

TECHNICAL WORKING GUIDANCE #6

STRENGTHENING THE HEALTH SYSTEM RESPONSE TO COVID-19

Preventing and managing the COVID-19
pandemic across long-term care services
in the WHO European Region
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Contents

Summary	2
Urgency	2
Introduction	3
Unique challenges facing decision-makers when addressing LTC systems	4
Governance of the long-term care system often involves different levels and elements of government	4
Long-term care services are provided by a mix of public, private for-profit and non-profit service providers	4
The amount of public funding allocated for long-term care varies between countries	4
Public benefit schemes for long-term care support are usually need- and means-tested and often require co-payments	4
Care workers are predominantly women and experience relatively poor working conditions and low pay	4
Family caregivers provide an important share of care but support structures are limited	5
People with long-term care needs often require continuous, complex and personalized support structures	5
Ten policy objectives to prevent and manage the COVID-19 pandemic across LTC services	5
Policy objective 1: Prioritize the maintenance of LTC services during the COVID-19 pandemic through an effective governance mechanism	6
Policy objective 2: Mobilize additional funds for the LTC system to respond effectively to the COVID-19 pandemic	8
Policy objective 3: Ensure infection prevention and control standards are implemented in LTC services to prevent and safely manage COVID-19 cases	9
Policy objective 4: Implement safety measures that recognize the mutual benefits of the safety of people receiving and providing LTC services	11
Policy objective 5: Prioritize testing, tracing and monitoring the spread of COVID-19 among people receiving and providing LTC services	13
Policy objective 6: Identify and mobilize surge capacity to secure staff and resources for delivery of appropriate LTC services during the COVID-19 pandemic	14
Policy objective 7: Scale-up support for family caregivers during the COVID-19 pandemic	16
Policy objective 8: Coordinate between services to ensure the continuum and continuity of LTC services during the COVID-19 pandemic	17
Policy objective 9: Secure access to dignified palliative care services during the COVID-19 pandemic	19
Policy objective 10: Prioritize the emotional well-being of people receiving and providing LTC services throughout and after the COVID-19 pandemic	20
Definitions	22
Key WHO documents	23
References	24

Summary

The number of COVID-19 infections and deaths in care facilities and long-term care (LTC) facilities have alarmed decision-makers, health care providers and communities. International experience has, however, shown that COVID-19 spread is not inevitable among LTC settings, and that some countries have been able to avoid large shares of death in care homes. Early evidence gathered over the course of the COVID-19 pandemic suggests that it is possible to mitigate the impact of the virus on LTC systems through timely and comprehensive policy action that reflects an understanding of how services are received and delivered.

This technical guidance identifies 10 policy objectives for decision-makers, policy-makers and national or regional health authorities as they strive to prevent and manage the COVID pandemic in LTC settings.

While those making decisions for LTC systems are often structurally separate from those tasked with managing health systems, during the various stages of the pandemic certain objectives should be pursued in cooperation and given equal weight in official guidance, public communication and planning measures. Such cooperation would not only help to strengthen and secure the availability of LTC services during the COVID-19 pandemic for people receiving these services but would also help to minimize pressure on health systems.

LTC services benefit people of all ages, but the focus here is on older people above the age of 65 years who use LTC services in their homes, day centres or designated facilities (residential homes and nursing homes). Older adults are susceptible to severe COVID-19 outcomes because of their age and, in many cases, underlying health conditions.

Urgency

- Some countries with community transmission, reported over 40–60% of total confirmed COVID-19 deaths in long-term care (LTC) facilities (Comas-Herrera et al., 2020). Older people using LTC services make up a large proportion of those most affected by COVID-19. These infections are transmitted to older people by the people caring for them (families and care staff). Without addressing this aspect, it is difficult to control the spread of the virus.
- Not addressing the needs and safety of those who receive LTC services and those providing care during the COVID-19 response is also a matter of human rights and dignity as it leaves two populations who are already at risk of exclusion (both care users and care providers) in an increasingly vulnerable situation. There are also important ethnic and gender dimensions given that women dominate the LTC workforce, and LTC services often depend heavily on migrants (Christensen, Hussein & Ismail, 2016).
- The lack of prevention and management of COVID-19 in LTC systems can be very costly for individuals and the chain of people affected, but also for health systems as many people will need to be moved into hospitals for further treatment.
- Health care systems have a responsibility to care for all people and should offer safe, quality care for more vulnerable and frail populations when they require health care, irrespective of choice.

Introduction

Older people (those above 65 years), and those with underlying health conditions who require care and support from others, have been cited as being particularly susceptible to severe infection by COVID-19 (United Nations, 2020; WHO, 2020d). As countries consider how they will shield and minimize spread of the disease among people over 65 years of age who have been particularly hard hit by COVID-19, it is important to analyse the needs of this group and what makes this population susceptible to severe COVID-19 disease. In so doing, it is important to understand that it is not chronological age that is the determinant of infection risk. Rather, an important point of susceptibility is that many older people are recipients and dependents of long-term care (LTC) services and usually have multiple underlying conditions, whether they live in their homes, day centres or communal settings (WHO, 2020d).

Following guidance on, for example, physical distancing is particularly difficult for people who live in communal settings or who rely on carers who are not living with them and who travel back and forth, often working in multiple facilities. As such, it is not surprising that in some countries as many as half of all COVID-19 deaths appear to have been among LTC home residents. In WHO European Region countries with large numbers of deaths, over 40% of total confirmed COVID-19 deaths are in LTC facilities (Comas-Herrera et al., 2020). Less is known of the impact on those receiving LTC in the community.

The number of infections and deaths in care and nursing home facilities and the lack of timely and reliable data have alarmed decision-makers, health care providers and communities. Yet international experience has shown that the Republic of Korea (Kim, 2020) and the Hong Kong Special Administrative Region, China (Wong et al., 2020), have been able to avoid large numbers of deaths in care homes. COVID-19 spread is not inevitable among LTC services, and this international experience shows that it is possible to mitigate the impact of the virus on LTC systems through timely and comprehensive policy action that reflects an understanding of how services are received and delivered.

LTC settings, however, do not fall exclusively within the scope of health systems. In fact, the majority of services are provided outside the health care system (WHO, 2015). This structural element of how, where and who is responsible for delivering LTC care to older people appears to have created difficulties in developing coordinated responses to prevent and manage the impact of COVID-19 in many settings, and in keeping those delivering these services safe. Before considering how to ensure the safety of services in the LTC system during the COVID-19 pandemic, it is therefore important to review several key challenges facing LTC systems in the WHO European Region.

Unique challenges facing decision-makers when addressing LTC systems

Several challenges with the LTC system that pre-date the COVID-19 pandemic can help explain some of the difficulties facing the COVID-19 pandemic response in this sector. These challenges are considered briefly before the 10 policy objectives for a more effective response to COVID-19 are presented.

Governance of the long-term care system often involves different levels and elements of government

LTC services are often managed apart from and secondary to the health system (WHO, 2019). As a result, LTC systems are often exempt and separate from health system oversight in the way they are financed, the collection and management of information/data, the training and procurement of staff (OECD, 2019d) and resources. In addition, countries frequently distribute responsibility for LTC vertically across national, regional and local actors (Spasova et al., 2018).

Long-term care services are provided by a mix of public, private for-profit and non-profit service providers

In addition to a complex governance structure, LTC services are characterized by a mix of public, private not-for-profit and for-profit service providers (King & Zigante, 2020). Most of these providers sit outside the health care system. This mix of diverse actors involved in the delivery of support for people with often complex LTC needs creates challenges in maintaining oversight of the quality of services provided (WHO, 2019). In most countries these structures result in a lack of ownership, diffused accountability, problems with coordination and underdeveloped information systems (WHO, 2019).

The amount of public funding allocated for long-term care varies between countries

The complexity of governance also has implications for financing. While some LTC public systems spend between 1.1% GDP to 3.7% GDP, other countries spend only around 0.2%. Public LTC in European countries is usually financed either through tax-based systems or social insurance: each system has its own advantages and disadvantages (Rodrigues, 2015). In many countries, public social protection schemes cover a larger share of cost in institutional than in community care.

Public benefit schemes for long-term care support are usually need- and means-tested and often require co-payments

Public LTC support, whether made in cash or in-kind, are frequently needs- and means-tested (Coste & Ces, 2019). Those with greater needs often receive more support but some countries also set boundaries in the amount that can be covered through public resources. While some countries protect the most vulnerable from additional costs, considerable out-of-pocket costs are common across countries for most people receiving LTC services (Hashiguchi & Llana-Nozal, 2020).

Care workers are predominantly women and experience relatively poor working conditions and low pay

The workforce supporting people with LTC needs is predominantly female (90%). The shortage of care workers experienced across countries is aggravated by low pay and relatively poor working conditions as well as the perception that care work is “low-skilled” (OECD, 2019e). In some European countries, such as Austria, France and Italy, migrant care workers make up a large proportion of the LTC workforce (Rodrigues, Huber & Lamura, 2012).

Family caregivers provide an important share of care but support structures are limited

An important share of LTC across all countries is provided by family caregivers, both by providing care directly, and also in helping coordinate and complement formal services. The largest share of this care is provided by women (61%). The number of male carers providing care at home increases with age. At older ages, men and women are equally likely to provide a certain amount of care for their spouses (Rodrigues, Huber & Lamura, 2012). There are also young carers, children, adolescents and young adults, who support family members with LTC needs. While each of these groups face their own challenges, the provision of intense levels of care has generally been associated with reduced labour force attachment (for those of working age), lower income and ultimately higher poverty rates (OECD, 2019a). In addition, family caregivers have a higher prevalence of mental health problems (OECD, 2019a). Some countries have recognized the impact family care giving can have and offer support structures, such as paid care leave, flexible work arrangements, respite care, psychological interventions as well as cash benefits to mitigate the impact (OECD, 2019a). However, support structures for family carers, such as respite care, training or care leave schemes remain limited and family caregivers traditionally provide support without compensation. Moreover, governments aim to strike a balance between supporting family carers and incentivizing labour market participation (Hashiguchi & Llana-Nozal, 2020).

People with long-term care needs often require continuous, complex and personalized support structures

Most people with LTC needs require regular support with personal care (e.g. bathing, dressing, eating, using the bathroom) and/or with instrumental activities (e.g. shopping, housework, meals, transportation). In many countries the majority of care home residents have dementia (WHO, 2017b; Wang, 2020). Personal care tasks in particular require high levels of physical and emotional contact, and people who are receiving this care, and who are dependent on this support, benefit enormously from continuity of care (WHO, 2015). Some people with LTC needs, such as people living with dementia, experience changes in their physical and cognitive status. For them, rapid changes to their routine may increase their vulnerability (Alzheimer Europe, 2020).

Ten policy objectives to prevent and manage the COVID-19 pandemic across LTC services

The following 10 policy objectives are presented to decision-makers, policy-makers and national or regional health authorities to consider as they strive to prevent and manage the COVID-19 pandemic in LTC settings. These measures seek to increase the cooperation and coordination between the health system and the LTC system and recognize their interdependence.

Each policy objective is presented with accompanying evidence and a set of key actions that can help achieve these policy objectives. Each policy objective is also illustrated using examples from countries in Europe. Unless otherwise indicated, country examples come from reports contributed by international experts to the International Long-Term Care Policy Network based at the London School of Economics and Political Science¹.

This technical guidance is intended to support and complement existing WHO guidance to prevent infection by COVID-19, rapidly diagnose and treat individuals with COVID-19, maintain essential health services, create critical surge capacity and protect vulnerable populations (see Key WHO documents section).

¹ LTC responses to COVID-19. International Long-term Care Policy Network: <https://ltccovid.org/>

Ten policy objectives to prevent and manage the COVID-19 pandemic in long-term care services

1. Prioritize the maintenance of LTC services during the COVID-19 pandemic through an effective governance mechanism.
2. Mobilize additional funds for the LTC system to respond effectively to the COVID-19 pandemic.
3. Ensure infection prevention and control standards are implemented in LTC services to prevent and safely manage COVID-19 cases.
4. Implement safety measures that recognize the mutual benefits of the safety of people receiving and providing LTC services.
5. Prioritize testing, tracing and monitoring the spread of COVID-19 among people receiving and providing LTC services.
6. Identify and mobilize surge capacity to secure staff and resources for delivery of appropriate LTC services during the COVID-19 pandemic.
7. Scale-up support for family caregivers during the COVID-19 pandemic.
8. Coordinate between services to ensure the continuum and continuity of care, including access to health care personnel and equipment in care homes, during the COVID-19 pandemic.
9. Secure access to dignified palliative care services during the COVID-19 pandemic.
10. Prioritize the emotional well-being of people receiving and providing LTC services throughout and after the COVID-19 pandemic

Policy objective 1: Prioritize the maintenance of LTC services during the COVID-19 pandemic through an effective governance mechanism

The ongoing COVID-19 pandemic has made it clear that there needs to be more coordination of monitoring, information, guidelines, staff, and other resources (financial and equipment) to ensure quality and safety for people receiving services, those delivering services and the families and communities connected to these people.

The complex and often separate governance structure of LTC systems calls for immediate action to ensure that LTC services are being monitored and maintained for this vulnerable group and which considers the need for continuity and safe coordination across the care continuum. Capturing the number of cases and deaths (probable and confirmed) that occur in long-term care facilities in the national surveillance data mortality statistics will be of vital importance and need to be included in international and national monitoring networks and platforms. Furthermore, maintaining both existing levels of care, while also providing care by LTC services to people who might otherwise have stayed longer in hospitals, will not only require a maintenance of existing capacity but also an expansion of capacity in the LTC system.

Since countries vary enormously in terms of what services are included in the LTC system, their country plans to prevent and manage COVID-19 in LTC systems will have to individually address what is and

is not provided to older people by these two systems. Member States will need to consider ensuring that the most up to date guidance is provided, and that medical equipment, medications and personal protective equipment (PPE) is procured quickly for both care homes and home care services (WHO, 2020a). Any guidance, however, must also be contextualized to the LTC system with input from experts in this area. These experts in turn will need to be connected with any COVID-19 efforts and specific governance mechanisms to act, respond and report to the larger COVID-19 efforts when needed.

Key actions

Consider establishing a system of governance characterized by the following:

- A focal point to manage services for older people and people who need care, with special focus on LTC providers, in the overarching COVID-19 governing structure/body.
- Assessing and monitoring ongoing delivery of LTC services during COVID-19 to identify gaps and potential need to reconfigure services.
- Establishing triggers/thresholds that activate a phased reallocation of routine comprehensive health service capacity towards LTC services.
- Establish a surveillance system that captures the number of cases and deaths (probable and confirmed) that occur in long-term care services and ensure that these are integrated with existing surveillance systems.
- Establishing a mechanism to secure and transmit up-to-date information and guidance on a regular and frequent basis to LTC providers, public health authorities and the public.
- Establishing a mechanism to plan, prioritize and support implementation of measures to protect staff and people receiving LTC from infection or spread of COVID-19.
- Establishing a team to develop, adjust and update guidelines and protocols for LTC services during COVID-19, based on the best available evidence and by consulting various WHO guidance.
- Setting up links between health and social care procurement chains to ensure a continuous and not conflicting supply during COVID-19.

Country examples:



In Ireland, a National Public Health Emergency Team was established to oversee, guide and support the national response. Care home providers have to report COVID-19 outbreaks to the Health Information and Quality Authority (Pierce, Keogh & O'Shea, 2020).



In Germany, local health authorities need to be informed of suspected and confirmed cases. Teams from the Robert Koch Institute support outbreak containment in residential care settings. In the federal state of Bavaria, an Infectiology Task Force is mobilized if an infection occurs in a care home. If domiciliary care providers in Germany can no longer provide services, they have to contact the care insurance and explore alternative care provision in collaboration with health and regulatory authorities (Lorenz-Dant, 2020b).



During the COVID-19 pandemic Austrian regional (state) governments inform a centralized management team about their hospital and long-term care capacities (Schmidt et al., 2020).

Policy objective 2: Mobilize additional funds for the LTC system to respond effectively to the COVID-19 pandemic.

During the COVID-19 pandemic additional and stable funding will be needed to provide additional care in the short and long term, and to keep services safe for people receiving LTC services and staff (WHO, 2020d). The amount of additional funds required will depend on how well- or under-funded existing systems are.

While governments of most Member States in the WHO European Region provide state funding for LTC services, frequently delivered by private providers, in some countries this funding usually only provides a very basic level of care which is far below the levels of care people require (Spasova et al., 2018; OECD/European Union, 2013). Hence, it is very common for necessary additions to be covered by individuals and families; for example, extra hours, private rooms, bedding and linen, hygiene products and medical equipment are paid out of pocket. Where this is not possible, quality may be reduced and the level of inequities and variability in the quality of care people receive increased (Hashiguchi & Llana-Nozal, 2020; Muir 2017).

Given the increased needs for equipment and staff, and either lower or higher occupancy rates in care homes during COVID-19, subsidies will need to be stabilized and provided equitably so that a standard level of service is being provided that meets infection prevention and control (IPC) standards and COVID-19 control measures.

In addition to securing funding to pay for the equipment to keep LTC services safe, financial remuneration for staff will need adjustment. Given the low pay, compared with other health care staff, and poor job conditions, it is very common for LTC staff to move between settings and the people they are caring for to make up the income; care staff are often on zero hours contracts. This can increase risk of exposure to COVID-19. Adequate financial compensation of staff will therefore be essential to ensure that movement is minimized and that staff do not face loss of income if they need to self-isolate.

Key actions

- Consider increasing the standard remuneration for all LTC staff to more adequately recognize their work and to minimize their movement between settings and people receiving LTC services.
- Consider ensuring that LTC staff have sick pay.
- Consider injecting extra ring-fenced funds for LTC to cover the costs of increased staff numbers, compensate for lower occupancy rates, and pay for IPC measures (PPE, cleaning supplies, etc.).

Country examples:



In Ireland a €2.5 million fund is available for community and voluntary organizations who provide frontline services, such as the delivery of meals. In addition, private and voluntary nursing homes can receive immediate temporary assistance payment to respond to a COVID-19 outbreak (Pierce, Keogh & O'Shea, 2020).



In Austria, €100 million has been allocated to support the long-term care sector. Some of this money is intended to expand residential care bed capacity for people who cannot be cared for sufficiently in their own home and to provide one-off payments of €500 to migrant care workers who have remained in the country to provide care (Schmidt et al., 2020).



In Slovenia pensioners with low pensions can apply for a one-off payment (Oven, 2020).



In the Netherlands, the regional Dutch long-term care offices can support LTC providers financially if they face additional costs due to COVID-19 (Kruse, Remers & Jeurissen, 2020).



In Germany, institutions that incur additional costs or loss of revenue due to COVID-19 can be reimbursed by the long-term care insurance. In addition, the minimum wage for care workers is going to be raised. The federal states of Bavaria and Schleswig-Holstein have announced that they will pay a one-off bonus to care workers. In addition, Bavaria financially supports catering for staff in institutional care settings (Lorenz-Dant, 2020b).



In the the United Kingdom, Scotland and Wales have raised wages and offered special one-off payments to incentivize staff (Government of Scotland, 2020b; BBC, 2020a).

Policy objective 3: Ensure infection prevention and control standards are implemented in LTC services to prevent and safely manage COVID-19 cases

There have been particular challenges in getting PPE to LTC services across the Region. Many LTC providers (e.g. residential care homes) have not previously required large amounts of PPE so supply chains had not previously been established. It is therefore not surprising that the Region has many examples whereby LTC services were not included in early distribution of PPE, despite the particularly high need for PPE in a line of work that involves very close physical contact and therefore increased risks of spread, further exacerbated by the trend of LTC staff to work in multiple settings (International Long-Term Care Policy Network, 2020). The sector therefore requires additional support in establishing these supply chains.

Although use of PPE is the most visible control used to prevent the spread of infection, it is only one of a series of IPC measures and should not be relied on as the only prevention strategy. It is also important that staff are able to recognize symptoms and know how to manage people who have COVID-19. Training to keep up with IPC practice (WHO, 2020f) will require securing time and resources. Member states can adjust the guidance available from WHO and should review how the guidance is being applied on a regular basis (WHO, 2020d). In the absence of effective administrative and engineering controls, PPE has limited benefit, as described in the document Infection prevention and control of epidemic- and pandemic-prone acute respiratory infections in health care (WHO, 2014).

The summary of relevant IPC controls is:

- **Administrative** controls include ensuring resources for IPC measures, such as appropriate infrastructure, the development of clear IPC policies, facilitated access to laboratory testing, appropriate triage and placement of patients, including separate waiting areas/rooms dedicated to patients with respiratory symptoms, and adequate staff-to-patient ratios and training of staff. In the case of COVID-19, consideration should be given, wherever possible, to establishing differentiated care pathways that minimize mixing of known or suspected COVID-19 patients with other patients (e.g. through separate health facilities, wards, waiting and triage areas). In the LTC context some adjustments will be necessary (i.e. no triage areas) while still maintaining clear delineation of risk zones (Fewster, 2020).

- **Environmental and engineering controls** aim at reducing the spread of pathogens and the contamination of surfaces and inanimate objects. They include providing adequate space to allow social distance of at least 1 meter to be maintained between patients and health care workers and ensuring the availability of well-ventilated isolation rooms for patients with suspected or confirmed COVID-19, as well as adequate environmental cleaning and disinfection (WHO, 2020d).
- **Training and decision supports** can also be effective ways of supporting the workforce at all hours of the day, especially where staff are isolated as is common with staff providing services in people's homes, to practice according to guidelines and improved practice. Frequent and regular communication with families and staff will be needed so they feel safer and more informed.

Key actions

- Ensure that everyone involved in direct delivery of care (staff and family caregivers), in care homes or in home care services, has access to IPC training (including rational use of PPE, hand hygiene, cleaning and disinfection of environments, etc.). This should be carried out regardless of their role and especially for those having direct contact with older people with underlying health conditions.
- Ensure that the necessary IPC protocols and guidance are made available and are clearly visible in easy-to-understand formats for all staff and visitors to facilities.
- LTC facilities should have an IPC focal point to lead and coordinate IPC activities, ideally supported by an IPC team with delegated responsibilities and advised by a multidisciplinary committee.
- Increase training and decision-making supports for the health and social care workforce working in homes or in home care services to effectively manage COVID-19, including family caregivers.
- Set up 24-hour/7-day telephone, online or in-person support for staff to be able to reach out with questions and concerns when caring for older people during the COVID-19 pandemic.
- Ensure that all staff and family caregivers are given training on early recognition, isolation, care, and source control (prevention of onward spread for an infected person).
- Establish clear lines of communication to ensure this is secured on a regular and frequent basis with all LTC staff.

Country examples:



In **Austria**, the Federal Ministry of Social Affairs, Health, Care and Consumer Protection has provided recommendations for preventive and protective measures for care workers in different settings and guidance on the use of face masks for health and social care professionals. The responsibility for the development of guidance in LTC settings, their implementation and monitoring has been given to newly established task forces (Schmidt et al., 2020).



In **Italy** the guidelines for nursing homes published by the Ministry of Health require providers to ensure the training of care workers (Berloto et al., 2020).



In the **Netherlands** the government became the centralized purchaser for protective equipment. Distribution is responsive to risk, which means that only LTC staff at risk will be provided with PPE (Kruse, Remers & Jeurissen, 2020).



In **Germany**, the Federal Ministry of Health as well as a number of federal states have become involved in the procurement of PPE (Lorenz-Dant, 2020b).



In **Ireland**, the performance of a risk assessment to ensure that facilities had adequate supplies, including PPE, has been recommended (Pierce, Keogh & O'Shea, 2020).



In **Slovenia** all care settings have prepared pandemic plans (Oven, 2020).

Policy objective 4: Implement safety measures that recognize the mutual benefits of the safety of people receiving and providing LTC services

The safety of those who use care services is inextricably linked to staff safety. Beyond the issues around IPC addressed in Policy objective 3, approaches have varied due to difficulties in some countries with managing shortages in testing capacity. Residents in care homes are particularly vulnerable as many people at high risk live in close spaces (often sharing rooms/community spaces) as care homes have not always been originally designed to accommodate infection prevention and control measures (WHO, 2017a). Where care home are not conducive to effective IPC, management facilities will need to be reorganized, re-zoned or alternatives will need to be considered and where they cannot be implemented to ensure national recommendations, including physical distancing measures, will need to be reassessed after the acute phase of the COVID-19 pandemic.

While measures restricting visitors into care homes, screening of staff, etc. have been adopted in most countries, it is important to recognize that these measures alone are not effective and a bundled approach is necessary. Furthermore, bans on visitors can have negative impacts on care home residents, and it is therefore important to look at ways of making visiting safer rather than keeping blanket bans active for too long.

The response to COVID-19 in LTC settings is based on early recognition, isolation, care, and source control (prevention of onward spread for an infected person).

WHO has issued an interim guidance aimed at preventing the COVID-19 virus from entering facilities, preventing COVID-19 from spreading within facilities, and preventing COVID-19 from spreading to outside facilities (WHO, 2020d).

Key actions

- Make available guidance and training for all LTC service staff and families on the necessary isolation and protection measures for those sick with COVID-19 or suspected of having COVID-19.
- Make available guidance and training for all LTC service staff and families on the necessary measures for those who are not sick but who are living in LTC facilities and LTC services.
- Make available guidance on thresholds as to when and how to phase in/out isolation of residents.
- Consider threshold points and guidance on when and how to restrict visitors to care homes.

- Consider developing and circulating standard operating procedures (SOPs) that give direction on how and when to rapidly isolate people receiving LTC services, using the most up-to-date COVID-19 guidance.
- Implement extended IPC precautions for people discharged from hospital.
- Consider making guidance available on how to divide nursing homes into isolation zones for suspected and confirmed COVID-19. In some facilities the physical layout may mean that this is not feasible, or there may not be enough capacity, in which case it is important to consider measures such as moving residents who are suspected cases for COVID-19 (either because of symptoms, contact with positive cases), or confirmed through testing, to alternative quarantine centres.
- Provide additional support, financial, human and material resources to LTC services to ensure LTC services can implement these measures.
- Translate any SOPs strategies into clear referral systems that are made available to all staff delivering LTC services.

Country examples:



In the **Netherlands**, the Dutch Health and Youth Inspectorate assesses how LTC providers manage the situation in their facilities. This includes the availability of PPE and quality and safety of care (Kruse, Remers & Jeurissen, 2020).



In **Ireland**, a Regulatory Assessment Framework published by the Health Information and Quality authority aims to support centres for older people in preparing for a COVID-19 outbreak. The self-assessment will be followed up by an on-site assessment (Pierce, Keogh & O'Shea, 2020). In addition, the Health Service Executive will provide expert advice and training. Where necessary, the Health Service Executive can support staff with alternative accommodation and transport. Each nursing homes will identify a person as a COVID-19 lead. National and regional outbreak teams have been set up to oversee, prevent and tackle COVID-19 clusters in residential LTC settings. A new Infection Prevention and Control Hub offers residential LTC settings guidance outbreak preparation and management, information on infection prevention and control, support with applying national advice in specific settings and responds to staff questions regarding infection prevention and control. There are also tele-mentoring interventions and webinars to support nursing homes. The Health Service Executive has also provided guidance for domiciliary care workers. In addition, the national membership organization of home care providers has developed a COVID-19-specific National Action Plan (Pierce, Keogh & O'Shea, 2020).



In **Germany**, the Robert Koch Institute has developed recommendations for care workers in different settings, including recommendations for domiciliary care workers. Recommendations on isolation and cohorting have been implemented across many federal states and rehabilitation hospitals, and other facilities have been cleared so that people could be moved there temporarily when on-site isolation is not possible. In the federal state of Bavaria a named commissioner for the pandemic should be appointed in each residential care setting (Lorenz-Dant, 2020b).

Policy objective 5: Prioritize testing, tracing and monitoring the spread of COVID-19 among people receiving and providing LTC services

Growing evidence of asymptomatic and pre-symptomatic transmission in care homes highlights the importance of regular prospective surveillance for COVID-19 among residents, visitors and staff (Arons et al., 2020). Geriatricians are also raising concerns that, among LTC home residents, the symptoms of COVID-19 may not be the typical cough and fever that is covered in the guidance documents for care homes in many countries, but that a range of other symptoms (delirium – hypo and hyperactive, diarrhoea, lethargy, falls and reduced appetite) are more frequent among care home residents with COVID-19 (British Geriatric Society, 2020a).

There is evidence that SARS-CoV-2 shedding is highest early in the illness (Zou et al., 2020). The potential for viral shedding from staff members with COVID-19 infection during either the pre-symptomatic or the mildly symptomatic phase of the illness reinforces current recommendations for expanded symptom screening for health care personnel in LTC facilities (WHO, 2020d).

Early identification, isolation and care of COVID-19 cases is essential to limiting the spread of the disease in the LTC facilities (WHO, 2020d; CDC, 2020). Knowing the scale of the problem helps prioritize resource allocations (in terms of which providers, which professionals and which people need more attention) (WHO, 2020b); however, currently, testing appears to be imperfect in most countries for affected older people in LTC facilities and in the staff (Comas-Herrera et al., 2020). Due to the high variability in regional policies on testing, the number of positive cases is understood to be much higher than the number of cases being reported (Berloto et al., 2020; Laurent, 2020).

Key actions

- Implement prospective surveillance for COVID-19 among residents, visitors and staff.
- Ensure facilities providing LTC services establish isolation and quarantine areas that are appropriate in size for the number of residents.
- Confirmed cases should be rapidly relocated to isolation areas to avoid crosscontamination with other residents and staff.
- Ensure that residents returning from hospitalization, or new residents to facilities, are placed separately in the isolation area for 14 days.
- Report COVID-19 cases occurring among people receiving care in LTC facilities, care homes or home care to health authorities.
- Ensure contact tracing and isolation based on contact with confirmed cases.
- Trace any clusters of infections or deaths of people in LTC facilities and care homes or in those receiving home care services.
- A mechanism should be set up to ensure these numbers are reported and analysed at least once a week by governments.

Country examples:



In **Austria** the government plans to test people living and working in care homes nationwide and to increase testing for hospitalized people in need of LTC to facilitate their discharge to the care setting (Schmidt et al., 2020).



In **Ireland**, people receiving and providing care in nursing homes are included as a priority group for testing. In addition, health checks are recommended for people receiving and providing care. Care workers in nursing homes will be screened for symptoms twice a day (Pierce, Keogh & O'Shea, 2020).



In the **Netherlands**, symptomatic care workers can be tested (Kruse, Remers & Jeurissen, 2020).



In **Slovenia**, mobile medical teams undertake testing in nursing homes (Oven, 2020).



In **Germany** the rules of testing vary slightly between federal states but most states require testing of all people receiving and providing care in contact with a confirmed COVID-19 case. In some federal states all residents and staff are required to be tested if a COVID-19 case is confirmed. Germany prioritizes contact tracing in residential care settings. In addition, the Robert Koch Institute recommends daily clinical monitoring of staff and residents and testing of at-risk populations at a low threshold (Lorenz-Dant, 2020b).

Policy objective 6: Identify and mobilize surge capacity to secure staff and resources for delivery of appropriate LTC services during the COVID-19 pandemic

As measures are pursued to test, isolate and increase existing funding and capacity for preventing and managing the pandemic, the issue however is one of mobilizing more human resources and space. More capacity, not less, will be needed to deliver LTC services as contact points will need to be minimized.

Additional human resources and space (surge capacity) will be needed both in hospitals to manage older people with dignity and respect but also in LTC services. Deploying additional health care staff to LTC systems has provided major relief and arguably increased capacity to prevent and manage the virus. As isolation requirements and plans are identified, more space will also be needed.

Ensuring LTC services and palliative care homes have adequate supplies of medicines and equipment is clearly vital for the response, and given the different procurement chains, it may be necessary for the health sector to coordinate and step in to help with supply. There are some examples where governments have stepped in with army personnel and fire brigades to help alleviate the pressure on LTC staff and resources.

Key actions

- Establish rosters and secure staff from health systems who can be repurposed to support staff in LTC settings.
- Estimate surge capacity needed to support LTC services in coordination with the focal point on LTC.

- Cooperate with the health sector to identify the health workforce available for LTC services.
- Secure and reorganize staff in both hospitals and LTC services to support accelerated discharge and admission to support the creation of additional surge capacity for COVID-19 patients in hospitals, while keeping people receiving LTC services and staff safe.
- Recruit additional staff – look to recruit retirees, students from health and long-term care training programmes, volunteers, people whose visas may place restrictions on them, and those who have left the sector.
- Allowing staff with restricted work visas to work more hours, and accelerate reregistration for those whose qualifications/registration may have lapsed.
- Address contractual and related issues and put in place policies that explain measures to keep staff safe but able to work in a flexible manner and move from health care services into LTC services.
- Where possible, reduce care home occupancy to facilitate management of potential outbreaks, or increase designated spaces in the community and hospitals to manage different stages of virus transmission.
- Consider short-term transfer of residents to alternative accommodation.

Country examples:



In **Austria** staffing and licensing regulations for care workers have been lowered substantially during the COVID-19 pandemic. This enables people who have done national service (mostly those who opted for civilian duties) to provide basic care. The government has the ability to enforce their employment as care workers. In addition, people undertaking training in relevant areas and interested unemployed people can also step in (Schmidt et al., 2020).



In the **Netherlands**, nursing homes can recruit care workers more widely (e.g. medical students) (Kruse, Remers & Jeurissen, 2020).



In **Ireland**, Nursing Homes Ireland set up a recruitment campaign for nursing homes (private and voluntary). There has also been an agreement that enables the Health Services Executive (HSE) to redeploy HSE staff to private nursing homes on a voluntary basis (Pierce, Keogh & O'Shea, 2020).



In **Slovenia**, medical teams can be deployed to residential care setting if the regular staff becomes exhausted or overwhelmed (Oven, 2020).



In **Germany**, residential care setting can deviate from some staffing rules and operational frameworks. Three federal states (Bavaria, Bremen and Rhineland-Palatinate) have created online registers where people with relevant qualifications but not currently practicing in the LTC workforce can register. In Bavaria, these volunteers can be freed from other employment and continue to receive their normal incomes (Lorenz-Dant, 2020b).

Policy objective 7: Scale-up support for family caregivers during the COVID-19 pandemic

LTC systems are characterized by a high reliance on family caregivers, many of which are themselves vulnerable (Colombo et al., 2011). The physical and mental implications on family caregivers have been well documented (Rodrigues, Huber & Lamura, 2012).

During COVID-19, as many day centres and respite services are closed, many carers have been given extra responsibilities, their support structures have disappeared and many have been left to fend for themselves. Women between the ages of 65–75, and men over 80 years are disproportionately affected in this (Wenham, Smith & Morgan, 2020). In some cases family caregivers can be very young. Understanding how these family caregivers experience their situation during the pandemic will be important (Carers UK, 2020a).






Despite playing a major role in the provision of LTC services, family caregivers were already rather neglected before the COVID-19 response (Brimblecombe et al., 2018). It will therefore be necessary to scale-up support for family caregivers. Furthermore, little evidence of additional financial/practical support in the context of COVID-19 has been recorded across the Region (OECD, 2019b; Carers UK, 2020b).

Important measures include providing information and training on how to care for their family member, with regards to IPC and any new technologies, medicines and equipment that are being used. Guidance and advice for these family caregivers who themselves may need to self-isolate is equally important (WHO, 2020c). Helplines can be helpful not only for information but for psychosocial support as an increased risk in violence and abuse has already been noted during this pandemic; this is something that family caregivers are particularly vulnerable to (WHO, 2020f).

Key actions

- Provide information, support and, if possible, respite care to caregivers, particularly those caring for older people with dementia, including information on how to manage increased care giving responsibilities and stress.
- Consider rolling out an assessment to monitor family caregiver needs.
- Develop information and training for family caregivers to keep them and the person receiving care safe.
- Develop clear guidance for family caregivers on when and how to self-isolate.
- Increase vigilance and monitoring of domestic violence towards family caregivers.
- Provide increased access to psychological support to family caregivers.
- Provide increased access to equipment and medications.
- Increase financial support for family caregivers.

Country examples:

-  In **Austria**, telephone hotlines providing psychological counselling; online support networks as well as guidance and resources are available for family carers. The Austrian Red Cross offers a dedicated online course for family carers.
-  In **Scotland (UK)**, as part of the emergency coronavirus legislation, the Scottish Government has proposed an additional £19.2 million investment in Carer's Allowance Supplement to recognize the additional pressure that carers are under as a result of the pandemic. This means that in June around 83 000 eligible carers will get an extra £230.10 through a special one-off Coronavirus Carer's Allowance Supplement. They will not need to do anything to get this extra payment as it will be paid automatically to people in receipt of the existing Carer's Allowance. (Government of Scotland, 2020a).
-  In **Ireland**, carers in receipt of the meanstested Carers Allowance continue to receive this financial support. Family carers who have lost their job qualify additionally for the Pandemic Unemployment Payment of €350. The Irish Life Insurance Company donated €350 000 to Family Carers Ireland. The organization has distributed information and advice to support family carers (Pierce, Keogh & O'Shea, 2020).
-  Family carers in the **Netherlands** should soon be able to qualify for symptomatic testing. In addition, guidelines on hygiene standards and for carers supporting a person developing COVID-19 symptoms have been issued (Kruse, Remers & Jeurissen, 2020).
-  In **Germany**, people with care needs in receipt of in-kind support, such as day care, that has become unavailable during the COVID-19 pandemic can be reimbursed (up to a limit) for replacement support. In addition, people with care needs are entitled for financial support (€125 per month) to reimburse recognized sources of support. In some federal states the barriers to becoming a recognized source of support have been lowered. In addition, existing legislation allows family carers to take leave to provide and/or organize replacement care. Family carers can also reduce employment for a certain period of time to provide care. An interest-free loan can be accessed to support the loss of income (Lorenz-Dant, 2020b).

Policy objective 8: Coordinate between services to ensure the continuum and continuity of LTC services during the COVID-19 pandemic

Several countries in the Region have issued guidelines preventing access to hospital care for older people. Such measures, however, are not recommended where basic clinical standards of care are not provided in by LTC services. Adequate and appropriate access to health care services needs to be adhered to both in terms of care home residents being transferred to hospital when appropriate, but also the provision of services in their homes and by primary care. In the context of an acute infection, such as COVID-19, saturation monitoring and early oxygen supplementation by mask or nasal prongs once oxygen is below 95% is recommended (WHO, 2020h). If LTC services and facilities are not able to provide this to dyspnoic patient, then the patient should be offered a placement where such treatment can be provided. Neglecting to do so is a matter of denying these individuals access to care (WHO, 2020h). Examples of older people being denied care (ie. counselling, access to oxygen, saturation monitoring or access to hospitals or critical care) on the basis of their chronological age, their vulnerability or displaced notions of utility are concerning and are not recommended.

Guidance available for maintaining essential health services has been provided by WHO (2020f). As countries try to maintain the continuum and continuity of LTC services, increased scrutiny and attention will need to be devoted to the coordination between the health system and the LTC system. As attention for maintaining health services during COVID-19 turns towards different platforms or modalities of care (WHO, 2020e; WHO 2020i) and new or alternative escalation of care strategies are considered for hospitals (Bennold, 2020), special attention will be needed in terms of how older people receiving LTC services react and adjust to these changes and to ensure that these strategies are appropriate. While technologies can be sometimes used to engage with older people, these technologies are often inappropriate for older people.

People with care needs (especially some groups, such as people with dementia) build relationships with their carers. It is difficult for them to adapt to other people or to carers wearing protective equipment. People in care homes often benefit from routines (including activities) and these have now been disrupted. It is therefore important to emphasize the fragile balance that needs to be considered between keeping older people safe with regard to COVID-19 and also safe from neglect and isolation, given emerging evidence (Diamantis et al., 2020).

Hospitalization can be highly stressful (especially for people with a cognitive impairment). Sudden or unplanned discharge from hospitals are often disruptive for older people, but during COVID-19 they can be dangerous, given that some people may still have the virus and be infectious to others they meet in the community (WHO, 2020c) or encounter in LTC facilities (Lorenz-Dant, 2020a). Focusing efforts on how to avoid admissions from LTC facilities or homes to hospitals with strong rapid response teams that can visit older people in their homes or in facilities will need consideration, and it will be necessary to ensure that people are being transferred to hospitals only when appropriate and, when appropriate, are given access to health care services within LTC settings.

Key actions

- Establish clear criteria for LTC services on when and how people living in LTC facilities can move to and from hospitals to protect both staff and other residents.
- Consider developing clear protocols with regard to escalation to primary and secondary care for both COVID-19 and non-covid-19 symptoms.
- Optimize and adjust current delivery platforms and develop alternative delivery platforms for LTC services in line with older people's needs.
- Establish rapid response teams with geriatric training to reduce avoidable hospitalizations.
- Consider appropriate tele-health and virtual technologies for consultations, in consultation with older people, and provide any supports necessary to use this technology effectively.

Country examples:



In the **Netherlands** general practitioners (GPs) have been asked to monitor people who are housebound and frail and to take on the case-manager role if they develop COVID-19 symptoms (Kruse, Remers & Jeurissen, 2020). Health residents in Slovenia, where possible, will be moved to other facilities if a COVID-19 case emerges in a care home (Oven, 2020).



In **Germany**, the National Association of Statutory Health Insurance Funds enables reimbursement of replacement support if usual care cannot be provided. The Robert Koch Institute has issued recommendations for the discharge of patients from hospitals to different care settings. Some federal states have implemented legislation, such as required testing before transferring residents between care settings; other federal states have created capacity in different care settings, such as rehabilitation hospitals (Lorenz-Dant, 2020b).

Policy objective 9: Secure access to dignified palliative care services during the COVID-19 pandemic

Providing access to quality care also includes access to palliative care where this has been requested by an individual in an informed manner and once all treatment measures have been considered. Under no circumstances is it appropriate to justify palliative care without proper counselling. Nor should palliative care plans, advanced directives or do-not-resuscitate directives be left unreviewed with individual and their families in the new COVID-19 context, without clarifying that their wishes are to pursue palliative care despite COVID-19. Palliative care plans and advanced directives on end of life may have shifted in some cases in the COVID-19 context and will therefore need to be revisited; the pandemic has placed additional pressure on palliative care which will need to be addressed.

Further, for those who request continuing with palliative care, this care will need to be provided in a safe and secure manner. Clinical management specific to COVID-19, including the provision of oxygen, should be considered (WHO, 2020h). Palliative care is needed for people in facilities but also for people in their own homes. Many people receiving palliative care receive it at home and, when given a choice, most people wish to die at home which makes palliative care an essential service that needs to be integrated and maintained (WHO, 2018a).

Barriers to providing quality palliative and end-of-life care include lack of IPC standards, access to palliative care medication and inconsistent financial measures to support palliative care (Bauer, Dixon & Comas-Herera, 2020).

Finally, all people dying of COVID-19 should have the right to die with dignity and to have access to palliative care if all other measures have been taken to provide quality care, including oxygen therapy. No person in need of palliative care, including end-of-life care, should be abandoned or neglected. This will require palliative care capacities to be increased in hospital settings and will involve staff who are not familiar with palliative care methods.

Key actions

- Ensure all palliative care plans and advanced directives are revisited in the context of COVID-19.
- Ensure national and regional policies, programmes and guidelines to support the provision of palliative care in care homes are revisited in the context of COVID-19.

- Incorporate a palliative care training curriculum and core competencies for staff who are not already familiar with palliative care and who may need to have these competencies.
- Ensure that older people receiving palliative and end-of-life care and their loved ones continue to receive psychological and spiritual support.
- Include palliative care data in care homes as a part of national minimum data sets and reporting.
- Ensure quality standards are in place and staff are trained to discuss advanced care planning based on informed, inclusive and autonomous decisions.

Country examples:



The national association for palliative care in **Austria** has issued a position paper on palliative care during the COVID-19 pandemic and has provided guidance on ensuring access to palliative care who will not receive the intensive care that normally is provided. The association also published guidelines for family caregivers and LTC workers. Furthermore, multidisciplinary guidance provided by the government is available to support people with COVID-19 who are reaching end of life. There are also clinical guidelines and resources on how to facilitate social support and on bereavement for family carers and care workers supporting a person who reaches the end of life during the COVID-19 pandemic (Schmidt et al., 2020).



In **Germany**, people at the end-of-life living in residential care settings can receive visitors. In addition, guidelines from the federal state of Baden-Württemberg have been produced on advance directives in the context of COVID-19 (Lorenz-Dant, 2020b).



In **Ireland**, a section on pastoral care, care of the dying and those recently deceased has been added to interim guidance (Pierce, Keogh & O'Shea, 2020).

Policy objective 10: Prioritize the emotional well-being of people receiving and providing LTC services throughout and after the COVID-19 pandemic

Staff well-being is a major concern during the COVID-19 pandemic and reduced staff well-being may be attributed to higher rates of infection and burn-out. Various resources are being developed to support health workers. As resources are developed, it will be important that LTC staff have parity with health service workers in terms of the support available to them. Similarly extra measures will need to be taken to support the high number of migrant workers that make up this sector (Erizanu, 2020).

The Inter-Agency Standing Committee has described the potential mental health and psychosocial supports (MHPSS) to be delivered at four levels (IASC, 2020): specialized one-to-one counselling; non-specialized counselling, but delivered one-to-one by health professionals or trained community members (WHO, 2011); strengthening family and community supports; and basic services and social security. Health systems can roll out measures on the first two levels by ensuring these resources are available, but can also work with other ministries to establish the support needed at the last two levels.

In terms of people receiving care it has already been made clear that many people receiving LTC services benefit enormously from interactions with staff, their caregivers and families. Social participation,

meaningful activity and engagement and social contact is important to the well-being of older people. These interactions also decrease the rate of medical errors, and hospitalizations, so protecting the continuity of these relationships are a matter of safety for older people.

In a COVID-19 context that promotes physical distancing, older people in isolation and especially those with cognitive decline/dementia may become more anxious, angry, stressed, agitated, withdrawn and overly suspicious during the outbreak and while in quarantine (Social Care Institute for Excellence, 2012; IASC, 2020; NICE 2015; Wang et al., 2020). In addition, emerging evidence is also showing a rise of abuse towards older people. Before the pandemic, it was estimated that 16% of older adults over 60 were affected by some form of abuse (Yon et al., 2017; 2019). That number was even higher for at-risk individuals, including people with physical or mental disabilities and people living in LTC facilities (Storey, 2020). Since the pandemic began, it is believed that abuse towards older people has risen as much as tenfold (CTV, 2020). This has occurred in the community, in institutions such as residential and nursing care facilities for older people, and online, with a surge in scams directed at older people. Lockdown and “stay-at-home” orders, likely to last longer for older people, are fuelling precisely those factors which put older people at risk of violence (Storey, 2020): even greater social isolation, more mental health problems, increased dependency on carers, more alcohol and substance abuse, and increased financial difficulties. Ageism, pervasive before the pandemic and a risk factor for violence against older people, has become worse during this pandemic which disproportionately affects older people (Han & Mosqueda, 2020) and gender inequalities have been compounded increasing risks of gender-based violence against older women (WHO, 2020g). The impact of the pandemic on institutions for older people, leading to staff reductions due to illness and suspension of family visits, is increasing the isolation of residents and the already high risk of violence (Gardner, States & Bagley, 2020). It is important for decision-makers therefore to take an active role in monitoring and preventing this violence. Equally important is the provision of resources to families to understand what constitutes abuse of older people and what the signs of it are.

Key actions

- Establish a intersectoral working group to monitor LTC staff stress and burnout, assess and implement strategies to provide MHPSS to staff delivering LTC.
- Establish a dedicated hotline for psychological support for anyone who requests it.
- Scale-up access and resources for migrant live-in care workers.
- Consider introducing psychological first aid training for volunteers and community members to support staff in high stress areas, using digital and other platforms. Consider child care and other care support options for health workers; for example, when schools close due to spatial/ social distancing measures, or for health workers with caring commitments for older relatives.
- Increase recruitment of retirees and volunteers to help with providing social interaction for isolated residents.
- Create awareness of increased risk of violence against LTC staff and older people in the public and provide information via radio, TV, print media and the Internet on how victims can seek help and receive support safely.

- Support the monitoring of violence towards older people using short-item elder abuse screening tools; facilitating residents' contact with family and friends by phone, the Internet or via written messages if access is restricted; review staffing procedures (e.g. flexible schedules, work breaks) to better manage the burden of care; and seek to reduce the use of physical restraints.
- Ensure mental and emotional support is available from mental health professionals and family caregiver networks, including families using digital media when required.

Country examples:



In **Austria** an organization support people with mild dementia through telephone counselling, group calls and video encounters. Counselling services for migrant care workers are available through the Chamber of Commerce. In addition, online support networks have developed (Schmidt et al., 2020).



In **Ireland**, information of activities that could be offered to people living in residential care settings and on ways to maintain contact with families has been provided to mitigate the impact on visiting restrictions. In addition, the national initiative “Comfort Words” is encouraging children to write to people living in nursing homes. For people living in the community, the volunteer based initiative “Community Call” support vulnerable people with collection and delivery of groceries, communication or meal deliveries. A telephone helpline has also been launched (Pierce, Keogh & O’Shea, 2020).



In **Slovenia**, it has been announced that a psychosocial assistance network will be started to support care home staff (Oven, 2020).

Definitions

Long-term care services. The activities undertaken by others to ensure that people with a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity (WHO, 2015). Throughout the document, the use of the term long-term care services necessarily covers both community-based care and residential and nursing homes (or other group living facilities), unless otherwise specified.

Long-term care systems. National systems that ensure integrated LTC that is appropriate, affordable, accessible and upholds the rights of older people and caregivers alike. Depending on the national context, funding and care may be provided by some combination of families, civil society, the private sector and/or the public sector. Governments do not need to do everything but should take overall responsibility for ensuring the system’s functioning (WHO, 2015).

Family caregiver. This document uses the family caregiver to refer to someone providing unpaid care to a family member, friend neighbour or volunteer (WHO, 2015). Unpaid care work is defined as an individual’s activity to provide what is necessary for the health, wellbeing and maintenance and protection of someone or something that involves mental or physical effort, is costly in terms of time resources and is not remunerated (WHO, 2018b).

Key WHO documents

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