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Active and healthy ageing for better long-term care

A fresh look at innovative practice examples

Policy Paper

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Content

Executive Summary

Abstract

This paper aims to enhance the knowledge-base of policy-makers and stakeholders to support the development of active and healthy ageing policies in the Czech Republic. Based on a brief introduction to the concept of active ageing it presents results from the Active Ageing index (AAi). By comparing the performance of the Czech Republic with other EU Member States some priority areas of action are identified for policies to promote active and healthy ageing at the national, regional and local level in the Czech Republic. Related strategies and policies from selected countries are outlined and illustrated with practice examples of recent initiatives in selected countries. A special focus is given to emerging long-term care policies designed to enable active and healthy ageing for older people in need of care to illustrate potentials for change and innovation.

Summary

In the context of growing life expectancy and reduced fertility rates across Europe, older people are expected to account for a significantly higher proportion of the population. The concept of active ageing challenges the assumption of older people as passive recipients of welfare transfers and recognises their important role in society and the relevance of maintaining health and independence for older people's quality of life. Active ageing is thus "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (WHO, 2002: 12). As a multidimensional concept it is anchored around three main pillars: health, comprising its physical and mental aspects; participation, both in the form of labour market participation and contribution to society through non-market activities (e.g. through political participation and/or caring for children or older people); and security, which includes safety from physical and psychological abuse and having sufficient financial resources to age in a dignified manner.

Comparative results of the Active Ageing index (AAi) for the Czech Republic suggest some priorities that reach from facilitating and promoting social relationships to preventative approaches. These priorities include the promotion of physical exercise and agencies that help coordinate various organisations, sectors and professionals. Furthermore, strategies and initiatives should be prioritised that support mental health in a broader sense, promote healthy lifestyles also at higher ages, support informal carers and improve the linkage between formal and informal care.

Active ageing strategies call for a pro-active policy approach that enables initiatives which are started and implemented by a wide range of stakeholders. Active ageing can thus not be decreed top-down, but calls for multi-stakeholder and multi-level governance. Enabling instruments and mechanisms for this approach include:

- a **national strategy** developed by relevant stakeholders and expressed by a clear policy statement;
- the definition of **priorities and objectives** linked to tangible resources that will be put in place;
- **regional guidelines** defining the scope and the regional priorities of active ageing policies;
- **local adaptation** of these guidelines with a clearly defined focus on local priorities and feasible action plans within a defined period of time;
- activation of citizens' groups and existing stakeholders by raising awareness and providing incentives;
- **'institution-building'** for Active Ageing (e.g. by establishing 'citizens bureaus');
- a pro-active strategy to **assess citizens' needs and proposals** for improvement in a bottom-up process involving citizens.

When it comes to specific areas of active and healthy ageing policies such as long-term care, European examples have shown that progress largely depends on the coordination of and cooperation between social and health care, and on professionals' ability to apply resources more effectively and efficiently without over-burdening informal carers. Apart from the necessity to invest in long-term care as an emerging area at national level (targeted funding, definition of eligibility etc.), examples from other countries have shown the following strengths from which initiatives on regional and local levels could learn:

- Raising awareness for 'care in the community' with a view to professional approaches to case and care management, e.g. one-stop-shops to provide information and counselling for people with care needs and their carers;
- Improved linkages between primary and secondary care, and support of local providers of care homes, primary care and home care in defining joint visions and implementing a more efficient use of premises, e.g. by facilitating exchange between professional groups to overcome existing boundaries;
- Improved planning based on surveys and workshops with input from experts and a broad participation of stakeholders;
- Activation of local resources also in terms of voluntary engagement, solidarity and the exchange of civil engagement, e.g. by establishing a coordination centre for volunteers.

These recommendations and examples show potential ways to improve the performance of active ageing policies in the Czech Republic. However, this potential has to be adapted to national, regional and local characteristics, to general governance approaches and individual needs and expectations of citizens. Transfer of knowledge and its translation to local characteristics will be an important task of the next steps within the project 'Innovative policies to support healthy, active and dignified ageing'.

Introduction

The growing life expectancy experienced by Europeans in the past decades is a testimony to the achievements in health and living standards in post-war Europe. According to the latest available figures, an average European man born in 2010 can expect to live between 73.5 years (Latvia) and 82.6 years (Spain), while life expectancy at the age of 65 varies between 15.4 (Bulgaria) and 21.4 years (France).[1] In the Czech Republic life expectancy at birth is 77 years while at 65 is 20.7 years. These figures are even higher for women. While part of these life years gained will be lived with activity limitations, there is some evidence that people reach the age of 65 in an improved health condition relatively to older cohorts (Costa, 2002). While growing life expectancy and increasing health are undoubtedly positive outcomes for individuals, it raises the need for social protection systems and societies to adapt to the challenges that arise from an ageing population. In particular, this means **fostering conditions to maintain an older population active for longer periods and in healthier conditions**.

In this context the European Union puts special emphasis on areas where the potential of older people is not fully realised. The European Union has therefore designated the year 2012 as the European Year for Active Ageing and Solidarity between Generations (Decision 940/2011/EU) where a set of principles are defined to foster active ageing including supporting Europeans to live healthy, physically active lives, to enhance their capacity to live independently through training, rehabilitation and the use of new technologies and to create age friendly environments that aim to empower older citizens (Haekkerup, 2012).

In parallel to this far-reaching European political agenda, active and healthy ageing is a key priority area within Europe 2020, the 'European strategy for smart, sustainable and inclusive growth'. Also, in this context the European Innovation Partnership Pilot Project on Active and Healthy Ageing (EIPAHA), was launched in 2010. The Pilot Partnership represents a significant contribution from the European Commission's initiatives to achieve the objectives of the European Year for Active Ageing and Solidarity between Generations (EY2012). It aims to pursue a triple win for Europe by enhancing health and quality of life of older people, improving efficiency and sustainability of health care systems and by stimulating an innovative market responding to the needs of older persons. The EIPAHA in particular emphasises prevention, health promotion and integrated care, as well as active and autonomous living for older people. Its overarching goal is to raise average healthy life expectancy at birth in the EU by two years by 2020 (European Commission, 2012).

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[1] Eurostat, mortality data retrieved on the 26th June 2012.

Underlying the objective of active ageing is **the empowerment of older people to remain in charge of their own lives as long and as much as possible**. In order to achieve this objective all levels of governance, at the national, regional and local levels, are required to scale-up their efforts. The EY2012 therefore aims to facilitate an exchange of good practices and to raise awareness of the value of active ageing by disseminating good practices and encouraging policy makers and **stakeholders at all levels** to promote active ageing. One important area concerns efforts to overcome fragmentation in governance through **innovative models to better align coordinated health and long-term care service provision with emerging care needs to meet active ageing objectives**. In this context the identification of practices which can be replicated and implemented at larger scale is crucial for the development of new policy frameworks that are able to adequately address active, healthy and dignified ageing.

Approaches to and good practices for healthy and active ageing concern different fields of intervention on various levels of governance, which often reflect multiple aspects and domains of active ageing. **The multidimensionality of active ageing** is important to keep in mind when designing and implementing policies for active ageing. This Policy Paper will therefore first outline the multidimensional concept of active ageing. Section 2 discusses a set of indicators identified as being relevant in monitoring healthy and active ageing in the areas of health and long-term care policies and presents a composite measure which integrates a wide range of indicators in a recently developed Active Ageing Index (AAi) (Zaidi et al., 2012). This tool will enable the identification of priority areas for policy actions in the Czech Republic.

Section 3 outlines some of the key challenges in active ageing policies. These include multi-level governance, the coordination and involvement of a multitude of stakeholders. With a view to better governance and implementation of healthy and active ageing measures in selected European countries, this section will then highlight that 'active ageing strategies' on national, regional and local levels are scarce and lack in comprehensive approaches. Still, some of the existing attempts to make (active and healthy) 'ageing' a transversal issue of innovative approaches will be briefly presented drawing on policy and practice examples from mainly regional and local levels of selected countries.

Section 4 addresses long-term care as a crucial policy area for healthy and active ageing strategies and a focal area of the project with a view to social innovation. Related examples of good and innovative practices from several European countries will be presented to show the way forward in coordinating social and health care, creating preventive organisational structures and integrating formal and informal care.

The paper concludes with lessons learned from innovative practice across Europe to aid policy development in the Czech Republic in focusing national and local strategies towards healthy and active ageing.

1 Active ageing – a multidimensional concept

Demographic ageing has prompted a shift in the paradigm and policy discourse surrounding the ageing process. This shift accentuates the positive aspects of ageing which go beyond the focus on the passive process of physical and cognitive decline to secure survival. Rather, the emerging paradigm emphasises maintaining quality of life, autonomy and independence in old-age. This has been accompanied by the widening of the scope of gerontology research from a biological and medical focus on the physical aspects of health to one encompassing also the social sciences and highlighting the contribution of the physical and social environment, financial resources and psychological wellbeing to the maintenance of quality of life in old-age (Buys & Miller, 2012).

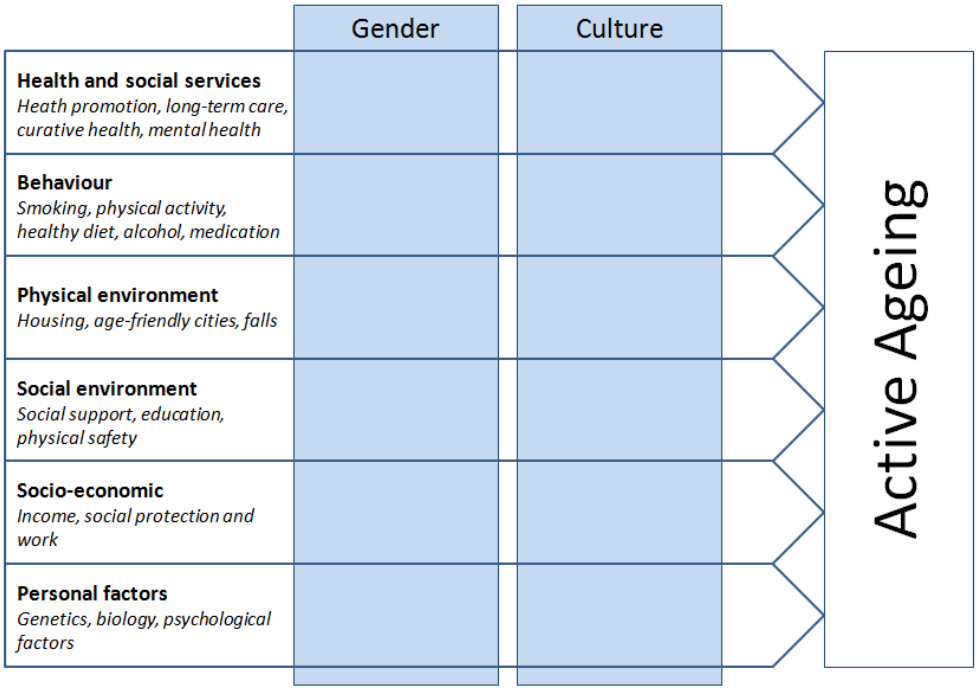
Several frameworks of ageing have been set forward, from *Successful Ageing* (Rowe & Khan, 1998) to *Healthy Ageing* (Hansen-Kyle, 2005), each highlighting different aspects of ageing and thus are subject to the criticism in failing to deliver a holistic vision of ageing (see Buys & Miller, 2012 for a recent review). Arguably the most comprehensive and holistic framework of ageing continues to be thus far the *active ageing* framework set forth by the World Health Organisation (WHO, 2002).

The concept of active ageing refers to "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (WHO, 2002: 12) for both individuals and population groups. A multidimensional notion, active ageing is built around three main pillars that are liable to impact the quality of life and wellbeing of older people:

- Health: this refers to the physical, mental and social wellbeing aspects of health.
- Participation: it includes not only maintaining labour market attachment (i.e. working longer), but also being able to take part in societal life (e.g. political participation) and contribute to it through non-market activities (e.g. caring for children or older people).
- Security: it pertains to protection from physical and psychological abuse, but also to the social and financial resources necessary to age in a dignified manner.

Additionally, the active ageing framework presented by the WHO also details the factors that are likely to impact active ageing – i.e. the determinants of active ageing (Figure 1.1). It comprises both transversal determinants, such as culture and gender, as well as a number of specific determinants of active ageing that reflect the holistic underpinning of this framework and the contributions of both health and social sciences.

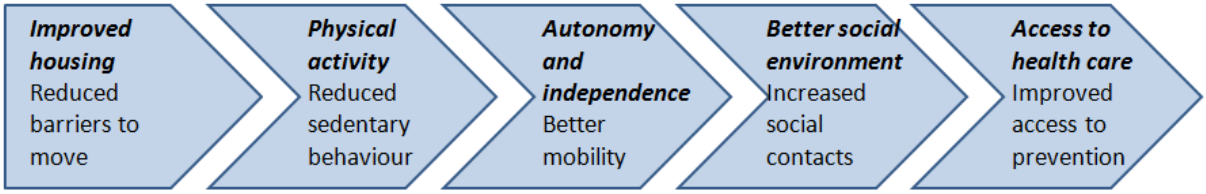
Figure 1.1: Determinants of Active Ageing



Source: Adapted from WHO (2002: 8ff).

Reflecting the strong policy-oriented approach of the active ageing framework, the determinants of active ageing not only provide insights into the causality channels but, equally important, inform guidelines for policy action. Furthermore, the framework highlights the potential trickledown effect that policies could have (Figure 1.2). For example, addressing housing conditions and eliminating barriers to move around could contribute to active ageing by bringing about changes in sedentary behaviour. The compounded effect of both improved housing and increased physical activity could contribute to maintain older people's autonomy and independence, for example by allowing them to continue to perform activities essential for their daily life such as shopping. This would in turn increase the opportunity for developing or maintaining social contacts, which could improve the possibility of older people to rely on the support of friends and relatives in navigating access to mainstream healthcare (Figure 1.2). The contributions of a given policy action to active ageing are not reduced to their direct impact, but rather the result of the compounded effect that policy action has on several determinants of active ageing.

Figure 1.2: Trickledown effects of public policies on active ageing – an example



However, if the framework proposed by the WHO is strongly-policy oriented and thus well suited to guide the development and implementation of public policies, it provides limited guidance as to measure and monitor active ageing (Buys & Miller, 2012). In part, this reflects the on-going debate and lack of consensus on how best to measure active ageing, e.g. there is little theoretical underpinning for choosing one single and particular indicator to monitor active ageing. For example in the context of the European Innovation Partnership on Active and Healthy Ageing (EIPAHA)[2] the target is set to increase average healthy life expectancy by 2 years until 2020. While this indicator is commonly accepted as reflecting health gains arising through improved living conditions including wide-ranging access to safe health care, it does not capture all social and environmental dimensions to foster 'successful ageing'. Thus, to better monitor progress in this area it is necessary to employ a range of indicators which are identified as suitable to reflect the multidimensional challenge of developing policies to promote active and healthy ageing. The next section presents a set of indicators which have been identified as reflecting some of the dimensions of active ageing with a particular focus on the dimensions related to health and physical activity as well as autonomy and independent living.

[2] More information on http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=about.

2 Active ageing: from concepts to indicators at a glance[3]

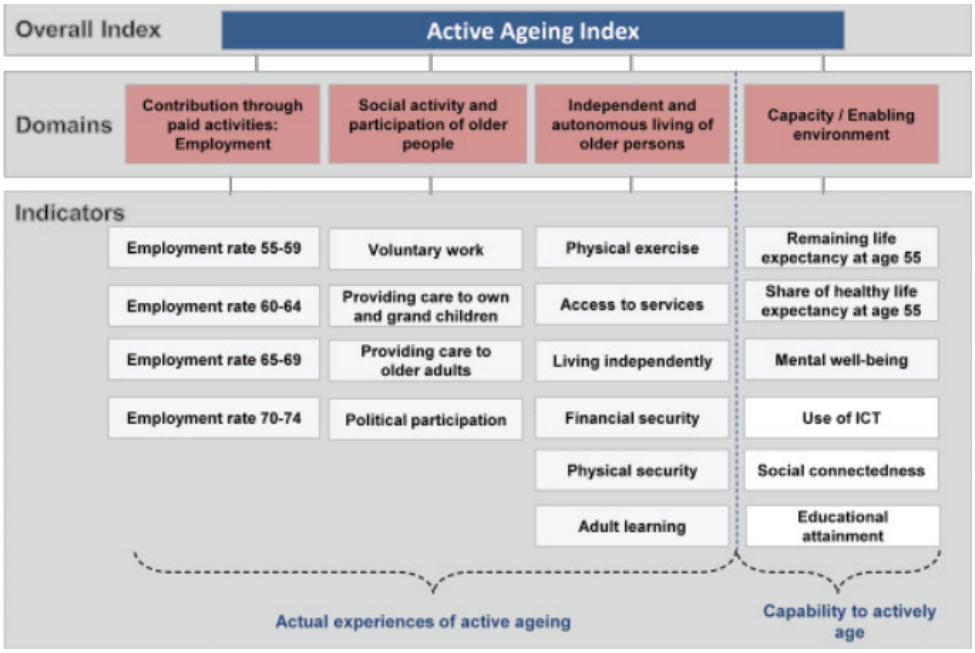
Bearing in mind the above discussion on the multi-faceted concept of active ageing and the absence of clear theoretical guidelines for measuring its outcomes, this section aims to provide a selected range of indicators which have been identified as relevant for active and healthy ageing. Section 2.1 outlines the steps taken in calculating a composite measure to assess the multi-faceted concept of active ageing in Europe. Based on the indicators more closely related to long-term care and health, the situation of the Czech Republic in the wider European context will then be analysed in Section 2.2.

2.1 Calculating the Active Ageing Index

The Active Ageing Index (AAi) aims to capture this complexity by combining a range of currently available indicators, which are summarised to a composite index within four domains (see also Zaidi et al., 2012):

a) Contribution through paid activities / employment
b) Contribution through unpaid activities / non-marketed productive activities
c) Independent and autonomous living
d) Capacity for active ageing / enabling environment

Figure 2.1: Domains and indicators of the Active Ageing Index (AAi)



Source: Zaidi et al., 2013 (Figure 3.1).

[3] This section employs selected results from a EU commissioned project: "Active Ageing Index (AAi)", which is led by Asghar Zaidi with Katrin Gasior, Maria M. Hofmarcher, Orsolya Lelkes, Bernd Marin, Ricardo Rodrigues, Andrea Schmidt, Pieter Vanhuysse and Eszter Zólyomi contributing. The final output of the project is currently under preparation, for more information please see: http://www.euro.centre.org/detail.php?xml_id=2004.

The calculation of the AAi closely resembles the methodology and underlying rationale of the Human Development Index (HDI) of the United Nations Development Programme (Zaidi et al., 2012). Each indicator ranges between 0 and 100 per cent with the normative interpretation that the higher the value of an indicator the better, with an upper bound of 100.[4] Indicators are first aggregated within domains, using a weighted average, and domains are subsequently aggregated into the AAi, also using a weighted average. Weights were assigned on the basis of expert judgements in a focus group design (Zaidi et al., 2013) and thus reflect expert decisions on the relative importance of domains and indicators within a domain. The weights given to each domain and each indicator are presented in Table 2.1.

Table 2.1: Weights assigned to domains and individual indicators within the AAi

Domain	Domain weight	Indicator	Indicator weight
Contribution through paid activities / employment	30	Employment rate 55-59	7.5
		Employment rate 60-64	7.5
		Employment rate 65-69	7.5
		Employment rate 70-74	7.5
Contribution through unpaid activities / non-marketed productive activities	40	Voluntary work	10
		Providing care to own and grandchildren	10
		Providing care to older adults	12
		Political participation	8
Independent and autonomous living	10	Physical exercise	1
		Access to services	2
		Living independently	2
		Relative median income	1
		No poverty risk	1
		No material deprivation	1
		Physical security	1
		Adult learning	1
Capacity for active ageing / enabling environment	20	Remaining life expectancy at 55	6.67
		Share of healthy life expectancy at 55	4.67
		Mental well-being	3.33
		Use of ICT	1.33
		Social connectedness	2.67
		Educational attainment	1.33

Note: The indicator weight refers to the contribution to the overall AAi of a given indicator, taking into consideration both the individual indicator weight and the weight of the domain to which it belongs.

[4] The complete list of indicators, their definitions and sources can be found in Annex I.

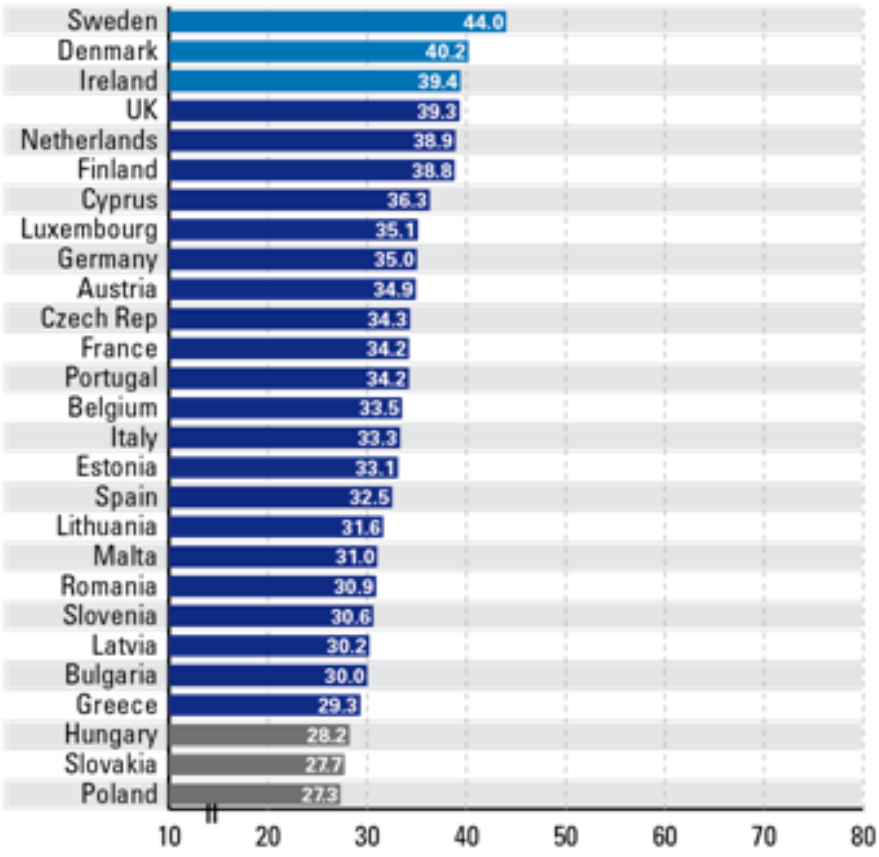
The values of the AAi also range between 0 and 100 and can be interpreted as the extent to which active ageing has been achieved in a given country.

2.2 Active ageing in the Czech Republic at a glance – analysis of the AAi results

Figure 2.2 shows overall AAi results ranked from the highest to the lowest value. The Nordic Member States of the EU and the Netherlands fare best overall. The Czech Republic ranks slightly above the median and achieves the highest value of the New Member States.

Although the AAi incorporates information on employment, income and unpaid activities/social participation, among others (Table 2.1), this section will focus on the domains and indicators that are closely related to health and long-term care. In particular, indicators in the area of social activity, participation of older people, independent and autonomous living of older persons and an enabling environment are important sources of information in developing adequate policies to promote active ageing. In the Czech context this concerns mainly the area of health and long-term care. Thus, relevant indicators falling into these domains will be analysed in greater detail.

Figure 2.2: Overall results of the AAi



Source: Zaidi et al., 2013: Figure 4.1. Note: Results are expressed in percentage.

The Czech Republic fares better in relative terms (i.e. how the weighted aggregated values of the indicators that compose one domain compare to the EU average for that domain) in the domains 'contribution through unpaid activities' and 'independent living'. In absolute terms, however, the value of each indicator for the Czech Republic is in general lower in the domain 'contribution through unpaid activities', which is also the case for most other EU countries. Overall, however, the Czech Republic is the best of the New Member States and fares better in terms of the AAi than countries with a higher GDP per capita such as France, Italy and Belgium.

A closer look at the results per indicator provides further explanations for the relative position of the Czech Republic and highlights areas of special concern for public policy, i.e. those in which the potential for catching up is highest (Table 2.2).

Table 2.2: Overview of AAi individual indicator performance by the Czech Republic

Indicator	*Value Czech Republic, in %*	*Value best-performing country, in %*	*Best-performing country*
Employment rate 55-59	67.1	80.7	Sweden
Employment rate 60-64	25.2	61.0	Sweden
Employment rate 65-69	9.5	24.5	Romania
Employment rate 70-74	3.6	21.4	Romania
Voluntary work	12.9	32.7	Austria
Providing care to own and grandchildren	37.2	53.7	Italy
Providing care to older adults	14.8	17.1	Finland
Political participation	12.3	26.5	Sweden
Physical exercise	5.4	28.9	Sweden
Access to services	94.8	99.0	Slovenia
Living independently	86.2	99.3	Sweden
Relative median income	82.0	100.0	Luxembourg and Hungary
No poverty risk	98.7	98.7	Czech Republic
No material deprivation	95.7	99.9	Luxembourg
Physical security	89.8	95.1	Poland
Adult learning	4.2	22.3	Denmark
Remaining life expectancy at 55 (a)	50.6	59.2	France
Share of healthy life expectancy at 55	57.6	77.1	Sweden
Mental well-being	61.0	87.2	Denmark
Use of ICT	31.0	75.0	Sweden
Social connectedness	47.5	75.6	Portugal
Educational attainment	83.4	85.7	Germany

Note: Highlighted indicators refer to those analysed in this section; (a) expressed as % of 50 years of life expectancy at the age of 55.

Indicators highlighted in Table 2.2 show the scope for catching up with the forerunner countries. In this context the potential for improvement for the Czech Republic is highest in areas such as 'voluntary work' or 'caring for grandchildren'. Better health positively impacts the capacity for active ageing and as such the scores for the Czech Republic on physical exercise, healthy life expectancy, mental wellbeing and social connectedness are also cause for concern.[5]

Priority area 1: Better health outcomes through prevention and healthy life-styles

When looking at health-related indicators of active ageing, the relative performance of the Czech Republic is poor in comparison with the front-runner countries or even with the EU average for most of these indicators (e.g. physical exercise, remaining life expectancy at 55 or mental wellbeing). This is in line with findings from recent research on 'successful' ageing in Europe – the concept that is closer to a more health-related conceptualisation of ageing – which also found older people in the Czech Republic (together with Poland, Spain and Italy) to fare not so well in health (Hank, 2011).

The importance of physical exercise as a determinant of both good physical and mental health has been shown in a number of studies (cf. Blair et al., 1995; Taylor et al., 1985; Herman, 2000; Paterson & Warburton, 2010; and for a review of evidence Kruk, 2007). At an individual level, research shows that besides the availability of sports equipment, keeping social connectedness has a positive influence on the performance of moderate physical exercise (Wendel-Vos et al., 2007).

While evidence of the effect of age on physical activity is mixed (cf. Koeneman et al., 2011), cross-sectional data show that older people undertake much less physical activity than the rest of the population. The Czech Republic is no exception, but its physical activity levels among older people are particularly low.

This is in line with an overall poor performance related to risk factors, such as tobacco, alcohol consumption and obesity (Table 2.3). On all these risk factors the Czech Republic performs poorly when compared to OECD average (OECD Health Database). For example, Czechs have the fourth-largest intake of alcohol among OECD countries and the prevalence of daily smokers among the adult population has actually increased, which is at odds with the downward trend observed in almost all other OECD countries (OECD, 2011). Efforts in screening for breast cancer – the leading form of malign neoplasm in women – and cervical cancer – a preventable and treatable form of malign neoplasm when detected early – in the Czech Republic remain among the lowest in the OECD. Differences in the take-up of preventive measures are not just a function of available health resources, or access to health care – older Czechs report a low level of unmet needs on health and dental care – but depend also on financial incentives imbedded in the health care system, e.g. how GPs are paid in relation to screening procedures (Josut et al., 2012).

[5] Social isolation (lack of contact with friends or relatives) is a symptom and cause of psychological distress and a key determinant of subjective wellbeing.

Table 2.3: Selected indicators on risk factors and cancer screening for the Czech Republic and OECD – 2009 or latest available year

	Daily smokers (% adult population)	*Alcohol intake (litres per persons 15+)*	*Obese population (% total population) (a)*	*Regular physical exercise (% persons 55+) (b)*	*Mammography screening (% of women 50-69)*	*Cervical cancer screening (% of women 20-69)*
Czech Republic	24.6	12.1	17.0	5.4	48.5	47.7
OECD average	22.1	9.1	16.9	--	62.2	61.1

Source: OECD Health Database (Data accessed on 18 January 2013). Own calculations based on Eurobarometer, Special Edition 334/2010. Notes: (a) Measured obesity, BMI≥30; (b) Regularly exercising refers to those doing physical exercise or sport at least 5 times a week.

Smoking, alcohol consumption and sedentary lifestyles are among the risk factors for the leading causes of death in the Czech Republic such as respiratory diseases and malignant neoplasm. For the former the standardised rate of mortality was 344.14 per 100,000 deaths for the Czech Republic, which was lower than the average for the New Member States but twice the average of the EU (WHO Europe, Health for all Database)[6]. For the latter, the standardised mortality rate was 195.59, which was higher than both the EU and New Member States averages (WHO Europe, Health for all Database)[7].

This is reflected in the level of life expectancy at age 55.[8] At 25.3 years, life expectancy for both Czech women and men aged 55 is low in comparison with other EU countries, e.g. compared to 29.6 years in France (Eurostat[9]). However, and as also observed in other areas, the Czech Republic's performance measured with this indicator is still the highest among the New Member States.

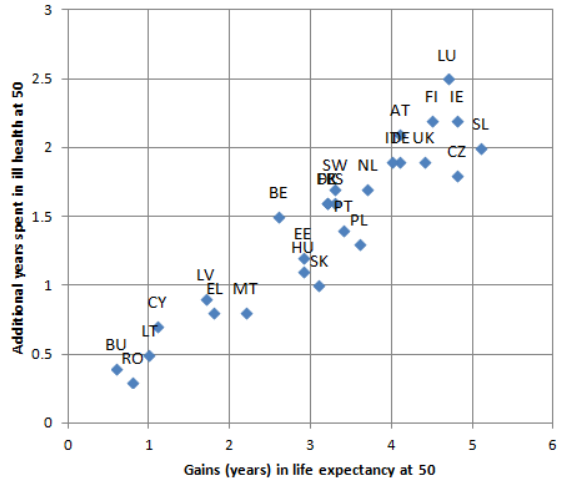
Despite its relatively low life expectancy at 55, the Czech Republic has nonetheless shown marked progress in life expectancy in the past (Bryndová et al., 2009). The concern, however, is that these gains in life expectancy have been made at the expense of reduced health in old-age and that this trend continues: people will be living longer, but increasingly unhealthier lives. Of the 25.3 years that Czechs are on average expected to live after the age of 55, only about half will be spent in good health, i.e. without any activity limitations. Data from the Global Burden of Disease Study 2010 (Institute for Health Metrics and Evaluation, 2013)[10] show that between 1990 and 2010 and for the

6 Data accessed on 18 January 2013.
7 Data accessed on 18 January 2013.
8 The actual indicator refers to the life expectancy at 55 taking 50 years as the reference. Taking the Czech Republic, this means that life expectancy at 55 is only half of 50 years, i.e. life expectancy at 55 is 25.3 years.
9 Data accessed on 18 January 2013.
10 Data is not strictly comparable with the Healthy Life Expectancy data published by Eurostat. For more details on methodology please refer to Salomon et al., 2012.

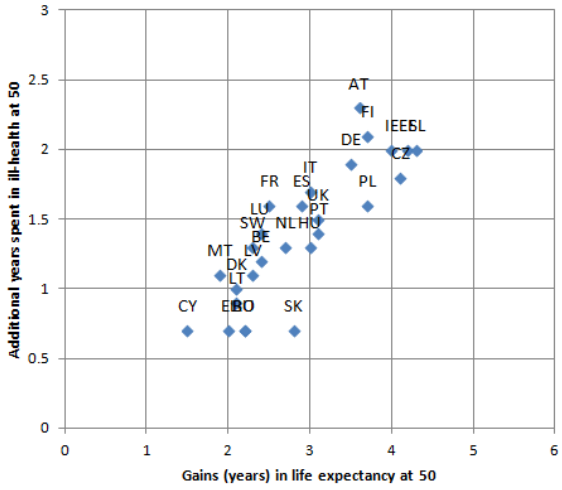
EU as a whole, gains in life expectancy at the age of 50 have been accompanied by an expansion of the number of years lived with poor health, both for men and women. The gains in life expectancy at this age for both Czech men (+4.8 years) and women (+4.1 years) were quite substantial, but almost half of the life expectancy gained will be spent in poor health. This creates additional challenges in terms of activating older people that may live a longer part of their remaining lives in poor health.

Figure 2.4: Gains in life expectancy and in years spent with ill-health at the age of 50 1990-2010

Men



Women



Source: Own calculations based on Global Burden of Disease Study 2010 (Institute for Health Metrics and Evaluation, 2013). Note: Years spent in ill-health are defined as the difference between life expectancy at 50 and health adjusted life expectancy at 50.

Priority area 2: Enabling participation of older people in society

Patterns of care provision vary among other factors with intergenerational co-residency patterns, availability of child care facilities and employment rate of women of working age (Hank & Buber, 2009). In the case of the Czech Republic, whilst formal childcare provision is relatively scarce, employment rates of mothers are also relatively low (OECD, *Family Database*[11]): 58.8% for the Czech Republic in comparison to 66.2% of the OECD average.[12] A lower propensity for grand-parenting in the Czech Republic may thus reflect a lower "need" for this type of care as labour market participation of Czech women is comparatively low.

Results from Survey of Health, Ageing and Retirement in Europe (SHARE) data show that older people in the Czech Republic rely heavily on informal care to have their care needs met (Rodrigues et al., 2012). According to data in Table 2.2, a sizeable share of

11 Data accessed on 17 January 2013.
12 Employment rate of mothers with child under 15 years of age.

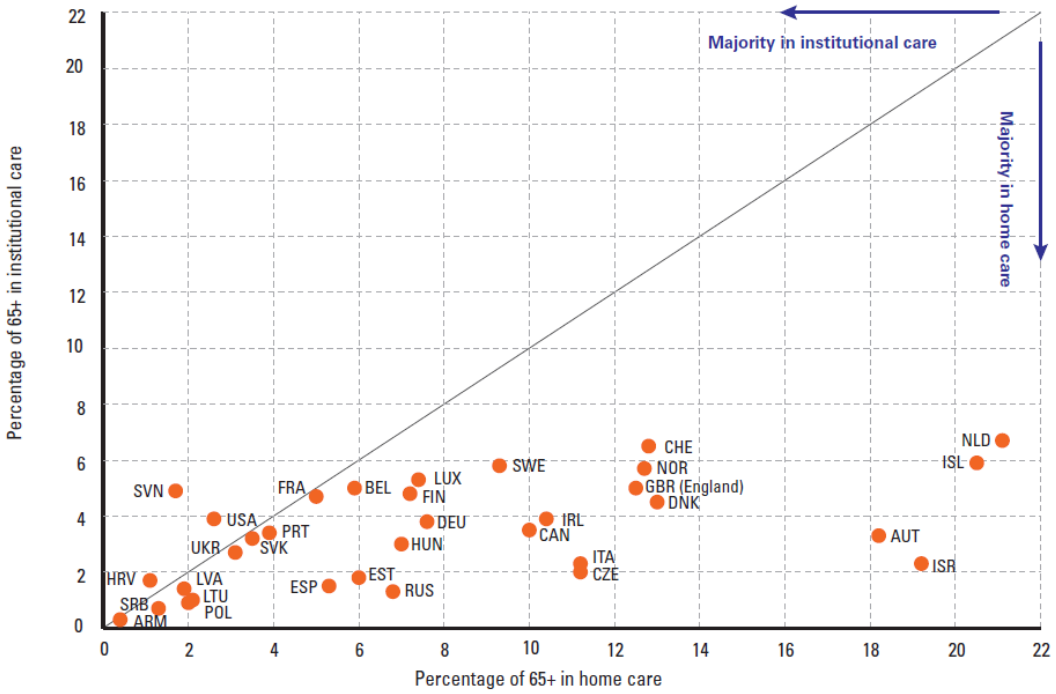
informal care is provided by older people, when compared to the best-performing country in this indicator, albeit this share is lower than grand-parenting.

In countries with a relatively low availability of formal care services and/or greater reliance on cash benefits for older dependent adults, informal care seems to occupy a lower proportion of people in their later stages of life but more intensively, i.e. delivering more care hours (Bolin et al., 2008). This suggests a relationship between care services and provision of informal care by older adults that is far more complex than the 'crowding-out' hypothesis, i.e. provision of care services may actually enhance participation of more informal carers providing care in a limited number of hours. In a way, this is much more compatible with active ageing, as it allows for continued but limited provision of care and thus the maintenance of older carers' health (Hoffmann et al., 2012). Availability of cash for care benefits, such as in the Czech long-term care allowance, may also incentivise the provision of care by members of the household, including older people. The danger is that care thus provided may be too intensive and have detrimental effects on the health of older carers. The mean amount of weekly hours of care provided by people 50+ in the Czech Republic is around 12 hours (Rodrigues et al., 2012: 64).[13] While this level of care burden is much lower when compared to e.g. the average of 20 hours that people 50+ in Spain provide, it is nonetheless relatively high. Furthermore, many of those carers have relatively low levels of education and are at higher risk of ill health. This indicator of social participation of older people therefore offers an ambivalent picture of active ageing.

The provision of long-term care benefits may also shape the participation of older people in society. For example, cash benefits may provide an incentive for older people to take up caring roles and contribute to society through non-market activities. But the availability of institutional-home care mixes may also contribute to keep people in their communities for as long as possible. While coverage of long-term care formal services is lower when compared to other countries in Europe, the Czech Republic nevertheless appears to have a mix of benefits that privileges care provided to older people in their own homes; this goes hand in hand with a low level of institutional care for older people (Figure 2.3). Moreover the coverage of its cash for care benefit (the long-term care allowance) is relatively high for European standards.

[13] Source is SHARE data for provision of care outside the household.

Figure 2.3: Care mix (home and institutional care) of long-term care benefits for older people (2009 or most recent year)



Source: Rodrigues et al., 2012: Figure 7.3 (reproduced figure). Note: Belgium and Austria for 60+. France for 60+ for home care. Some of the national sources refer to age groups which may not coincide with the 65+ cut-off (see Statistical Annex of Rodrigues et al., 2012). Italy (a) refers to *Indennità di accompagnamento*. United Kingdom refers to England only.

While home care appears an important pillar in providing formal or informal services to older people in need of care the Czech Republic fares rather poorly in the area of social contacts as measured through indicators of mental health and subjective wellbeing of older people. In this context, the Czech Republic is no different, albeit a bit better, than other New Member States, which also have lower scores in these two indicators. Focusing on social contacts, it is worth highlighting potential trickle down effects and links with other dimensions of active ageing. Wendel-Vos et al. (2007) show that social connectedness is positively linked with practicing physical activity. This indicates that interventions in some areas of active ageing could entail potential positive externalities in other areas and reinforce the capacity for older people to actively age in Europe.

Participation in voluntary work is also an area where the Czech Republic shows greater room for improvement. Engagement in voluntary work varies markedly across countries. However on the individual level voluntary work seems to be related to health condition, income and age (Ehlers et al., 2011). The conventional wisdom is that older people should find it easier to volunteer, as they possess both the time and financial resources to undertake voluntary activities (Wiepking & James III, 2012).

In this sense, the Czech Republic, as many Eastern European countries should do relatively well as its poverty rates among older people are relatively low. Volunteering, however, seems to be more complex and strongly shaped by country effects (Acik-

Toprak, 2009). These include chiefly the degree of political participation and transparency in a given society, but also historical factors such as the presence of a strong civil society or a long-lasting democracy and welfare regime. As a consequence, more inclusive and generous welfare regimes that place emphasis on equality are positively associated with higher volunteering. In line with this, the lower participation in volunteering among older people in the Czech Republic may be rooted in wider societal issues: the Czech Republic as other countries with poor participation in volunteering has low scores in the OECD indicator of political participation and consultation on law-making (OECD, Better Life Index).[14]

Besides improving general equity and political governance, there are, however, other factors where social policy could make an impact. Kholi et al. (2009) show that participating in what the authors call *formal social relations*, e.g. taking part in volunteering or political organisations, is positively correlated with maintaining social connections. In this sense, promoting social contacts for older people could also contribute to achieving higher participation in volunteering.

To sum up, the analysis of AAi-results for the Czech Republic suggests that public policy actions need to be comprehensive and inclusive. To promote the capacity of citizens in the Czech Republic to age actively and healthy, specific priorities have emerged. According to these priority areas, strategies and policy initiatives should:

- address preventative approaches, including physical exercise and agencies that help coordinate various organisations, sectors and professionals;
- inform about and promote healthy lifestyles also at higher ages;
- support informal carers and improve the linkage between formal and informal care;
- address mental health in a broader sense, and support (older) people with mental health problems;
- facilitate and promote social relationships (in the neighbourhood, in the local environment) and participation of older people in volunteering, which can be self-reinforcing policies.

The development of such strategies and reforms calls for the participation and coordination of several stakeholders from different government levels (e.g. central, regional and local levels of administration) and policy areas (e.g. health and long-term care). This highlights the importance of multi-level governance in achieving active ageing. The following section will address the challenges of developing active ageing policies from the governance point of view. It will do so by presenting selected strategies from other EU countries involving different levels of government.

[14] Data accessed on 27 January 2013.

3 Multi-level governance strategies to promote healthy and active ageing

One of the objectives of the European Year for Active Ageing and Solidarity between Generations (2012) defined by the European Parliament and the Council has been "to raise general awareness of the value of active ageing and its various dimensions and to ensure that it is accorded a prominent position on the political agendas of stakeholders at all levels" (Decision No 940/2011/EU). Indeed, many countries had already started to pursue this goal over the past 20 years as a reaction to demographic ageing and related challenges that had been addressed by a number of international initiatives starting with, for instance, the UN Assembly on Ageing (Vienna 1982, but in particular Madrid 2002, with a crucial input from WHO, 2002), related initiatives for monitoring and evaluating progress and within the academic debate (Marin & Zaidi, 2007). Ageing policies that go beyond the traditional tasks to secure pensions and health care have emerged only very slowly as a transversal policy area touching upon a wide range of issues and stakeholders.

Depending on the political culture, national governance structures and traditions, these issues have been tackled in some countries by the national authorities (e.g. UK, France) while, for instance, federal states such as Austria, Switzerland or Germany have witnessed a more decentralised approach.[15] Generally, comprehensive ageing policies, not to speak of 'active ageing policies', remain scarce, although a number of policy and strategy papers ('White Papers') can be identified. Even if real interventions, including legislation, are often scattered across various policy domains – from labour market and pension policies to health, social welfare and education as well as gender, housing and political participation in general – there are indications for tangible reforms and actions. Some considerations concerning challenges arising from multi-level governance will be briefly addressed to foster a better understanding of national differences (Section 3.1). It would go beyond the scope of this paper to analyse details of all Member States. The choice of countries was therefore driven by pragmatic considerations concerning geographic vicinity, language and availability of interesting, relevant and innovative practice examples that address the identified priorities for active ageing policies in the Czech Republic across the various levels of governance. The focus on Austria and Germany had been paramount to prepare for the planned study visits to these countries. These considerations as well as hints by national experts and previous research helped identify practice examples. This will be followed by outlining some examples at the national (Section 3.2) and regional/local levels (Section 3.3). It will be up to local

[15] Given the administrative differences across Europe, it should be underlined that what is called a 'region' in one country might cover the population of a 'municipality' in another.

research and development to adapt the briefly outlined ideas and approaches to the local structures, needs and expectations in the Czech Republic.

3.1 Challenges arising from multi-level governance

'Multi-level governance' has gained importance with EU integration related to the process of 'vertical integration' between EU, national, regional and local politics where, as a consequence, policy development should be based on the principle of subsidiarity and on coordination within individual policy areas. However, a number of concomitant developments have inhibited the full potential of 'best-practice policies' from emerging (Peters & Pierre, 2001: 132f.; Kazepov, 2010):

- New Public Management and the growing importance of EU and other supra-national institutions as such have challenged the nation-state as the major and unique decision-maker.
- Administrative reforms have led to new forms of relationships between the different tiers of government and newly emerging stakeholders; this process has been coined as 'rescaling' of policies that includes vertical de- and recentralisation but also horizontal shifts of competences in their planning, funding, organising, delivering and monitoring.
- These developments also offer new opportunities to sub-national tiers of government as new forms of negotiated arrangements and bi- or multi-lateral contracts between stakeholders have partly replaced the unilateral hierarchic way of decision-making and legislation.

All these issues have their specific consequences, in particular in transversal policy-arenas such as 'active ageing'. For instance, new types of stakeholders have emerged such as private for-profit providers in social and health care, social cooperatives or social businesses as well as organisations representing users, patients or carers. These developments have been labelled as 'horizontal re-scaling' within mixed welfare regimes (Kazepov, 2010) and they highlight the importance of new regulatory instruments to govern transversal policy areas such as 'active and healthy ageing'.

With the on-going fiscal crisis as an additional factor, it has become obvious that innovation, improvement and guidance may no longer be provided by any single 'social planner'. Rather, networking, co-production and collaborative (public/private) partnerships have become crucial to shape individual policies in different policy areas. These multiple conditions call for involvement of relevant organisations and citizens themselves. For instance, the assessment of local needs and the development of appropriate measures require local planning with broad involvement of the population. At the same time involvement from the regional and national levels are being called for to ensure consistency in decision-making. This aligned coexistence of governance levels refers to 'vertical re-scaling' (Kazepov, 2010).

Table 3.2 provides an overview of various patterns of horizontal and vertical levels of governance in different types of European welfare systems. This variety does certainly

not facilitate comparisons, but the different national governance patterns have to be considered as a context for the emergence of specific practice examples (for a more specific overview in the area of LTC see Section 4, Table 4.2).

Table 3.2: Overview of vertical and horizontal levels of governance in old-age policies with an impact on 'Active Ageing policies and frameworks' in selected countries

	Vertical level of governance	*Horizontal level of governance*
Country (Type of welfare regime)	Governance	Provision
Austria (Corporative decentralised)	National: various Ministries Regional: different regional ministries characterised by 'proportional government' (all political parties involved) Local: local public care organisations (SHV)	Mixed with a long tradition of non-profit organisations affiliated to political parties or churches
France (Corporative centralised)	Strong central state with tendencies to decentralisation in social care and welfare	Non-profit providers, but tendency to more for-profit provision (voucher system)
Finland, Sweden (Social-Democratic, decentralised)	National framework legislation, but old age policy strategies are planned and implemented by municipalities	Public provision; minor involvement of private for-profit providers
Germany (Corporative decentralised)	National (Social Security), but decentralised responsibilities for many areas of ageing policies	Important role of third sector organisations (many affiliated to churches or political parties)
The Netherlands (Social-Democratic, mixed)	National: Ministry of Health, Welfare and Sport, decentralised responsibilities for social care; tendency to further decentralisation	Most providers are non-profit organisations
United Kingdom (Liberal)	National: different Ministries, local authorities, National Health System (NHS)	Most providers are private (for-profit and non-profit)

Source: inspired by Kazepov, 2010.

In the case of the Czech Republic, responsibilities for governance of social care services, for example, are divided among the central government, 14 regions (including Prague) and municipalities. Among the latter there are still municipalities with 'special responsibilities' (numbering 205 out of 6,249 municipalities, mostly larger urban centres) to which the state has delegated powers such as processing the long-term care allowance. Within this framework, distribution of resources to the regions is conditional

on the social assessment made in regional development plans (e.g. number of beneficiaries of long-term care allowance, capacity of existing services, etc). However, providers can apply directly to funds from the central government, thus bypassing the regional development plans (Leichsenring et al., 2010).

As for the actual provision of care services, in-house provision by regions or municipalities is still predominant, with the non-for-profit sector as the other main provider of care services (Rodrigues et al., 2012). There is however not a clear purchaser-provider split as public and private providers do not compete for the same funding. Providers rather take many times the initiative to propose the development of new services and ask for funding from municipalities (Leichsenring et al., 2010).

3.2 Selected strategies of active and healthy ageing on national levels

Some national governments have started to develop strategies in various policy domains concerning the challenges of ageing societies with a view to change images of ageing, active participation in society and healthy lifestyles. Given the focus of this paper it is important to underline that, although active ageing has become a general buzzword in particular with respect to increasing the factual pension age and labour market participation of older workers, issues of health and social care remain high on the agenda.

The following examples outline some national policies and pathways European countries have taken to tackle challenges of societal ageing. Like the local initiatives that will be discussed in Section 3.3, the selected national strategies do not necessarily tackle exclusively one single priority area identified in Section 2.2, but rather aim to address several of the identified priority areas for the Czech Republic.

3.2.A Switzerland – From national to local guidelines

The Swiss government (Bundesrat, 2007) has presented a strategy paper for ageing policies in 2007 consisting of guidelines for the various areas of societal challenges: health and care, housing and mobility, work and transition toward retirement, economic situation of retired people, social engagement and participation. The guidelines are based on an approach that should focus on resources and potentials of older people (participation, autonomy, independence, contributions) as well as on their needs (access to health and social care). It considers existing preconditions for taking action and outlines 'potential options' to address the identified challenges. In line with the Swiss federal principles, these guidelines have been adapted to regional and local requirements by a number of cantons – many of which coincide with the larger municipalities – that developed 'Cantonal Guidelines' (Martin et al., 2010).

3.2.B Germany – A bottom-up approach to active ageing policies

An interesting approach to planning and incentivising ageing-related initiatives across the country can be found in Germany, where the Federal Ministry for Family, Senior Citizens, Women and Youth defines a specified budget for each year under the heading

'Federal Ageing Plan'. Rather than producing policy papers, tangible projects, initiatives, associations, federations, but also individual events, conferences or international exchange in the field of ageing policies are funded based on a tendering procedure that is open to all citizens. This (co-)funding tool helps a large number of initiatives to start-up or maintain their activities, to support active participation and to facilitate the activation of existing resources (BMFSFJ, 2009), even if the extent of budgetary allocations is limited.

3.2.C Austria – A consensual policy paper towards 'mainstreaming ageing'

At the occasion of the European Year of Active Ageing and Solidarity between Generations the Austrian government has elaborated on a 'Federal Plan for Senior Citizens' together with the Federal Council of Senior Citizens (BMASK, 2012). This 'Federal Plan' contains a synthesis of most relevant developments in the areas of participation, education, quality of life, older workers, poverty etc. as well as objectives and recommendations for these issues. For example, it aims to implement the principle of 'mainstreaming ageing' as a political guideline in all decision-making processes, to extend housing opportunities in terms of 'age-friendly' adaptations and concepts, but also to combat age discrimination and abuse of older people.

3.2.D United Kingdom – Focusing on care reform

In the UK there is no specific active ageing policy although related approaches may be traced 'in specific areas such as employment, education, pensions, health and health care' as Mayhew (2005) concluded already with a view to the WHO concept of active ageing. In particular White Papers of various governments have been a mechanism to launch and implement new policies related to ageing. For instance, in July 2012 the government issued the White Paper 'Caring for our future: Reforming care and support' that outlines the vision "to promote people's independence and wellbeing by enabling them to prevent or postpone the need for care and support" (HM Government, 2012: 18).

3.3 Selected initiatives for active and healthy ageing on regional and local levels

A wide range of initiatives have been developed across European Regions by local authorities and Third-Sector organisations, dealing with individual aspects of active ageing and/or general challenges linked to societal ageing. Some of these initiatives are explicitly related to national frameworks or policies, but many have resulted from considerations addressing tangible shortcomings at the local or regional level. In particular, they exemplify the multi-governance and multi-stakeholder approach which is currently taken-up by many regions and communities across Europe in designing innovative responses to ageing societies. Some of the initiatives focus on specific priority areas that have been previously identified for the Czech Republic – see for example initiatives 3.3.F and 3.3.G in the areas of physical activity and healthy life-styles. A greater priority was however given to initiatives that tackle several of the priority areas identified.

3.3.A Switzerland: Elaboration of a global policy for older people 'Senior+'

In 2006, two members of the Fribourg canton parliament presented a request for a global policy for older people that would be developed with the participation of 'concerned target groups', i.e. older people and professionals (Lucas, 2010). In this context, the goal of the research project 'Senior+' is to develop a concept and a legal framework by taking into account the complexity of variables that have an impact on social and health factors and on the ageing process.

The project focuses on three main aspects of the life of older people: health (in particular the period of frailty and of higher risk of dependency, as well as end of life care), social integration and their financial situation. The basic idea is that older people have resources from which society could benefit and are not just a cause of problems. The project's methodology includes involving partners through focus-group discussions of representatives from health, social and economic fields. These focus-group discussions aim to bring together people who will have to put elements of the new old age policy into practice. The new policy should be finalised with a new law in 2013 or 2014.[16]

3.3.B Germany/Bavaria: Regional concept for senior policies

The regional government of Bavaria has developed a concept for senior policies to respond to the challenges of demographic ageing (Bayerisches Staatsministerium, 2005). In 2007, a legal regulation (Artikel 69 des Bayerischen Gesetzes zur Ausführung der Sozialgesetze) stipulated that all local authorities should adapt and implement their own concepts, based on local surveys, public debates and working groups, to underline that ageing does not only mean long-term care and disease. To provide incentives for municipalities, the Bavarian government introduced a special award for innovative 'Municipal Senior Policies' in 2008. Conceptual key-issues involve integrated planning of local development, housing, counselling and information, prevention, social participation, civic engagement, care and attendance, support for informal carers, networking and palliative care. In the meantime, many districts and municipalities have presented their local concepts and have started to implement new initiatives (Bayerisches Staatsministerium, 2009).

Example B.1: A political strategy for older people in Eichstätt (Bavaria)

The Bavarian region Eichstätt has adopted a political strategy for its older citizens in 2010. This political strategy was elaborated on the basis of several surveys conducted in LTC institutions with senior citizens as well as by running workshops with LTC experts. The strategy entails 11 areas of action including policy recommendations (see Arbeitsgemeinschaft Sozialplanung, 2010): (1) Integrated urban development for mobility and local supply, (2) Living at home, (3) Support for caring relatives, (4) Participation in society, (5) Preventive offers, (6) Social and political involvement, (7) Guidance, information and public relations, (8) Governance, coordination, cooperation

[16] Website: http://www.fr.ch/sps/fr/pub/projets/senior_plus/contexte.htm

and networking, (9) Provision for specific groups, (10) Provision of hospice and palliative care, (11) Support and care.

In a second step the political strategy outlines future care demands and draws different possible scenarios of care provision in the next years. Since the adoption of the political strategy in 2010 the region Eichstätt has appointed a manager in charge of the implementation of this strategy, which is novel for Bavaria.

3.3.C Germany (Baden-Württemberg): Regional concepts for citizens' involvement

Since 1990 the Land Baden-Württemberg systematically supports citizens' involvement throughout its funding programme 'citizens' involvement'. The following two initiatives received support from this programme and represent practice examples of citizens' engagement in care of older persons.

Example C.1: The 'Citizens' community' Eichstetten

The municipality Eichstetten (3,320 inhabitants) founded the non-profit association 'Citizens' community Eichstetten' in 1998 with the objective to create a village of solidarity between generations and of collective support for older citizens.[17] Through the association older persons in need can receive daily services of care and domestic work from members of the associations against compensation. Since 1998 the association is in charge of two care homes, including daily care services to support caring relatives.

Example C.2: Citizens' involvement for quality of life in old age (BELA Network)

In the context of the regional funding programme 'citizens' involvement' of Baden-Württemberg the programme BELA (Citizens' involvement for quality of life in old age) has been created in 2003.[18] BELA seeks to systematically integrate and support volunteers in the work of care homes. BELA has the objective to improve the life of older people in care homes through involvement of citizens' engagement by providing continued training and by adequately acknowledging these forms of engagement.

The BELA network counts 100 member organizations, which are mainly care homes. An evaluation of BELA in 2010 showed that the initiative is positively perceived by all stakeholders (volunteers, care homes, communities), among others, in terms of external inspiration, acquisition of new volunteers and joint trainings with volunteers. However, the objective to create a Baden-Württemberg wide network for quality improvement was not met though in some regions independent dynamics developed among several care homes.

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[17] See website (German only): http://www.buergergemeinschaft-eichstetten.de/

[18] See website (German only): http://www.bela3.de/

3.3.D Germany: Regional management

The regional management of the collaboration 'Obere Vils-Ehenbach' close to the Czech border has developed a range of interesting local initiatives to support active ageing and intergenerational solidarity, in particular by assisting small, rural municipalities to develop local concepts, to boost civic engagement and to support exchange between older and younger generations, e.g. by means of a project called 'pocket-money exchange', counselling for the adaptation of old houses to new housing needs or other civic initiatives to support older citizens to stay in their traditional environment.[19]

3.3.E Austria (Salzburg): 'Ageing in good company'

Within the social community development the regional government of Salzburg has initiated the project 'Ageing in good company' to support local initiatives that wish to become active in the field of healthy and active ageing.[20] These initiatives are created by local working groups consisting of representatives of associations for older people, mayors, social care associations and volunteers that set up their own agendas and objectives intervening in different domains for independent and autonomous living of older people (Moser, 2012). These initiatives have achieved to establish and to set up:

- a case manager in the communities as contact person for caring relatives;
- trainings and workshops for older people in relation to security and mobility in daily life (transport, traffic, secure living environment) and in health topics (nutrition, diseases etc.);
- trainings for caring relatives, e.g. in cooperation with Caritas to train volunteers for supporting and accompanying caring relatives in their daily life and, starting in 2012, the pilot project 'Gut umsorgt vor Ort' ('well cared-for in place') that has been jointly implemented with a nursing school to provide technical support and guidance for caring relatives.

3.3.F United Kingdom: 'Fit as a fiddle' – A nationwide physical activity, nutrition and wellbeing programme for older people

'Fit as a fiddle', a nationwide programme funded by the Big Lottery, aims to support sustainable lifestyle changes which lead to improved health, reduced isolation and greater independence. It is run nationally by a team at Age UK in London, and delivered locally by 8 regional teams, working in partnership with regional and national organisations. 'Fit as a fiddle' has reached and supported over 300,000 older people (aged over 50) across England with physical activity, healthy eating and mental wellbeing during a five-years period, until October 2012. Regional 'fit as a fiddle'-programmes deliver a wide range of innovative and varied projects that promote participation, volunteering and new ways to enhance and sustain work on health and wellbeing. For instance, the Eastern region runs eight different projects that promote

[19] See website (German only): http://www.aove.de
[20] See http://www.gemeindeentwicklung.at/fileadmin/PDFs/GE_Folder.pdf

physical activity, healthy eating and wellbeing for older people, including Dancing for Fun; Eating Well, Feeling Well; as well as cookery and tea dances. The North East's fit as a fiddle 'Fifty Ways to Health' programme trains volunteers as Senior Health Mentors, who organise physical activity and well-being sessions for older people, including yoga, Tai Chi, bowls and balance sessions.[21]

3.3.G United Kingdom: 'Keeping Well' – A local approach to delivering health advice and information for older people

The National Service Framework for Older People (DH, 2001) and Moving Forward (DH, 2002) are initiatives that recognize and address effective service needs for older persons and the challenge for health and social services to work together in health and active lifestyle promotion. In this context the West Suffolk Intermediate Care has created the Keeping Well Centre in order to realise this objective. The Keeping Well Centre is an innovative type of day service provision with an emphasis on education, advice and information (health promotion and fall prevention) for older people receiving little or no formal support through district nursing and social services and having difficulties to remain independent in their own homes.

The Centre aims to provide a co-ordinated and multidisciplinary approach to individual care programmes while enabling older persons to maintain and improve their independence. Further, the Keeping Well Centre is trying to educate older persons in order to enable them to make informed decisions and thus prevent a crisis that might require intervention and hospital admission. The education programmes mainly seek to "boost clients' confidence about looking for intervention before any problem or need becomes distressing and possible unmanageable within their own home" (Hunt, 2005). Sessions offered at the Centre include among others Tai Chi classes, balance classes and information events on fall prevention.

The selected examples from European countries to promote active and healthy ageing have shown various strategies pursuing similar objectives. It seems important to note that national framework legislation, at best linked with defined resources, can serve as a trigger for initiatives at other levels and by various stakeholders. At this very moment it is necessary to allow for innovation and active engagement of citizens in a different way than before, responding to new social problems with new methods. In the long-run it will also be necessary to show and to prove that new approaches deliver additional social value, certainly less in terms of profit and more in terms of "quality of life, solidarity and well-being" (BEPA, 2011: 33). Still, such criteria widely remain to be developed. Initiatives by civil society, public and private stakeholders need to be supported in this search, rather than being restricted to pre-defined indicators. The process dimension of social innovation is therefore at the centre of attention, but it should be ensured that these processes are constantly monitored, accompanied and

[21] http://www.ageuk.org.uk/health-wellbeing/fit-as-a-fiddle/

evaluated to facilitate capacity-building over a longer period of time, rather than by short-term projects.

This applies also to more specific targets of active and healthy ageing policies such as the area of long-term care that is at the centre of this paper and will be addressed in the following section.

4 Integrating long-term care as focal point for active and healthy ageing

This section outlines some of the key challenges and related examples of good practice for governing and implementing integrated long-term care as a major area in the context of active ageing. It maintains the focus on the issues of autonomous and independent living and health that were highlighted in the previous sections as priority areas for action in the Czech Republic. This focus is following suggestions of the Strategic Implementation Plan of the European Innovation Partnership (EIP) on Active and Healthy Ageing (European Commission, 2012). In particular, special attention will be given to the thematic pillar "care and cure" where 'capacity building and replicability of successful integrated care systems' is a priority action area (Table 4.1).

Table 4.1: Thematic pillars and priority areas of the EIP on Active and Healthy Ageing

Pillar	*Priority Action Area*	*Specific Action*
Prevention, screening and early diagnosis	Health literacy, patient empowerment, ethics and adherence programmes, using innovative tools and services	Identifying innovative solutions to ensure better adherence to treatment at regional level
	Personalised health management	Finding innovative solutions to better manage own health and prevent falls by older people
	Prevention and early diagnosis of functional decline, both physical and cognitive, in older people	Helping the prevention of functional decline and frailty
Care and cure	Capacity building and replicability of successful integrated care systems based on innovative tools and services	Promoting integrated care models for chronic diseases, including the use of remote monitoring at regional level
Active Ageing and Independent Living	Extending active and independent living through Open and Personalised solutions	Developing ICT solutions to help older people stay independent, more active and mobile for longer
Horizontal issues	Thematic marketplace: Innovation for age-friendly buildings, cities and environments	Promoting innovation for age-friendly and accessible buildings, cities and environments

Source: European Commission, 2012: 4.

The importance given to 'care and cure' as well as to 'active ageing and independent living' in the context of the EIP shows that the area of long-term care has been identified as a major field in which 'social innovation' is needed. Indeed, *'social innovation'* has

recently become a buzzword and guiding concept for EU policies. In particular, it materializes from the Europe 2020 Strategy, i.e. 'European strategy for smart, sustainable and inclusive growth' (European Commission, 2010).

In the following, the potential for social innovation in the area of integrated care will be defined and discussed in Section 4.1, while Section 4.2 will specify the challenges of 'multi-level governance' in integrating long-term care that have already been addressed for ageing policies in general. These contextual conditions are important to keep in mind in order to assess the transferability of innovative practice examples in integrating long-term care into active ageing strategies (Section 4.3).

4.1 Integrated long-term care: is there potential for social innovations?

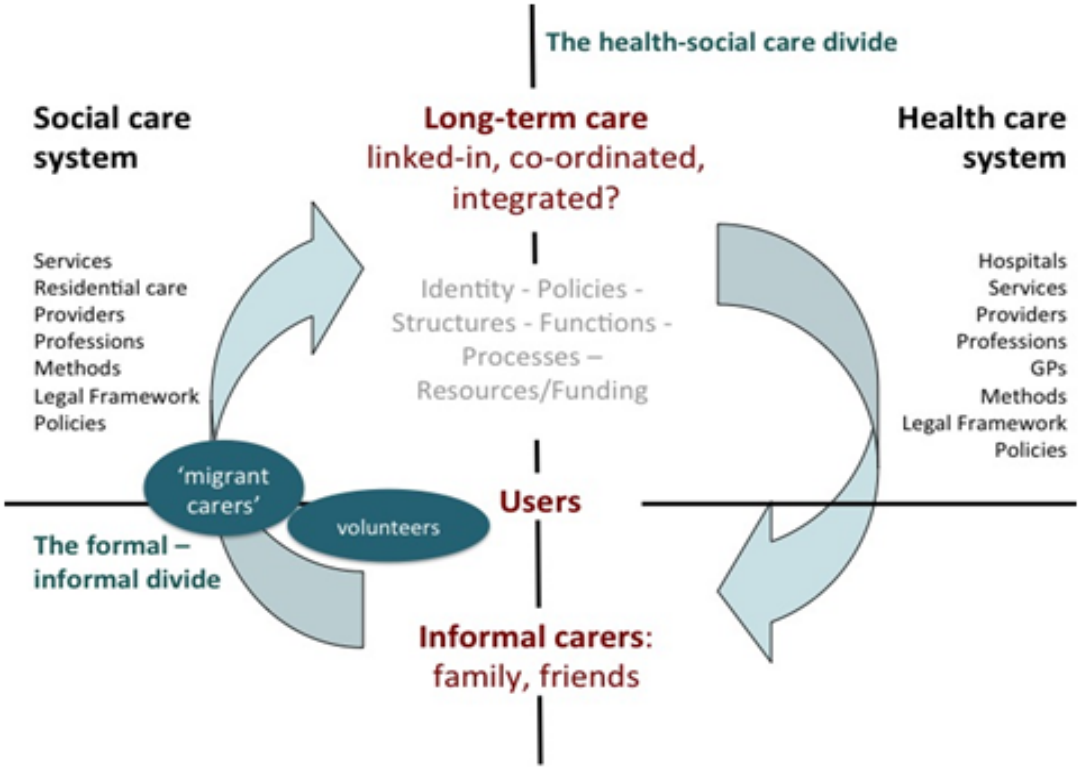
Figure 4.1 illustrates a validated definition of *long-term care at the interfaces between health and social care as well as between formal and informal care* as developed by INTERLINKS (Leichsenring et al., 2013).[22] Indeed, some of the most salient difficulties and shortcomings of emerging long-term care systems are experienced by users and their carers, but also by professionals, researchers and policy-makers, at these very interfaces.

Indicators reflecting the 'cure and care' divide in devising integrated policies largely relate to unequal access, selective funding, unclear responsibilities, wrong incentives and avoidable hospital stays, the lack of properly trained staff and quality standards, and different organisational cultures (Huber et al., 2008; Marin et al., 2009; Colombo et al., 2011; Glasby, 2012).

Another indicator for shortcomings in the formal care systems that still rely heavily on (female) family carers is reflected by the phenomenon of migrant personal assistants, for instance in countries such as Austria, Germany, Italy and Spain. Growing care needs and lower birth rates, but also rising mobility and growing labour market participation of women have resulted in a changing role of family care. Migrant care workers, mostly coming from Central and East European Countries, often serve as a substitute arrangement to family care in situations where heavy care needs emerge. These arrangements are generally characterised by a lack of training and by neither legal nor social security of migrant care workers (Di Santo & Ceruzzi, 2010; Triantafillou et al., 2010), even though some EU countries made progress to legalize their status and integrate them into the formal workforce, e.g. Austria (Schmidt et al., 2012).

[22] This section employs selected results from the EU 7th Framework funded project 'INTERLINKS', coordinated by the European Centre. For more information please see: http://interlinks.euro.centre.org.

Figure 4.1: Towards integrated long-term care systems?



Source: http://interlinks.euro.centre.org, Leichsenring et al., 2013.

These shortcomings have been identified in theory and practice across EU Member States and clearly qualify long-term care for older people as an area in which social innovation is needed in terms of "new ideas (products, services and models) that simultaneously meet social needs (more effectively than alternatives) *and* create new social relationships or collaborations" (European Union & Young Foundation, 2010: 17f.). Yet over the past decade innovations that would meet all these criteria have been rather scarce and often remained restricted to single interventions, time-limited projects or small-scale initiatives that were not able to influence mainstream provision, even if they were able to show evidence for their effectiveness (Billings, 2013).

However, some of these initiatives that will be depicted in Section 4.3 have shown the potential for being scaled up and to be transferable to other countries if they are adapted to the national and local context. The following section will therefore outline some of the most important factors that have to be considered to assess the transferability of individual projects in the context of idiosyncrasies linked to the governance of long-term care.

4.2 Multi-level governance in the area of long-term care

While section 3.1 laid out some specific governance features of the global 'active and healthy ageing agenda' multi-level governance issues related to long-term care in individual countries require special attention. For example, decentralisation has occurred in a number of countries (e.g. France) resulting in new responsibilities for

planning and organising social services at the regional or local level (as against acute health care that tends to be regulated on central levels of government). At the same time, some countries have (re-)centralised specific responsibilities (Table 4.2; see also Annex II). For example, in Germany the funding, regulation and monitoring of long-term care was centralised in 1995 within the long-term care insurance as a part of the social health insurance. Also in Austria, funding of long-term care was moved to the federal level by the introduction of a comprehensive long-term care allowance that is funded by general taxation. These differences offer insights into potential opportunities, for instance for a more appropriate allocation of resources and better coordination if social and health care are administered within a single ministry (e.g. Sweden, The Netherlands). At the same time, decentralised governance is paramount for organising social and health care services, although this entails the risk of producing regional inequalities in the provision and access to services. This seems to be the case even in countries with strong national framework legislation (Trydegård & Thorslund, 2010).

Privatisation and market-oriented governance mechanisms in the context of New Public Management (competitive tendering, purchaser-provider split) prompted the emergence of new stakeholders such as private for-profit providers in countries where traditionally mainly public (Nordic countries, UK) or non-profit organisations (Germany, Austria, The Netherlands) had provided social and health care services (Leichsenring et al., 2010). In relation to this 'horizontal rescaling', two sets of patterns may be observed. Countries with a long tradition of non-profit providers in social and health care (e.g. Austria, Germany, The Netherlands) have partly replaced relationships that were based on trust between public authorities (purchasers) and providers by more contractual relationships. Those countries where public provision had been the general rule (Nordic countries, UK), have introduced a wide range of mechanisms to select, monitor and control new types of (mainly for-profit) service providers (Leichsenring et al., 2013).

Table 4.2: Characteristics of vertical and horizontal levels of governance in selected countries: The example of long-term care

	Vertical level of governance		*Horizontal level of governance*
Country	*Governance*	*Funding*	*Provision*
Austria	Prices (and thus, implicitly, users' co-payments) are regulated by the regional governments, which manage supply of services through development plans. Regional governments are also responsible for setting up quality standards and carrying out inspections (with local authorities).	Increasing responsibility for funding the LTC allowance from the federal budget. Regional governments are responsible for funding social assistance.	50% of care homes are public, while the remaining are more or less equally divided between for-profit and non-for-profit providers. There is a strong sector of privately hired 24h personal carers usually made up of migrant care workers.

France	Social care is regulated by the third tier of government (Départements), which is thus responsible for regulation of home care as well as care homes and also accredits LTC providers.	The national non-means-tested attendance allowance for citizens with care needs above 60 years, 'allocation personalisée d'autonomie' (APA), can be used to cover social services and other support costs.	The majority of LTC providers are non-profit though an increasing number of private for-profit providers enter the market. LTC has been developed as a quasi-market both to increase competition with the entry of for-profit providers as well as to increase employment opportunities by subsidizing service vouchers.
Finland	The framework legislation in health and LTC is issued by the national government whereas services and facilities as well as old age policy strategies are planned and implemented by municipalities.	In 2009 52% of care services for older persons was funded by municipalities, one third by the state and the rest by private co-payments.	The majority of providers are public with a minor involvement of private for-profit providers.
Germany	Regional markets of care with open access to providers that comply with standards. Quality inspections are carried out by federal bodies and regional authorities.	Main benefit (LTC allowance) is funded through a specific LTC social insurance at a federal level.	Open markets of care contributed to a sharp increase in private for-profit provision regulated by specific contracts and intense monitoring (public reporting). There is a strong reliance on paid informal care by users residing in their own homes.
The Netherlands	Health care remains the responsibility of the central government, while governance of long-term care is shared between the social insurance (the Exceptional Medical Expense Act – AWBZ) and local authorities along service lines.	Nursing homes are financed by a centrally managed social insurance (AWBZ). Home help is funded by the local authorities. Personal budgets are funded by both, depending on the services covered.	Most providers are non-profit organisations. There is some competition between insurance companies in relation to supplementary insurance. Hired informal carers and personal assistants play an important role through the personal budgets.
Sweden	Central government issues nationwide frameworks (e.g. caps on users' co-payments, user choice mechanisms) whose implementation is left to the local authorities.	Local municipalities mainly fund long-term care, while health remains the responsibility of the central government and intermediate	Private providers (mostly for-profit) account for 15% of the provision of formal care with an upward trend. Supply has been managed through institutional consumerism (e.g. purchaser provider split)

	Intermediate levels of government (councils) are responsible for hospital and out-patient care. Local authorities are responsible for LTC, including certification and quality.	levels of government (councils).	with user choice models (e.g. vouchers) being rolled-out to individual users since 2009. Hired or paid informal carers remain limited.
United Kingdom (England)	LTC services fall under the responsibility of local authorities whereas health care is regulated by the National Health Service (NHS).	In contrary to the free access to health care services, social care for adults is based on means-tests, eligibility criteria and user charges.	Most providers are private (for-profit and non-profit); Informal carers such as relatives and friends can receive several support services upon assessment of their needs.

Source: INTERLINKS country information, available at http://interlinks.euro.centre.org; see also Annex II for further details.

The structural and political differences in the organisation and delivery of social and health care in Europe show some important levers for change and reform. These include the definition and assessment of long-term care needs, the linkage between health and social care policies on the national level, the cooperation between health and social care sectors and professionals, and the governance of various providers. The adaptation of individual measures must therefore address the following questions:

- How and by whom are the needs for long-term care defined and assessed (at individual and societal level)?
- What resources and which type of resources (cash, in-kind) are dedicated to long-term care, at which level and with which scope?
- Which mechanisms are in place to foster cooperation and co-ordination along the care pathways, between sectors and between different types of care providers?
- By which mechanisms are the different providers as well as people in need of long-term care and their informal carers involved in decision-making and enabling measures?

The attempts to address these issues to develop long-term care as an important part of active and healthy ageing policies in selected countries will be illustrated in the following section by focusing on regional and local initiatives.

4.3 Innovative practice in long-term care: selected initiatives

The description and analysis of emerging long-term care systems for older people entails a broad range of themes, sub-themes and key-issues that have been systematically addressed by the INTERLINKS Framework for long-term care (http://interlinks.euro.centre.org; Leichsenring et al., 2013). From its 135 key-issues, many are focusing on joint working, coordination and other aspects of partnership working, quality measurement and development of support mechanisms for informal carers, e.g.

- Values and mission statements that address the interfaces with health and social care services, and with informal carers
- Initiatives to promote prevention and rehabilitation, quality development and empowerment of users
- Fostering a culture of collaboration, inter-professional exchange and transfer of information
- Establish leadership competencies regarding the management of networks
- Shaping (new) job profiles, fostering and mutual understanding of comprehensive pathways
- Using contracts or agreements to enable and sustain processes between services and/or organisations
- Facilitate individual and multi-professional care planning

With these key-issues in mind, approaches and potentials of practice examples will be illustrated in terms of innovation or improvement at the interfaces between cure and care, between formal and informal care delivery and in the area of general local policies in ageing societies.

The following outlines focus on Austria and Germany and highlight two practice examples from the Netherlands and Finland that showed significant evidence for improvement and cost-efficiency according to research and findings from the INTERLINKS project (http://interlinks.euro.centre.org; Leichsenring et al., 2013). Targeted research (expert contacts) was carried out in Austria and Germany to prepare for the planned study visits.

4.3.A Austria (Upper Austria): Care as a labour market of the future – Developing competencies in care

This INTERREG Project, coordinated by the Upper Austrian Chamber of Work, aims at developing competencies of relevant stakeholders in the area of long-term care and health services, in particular those of managers and staff, (local) policy-makers and other change agents. The activities include the development of innovative concepts for the future of long-term care together with four pilot municipalities. These municipalities have started their planning activities based on surveys and expert-workshops.[23]

Participation, networking, research, development and sustainability are the keywords for training, policy consultancy and community development along the border-region between Upper Austria and Germany. Local needs assessment is carried out by a participative research project to identify gaps in the provision of services and related solutions at the local level. Community development is also supported by accompanying evaluation research and participative concepts that are being tested in selected municipalities (Staflinger, 2012).

[23] See website (German only): http://www.zukunft-pflegen.info/pflegezukunft/

4.3.B Austria (Carinthia): 'Village Service'

The NGO (Association) 'Home-, Family- and Corporative Service' (Verein für Haushalts-, Familien- und Betriebsservice) has established an initiative called 'Village Service' (Dorfservice) that has served as a regional development agency since 2007. In 12 Carinthian municipalities (District of Spittal) 'Village Service' has created a support network with 10 employees and 105 volunteers to strengthen community-based social structures by "mobilising voluntary social work, installing of a platform for social and health affairs in every single municipality, building social networks in the district and creating jobs for women returning from parental leave" (Ebenberger, 2012).

The professional support facilitated civil engagement by which gaps in social support could be closed and a lively process of social integration has been created. The municipalities serve as important partners and as contact points for the users.[24]

In particular older people have used the services that consist in informal transport and visiting services, help in case of emergencies, and information on health and social care services. Apart from organising tangible services, the initiative's rationale consists mainly in regional development to promote solidarity in lively villages.

'Dorfservice' won the Austrian Award for Social Innovation 'SozialMarie' in 2012.

4.3.C Austria (Vorarlberg): Integrated Care for Older People (IAP an der Lutz)

The Regional Government of Vorarlberg has started already during the 1990s to support and develop integrated care for older people in municipalities to promote ageing in place, community care rather than residential care, and to facilitate local solidarity by satisfying the needs of all stakeholders involved. Ludesch is one municipality where this model has been developed in a particularly efficient way, including case management and networking between several partner organisations.

The model has shown that traditional social planning must take into account that social innovations and the definition of clear goals may overhaul mainstream scenarios. For instance, while the regional plan for the nine municipalities coordinated by the social and long-term care centre situated in Ludesch had stipulated that 51 places in care homes would be needed by 2015, today there is hardly any need for about 30 places in residential care (19 long-term, 7 short-term and 4 day-care), although the proportion of residents above the age of 75 has risen consistently. Systematic case management, cooperation and mutual understanding between relevant stakeholders facilitated good quality care in the municipality.[25]

(4.3.D) The Netherlands: Care in the neighbourhood ('Buurtzorg')

The Buurtzorg model was designed by experienced district nurses in 2006 with the objective to provide integrated home care, i.e. with connections to social services,

[24] See website (German): http://www.dorfservice.at/hneu/
[25] See website (German): http://www.ludesch.at/index.php?id=352

general practitioners, and other providers, for all persons who need care at home.[26] Care is delivered by small self-managing teams with a maximum of 12 professionals. To keep organisational costs as low as possible, ICT is used for the organisation of care with a small but efficient centralised back-office. The Buurtzorg method has six sequential components, which are delivered as a coherent package and cannot be delivered separately. The package includes assessment, mapping and involving the network of informal care as well as formal carers, care delivery, support of the client in his/her social roles and the promotion of self-care and independence. The model was introduced on the strictly regulated quasi-market of Dutch home care and had to compete with usual providers for clients and contracts.

By mid-2010, teams were active in 250 locations, with a total number of staff in these teams of 2,600 (amongst them 1,500 qualified district nurses) who serve about 30,000 clients annually. The growth rate of Buurtzorg has continued since with about 70 staff members in 5 to 10 teams per month. The centralised back-office consists of about 30 professionals. Today, Buurtzorg ranks number 1 amongst all home care organisations in user satisfaction according to results of the mandatory national quality of care assessment. In 2011, the organisation has been awarded a prize as the best employer of the Netherlands in organisations with now more than 6,000 employees. A significant result is the impressive decrease of costs that seem to be less than half than those for usual home care. Buurtzorg may be setting a new standard for home care in the Netherlands. Its main strength is to successfully bridge gaps in local level home care (Huijbers, 2011).

4.3.E Finland: Integrated home care and discharge practice for home care clients (PALKOmodel)

The well-known shortcomings in the flow of information between hospital and home care, the lack of clarity on responsibilities and the distribution of work, ad hoc discharges and a lack of integration in services triggered an important initiative in Finland called 'Integrated home care and discharge practice for home care clients' (PALKOmodel). The PALKOmodel was implemented since 2000 into 22 municipalities (hospitals and home care agencies) and consists of practice which promotes different aspects of integrated care: flow of information, cooperation across/inside organisations, and coordination of the services. The main principles of integration of care were shared visions and aims, and shared practice, resources and risks in care pathways. Further aims were that all actors identified their place and tasks in the care pathway and for service users to perceive their care as 'seamless' by means of standardised practice based on written agreements between hospital and home care and within home care in a municipality. An important role was given to a care/case manager pair to coordinate the multidisciplinary team around each client of home care services (Hammar et al., 2007).

[26] See website: http://www.buurtzorgnederland.com/

4.3.F Austria: The city of Wels as a 'Dementia-friendly municipality'

The city of Wels in Upper Austria counts about 60,000 inhabitants. Over the past few years the municipal government developed a concept for becoming a 'dementia-friendly municipality' based on an analysis of citizens' needs and preferences. To realise this vision, awareness-raising campaigns have been initiated for various target-groups such as younger people, public services, employees, shop-owners and the general public. Furthermore, a range of new and additional services (care consulting, day care, palliative care teams, transport etc.) and new types of housing opportunities (group housing, small units for people with dementia, assisted living) were established. The comprehensive strategy included also the construction of Austria's most energy saving care home (Stadt Wels, 2012).

The selected practice examples illustrate that novel ways to address challenges of integrated care for older people may be realised, if enabling strategies, policies as well as financial and human resources are put in place. This applies, among others, to bottom-up initiatives such as 'Buurtzorg', which has grown in the context of the Netherlands' highly regulated care market, as well as to the city of Wels, where public and non-profit providers have worked together under the guidance of the municipal government. Also the 'Village Service' that has its origins in a private local initiative was able to find at least basic resources by citizens' engagement as it was guided by common values and a sound assessment of needs.

A 'culture of collaboration' can be observed in all selected initiatives, be it between public and private (non-profit) providers, between health and social care or between formal and informal care. All stakeholders involved have acknowledged that networking skills are an important precondition, but also an issue for further training and development, not only in 'Care as a labour market of the future'. Indeed, new competencies in case management, care counselling, facilitation, biographic work with people suffering from dementia, palliative care etc. all call for an interdisciplinary approach and mutual understanding. It goes without saying that these competencies can also be enabled by defining more comprehensive job profiles and training curricula such as, for instance, 'community nursing' or social management.

5 Conclusions: Learning from experiences across Europe and adapting them to the priorities and realities of the Czech Republic

This paper aims at enhancing the knowledge-base of policy-makers and stakeholders to support the development of active and healthy ageing policies in the Czech Republic.

Differences in the 'performance' of countries related to indicators used in the Active Ageing index (AAi) as presented in Section 2 inform broadly about gaps and potentials of the Czech Republic in this area. The Czech Republic has a relatively low level of unmet needs in health and dental care and its long-term care system provides cash benefits to a relatively large share of its older population. Moreover, the majority of older people are able to remain in their communities, which means that there is a potential for Czech older people to remain engaged and participating in society.

Despite remaining in their communities, participation in volunteering remains low and contacts with friends and relatives are many times scarce among Czech older people. Mental and physical health of the older population in the Czech Republic may preclude them from remaining active as they age. Furthermore, there is great scope for improving healthy life-styles, for example by increasing physical activity, and improving access to preventive measures, whose take-up in the Czech Republic is below EU level. This calls for active ageing policies that apply a life-course perspective and target also people of working age.

The question is thus how to harness the potential for active ageing by improving the health status and bringing about a greater active participation of older people in the Czech society.

This policy paper presented a unique summary of recent initiatives in selected countries to change governance structures and policies to promote active and healthy ageing at national, regional and local level. From these initiatives it is possible to draw general lessons for the implementation of active and healthy ageing policies in the Czech Republic. Active ageing calls for a pro-active policy approach that enables initiatives started and implemented by a wide range of stakeholders. Active ageing cannot be decreed top-down, but needs to be guided by multi-stakeholder and multi-level governance. Enabling instruments and mechanisms include:

- a **national strategy** developed by relevant stakeholders and expressed by a clear policy statement (e.g. a 'White Paper' supported by responsible Ministries and the Parliament);
- the definition of **priorities and objectives** linked to tangible resources that will be put in place to plan, implement and monitor activities to reach these

objectives (e.g. increasing the employment rate, reducing the number of people in residential care, increasing political participation etc.);
- **regional guidelines** defining the scope and the regional priorities of active ageing policies, including the definition of stakeholders to be involved and resources to be employed and mobilised (e.g. assessment of needs and shortcomings, definition of priority areas in different policy domains);
- **local adaptation** of these guidelines with a clearly defined focus on local priorities and feasible action plans within a defined period of time;
- **activation of citizens' groups and existing stakeholders** by raising awareness and providing incentives (e.g. open tenders for projects and activities with clearly defined objectives for eligibility and accountability);
- **'institution-building'** for active ageing (e.g. by establishing 'citizens bureaus' or agencies to coordinate bottom-up activities, to provide advice and opportunities for bringing engaged citizens together);
- a pro-active strategy to **assess citizens' needs and proposals** for improvement in a bottom-up process involving citizens in focus groups (e.g. focusing on specific policy areas) and/or surveys covering different issues at the local level.

A challenge in implementing ageing policies in the Czech Republic – as in other countries – arises from its multi-level governance structure: besides the central administration, responsibilities for ageing policies are shared by regions, municipalities with "delegated powers" and the remaining municipalities. Multi-level governance has the potential to bring decisions and planning closer to the local level, i.e. to citizens, and better adapt policies to local changing circumstances. It requires, however, the bridging of institutional divides and the overcoming of sometimes contradictory funding incentives.

When it comes to specific areas of active and healthy ageing policies such as long-term care, European examples have shown that progress depends heavily on the coordination of and cooperation between social and health care, on the definition of long-term care as a social risk that calls for societal action, and on professionals' ability to apply resources more effectively and efficiently. The Czech long-term care allowance, although falling short of being a full social insurance for long-term care, plays a very important role in providing resources for dependent older people, enabling them to remain in their homes. As in other countries, however, it has mostly been used to pay informal carers rather than to buy services, thus risking overburdening informal carers.

Apart from the necessity to invest in long-term care as an emerging system at the national level (targeted funding, definition of eligibility etc.), related initiatives on the regional and local levels could learn from the following examples:

- Raising awareness for 'care in the community' with a view to professional approaches to case and care management, e.g. one-stop-shops to provide information and counselling for people with care needs and their carers (see examples 'Ageing in good company' – Salzburg, The 'Citizens' community'

Eichstetten – Baden-Württemberg, 'Dementia-friendly municipality Wels' – Upper Austria).

- To better link primary and secondary care, and to support local providers of care homes, primary care and home care in defining joint visions and implementing a more efficient use of premises, e.g. by facilitating exchange between professional groups to overcome boundaries between them and respective settings in which they are working, but also by contractual arrangements that may guide cooperation and collaboration in the local context (see examples 'IAP an der Lutz' – Austria, 'Keeping Well Centre' – UK, 'Care in the neighbourhood' – The Netherlands).
- To improve planning based on surveys and workshops with input from experts and a broad participation of stakeholders (see examples 'Region Eichstätt – Bavaria', 'Care as a labour market of the future' – Upper Austria).
- To mobilise local resources also in terms of voluntary engagement, solidarity and the exchange of civil engagement, e.g. by establishing a coordination centre for volunteers (see examples: 'Dorfservice Carinthia' – Austria, 'Fit as a fiddle' – UK).

These recommendations and examples show potential ways to improve the performance of active ageing policies in the Czech Republic by integrating health and long-term care. This is all the more important as, for example, discharge patients from hospitals are still often not formally transferred or referred to other services in the Czech Republic (Leichsenring et al., 2010).

However, this potential has to be adapted to the national, regional and local characteristics, to general governance approaches and individual needs and expectations of citizens as elucidated in this paper. The transfer of knowledge and its translation to local characteristics will be an important task of the next steps within the project 'Innovative policies to support healthy, active and dignified ageing'.

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Annex I

Information on indicators for AAi in the areas of long-term care and health

Indicator	*Definition*	*Source*	*Year*
Voluntary work	Percentage of older population aged 55+ providing unpaid voluntary work through the organisations	European Quality of Life Survey	2011
Providing care to own and grandchildren	Percentage of older population aged 55+ providing care to their children, grandchildren (at least once a week)	European Quality of Life Survey	2011
Providing care to older adults	Percentage of older population aged 55+ providing care to elderly or disabled relatives (at least once a week)	European Quality of Life Survey	2011
Physical exercise	Percentage of people aged 55 years and older undertaking physical exercise or sport at least 5 times a week	Own calculations based on micro-data from Special Eurobarometer 334 (European Commission, 2010).	2009
Access to services	Percentage of people aged 55 years and older who report no unmet need for medical and dental examination or treatment during the last 12 months preceding the survey.	EU-SILC	2010
Remaining life expectancy at 55 (a)	Life expectancy at 55 as percentage of the benchmark of 50 years as life expectancy at 55	Eurostat	2009
Share of healthy life expectancy at 55	Percentage of life expectancy at 55 lived without any activity limitation	European Health and Life Expectancy Information System (EHLEIS)	2009
Mental well-being	Percentage of the population aged 55+ reporting to have good or very good mental wellbeing, using the WHO scale	European Quality of Life Survey	2011
Social connectedness	The indicator measures the share of people aged 55 or more that meet socially with friends, relatives or colleagues several times a week or every day	European Social Survey	2009 or most recent year

Note: for more information see Zaidi et al., 2013: Annex.

Annex II

Country information on long-term care

This Annex provides some contextual information on long-term care in selected EU Member States (Austria, Finland, France, Germany, Sweden, The Netherlands, UK). Information is focused on funding and other governance mechanisms that might facilitate or hamper coordination, quality development and the support of informal carers. The choice of countries was based on pragmatic considerations in relation to the availability of information (mainly from http://interlinks.euro.centre.org) on good practice examples that are able to show the way forward in terms of healthy and active ageing for people in need of long-term care.

Austria

Funding: Since the introduction of the comprehensive LTC allowance in 1993, the federal state has increased its responsibilities for funding these allowances from the general budget, since 2012 the federal level is completely in charge of its administration. Beneficiaries have to qualify for seven different levels of care needs and receive a lump-sum payment of between €154 and €1,656 per month. This benefit is needs-tested, but not means-tested and can be used by beneficiaries at their own discretion. For services in kind users are charged about 1% of their income (including LTC allowance) per hour (up to a maximum of about 100 hours per month). In care homes, residents pay with their income and LTC allowance (except pocket-money) and assets, if available, except when regional governments complement costs from their social assistance budget.

Governance: The Austrian LTC system is largely supply-driven – with gaps in particular for those target groups who need more than 2-3 hours of care per day and continue to live at home. As a federal state, Austria displays differences in scope and breadth of supply between and within the nine regions. In most regions home care is delivered by private non-profit organisations employing both home care nurses and home-helpers; about 50% of care homes are public, 25% are provided by private non-profit organisations and 25% by commercial providers. Prices are usually capped and regulated by the regional governments that are also responsible for defining and controlling quality criteria. In order to improve difficulties at the interface between hospital and community care, many hospitals provide for 'discharge management', but health and social care have remained quite distinct areas.

Informal carers of LTC allowance beneficiaries (level 3-7) can obtain social insurance free of charge, respite care services are relatively scarce. Employment of 24-hours-carers ('migrant private assistants') has been partly regulated in 2008, but monitoring remains scarce.

Quality development: Inspections are carried out by regional or county authorities between once per year and once every two years. Inspection reports remain undisclosed. The introduction of quality management systems has started in residential care on a voluntary basis, also the 'National Quality Certificate' for care homes that was introduced over the past few years and is based on a third party audit is voluntary, about 25% of care homes have introduced a quality management system (E-Qalin, ISO, EFQM/QAP).

France

Funding: Citizens with care needs above the age of 60 can apply for the 'allocation personalisée d'autonomie' (APA), the French attendance allowance to cover the costs of social care services and other types of support (e.g. technical devices) according to the national assessment tool AGGIR that stipulates four levels of care needs. The allowance is not means-tested. However, co-payments according to the individual income are foreseen, reducing the maximum amounts ranging between €552 (level 4) and €1,288 (level 1). The allocated amount must be used to employ a defined caregiver, to buy services from an accredited home care provider, to buy 'chèques emploi' (Cesu) or to contribute to the costs of residential care. However, as the allowance covers on average only 28% of assessed needs, it is up to the individual or his/her family to cover remaining costs from own income, savings or assets. A means-tested social assistance benefit may be requested if the beneficiary or his/her family is unable to pay.

Governance: Secondary and tertiary health care, including rehabilitation hospitals and so-called 'hospital at home' services are regulated by regional agencies (ARH) under the supervision of the Ministry of Health while GPs and specialists are regulated by the national health agency (NHA). Nursing home care agencies are under the remit of the national health agencies and the regional body of the Ministry of Health (DRASS). All social care issues are governed by the General Councils as executive bodies of the third tier of government ('Départements') which are thus responsible for planning and regulating the delivery of home help and personal care by providers of home care or care homes. All providers – most of them private non-profit organisations but also in France private for-profit providers have gained in importance – have to be accredited by the respective General Council or by the state representative in each 'Département' (préfet). Key coordination problems have been reported due to the health-social care divide, in particular for people needing both nursing and social care at home as they might have to deal with at least three different types of services: nursing agencies, home help agencies and 'hospital at home' services. The LTC sector has been governed in terms of distinct (quasi-)market mechanisms that were used on the one hand to increase competition and the entry of for-profit providers, and on the other hand to increase employment opportunities in particular at the lower end of jobs in 'proximity services', e.g. by issuing subsidised service vouchers ('chèques emploi').

Informal carers indirectly benefit from the APA, as it is also possible to employ a family member (except the cohabiting wife or husband). In reality only 11% of informal carers are employed via this mechanism, while 75% of all APA beneficiaries still benefit from important contributions of their family members as informal carers.

Quality development: Minimum standards are guaranteed by authorisation and accreditation mechanisms that all providers have to pass. Inspections are relatively scarce and unsystematic. In 2007, a new agency (ANESM) was created to develop practice guidelines for professionals in LTC, but it remains to be seen in how far these guidelines and respective examples of 'good practice' will be implemented by providers. In the residential care sector, most providers have implemented an internal self-assessment and quality management system called 'Angelique'.

Finland

Funding: In 2009 a total of 52% of care services for older people were financed by municipalities, 31% by the state and 17% by clients' co-payments. The relatively low level of the latter is due to the fact that municipalities charge service users only up to a maximum threshold as a percentage of the client's monthly income. In residential facilities, residents pay up to a maximum of 85% of their disposable income (not property).

Governance: The Finnish national government is responsible for framework legislation in health and long-term care, while services and facilities are planned and organised mainly on the level of municipalities with a relatively strong autonomy that includes the right to levy taxes. Most services are provided by public entities, with still a small proportion of private for-profit providers. The municipalities are also responsible for planning and implementing general old age policies. Respective strategies have been developed over the past decade by more than 80% of all municipalities, often in cooperation with other municipalities, with ample involvement of relevant stakeholders such as the administration, citizens, service users and family members, councils for older people, non-governmental organisations, parishes and local business firms. The strategies for old age policies must take into account the ageing population in all aspects of municipal decisions and activities, such as in community planning, the planning of traffic and housing policies, cultural and recreational activities, educational and participatory opportunities, and in the production of services and promotion related to well-being and health. The execution of the strategy is integrated into the municipal budget and budget plan. The implementation is monitored and assessed on a regular basis, and the follow-up and assessment reports are utilised to further develop these activities.

Informal carers: In Finland, national legislation helps caregivers receive support to better balance their own life, work and care. Apart from a wide range of information

facilities and respite services, informal carers (also pensioners) may also apply for a care allowance that amounts on average to about €414 per month.

Quality development: The Finnish government has set quantitative national targets to be reached by 2012 for older people over 75 years of age in a 'Framework for High-Quality Services for Older People', e.g. 91-92% should live at home independently or using appropriate health and welfare services granted by assessing their overall needs, 13-14% of which with regular home care, while the remaining 8-9% should be provided 'service housing' or a place in a nursing home. There are also targets for the service structure and staffing level that have been adapted by the municipalities according to their local context. Most public providers and almost all commercial providers have introduced quality management systems based on ISO or EFQM. Furthermore, more than one third of residential facilities and approximately 25% of home care services are using the Residents Assessment Instrument (RAI) to assess and monitor care needs and outcomes. These data are also used for benchmarking purposes to work directly on improving the long-term care delivery.

Germany

Funding: In Germany, long-term care has been introduced as the 'fifth pillar' of the social insurance system in 1995. The LTC insurance provides cash benefits or benefits in kind (home care and residential care) for 3+1 levels of care needs.

Governance: The LTCI is based on a market-oriented governance, i.e. market access for care providers that comply with defined standards is open. Although the LTC Insurance is part of the social health insurance it remains a partly isolated area with many overlaps at the regional and local level, e.g. inspections are carried out both by the Medical Service of the LTCI and regional authorities.

Informal carers of people in need of care have a legal right to up to four weeks of respite care, information and counselling services and courses for informal carers. Furthermore, a 'Care Leave Act' has recently been introduced for employees who want to take (unpaid) time-off to care for a family member. Private assistance by migrant carers is not yet regulated.

Quality development: The Medical Service of the LTC Insurance has developed an intense inspection scheme for all providers of care, resulting also in a rating system providing school marks for the quality of care. These ratings are publicly reported on a website with the aim to allow (potential) users to compare providers.

Sweden

Funding: Swedish health and social care services are funded by the general budgets on national, regional and municipal levels. Long-term care services are funded mainly (about 85%) by municipal local taxes, user fees are minimal (below 5%).

Governance: The central government ensures that the principles governing care are the same throughout Sweden by framework legislation, but their implementation has been decentralised to counties and municipalities. County councils manage hospitals and out-patient care, while the municipalities are responsible for social and long-term care. Since the 1990s there is a trend towards privatisation by means of compulsory competitive tendering for individual facilities or areas, resulting in about 15% of services being provided by private for-profit providers today. Since 2009, a new Act stipulated the introduction of freedom of choice models: older people are now given a voucher and can choose between providers in their catchment area. The pool of available providers is defined by each municipality based on a certification process.

Informal carers have gained in importance over the past decade, in particular through legally binding regulations that force municipalities to offer support to relatives who provide care on a regular basis to their kin. This includes in particular the availability of respite services, but their scope and extent remains to be decided by each individual municipality.

Quality development: While there are several mechanisms and registries for monitoring quality of acute health care facilities, quality assessment and control for long-term care remain restricted to individual initiatives and activities by municipalities.

The Netherlands

Funding: The Netherlands introduced the first mandatory LTC Insurance in Europe entitled Exceptional Medical Expense Act (AWBZ) already during the 1960s, initially mainly covering nursing homes, later also other types of residential care and community care. Since 2006, however, the responsibility for funding home help and other assistive care services has been decentralised to local authorities (except personal budgets).

Governance: The decentralisation of responsibilities has increased the fragmentation of care provision not only between health care, AWBZ and local authorities, but also between the various levels of governance (e.g. duplication of needs assessments). Another problem for coordination and collaboration consists in the fact that, in each region, the largest AWBZ insurer administers regional offices on behalf of all insurers with the very same organisation might be in competition with as a health care insurer. Reforms have been proposed to install one-stop windows for beneficiaries and to improve coordination mechanisms. In the meantime, a range of initiatives for specific target groups have been installed, e.g. case management for people with dementia. Services are provided mainly by private non-profit organisations.

Informal carers are an important resource also in the Netherlands, but rather than designing specific services for carers the general approach is to provide services and facilities for people in need of care.

Quality development: Specific institutions and organisations have been founded in the Netherlands to assess and monitor the quality of health care (Health Care Inspectorate) and long-term care (Bureau for Transparency on Quality of Care). Several instruments have been developed to facilitate transparency and public reporting, e.g. the 'Quality Framework for Responsible Care', which is in particular meant to measure clinical nursing care quality, and the 'Consumer Quality Index', which is a standardised survey to assess and report customer experience in health and long-term care.

United Kingdom (England)

Funding: The English welfare state has tended to distinguish between people who are *sick* and have *health care* needs, met by the National Health Service (NHS) free at the point of delivery, and people who are merely *frail or disabled* who are seen as having *social care* needs that fall under the remit of local authority social services and that are frequently subject to a means test and user charges. Whereas most health care is freely available to all in an emergency or available via GP referral for planned care, adult social care is subject to increasingly stringent means-testing and eligibility criteria. However, current debates focus on the possibility to roll out a national system of personal budgets throughout all adult social care.

Governance: The division of tasks between the NHS and local authorities entails a series of organisational, financial, legal, professional and cultural barriers for cooperation. Despite a number of initiatives and measures (e.g. the foundation of – if they wish to work together more effectively

Informal carers: Families, friends or neighbours who choose to provide care for older people have a legal right to an assessment of their needs and can receive a number of support services (either provided to the person they care for or in their own right).

Quality development: At a service level health and social care services are registered and inspected by the Care Quality Commission (CQC). Registration ensures that they meet a number of common quality standards. After providers have been registered, they must show that they continue to meet the common quality standards. This happens through periodic reviews, inspection, collecting information to monitor their service, and by self-assessment. In general, quality assurance is moving towards continuous monitoring focussed on the individual patient experience rather than systems and processes and past performance.