



## GUIDELINES ON HOMECARE SERVICES

### Why these guidelines?

The goal of these guidelines is to emphasize some key messages which are necessary to render homecare better and more accessible to users of diaconal social services. Eurodiaconia member organizations are committed to delivering community-based services which link care recipients to their families, friends and communities. In this context, homecare represents a promising way to provide health and social services to a large number of users who wish to retain their independence within their home settings. These guidelines stress a number of key points which should be taken into account by policy makers at both EU and Member State levels, contracting authorities, service providers and users to release the full potential of homecare and boost its quality levels. In fact, this document should be framed within the wider context of Eurodiaconia's *Principles for quality diaconal social services: a renewed commitment and call for action*<sup>1</sup>.

### What is homecare?

The concept of homecare refers primarily to care services which are provided in the homes of users. The range of services falling under this category is wide and comprises both health and social services. Health care services provided in a home setting may cover the full care continuum and touch upon the preventive, acute, rehabilitative and palliative stages of care needs. Social services, in turn, may cover personal care – i.e. personal activities of daily living (ADL) such as assistance with dressing, feeding, washing, etc.– and technical or domestic aid –i.e. in activities such as shopping, housekeeping, transportation or financial administration; also known as instrumental activities of daily living (IADL)-.

When faced with the choice between care options in institutions or at home, most older people, persons with disabilities and other care users usually prefer to stay in the more familiar environments of their own homes and local communities<sup>2</sup>. In these cases, as long as acute care and long-term institutionalization can be avoided, homecare could be pursued. In addition, there is also a perception that providing services at users' homes may also be more cost-effective than in institutions, once a comparison is made on the basis of comparable needs of residents and equivalent quality of care, and the full potential of assisted-living technologies is released<sup>3</sup>.

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<sup>1</sup> [\*Principles for quality diaconal social services: a renewed commitment and call for action\*](#).

<sup>2</sup> World Health Organization Europe (2008): *Homecare in Europe. The solid facts*, Milan. W. Boerma and N. Genet (2012): 'Introduction and background', in N. Genet et al. (eds.), *Home care across Europe. Current structure and future challenges*, European Observatory on Health Systems and Policies, p.2.

<sup>3</sup> Cost-effectiveness arguments may also stress the fact that the efficiency of homecare is further aided by the availability of informal carers, who usually take a complementary role in caring for users at the home setting. While this may be perceived as free of cost, the reality of informal care is that high costs, both monetary and non-monetary, often fall on families: loss of employment, stress-related





The international legal framework also underpins the need to promote community-based care solutions and homecare in particular. The UN Convention of the Rights of Persons with Disabilities enshrines the right of people with disabilities to *'live in the community with choices equal to others'* and requires that states give access to *'a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community and to prevent isolation or segregation from the community'* (art. 19). The revised European Social Charter, a Council of Europe treaty, also sets out that *'disabled persons have the right to independence, social integration and participation in the life of the community'* (art.15).

EU initiatives have added momentum for homecare and stressed the need to promote a shift from institutional care to community-based care, as a way to enhancing independent living<sup>4</sup>. Most importantly, this commitment has been translated into related EU funding provisions. In this way, the European Structural and Investment Funds (ESIF) regulations corresponding to the current programming period 2014-2020, promote explicitly the transition from institutional to community-based care, together with the development of social and health services and the training of support services' staff.

Eurodiaconia members are providers of social services both in the homes of users and within care establishments. Therefore, these guidelines should not be read from a prescriptive point of view which favours homecare over institutional care in all cases. Whilst homecare may respond more effectively to the preferences and demand for independent-living environments of users, quality residential care represents an equally essential part of the overall social services picture, most notably when homecare options are not feasible due to acute conditions. More importantly, residential care may equally deliver as community-based services allowing for users' full integration within their communities. Furthermore, the distinction between home and institutional care becomes blurred in cases like day care centres or group residential settings where users receive care in their own, fully equipped, apartments and retain a large share of autonomy. In light of this, it is essential to stress the quality of service, irrespective of its setting, as the relevant variable to look at.

## Why is homecare increasingly important?

The protection of persons with decreased autonomy in the EU constitutes a major challenge. Older people, persons with disabilities and all other recipients of care represent a significant population share, which is only expected to grow in the coming years. The share of people aged 65 and over alone represents today roughly one fifth of the EU population, and this figure is expected to rise dramatically over the next decades. An added reason for concern is the composition of this age group, because the number of the very old people – that is, aged 80 or more, which concentrates health and care needs, is expected to grow even faster. However, as the WHO<sup>5</sup> has recently stated, with increasing longevity, diversity of older population is increasing and age is only loosely related with care need: *'As the evidence shows, the loss of ability typically associated with ageing is only loosely related to a person's chronological age. There is no "typical" older person. The resulting diversity in the capacities and health needs of older people is not random, but rooted in events throughout the life course that can often be modified, underscoring the importance of a life-course*

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illnesses; J. Mansell et al. (2007), *Deinstitutionalisation and community living-outcomes and costs: report of a European study*, University of Kent, p. 49.

<sup>4</sup> COM(2012) 83 final, 'Taking forward the strategic implementation plan of the European Innovation Partnership on Active and Healthy Ageing'; see also the European Economic and Social Committee opinion (2015/C 332/01) on long-term care and deinstitutionalization.

<sup>5</sup> World Health Organization (2015), [World report on ageing and health](#), Luxembourg.



approach (p. vii)'. Therefore, it is important to enable people to live in their communities, and support age-friendly environments, especially housing.

While the demand for care is expected to rise with age, it is also true that significant progress has been made in delaying the onset of disability and decreased autonomy as healthy life expectancy is increasing, in spite of significant inequality among and within European countries; and with women living longer, but often under disability and chronic diseases. The rise in income levels –even accounting for the partial reversal due to the crisis impact–, together with improved lifestyles and increased health awareness are, among other factors, accountable for net gains in well-being which result in less (or less intense) demand for care at the individual level (and therefore, able to circumvent the residential setting).

- Homecare should, therefore, promote its preventive function in order to continue lifting health status among care recipients. This will further potentiate the virtuous circle through which users wellbeing and autonomy is maximized at the same time that acute –and often more costly– care needs are postponed.

The pattern of health issues, diseases and conditions has changed as well. Conditions like dementia have become more prevalent and, with it, there is now greater awareness and knowledge on how such conditions can be treated at the homes of users and delay as much as possible their admission into care establishments. In the same vein, increased recognition and treatment of mental illnesses has also resulted in an established preference of community care over institutionally-based care. Also, the numbers of people living on a daily basis with the consequences of diabetes, heart and respiratory diseases, cancer have resulted in the realization of the need to effectively manage these conditions at home with appropriate and targeted support. Therefore,

- Homecare has shown great flexibility and succeeded to give quality solutions to a growing variety of increasingly complex conditions. For this reason, homecare options should be pursued by default as a way to maximize users' well-being, boost change in social attitudes towards health conditions and stimulate innovation in service provision.

Changes in social attitudes and household structures have also favoured an increased demand for homecare services. The fragmentation of the traditional large family group into more atomized household units in predominantly urban contexts reduces the potential number of informal carers who can provide care to dependent family members in their homes. The development of homecare services is, hence, a way to meet the preference of users who otherwise would have resorted to informal carers. Conversely, such autonomy also helps families and friends, who have the possibility to develop their careers in formal labour markets.

## Service provision

Bringing care provision to the homes of users yields health, social and emotional benefits for them. However, as a relatively new setting for health and social care services, access to and knowledge of homecare options may represent a challenge for potential users.

- Homecare users, therefore, need to have more and better **information** on where and how to apply for homecare, the detailed menu of services available and the conditions under which these are offered. Because of this, it is key that measures aimed at bridging the information gap between users and homecare service providers are developed.



- In first place, **counselling services**, information points should be accessible and effective in dealing with the homecare demands of users. Also, these procedures need to be simplified as much as possible, ideally through one-stop information shops with ICT support,
- The promotion of integrated **case managers** – who assess multiple needs of a potential service user and makes a mix of services accessible<sup>6</sup>– is necessary, as well as an adequate multidisciplinary briefing of care professionals and community workers; in order to ease the link between users and service providers.
- Also the institutional acute medical care for fragile and very old people in hospitals must be coordinated with homecare and community services, and with informal family care. Therefore, the planning of the discharge, multidisciplinary collaboration and complex evaluation of the functional and health status and needs of patients before their return home must be integrated into the care system.

The domestic dimension of homecare both requires and favours a reinforced person-centric approach to service provision.

- Service providers and practitioners should, therefore, be able to look at the emotional and social side of users' lives, their skills, abilities, cultural background and faith needs, as well as support network. These aspects should be coordinated and embedded into service provision.

The overseeing of quality standards in homecare is key. On the one hand, the extreme decentralization of service provision at the home setting may be prone to quality imbalances. On the other hand, the household level raises some difficulty to monitor how service is provided at the household level.

- In this context, it is essential that public authorities safeguard users against low-quality providers of homecare and provide users and/or their families with the necessary instruments to exercise their rights.

The latter is only one aspect of the much wider role that empowered users should have in homecare services<sup>7</sup>. The person-centred approach which any social service should have is especially necessary when such services are performed in users' own homes.

- In this case, service users should make the most of their increased autonomy as recipients of services in their own homes and translate this further into a more active role and a greater control over services which should be tailor-made to their needs. Families must be included into this process.
- On the other hand, the misuse of homecare services by users and their families should also be taken into account. Care for carers, as well as their support and supervision, must be made accessible to prevent burnout risks.

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<sup>6</sup> European Social Network, *Peer review on priorities in reform of care services. Comment paper*, 2013.

<sup>7</sup> For further information on this key issue, see Eurodiaconia's *User participation and empowerment toolkit*.



## Integration of homecare services

Integration of homecare services is important to prevent overlap or gaps in service provision and, consequently, enhance its quality and efficiency. The traditional separation between health and social care services emerges because health matters are usually regulated within the framework of national health systems or statutory social insurance systems, whereas social welfare systems (usually run at regional or local levels) are usually responsible for social care issues.

- Creating a single agency responsible for a range of basic home care services, both health and social, would solve some of those problems. However, integration should also be extended to all other levels of homecare and acute health care, in order to better manage transitions to discharge, time continuity between hospital care and home-based services, and have a better understanding of home aftercare possibilities<sup>8</sup>.
- Initiatives to increase coordination between homecare services, and between home care and other types of health care, may take several forms. For instance, introducing multidisciplinary care teams; formal cooperation between providers or services, potentiation of the role of case managers, shared care plans and information systems and coordinated care pathways. The key level for measures targeting integrated care is the local one. Municipalities should receive more incentives –including financial ones–, support from central government and increased competences in order to promote the integration of social and health community services, throughout planning, provision, financing and evaluation stages.

## Homecare staff

Homecare is a labour-intensive activity which requires a diverse professional profiles to deliver the multi-faceted range of health and social services, as well as any other informal service, in the homes of users. Such wide spectrum may comprise from nurses and physicians to therapists, home care assistants, social workers, homemakers or volunteers.

However, the problem of staff shortages, common to most care areas, is accompanied in this case by the significant number of professionals working in the grey economy<sup>9</sup>. These elements represent a challenge for the availability and quality of care provided at the homes of users<sup>10</sup>.

Notwithstanding this, the positive trend of job creation in the homecare sector shows its large employment potential. This, combined with big pools of unemployed persons across the EU, creates some positive expectations on the recruitment opportunities within the sector<sup>11</sup>.

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<sup>8</sup> World Health Organization Europe (2008): *Homecare in Europe*, *Ibid*, p. 26

<sup>9</sup> The proposed [European Platform to tackle undeclared work](#), agreed in November 2015 between the European Council and the European Parliament, should constitute a framework to address this phenomenon.

<sup>10</sup> Eurodiaconia is looking with interest at this specific aspect as partner of the For Quality project, aimed at promoting quality in personal and household services across the EU, <http://forquality.eu/>

<sup>11</sup> SWD (2012) 93 final, *European Commission staff working document on an Action Plan for the EU Health Workforce*. This document, which accompanies COM (2012) 173 final, *Towards a job-rich recovery*, mentions the job potential of increased transfer of daily tasks done in the home, including child and elderly care, to service providers.



- Labour reserves should, therefore, be targeted in order to bring more employees into the homecare sector and respond adequately to the dependency crisis<sup>12</sup>.

However, such large potential has to be balanced with the equally pressing need to safeguard quality levels in the sector.

- To do so, the qualification and training of employees, both current and potential, has to be promoted and facilitated. Creating clearer career paths, encouraging vocation among young entrants in the labour market, improving working conditions and tying in more effective ways the demands of labour markets with the skills offered by education and training institutions should be envisaged, among other measures, to ensure that more and better professionals join the sector, endowed with specific skills and knowledge. This should, in turn, reduce staff turnover, contain ageing of the workforce and lift working standards in the care sector.

Recent technological change and productivity gains in the sector are shaping the skills on demand. For instance, homecare has recently witnessed an increasing deployment of assisted living technology, such as domotics (home automation), telecare and digital participation services<sup>13</sup>.

- Telecare systems –e.g. any technology designed to help people stay independent and feel safe at home when they are alone– could alleviate some of the staff needs in homecare, or delay the admission of users to long-term care institutions. Investing in telecare and assistive technologies will reap decisive benefits in terms of enhanced efficiency on service provision. It will also be key to close the gap of unmet care needs, especially in more remote geographical areas.

However, in spite of these relevant initiatives, homecare remains a hands-on activity, with a very important role reserved for **soft skills**, which are key to fulfil the person-centred focus needed by homecare services. Homecare practitioners frequently evaluate people who receive homecare, develop care plans and establish if other services are required.

- The homecare setting clearly requires more independent judgement, as well as a more intense relation with users. A good emphasis on practice rather than theory should also be pursued, along with learning on the job.

Notwithstanding this, greater harmonization of qualification levels among homecare professionals should be envisaged. Educational requirements, as well as recertification, are widespread for nurses, but less common among personal care professionals. Domestic aid professionals, instead, are rarely subject to education requirements. In light of this, staff quality monitoring devices should be explored for all types of profiles involved in homecare services.

The key role of informal carers, in combination with formal homecare or not, should not be overlooked. Therefore, homecare services should also target carers' own needs with regard to, at least:

- (a) information, allowing informed choice among informal carers; (b) prevention and treatment of carers' physical problems, mental and emotional challenges, including easy access to respite care

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<sup>12</sup> Eurofound (2013), *More and better jobs in home-care services*, Dublin.

<sup>13</sup> Eurofound, *Ibidem*, p. 31



and to professional care; (c) education and training in practical caring and skills in coping emotionally with caring, and d) harmonizing care and work, enabling family carers to maintain their qualifications, employment status, income levels and social inclusion (for instance, through carers' leave provisions, shortened working time, home office, etc.).

## Funding

In parallel to the tightening of public resources available, the funding of homecare services has witnessed the rise of alternative models in the last years. The traditional provision of homecare benefits in kind may, under certain circumstances, entail some rigidities which may distance service provision from users' needs. Functional divisions in competent bodies in charge of deciding service entitlement –again, most notably, the classical divide between health and social services– are frequently responsible for these.

On the other hand, out-of-pocket payments, vouchers, personal budgets, etc. –e.g. giving users the resources to purchase professional care themselves or pay family members to take care of them–, may correspond more closely to clients' choice, shaped by his own needs.

- Whilst user-led care may be seen as an opportunity to translate services into more person-centred products, it also gives users added responsibilities which require sufficient empowerment and, in particular, information. In this regards, the effectiveness of user-led care is conditional to having a range of services to choose from and providing them with the tools to exercise such choice. Information gaps between users and service suppliers, therefore, need to be closed.
- Adding to this, the use of direct payments means that users take on the duties of an employer. This may represent a challenge to users and their families, who may find difficulty in meeting such requirements, especially when cognitive impairments are involved<sup>14</sup>.

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<sup>14</sup> V. Garms-Homolová et al. (2012): 'Clients in focus', in N. Genet et al. (eds.), *Home care across Europe...Ibid*, p. 60.