POLICY BRIEF - PRE-PUBLICATION VERSION

TITLE Achieving sustainable and appropriately trained health and social care workers for ageing populations

AUTHORS Salsberg E, Quigley L.

AFFILIATION a George Washington University

This pre-publication version was submitted to inform the deliberations of the High-Level Commission on Health Employment and Economic Growth (the Commission). The manuscript has been peer-reviewed and is in process of being edited. It will be published as part a compendium of background papers that informed the Commission. The manuscript is likely to change and readers should consult the published version for accuracy and citation.

© World Health Organization 2016. All rights reserved.

The designations employed and the presentation of the material in this manuscript do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this manuscript. However, the material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

The manuscript does not necessarily represent the decisions or policies of the World Health Organization.
Achieving sustainable and appropriately trained health and social care workers for ageing populations

Edward Salsberg and Leo Quigley
George Washington University
Health Workforce Institute and
School of Nursing
KEY MESSAGES

- Chronic illnesses increase with age while intrinsic capability decreases. Globally, the population age 60 and over is projected to grow from 901 million, 11% of the world’s population in 2015, to 2.1 billion, 22% of the world’s population, by 2050. Such rapid growth of this high need population will drive a need for services.

- The goal of healthy ageing includes maximizing quality of life as people live longer. Achieving this will depend on social services and supports in addition to clinical interventions. Better integration of health and social services is required to improve outcomes and increase efficiency.

- Most countries already face health worker shortages; in low income and middle income countries, these are severe. Universal coverage will increase demand and exacerbate existing shortages if supply does not increase.

- More workers will be needed, but resources are limited. Funds for training, employing and deploying human resources for health (HRH) must be allocated effectively and efficiently.

- A three pronged workforce strategy to ensure an adequate supply and distribution of health and social workforce to meet the needs of an ageing population is recommended:
  - Support countries to assess the quantitative and qualitative gaps between services currently available and those needed in the next 5-10-15 years, and to design workforce strategies to meet the needs of an ageing population
  - Ensure an adequate supply and distribution of HR to meet the needs of older people and ensure that HR have skills and competencies to provide high quality, effective care to older people; support a cadre of health workers with expertise in geriatrics.
  - Organize and deploy the workforce to make effective and efficient use of health and social service workers. This includes: expanding the scope of practice of many existing professionals; deploying more workers with specific roles such as care coordinators to engage with needed health and social support services; and expanded use of care teams as part of an enhanced primary care infrastructure.
INTRODUCTION AND METHODS

As the World Health Organization (WHO) noted in its 2015 report on ageing and health\(^1\), both the proportion and absolute number of older people around the world are increasing dramatically and will continue to do so for many years to come, leading to increased need for health services adapted to the needs of older people. There is a strong rationale for believing that responding to this increased need requires more than simply increasing the capacity of the existing health systems. Health systems around the world are largely designed around disease-driven, episodic care using a biomedical approach that emphasizes finding a medical problem and fixing it\(^2\). However, the health needs of ageing populations are interlinked with their social needs. Furthermore, these needs are typically complex and long-term, span a range of areas of functioning, wax and wane over time, and require a goal of maintenance of functional ability rather than cure of disease. In addition, older people face many barriers that limit their access to health services, particularly in low and middle income countries and among disadvantaged people in higher-income countries\(^3\). The complex organizational and professional structures and skills required to address these concerns suggests the need to rethink health system design.

A key component in system redesign is the workforce. The health workforce is typically trained to identify and treat symptoms and conditions using an episodic approach to care, deployed in a compartmentalized fashion according to clinical role or disease specialty\(^4\), and tied to clinical settings in ways that limit their ability to address important social determinants of health. In part as a consequence of the limits of current curricula, many members of the health workforce have not achieved competency in geriatric health care or in critical non-clinical processes such as shared decision-making, team-based care, information technology, and quality improvement\(^5\).

Achieving our workforce goals for ageing and health requires a strategy that includes five interconnected steps: assessment of existing workforce needs and gaps; developing the right numbers of workers; giving them the right knowledge and skills; deploying them in the right organizations and geographical locations; and using them in the right roles to deliver care that meets the needs of a growing older population in a cost-effective manner. There is not a single blueprint: how these strategies are implemented will vary from country to country depending on factors like national wealth, the structure and financing of health systems, geography, cultural specificities and social structures.

This policy brief on workforce strategies for ageing and health synthesizes material from peer-reviewed research and WHO reports in three areas: demand and need projections; workforce issues relating to supply, utilization and organization; and tested or proposed policy solutions. The brief draws on prior work of the WHO including:

\(^1\) World Health Organization. World report on ageing and health. 2015
\(^2\) Ibid p. 93
\(^3\) Ibid p. 89
\(^4\) Ibid p. 94
• The World Report on Ageing and Health\(^1\);
• Global strategy on human resources for health: Workforce 2030\(^6\);
• WHO Framework on integrated people centred health services\(^7\);
• Multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health\(^8\);
• Progress Report on Health Workforce Education, 2013-15\(^9\);
• Scaling up, Saving Lives: WHO/GHWA Task Force on Scaling Up Education and Training for Health Workers\(^10\)
• Primary Health: Now More than Ever\(^11\)
• Health Systems Financing: The Path to Universal Coverage\(^12\)

In addition, the following reports were also important sources of data:

• Reshaping the workforce to deliver the care patients need by the Nuffield Trust\(^13\)
• World Bank reports on universal health coverage (UHC)\(^14\).
• An Aging World: 2015 by the US Census Bureau\(^15\)

FINDINGS

1. Implications of the demographic transition for health workforce requirements

a) The Demographic Transition

The U.S. Census Bureau in its report An Aging World 2015 notes that: “The demographic transition is shifting population epidemiology from primarily acute infectious disease to primarily chronic infectious and non-infectious disease. This alone would suggest a need to reorient health systems to ensure services meet population needs, where health and social services are integrated, with continuity of care across different services. Ageing populations will have different health care needs, with more people

\(^7\) World Health Organization. WHO Framework on integrated people centred health services. 2016
affected by dementia, stroke, cancer, fractured hips, osteoporosis, Parkinson’s disease, lower back pain, sleep problems, and urinary incontinence, for example.”

Two trends are driving the ‘demographic transition’: longer life-spans, and falling fertility rates. First, the population over the age of 60 is growing rapidly across the globe. As of 2015, life expectancy exceeded age 80 in 24 countries.

In 2015, there are 106 countries where less than 10% of the population was 60 and over, mostly in Africa and parts of Asia, Latin America and the Caribbean; by 2050 only 41 countries will have less than 10% of their population aged 60 and over. Further, while only 1 country had more than 30% of its population over 60 in 2015, this will grow to 57 countries in 2050. (Figure 1)

16 Ibid, page 67
17 Ibid, page 3
18 Ibid
The second trend is a decrease in overall fertility rates, with the result that the percent of the population under age 5 has been steadily decreasing while the percent that is older has been increasing. A net result of the two trends is that the representation of children under 5 and the population over 65 as a percent of the world’s population will nearly reverse between 1950 and 2050 as indicated in Figure 2. This means that while the need for care of an ageing population is increasing, the younger population entering the future workforce to supply this care is diminishing.
b) Health Needs of an Ageing Population

Older people not only have higher medical care needs than younger populations, they experience decreasing intrinsic capacity and decreasing functional ability that increases the need for support and social services to enable people to live meaningful lives and have a good quality of life. All countries face a substantial challenge in reorienting their healthcare services from treating pervasive yet relatively inexpensive to treat short term conditions to the far more costly treatment of chronic diseases like cardiovascular disease and diabetes\(^\text{19}\).

Both clinical and social support needs of older people are driven not only by the increasing prevalence of disease but also by chronic conditions that can include hypertension, dementia, disabilities, frailty, and loss of sensory capability, often in combination. This creates very complex health needs. Not surprisingly, loss of functional ability and independence in older people impacts both physical and mental health and, as they age, older people need help with the activities of daily living.

Many of the chronic conditions of old age can be prevented or delayed by healthy behaviours. Indeed, even in very advanced years, physical activity and good nutrition can have powerful benefits on health.

and well-being. Other health problems and declines in capacity can be effectively managed, particularly if detected early enough. And even for people with declines in capacity, supportive environments can ensure that they can live lives of dignity and continued personal growth. Yet the world is very far from this ideal, particularly for poor older people and those from disadvantaged social groups. Comprehensive public health action is urgently needed\(^2^0\).

Even if countries are successful in improving care and the quality of life of older people, the reality is that the increasing number of older people also means there will be more people reaching the end of life. Improvements in end of life care are needed.

c) Workforce Implications

The implications for the workforce are enormous, especially if the goal is healthy ageing with empowered and engaged seniors. More specifically there is a need for:

- More clinical providers with relevant skills and qualifications and in the right locations providing the needed range of service (promotion, prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care). A pre-condition in low income and middle income countries is increasing the general supply of health providers;

- More social service providers/assistants and individuals to provide support services such as assistance with the activities of daily living and transportation;

- Greater coordination to support patient-focused care and people-centred, integrated health services. This includes health workers functioning as care coordinators, case managers etc. in chronic disease management and in primary care to fill the gaps and attend to non-clinical needs; and

- Health and social service practitioners knowledgeable and skilled around care for individuals with terminal illness and those nearing death.

High-income countries may differ from low- and middle-income countries in readiness or resources available to provide health care for an ageing population\(^2^1\), albeit there are a number of European countries where geriatrics is not recognized as a medical or nursing specialty and other professionals such as dentists, pharmacists or nutritionists need to develop competencies adapted to older persons' needs.

In general, all countries would benefit from:

\(^{20}\) WHO, A69/17: Multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health; report to the secretariat. April 22, 2016

• An increased supply of non-physician clinicians such as advanced practice nurses and physician assistants, particularly in ambulatory settings;
• Greater coordination among health workers and between health and social service sectors;
• Implementation of multi-disciplinary care teams with appropriate skill mix;
• Increased attention to workforce mal-distribution; and
• Attention to health and social financing streams.

Lower and middle income countries in particular need to focus on occupations with education pathways of up to 3 years and on scaling up technical and vocational training while taking into consideration rural training to reach the underserved. This includes physician assistants, registered nurses and community health workers.

2. Evidence of health systems and health workforce reforms responding to the needs of an ageing population

While much needs to be done to reform health systems and the health workforce to meet the needs of the world’s growing ageing population, there are some examples to help inform planning and policies. These examples cover funding reforms, community-level reforms, service integration reforms and wider workforce reforms and include both progress and lessons learned. There are also examples of good practice from sources including experienced service provider leadership.22

A review of the reforms reveals a number of common features for many of the reforms. This includes:

• Integration or extensive coordination of services;
• Use of multi-disciplinary teams;
• Implementation at the local, community level, sometimes with central or regional support or guidance;
• Encouragement of care in the home and community based services, over care in hospitals and long term care facilities; and
• Support for individual involvement and empowerment in regards to their care and lives.

The reforms also reveal the benefits of having a steady source of funds to support the services to older people.

Box 1: Health System and Health Workforce Reform Examples

• Asia: Older people’s associations represent an innovative approach to taking community-based action, empowering people in later life by using their skills, capacities, and willingness to actively engage with and serve their communities. For example, China recently issued a policy promoting the improvement and expansion of their 490,000 associations to align them better

22 See Appendix for a description of the literature search process used in locating these examples.
with their development goals. Older people’s associations are multifunctional and conduct a wide range of activities including: improving incomes through microcredit and income-generating activities; providing health and care for older people, including through community-care programmes aimed at care-dependent older people; providing social and cultural activities as well as disaster preparedness; and enabling social participation. Associations in Viet Nam have demonstrated financial sustainability through their capacity to fundraise.

- **Denmark:** The success of Denmark's community-based experimentation with new models of home care and housing for older people, initiated in the early 1980s, resulted in a national decision to eliminate new construction of nursing homes and increase access to publicly funded home care. Lingering concern that the provision of paid assistance for older people could undermine family structure was allayed by the findings of a survey showing that three-fourths of older people reported seeing their children on a weekly or more frequent basis. Findings from the Danish experience provide evidence that community-based services can aid family caregivers, enable the frail person to live in the setting of their choice, and be cost-effective from a public policy perspective. However, another study found that home care reforms have struggled to reconcile the conflicting principles of standardization and the individualization of care provision.

- **Hong Kong:** Since 2008, the Hong Kong Government has taken forward various payment initiatives to promote primary care and encourage more use of private service. Nevertheless, a study found that the willingness of older people in Hong Kong to pay for specific primary care and preventive services in the private sector fell below the current market prices, and was associated with concerns over affordability and uncertainty (of price and quality) in the private sector. These results suggest that most older people, who are heavy users of public health services but with limited income, may not use more private services without seeing significant reduction in price. A separate study of the introduction of vouchers in Hong Kong to encourage older patients to use primary healthcare services in the private sector found that the voucher alone was not enough to realize the government’s policy of greater use of the private primary care services.

- **Japan:** In 2000, in response to escalating demand, Japan introduced an insurance system for long-term care to reduce the burden on family caregivers and integrate health care and welfare

---

23 Ibid, box 5.4
27 Yam, Carrie HK, Su Liu, Olivia Hy Huang, Ek Yeoh, and Sian M. Griffiths. 2011. Can vouchers make a difference to the use of private primary care services by older people? experience from the healthcare reform programme in Hong Kong. *BMC Health Services Research* 11 (1): 255-.
services into a comprehensive plan. The system provides community-based and residential care services as well as choice of services and providers. While the number of community support centers rose to 3,976 in 2011, reforms were instituted in 2012 to improve coordination of services between the health and social services and increased oversight of for-profit providers.28

- **Netherlands**: Long term care reforms give local authorities a predominant role in providing community-based long-term care. Outpatient personal and nursing care have been transferred to the health insurance system where only the most intensive forms of residential long-term care are covered. Meanwhile, social support, including certain home-care services and respite care, has been devolved to municipalities who must ensure that people can live in their own homes for as long as possible and receive the assistance that they need to do so.29 30

- **Pakistan**: Pakistan established its first day centre for people at all stages of dementia with technical collaboration from Alzheimer’s Australia in Western Australia. Care workers provide education, support groups, and counselling for families as well as a broad package of services including door-to-door transportation to and from the centre, activities such as painting, cooking, gardening, reading the newspaper, daily exercise, and help with personal care.31

- **Sweden**: The Swedish government implemented the Adel reform in the care of older citizens in 1992 so that the communities where older people live became responsible for their care and housing. An important component in the reform was an expanded need for community nurses to refer patients for emergency treatment. Nurses were appointed to make sure that older people were given accurate care and to act as supervisors for nurses’ aides.32

- **United States**: ‘Programs of All-Inclusive Care for the Elderly’ (PACE) serve individuals who are age 55 or older, certified by their state to need nursing home care, able to live safely in the community at the time of enrolment and live in a PACE service area. PACE programmes deliver all needed medical and supportive services, providing the entire continuum of care and services to seniors with chronic care needs while maintaining their independence at home for as long as possible. The programmes provide care and services in the home, the community, and at PACE centers. There are now 116 programmes in the US serving several thousand enrollees. Comprehensiveness and coordination are key aspects of the programme. Costs of care are

---


29 World Health Organization. World report on ageing and health. 2015. Box 5.10


31 Ibid, box 5.7

covered by Medicare and Medicaid. There is some evidence that the model reduces hospital use and reduces mortality though it is still unclear whether it reduces overall expenses\textsuperscript{33}.

- **United States**: Although the acute hospital is the standard venue for treating acute serious illness, it is often a difficult environment for older adults, who are highly susceptible to functional decline and other iatrogenic consequences of hospital care. Hospital care is also expensive. Providing acute hospital-level care at home, in lieu of usual institutional care, is viable. As an emerging service model, the definition of hospital at home (HaH) remains unsettled. Data favor HaH models that provide substantial physician inputs and are geared toward substituting for hospital care, provide service that is highly satisfying to patients and their caregivers, are associated with less iatrogenic complications and are less expensive. Dissemination of HaH in integrated delivery systems is feasible. Widespread dissemination of HaH in the United States will require payment reform that acknowledges the role of HaH in the health care system\textsuperscript{34}.

- **United States**: The US and other countries with poorly developed primary care systems, have promoted the ‘medical home’ as a core method for improving the delivery of care. In the medical home model patient care is coordinated by a primary care team through personalized care plans and medication review supported by coaching, advice and encouragement\textsuperscript{35}. This model is particularly pertinent to the chronic but preventable conditions which disproportionately affect older people. Nevertheless, a review of medical home implementation for older adult patients in primary care found that external stakeholders are less apt to recognize, encourage, or incentivize elements of medical home transformation that derive from the existing practice social structure and everyday interactions between staff and patients. These results suggest that there may be no standardized, one-size-fits-all approach to making medical home implementation work, particularly for special patient populations such as older people\textsuperscript{36}.

- **United States**: Home and community-based services: A significant rebalancing of the long-term care system away from nursing homes toward home- and community-based services (HCBS) has occurred over the past two decades. In the Commonwealth Fund Long-Term Care Opinion Leader Survey on issues related to supporting HCBS, respondents expressed strong enthusiasm for rebalancing of the long-term care system toward HCBS. In particular, respondents supported system-based approaches for this expansion, with the majority indicating that greater care

\textsuperscript{33} http://www.npaonline.org/pace-you  
https://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html  
https://aspe.hhs.gov/execsum/evaluating-pace-review-literature-executive-summary  
\textsuperscript{34} Cheng, Jennifer, Michael Montalto, and Bruce Leff. 2009. Hospital at home. *Clinics in Geriatric Medicine* 25 (1): 79-91  
\textsuperscript{35} Patient Centered Primary Care Collaborative, Defining the Medical Home, available from https://www.pcpcc.org/about/medical-home, downloaded 24 May 2016  
coordination was the single most preferred approach for rebalancing the system, helping consumers make informed long-term care choices and supporting caregivers.

- **Zambia**: In 2010, the Ministry of Health in Zambia developed the National Community Health Assistant strategy, aiming to integrate community health workers (CHWs) into national health plans in order to address the human resources for health shortage and the challenges facing the community-based health workforce in Zambia.

### 3. Evidence of health workforce education and training reforms responding to the need for people-centred services for ageing populations

While some progress has been made over the past several decades to develop curriculum appropriate to assure that future health workers have the competencies and skills needed to provide people-centred care to older people, far more needs to be done. Major challenges include the large number of occupations involved in providing services to older people, the very limited cooperation across occupations regarding curriculum, and the large number of existing workers who do not have the necessary competencies and skills. In addition to the consequent need to modify existing curriculum to have greater content related to older people needs that all countries face, many low and middle income countries also face the urgent need to significantly increase the number of health workers being educated and trained.

In 2008, the American Geriatrics Society brought together 21 organizations to form the Partnership for Health in Aging with the aim of ensuring that competencies in different professional curricula are aligned. A workgroup from ten disciplines developed a set of multidisciplinary competencies in the care of older adults that can be used to supplement existing professional competencies at entry level in all the disciplines (Box 2).

---


There are also examples of educational reforms designed to either scale up or to better serve high need populations that are models to be considered to better educate health workers on the needs of older people (Box 3). Education must address the needs both of specialists in care of older people and of

---

generalists who are needed to implement service reforms – like community-based care - that respond to the rise in the number of older people.

Box 3: Examples of Educational Reform

- **Brazil**: The PRO-SAUEDE programme provides training institutions with financial support, through a competitive bidding process, for projects aimed at reorienting the health system to meet the needs of communities. In 2007, 90 medical, nursing and dental schools received funding for curricular changes that promoted interaction between the professions, primary care and action learning. As a result of this training, the programme aims to expand to 40,000 the number of community based family health teams providing primary care.\(^{40}\)

- **United Kingdom**: General practice in the UK is experiencing difficulty with medical staff recruitment and retention. A cultural change amongst medical educationalists is needed to promote general practice as a career choice that is equally attractive as hospital practice. The introduction of Pre-Registration House Officer (PRHO) placements in general practice and improved flexibility of GP vocational training schemes, together with plans to improve the quality of Senior House Officer (SHO) training in the future should address some concerns about poor quality GP training raised by survey respondents. The reluctance of newly qualified GPs to enter principalships, and the increasing demand from experienced GPs for less-than-full-time work indicates a need for a greater variety of contractual arrangements to reflect doctors' desires for more flexible patterns of working in general practice.\(^{41}\)

- **United Kingdom**: Recently NHS England decided to create a new cadre of "nursing associates" to enable nurses to concentrate on more complex tasks\(^{42}\). The United Kingdom is also experimenting with nurse-led practices:\(^{43}\)

- **South Africa**: Walter Sisulu University’s Faculty of Health Sciences was created in 1990 with the specific goal of producing health professionals for underserved areas. The Barrio Adentro ‘micro-school’ project in Venezuela carries out all education and training in supervised community settings, responding directly to patients’ needs. The University of the Philippines collaborates extensively with government health services in decentralized clinical settings, to help students better understand and improve local health systems."\(^{44}\)

---


\(^{43}\) E.g. http://cuckoolanesurgery.co.uk/

4. Strengthening collaboration between the health and social sector actors in service provision

Many older people, especially as their intrinsic capability declines and/or in the face of multiple chronic illnesses, need both clinical care and social service support if they are to be able to live a meaningful and fulfilling life. Formal integration of health and social sector services presents many challenges given the need to replace traditional hierarchical coordination with more or less voluntary cooperation or collaboration between organizations\textsuperscript{45}, rendering this high-level approach problematic, time consuming, and costly\textsuperscript{46}. Furthermore, the evidence suggests that most financial and organizational system-level reforms have had either inconclusive or negative effects\textsuperscript{47}.

As an alternative to large scale organizational restructuring, an emerging tactic for improving collaboration between health and social sector services is the introduction of the new workforce role of care coordinator or case manager\textsuperscript{48}. The core competencies for the role typically include advocacy, teamwork, cross-setting communication, and patient education and support, but the professional background of care coordinators can vary: at least some of the care coordination function can be carried out by entry-level workers like community health workers if they operate in a supportive and systematic service delivery system\textsuperscript{49}. Care coordination programmes require careful design but they are most likely to be successful when tailored to meet the needs of particular populations, such as older people\textsuperscript{50}.

DISCUSSION

Challenges

There are 3 major challenges to ensuring an effective workforce to achieve the healthy ageing goals of maximizing quality of life in old age and giving older people a say in how that is achieved through action to combat ageism in policy-making and service delivery.

\textsuperscript{45} Axelsson R, Axelsson SB. Integration and collaboration in public health—a conceptual framework. The International Journal of Health Planning and Management. 2006 21, (1): 75-88
1. **Organization of work.** The first component is the deployment of the workforce needed to support healthy ageing. The lack of effective links between professionals and sectors - despite the fact all may be essential for healthy ageing for many seniors - includes major gaps between health professions within the health sector and gaps between the health and social services workforce. These gaps have led to an increased need for care coordination. However, the reality is that, given the complexity of illnesses of older people and the number of clinical and non-clinical services needed, care coordination can be extremely challenging involving use of IT, multiple referrals, self-care by the patient and a role for volunteers and relatives. Box 4, for example, shows some of the workers typically involved in the care of an Alzheimer’s patient.

Another component of the organization of work concerns unnecessary limitations in most countries on the permissible scope of practice of many health professions, preventing them from working to the full extent of their education, training and capacity. Examples include allowing pharmacists to address drug interactions in polypharmacy; allowing nurse practitioners, physician assistants, community health workers and home health aides to use their training and expertise to the full. Unnecessary scope of practice limitations not only weaken the effectiveness of the workforce, they are also costly. However, there may be resistance from professional associations to expand the scope of existing occupation as well as to recognizing new types of workers, but much may be achieved simply by maximising the extent to which each professional operates at the top of their licence to practise\(^\text{51}\). There may also be legal and regulatory issues that need to be addressed.

Another key component to the organization of work is the development of people-centred and integrated health services. The WHO has documented the evidence showing the benefits of this approach to care\(^\text{52}\). It is within this framework that a wide variety of health and social service providers can be effectively employed and work to the full extent of their education and capabilities.

---


\(^{52}\) WHO: *People-centred and integrated health services, an overview of the evidence- Interim Report; 2015*
2. Another major challenge is the **lack of adequate preparation of health workers on the clinical and social service needs of older people**. This includes inadequate curriculum related to ageing in the training of physicians, nurses, and other health workers. Most countries have few experts in geriatrics, which hinders both care and education of other health professionals.

3. A third major challenge is a **basic shortage of practitioners to care for older people**. The workforce for care for older people is large but with substantial variation between countries, some, but not all of which, is explained by differences in job categorization and in the prevalence of part time arrangements. For example, the number of formal long term care workers per 1000 population over 65 years old ranges between 16 in France and 213 in the Netherlands. Care for older people is often regarded as a low-status, low-wage and physically and mentally challenging occupational sector which may contribute to shortages. Home health aides in the United States, for example, earned 51% of the average wage in 2007. Working

---

53 WHO Global Strategy on People-Centred and Integrated Health Services, adapted from National Voices 2013
54 Rie Fujisawa and Francesca Colombo The Long Term Care Workforce: Overview and Strategies to Adapt Supply to a Growing Demand OECD 2009 p. 23ff
55 Ibid p. 21 & 22
hours are often long and irregular, with Canadian LTC workers sometimes require to be on site for 12 to 14 hours to accumulate 6 to 8 hours of paid and career progression is largely absent in most countries. Even in upper income countries that have an adequate total supply, practitioner distribution is often not well aligned with high need populations, including older people. Geriatric care-management programmes aiming at improving the skills of personal care aides are found to have strong influence on retention and job satisfaction.

POLICY OPTIONS

“Healthy Ageing is the process of developing and maintaining the functional ability that enables well-being in older age.” Health and social care workers work in health systems and structures which operate within the values and beliefs of the community at large. There are four environmental and structural changes that are needed to support the policy recommendations related to human resources for health of an ageing population. These changes will greatly magnify the impact and effectiveness of a well prepared workforce.

- **Combating ageism**: Societal attitudes -- including attitudes within the health system -- have to recognize the dignity of each individual regardless of age or physical or mental capacity if the goals of empowerment and engagement of older people are to be attained.

- **Reframing sickness care to health care**: The health care system, in collaboration with the social services sector, needs to reframe its role from care of the sick to preservation of health and the quality of life.

- **Assuring a robust primary health care (PHC) system**: The health care system and its workers will be more effective and productive if they can work in a health care system with a well-designed system for PHC.

- **Modifying health care financing systems**: The workforce needed for healthy and meaningful ageing extends across many services and also includes caregivers not usually considered as part of health care delivery and not provided for in health services funding. Health organizations and funders must recognize the contribution of social and community-based services, supports, and workers, such as social workers and community health workers, to the health and well-being of older people, along with the very real difficulties associated with coordinating those services in practice. Without expanded financing/reimbursement these needed services are not likely to be covered or provided.

---

56 Ibid p. 22
57 Ibid
58 Ibid p. 33
Workforce Recommendations to Support Healthy Ageing

1. **Organize and deploy the workforce to make effective and efficient use of health and social service workers to meet the needs of older people.**
   
   a. Assess needs and service requirements and identify existing gaps to inform policies and programs for older people.
   
   b. Promote the widespread adoption of teams with a wide range of skills and competencies to meet the needs of older people. The teams should include both health and social service workers and have the capability to reach out to the community to provide more accessible health care to older people and to take advantage of community-based non-health services that may help promote independence and autonomy.
   
   c. Extend the roles of existing health workers – role enhancement - by removing unnecessary barriers to their scope of practice.
   
   d. Expand the use of technology across the continuum of care for older people and to extend team membership to isolated, rural workers.
   
   e. Promote the development and expanded use of workers such as community health workers, care coordinators, case managers, registered nurses and others who can be part of teams, function as connectors between health and social services and promote steps to improve the quality of life of older people. There are many examples of the effective use of community health workers.60
   
   f. Promote programs and policies that empower and assist individuals to make care decisions and to care for themselves. Also encourage and provide support for volunteers.

2. **Ensure that health and social care workers have the skills and competencies needed to provide high quality and effective care to older people.**
   
   a. Ensure competencies related to healthy ageing are included in the curriculum of all health professions students. This includes - in addition to an understanding of symptoms and care of chronic and multisystem disease - competencies around communication and empowerment, inter-professional practice, cultural competence, and knowledge of measures that can slow loss of functional capacity.
   
   b. Ensure that credentialing organizations include skills and competencies related to ageing and health of older people in certification and re-certification examinations.

---

c. Educate and train all health workers to practise collaboratively in teams of health professionals and others, and increase exposure and cross fertilization during the educational process (both during entry into the field and in continuing professional education) of health and social service providers.

d. Support the education and training of a small number of specialists in geriatrics to provide clinical, educational, and policy guidance to primary care practitioners and other health workers.

e. Support the education and training of a small number of specialists in palliative care for the terminally ill and those near death.

f. Ensure affordable and accessible continuing professional education in ageing and health care for existing health workers, including training in teams.

3. **Ensure an adequate supply and distribution of appropriately skilled health and social care workers to meet the need of the older population.**

   a. Assess at the country level the supply, demand, need, and distribution of health and social care workers who serve older people.

   b. Countries should give priority to workers who can be educated and trained quickly and at a modest cost but can provide a wide range of services needed by an ageing population. This includes medical assistants, health officers, dental assistants, community health workers, nurse assistants and others. In addition, priority should also be given to non-physician clinicians and other advanced practitioners such as nurses, advanced practice registered nurses (nurse practitioners, nurse mid-wives and clinical nurse specialists), physician assistants, pharmacists and social workers.

   c. Support programmes and policies that encourage practitioners to practise in areas with shortages in their occupation. This could include scholarships or loan repayment for service, dissemination of information on areas of need, promotion of educational opportunities to those most likely to make careers in shortage areas, and reimbursement incentives for practice in under-served areas. Priority should also be given to supporting students from under-served areas, and to education programmes in those areas, as recommended by WHO in 2010\(^{61}\).

   d. As noted above, there is a need to modify reimbursement/financing policies to cover both clinical and social services to older people. Clinical staff alone cannot be expected to take responsibility for reform and redesign of health systems.

---

\(^{61}\) “Increasing access to health workers in remote and rural areas through improved retention: Global Policy Recommendations”; World Health Organization, 2010
e. Lower-income countries in particular will need to consider how to educate and train the administrators who will share responsibility with clinicians for ensuring that health care delivery meets high level goals like efficiency, equity, and effectiveness.
Appendix: Ovid Database Search Process

Search Terms

(‘older people’ OR ‘older adult$’ OR ‘elderly’ OR ‘senior$’ OR ‘later life’ OR ‘long term care’) AND
(‘workforce’ OR ‘physician$’ OR ‘doctor$’ OR ‘nurs$’ OR ‘pharmac$’ OR ‘Primary care$’ OR ‘dentist$’ OR
‘dental’ OR ‘care coordinat$’ OR ‘case manag$’ OR ‘care manag$’ OR ‘community health worker’ OR
CHW) AND
(‘federal’ OR ‘government’ OR ‘state’ OR ‘nation$’) AND
‘reform’

Filters

English language
2006 or later

Databases Searched

Ovid: Global Health and all available Medline databases

Search Results

The search was run in May 2016 and yielded 184 results. Removal of duplicates, non-English language
articles that had not been filtered out, and articles that were clearly not relevant left 127 articles which
were reviewed and classified for subject relevance.

A full listing of the 127 articles is available on request from esalsberg@email.gwu.edu or
lquigley@email.gwu.edu