

The growing need for home health care for the elderly

Home health care for the elderly as an integral part of primary health care services



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Introduction

Population ageing and the rapid increase in the percentage and number of elderly people is a global phenomenon resulting from decreasing fertility and increasing life expectancy (1). It is expected that by 2030, more people than ever will be at risk of developing the chronic diseases, ill-health and dependence that often accompany advanced old age.

It has been estimated that in 2050, there will be two billion people over the age of 60 years, with 80% of them living in developing countries (2). The global shift in the burden of illness from acute life-threatening infectious diseases to chronic disabling noncommunicable diseases associated with population aging can cause limitations with temporary or permanent functional disabilities and diminished quality of life. This will be a major challenge for the health care delivery system due to the increased costs of health care and long-term care (3). It is also a challenge for the community and government to find alternative care strategies to meet the specific demands of the elderly and their families (4). It had been reported that in United States of America (USA), in 2007, more than one million men and women, aged 65 years and over, received home health care each day (5).

The Eastern Mediterranean Region is experiencing a fast rate of development and urbanization and an aging population, with the prevalence of noncommunicable diseases increasing at alarming rates that exceed those of

Data collected by the STEPwise survey among adults, aged 15–65 years, in the World Health Organization (WHO) Eastern Mediterranean Region found that almost one quarter of the adult population was hypertensive. A high prevalence of hypercholesterolaemia was also noted, ranging between 20% and 40%. Furthermore, six out of 10 countries with the highest prevalence of diabetes in the world are from the Eastern Mediterranean Region: Bahrain, Egypt, Kuwait, Oman, Saudi Arabia and United Arab Emirates (6).

All these changes are leading to increasing demands by this increasing segment of the population on the health systems in the countries of the Region for affordable and quality health care for the elderly (7).

The definition of “older adult” varies, depending on different perspectives and purposes. For example, gerontologists traditionally focus on persons aged 60 years and older. Researchers identify subgroups of “older adults” as “younger old” (65–75), “older-old” (75–85), and “oldest old” (85 +). Age ranges vary across studies (8).

In 1991, the Thirty-eighth session of Regional Committee for the Eastern Mediterranean passed resolution EM/RC38/R.7, urging both Member States and WHO to take urgent measures to promote and protect the health of older people so that they can lead healthy and active lives.

Given the above, the WHO Regional Office for the Eastern Mediterranean has produced this report to examine the need for home health care for the elderly as an integral part of primary health care services. The home health care approach has been proven to be cost-effective in providing needed health services for the elderly in their homes. The report reviews the requirements for providing home health care services in terms of the kind of services required, who can provide the services, and eligibility for receiving the services, as well as the benefits and cost-effectiveness of home health care,

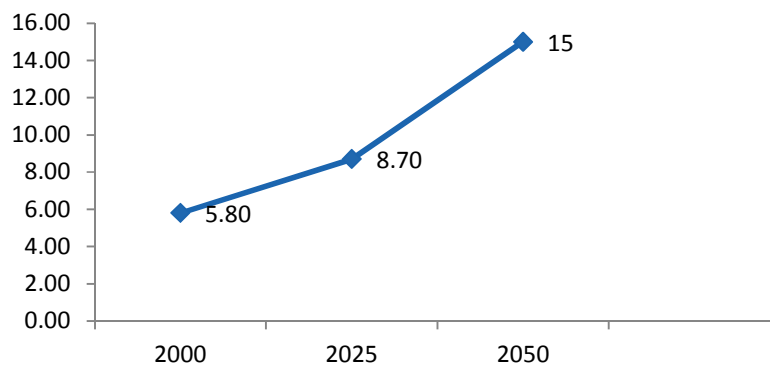
patient satisfaction, quality assurance and patient safety in providing the services in home settings, establishing an effective referral system, and experiences from other Regions. The report provides evidence-based advocacy material for integrating home health care in health care delivery in the Eastern Mediterranean Region and encouraging countries to develop national strategies for promoting home health care.

Demographic profiling and trends in ageing and chronic diseases

Chronic diseases are defined by WHO as those conditions requiring “ongoing management over a period of years or decades”. Chronic illnesses include heart disease, diabetes, hypertension, chronic obstructive pulmonary disease, asthma and cancer. This definition can be further expanded to include some communicable diseases such as HIV/AIDS, as well as mental disorders, vision and hearing impairment, genetic disorders and musculoskeletal disorders. Most of these conditions and illnesses are common in old age and require a complex and comprehensive response over an extended time period by a wide range of health professionals, along with access to essential medicines and monitoring systems.

The Eastern Mediterranean Region is experiencing an increase in the number and percentage of the population aged 60 and over, and epidemiological research reveals high levels of chronic, noncommunicable diseases and disabilities among older age groups in the Region. Based on the Pan Arab Project for Family Health (2008) survey conducted in nine Arab countries by the League of Arab States, the percentage of older adults suffering from at least one chronic disease ranges between 13.1 % in Djibouti and 63.8 % in Lebanon, with the majority of the countries having rates above 45%.

Over the past decades, many countries in the Region have experienced changes in trends and projections in the demography of aging (Fig. 1), increased percentages of the population aged over 60 years and increased life expectancy at birth (Annexes 1 and 2). This is an important driver of increases in the total burden of noncommunicable diseases.



Source: Global status report on noncommunicable diseases 2010. Geneva: World Health Organization; 2011.

Fig. 1. Projections trends (%) of persons aged 60 and older in the Eastern Mediterranean Region

Table 1. Life expectancy at birth in the three groups of countries

Life expectancy at birth	Group 1	Group 2	Group 3
More than 70 years old	Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates.	Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Libya, Morocco, occupied Palestinian territory, Syrian Arab Republic, Tunisia	
Between 60 to 69 years old			Pakistan, Yemen
Less than 60 years old			Afghanistan, Djibouti, Somalia, South Sudan and Sudan

Countries of the Region can be categorized into three groups based on population health outcomes, health system performance and level of health expenditure. Group 1 comprises countries where socioeconomic and health development has progressed considerably over the past decades. Group 2 comprises largely middle-income countries which have developed extensive public health infrastructure but face resource constraints. Group 3 comprises countries which face constraints in improving population health outcomes as a result of lack of resources, political instability and other complex development challenges. Table 1 summarizes the life expectancy at birth for the countries in each group (see Annex 2).

Why home health care?

The aging of the population as a whole, and the growth of the very oldest segments within it, are associated with the transition from informal to formal home health care delivery (9,10). Home health care is defined by the National Clinical Homecare Association (2011) as “the provision of medical supplies and/or clinical services directly to patients in the community”. Many different treatments can be delivered in this way, covering a wide range of conditions and therapy areas. Treatment is delivered and/or administered by an appropriately-qualified health care staff/volunteer under the direction of a referring clinician (family physician), who remains responsible for, and in control of, the patient’s care (11).

The provided services may include medical, psychological or social assessment, wound care, medication education, pain management, disease education and management, physical therapy, speech therapy, medication reminders, and empowerment for health promotion and prevention.

Home care can also be an integral component of the post-hospitalization recovery process (transitional care), especially during the initial weeks after discharge when the patient still requires some level of regular physical assistance.

Home health care services must be individually planned and coordinated packages of care tailored to help the elderly receive the needed services while remaining in their own homes. Home health care is usually less expensive, more convenient and as effective as care received in a health care facility (12).

It has been suggested that in-home and community-based services contribute to encouraging individuals to live independently at home as long as possible (13) and that the users of home and community-based services are less likely than non-users to be hospitalized or institutionalized.

Home health care will reduce pressure on family members — many of whom are already balancing full-time employment and parenting — to act as care providers. It is also the most cost-effective way to increase access to primary health care services for such a vulnerable group.

Current challenges in elderly health services

Health systems in the countries of the Eastern Mediterranean Region are supposed to provide quality health care to their populations. However, care of the elderly as a special group has not been paid enough attention in most countries of the Region.

Geriatricians or physicians with specialist training in the care of the elderly are rare among medical practitioners in both the public and private sectors. Health professionals in medical, nursing and paramedical fields do not receive enough education about the elderly either in the curricula of medical schools nor through in-service training activities.

The health system in the countries of the Region must consider the following changes for better provision of services for the elderly.

- The style of medical care will need to change from one-time interventions that correct a single problem to the ongoing management of multiple diseases and disabilities. Doctors and patients will have to have an ongoing relationship designed to help patients cope with illnesses rather than curing them.
- With chronic illness often comes disability that requires accessible long-term care services, such as home health care, nursing homes, personal care and day care. In addition, the empowerment and training of family members as caregivers must be done.
- New ways will be needed to integrate medical and long-term care services in routine primary health care services.

The Madrid International Plan of Action on Ageing (2002) and the Political Declaration adopted at the Second World Assembly on Ageing in April 2002, prioritize access to primary health care in order to provide the regular, continuing contact and care that older people need to prevent or delay the onset of chronic, often disabling diseases.

Many countries are trying to find ways to improve the provision of home care, rather than invest in more institutional care. For instance, in Illinois in the mid-western USA, the Department on Ageing spends about US\$ 117 per day for people in nursing homes, compared to a monthly cost of just US\$ 650 for home care (14).

Studies have shown that home assessment and the resulting tailored interventions can reduce recurrent falls of old people by 36% (15) or 38% (16).

The concept of “home health care” is that health care professionals provide the required health care in the patient’s home making it possible for people to remain at home rather than using institutional-based nursing care.

Primary care and home health care for the elderly (17)

Primary care is not a fixed organizational structure but a combination of functional characteristics which has developed to respond to the emerging needs of the population. Comprehensive primary health care offers health promotion and preventive measures from which older people may benefit in terms of their health and independence. Proactive geriatric assessment of individual medical, functional and social needs, including loneliness and isolation, has been shown to be useful if it is incorporated in primary health care.

As most people prefer to be in their own environment (home, community) during the last stage of life, so providing end-of-life care in the community is a challenge for primary care because it requires continuity, coordination and trained health care outreach teams. The composition of teams and how to provide individualized care with standardization at the organizational level are among the main challenges in this. However, successful models of care do exist in some countries outside the Region.

The Thirty-eighth session of Regional Committee for the Eastern Mediterranean passed resolution EM/RC38/R.7, which urged both the Member States and WHO to take urgent measures to promote and protect the health of older people so that they can lead healthy and active lives.

At the Fiftieth session of the WHO Regional Committee for the Eastern Mediterranean in 2003, a technical paper on health care of the elderly in the Eastern Mediterranean Region, its challenges and perspectives, was presented and discussed. The Regional Committee adopted resolution EM/RC50/R.10 regarding health care for the elderly in the Region and advised Member States to undertake a comprehensive review of their national policies and strategies for care of older people to improve the integration and coordination of health and welfare programmes and services in addressing their needs and to improve primary health care systems for the promotion of healthy lifestyles throughout the life course.

There is also a need for the creation and maintenance of an up-to-date database for evidence-based decision-making regarding comprehensive care for the elderly at country level as an integral part of the primary health care system. This requires the support of research and training in the health of elderly people and community care.

Primary health care needs to be strengthened to become the centre for health care provision to the elderly, including home care through the outreach teams, based on a country's resources and situation.

Delivering continuous, integrated case-management care to older people must be a central theme in primary health care, especially with the increase in the elderly in all countries.

What services can be offered in home settings?

Home health care services must be flexible and designed to fulfill individual health care needs. The types of services that may be provided as part of the home health care package include the following.

- Health education: for the elderly and family members, including on nutrition, prevention of falls, healthy lifestyles, and so on.
- Personal care: exercising, checking vital signs such as blood pressure, pulse, heart rate and blood glucose level.
- Preventive services and early detection: prevention of bed ulcers, dressing of wounds if needed, measuring blood pressure, regular laboratory tests, breast self-examination.
- Psychosocial support and social services: counselling for the elderly and family members. Studies on social support as a determinant of health of the elderly conclude that social support slows cognitive decline, the onset of dementia and the progression of disability (both mental and physical) (18).
- Building the capacity of family members to provide day-to-day care.
- Management of simple diseases and follow-up.
- Transitional home health care (after release from hospitalization) to empower the elderly to become more involved in managing their chronic illnesses and more confident in communicating with health care professionals (19). Many studies have found that patients who received transitional home health care are approximately half as likely to return to hospital as patients who do not, and that this positive health outcome continues for more than six months (19).

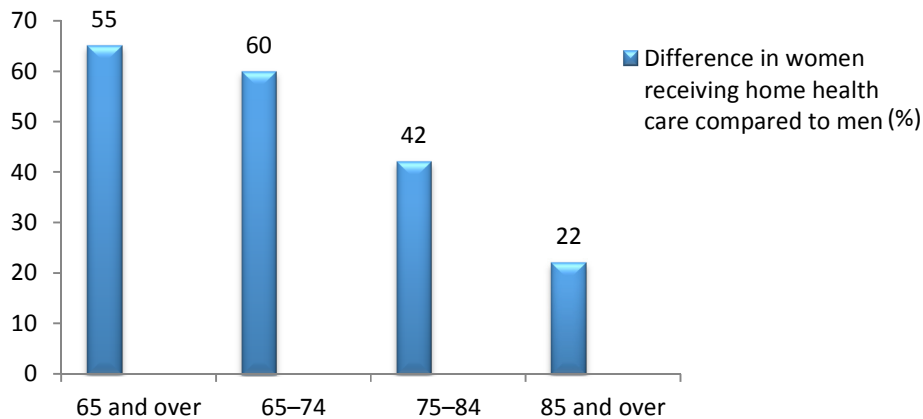
Linking the elderly and their families with other services in the community, such as supported housing, community social services and volunteer-based services.

Health care for aging populations is a challenge not only for their families but also for health care systems. Elderly patients do not have special care systems, such as special units, separate wards in hospitals, special outpatient facilities, and no outreach services exist for the elderly at the community level. The integration of care of the elderly

Who is eligible for receiving home health care services (20)?

The elder person can receive home health care if he/she is under the care of a primary health care doctor (family physician) and is certified that he/she is:

- housebound because leaving home is not recommended because of a health condition or cannot be done without help, such as using a wheelchair or walker, needing special transportation, or getting help from another person
- in need of skilled nursing care
- in need of physiotherapy and psychosocial therapy
- in need of social services: counselling for the elderly and family members
- in need of transitional home health care after release from hospitalization.



Source: Based on data in (21)

Fig. 2. Gender differences in the use of home health care (%)

A gender perspective on home health care

In all the countries of the Region, the life expectancy at birth is higher among females (see Annex 2), so gender must be taken into consideration to assist health care providers in planning and implementing home health care, such as the kind of services needed, appropriate care providers, cost of services and financial coverage.

For instance, in the USA, the Centers for Disease Control and Prevention's National Center for Health Statistics has estimated the differences in the use of home health care between men and women aged 65 years and over through reviewing the data from the 2007 National Home and Hospice Care Survey (21). The study revealed that there are gender differences in the use of home health care among adults aged 65–84, with women having significantly higher rates of home health care use than men (Fig. 2).

Among home health care patients aged 65 years and over, men were more likely than women to receive home health care immediately after an inpatient stay and more likely to receive services that were associated with post-acute care such as wound care and physical therapy, while women were more likely to receive housekeeping services and to receive home health care for longer periods of time. Men aged 65 and over were more likely to have their spouse as their primary caregiver; whereas women were more likely to be widowed and rely on an adult child or other non-spousal family member as their primary caregiver. Women aged 65 and over were more likely than their male counterparts to have essential hypertension and osteoarthritis and allied conditions and less likely to have cancer (malignant neoplasms).

Benefits and cost-effectiveness of home health care

The social costs of hospitalization of the elderly are growing (22) and the majority of elderly people prefer to stay in their homes, even if they have a serious disability (23). A study conducted in Japan on the impact of home and community-based services on hospitalization and institutionalization found that

users of home and community-based services were less likely than non-users to be hospitalized or institutionalized (13).

Two possible mechanisms may explain the effects of home health care services in preventing hospitalization and institutionalization: one is that home health care services prevent a decline in the physical and mental state of individuals certified as needing long-term care (prevention of decline) (24), and the other is that these services reduce the care burden of caregivers, allowing them to maintain their ability to provide care (maintenance of caregivers' ability) (25, 26, 27).

One of the best ways to track the impact of reduced access to home health care services is to look at the number of hospital patients who do not require acute care but continue to occupy a hospital bed because the appropriate residential or home health services are not available. These patients are called "alternate level of care" (ALC) patients. The British Columbia Health Coalition in Canada reported that between 2005/06 and 2010/11, there was a 35.5% increase in the number of hospital beds across British Columbia occupied by people classified as ALC patients (28).

Workforce planning: who can provide home health care?

Home health care can be provided by:

- community health workers/volunteers
- nurses
- social workers
- general practitioners/family doctors
- nutritionists
- physiotherapists
- geriatricians and specialized physicians (psychiatrists, cardiologists, etc.).

Training needs

While training programmes may vary according to health needs, previous education and qualification of service providers, required tasks and kind of services that will be provided, there must be a minimum number of training hours (theoretical and didactic) and the passing of a competency exam to obtain certification.

The training must cover the following general areas:

- communication skills
- counselling
- patient support
- wound care
- nursing services
- emergency and first aid management
- professional training and skills according to the task
- health care supervision
- monitoring and case evaluation
- case assessment and information management.

Patient satisfaction and quality of home health care

The demand for high quality home care needs to receive more recognition to make home care more responsive and flexible to meet people's aspirations and needs. Delivery of high quality home health care services must be designed around the needs and desired outcomes of the service users. So user satisfaction is one of the most important efficacy indicators in home health care for assessing quality (29). Home care presents a significant challenge in terms of ensuring quality and patient satisfaction.

The investigation of quality of care from the patient's perspective of home health care represents a challenge due to the multidisciplinary nature of home health care services and because users are often in vulnerable circumstances and it is more difficult to observe them than in a hospital ward or other health facilities.

So quality assurance and safety assessment of provided home health care services must be based on the feedback that is received from the patient themselves and their families.

The following are the main basic quality requirements for providing home health care services.

- Privacy and dignity.
- Involving people in making choices and decisions about their care.
- Assessment of individual needs when the home care service starts.
- Care delivery planning based on assessed care needs. This requires high priority in terms of regular reviews and updates to make sure that care plans reflect people's current needs and preferences. This allows any changes in needs to be quickly identified and monitored. Quality of care plans should be regularly assessed and form part of staff development plans.
- Safeguarding and safety. It is unacceptable to come across any staff providing intimate personal care to people in their own homes who do not fully understand their responsibilities with regard to safeguarding and whistleblowing.
- Commitment to infection control and patient safety measures.
- Medication management to prevent adverse events associated with poor medication management. It had been found that many older home health care patients have a potential medication problem or are taking a drug considered inappropriate for older people who are especially vulnerable to adverse events from medication errors. Older people often take multiple medications for a variety of comorbidities that have been prescribed by more than one provider (30).
- Wound and pressure ulcer prevention and management.
- Supervision and monitoring of quality on a regular basis.
- Continuous training of staff and refresher training of family members based on the patient's case and condition.
- Risk assessment and management.
- Managing and monitoring complaints.
- Continuity of care workers. The elderly are often psychologically fragile and prefer to receive their care by the same care workers and not by a series of strangers in their own home.
- Establishing an effective referral and feedback system.

A set of indicators can be developed based on these key elements to be used in quality assessment.

Infection prevention and control, and patient safety, in home health care

Current infection control guidelines for acute and long-term care institutions have been used to “bridge the gap” with home health care settings (31). Although home health care differs from institutional health care settings, adapting institutional infection control guidelines to home health care can be done (32). However, the risks of transmission of infection associated with multiple patients receiving care from multiple providers in one area of an institutional setting are not present in the home health care setting.

For instance, some home health care agencies in the USA have adapted infection prevention and control guidelines from the Association for Professionals in Infection Control (33), the Centers for Disease Control and Prevention (CDC) Healthcare Infection Control Practices Advisory Committee (HIPAC) (34), or the US Department of Health and Human Services.

The following are recommended based on the results of a study on infection control in home health care (35).

- Standardization of infection prevention and control practices in home health care.
- Providing infection prevention and control educational programmes for frontline staff on an ongoing basis. These educated frontline clinicians can then teach their patients/families about standard precautions, hand-washing and basic infection prevention.
- Establishing strategies and methods for monitoring and improving clinician adherence to recommended practices and evaluation of patient and caregiver implementation of infection prevention and control practices.
- Assessing infection risk during the provision of home health care that address the home environment and cleaning.
- Regular reporting and feedback for refining and improving home health care infection prevention and control measures.

Establishing a referral system

The presence or absence of referral systems and the degree to which they are effective are indicators of access to care. This requires a range of skills, facilities and health care professionals/workers at different levels of care in order to best serve the needs of a given population. A two-way referral system in home health care delivery should be in place to allow an effective two-way relationship between the primary health care provider and a higher-level hospital or facility. A model public health referral system is illustrated in Fig. 3.

Referrals may come through the hospital discharge planner, a social worker, physician or nurse. Before designing a home health care referral system, the following activities must be undertaken.

- Examining existing referral policies, protocols (standard case management, treatment protocols and guidelines) and administrative guidelines between levels of care.
- Categorizing services that can be provided at home settings and health facilities at all levels (primary, secondary and tertiary).

- Mapping health care facilities according to the kind and level of services provided, taking into consideration geographical factors, time, affordability and emergency services.
- Reviewing the current health service referral system (horizontally and vertically) and critically assessing the strengths and weaknesses of the system in terms of monitoring, supervision and evaluating the quality of care, referral practices and feedback mechanisms.
- There are other factors that should be in place in order for referral systems to function effectively, including the availability and competency of health workers personnel, clearly defined roles and responsibilities, and referral back to the primary care level after discharge.
- Referral from home to higher levels of care should occur when the patient needs a specific procedure, such as a laboratory examination, X-ray or physiotherapy, that cannot be done at home, requires a technical intervention that is not within the capacity of the home health care providers or when a patient needs surgery or in-patient care. In these cases, a suitable way of transferring the patient must be agreed (such as in an ambulance).
- For cases of post-acute care or release from hospital to receive further treatment as transitional home health care, a special format must be designed to clarify the required services.

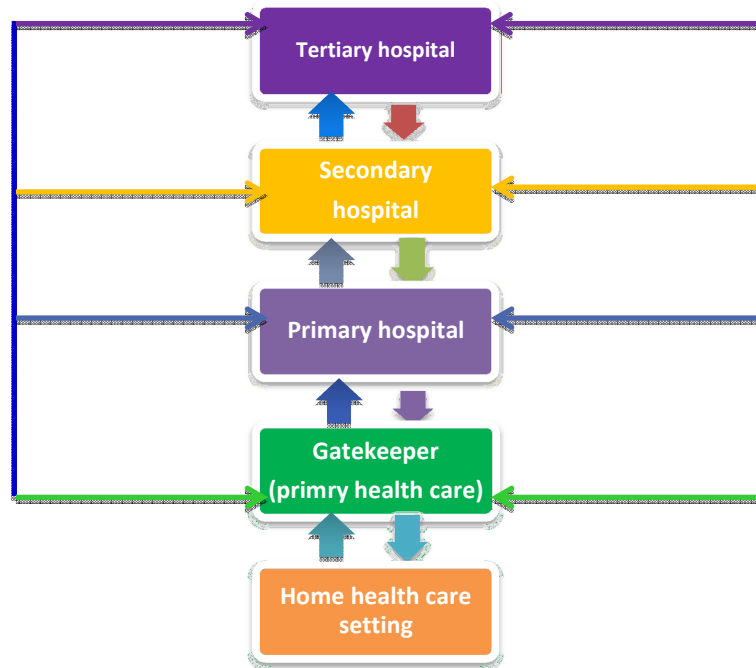
Successful home health care experiences

The role of insurance programmes in home health care: Medicare and home health care in the USA (20)

Like the rest of the world, the USA is an ageing society. Between 2000 and 2050, the number of older people is projected to increase by 135%. Moreover, the population aged 85 and over, which is the group most likely to need health and long-term care services, is projected to increase by 350% by 2050. This will increase burden on publicly-funded health, long-term and income support programmes for older people (12). Medicare is a publicly financed and administered, social insurance programme for home health care in the USA. In addition to older people, who have a significant work history, the programme also covers younger people with disabilities.

Medicare pays for getting home health care services if the patient meets certain eligibility criteria and if the services are considered reasonable and necessary for the treatment of illness or injury as certified by medical doctors. The programme operates as an open-ended entitlement to individuals. Medicare covers a fairly broad range of services, but does not cover prescription drugs outside of institutions, dental services or eyeglasses, and has extensive cost-sharing requirements. Some states are developing pharmaceutical assistance programmes for the low-income elderly and disabled populations.

Home health care services must be provided under the direction of a referring clinician, who remains responsible for, and in control of, the patient's care.



Source: Adapted from Innovative care for chronic conditions: building blocks for action. Geneva: World Health Organization; 2002.

Fig. 3. Model home health care referral system

Medicare covers the following home health care services.

- Skilled nursing care: skilled nursing services are provided by registered or licensed nurses. Home health nurses provide direct care and teach the patient and family how they can continue caregiving at home. They also manage, observe, and evaluate the patient's status. Examples of skilled nursing care include: giving intravenous drugs, injections or tube feeding; changing dressings; and education on taking prescribed drugs or diabetes care.
- Physical therapy, occupational therapy and speech pathology services.
- Medical social services: these services are provided by social workers or medical doctors to help patients to overcome the social and emotional concerns related to the illness. This might include counselling or help finding resources in the community.
- Medical supplies: supplies, like wound dressings, are covered when they are ordered as part of the care.

Medicare beneficiaries have complete freedom of choice of providers, who are overwhelmingly private, nongovernmental organizations or suppliers. Financing for long-term care services, such as nursing home care, and home and community-based services, is through a combination of Medicaid (the federal-state health programme for low-income people or people with high medical expenses), Medicare, state-funded programmes, out-of-pocket payments and private insurance.

Medicare covers skilled, relatively short-term care provided by home health agencies and nursing homes, not traditional long-term care. Private long-term care insurance has been growing steadily since

the mid-1980s, but finances < 5% of total long-term care expenditures (36). The lack of public or private insurance coverage and the means-tested character of Medicaid mean that out-of-pocket payments account for a large portion of long-term care expenditures.

The role of voluntary not-for-profit organizations in home health care: United Kingdom Homecare Association (37)

Home care has grown rapidly in the United Kingdom (UK) since the early 1990s. The United Kingdom Homecare Association (UKHCA) is the professional association of over 2000 home care providers from the independent, voluntary, not-for-profit and constitutional sectors in Great Britain and Northern Ireland.

UKHCA was formed in 1989 to represent the views of independent sector providers of home health care and to respond to needs arising from changes in health and social care legislation. UKHCA's mission is to promote high quality, sustainable care services in the home setting so that people can continue to live at home and in their local community.

UKHCA has grown and now represents 33% of independent and voluntary sector providers for home health care across the UK, who employ over 119 000 home care workers, delivering over 2.79 million hours of care per week to around 166 000 service users, valued at UK£ 1.62 billion per annum.

The Association takes an active role in liaison with local and central government on all domiciliary care and related issues. It represents its member organizations in the rapidly changing social care sector through contact with:

- national government and the devolved administrations
- local government
- legal regulators
- social care commissioners
- voluntary and campaigning organizations
- the media
- the general public.

UKHCA helps organizations that provide social care, which may include nursing services, to people in their own homes, promoting high standards of care and providing representation with national and regional policy-makers and regulators. UKHCA produces information on good practice as a focal point for innovation and quality within the home health care industry. It fosters the exchange of information and ideas between members, monitors developments in the UK and internationally which may be of interest to members and networks with other organizations and individuals having similar objectives where

Home health care can positively affect the hospitalization and institutionalization of the elderly.

cooperation will benefit members and recipients of home care. Their activities include research, business support, training, and communication and campaigning on behalf of members in the UK on issues affecting home care providers, service users and others in the community.

In July 2011, UKHCA launched "Raising the standard for care", a strategy statement defining their strategy for 2011 to 2016. This five-year strategy is designed to deliver support to the Association's

members to enable them to adapt successfully to the challenges of the next two decades, so that people can continue to receive high quality, sustainable services of choice in their home and community. The strategy will provide leadership and support for members, so that they in turn can provide excellent care services that can satisfy the patients and clients.

What do countries need to do to start providing home health care for the elderly?

To start home health care service provision, countries need to:

- make an assessment and map existing capacities and the need for home care services based on demographic and epidemiological data
- develop a list of the specific services needed based on local circumstances and disease prevalence (noncommunicable diseases and geriatric care)
- assess the knowledge and skills of the health workforce in primary health care facilities who can participate in the delivery of home health care
- facilitate engagement of the private sector for delivery of home health care in a regulated manner
- train the health workforce using WHO training manuals and assign them to map the elderly and people with chronic diseases in need of home health care within the catchment area of each health care facility
- monitor home care services, reassess them periodically and make needed adjustments
- assess the financial requirements related to home health care services, and decide whether they should be included as part of health insurance, free of charge as part of primary health care services, as an affordable out-of-pocket health expenditure or as a mixture of these financing methodologies
- undertake a pilot study to find the most effective and efficient model for integration of care of the elderly and chronic patients into primary health care.

How can WHO support countries to develop home health care for the elderly as an integral part of primary health care?

WHO can support countries to develop home health care for the elderly as an integral part of service provision by:

- identifying modalities and elements of integration of services for the elderly into primary health care and defining outreach home health care teams/nurses, probably from primary health care facilities or private care providers, as an integral part of service provision
- urging countries to incorporate home health care as one of the strategies for service provision with priority given to care of the elderly and people with chronic diseases
- defining the composition and responsibilities of service providers in primary health care facilities and volunteers at the community level who are trained and able to provide home health care for the elderly and people with chronic disorders and educating families on their role as carers
- developing guidelines and training materials for home health care covering health promotion and prevention, early detection and diagnosis, and providing basic services and referral where needed

- supporting in capacity-building activities for health professionals on providing quality home health care to the elderly and people with chronic diseases
- supporting in the integration of training materials into nursing and other health professionals curricula
- facilitating short-term training in advanced centres through the WHO fellowship programme to help health professionals become focal points for developing care of the elderly in countries
- recognizing the relief and rehabilitation needs of older people and those suffering from chronic diseases during conflicts and emergency situations
- contributing to recovery efforts during transitional care after hospitalization and to linkages of primary health care facilities with hospitals
- providing technical support in evidence-building and research methodology for updating the database on the elderly population and mapping people with chronic disabilities
- establishing regional and international networks among agencies, organizations and academic institutions concerned with the health of the elderly and home health care
- preparing relevant indicators for monitoring and evaluation of the programme.

Conclusion

Population ageing and the prevalence of noncommunicable diseases are increasing in the Eastern Mediterranean Region. Home health care is an accepted strategy worldwide for a cost-effective approach that leads to patient satisfaction, a lesser burden on hospital bed occupancy rates and lower hospital infection rates.

In response to the ageing of populations and the resulting shift to high prevalence rates for noncommunicable diseases, there is a need to shift the scope of health care delivery to the elderly and patients with chronic diseases from hospital-based care to an accessible and convenient strategy for patients and their families.

Home health care services need to be planned at the national level and coordinated as packages of care that are tailored and delivered to patients in their own homes. The planning of home health care service delivery should focus on identifying the services needed, the type of health care professionals who will provide the services, the basic and ongoing training required for home health care service provision, the required medical supplies and equipment, the expected results and impacts, and the level of community involvement.

Home health care should be accepted as an integral component of the primary health care service package, in coordination with private care providers. It should be affordable by the community and provide acceptable quality of care. Among the major issues that need to be considered by national authorities are community culture, the safety of care providers in the home, the continuity of care and the linkages of home health care with existing health services to ensure functional referral channels. The overall objective of this additional strategy for service provision is to ensure the highest attainable standard of health and well-being for the growing numbers of older citizens and patients with chronic diseases in the Region.

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Annex 1. Percentage of the population aged > 60 years in countries of the Eastern Mediterranean Region (2000–2050)

Country	2000	2009	2025	2050
Group 1. High income countries				
Bahrain	4.7	4.0	20.4	24.0
Kuwait	4.4	4.0	15.7	25.0
Oman	4.2	5.0	6.6	21.0
Qatar	3.1	2.0	21.8	20.0
Saudi Arabia	4.8	4.0	7.9	19.0
United Arab Emirates	5.1	2.0	23.6	18.0
Group 2. Middle income countries				
Egypt	6.3	7	11.5	19.0
Iran (Islamic Republic of)	5.2	7.0	10.5	28.0
Iraq	4.6	5.0	7.5	13.0
Jordan	4.5	6.0	7.0	19.0
Lebanon	8.5	10.0	13.5	26.0
Libya	5.5	7.0	9.9	23.0
Morocco	6.4	8.0	11.2	23.0
Occupied Palestinian territory	4.9	4.0	5.6	11.0
Syrian Arab Republic	4.7	5.0	7.7	19.0
Tunisia	8.4	10.0	13.4	28.0
Group 3. Low income countries				
Afghanistan	4.7	6.0	5.2	6.0
Djibouti	5.5	5	6.2	5.8
Pakistan	5.8	6.0	7.3	15.0
Somalia	3.9	4.0	4.0	7.0
Sudan	5.5	6.0	7.9	13.0
South Sudan	N/A	N/A	N/A	N/A
Yemen	3.6	4.0	3.6	10.0
Regional average	5.3	5.8	8.7	15.0

Source (crude): Population Division, Department of Economic and Social Affairs, World Population Aging, New York. United Nations, 2010 revision

Annex 2. Life expectancy at birth (years) in countries of the Eastern Mediterranean Region

Country	Life expectancy at birth (years)		
	Males	Females	Total
Group 1. High income countries			
Bahrain	75.0	78.3	76.4
Kuwait	77.5	78.6	77.7
Oman	70.0	75.7	72.7
Qatar	78.0	78.7	78.2
Saudi Arabia	72.7	75.1	73.8
United Arab Emirates	75.1	80.2	77.4
Group 2. Middle income countries			
Egypt	70.9	75.5	73.2
Iran (Islamic Republic of)	71.1	73.1	72.1
Iraq	70.9	74.6	72.7
Jordan	71.6	74.4	73
Lebanon	79.6	83.2	81.5
Libya	70.2	74.9	72.3
Morocco	73.9	75.6	74.8
Occupied Palestinian territory	71.0	73.9	72.5
Syrian Arab Republic	71.6	74.7	73.1
Tunisia	72.7	76.6	74.7
Group 3. Low income countries			
Afghanistan	64.0	62.0	NA
Djibouti	51.8	54.1	52.9
Pakistan	64.2	67.9	66.0
Somalia	NA	NA	50.0
South Sudan	NA	NA	42.0
Sudan	NA	NA	59.8
Yemen	61.1	62.9	62.0

Source: Demographic, social and health indicators for countries of the Eastern Mediterranean (2012)

Population ageing is a global phenomenon, with more people than ever at risk of developing the chronic diseases, ill-health and dependence that often accompany advanced old age. The global shift in the burden of illness from acute life-threatening infectious diseases to chronic disabling noncommunicable diseases is leading to a rise in temporary or permanent functional disabilities and diminished quality of life, especially in the elderly. This is becoming a major challenge for health care delivery systems due to the increased costs of health care and long-term care, giving rise to the need to find alternative care strategies to meet the specific demands of the elderly and their families.

The WHO Regional Office for the Eastern Mediterranean has produced this report to examine the need for home health care for the elderly to become an integral part of primary health care services in the Region. The home health care approach has been proven to be cost-effective in providing health services for the elderly in their homes. The report reviews the requirements for providing home health care services in terms of the kind of services required, who can provide the services and eligibility for receiving the services, as well as the benefits and cost-effectiveness of home health care, patient satisfaction, quality assurance and patient safety in providing the services in home settings, establishing an effective referral system and experiences from other Regions. The report provides evidence-based advocacy material for integrating home health care in health care delivery in the Eastern Mediterranean Region and encouraging countries to develop national strategies for promoting home health care.