of their choice.	Interventions to enhance friendly communities and neighbourhoods can include improving access to services in the community and ensuring compassionate neighbourhoods and dementia-inclusive communities
<b>Modifications of the home environment</b>	Strategies and actions to assess the home environment and necessary modifications to compensate for loss of an older person's capacity, improving mobility and reducing the risk of accidents according to their preferences and expectations.	Interventions to modify the home environment can include assistance in home repairs, installation of handrails, grab bars, portable ramps, information tools, checklists and resources to help older people and carers to identify changes to ensure safety, comfort and functioning.
<b>Housing programme</b>	Strategies and actions to provide housing for older people, particularly vulnerable individuals, through access to housing programmes and arrangements.	Interventions to provide housing can include tools for individuals to access housing, such as co-housing, house-sharing, housing cooperatives, multigenerational living and retirement communities.



Interventions for carers	Assessment	Management
<b>Environmental modifications for carers</b>	Strategies and actions to identify and understand carers' physical needs and difficulties while providing care and to optimize the functioning and independence of older people to reduce strain on carers	Interventions in the environment to reduce carers' burden can include widening doors, installing handrails or a ramp, moving supplies and objects for ease of access or to keep them out of sight
<b>Transition care</b>	Strategies and actions to provide timely assessment of needs when older people are in hospital or another acute care facility and are to be discharged home, starting at the time of admission and throughout the patient's stay, planning discharge care according to the resources available in the community	Interventions to promote adequate transition care can include nurse visits to older people and carers while still in hospital and appropriate arrangements at home, helping carers to navigate social systems, provision of home personal carers and other community programmes

# Annex 4. Actors in the long-term care network

**Table A4.1.** Actors in the long-term care network

Actors	Role description
<b>Carers</b>	Deliver care in households or in the community, commonly with a familial or previous social relationship with the older person in need of care, including spouses, adults' offspring, other relatives, friends and neighbours. They provide direct support and assistance with ADL and IADL, such as showering, transferring, eating, toileting, driving to health appointments, shopping, preparing meals and giving medications. The type and level of care can vary considerably. The work provided by family carers can be supported by social benefits, such as paid leave and cash-for-care transfer schemes.
<b>Domestic helpers, domestic workers, cleaners, home aides</b>	Perform light housekeeping (e.g. sweeping, vacuum-cleaning, washing and ironing clothes, washing dishes), preparing, cooking and serving meals and refreshments, purchasing food and other household supplies and other tasks. These workers may be affiliated to an agency or may be hired directly by families, often as domestic workers. They often provide direct personal care and companionship to older people.
<b>Personal care workers (home and institutional)</b>	Perform tasks such as assisting with personal care (e.g. dressing, bathing, eating), giving or ensuring that people take medications, watching for any sign of deterioration in the person's health and informing the relevant medical doctor or social services. In houses, they usually do light housecleaning, cooking, grocery shopping, laundry and transport. They can be trained to provide companionship and assist in recreational activities. They work either in homes or in LTC facilities. They are also known as nursing aides, health aides, personal care assistants and care assistants.
<b>Volunteers</b>	Members of organizations who give their time and work without monetary compensation. They provide help in direct, personal care (e.g. transferring, positioning, eating) and indirect activities (e.g. shopping, cleaning). They may also provide companionship and recreational activities (e.g. arts and crafts, music, going to a library, visiting friends). They may work in households or in LTC facilities.
<b>Community health-care workers (community health worker, community health aide, community health promoter, village health worker)</b>	Provide health education, referral and follow-up, case management, basic preventive health care and home visiting. They usually live in the community they serve. They provide support and assistance to individuals and families in navigating health and social services systems.
<b>Generalist medical doctors (general practitioners, family medical practitioners, primary health care physicians, district medical doctors)</b>	Diagnose, treat and prevent illness, disease, injury and physical and mental impairment and maintain general health by applying the principles and procedures of modern medicine. They do not limit their practice to certain disease categories or methods of treatment and may assume responsibility for the provision of continuing, comprehensive medical care to individuals, families and communities.
<b>Specialist medical doctors (geriatrician, ophthalmologist, psychiatrist, rheumatologist, neurologist, palliative care specialist)</b>	Diagnose and treat certain diseases and specialize in certain types of patient or method of treatment; may conduct medical education and research in their areas of specialization.

Actors	Role description
<b>Nursing associate professionals (nurse assistants or technicians or a licenced practical nurse)</b>	Provide basic nursing and personal nursing care; usually assist nurses in data collection, care planning and delivery, and monitoring older people's condition. Their specific roles depend on the tasks and their responsibility in executing them, as well as on national educational and training requirements. Nursing assistants also work as personal care workers, either at home or in LTC facilities.
<b>Nursing professionals (registered nurse, nurse practitioner, advance practice nurse, clinical nurse specialist, community nurse)</b>	Provide treatment, support and care services and assume responsibility for planning and managing the care of patients, including supervision of other health-care workers, either autonomously or in teams with medical doctors and others in clinical and community settings. Usually assume the role of case managers and care coordinators in multidisciplinary teams.
<b>Social workers</b>	Assess and identify needs, assist clients in developing skills and accessing resources and support services to respond to health problems, life transitions, addiction and other personal, family and social problems. They liaise with other social service agencies and health-care providers to advocate for client and community needs. They also provide counselling, therapy and mediation services to individuals, families, groups and communities for social or personal difficulties.
<b>Dieticians and nutritionists</b>	Assess, plan and implement programmes to improve the nutrition of individuals and communities. They conduct nutritional assessments and monitoring and create and assist in personalized nutritional care plans.
<b>Occupational therapists<sup>a</sup></b>	Promote health and well-being through occupation, enabling older people to participate in meaningful activities of everyday life in the community and in LTC facilities. They conduct training and provide recommendations for ADL, use of assistive technology, carer training, techniques to aid cognitive functioning and falls prevention and home safety and accessibility.
<b>Physiotherapists</b>	Assess and manage movement dysfunction to prevent, maintain, restore and maximize function and activity for the health and well-being of older people, carers and communities. They apply a broad range of physical therapies and techniques, such as movement, ultrasound, heating and laser. They may develop and implement programmes for screening and prevention of common physical ailments and disorders.
<b>Audiologists and speech therapists</b>	Assess, manage and treat physical and cognitive disorders that affect human hearing, speech and swallowing. They prescribe corrective devices or rehabilitative therapies for hearing impairment, speech disorders and related sensory and neural problems. They plan hearing screening programmes and provide counselling on hearing safety and communication.
<b>Dentists (dental practitioner, dental surgeon, endodontist, oral or maxillofacial surgeon, orthodontist, prosthodontist, stomatologist)</b>	Diagnose, treat and prevent diseases, injuries and abnormalities of the teeth, mouth, jaws and associated tissues. They use a broad range of specialized diagnostic, surgical and other techniques to promote and restore oral health.
<b>Dental prosthetic technicians (prosthetists)</b>	Design, fit, service and repair dental devices and appliances (e.g. dentures, and dental crowns and bridges) according to prescriptions or instructions.
<b>Dental assistants and therapists</b>	Provide basic dental services for the prevention and treatment of diseases and disorders of the teeth and mouth according to care plans and procedures established by a dentist or other oral health professional (e.g. dental hygiene, basic or routine clinical dental procedures).
<b>Optometrists and ophthalmic opticians (optometrist, orthoptist)</b>	Provide diagnosis, management and treatment of disorders of the eyes and visual system. They counsel and advise on eye care and safety and prescribe optical aids or other therapies for visual disturbance.

Actors	Role description
<b>Clinical psychologists</b>	Promote personal, social, educational or occupational adjustment and development. They conduct psychological assessments, establish individual, family or group interventions to improve psychological well-being.
<b>Podiatrists</b>	Diagnose and treat problems affecting the feet, ankles and lower limbs, such as bunions and hammertoes, nail disorders, diabetes, arthritis and orthotics.
<b>Pharmacists</b>	Store, preserve, compound and dispense medicinal products. They counsel on the proper use and adverse effects of drugs and medicines prescribed by medical doctors and other health professionals.
<b>Pharmaceutical technicians and assistants</b>	Perform a variety of tasks associated with dispensing medicinal products under the guidance of a pharmacist or other health professional. They inventory, prepare and store medications and other pharmaceutical compounds and supplies and may dispense medicines and drugs to clients and instruct them on their use as prescribed by health professionals.
<b>Recreational therapists</b>	Use recreational medical treatment to help reduce depression, stress and anxiety; recover basic physical and mental abilities; build confidence; and socialize effectively.
<b>Music therapist</b>	Music therapists use music and sound to improve people's emotional well-being, relieve stress and build confidence.
<b>Traditional medicine practitioners and faith healers</b>	Advise on methods to preserve or improve health and treat mental and physical illness by techniques traditionally used in the community and believed to act by assisting and stimulating nature or by the power of faith and spiritual advice.
<b>Community transport drivers</b>	Provide door-to-door service for people who cannot easily use public transport.

Adapted from: International Labour Organization (1)

<sup>a</sup> From: World Federation of Occupational Therapists (<https://wfot.org/>).

## Reference

1. International Standard Classification of Occupations. Geneva: International Labour Organization; 2004 (<https://www.ilo.org/public/english/bureau/stat/isco/isco88/major.htm>).



# Annex 5. LTC settings

**Table A5.1.** LTC settings

Setting	Description	Examples of services provided
<b>Home and community care</b>		
<b>Home</b>	<p>Home care addresses the health and social care needs of older people and includes a wide range of services that allow them to live safely in their homes and participate in the community. It also supports the needs of carers so they can provide high-quality care, reduce their overload and relieve stress.</p> <p>Integrated home care services can avoid unnecessary hospitalization, aid recovery after an acute illness or injury, or reduce the length of a hospital stay.</p>	<ul style="list-style-type: none"> <li>• Multidisciplinary care and case management (e.g. visits by doctors and social workers, nursing care, speech therapy, physical and occupational therapy, community health visitors) to screen, assess and manage health problems such as cognitive decline, incontinence, limited mobility, falls and loneliness.</li> <li>• Care coordinators connect older people and carers with local groups and community support services.</li> <li>• Volunteers (e.g. from religious organizations, neighbourhood organizations, social organizations) provide activities for older people and carers, such as companionship, light housekeeping, escorted transport to medical appointments and groceries, shopping.</li> <li>• In home personal care, trained personal care workers assist older people in their needs (e.g. showering, preparing meals, taking medication, cognitive stimulation activities, companionship, escorting to medical appointments and other personal care tasks). Services can also include light housekeeping, laundry and shopping.</li> <li>• Other services include transport or escorting older people to attend medical appointments, examinations, rehabilitation and participate in community activities; meals-on-wheels deliver daily meals to home-bound older people who are unable to buy or prepare meals and have no daily carer to assist them.</li> </ul>
<b>Day-care centre</b>	<p>Care services for older people who require assistive and supportive services during the day, usually regularly, or need opportunities to socialize. Most centres are located within the community, close to older people's homes.</p> <p>Day centres also offer an opportunity for carers to take systematic breaks to meet their personal needs or to overcome feelings of isolation.</p>	<ul style="list-style-type: none"> <li>• Help with ADL, such eating, grooming, managing incontinence, promoting oral health</li> <li>• Provide meals and therapeutic diets</li> <li>• Provide cognitive stimulation, social and recreational activities</li> <li>• Provide rehabilitation services, such as occupational therapy, speech therapy and physiotherapy, in individual or group sessions to restore, maintain or optimize functional abilities</li> <li>• Assess and monitor health and social needs</li> <li>• Provide information for navigation of systems to access other services</li> <li>• Some day-care centres offer specialized services for people with dementia</li> <li>• Some day-care centres deliver medical and nursing services</li> <li>• Provide psychoeducational support groups and counselling for carers</li> <li>• Transport is provided to and from day-care centres</li> </ul>

Setting	Description	Examples of services provided
<b>Day hospice centre</b>	Also known as day hospice or palliative care day unit. Designed for patients who are cared for in the community, as a complement to the care they receive at home. They operate during the day. May be in a hospital, hospice, palliative care unit or another health-care facility. May also be in a church or community hall not otherwise used during the day.	<ul style="list-style-type: none"> <li>• Provide multidisciplinary palliative care such as nursing care, medical specialist consultations, physical therapy, occupational therapy, music therapy, spiritual counselling.</li> <li>• Interventions are tailored to each patient's interests and abilities and include arts and crafts, music and pet therapy</li> <li>• Counselling and support are also offered for carers.</li> <li>• Volunteers may be engaged but must be educated in palliative care</li> <li>• Transport is provided to and from hospice centres.</li> </ul>
<b>Recreational or community centre</b>	Centres to improve and maintain the physical and mental capacities of older adults and provide opportunities to connect with community resources. Usually located in local community buildings, such as public buildings in parks, clubs, churches and neighbourhood organizations. Most centres are run by local governments or non-profit organizations. Also known as seniors' recreation centres, senior citizen activity centres, older adult centres	<ul style="list-style-type: none"> <li>• Programmes and activities differ among centres but can include meals and nutritional programmes, social and recreational activities (e.g. trips, holiday celebrations, art, music and dance classes, exercise classes)</li> <li>• Some centres offer classes in self-management of chronic disease, well-being programmes and opportunities for volunteering and civic engagement.</li> <li>• Some centres offer information and assistance on navigating social and health systems, such as employment assistance, tax preparation, benefits counselling.</li> <li>• Some centres offer both in-person and virtual activities.</li> </ul>
<b>LTC facilities</b>		
<b>Hospitals specialized in chronic care</b>	Also known as long-term chronic care hospitals or community hospitals. They provide services for people with more extensive medical needs or intermediate care while recovering from a medically complex condition (e.g. pressure injury, severe stroke, post-trauma or post-surgery). Their aim is to achieve maximum functional recovery or stabilize the clinical status to allow discharge to home.	<ul style="list-style-type: none"> <li>• Services include medical care 24 h/day, 7 days/week (with input from geriatric and palliative doctors), skilled nursing care, comprehensive rehabilitation programmes and other social care services</li> </ul>
<b>Assisted living facilities</b>	Provide housing, hospitality services and personal care for adults who can live independently and make decisions on their own behalf but require a supportive environment due to decreased functional ability and are at risk when living in their own home. Can consist of a room, an apartment unit in a building or a private home in a retirement community	<ul style="list-style-type: none"> <li>• Personal care services that include assistance in tasks like bathing, grooming, dressing and mobility</li> <li>• Meals, housekeeping and laundering</li> <li>• Recreational and well-being activities</li> <li>• 24-h emergency response system</li> <li>• Can also include monitoring of chronic conditions and rehabilitation services</li> </ul>

Setting	Description	Examples of services provided
<b>Nursing homes or skilled nursing facilities</b>	<p>Provide 24-h medical care and skilled nursing support in addition to residential care. Usually provide care for older people with severe sensory, cognitive, behavioural, nutritional or mobility problems or bowel or bladder incontinence, which make them highly dependent</p> <p>Some people stay in a nursing home for a short time after discharge from hospital.</p>	<ul style="list-style-type: none"> <li>• Skilled nursing care by personnel trained to identify symptoms and changes in residents' conditions and functioning, providing care to meet residents' needs.</li> <li>• Accommodation and meals, including therapeutic diets, meal replacements and nutritional supplements prescribed by a physician and tube feeding</li> <li>• Incontinence and pressure injury management</li> <li>• Multidisciplinary services (e.g. medical care, rehabilitation and social work)</li> <li>• Other specialized services (e.g. specialized dementia or palliative care)</li> </ul>
<b>Residential care facilities, residential homes, care homes, aged care homes</b>	<p>Provide 24-h personal care and support for daily tasks for people who do not need skilled nursing care. The aim is to provide a safe, supportive environment where people can leave a meaningful life. Although older people living in residential care facilities might have chronic conditions and decreased functional ability, medical and skilled nursing services are not required continuously. For example, with the progression of dementia, older people might have to be cared for in a nursing home. Facilities varies in size and amenities. Some allow people to bring their own furniture.</p>	<ul style="list-style-type: none"> <li>• Accommodation, laundry and personal care for daily tasks (e.g. hygiene, eating, dressing, going to the toilet, taking medicines, transferring)</li> <li>• Recreational and social activities</li> <li>• Activities to encourage physical activity and avoid sedentary behaviour</li> <li>• Cognitive stimulation</li> <li>• Rehabilitation and other specialized personnel, such as dentists, pharmacists, podiatrists and psychologists, can be organized according to need</li> <li>• Some care homes offer hairdressers, massage, transport and other services</li> </ul>
<b>Inpatient hospice facilities</b>	<p>The characteristics of these facilities vary widely according to the structure of the LTC system. Some facilities provide highly skilled medical and nursing care, similar to that in hospitals but in a more peaceful environment, while others offer a shelter for older patients with serious illness or facing end-of-life, with no home or carer</p>	<ul style="list-style-type: none"> <li>• Provide multidisciplinary palliative care to maximize the comfort of older people with a serious illness or facing end of life by reducing pain and addressing physical, psychological, social and spiritual needs (e.g. palliative nursing and medical care, pharmacists, personal assistants, music therapists, spiritual counsellors)</li> <li>• Speech, physical and occupational therapy can be provided if needed</li> <li>• Also provide carers' support, respite and bereavement care</li> </ul>

# Annex 6. Topics for education and training for carers and LTC workers

**Table A6.1.** List of topics for education and training of carers

Topic	Summary
<b>Training in care of older people who need assistance</b>	Older people who need assistance in ADL and IADL should be cared for with respect, dignity and compassion in order to maintain their autonomy and independence as long as possible. They should receive high-quality care according to their health condition, capacity and functional ability. Unmet needs and tensions between care recipients and carers should be avoided. Feelings of being unprepared or overwhelmed can be distressful for carers. Information and techniques for providing personal care (e.g. moving in bed, transferring, bathing, eating) and creating supportive environments can reduce the burden.
<b>Training to identify deterioration in signs in functioning</b>	Older people's needs are frequently complex and always unique. Carers are an important source of information on changes in functioning and can help to map progressive deterioration and sudden decline that may indicate acute illness. Carers interact with older people in their daily routine and can help the multidisciplinary team to identify subtly changes in physical and mental capacity and in functional ability over time and better understand multifactorial causes.
<b>Training in prevention and responses to falls</b>	A multifactorial risk assessment, including the history and circumstances of falls, and a management plan can be optimized with information and interventions conducted by carers. Carers can identify home hazards and risky behaviour and help to plan home modifications. An emergency response with first-aid measures after a fall event should be anticipated and planned.
<b>Training in promoting physical activity and avoiding sedentary behaviour</b>	Adoption of physical activity recommendations and supervision of basic exercises at home can be optimized by carers. Physical activity at home can be promoted by encouraging older people to be as active as possible during their daily activities and by identifying barriers and facilitators to increasing physical activity. Carers and care teams can help to promote an active lifestyle.
<b>Training in care of people living with dementia</b>	Carers provide everyday care for people living with dementia and have a key role in preventing and managing behaviour changes. Dementia can affect ADL (i.e. eating, drinking, toileting, continence, showering, bathing, grooming) in various ways, depending on the stage of dementia and other health conditions. Learning to assist a person with dementia and managing health-related problems help carers to provide good-quality care and avoid unnecessary health complications. Dementia can change how people behave, think and act, leading to behaviour (e.g. memory loss, aggression, difficulty in sleeping, delusions and hallucinations, wandering) that can be stressful for carers. Learning how to handle behaviour changes and reducing and preventing them can facilitate care provision and prevent strain in carers and abuse of older people.
<b>Management of medications and polypharmacy</b>	Carers should understand the risks involved in use of multiple and over-the-counter medications and non-adherence to prescribed medication regimes. They should be able to identify symptoms related to negative side-effects and to drug interactions and should strengthen their knowledge and skills to manage medications safely and effectively.

Topic	Summary
<b>Management of pain</b>	Carers encounter numerous challenges when managing pain due to complex chronic conditions common in older people and the various interventions to decrease pain. They should be able to understand the multidimensional, subjective nature of pain, which can influence a positive dyad relationship, and improve their knowledge and self-efficacy for pain management, particularly in palliative care and end-of-life situations.
<b>Identify and handle low mood and depression</b>	Carers can help to recognize common presentations of depression and support older people in assessment and management of depression, avoiding negative attitudes and misconceptions of the situation. Carers should strengthen their knowledge to support social activities, encourage functioning in daily life, participation in community-based exercise programmes and skills development and assist in managing pharmacological interventions. Partners and family members can help to prevent loneliness and isolation.
<b>Palliative care, including end-of life care</b>	Carers should be trained to recognize the sources of suffering, which involves understanding issues beyond physical symptoms. They can learn to help older people to live as actively as possible until death, paying attention to their specific needs and priorities (e.g. pain relief, difficulty in breathing, emotional and spiritual demands) and participate actively in the palliative care plan.
<b>Navigate health and social services and systems</b>	Carers may find it difficult to find information themselves, as it may be difficult to find accessible, clear information. They should receive training in how and where to obtain useful, trusted information, understand how systems work, how to overcome barriers to access to services and how to continue to receive care when health, functioning and social conditions change.

**Table A6.2.** Topics for education and training of LTC workers

Topic	Summary
<b>Training in care for older people in need of assistance</b>	<p>Strengthen knowledge and skills to provide everyday care for older people in need of assistance to perform ADL and iADL in different settings.</p> <p>A wide range of care workers, including personal assistants, home health aides, domestic workers are responsible for providing direct or indirect (e.g. counselling, case management and support) everyday care. Frequently, personal care workers' tasks are related to ADL provision (e.g. positioning, transferring, personal hygiene, bathing, dressing, transporting and preparing meals). They can act as partners and collaborators in identifying and anticipating health and social problems and organizing screening for malnutrition or loneliness, monitoring health care and promoting independence and autonomy. Other common tasks include maintaining older people's hygiene standards, monitoring the evolution of their health status and response to care, transporting them outside and providing cognitive stimulation and psychological support.</p>
<b>Training to identify and manage declines in functioning</b>	<p>Strengthen knowledge and skills to identify and manage declines in intrinsic capacity and in functional ability.</p> <p>Older people in need of assistance have complex chronic conditions and various levels of frailty and disability, resulting in specific needs in terms of prevention, assistive care, rehabilitation and palliation. Declines in functioning can progress slowly or can be a result of an acute event. In all cases, care workers are responsible for identifying and managing such losses in various types of intrinsic capacity (e.g. vision and hearing, cognition, locomotion) and functional ability (e.g. being mobile, meeting basic needs, building and maintaining relationships).</p>



Topic	Summary
<b>Training in communication skills</b>	<p>Strengthen knowledge and skills for improving communication with older people with sensory, language and cognitive impairments.</p> <p>Older people may experience sensory, language and cognitive impairments that make communication difficult. The impairments may be age-related or a result of a condition or disease (e.g. Parkinson disease, dementia, stroke, glaucoma). Older people must be able to communicate to express their feelings, wishes and preferences of care. Care workers should strengthen their compassion and their skills in being supportive and attentive. Engaging and being empathetic with older people and their carers are important for responding to their needs. Communicating with a person living with dementia can be particularly challenging, as the problems vary according to the progress of cognitive decline, although communication can be improved.</p>
<b>Training on oral health</b>	<p>Strengthen knowledge and skills in the prevention of oral health issues.</p> <p>Oral health is strongly linked with the overall health of older people. Periodontal diseases have been linked with systemic diseases, and several chronic diseases can affect oral health. Skills in screening, identification and management of oral health problems are important to prevent systemic diseases and malnutrition. Oral health and comfort generally receive inadequate attention amid competing care priorities, compromising identification of oral disorders and assistance in oral hygiene. Training of care workers to assist older people who require assistance in mouth care, toothbrushing and cleaning dentures and in relieving discomfort and difficulties associated with eating and speaking are particularly important for maintaining the quality of life of older people.</p>
<b>Training in infection prevention and control</b>	<p>Strengthen skills and knowledge of best practices in infection prevention and control (e.g. hand hygiene, food safety measures, use of personal protective equipment, contact precautions) in LTC settings to protect older people from health-care-associated infections and to prevent the spread of infections among residents, health-care providers, carers and others.</p>
<b>Training in preventing and managing violence against older people</b>	<p>Strengthen knowledge about violence against older people (physical, psychological, financial, sexual), including recognition of signs of abuse, neglect and violation of rights.</p> <p>Violence against older people is described as older people abuse and “includes physical, sexual, or psychological abuse, as well as neglect, abandonment and financial exploitation by another person or entity and occur in any setting, either in a relationship where there is an expectation of trust or when an older person is targeted based on age or disability” (1). LTC providers should offer formal training in older people abuse and its signs and create abuse reporting procedures. Multidisciplinary teams can address domestic violence and assure the main areas of competence: professional, socio-communicative and methodological. Professional competence includes understanding the multifaceted nature of violence against older people, the challenges that older people face and methods and procedures for recognizing signs of violence and violation of rights and preventing it.</p>
<b>Training in palliative care, including end-of life care</b>	<p>Strengthen knowledge and skills for identifying early physical, psychological, social and spiritual suffering, assessing palliative needs and preventing and controlling symptoms.</p> <p>All health and social care professionals should be sensitized and trained in core palliative care skills (e.g. communication, loss, grief and bereavement, identifying and relieving symptoms, planning care goals). The level of training depends on the professional role (e.g. pain management and prescription of opioids, management of delirium, emergencies).</p>
<b>Training in prevention and response to falls</b>	<p>Strengthen knowledge and skills for preventing falls and for provide first aid after a fall event.</p> <p>The goal is to reduce the occurrence of falls among older adults in every setting by conducting a comprehensive, person-centred assessment of the risk of falls and implementing evidence-based interventions to reduce modifiable risk factors (e.g. demonstrate use of tools for screening falls, discuss risky attitudes with older adults, provide counselling on proper footwear, multimodal exercises, identification of inappropriate medications that increase the risk).</p>

Topic	Summary
<b>Training in promoting physical activity and avoiding sedentary behaviour</b>	<p>Strengthen knowledge and skills for adoption of physical activity recommendations and for supervising exercises.</p> <p>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.</p>
<b>Training in care for people living with dementia</b>	<p>Strengthen knowledge and skills for preventing and coping with behaviour changes and provision of everyday care.</p> <p>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.</p>
<b>Training care workers in preventing malnutrition</b>	<p>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.</p>
<b>Training care workers to identify and manage incontinence</b>	<p>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)</p>
<b>Training care workers in swallowing dysfunction</b>	<p>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).</p>

Topic	Summary
<b>Training care workers in polypharmacy</b>	Strengthen knowledge and skills to address polypharmacy, and eliminate unnecessary prescriptions. Includes understanding the terminology of polypharmacy and what it means for patients and the health and social care team, identify causes (e.g. various physicians and providers, incorrect prescriptions, personal resistance to withdrawal of medications, lack of social support) and the consequences of polypharmacy, principles of medication review and interventions to manage polypharmacy, including educational support for patients and carers, shared decision-making to respect individual priorities and goals and regular follow-ups.
<b>Training care workers in pain management</b>	Strengthen knowledge and skills for the assessment and management of pain, including understanding the concept of pain, differentiation of types of pain, myths about pain in older people (e.g. “pain is expected with ageing”, “narcotic medications are always inappropriate”), identification of factors that affect older people’s pain experience, tools for assessing pain, especially in older people with communication and cognitive problems, and principles of pharmacological and non-pharmacological pain management. Also includes the particularities of pain management in older people in palliative care.
<b>Training care workers to identify and handle low mood and depression</b>	Strengthen knowledge and skills for the assessment, management and follow-up of depression, including the common presentations and symptoms of depression and its impact on daily functioning in personal, family and social life, and the presence of other physical conditions that can resemble or exacerbate depression (e.g. anaemia, malnutrition, hypothyroidism, substance use and medication side-effects) and other symptoms such as suicidal ideation, beliefs of worthlessness and psychotic symptoms. Discuss pharmacological and non-pharmacological strategies (e.g. psychoeducation, relieving stress and strengthening social interactions and support, brief psychological treatments).

## Reference

1. Heisler C, Laatsch A, Costello E. Family violence and abuse in later life. Washington DC: National Center on Law and Elder Rights; 2023 ([https://pstrapiubntstorage.blob.core.windows.net/strapib/assets/Family\\_Violence\\_Slides\\_1e35c7e024.pdf](https://pstrapiubntstorage.blob.core.windows.net/strapib/assets/Family_Violence_Slides_1e35c7e024.pdf)).







